

**DEPARTMENT OF VETERANS
AFFAIRS**

38 CFR Part 17

RIN 2900-AQ46

Veterans Community Care Program

AGENCY: Department of Veterans Affairs.

ACTION: Final rule.

SUMMARY: The Department of Veterans Affairs (VA) adopts as final a proposed rule amending its regulations that govern VA health care. This final rule implements its authority from the VA MISSION ACT of 2018 for covered veterans to receive necessary hospital care, medical services, and extended care services from non-VA entities or providers in the community.

DATES: *Effective Date:* This rule is effective on June 6, 2019.

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SUPPLEMENTARY INFORMATION: On June 6, 2018, the President signed into law the John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018 (hereafter referred to as the “MISSION Act,” Pub. L. 115-182, 132 Stat. 1395, as amended). This final rule implements section 101 of the MISSION Act, which requires VA to implement a Veterans Community Care Program to furnish required care and services to covered veterans through eligible entities and providers. Section 101, which amends 38 U.S.C. 1703 upon the effective date of these final regulations, further establishes the conditions under which VA determines if covered veterans are eligible to elect to receive such care and services through eligible entities or providers, as well as other parameters of the Veterans Community Care Program. This final rule implements in a regulatory framework the requirements in amended section 1703, consistent with the mandate in section 101(c) of the MISSION Act that VA promulgate regulations to carry out the Veterans Community Care Program. For the sake of convenience and understanding, we will refer to provisions of section 1703 as it will be amended on June 6, 2019, the effective date of this final rule. We additionally clarify that throughout this final rule, the abbreviation U.S.C. or the term

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

VA published a proposed rule regarding the criteria for determining when covered veterans may elect to receive care and services through community health care entities or providers, as well as other parameters of the program, on February 22, 2019. 84 FR 5629. In response to this proposed rule, VA received 23,557 comments. Over 18,000 comments were duplicated form responses that expressed strong support for the overall rulemaking, with some suggestions for substantive revisions to provisions from the proposed rule. We received 1,297 comments that were unique in that they were not duplicated form responses in support of or in opposition to at least one portion of the proposed rule, although VA did consider substantive issues raised in such duplicated comments. More than 700 comments expressed support for the proposed rule, in whole or in part, without substantive comment on provisions in the proposed rule. We appreciate the support of such comments, and do not address them below. Other comments expressed support or disapproval, in whole or in part, with substantive provisions in the proposed rule, and we discuss those comments and applicable revisions from the proposed rule below. We note that the discussion below is organized by the sequential order of the provisions as presented in the proposed rule, from §§ 17.4000 through 17.4040. As many of the comments we received were related to the access standards as proposed, we alert readers that the discussion on access standards can be found under the last section header § 17.4040 in this final rule, near the end of the **SUPPLEMENTARY INFORMATION** section of this published document.

We make two technical corrections to the proposed revisions to §§ 17.46 and 17.55 to clarify the sunset date of these

regulations as they apply to VA’s community care program such that these will not apply to care furnished after June 6, 2019.

§ 17.4000, Purpose and Scope

We received over 200 comments that did not relate to specific provisions of the proposed rule, but that related to the overall effect that implementation of the Veterans Community Care Program (VCCP) would have on either: (1) The care and services that VA directly furnishes, or (2) the U.S. healthcare industry at large. We discuss these comments in the context of § 17.4000(a) as proposed, because § 17.4000(a) established that §§ 17.4000 through 17.4040 would generally implement the VCCP as authorized by 38 U.S.C. 1703.

With regard to the effects on the care and services that VA directly furnishes, commenters expressed concern that implementation of the VCCP would deplete VA’s allotted budgetary resources and thereby negatively impact VA’s ability to directly furnish care and services to veterans (some comments referred to this impact as the “privatization of VA”). Commenters offered multiple reasons why implementation of VCCP would negatively affect VA’s direct provision of care, all stemming from the assumptions that more covered veterans would choose VA community care if access to such care were expanded, which would then create a decreased need to fund VA’s direct provision of care (i.e., provision of care in a VA facility). A few comments further stated that decreased funding of VA’s direct provision of care would be unavoidable unless such care was funded separately from the VCCP (presumably, separately funded by Congress specifically through the Federal appropriation process). Many of these comments further argued that, rather than potentially expand the provision of non-VA care in the community through implementation of the VCCP, VA should focus on improving its own infrastructure, hiring practices, and quality of care and services it directly provides. Some of these comments additionally provided more specific suggestions for how VA could use resources required to implement the VCCP to instead improve VA’s direct provision of care and services (e.g., VA could hire additional specific types of providers or increase pay scales for its providers generally; or VA could open additional VA facilities, expand or improve its existing facilities, or expand sharing agreements with non-VA facilities).

We do not disagree with portions of these comments requesting that VA look

to improving its direct delivery of care and services; indeed, a portion of the proposed rule that was organized under a header titled improving VA (see 84 FR 5629, 5645–5646) discussed how the MISSION Act will assist VA in doing so. We do not, however, make any changes to § 17.4000 or any other part of the rule as proposed based on these comments. Section 1703 requires VA to implement the VCCP and to establish the conditions under which VA would determine if covered veterans are eligible to elect to receive such care and services through eligible entities and providers (see sections 1703(a)(1) and (d)). Section 1703(a)(1) establishes a program to furnish hospital care, medical services, and extended care services to covered veterans through eligible entities and providers; it is VA's responsibility to implement the VCCP. Section 1703(d)(3) creates a key condition on the operation of the VCCP: that the covered veteran must elect to receive care in the community, versus through VA. This election was further identified and explained in §§ 17.4000(b), 17.4010, and 17.4020(a) as proposed. VA's obligation to implement the VCCP does not diminish VA's obligation to directly provide care and services to eligible individuals as otherwise required by title 38 U.S.C., particularly for covered veterans who are eligible for but do not elect to receive care through the VCCP or veterans who are not eligible to receive care through the VCCP. As Congress appropriates funding for VA, VA will use those resources to implement the requirements Congress has set forth. The regulatory impact analysis for this final rule and VA's budget requests identify our anticipated needs, and we will closely monitor utilization of our available resources.

With regard to the effects that implementation of the VCCP would have on the U.S. healthcare industry at large, we find such comments generally beyond the scope of the rule where they do not relate to VA's direct provision of care and services or VA's ability to maintain its other core missions. For instance, some comments asserted that covered veterans seeking non-VA care could displace non-veteran patients that rely on other Federal health care coverage (*i.e.*, Medicare or Medicaid), particularly if VA did not consider potential reductions to other Federal health care funding in developing the proposed rule. Conversely, other comments expressed concern that implementation of the VCCP could put covered veterans seeking non-VA care in the position to compete with non-

veteran patients who have private insurance, because non-VA providers simply will not have the capacity to absorb covered veterans as additional patients. We do not make changes to the rule based on these comments that relate to the potential effects that VCCP implementation may have on capacity of non-VA providers to see patients, either to a covered veteran's advantage or disadvantage when compared with other patient cohorts as asserted by the comments. However, we believe that the contracts, agreements, or other arrangements VA enters with eligible entities and providers will help to ensure provider availability for covered veterans who elect to receive care through the VCCP; we have no reason to believe that the effect, if any, on non-veteran patients would be significant. We similarly do not make changes based on comments that generally argued that expansion of eligibility for VA community care could create increased consolidation of health care markets in a manner to require VA to pay higher rates for non-VA care. We do not believe our actions in implementing the VCCP will have that significant of an effect on the health care industry. According to the National Health Expenditure Data set, the United States spent \$3.5 trillion on health care in 2017. By comparison, VA obligated \$12.9 billion for community care in FY 2017 or 17.8 percent of total VA Medical Care spending. As for other comments that specifically noted that implementation of the VCCP could have detrimental effects on the U.S. health care industry at large because VA would not be able to maintain its core missions of research and health care provider and clinician training, VA's obligation to implement the VCCP does not diminish VA's obligation to fulfill any of its core missions as otherwise required by title 38 U.S.C.

§ 17.4005, Definitions

We received more than ten comments that either suggested revisions to or clarification of some terms defined in the proposed rule, or that requested VA define additional terms. We address these comments below as they relate to the terms in the order they were presented in § 17.4005 as proposed.

One comment requested revision of the definition of the term appointment to expressly include telehealth and same-day encounters. While we believe the definition of appointment as proposed did include telehealth and same-day encounters (by using the separately defined term schedule), we agree with the suggestion to revise the definition to expressly add these terms.

The definition of appointment is therefore revised to include telehealth and same-day encounters.

A few comments requested revisions to the term covered veteran. The term covered veteran as proposed is identical to the statutory definition in section 1703(b), which is limited to veterans. We reiterate from the proposed rule that the regulations at §§ 17.4000–17.4040 do not affect other VA authorities to provide care or services for non-veterans. Therefore, VA's limited authority to furnish care or services for non-veterans is generally not affected by regulations that implement the VCCP. Other comments requested that VA add a regulatory citation to 38 CFR 17.37(c) to the definition of covered veteran, as this regulatory citation corresponds to the statutory citation 38 U.S.C. 1705(c)(2) in the definition that authorizes eligibility for certain veterans who do not have to enroll prior to receiving VA care. We agree with the commenter that providing a relevant regulatory citation for these certain veterans would make the definition more consistent, as the definition does include the regulatory citation for § 17.36 as it relates to those veterans who do have an affirmative requirement to enroll prior to receiving care. We therefore revise the definition of covered veteran to reference 38 CFR 17.37(a)–(c), which implement section 1705(c)(2) related to veterans who may receive VA care without first enrolling in VA's system of patient enrollment. We do not further revise the definition as requested to require enrollment for these certain veterans as a condition of receiving non-VA care under the VCCP, because that is not a requirement of section 1703 and believe such a revision could frustrate efforts to assist veterans transitioning from service in the Armed Forces.

One comment requested revision of the term eligible entity and provider to expressly include the standards by which VA will assess these entities and providers for adequacy, such as assessment for compliance with VA's access standards as proposed, or compliance with other Federal laws such as the Americans with Disabilities Act. We do not make changes to the definition based on this comment, as the definition itself references the relevant section related to entities and providers, § 17.4030 as proposed. We will discuss comments related to entities and providers in the section of the final rule related to § 17.4030.

In the definition of episode of care, VA's only substantive proposed change from the definition used in § 17.1505 regarding the Veterans Choice Program

was to remove the qualifying language that stated the one-year duration for the episode began from the date of the first appointment with a non-VA health care provider. We received one comment that requested we add this qualifying language back to the definition, to ensure it was clear that an episode of care included follow-up appointments and ancillary and specialty care as needed. We do not make any changes based on this comment, as the definition as proposed expressly included follow-up appointments and ancillary and specialty services.

A few comments requested revisions to the term extended care services. Some comments stated that defining the term extended care services by referencing its applicable authority at 38 U.S.C. 1710B was insufficient to indicate what services were covered under the VCCP, particularly to ensure coverage of certain extended care services that comments asserted were not covered by Medicare (such as adult day health care). Other comments more specifically stated that the definition should expressly list the types of extended care services that would be covered, with some comments further advocating for inclusion of particular services such as assisted living, or hourly nursing services provided by home health agencies. We do not make changes based on these comments. We believe the reference in the definition to section 1710B(a) is sufficient to indicate the types of extended care services covered because it does provide a specific listing of services that encompasses both institutional and non-institutional extended care services (section 1710B(a)(4), for example, references adult day health care directly). Moreover, we see two benefits to referencing the statutory authority instead of defining it further in this rule. First, such a change would allow for any amendments to the law (section 1710B) to have automatic effect on this rule, and second, VA's interpretation of that provision of law will also automatically carry over to this rule.

A few comments requested clarification of or revisions to the definition of full-service VA medical facility. One comment requested clarification of what a full-service VA medical facility was. We reiterate from the proposed rule that this term means a VA medical facility that provides hospital care, emergency medical services, and surgical care and having a surgical complexity designation of at least standard. This definition includes a note that states that VA maintains a website with a list of the facilities that have been designated with at least a

surgical complexity of standard, which can be accessed on VA's website. One commenter indicated that this note was not adequately specific and should provide the exact hyperlink where this information can be found. We do not make changes based on this comment, as we do not want to create a gap in our regulations should VA's website locations change in the future. For the public's awareness, as of the publication of this final rule, this information can currently be found at www.va.gov/health/surgery. Another commenter stated that the definition should be revised to expressly include inpatient and outpatient mental health services to ensure that veterans (particularly in rural and remote areas) have access to such services. The definition of a full-service VA medical facility is only relevant for determinations of veteran eligibility under § 17.4010(a)(2) as proposed, which, consistent with section 1703(d)(1)(B), means that covered veterans are eligible for VCCP if they reside in a State where VA does not operate a full-service VA medical facility. Therefore, while we understand the comment's concern that not including a specific type of care in the definition would seem to affect eligibility for the VCCP, we note that veterans requiring inpatient or outpatient mental health services may be eligible under one of the other five eligibility criteria in § 17.4010(a)(1) and (a)(3) through (6) as proposed, should a facility meet the requirements of this definition for full-service medical facility but not have inpatient or outpatient mental health services. We also note that the exclusion of a listed service from the definition of full-service medical facility is not intended to indicate that such services are not available from these facilities—to the contrary, the existence of services that are included in the definition, such as surgical services, tends to indicate that such facilities are more complex medical facilities that offer many services such as mental health, primary care, and many forms of specialty care, etc.

One comment requested that VA add a new definition regarding the best medical interest of the covered veteran, to assist in clarifying this concept for the purposes of determining eligibility for the VCCP under § 17.4010(a)(5) as proposed. We do not make changes to the definitions section based on this comment, although we will address the comment's concern regarding clarification of the best medical interest eligibility criterion in our consideration

of comments on § 17.4010, which discusses eligibility for the VCCP.

One comment requested clarification of the terms hospital care and medical services, specifically seeking clarification of the explanation for the terms that was provided in the preamble of the proposed rule. The preamble of the proposed rule explained these terms in part by referring to the medical benefits package at § 17.38(b), where hospital care and medical services will be provided only if determined by appropriate healthcare professionals that the care is needed to promote, preserve, or restore the health of the individual and is in accord with generally accepted standards of medical practice. We clarify, as requested by this comment, that appropriate healthcare professionals can mean both VA and non-VA providers but are not making any revisions to the regulations.

The definition of the term other health care plan contract as proposed included language that stated such contracts did not include a policy, contract, agreement, or similar arrangement pursuant to 10 U.S.C. chapter 55, which is the authority for the Department of Defense TRICARE healthcare and insurance program. One comment requested a revision to this definition to remove the exclusion related to 10 U.S.C. chapter 55, to permit VA to bill TRICARE for non service-connected care provided under the VCCP. This comment asserted that VA was not legally barred from treating TRICARE as a health care plan contract for purposes of collecting reasonable charges for care or services furnished under 38 U.S.C. 1729. We do not make changes based on this comment, because we do not agree that section 1729 permits this practice. The plain language of the statute does not support the conclusion that VA may seek recovery from another Federal entity under section 1729. Specifically, TRICARE is another Federal program and, as such, does not meet the definition of "health plan contract" under section 1729(i)(1)(A). Additionally, while the definition of "third party" in section 1729(i)(3) includes a "State or political subdivision of a State[.]" it does not include "a Federal entity." Moreover, case law does not support the conclusion that VA may seek recovery from another Federal entity under section 1729. In *United States v. Capital Blue Cross*, the United States Court of Appeals for the Third Circuit found that by excluding other Federal programs, such as Medicare, from the reach of section 1729, Congress avoided the "inefficient procedure of having one

arm of the federal government reimburse the another.” 992 F.2d 1270, 1275 (3d Cir. 1993). Finally, the legislative history of 38 U.S.C. 1729 does not support the conclusion that VA may seek recovery from another Federal entity under section 1729. See, e.g., H. Rep. 99–300, (finding that no reimbursement could be obtained from Medicare or Medicaid by VA). We note that this discussion of what is permissible under section 1729 does not prevent VA from billing DoD under agreements that control the exchange of services under 38 U.S.C. 8111.

One comment requested a revision to the term residence to add language that would clarify a residence as the place the covered veteran stays on the date of the appointment. We do not make changes based on this comment, as we believe the definition as proposed, which defines a residence as where the covered veteran is staying at the time they want to receive care or services, provides for the same outcome without requiring constant monitoring by VA or updates by covered veterans. A few comments communicated that individuals who maintain more than one residence (the most common example provided was maintaining a different residence in a warmer climate during winter months, to accommodate health issues) can experience difficulties with receiving non-VA care. These comments did not suggest changes to any of the criteria or provisions in the proposed rule, so we are not making any changes as a result. We believe it is sufficient to state that the term residence in § 17.4005 as proposed does not preclude covered veterans from maintaining more than one residence at a time, but a covered veteran may have one residence at a time. Such residence is assessed in accordance with where the individual is physically staying at the time the care or services are needed.

A few comments requested that VA add a definition of unusual or excessive burden, to clarify how this term is used in the assessment of whether the best medical interest eligibility criterion is met under § 17.4010(a)(5)(vii) as proposed. We do not make changes based on these comments. This term has qualifying language in § 17.4010(a)(5)(vii)(A)–(E) that we believe is sufficient to inform these determinations, and we will address this qualifying language as raised by comments more specifically in the section of this rule that discusses eligibility.

One comment requested that VA add a definition for the term VA care coordination team to provide examples

of VA staff or clinicians who comprise such a team. This comment requested this definition be added because it was used in the preamble of the proposed rule to provide an example of assessing when a covered veteran might be eligible for VCCP under § 17.4010(a)(1) as proposed, or eligibility when no VA facility offers the care or services needed. We do not make changes based on this comment. This term was used in the preamble of the proposed rule to help provide background on the types of individuals who might assist a covered veteran with understanding whether VA facilities at large might not offer certain services (such as full obstetrics care), but this term is not material to determinations of eligibility under § 17.4010(a)(1) and is not used in the regulatory text, so its addition would be superfluous.

One comment stated that the term VA facility as defined in the proposed rule was too broad to be useful for veterans to distinguish between VA facilities, and suggested that VA should instead use: The term center for non-medical facilities; the term hospital for full-service facilities; and the term clinic for all medical service facilities that are not full-service. We reiterate from the proposed rule that the term VA facility references the types of care a facility provides (*i.e.*, hospital care, medical services, or extended care services), rather than designations of VA facilities (such as a VA medical center, or community-based outpatient clinic), to ensure that any future re-designations of VA facility types would not result in a gap in our regulations. If the public is interested in how VA currently defines the scope of services available at different facility types, Veterans Health Administration (VHA) Handbook 1006.02, VHA Site Classifications and Definitions, should be instructive and is available online. Additionally, we clarify that this term is relevant for determinations of eligibility under § 17.4010, and that such determinations can only be consistently made with a broad definition that references the types of care a facility provides rather than the designation of a facility.

Lastly, one comment requested that the term VA medical service line be revised to mean a clinic within a Department medical center, to ensure that entire clinics could be designated as underperforming as needed. While the commenter’s suggestion would match the definition in section 1703(o)(2), it would not clarify the meaning of that phrase for purposes of this regulation, as we believe the proposed definition does. The term clinic, in the context of health care, can

have several different meanings. Merriam-Webster, for example, defines a clinic in the context of health care as a facility (as of a hospital) for diagnosis and treatment of outpatients, as well as a group practice in which several physicians work cooperatively. Merriam-Webster online, <https://www.merriam-webster.com/dictionary/clinic>. The Cambridge English Dictionary, alternatively, defines a clinic as a building or part of a hospital where people go for medical care or advice. Cambridge Dictionary online, <https://dictionary.cambridge.org/us/dictionary/english/clinic>. We believe these definitions reflect the common understandings of the term clinic, as well as the ambiguity in that term. In some contexts, a clinic is a physical structure, and in others it is an organizational component of a larger institution. We believe in the context of section 1703(o)(2) that the latter interpretation is more reasonable, as it would be illogical for Congress to define the term VA medical service line to mean a physical structure within a larger physical structure. The very term service line also reinforces conceptually that this authority is limited to a group practice in which several physicians or clinicians work cooperatively. VA policy also repeatedly uses the term service line to refer to specific practice areas, such as cardiology, radiology, oncology, and others. Each service line has different applicable access standards or standards for quality for the purposes of assessing underperformance under § 17.4015 as proposed, which could serve as a basis for eligibility for a covered veteran to participate in VCCP under § 17.4010(a)(6) as proposed. In this context, the definition of VA medical service line as proposed, to be limited to a service or set of services within a Department medical center, is more consistent with the general meaning of the term, provides clarity as to the intended effect of this provision, and more appropriately captures those types of services that are actually underperforming and not other services that could in fact be excelling. We note that it is theoretically possible, however, for all VA medical service lines within a clinic to be designated (depending on the organization of that clinic, and the assessment of such medical service lines against VA’s standards, etc.), although we believe it would be unlikely that this would actually happen.

§ 17.4010, Veteran Eligibility

We received over 18,000 comments concerning the criteria under which VA determines a covered veteran may elect

to receive care and services under the VCCP. We address these comments below in the order in which they raise issues related to provisions in paragraphs (a)(1) through (6) of § 17.4010 as proposed. We note at the outset that the comments we received related to eligibility based on designated access standards in § 17.4010(a)(4) as proposed we be addressed in the section of this document that discusses § 17.4040 where such comments raised particular substantive issues related to the access standards. We will only discuss access standards in relation to § 17.4010 below where comments raised broad versus specific concerns regarding VA's establishment of such standards. We also note that a majority of these comments are the result of a duplicated form letter, within which at least one of the eligibility criteria from § 17.4010 as proposed was discussed.

We did not receive any comments that suggested changes to § 17.4010(a)(1) as proposed, regarding a covered veteran being eligible to receive care and services under the VCCP if no VA facility offered such care or services. However, some comments seemed to assert that this criterion could be unduly limiting if it was interpreted in a manner that barred eligibility if a single VA facility offered such care or services. One comment further requested clarification as to whether the access-related eligibility criterion in § 17.4010(a)(4) as proposed would apply if the criterion in § 17.4010(a)(1) was not met. We clarify, by reiterating from the proposed rule, that the criterion in § 17.4010(a)(1) will not be used to limit access to community care in instances where a single VA facility offers the care or services required; in such a case, covered veterans will be assessed under one of the other five eligibility criteria in § 17.4010(a)(2) through (6), for instance, the access-related criterion in § 17.4010(a)(4). The criterion in § 17.4010(a)(1) will function as a unique qualifier for covered veterans that need certain types of care that VA simply does not provide in any of its facilities (such as full obstetrics care), and any covered veteran requiring such care or services would not have to be assessed any further under other proposed eligibility criteria for community care. We do not make any changes based on these comments.

We received some comments related to § 17.4010(a)(2), regarding a covered veteran being eligible to receive care and services under the VCCP if there is not a full-service VA medical facility in the State in which the veteran resides. One comment seemed to oppose this criterion, asserting that this eligibility

criterion was inappropriate because it did not consider full-service facilities across state lines that may be accessible to veterans. Another comment seemed to support this criterion, but also asserted that it was not appropriate because it did not consider that in-state transit times vary by State. We clarify that the criterion in § 17.4010(a)(2) is an assessment of VA facility locations within States, and does not consider transit times to facilities, in accordance with section 1703(d)(1)(B). This criterion is consistent with the statute, as well as prior VA practice in the Veterans Choice Program. We do not make changes based on these comments.

A few comments asserted that VA should not eliminate the 40-mile distance eligibility criterion from the former Veterans Choice Program. We interpret these comments to be expressing concern with the limited grandfathering provision in § 17.4010(a)(3)(ii) as proposed, where the 40-mile criterion will be carried forward indefinitely for some, but not all, covered veterans. We reiterate from the proposed rule that the 40-mile grandfathering provision is consistent with 38 U.S.C. 1703(d)(1)(C), where such eligibility is carried forward indefinitely for only those covered veterans that reside in Alaska, Montana, North Dakota, South Dakota, or Wyoming and meet additional criteria. Any covered veterans who do not reside in one of these States can only be considered to have grandfathered eligibility related to the 40-mile criterion until June 6, 2020. We therefore do not make any changes based on these comments, although we note that other VCCP eligibility criteria may apply for covered veterans after June 6, 2020, even if they do not reside in the States identified for the indefinite grandfathering provision.

Some comments objected to VA establishing any eligibility based on access standards under § 17.4010(a)(4) as proposed, suggesting instead that VA community care should not have any qualifying limitations related to VA's assessment of access. We do not make any changes to § 17.4010(a)(4) based on these comments. Congress authorized veterans to elect to receive community care if VA was unable to furnish care or services in a manner that complies with VA's designated access standards under section 1703(d)(1)(D). Congress further authorized the Secretary to establish access standards under section 1703B. As explained in the proposed rule, as well as our report to Congress, the Secretary is exercising his authority to establish and designate access standards for purposes of eligibility. We reiterate

that we will discuss comments related to the substantive criteria of the access standards themselves from in the section related to § 17.4040 later in this document.

We received many comments related to the best medical interest criterion in § 17.4010(a)(5) as proposed. While some comments merely sought clarification of this criterion, others asserted that the covered veteran and his or her non-VA provider did not have enough control in determining when the criterion could be met, and that a determination by a non-VA provider that the criterion was met should not be subject to VA's review or approval (specifically, over 18,000 comments received were duplicate form requests that VA should not administratively or clinically review such determinations from non-VA providers). Conversely, other comments asserted that VA must retain review and approval for best medical interest determinations, or even prevent such determinations from being made by non-VA providers. Other comments more specifically suggested that certain conditions should be found to create eligibility under this criterion. For instance, some comments argued generally that a covered veteran's dissatisfaction with care they received directly from VA in the past should meet the criterion of best medical interest. Other comments suggested that certain conditions or factors should be considered to constitute an unusual or excessive burden as assessed under the best medical interest criterion in § 17.4010(a)(5)(vii), such as a veteran requiring oxygen to travel, or a veteran having experienced military sexual trauma.

We first address the issue within the comments concerning the level of review or approval that may be required to find that a determination of best medical interest has been met for purposes of eligibility for VCCP. These comments offered opposing interpretations of whether VA review or approval would (or should) be required to find that a determination of best medical interest had been met. We believe these opposing interpretations in the comments are due to an inconsistency between the preamble explanation for § 17.4010(a)(5) as published in the proposed rule and the regulation text at § 17.4010(a)(5) as proposed. The preamble of the proposed rule contained language that qualified a determination of best medical interest in § 17.4010(a)(5), by stating that such a determination must be for the purpose of the veteran achieving improved clinical outcomes by receiving the care or services in the community versus

from a VA health care provider. In turn, the preamble of the proposed rule further explained that the factors in § 17.4010(a)(5)(i)–(vii) as proposed would be considered in the context of clinical decision making (where the referring clinician could be either a VA or a non-VA clinician) to assess whether improved clinical outcomes would likely be achieved by receiving care in the community.

Although the preamble explained that the qualifying language related to a veteran's improved clinical outcomes would be in § 17.4010(a)(5) as proposed, it was inadvertently omitted by VA in the regulation text for § 17.4010(a)(5). We clarify that VA intended for this qualifying language to be in § 17.4010(a)(5) as proposed to allow VA to retain the ability to conduct a review of a best medical interest determination made by a non-VA or a VA provider if such determination did not appear to meet the standard for achieving improved clinical outcomes. To clarify this intent, we revise § 17.4010(a)(5) to add the qualifying language as stated from the preamble of the proposed rule that best medical interest determinations are made for the purpose of the veteran achieving improved clinical outcomes. We believe this revision effectuates VA's intent as evidenced in the preamble of the proposed rule. While we realize that this revision does not establish an absolute VA review of best medical interest determinations, and does not remove VA's review of these decisions as suggested in some comments, we reiterate from the preamble of the proposed rule that an assessment of best medical interest under § 17.4010(a)(5) is a clinical decision, and as such is made on a case by case basis depending on the individual circumstances of a covered veteran, to be guided by the factors further established in § 17.4010(a)(5)(i)–(vii). We believe that it is neither veteran-centric nor administratively feasible for VA to regulate an absolute requirement to review all determinations of best medical interest from non-VA or VA providers. We do not make changes to add certain specific qualifying conditions to § 17.4010(a)(5) in response to comments that requested VA consider specific conditions as meeting the best medical interest criterion (as raised earlier, conditions such as a veteran requiring oxygen to travel, or a veteran having experienced military sexual trauma). We believe that the language in § 17.4010(a)(5)(i)–(vii) is comprehensive to permit appropriate clinical decisions on a case by case basis

without being overly specific or restrictive.

We received a few comments that requested clarification of how VA would distinguish between a best medical interest determination that may simply be for the convenience of the veteran (which was not permitted under § 17.4010(a)(5) as proposed), and a determination of best medical interest based on an unusual or excessive travel burden (which was permitted under § 17.4010(a)(5)(vii)). One comment further requested clarification of whether the undue or excessive burden determination was clinical in nature, and whether it could relate to the drive time access standard. To address the request to clarify when the undue or excessive burden factors in § 17.4010(a)(5)(vii)(A)–(E) might be met, we will not make changes from the proposed rule, but we clarify that VA will work to develop guidance for VA staff (that can be made available to VA and non-VA providers) regarding how VA will interpret the factors to ensure there is a consistent understanding of how the undue or excessive burden considerations are assessed and applied. As a general example, a covered veteran who requires physical therapy multiple times a week in relation to a neck injury might be considered eligible under the criterion in § 17.4010(a)(5)(vii)(C), if the veteran's injured neck is a medical condition that affects his or her ability to travel even short distances. In such a case, it would not be for the mere convenience of this veteran to be seen in the community at a location that would be closer to their residence.

We further clarify, without making changes to § 17.4010(a)(5)(vii), that the unusual or excessive burden assessment would ultimately be a clinical determination, as we previously clarified that the overarching best medical interest criterion is met when it is clinically determined that a covered veteran could be expected to experience improved clinical outcomes. Lastly, we clarify without changes that the unusual and excessive burden factors in § 17.4010(a)(5)(vii)(A)–(E) are independent of the access standard eligibility in § 17.4010(a)(4) and the standards themselves in § 17.4040; the undue and excessive burden factors might qualify a veteran for VCCP, even if the access standard related to average drive time might not be met. For example, a covered veteran could require daily dialysis care that could be furnished at a VA facility that is 29 minutes away from the veteran's residence by average drive time. If VA could furnish the care within the wait-time standard in § 17.4040, this veteran

would not qualify under § 17.4010(a)(4). However, given the need for daily travel and the effect of travel for nearly an hour in transit every day, the veteran and the provider could determine it is in the best medical interest of the veteran to receive this daily dialysis care through the VCCP at a non-VA facility that is only a five-minute average drive from the veteran's home.

We received one comment related to § 17.4010(a)(6) as proposed, regarding a covered veteran being eligible to receive care and services under the VCCP if VA determined that a VA medical service line that would furnish the care or services the veteran requires is not providing such care or services in a manner that complies with VA's standards for quality. This comment asserted that VA should revise this eligibility criterion to be discretionary and not mandatory, to be consistent with 38 U.S.C. 1703(e), which is the statutory provision related to discretionary eligibility based on a finding that a VA medical service line is not providing care that complies with the standards for quality VA further establishes under section 1703C. We agree section 1703(e) authorizes and does not mandate the furnishing of care when VA medical service lines are underperforming, but we do not read our regulations in §§ 17.4010(a)(6) and 17.4015 as proposed to collectively to eliminate that discretion. Section 17.4015 permits, but does not require, the Secretary to identify underperforming VA medical service lines. It further permits the Secretary to establish limitations or conditions on the ability of veterans to elect to receive care and services in the community. If the Secretary makes a determination under § 17.4015 and identifies underperforming VA medical service lines and the conditions under which covered veterans seeking care or services from such a medical service line can elect to receive care in the community, then § 17.4010(a)(6) would apply and covered veterans could elect to receive care or services in the community consistent with the Secretary's determination. Sections 17.4010(a)(6) and 17.4015 therefore effectively preserve the discretionary nature of section 1703(e). We will address comments related to the establishment of or notice procedures for VA's standards for quality in the portion of the final rule that discusses § 17.4015.

We received one comment that requested clarification of VA's rationale to require a covered veteran to submit to VA information related to a change in the veteran's address in § 17.4010(b) as

proposed, and information on any other health-care plan contract under which the veteran is covered prior to obtaining authorization for care and services the veteran requires. We reiterate from the proposed rule that this information is required so that VA may make accurate eligibility determinations under § 17.4010(a)(2)–(6) that rely on a veteran's place of residence, and so that VA can continue to recover or collect reasonable charges for care and services furnished in the community for a non-service connected disability from a health plan contract, consistent with section 1703(j). We further note that veterans are required to submit information regarding other health insurance under section 1705A. Related to this comment concerning the provision of information by the covered veteran, one comment asserted that VA should make VCCP use conditional on the covered veteran's acceptance of an automatic release of their medical information to non-VA providers. The commenter asserted that this was necessary because it was inefficient to require veterans to authorize individual releases of their medical information, or to rely on non-VA providers to attest that records were received. We do not make changes based on this comment. VA currently has the authority to release veteran medical information for treatment purposes without the written consent or authorization of the veteran under applicable statutes and their implementing regulations (see 38 U.S.C. 7332(b)(2)(H)). Therefore, there is no need to require veterans to authorize individual releases of their medical information if a veteran is receiving treatment using VCCP.

Section 17.4010(d) as proposed established that eligibility determinations for covered veterans to receive hospital care, medical services, or extended care services through the VCCP would be subject to VA's clinical appeals process, and not be appealable to the Board of Veterans Appeals. We received some comments that suggested these eligibility decisions should be appealable to the Board. We make no changes based on these comments, as section 1703(f) expressly provides that these eligibility decisions be subject to VA's clinical appeals process and not be appealable to the Board of Veterans' Appeals. Other comments did not request revisions to § 17.4010(d) per se, but did suggest that VA's appeals process should be comprehensive, and more specifically that VA should develop a unique process within its clinical appeals process, to ensure that individuals adjudicating the VCCP

eligibility determinations are not the same VA facility or VISN staff that made the initial eligibility determinations. We clarify that VA's current clinical appeals process can be found in VHA Directive 1041, Appeal of VHA Clinical Decisions, which can be found on VA's website and provides for a comprehensive process of appealing clinical decisions that includes elevating disputes beyond initial staff-level determinations.

Lastly, one comment raised several concerns about different provisions discussed in the proposed rule that potentially related to eligibility, based on several assertions: First, the comment asserted that VA's proposed rule would limit eligibility for VA community care to only certain service-connected veterans, or veterans with only certain discharges from active service; second, the comment asserted that the rule would limit eligibility for care for a recently discharged veteran to 12 months; and third, the comment asserted that veterans should be treated for service connected disabilities regardless of their character of discharge. All of the provisions cited in this comment refer to other provisions of law unaffected by VA's rule, namely § 17.46 (concerning the first issue identified above), which we are making no longer effective; section 1705(c)(2), which authorizes VA to furnish care notwithstanding a veteran's failure to enroll (concerning the second issue identified above); and section 5303(a), which statutorily limits VA's ability to furnish benefits to certain persons. Because these authorities are either being made ineffective through this rule (in the case of § 17.46) or are statutes that were unaffected by this rule (in the case of section 1705(c)(2) and section 5303(a)), we do not make changes based on this comment.

§ 17.4015, Designated VA Medical Service Lines

We received over 25 comments concerning the process by which VA would designate those VA medical service lines that were not able to furnish care or services in a manner that complied with VA's standards for quality, so that covered veterans who would receive care or services through such VA medical service lines would be eligible for the VCCP. We address these comments below in the order in which they raise issues related to the provisions in paragraphs (a)–(e) of § 17.4015 as proposed.

As a general matter, one comment suggested that any proposal to eliminate entire service lines at VA facilities should not be implemented. We clarify

that no provision in the proposed rule sought to eliminate VA medical service lines at VA facilities. Section 17.4015 as proposed sought to establish criteria by which VA would assess VA medical service lines within its facilities to determine if they were underperforming. If such medical service lines were so identified, then § 17.4010(a)(6) as proposed would allow covered veterans to elect to receive the care or services they would have received under those underperforming VA medical service lines through the VCCP. We do not make any changes to the proposed rule based on this comment. We note that section 1706A, as added by section 109 of the MISSION Act, expressly requires remediation of any VA medical service lines identified under this criterion, and as we discussed near the conclusion of the preamble to the proposed rule, VA's remediation efforts will not be limited to just those medical service lines designated under § 17.4015. These remediation efforts are intended to bolster and support VA's medical service lines.

We received multiple comments related to § 17.4015(a) as proposed, concerning VA's basic parameters for identifying its underperforming medical service lines. First and most generally, one comment requested that VA revise paragraph (a) to make this provision mandatory by using the word "shall" instead of "may"; in the alternative, the commenter suggested that VA must otherwise clarify if it interprets the quality monitoring mandates imposed by section 1703(e) and 1703C to be optional. We do not make changes based on this comment and clarify that not all provisions in the MISSION Act require VA to take action. VA used the term "may" in § 17.4015(a) as proposed because VA is not required, and may be practically unable, to identify any VA medical service line as underperforming, and consequently, it may be the case that no covered veterans qualify for community care under this criterion. We also, as noted above, allow the Secretary to place conditions or limitations on the ability of covered veterans to elect to receive care under this criterion.

One comment requested that VA revise § 17.4015(a) to provide for a comparison of timeliness between VA and non-VA medical service lines, as this comparison of timeliness is not expressly prevented by section 1703 or 1703C. We do not make changes based on this comment, as the comparison of timeliness between only VA medical services lines is consistent with section 1703(e)(1)(B)(i). We further note,

however, that § 17.4015(a) identifies timely care as the first domain of care, and hence the timeliness of care with non-VA service lines would be considered indirectly.

We received multiple comments related to VA's standards for quality themselves, a majority of which we interpret as beyond the scope of the proposed rule because such standards are to be established and announced via a separate process in the **Federal Register**, as stated in the proposed rule. However, we summarize those comments here as they could be interpreted to apply to § 17.4015(a) as proposed, and that paragraph's express statements of using VA's standards for quality to determine when VA medical service line are underperforming. Multiple comments argued that VA should not use VA's standards for quality, but rather should use existing industry standards related to quality monitoring (such as the National Committee for Quality Assurance's Healthcare Effectiveness Data and Information Set, or Centers for Medicare and Medicaid Services Merit-Based Incentive Payment System), versus developing VA-based quality measures as indicated in § 17.4015(a) as proposed. One comment more specifically requested that VA revise § 17.4015(a) accordingly to reflect that VA will use industry standards for quality. Conversely, other comments suggested that there seemed to be a deficiency of reliable data available to VA that is related to quality measures or metrics concerning non-VA providers; one comment further stated that until non-VA providers are able to produce comparative data to be used in assessing VA medical service lines, VA should only use its data to identify and remediate its medical service lines. Other comments more specifically recommended that VA use its existing tools such as VA's Strategic Analytics for Improvement and Learning tool to identify its underperforming service lines. Some of these comments further stated that VA should consider unique veteran populations when developing standards, with one comment requesting that VA require vascular surgery quality outcomes to be assessed to ensure non-VA outcomes match VA outcomes. Other comments did not suggest a particular approach regarding the use of VA or non-VA quality measures, but rather requested clarification of what quality measures or metrics VA would use. We do not make changes to § 17.4015(a) based on these comments, but we reiterate from the proposed rule that VA's standards for quality will be

announced through a separate document published in the **Federal Register** as set forth in § 17.4015(c) as proposed. We do note that VA's proposed standards for quality, as submitted to Congress in a report earlier this year, focused on the framework for quality identified by the National Academy of Medicine.

We did not receive any comments on § 17.4015(b) as proposed and are not making any changes from the language we proposed.

We received a few comments related to VA providing notice of its standards for quality once established, as well as comments on other provisions set forth in § 17.4015(c) as proposed. At the outset, we note that multiple comments urged VA to publicly release VA's report detailing its standards for quality that was submitted to Congress on March 4, 2019. We do not make changes to § 17.4015(c) based on this comment, as we believe § 17.4015(c) makes adequate provision for public notice of the standards of quality.

Section 17.4015(c) as proposed contained language to establish potential limitations of when and where covered veterans could receive qualifying non-VA care and services at their election based on VA's identification of its underperforming medical service lines. These possible limitations on receiving qualifying non-VA care included a limitation by defined geographic area. We received one comment that stated this language implied that VA will interpret its standards for quality based on a regional geographic standard versus a national standard and asked that VA clarify whether this is the case. We clarify that while VA will have national standards for quality, VA's quality comparisons will generally be based on care that is locally available and not on national averages. It would be of little use to patients in a particular area or region to have VA care that is locally available to them compared to care that is not locally available. The language in § 17.4015(c) related to limitations (including the limitation based on geographic area) therefore serves to alert covered veterans that the qualifying non-VA care they may elect to receive may be limited in its location, in the type of care that may be received, etc., as it would be offered as an option to the specific care that would be designated in the specific VA medical service line that VA would have identified as underperforming. We do not make changes based on this comment.

A few comments requested clarification of whether direct notice to

covered veterans of underperforming VA medical service lines, as set forth in § 17.4015(c) as proposed, would include other than electronic communication (to include notification by mail, phone, etc., as well as a **Federal Register** document). A related comment requested that VA ensure non-VA providers are provided the direct notice VA would conduct when making determinations under § 17.4015(c) on VA medical service lines. We do not make changes based on these comments. We reiterate from the proposed rule that VA will take reasonable steps to provide direct notice to covered veterans affected under this section to include written correspondence, electronic messages, or direct contact (in person or by phone). We do not believe it necessary to regulate VA's notice to community providers.

A few comments requested that VA revise § 17.4015(d) as proposed to permit VA to identify more than three underperforming VA medical service lines and more than 36 underperforming VA medical service lines nationally. One comment stated that there should be no limit on the number of designated VA medical service lines per facility or the total number nationally that could be designated as underperforming, and one comment urged VA to seek a legislative fix to allow VA to designate more than 36 VA medical service lines nationally. We do not make changes based on these comments, as VA is limited by statute to designating no more than three service lines per facility and 36 service lines nationally, in accordance with section 1703(e)(1)(C). As the comment indicates, any resolution to allow more than the permitted number of VA medical service lines to be designated would require Congressional action and therefore is beyond the scope of the proposed rule.

Multiple comments raised issues related to the factors VA would consider when determining whether its medical services lines would be identified as underperforming, as set forth in § 17.4015(e) as proposed. One comment noted that VA should limit comparison of underperforming VA medical service lines against only similarly underperforming non-VA medical service lines (and further, only those non-VA underperforming medical service lines that are accessible to covered veterans), to ensure that a covered veteran would not have the option to choose to receive lower quality care from a non-VA medical service line than a VA medical service line. Another comment asserted that VA must consider whether non-VA medical

service lines would be able to provide the same type of care or better care before designating a VA medical service line as underperforming. We interpret these comments to be related to § 17.4015(e)(1) as proposed, as the general paragraph that would establish whether differences in performance between VA and non-VA medical service lines were clinically significant. We do not make any changes to § 17.4015(e)(1) based on these comments. The language in § 17.4015(e)(1) provides that VA will compare performance of its medical service lines against the performance of non-VA medical service lines to identify VA deficiencies. By the time VA is determining whether the differences in performance are clinically significant, it will have already assessed the quality of VA's medical service and non-VA medical service lines and identified that there is in fact a difference. We also reiterate from the proposed rule that the language related to clinical significance in § 17.4015(e)(1) would allow VA to appropriately discern differences in performance between VA and non-VA medical service lines to determine if VA medical service lines were underperforming. Determinations regarding performance will be made locally and should generally result in veterans being able to access better quality care in the community than they would receive from service lines designated as underperforming.

We received a few comments related to the factor in § 17.4015(e)(2) as proposed, that VA would consider the likelihood and ease of remediation of the medical service line within a short timeframe when determining whether it was underperforming. We reiterate from the proposed rule that the intent of this factor is to allow VA to designate as underperforming those medical service lines in need of the kind of intensive remediation envisioned by section 1706A, and not necessarily those medical services lines where a simple action (such as the purchase of new equipment) is likely to occur and would be sufficient to remediate underperformance. One comment requested that VA revise this factor in § 17.4015(e)(2) to permit a temporary designation of a VA medical service lines that may only require simple actions likely to occur in a short timeframe, to prevent scenarios in which veterans would receive what the comment asserted would be substandard care even if on a temporary basis. We do not make changes based on this comment. We do not agree with the comment's equating of potential

temporary underperformance of a VA medical service line with delivery of substandard care. Further, we reiterate from the proposed rule that § 17.4015(e)(2) is necessary to allow VA to be selective in engaging in remediation that will require allocation of VA resources. We further note that, in such temporary situations, covered veterans might still be eligible to receive care in the community under the best medical interest criterion in § 17.4010(a)(5), which may provide more nimble and timely access to care than the designation of a VA medical service line under § 17.4015. A related comment requested clarification of the effect of the factor in § 17.4015(e)(2), more specifically whether VA intended this factor to be used to identify only those medical service lines that could be remediated easily. We clarify that this is not the intent of § 17.4015(e)(2); to the contrary, we reiterate from above that this factor should allow VA to designate as underperforming those VA medical service lines in need of the kind of intensive remediation envisioned by section 1706A, and not necessarily those services lines where a simple action is likely to occur and would be sufficient to remediate underperformance. As other commenters noted, VA is limited to the number of VA medical service lines it can designate nationally and at any particular facility. It would be a poor use of this authority to waste one of those limited opportunities to designate a VA medical service line that could be improved easily and quickly.

We received one comment that requested VA provide more information on why data that may be required to assess the performance of VA and non-VA medical service lines could take as long as 18–24 months to collect or analyze, particularly if such data may already be collected by VA related to the performance of its medical service lines. The comment further urged VA to take steps to shorten this timeframe, to prevent scenarios where a covered veteran may receive what the commenter deemed sub-standard care for an extended time while VA determines whether its medical service lines are underperforming. We believe this comment is referring to the portion of the proposed rule that explained § 17.4013(e)(3), which is the factor that would permit VA to consider recent trends concerning a VA or non-VA medical service line when determining if a VA medical service line is underperforming. The preamble of the proposed rule provided that the process to gather, analyze, and verify quality

data could take as long as 18–24 months, and for this reason VA needed a factor that would permit it to consider more contemporaneous information to determine whether one of its medical service lines was underperforming. These data are inherently time-lagged, as much of the data we use is collected and reported by other entities (such as Medicare). Moreover, it may take months to collect enough data to support valid conclusions; small sample sizes are inherently unreliable, and if a particular VA medical service line simply does not furnish care to that many patients, it could take some time to generate enough cases to produce reliable results that would be actionable. We again reiterate, though, that covered veterans could still access care in the community under any of the five other eligibility criteria in § 17.4010, including the best medical interest criterion under § 17.4010(a)(5). We believe that § 17.4015(e)(3) as proposed actually resolves the concern in the comment, because it expressly allows VA to consider contemporaneous information, and we make no changes based on this comment.

We received one comment that urged VA to remove the designation factor in § 17.4015(e)(6) as proposed, related to considering the effect that designating a VA medical service lines would have on other VA medical service lines. The comment characterized this factor as a loophole that would allow underperforming VA medical service lines to avoid designation, due to the negative effects such designation would have on other medical services lines. We disagree with the comment's characterization of this factor. We do, however, maintain that this factor is critical to allow VA to be selective in its designations, particularly for medical service lines whose designation may be more vastly disruptive, both to other VA medical service lines and other programs, than we believe is the intent of identifying any underperforming VA medical service lines under section 1703(e) generally. We do not make changes based on this comment.

We received a few comments that did not seem clearly related to any of the factors in § 17.4015(e)(1)–(6) as proposed, but that suggested clarifications or potential changes to § 17.4015(e) based on particular services or particular veteran populations. One comment requested that VA clarify to what extent extended care services could be an underperforming medical service line, and another comment urged VA to consider the unique needs of women veterans in designating VA medical service lines as

underperforming. We do not make changes to § 17.4015(e) based on these comments but do clarify that the rule does not place any limitations on what type of VA medical service lines may be designated, so such VA medical service lines could be those that provide extended care services (e.g., geriatrics) if VA finds them to be underperforming. Additionally, we believe that § 17.4015(e) as proposed gives VA the latitude to consider all veteran populations, including women veterans, and we agree that VA should consider the unique needs of veteran populations when determining whether its medical service lines are underperforming.

Lastly, we received a few comments that urged VA to develop and make public a dataset that compares providers, facilities, and practices based on VA's standards for quality, to provide covered veterans with additional information they may use when determining whether to elect to receive care in the community. We do not make any changes based on these comments but note that we address VA's communication of comparative information to inform health care decisions in the portion of this final rule that discusses miscellaneous comments.

§ 17.4020, Authorized Non-VA Care

We received over 100 comments concerning the process and requirements for authorizing non-VA care under the VCCP. We address these comments below in the order in which they raise issues related to the provisions in paragraphs (a)–(d) of § 17.4020 as proposed (including VA's supplemental notice of proposed rulemaking related to transplant care). We note that some of these comments did not suggest changes to the regulation text in § 17.4020 as proposed, and further raised issues that were related more to administrative process rather than the regulatory requirements under which VA will authorize care. We will address below only those issues raised in comments regarding VA's requirements and authorities to authorize non-VA care as proposed and will address other issues related to administrative process in another section of this final rule related to miscellaneous comments.

We did not receive comments to revise a covered veteran's election to receive care under the VCCP should they be so eligible, under § 17.4020(a) as proposed. We do reiterate, however, in response to many comments that expressed concerns related to the effects of expanding non-VA care on VA's direct provision of care, that § 17.4010(a) requires a veteran's election

to receive non-VA care under the VCCP; VA does not force covered veterans to receive non-VA care.

Several comments did request clarification or revision of VA's authorization of care and services to be furnished through the VCCP if the covered veteran elects to receive such care, under § 17.4020(a) as proposed. Some of these comments broadly opposed VA's specific authorization of care and services, for instance, those comments that asserted that a veteran's VA identification card should be all that is required to present to obtain care without further review or authorization requirements. Other comments were more specific, for instance, that VA should reduce or eliminate the requirement for VA authorization of care or services from approved non-VA providers who have a record of effective and efficient care within the Veterans Choice program. Still other comments further advocated that VA should eliminate the requirements for additional authorizations that may be required within an episode of care (referred to as secondary authorizations) because they were concerned that these authorizations could unduly delay the provision of care or services, such as additional testing that may be found to be required. One comment more specifically requested that any authorization of an episode of care that includes a surgical procedure should automatically cover any other care furnished during that procedure, and a related comment even more specifically requested that VA should require that follow up care for vascular surgical procedures (particularly imaging) be provided by the same non-VA vascular surgeon who provided the initial care or services to the covered veteran. We do not make changes based on these comments.

We reiterate from the proposed rule that, in accordance with section 1703(a)(3), VA is required to authorize care or services that a covered veteran might elect to receive through the VCCP. This authorization of care and services covers an episode of care that may last up to one year, but only for care and services that are within the scope of the care or services initially authorized. VA has developed a process to facilitate access to necessary and ancillary services within an episode of care; we refer to these authorizations as standard episodes of care (SEOC). VA uses SEOCs to bundle services that are necessary and related so that referrals between different specialists are more easily facilitated and so that all specialty and ancillary services are included within the episode of care. For example, a

veteran in need of knee replacement surgery would be authorized through a SEOC for pre- and post-operative examinations, the surgery itself, and physical therapy. The same would follow for a veteran in need of vascular surgery, as raised by the comment described above, for all specialty care and ancillary services that would reasonably be expected to be medically necessary after the surgery itself. However, the regulation will not prescribe at so granular a level, for instance, automatic approvals for particular follow-up care or for care to be provided by the same providers that initially performed surgical procedures. Requests for authorization of services outside the SEOC further allow VA to assess the need for care or services recommended by a non-VA provider, and whether these services fall within the approved episode of care or whether they constitute a new episode of care.

Several comments asserted that a covered veteran's selection of a provider in § 17.4020(b) as proposed did not actually ensure that a covered veteran could see his or her provider of choice. The primary reasons offered for why providers of choice were not available were that delays in VA's payment of claims, or other complications associated with VA's administration of its community care programs, created too many disincentives for non-VA providers to participate in such programs. We will address these comments, as well as other comments regarding VA's administration of its community care programs, in another section of this final rulemaking related to miscellaneous comments. However, we do note that even setting aside these operational concerns, VA cannot compel a private provider to furnish care and services to a covered veteran. If the covered veteran identifies a particular entity or provider as his or her preferred source of care, and if that provider or entity is within VA's network and accessible to the covered veteran, we would refer the veteran to that entity or provider. If the identified provider is not part of VA's network and does not wish to become part of VA's network (and VA cannot otherwise secure the care through a sharing agreement, other arrangement, or Veterans Care Agreement), VA cannot compel that provider to treat the covered veteran. We do not make any changes to § 17.4020(b) as proposed based on these comments.

A majority of the comments VA received related to § 17.4020 as proposed raised issues related to emergency care that may be authorized by VA as set forth in § 17.4020(c) as

proposed. We reiterate that we will address below only those issues raised in comments regarding VA's requirements and authorities to authorize emergency care as set forth in § 17.4020(c), and we will address issues related more to administrative process of VA approving emergency care in another section of this final rule related to miscellaneous comments.

We received a few comments that requested VA clarify any potential intersection or sharing of assessment criteria or other standards between emergency care furnished under the VCCP and emergency care separately furnished under 38 U.S.C. 1725 and 1728. We interpret these comments to be related to § 17.4020(c) as proposed, as paragraph (c) established that it did not affect eligibility for, or create any new rules or conditions affecting, reimbursement for emergency treatment under sections 1725 or 1728. These comments ranged in their primary concerns for identifying the relationships between emergency care offered under different VA authorities. For instance, one comment wanted clarification of the reasonableness standard that would be applied under the VCCP to determine whether care or services were emergent in nature, and further advocated that the prudent layperson standard should be applied (specifically, to include post-stabilization). Another comment requested clarification of the relationship between the varying emergency care authorities to ensure that covered veterans would understand when VA will likely authorize emergency care and reimburse for such care, versus the veteran possibly being liable. We do not make changes based on these comments.

We believe that § 17.4020(c) is sufficient to indicate that emergency care furnished through the VCCP is distinct from and does not affect emergency care provided under sections 1725 or 1728. We do clarify, however, that because paragraph (c)(1) of § 17.4020 does reference section 1725(f)(1) to define emergency treatment, VA will use the prudent layperson standard as interpreted through section 1725. We understand this clarification that VA will use its section 1725 prudent layperson for emergency treatment furnished through the VCCP is not what was requested by the comment, which asserted that this very standard permitted VA to review decisions of reasonableness instead of VA using what would perhaps be considered a broader industry standard (for instance, as referenced by the comment to a Centers for Medicare and

Medicaid Services standard of prudent layperson in 42 U.S.C. 300gg-19a(b)(2)(A)). However, we believe VA's prudent layperson standard is reasonable to administer the furnishing of emergency treatment through the VCCP. This same comment also requested that VA revise § 17.38(a)(1)(iv) to expressly provide that emergency care under VCCP is part of the medical benefits package. We agree and are revising § 17.38(a)(1)(iv) accordingly. We believe this change will assist individuals in understanding that emergency care provided under the VCCP is separate from that provided under sections 1725 and 1728 and is a covered benefit under the VCCP.

We received a comment that requested VA clarify that the term emergency treatment includes mental health care, which we interpret to be related to § 17.4020(c)(1) as proposed as this paragraph referenced the definition of emergency treatment in 38 U.S.C. 1725(f)(1). We do not make changes based on this comment, as we believe the reference to the definition of emergency treatment in section 1725(f)(1) is sufficient to indicate that mental health services are considered within the scope of emergency treatment. Section 1725(f)(1) refers to medical care or services furnished in an emergency. We have interpreted this to apply to any care or services within VA's medical benefits package, which includes mental health services, as identified in § 17.38(a)(1)-(2).

Comments generally stated that the 72-hour rule in § 17.4020(c)(2) as proposed was not reasonable. Primarily, these comments asserted that the 72-hour timeframe was too short or did not provide exceptions where it may be exceeded. There were multiple reasons provided in the comments to support that the 72-hour rule should have exceptions, which we summarize and respond to below. We note that some of these reasons raise issues related to requirements in § 17.4020(c)(3) and (4) as proposed, related to requirements for approval and notice to VA, respectively.

One comment stated that § 17.4020(c) as proposed did not reflect what the comment asserted was the current regulatory option for an exception to the 72-hour rule, to provide VA notice within a reasonable amount of time after the emergency care was furnished. We note that no such exception exists in current regulation under § 17.54, and we see no reason to add such an exception here, as this rule would only apply to covered veterans and eligible entities or providers.

Other comments offered reasons to establish exceptions to the 72-hour rule

that were related to veterans or non-VA providers not understanding what VA facility should receive the notice or who to contact at such VA facility. Some of these comments more specifically noted that neither the appropriate VA official nor the nearest VA facility in § 17.4020(c)(4)(i) as proposed were clearly defined or characterized, particularly in instances where a veteran might be traveling and not be familiar with VA facility locations, or non-VA providers may not be familiar with VA facilities in their area. Some of these comments further requested clarification of who is considered an appropriate VA official, or requested that VA revise the requirement to allow notice to be delivered to any VA facility. As we explained in the proposed rule, only eligible entities or providers who have a contract or agreement to furnish care on VA's behalf may furnish care under § 17.4020(c). While veterans who are traveling may not know the local VA facility, we are confident that each community entity or provider in our network will know the right VA facility to contact.

Other comments offered reasons to establish exceptions to the 72-hour rule that were related to the nature of receiving emergency care or services. For instance, these comments asserted that in many cases a covered veteran seeking emergency care will be in a compromised medical state, and therefore should not be expected to understand whether they are seeking care from authorized entities or providers, or to understand whether all care offered might be covered by the medical benefits package.

Still other comments argued that exceptions are needed due to other circumstances, such as when the nearest VA facility might be closed after business hours or on holidays (to create delays in meeting the 72-hour rule), or when 72 hours may simply not be enough time for a non-VA provider to have obtained all information required under § 17.4020(c)(4) (for instance, if a covered veteran presents for emergency treatment without identification). One of these comments further requested that VA revise the rule so that the 72-hour period would not begin until the later of when the entity or provider began furnishing the care or the time when a reasonably diligent non-VA entity or provider would have the information necessary to submit a notice to VA in compliance with § 17.4020(c)(4).

We do not make any changes based on these comments to create exceptions to the 72-hour rule in § 17.4020(c)(2) as proposed. We reiterate from the

proposed rule that the 72-hour requirement is consistent with the window for approval under existing § 17.54(a), and we believe the 72-hour requirement continues to be a reasonable timeframe to allow notification upon stabilization of the patient or upon the next business day in the overwhelming majority of cases. VA will work to improve its communication materials for both veterans and eligible entities and providers concerning who may receive the notice and at what VA facility, without making changes to § 17.4020(c)(2) through (4). We believe this improved communication will assist with effective and timely provisions of notice within the 72-hour requirement. We also clarify that if the 72-hour window is not met, VA will consider any claims for reimbursement of the costs of the emergency treatment under other authorities, specifically sections 1725 and 1728, which authorize reimbursement of certain non-VA emergency treatment; there is no 72-hour requirement under either of these other authorities, but we do request notification under these authorities as soon as possible in the interest of coordination of care. We note that a veteran's personal financial liability, if any, could vary depending upon whether the care is authorized under section 1703 under the 72-hour rule or reimbursed under sections 1725 or 1728.

One comment requested that VA clarify if it will define someone acting on the covered veteran's behalf in § 17.4020(c)(2), or if VA will provide an exception to automatically approve care if a covered veteran is incapacitated (or, conversely, if VA will apply what the comment asserted was the current VA emergency room standard to non-VA emergency rooms). We do not make any changes based on this comment, as we believe the issues raised may be conflating the concept of a covered veteran's consent to receive emergency treatment with VA's approval of such treatment furnished through the VCCP.

One comment requested that VA revise § 17.4020(c) to permit that two emergency room visits be permitted through the VCCP at no charge to covered veterans. We interpreted this comment to be raising issues more related to VA's administration of its approval of emergency treatment, because it relayed concerns that covered veterans were unduly subject to cost liabilities for emergency treatment that the comment asserted VA failed to approve or pay timely. We will therefore address this comment in the section of this final rule that pertains to miscellaneous comments, although we

do clarify here that § 17.4020(c) as proposed does not limit the number of visits to an emergency room for a covered veteran to receive emergency treatment through the VCCP.

Lastly, one commenter asserted that VA should add urgent care in addition to emergency treatment as available care and services under the VCCP. We do not make changes based on this comment but do clarify that VA is promulgating separate regulations, published elsewhere in this issue of the **Federal Register**, to furnish urgent care through non-VA providers (see RIN 2900-AQ47, published as a proposed rule on January 31, 2019 (84 FR 627)).

On April 5, 2019, VA published a Supplemental Notice of Proposed Rulemaking (SNPRM) to amend VA's proposed rule by proposing a minor revision to paragraph (a) and a new paragraph (d) to account for section 1703(l) and its language concerning organ and bone marrow transplants. 84 FR 13576. VA received 10 comments on this SNPRM. One comment was a request for case management assistance, which VA has addressed but which was beyond the scope of the rulemaking. We make no changes based on this comment. Four comments supported the changes proposed by the SNPRM. We make no changes based on these comments. One comment raised concerns regarding billing and payments for community providers. The commenter stated that clear definitions of how payments will be processed and paid between VA and the community providers is important to minimize any confusion in the billing process. The SNPRM did not address claims or billing issues because these were separately addressed in § 17.4035 of the proposed rule. We received comment on the proposed rule regarding billing and claims payment, which we address more fully below. In brief, however, we do not regulate VA's process for claims submissions or billing at this time. VA contracts and agreements will establish these requirements between the parties, and rules of general applicability, particularly regarding prompt payment, will be regulated at a later time. We make no changes based on this comment.

One commenter requested that VA provide examples of medically compelling reason for a veteran to seek transplant services outside of the Organ Procurement and Transplantation Network (OPTN) region in which the veteran resides. We do not make changes based on this comment but clarify that examples of medically compelling reasons were provided in § 17.4020(d)(2)(i) through (iv) as

proposed and were discussed in the SNPRM. This same commenter requested for VA to clarify how OPTN regions and distance considerations in § 17.4020(d)(2)(iii) as proposed will interact in determining whether a transplant will be authorized. We do not make changes based on this comment but clarify that § 17.4020(d)(2)(iii) provides that VA will consider travel burden on covered veterans when deciding to authorize transplantation care at a transplant center outside the Veteran's OPTN region of residence. Geographical proximity of a qualified transplant center in an OPTN region adjacent to the patient's residence will be considered when burden of travel is meaningfully impacted. Availability of services in consideration for authorization of care in another OPTN region is cited in § 17.4020(d)(2)(iv) as timeliness of transplant center evaluations and management. Transplant program qualifications are further addressed by § 17.4020(d)(2)(i) and (ii). Transplant programs must meet standards for quality, and specific patient factors may include a disease process or transplantation procedure that warrants referral to selected transplantation centers, including those in a different OPTN region.

One commenter suggested that VA permit Veterans to be listed on more than one OPTN regional list if indicated, to increase their chance of being matched. We do not make changes based on this comment but clarify that the listing of Veterans on more than one OPTN regional list is not prohibited by the regulation. Related policy will specify that such listing is an appropriate consideration for authorization of care in an OPTN region other than that of the Veteran's residence.

One commenter asserted that the SNPRM failed to clarify the differences between solid organ transplant and bone marrow transplant. This commenter more specifically noted that bone marrow transplant falls outside of the scope of OPTNs, and that the proposed rule only indicated how VA Transplant Programs and VA Transplant Centers interact with OPTNs; hence, the commenter indicated that VA should clarify whether the rule captures bone marrow transplants. We do not make any changes based on this comment, as the MISSION Act includes provisions for both bone marrow transplantation and solid organ transplantation. VA understands that OPTN does not oversee bone marrow transplantation, but the rule does cover bone marrow transplants. This same commenter further suggested that the four factors in

§ 17.4020(d)(2) to be considered when determining a medically compelling reason to travel outside of the OPTN must be revised to include relevant details for bone marrow transplant. For instance, the commenter noted that the factor related to assessing facilities outside of an OPTN to determine whether they meet VA's standards for quality in § 17.4020(d)(2)(ii) as proposed was only explained in the preamble of the SNPRM in reference to Scientific Registry of Transplantation Recipients data, which is only applicable to solid organ. We do not make changes based on this further comment. VA understands that relevant patient factors may vary based upon the specific transplant both among solid organ types and bone marrow transplant, which is precisely why the SNPRM noted the four factors in § 17.4020(d)(2)(i)–(iv) were a non-exhaustive list. The Scientific Registry of Transplantation Recipients database is provided only as an example. Additional standards for solid organ transplantation programs and separate standards for bone marrow transplantation programs will be developed during policy and procurement processes.

We received one comment that requested that VA clarify that it is the veteran's choice whether to obtain a VA or non-VA transplant within the Veteran's OPTN (the commenter essentially asserted that the SNPRM was unclear that the veteran first has a choice of a non-VA transplant center within the OPTN prior to any consideration of travel outside of an OPTN). We do not make changes based on this comment. A covered veteran who is determined by VA to meet eligibility criteria for community care in proposed § 17.4010 has the ability to decide whether to receive transplantation care in the community within the OPTN region of residence. Veterans who meet eligibility criteria for community care may elect to receive care at a VA Transplant Center. This commenter also asserted that section 1703(l) requires only that a veteran be a covered veteran to be considered eligible for this expanded access to transplant care and does not require such a covered veteran to be separately assessed under any other criteria (*e.g.*, the criteria to receive community care generally under section 1703(d) or (e)). We believe this portion of the comment was prompted by VA's clarification in the SNPRM that this expanded access to transplant care only applies for a covered veteran (as defined in § 17.4005) who meets one or more of the eligibility criteria for community care

generally under § 17.4010. We do not make changes based on this comment. We read section 1703(l) as qualifying the conditions of eligibility set forth in section 1703(d) and (e); there is nothing in section 1703(l) that suggests it is intended to establish an additional, independent basis of eligibility for community care. Moreover, the expanded access to transplant care under section 1703(l) is available only if there is a medically compelling reason to travel to receive such care. VA cannot envision any instance in which a covered veteran would be found to have a medically compelling reason to justify travel outside of an OPTN, but not be found to qualify separately for community care generally under § 17.4010(a), particularly considering that the factors to determine a medical compelling reason under § 17.4020(d)(2)(i)–(iv) are related to many of the eligibility factors in § 17.4010 (for instance, factors exist under §§ 17.4010(a) and 17.4020(d) that relate to the specific medical needs of a veteran, the travel burden for a veteran, and the timeliness of care to be received). This commenter further asserted that VA should ensure a veteran's primary care physician receives deference over the Secretary in the determination of whether a veteran is eligible to travel outside of the OPTN. We do not make changes based on this comment. Section 1703(l) requires that the Secretary make the determination of whether to authorize community care for covered veterans requiring an organ or bone marrow transplant and who have a medically compelling reason to travel outside of the OPTN region in which they reside to receive the transplant. The Secretary's determination is only made when the primary care provider has opined that there is a medically compelling reason to travel outside the OPTN region in which the veteran resides to receive such transplant; this opinion is a threshold question of when the Secretary makes a determination, and not a final resolution of the matter. Lastly, this commenter urged that VA should include in the final rule a specific timeframe within which VA is required to make a decision on requests to travel outside OPTN for non-VA transplant, as well as a means for expedited decision or waiver of such a decision. We do not make changes based on this comment. Timeframes may be influenced by factors such as the type of transplant, patient disease process, and patient acuity. It would not be practicable to define specific timeframes by regulation, given the

variability of these factors. However, VA will develop policy that will address such timeframes.

§ 17.4025, Effect on Other Provisions

We received over 50 comments concerning the effects of §§ 17.4000 through 17.4040 as proposed upon provisions of VA law that establish other criteria for the receipt of care or services. We address these comments below in the order in which they raised issues related to the provisions in paragraphs (a)–(c) of § 17.4025 as proposed.

We did not receive any comments that requested revisions to or clarifications for § 17.4025(a) as proposed, although as a general matter we did receive some comments that seemed to call for expanding eligibility for certain care and services under the VCCP beyond that which is established in other specifically applicable provisions of VA law (for instance, multiple comments called for the expansion of eligibility for VA dental care). Other comments did not seek expanded eligibility for certain care or services under the VCCP but did assert that the rule as proposed did not provide adequate explanation of eligibility for certain benefits such as dental care. We do not make any changes based on these comments and reiterate from the proposed rule that consistent with section 1703(n)(2), no provision in the rule may be construed to alter or modify any other provision of law establishing specific eligibility criteria for hospital care, medical services, or extended care services (such as for dental care). If specific services such as dental care under §§ 17.160–17.169 have unique eligibility standards, only covered veterans who are eligible under proposed § 17.4010 and meet such eligibility standards can elect to receive them through the VCCP.

A majority of the comments we received on § 17.4025 as proposed related to § 17.4025(b), regarding VA's criteria under the VCCP to fill or pay for prescriptions issued by non-VA providers. Some of these comments did not suggest changes to or clarification of the regulation text in § 17.4025(b) as proposed, but rather seemed to present issues related to administrative process rather than regulatory requirements (primarily, VA's administrative practices in reviewing prescriptions issued by non-VA providers). We will address below only those issues raised in comments regarding VA's requirements in § 17.4025(b) as proposed, and will address other issues related to administrative process in another section of this final rule related to miscellaneous comments.

As proposed, § 17.4025(b)(1) established the rule that VA would pay for prescriptions written by eligible entities and providers for a course of treatment not to exceed 14 days, and paragraph (b)(2) established that VA would fill prescriptions written by eligible entities and providers without any accompanying 14-day limitation. As explained in the preamble of the proposed rule, the intent of § 17.4025(b)(1) and (2) was to establish in VA regulations the long-standing VA practice of limiting its payment for medications written by non-VA providers and filled through non-VA pharmacies, rather than limiting VA's direct filling of such prescriptions through VA's Consolidated Mail Order Pharmacy (CMOP) system. We first address a comment that revealed an inadvertent omission in the regulation text at § 17.4025(b)(1) as proposed, related to when VA will pay for non-VA prescriptions. This comment specifically urged VA to change its practice of requiring veterans to pay for urgent or emergent prescriptions filled outside of VA's CMOP and then seek reimbursement from VA. This comment correctly summarized VA's practice at the time the proposed rule published, although § 17.4025(b)(1) as proposed did not contain any qualifying language related to VA paying for prescriptions written by non-VA providers only when they were urgently or emergently needed. We therefore revise § 17.4025(b)(1) to include qualifying language that VA will pay for prescriptions no longer than 14 days written by eligible entities or providers for covered veterans, including over-the-counter drugs and medical and surgical supplies, available under the VA national formulary system to cover a course of treatment for an urgent or emergent condition. In response to the request in this same comment that VA correct its practice of reimbursing veterans, to instead pay directly for prescriptions urgently or emergently needed for a course of treatment not to exceed 14 days, we clarify that VA's use of the term "pay" versus "reimburse" in § 17.4025(b)(1) was intended to and does create the option for VA to pay directly for these prescriptions. VA expects that upon full implementation of the Community Care Network of eligible entities and providers, the pharmacy benefits management options under those contracts will provide for VA to pay non-VA pharmacies directly for prescriptions written by eligible entities and providers to cover a course of treatment for an urgent or emergent condition and not to exceed 14 days.

We received multiple comments that indicated a general dissatisfaction with VA's practice of limiting payment for prescriptions written by non-VA providers, as well as comments that more specifically asserted that the 14-day limitation in § 17.4025(b)(1) as proposed was unreasonable because VA did not establish any exceptions to this limitation, with one comment requesting a revision to § 17.4025(b)(1) to allow for payment of a course of treatment greater than 14 days if VA is unable to fill that greater course through its Consolidated Mail Order Pharmacy (CMOP) system. Other comments requested an expansion of the 14-day limitation, such as a broad expansion of the limitation to 30 days, with one comment noting that a 30-day supply of medication should be approved for outpatient surgery specifically (to reduce potential post-surgical injuries or complications). We received other comments that did not suggest revisions or exceptions to the 14-day limitation per se, but that requested clarifications regarding its application. For instance, one comment requested clarification of VA's practices in paying for medications that are prepackaged for durations exceeding 14 days and that cannot be divided. We do not make any changes based on these comments that expressed general dissatisfaction with the 14-day limitation, or comments that VA should establish exceptions to or expand the 14-day limitation. As explained above, VA's only pays for non-VA prescriptions that are filled through non-VA pharmacies if they are needed to cover a course of treatment for urgent or emergent conditions. The 14-day limitation is a function of the limitation related to urgent and emergent conditions, as courses of medication for longer periods of time are not typically prescribed to treat urgent or emergent conditions. VA also has a responsibility to monitor the prescription of medications to ensure appropriate prescribing practices and general patient care. Using the outpatient surgery example as provided in one of the comments, typical medications issued following surgery such as antibiotics and pain killers are particularly important for VA to review and fill via the CMOP because such medications create medical concerns (such as antibiotic resistance, potential opiate monitoring issues, or other adverse events) if they were to be issued for and taken longer than 14 days. We also reiterate from the proposed rule that the current practice to limit payment for non-VA prescriptions allows VA to ensure that any amount of medication

exceeding 14 days would be filled through VA's CMOP system to ensure cost and quality controls. VA believes that the economies of scale related to bulk purchase of medications allow for the best use of Federal resources.

We received one comment that asserted non-VA providers must verify that prescribed medications are available through VA's formulary and comply with VA's practice guidelines, to avoid scenarios where covered veterans might receive prescriptions VA will not fill. We first note that we do not have anecdotal knowledge that there are widespread or recurring issues that non-VA providers are issuing prescriptions that VA cannot or will not fill because such medications are not on VA's formulary, or because the prescription contradicts VA's practices or guidelines. However, VA will review its administrative practices in reviewing and filling prescriptions issued by non-VA providers, to ensure it develops any necessary education or communication to non-VA providers to prevent those scenarios. We do not make any changes based on this comment but do note that § 17.4025(b)(1) and (2) as proposed generally requires that medications issued by non-VA providers must be available under the VA national formulary system. There are exceptions where VA may fill non-formulary prescriptions issued by non-VA providers, and such requests for exceptions are reviewed under specific procedures in VHA Directive 1108.08, VHA Formulary Management Process, which can be found on VA's website.

We received a few comments related to the prescribing of durable medical equipment (DME) by non-VA providers under § 17.4025(b)(3)–(4) as proposed. Some comments asserted that the rule should not require VA oversight or approval of prescriptions from non-VA providers for durable medical equipment (DME). Other comments were more specific, with one comment requesting clarification of who determines and what standards are used to determine when DME is immediately needed under § 17.4025(b)(3) as proposed, and further asserting that it should be determined by the prescribing clinician. Another comment requested that VA revise § 17.4025(b)(3) as proposed to specify that DME is an immediate need if it is required to safely discharge a patient from an urgent or emergent care setting, and that § 17.4025(b)(3) and (4) should be revised to expressly include home oxygen as covered under DME.

With regard to comments concerning general VA oversight and approval of DME that is prescribed by non-VA

providers, we reiterate from the proposed rule that because DME and medical devices prescribed by non-VA health care providers are specific to a particular clinical need and in most cases are further specifically tailored to fit or serve an individual, they require oversight and approval by VA (except when urgently or emergently needed) to ensure clinical appropriateness and the best use of Federal resources. We therefore do not make any changes based on those comments. With regard to comments concerning who determines and under what standards that DME is immediately needed, as well as the comments concerning the specific revisions related to immediate need, we first reiterate that DME to address an immediate need for urgent or emergent conditions does not require VA oversight or approval, and therefore would be issued by the treating or prescribing clinician without VA review. We next reiterate from the proposed rule that an immediate need for DME exists when a covered veteran has a medical condition of acute onset or exacerbation that manifests itself by severity of symptoms including pain, soft tissue symptomatology, bone injuries, etc. We believe the language in § 17.4025(b)(3) as proposed provides sufficient but non-exhaustive examples of the types of DME that are typically necessary to address such immediate needs (*i.e.*, splints, crutches, manual wheelchairs), and § 17.4025(b)(3) otherwise makes clear that urgent and emergent conditions meet the immediate need standards. We therefore do not make changes based on this comment. With regard to the comment concerning expressly adding home oxygen as covered DME, we clarify that home oxygen is considered DME for purposes of § 17.4025(b)(3) and (4) without further revisions to the proposed rule.

We received comments related to covered veterans' possible copayments in using community care under the VCCP, which we interpret to be related to § 17.4025(c) as proposed. Some comments urged that the rule should not change anything related to current copay structures and procedures. One comment asserted American Indian/Alaskan Native veterans should not be charged copayments for care received under the VCCP, as this was inconsistent with Federal trust obligations. We do not make any changes to the rule based on these comments and reiterate from the proposed rule that veterans will continue to be liable as applicable under §§ 17.108(b)(4) and (c)(4), 17.110(b)(4),

and 17.111(b)(3) for copayments for community care that is furnished through the VCCP. The VCCP will not alter the current treatment of veteran copayments under VA's traditional community care program or the Veterans Choice Program. We also reiterate from the proposed rule that veterans who receive care from the Indian Health Service (IHS) and Tribal Health Programs (THP) under a sharing agreement with VA will not be affected by regulations that implement the VCCP; the existing VA reimbursement agreements between IHS, THPs and VA control all parameters of how that care is provided, including whether copayments are charged.

§ 17.4030, Eligible Entities and Providers

We received over 200 comments related to non-VA entities and providers that may furnish hospital care, medical services, or extended care services through the VCCP. We address these comments below in the order in which they raised issues related to the provisions in paragraphs (a)–(c) of § 17.4030 as proposed.

A majority of these comments asserted that VA should ensure non-VA providers are similarly qualified and competent as VA providers to furnish the same levels of care as VA providers. These comments more specifically urged that non-VA providers must: Be properly licensed/credentialed; use evidence-based treatment; and have specific training in clinical areas where VA has developed particular expertise (*e.g.*, post-traumatic stress disorder, traumatic brain injury, etc.). Some of these comments further stated that if non-VA providers cannot furnish care or services as well as VA providers, then those providers should not be an option that covered veterans may choose to furnish community care under the VCCP. Lastly, a few of these comments also asserted that if non-VA providers do not submit full medical documentation for care or services furnished under the VCCP (and not mere submission of invoices or bills), VA must not pay them. We interpret these comments to be related to § 17.4030(a) as proposed, as some of the comments specifically alluded to VA establishing more specific requirements for providers in the contracts, agreements, or other arrangements the providers enter into under § 17.4030(a).

Regarding the general need for VA to establish requirements for non-VA providers, we agree with the comments that it is critical for covered veterans to receive competent care from qualified non-VA providers should such veterans

elect to receive care under the VCCP. However, we do not make any changes to § 17.4030 based on these comments. The rule at § 17.4030(c)(2) as proposed requires VA to assess the qualifications of the entity or provider to furnish the needed care or services in determining whether the provider is accessible to the covered veteran. These assessments can include licensing and credentialing information that VA collects under OMB control number 2900–0823. VA additionally requires submission of medical records as part of their claims for all non-VA care and services furnished under the rule (also under OMB control number 2900–0823) and as required by 38 U.S.C. 1703(a)(2)(A). VA reviews all licensing and credentialing information to ensure non-VA providers meet applicable standards for care needed, as well as medical records to ensure care was provided appropriately and within the scope of authorization. Although not part of the proposed rule, VA is establishing competency standards and requirements for the provision of care by non-VA providers in clinical areas where VA has developed special expertise, in accordance with section 133 of the MISSION Act. We are not regulating these standards to permit flexibility, as such standards are based on clinical practice and can be subject to change. VA's contracts, agreements, or other arrangements will impose requirements to meet these competency standards.

We received some comments that asserted VA should permit Medicare providers to participate in VCCP. We do not make changes based on these comments, as Medicare providers are a type of provider permitted under section 1703(c) to participate in VCCP, and are otherwise permitted to enter into contracts, agreements, or other arrangements with VA to furnish care and services under § 17.4030(a).

We received a few comments that requested clarification on whether or to what extent providers employed by VA could also participate in VCCP as eligible entities and providers to furnish care or services under § 17.4030(b) as proposed. We reiterate from the proposed rule, without changes to § 17.4030(b) as proposed, that providers who are employees of VA may not be acting within the scope of their employment while providing care or services through the VCCP. Essentially, VA providers may participate in VCCP as long as it is not during their VA-employed work hours.

We received a few comments that requested clarification of how VA would assess whether a non-VA provider is accessible to a covered

veteran under § 17.4030(c) as proposed. These comments generally seemed to inquire whether § 17.4030(c)(1) and (3) (related to VA assessing the length of time the veteran would have to wait to be seen by the non-VA provider, and the distance between the veteran's residence and that provider, respectively) were essentially VA's application of its access standards to non-VA providers, as such access standards were set forth in § 17.4040 as proposed. Those comments that assumed § 17.4030(c) did seek to apply VA's access standards to non-VA providers were primarily supportive of such an assumption. However, a few comments noted that applying such standards to non-VA providers was not feasible or advisable. One comment that opposed applying VA's access standards to non-VA providers more specifically asserted that non-VA providers would be discouraged from participating in the VCCP if they had to comply with VA's access standards, as this would amount to preferred treatment of veteran patients over non-veteran patients in terms of timeliness of appointments.

We clarify that VA did not intend for § 17.4030(c)(1) and (3) to establish a regulatory mechanism to apply VA's access standards as set forth in § 17.4040 to non-VA providers. This does not mean, however, that VA will not endeavor to ensure that community health care providers are able to comply with the applicable access standards established by VA, as VA is required to do so under section 1703B(f). To clarify VA's intentions, VA intends to establish access standards for non-VA providers in the contracts, agreements, or other arrangements that eligible entities or providers enter into under § 17.4030(a) as proposed, as opposed to establishing access standards for non-VA providers in regulation. We do not make changes to § 17.4030(c) as proposed based on these comments.

Although we do not make changes to § 17.4030(c) as proposed based on these comments, we do offer the following clarifications as requested by comments regarding how VA will use § 17.4030(c)(1) and (3) to assess whether a non-VA provider is accessible. 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 under § 17.4030(c)(1) as proposed, VA can ensure that veterans receive care as quickly as possible. If a veteran selects a non-VA provider who cannot see the veteran for several months, VA would probably determine that provider was inaccessible, and could then provide the veteran with other options of non-VA

providers to potentially schedule an appointment sooner. By considering the distance between the covered veteran's residence and the non-VA provider, VA can ensure that veterans receive care closer to their residence. If a veteran resides in New York and selects a provider in California (to receive care in California when they otherwise would not be residing in California at the time of the appointment), VA would probably determine that provider was inaccessible, and could then provide the veteran with other options of non-VA providers that would be closer to their residence at the expected time of the appointment. In either scenario (distance or time for an appointment), VA's decision regarding accessibility is not pre-determined; these will be case-by-case decisions. We believe these factors will be most relevant in situations where a covered veteran has not selected a particular non-VA provider, but is looking for VA to identify a non-VA provider that can furnish the care for them. In such cases, we would use these factors to determine which providers should be offered as possible options. If a covered veteran has selected a particular provider, we may determine in some cases that the provider is inaccessible (as in the New York/California example above), while in other cases, such cross-country travel might be approved (if, for example, there were only one or two providers in VA's network that furnished a specific type of service). In more typical cases, we anticipate that the veteran's selection of a particular provider will likely be approved, even if a particular provider might have a slightly longer wait time or be slightly further away from the veteran, as this would be the veteran's choice.

We also note that § 17.4030(c)(2) as proposed will consider the qualifications of the entity or provider to furnish the hospital care, medical services, or extended care 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 may not authorize a patient to receive care or services from that entity or provider. We raise this last factor in § 17.4030(c)(2) as proposed to reiterate as stated above that VA will consider these factors together to make accessibility determinations on a case-by-case basis, considering each veteran's specific needs. 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 an entity or provider is accessible.

We are making minor changes to paragraph (c) to use the term covered veteran in lieu of the term eligible veteran in several places. The term eligible veteran is used in § 17.1530 because it is a defined term in § 17.1505. Under the VCCP regulations, we use the term covered veteran, as defined in § 17.4005. This change simply removes any ambiguity as to the term and does not alter the effect or meaning of the rule.

Lastly, we received a comment that requested VA specifically include in these regulations outreach, training, and other assistance to non-VA providers to expand the Patient-Centered Community Care (PC3) network, as the commenter asserted that such expansion is particularly critical to deliver community care in underserved areas. We do not make changes based on this comment, as this comment presents an operational request that is more appropriately addressed through contract or policy. We do clarify, however, efforts on VA's part to improve education of providers regarding the formation of contracts under section 1703(h) through the Community Care Network in the portion of this document that discusses miscellaneous comments.

§ 17.4035, Payment Rates

We received over 25 comments concerning the parameters under which VA establishes payment rates for care and services furnished through the VCCP, as set forth in § 17.4035 as proposed. We address these comments below in the order in which they raised issues related to provisions in paragraphs (a)–(e) of § 17.4035 as proposed. We note that some comments we received related more to administrative processes associated with payment for care and services (e.g., how VA pays non-VA providers), rather than the regulatory requirements from the proposed rule; we will address such administrative comments in the section of this final rule related to miscellaneous comments.

We received some comments that asserted that VA should not pay below applicable Medicare fee schedules or prospective payment system amounts, to ensure non-VA providers are not

discouraged from participating in the VCCP. One comment was more specific, noting that VA should pay at full applicable rates for inpatient care that go beyond Medicare's professional fee schedule, including at academic hospitals that have both indirect medical education (IME) and direct medical education (DME) billing components. We do not make changes to § 17.4035(a) as proposed based on these comments. The limitation of VA's payment rates to be no higher than Medicare, versus being designated the same as Medicare rates, is consistent with section 1703(i)(1) that, with exceptions, the rates VA pays for care and services may not exceed the applicable Medicare rate. We clarify, however, that VA has typically paid at applicable Medicare rates under the Veterans Choice Program, to avoid the scenario raised by comments where non-VA providers are discouraged from participating in VA community care programs. With regard to the specific concerns in paying IME or DME billing for academic hospitals, we also do not make changes to § 17.4035(a) as proposed but do clarify that VA does pay adjustments to Medicare costing as applicable and appropriate.

One comment requested that VA provide more details on how it will determine payment rates for inpatient services provided by critical access hospitals, as the statutory authority for setting rates for such hospitals (42 U.S.C. 1395m) was referenced in § 17.4035(a) as proposed. This comment further voiced support for VA using a cost-based approach to determine rates for critical access hospitals. We do not make changes based on this comment. We believe the language in § 17.4035(a) and its reference to 42 U.S.C. 1395m is sufficient to allow VA to calculate appropriate rates for critical access hospitals.

One comment requested that VA confirm that use of the term Medicare rate in § 17.4035 generally means a rate unaffected by Federal budget sequestration. We do not make changes based on this comment and can only confirm that to the extent Medicare's rates or adjustments are unaffected by budget sequestration, so too will VA's rate setting be unaffected under the parameters established in § 17.4035. Similarly, and inversely, if sequestration did modify the rates paid under the Medicare program, VA's rates would also potentially change. We do not believe sequestration would change the Medicare fee schedule, but we acknowledge that it could affect the Centers for Medicare and Medicaid Services' (CMS) ability to pay. VA's

payment rates for any particular service to any particular provider will be established through the terms set forth in the contract or agreement and may reference the Medicare fee schedule in general. If such terms are fixed to a specific dollar amount, any change in the Medicare rate will not otherwise serve to modify the terms of that contract or agreement. However, if the terms in the contract or agreement are relative, such as by referencing the Medicare fee schedule, then changes to the Medicare fee schedule would carry over per the terms of the contract or agreement.

The parenthetical language in § 17.4035(a) as proposed would establish that VA's payment rate adjustments occur only on an annual basis in line with Medicare's annual payment updates. One comment requested that VA revise this parenthetical language to require VA to conform to Medicare's rate adjustment approaches in their entirety. This change would result in changes to VA's rates on a much more frequent basis than the annual payment updates issued by Medicare that VA presently follows. We do not make changes based on this comment. VA does not have access to the information or systems that Medicare uses to adjust payments on a more frequent basis than annually, based on such factors as quality or performance, utilization, etc., and as such, cannot operationalize this aspect of the Medicare program's payment schedule.

We did not receive comments concerning § 17.4035(b) as proposed, and therefore do not make any changes.

We received one comment recommending VA revise § 17.4035(c) as proposed, to expand the definition of highly rural area to include rural area. This comment further stated that VA should utilize the Rural-Urban Commuting Areas system, developed by the Department of Agriculture and the Department of Health and Human Services, to define rurality. We do not make changes based on this comment. We reiterate from the proposed rule that use of the term highly rural area is prescribed by and specifically defined in statute in section 1703(i)(2)(B).

A few comments requested clarification as to how VA will determine that limiting its payment rates to applicable Medicare rates is not practicable, as permitted under § 17.4035(d) as proposed. Some comments further requested clarification of how eligible entities or providers would be notified of allowable payment rates in excess of Medicare rates. One comment

specifically requested that VA should ensure women veterans' medical needs were considered as a factor when establishing rates in excess of Medicare. We do not make any changes based on these comments, although we do reiterate from the proposed rule that payment rates are ultimately set forth in the terms of the contract or agreement under which the care and services are furnished. As set forth in § 17.4035(d), the factors that could prove persuasive in terms of determining impracticability as identified in the proposed rule include patient needs, market analyses, and provider qualifications, among others. General market conditions usually establish that supply and demand can establish a price equilibrium, and we believe these conditions will also inform when it would be impracticable to pay the Medicare rate.

A few comments requested clarification as to how VA will determine payment rates for non-Medicare services, particularly for extended care services (*e.g.*, home health, adult day health care, and respite care). Some of these comments further requested that VA be transparent about establishing and updating these rates, but not necessarily that VA revise § 17.4035 to do so. We do not make changes based on these comments. As noted in § 17.4035(a), the rates paid by VA for hospital care, medical services, or extended care services furnished pursuant to procurement contract or an agreement authorized by §§ 17.4100 through 17.4135, will be the rates set forth in the terms of such contracts or agreements. Any services for which there is no Medicare rate will be determined in accordance with the defined terms in the contract or agreement.

We received one comment related to the portion of the preamble that explained § 17.4035(e) as proposed, which requested that VA explain why fiscal year (FY) 2003 data is used to determine amounts under VA's Alaska Fee Schedule. We do not make changes based on this comment but clarify that the VA Alaska Fee Schedule was originally introduced following an actuarial study completed by VA in 2001, in which VA determined that special circumstances exist in Alaska that warranted a specific fee schedule be calculated in order to avoid limitations on Veteran access to care. Based on this study, and pursuant to notice-and-comment rulemaking, VA promulgated a regulation at 38 CFR 17.56(d) to establish the VA Alaska Fee Schedule (*see* 70 FR 5926, February 4, 2005). The provision in § 17.56(d) as originally

promulgated used FY 2003 data and indicated that VA will increase the amounts on the VA Alaska Fee Schedule annually beginning in 2005 in accordance with the published national Medicare Economic Index (MEI). VA has used the MEI to annually update data from the previous fiscal year's Alaska Fee Schedule, since this schedule was first established. Given that these updates have occurred regularly, and that VA's systems are built on maintaining this schedule, we believe it would be administratively burdensome and likely of little value to change the baseline reference from FY 2003. We further note that we received no comments recommending a change from this baseline; the commenter simply asked for VA's rationale for using this data. We believe this methodology has proven effective for providers in Alaska.

We received a few comments that requested VA clarify or confirm, and further expressly revise § 17.4035 to reflect, that VA is always the primary payer for care and services that covered veterans receive through the VCCP. A related comment also requested VA revise § 17.4035 to indicate that VA's payment is payment in full and extinguishes a covered veteran's liability. We do not make any changes based on this comment but reiterate from the proposed rule that under section 1703(j), VA shall recover or collect reasonable charges for such care or services from a health plan contract described in section 1729 in accordance with such section. These provisions of law establish VA's role as the primary payer. We further note that VA will seek to ensure that the contracts or agreements VA enters into with eligible entities and providers will include terms that limit their ability to seek payment from a veteran when VA has made any payment for care or services furnished to that veteran on VA's behalf. There is no need for regulatory language to ensure that covered veterans do not face additional liability (other than applicable copayments) for using the VCCP.

Lastly, we received one comment that urged VA to adopt value-based reimbursement models, particularly for mental health care, as permitted under section 1703(i). This comment further stated that the ability of VA to use value-based models should encourage VA's development of innovative payment models, including bundled payment for certain episodes of care. We do not make any changes based on this comment. Again, the contract or agreement will set forth the terms of payment, which could include the use

of value-based models. To the extent such value-based models could result in payment that exceeds the limitation set forth in § 17.4035(a), VA has the option of utilizing the exception in § 17.4035(d) when applicable to permit the use of such models.

We are making minor changes to this section to reflect the promulgation of regulations implementing the Veterans Care Agreement authority in section 1703A. Specifically, we are replacing the reference to section 1703A of this title and referring instead to §§ 17.4100 through 17.4135, as these regulations were added to the Code of Federal Regulations through a separate VA rulemaking published on May 14, 2019 (RIN 2900-AQ45, see 84 FR 21668).

§ 17.4040, Access Standards

We received over 18,000 comments related to the substantive provisions of the access standards in § 17.4040 as proposed. For the sake of clarity, we have divided the discussion below into three main sections. The first section will address the general concerns in comments that are related to both the average drive time and wait time standards as set forth in § 17.4040 as proposed. The next section will address more specific substantive issues related to the average drive time standards, and the last section will address more specific substantive issues related to the wait-time standards. We also clarify that a majority of these comments were duplicated form responses, and we address the access standard issues as jointly raised below.

Access Standards Generally

We received comments that generally opposed both the drive-time and wait time access standards as proposed, based primarily on assertions that the access standards were arbitrary because they were not realistic, feasible, or sustainable, and VA did not conduct enough research of all existing access models to properly propose its own access standards. Some of these comments further asserted that VA should have delayed proposal of access standards until more research or analysis could have been completed (to include VA waiting on the anticipated results of the market area assessments required by section 7330C(a) as added by section 106 of the MISSION Act, and not before conducting pilot testing as needed).

Regarding the assertions in comments that the access standards as proposed by VA were arbitrary, we reiterate from the proposed rule that the drive-time standards were derived from specific analyses that showed trends of 30-

minute drive times for primary care and 60-minute drive times for specialty care in TRICARE, State Medicaid plans, State insurance departments, and commercial health plans. For instance, TRICARE Prime (the Department of Defense's most comprehensive managed care plan, uses a 30-minute drive time for primary care and a 60-minute drive time for specialty care for non-active duty beneficiaries. VA also assessed both the Medicaid Plans and other primary insurance plans of 14 States, and found a majority of those States have a 30-minute travel time standard for primary care, and a 60–90-minute travel time standard for specialty care under State Medicaid plans and 45–60 minute travel time standards for other primary State insurance plans. VA determined that it would be reasonable to fall in line with these other network expectations throughout the industry. VA further used the results of its access standards analysis to develop and model several options using VA's Enrollee Health Care Projection Model (EHCPM). VA's EHCPM allowed VA to consider best practices in the industry in its development of access standards as well as the financial impact of various access standard scenarios. After considering this information from analyses of similar drive times in other health care plans as well as from VA's EHCPM, VA determined that its access standards should reflect an average drive time-based criterion that considers the care or services needed in relation to the veteran's residence, which is a similar approach as TRICARE Prime related to travel standards (opting to use average driving time versus mileage). Similarly, the wait time standards were derived from research of non-VA network expectations throughout the industry, and they fell within the range of appointment wait-time standards found in other government organizations, State programs, and commercial entities (e.g., 7–28 days for primary care and 15–30 days for specialty care). Further, the proposed wait-time standards are achievable in most VA facilities and are consistent with capabilities identified in the private sector. On average, VA national wait times in March 2019 for new appointments (e.g., the first appointment in a new episode of care versus a subsequent appointment in the continuation of an existing episode of care) was approximately 20.6 days for primary care, 10.8 days for mental health care, and 22.4 days for specialty care. These wait times have decreased since the December 2018 reporting period included in the proposed rule. The proposed wait-time standard of 20

days for primary care and mental health, for example, is both in line with other similar industry standards and is a manageable goal for access to VA care. We do not make changes based on these comments, as we believe VA's access standards as proposed were based on reasoned research and analysis and are therefore not arbitrary.

Regarding the assertions in comments that VA should have delayed proposal of its access standards until more research or analysis could have been completed (to include waiting for VA's market area assessments and potential pilot testing to conclude), VA was unwilling to engage in such delay as we believe it would have delayed implementation of access standards well beyond the statutory deadline of June 6, 2019. Pilot testing is an extensive process, which would have required the results of the summary market area assessments, which themselves were not completed at the time of publication of the proposed rule.

We received a few comments that opposed the access standards generally because of VA's designation of nearly all hospital care, medical services, and extended care services available under its medical benefits package. According to the comments, VA's designation of so many services to have an applicable access standard was contrary to Congressional intent. According to these comments, Congress only intended for VA to designate a few types of care or services, and a designation of more care and services creates a risk of decreased funding of VA's direct provision of care. Particularly, one comment stated that VA's impact analysis for the proposed rule indicated that VA will consider the performance of its facilities on wait time access standards when making resource allocation decisions and inquired if funding or resources would be withheld from a facility if it did not meet the designated access standards. We do not make changes based on these comments. We acknowledge that VA did consider during the development process of the legislation that would become the MISSION Act that only a limited number of care or services might ultimately be designated as having access standards, VA proposed instead to designate a majority of the care and services available under its medical benefits package. VA's broader designation of most care or services maximizes the choice of covered veterans and prevents veterans from having to navigate a bifurcated system where more limited care and services would be available under the access standard eligibility than under any other eligibility criterion for VCCP.

Designation of access standards for a majority of VA care and services makes administration of the VCCP simpler for VA for this same reason and ensures better coordination of care. VA's designation of access standards for a majority of its care and services, however, does not force veterans into the community to receive care. We reiterate from the discussion at the beginning of this final rule that section 1703(d)(3), as regulated at § 17.4020(a), requires that eligible covered veterans must still elect to receive care and services through the VCCP. We clarify that VA's statement from the impact analysis for the proposed rule, as referenced in one of the comments, is not a statement of intent to withhold resources or funding per se if a facility is not meeting access standards. It is a statement that VA must consider use of its services when considering allocation of its resources, which could include investment into facilities that require assistance to meet access standards. Regarding the question of Congressional intent more specifically, we do not read any limitation in 38 U.S.C. 1703 or 1703B regarding the number of designated access standards; these statutes provide broad authority to the Secretary to make these determinations and do not constrain his authority in the ways described in the comments.

We received comments that opposed the access standards generally because it was unclear whether they would be applied to non-VA providers, with some comments further requesting that VA make non-VA provider participation in VCCP contingent upon compliance with the same standards VA adopts for its direct delivery of care and services. Essentially, these comments asserted that unless care available under the VCCP could meet (or exceed) VA's access standards, it should not be accessible to covered veterans because it would not be providing care that could be received sooner or closer than VA could provide. We do not make changes to § 17.4040 as proposed based on these comments. We first reiterate from the section of this final rule that discusses eligible entities and providers that VA will endeavor to ensure that community providers are able to comply with the applicable access standards established by VA. Such access standards for non-VA providers, however, will be used to measure network adequacy to ensure that covered veterans who elect to receive care through the VCCP are generally getting timely care that is near to their residence. VA will not strictly apply its access standards to eligible entities or providers as a factor to

determine their eligibility to furnish hospital care, medical services, or extended care services furnished the VCCP. Although we understand the rationale offered in the comments that assert VA should strictly apply its access standards to non-VA providers, the concept of access standards for determining VCCP eligibility is fundamentally different than the concept of access to care and services in the private sector. VA must ensure its access standards establish a consistent mechanism to provide the option of choice in the community to the covered veteran if VA cannot meet those standards. In the private sector, access standards are a mechanism to measure performance and network capacity, not eligibility. As we have said before, no covered veteran eligible to receive community care is required to seek care in the community. The veteran could elect to receive care from VA or could inquire about seeking care in the community and change his or her mind if the community options are not convenient (in terms of distance or scheduling availability). As VA gains more experience with VCCP, we anticipate our systems will be able to provide information to veterans and providers regarding community locations and wait-times so that veterans can make informed decisions that work for them. We also reiterate from the section of this final rule that discusses eligible entities and providers that we agree with a comment that stated that VA should not apply its access standards to eligible entities and providers for purposes of eligibility as this could amount to preferred treatment of veteran patients over non-veteran patients and could discourage eligible entities and providers from participating in the VCCP.

We received comments that opposed the access standards generally because the comments asserted that not having different (presumably, longer drive time or wait time) standards for specialized VA care or for VA's foundational services could erode patient volume necessary to sustain such care and services at VA, and that VA should take a more refined approach to distinguishing access for such services to ensure the quality of care and veteran satisfaction is maintained. A related comment more specifically urged VA to ensure that care and services to treat spinal cord injury be excluded from any designated access standard, to ensure that such care may only be provided by VA. We do not make changes based on these comments.

We reiterate from an earlier discussion in the purpose and scope

section of this final rule that expanding access to care and services in the community does not equate with forcing veterans into the community to receive care; covered veterans must still elect to receive care in the community if eligible under VA's access standards. We agree with the comments that it is critical for VA to maintain focus on all care and services it directly provides to veterans, and we reiterate from the proposed rule that VA will continue to sharpen its focus on directly providing those services that are most important to the coordination and management of a veteran's overall medical and health needs, including continued examination of whether its designated access standards should be revised with future rulemakings to account for specialized areas of VA expertise.

We received a few comments that requested clarification of why VA did not designate a particular access standard for VA foundational services, and one comment further seemed to assert that lack of such designation meant that these services were not covered under the VCCP. We do not make changes based on these comments but clarify that the designated access standards cover all forms of hospital care, medical services, and extended care services, with the exception of institutional extended care services (this exception is discussed further below).

We received one comment that requested VA either revise § 17.4040 to add an access standard for institutional extended care service (e.g. nursing home care) or provide a more robust rationale than provided in the proposed rule for why institutional extended care was not included within VA's designated access standards. We do not make changes based on this comment but do provide additional rationale as requested by the comment. Institutional extended care such as nursing home care is simply not apt to be measured in terms of access in the same manner as other care and services that, generally speaking, are more standardized and available in the community. For example, the law in each State controls admission factors for Medicaid-participating nursing homes, which introduces too many variables to provide relative comparisons to VA nursing home admissions. As another example, Medicaid-participating nursing home facilities in the community generally admit patients on a first-come, first-served basis, and maintains waiting lists for admission. When a bed is vacant, facilities consult the wait list to determine who is next on the list to be admitted, but it is not an accurate reflection of when any patient will be admitted, primarily because

many people on the wait list are not yet in need of nursing home care or they have been placed in another facility. In addition, a State's regulations could control when a patient may be admitted under circumstances beyond first-come, first-served—the most common example is admission to a nursing home facility directly from a hospital due to medical need. People being admitted directly from a hospital level of care may be seen as having a greater need before anyone on a wait list. Some States also have rules concerning placing only patients of the same gender together in each room, or rules permitting admission preference in cases requiring intervention by the Department of Human Services or Adult Protective Services (or similar agency). We cannot provide a full survey of all State laws that may control or influence Medicaid-participating nursing home facilities in the community, and it may be that these nursing homes also create special admission rules to receive Medicare-eligible individuals who are in need of acute rehabilitation (for instance, for a stay not to exceed 20 days). We reiterate that there are many variables for comparison to admission to VA nursing home facilities that make assignment of a designated access standard impracticable, as it would not reflect VA's relative ability or inability to directly provide nursing home care.

We received one comment that requested VA revise § 17.4040 to add an access standard specifically for mental health care and services that would be deemed to be needed immediately, as similar to any access standard that VA might apply for emergency care or same-day appointments. We do not make changes based on this comment. We will discuss more fully in the section of the rule below that addresses wait times specifically, but should any care or service under a wait time access standard be deemed necessary for a covered veteran prior to reaching the ending date of the applicable wait time standard under § 17.4040(a)(1)(ii) and (a)(2)(ii), then the best medical interest eligibility criterion under § 17.4010(a)(5) would enable a covered veteran to be seen for such care or services through the VCCP, assuming criteria under § 17.4010(a)(5) were met. We further note that emergent mental health care is available from VA on a same-day basis, and VA's urgent care benefit under § 17.4600 (section 1725A) should also make some services available on an expedient basis.

We received one comment that requested VA clarify the interaction between the average drive time and wait time standards, as both § 17.4040(a)(1)(i)

and (a)(2)(i) indicate that the standards are considered together to determine whether they are met (these regulatory clauses indicate that the drive time is considered as well as the wait time). The comment more specifically asserted that the average drive time and wait time should be independently assessed (the regulatory clauses should not use the term and as a connector, but rather a term such as either), to prevent scenarios where (in the case of the primary care standard) a facility that can provide the care or services may be more than 30 minutes away, but a covered veteran would not qualify for VCCP because that facility can offer the care or services within 20 days. We do not make changes based on this comment but do clarify that the average drive time is an independent qualifier and the wait time is not. The structure of the regulatory clauses in § 17.4040(a)(1)(i) and (a)(2)(i) qualifies instances where a VA facility that can offer the care or services may be within the average 30 minute driving time (in the case of the comment's primary care example), but still not able to provide the care within 20 days—in such cases, a covered veteran would be eligible to elect to use the VCCP. However, if a VA facility that can offer the care or services needed is not within 30 minutes average drive time (in this example), then the covered veteran would qualify for VCCP without any assessment of how long it would take a facility further away to provide the needed care or services. The wait time cannot be an independent qualifier because there must be a context within which to apply the wait time—otherwise, the wait time could be applied to any VA facility that could provide the care or services needed regardless of the average drive time from the covered veteran's residence. We believe that the regulation addresses the commenters concern: VA must be able to furnish care within the average drive time and the wait time standard. If VA cannot meet both conditions, or in other words if it fails either condition, the covered veteran would be eligible to elect to receive community care.

The proposed rule stated that if VA is able to furnish a covered veteran with care or services through telehealth, and the veteran accepts the use of this modality for care, VA would determine that it was able to furnish such care or services in a manner that complies with designated access standards. We received one comment that urged VA to ensure that the option for the veteran to have face-to-face care would be maintained if the veteran did not choose the telehealth modality. We do not make

changes based on this comment. As stated in the preamble of the proposed rule, VA will not require a veteran accept the use of telehealth for the purpose of meeting VA's designated access standards.

Lastly, we received a few comments that requested clarification of how VA will apply the access standards for homeless Veterans without a residence. We do not make changes based on these comments but clarify that homeless veterans may currently provide an address to VA that is recorded in the Veterans Health Information Systems and Technology Architecture; this address is used for other VHA benefits and may be applied to veterans seeking to participate in VCCP as well. For example, any homeless veteran who is residing in a place supported by a Department of Housing and Urban Development-VA Supportive Housing 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. Covered veterans that do not have a residence may be assessed under other eligibility criteria in § 17.4010(a)(1) through (3) and (5) and (6), to receive care or services through the VCCP.

Average Drive Time Standards

We first address comments similar to those discussed above regarding the access standards generally, where commenters suggested that VA should apply its average drive time standards to the locations of eligible entities and providers from which covered veterans might elect to receive care through the VCCP, to ensure such non-VA care would not be further away from a veteran's residence than VA care. Another comment urged VA to track zip codes of where non-VA care was provided through the VCCP, to ensure care was received at the nearest facility. We do not make changes based on these comments. We reiterate from the discussion above that the access standards VA will establish for eligible entities and providers will be used to monitor network adequacy and will not be used as a limitation on a covered veteran's eligibility to receive care and services through the VCCP. VA must ensure its access standards establish a consistent mechanism to provide the option of choice in the community to the covered veteran if the VA cannot meet those standards. In the private sector, however, access standards such as average drive times are a mechanism to measure performance and network capacity, not eligibility. We also restate

from discussion earlier in this final rule that VA will use § 17.4030(c)(1) and (3) to assess whether a non-VA provider is accessible. 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 under § 17.4030(c)(1), VA can ensure that veterans receive care as quickly as possible. If a veteran selects a non-VA provider who cannot see the veteran for several months, VA would probably determine that provider was inaccessible, and could then provide the veteran with other options of non-VA providers to potentially schedule an appointment sooner. By considering the distance between the covered veteran's residence and the non-VA provider under § 17.4030(c)(3), VA can ensure that veterans receive care closer to their residence. If a veteran resides in New York and selects a provider in California (to receive care in California when they otherwise would not be residing in California at the time of the appointment), VA would probably determine that provider was inaccessible, and could then provide the veteran with other options of non-VA providers that would be closer to their residence at the expected time of the appointment. In either scenario (distance or time for an appointment), VA's decision regarding accessibility is not pre-determined; these will be case-by-case decisions.

We received some comments that asserted VA should not use an average drive time standard but instead should continue to use a mileage-based distance standard, with certain of the comments additionally calling for new mileage standards (one comment advocated a new standard of 20 miles for vision-related care or services specifically, while other comments advocated new standards of 30 or 35 miles without specifying particular care or services). We do not make changes based on these comments. We reiterate from the proposed rule that a mileage-based access standard can be a poor indicator of actual conditions that affect travel to receive care and services, as such a standard does not recognize the inherent variation of driving speeds in rural versus urban areas (as traffic levels and speed limits typically allow rural residents to travel farther, faster than urban residents). Also, covered veterans may benefit from a drive-time standard as opposed to a mileage-based standard, such as the case with veterans in mountainous areas where it can take significantly longer than 30 minutes (or even 60 minutes) to travel 40 miles. We believe that use of an average drive-time

criterion versus a mileage standard will provide a more consistent and equitable standard of access for all covered veterans.

We received other comments that urged VA to adopt different average drive time standards than the 30 minutes and 60 minutes in § 17.4040(a)(1)(i) and (a)(2)(i) as proposed, respectively. Multiple comments advocated for an average drive time standard of 40 minutes for specialty care, 30 minutes for all services, 60 minutes for all services, or that the standards in § 17.4040(a)(1)(i) and (a)(2)(i) should be flipped, where 60 minutes would apply to primary care and mental health and 30 minutes would apply to specialty care. Particularly, the comments that advocated flipping the 30-minute and 60-minute average drive time standards stated that specialty care is arguably more urgently needed than primary care, or that travel to receive specialty care is more burdensome, and therefore the lesser timeframe of 30 minutes should be applicable to specialty care. We do not make changes to § 17.4040(a)(1)(i) or (a)(2)(i) based on these comments.

We reiterate from the proposed rule and the expanded discussion earlier in this final rule that the average drive-time standards are derived from specific analyses that showed trends of 30-minute drive times for primary care and 60-minute drive times for specialty care in TRICARE, State Medicaid plans, State insurance departments, and commercial health plans. We further clarify that the different drive-time standards for primary care versus specialty care particularly are not intended to reflect the relative importance of one type of care versus the other, but rather the relative availability of one type of care versus the other, as specialty care tends to be generally less available than primary care and therefore requires longer travel times to reach on average. Nearly all individuals in a geographic area require primary care at some point, typically several times per year. But only a subset of these same individuals may require specialty care, and not likely with the same frequency. We believe distribution of health care resources follows the basic premise outlined above, to result in specialty care generally being less widely geographically dispersed, particularly considering that such specialty services often require specialized facilities and equipment that are difficult and costly to replicate. For these reasons, we believe it is widely understood that patients often times will need to travel

a bit farther for specialty care than primary care.

We received multiple comments related to how VA will calculate average drive times under § 17.4040(b) as proposed. Many of these comments asserted that there were too many variables related to actual drive time (e.g., road or weather conditions, congestion or traffic) for VA's calculations to be accurate if it used a strict average of drive times throughout a day (or week, or other defined timeframe) versus using a predictive system that is related to the time of appointment. While some of these comments urged VA to adopt new definitions or clarifications to assist with calculating average drive times (e.g., defining the term hazardous weather in § 17.4010(a)(5)(vii)(A)), other comments suggested that, without disclosing proprietary information related to the geographic system software VA will use, VA's calculations should consider how factors change throughout a day, particularly traffic patterns. More specifically, a few comments urged that any drive time calculation VA uses must consider peak drive times to account for routine spikes in traffic. We do not make changes to § 17.4040(b) as proposed based on these comments. We believe that it is more veteran-centric to maintain the operational flexibility to refine and improve VA's calculations in response to experience, feedback, and changing real-world conditions, rather than to detail in regulation a specific methodology or considerations that could constrain VA's ability to improve the calculation of average drive time in the future.

We first note that further definition of terms in § 17.4010(a)(5)(vii)(A), as requested in one comment, does not have any bearing on eligibility determinations under § 17.4040(b) as proposed (we also believe that terms to characterize an unusual or excessive burden in § 17.4010(a)(5)(vii)(A) are sufficient as proposed). We address the comments that requested clarification on how VA will calculate average drive times with other comments regarding VA's administration of its community care programs in the portion of this final rule that discusses miscellaneous comments.

We received some comments that requested VA consider use of non-personal vehicles (e.g., public transit) when calculating applicable average drive times. We do not make changes based on these comments. We reiterate from the proposed rule that calculating average drive time based on the use of a personal vehicle applies to many of

the veterans we serve, and that it would be too difficult and potentially costly to consistently implement and operationalize a system that considers the variety of transportation options potentially available to an individual veteran. In major metropolitan areas, a veteran could travel by personal car, bus, or rail, and each of these would have different travel times.

Wait Time Standards

We first address comments that opposed the 20-day or 28-day wait time standards based on the timeframes themselves. Some comments stated that these timeframes were too long for covered veterans to wait to be seen when they may have conditions or concerns requiring more immediate attention, with a few comments further urging VA to adopt different standards (for instance, 14 days or less for all services, 20 days for all services, or 14 days for primary care and 20 days for specialty care). Other related comments asserted that the wait time standards in § 17.4040(a)(1)(ii) and (a)(2)(ii) should be flipped, where 28 days would apply to primary care and mental health and 20 days would apply to specialty care, because specialty care is arguably more urgently needed than primary care. We do not make changes based on these comments. To address the concern that 20 or 28 days as applicable is too long to wait to address more immediate health care needs, we clarify that these are timeframes by which VA can assess whether it can provide care and services under normal and not urgent or emergent circumstances. Should any care or service with an applicable wait time be deemed necessary for a covered veteran prior to reaching the ending date of such wait time standard, then the best medical interest eligibility criterion under § 17.4010(a)(5) might enable a covered veteran to be seen for such care or services through the VCCP (assuming criteria under § 17.4010(a)(5) were met). To address the comments concerning the 20-day and 28-day wait times being flipped, we reiterate from the section above that access standards for primary care versus specialty care are not intended to reflect the relative importance of one type of care versus the other, but rather the relative availability of one type of care versus the other, as specialty tends to be generally less available than primary care and therefore can require longer wait times on average.

The preamble of the proposed rule introduced the concept that VA preliminarily had established a goal of reducing the wait times for primary care and mental health services from 20 days

in § 17.4040(a)(1)(ii) as proposed to 14 days no sooner than June 2020. Although this reduction from 20 days to 14 days was not put forth in proposed regulation text, we invited and received comments on this issue, the vast majority of which recommended that VA should not wait until 2020 to reduce such wait times to 14 days. Conversely, we received a few comments that VA should not reduce the primary care or mental health wait times to 14 days prematurely, and that VA should focus on meeting the 20-day standard first. More specifically, one comment asserted that VA should wait for the results of VA's market area assessments to drive any potential future reductions in wait times. We do not make changes based on these comments, but reiterate from the proposed rule that presently, a 14-day wait-time standard would be difficult for VA to implement due to the current availability of providers and variability in appointment wait-times across VA facilities. However, VA will pursue additional rulemaking should we proceed with the goal to reduce the primary care and mental health wait time standards from 20 days to 14 days.

We received comments that did not necessarily oppose the wait-time access standards, but that requested clarification of how VA would determine whether care was primary care, specialty care, or mental health care. Some related comments more specifically asserted that certain care should fall within the 20-day standard for primary care, for instance, most women's health care services, physical therapy, and traumatic brain injury. Another comment advocated that certain case management services associated with assisting homeless veterans should be considered specialty care. We do not make changes based on these comments. We believe in a majority of cases that it will be clear what standard should be applied to what care. Because we believe these comments are primarily concerned that certain services will not be given the benefit of relatively shorter wait times, we reiterate that if care is determined to be needed prior to reaching the ending date of an applicable wait time, then the best medical interest eligibility criterion under § 17.4010(a)(5) would enable a covered veteran to be seen for such care or services through the VCCP (assuming criteria under § 17.4010(a)(5) were met). We further advise that VA is experienced in determining whether care is primary care or specialty care, as VA uses this distinction to assess copayments under § 17.108.

We received one comment that requested VA revise § 17.4040(a)(1)(ii)

and (a)(2)(ii) to establish that the start date to begin counting any applicable wait time should be the date that the services are clinically indicated to be needed, and not the date of request for an appointment. We do not make changes based on this comment. By shifting the start of the wait time standard under the VCCP from the clinically indicated date to the date of request, VA can optimize consistency in decisions of eligibility that employ the wait time access standard. Consistency in decisions regarding eligibility is desirable because it assists VA to accurately forecast the use of VCCP under this standard, and because it supports parity in eligibility determinations to support a sense of fairness in veteran experience in using the VCCP. Additionally, the option for the covered veteran to choose a later date in consultation with a provider still permits for the wait time standards to be counted starting on a date that is later than the date of request, which could encompass a starting date when the services would be considered clinically indicated.

Miscellaneous Comments

We received many comments that did not directly relate to any regulatory sections from the proposed rule, but that expressed concerns with VA's administration of its community care programs and further suggested improvements. Although we do not make changes to the proposed rule based on these comments because they are beyond the scope of the proposed rule or address issues that would best be handled through policy or contracting mechanisms, we summarize the comments below by grouping them by topic and indicate where we provide clarifications.

Transition From the Veterans Choice Program

We received comments related to VA's transition from the Veterans Choice Program (Choice) to the Veterans Community Care Program (VCCP), which primarily requested clarification of administrative issues related to VA's contracting efforts to ensure that there was a smooth transition to the VCCP. The largest administrative issue raised in comments was how VA would mitigate gaps in coverage in transitioning to the VCCP, where specific requests for clarifications included: Whether VA anticipated delays in implementation due to any contract protests; whether the same services offered under Choice contracts would be offered under VCCP contracts (and more specifically, Veterans Care

Agreements); whether providers under Choice provider agreements would be grandfathered into VCCP contracts or agreements (essentially asking whether Choice providers would be considered VCCP providers automatically until VCCP contracts can be finalized); and whether VA would issue guidance on transition from Choice to VCCP, to include more information on "other arrangements" under which care can be provided. VA has modified one of its community care contracts that provided coverage under the Veterans Choice Program to engage the same third-party administrator (TPA) (TriWest Healthcare Alliance) to provide for expanded nationwide coverage for the VCCP until VA's Community Care Network (CCN) contracts have established a fully functional network of providers. We believe this nationwide engagement of the same TPA from the Veterans Choice Program to administer the VCCP, until the CCN contracts are in place and the networks required by those contracts are fully operational, will allay many concerns regarding transition to the VCCP, as the administrative procedures should be familiar to those providers that participated under the Veterans Choice Program.

A related comment asserted that VA should standardize its contracts and contracting processes nationally, to avoid what the comment asserted was regional variation in contracts and contracting processes that are present in other non-VCCP community care programs. This comment also urged VA to make such contracts formed under section 1703(h) publicly available, and that any rules contained in such contracts that seek to control the actions of eligible entities and providers should be developed by notice-and-comment rulemaking so that stakeholders (that are not the entities or providers) can provide input on the impact of such rules on entities or providers. We do not make any changes based on these comments. Any VA decisions regarding contracting processes and standardization are implemented through separate processes and actions, potentially including policies and acquisition regulations. Separately, contracts within the meaning of section 1703(h), and solicitations leading to such contracts, are and will be subject to the existing, comprehensive legal framework governing public disclosure of information relating to such procurements and contracts. Any VA decisions regarding public disclosures of information relating to such procurements and contracts will be

made in accordance with those laws. Finally, VA does not commit to establishing all contractual requirements through notice-and-comment rulemaking, and does not commit to establishing only national contracts. Such commitments are incompatible with the legal and operational framework of Federal procurement, including the flexibility, discretion, and independence that are often integral to the process of defining requirements.

Veterans Need More Information To Inform Their Election To Receive Care Through the VCCP

We received comments that indicated VA was not providing enough information to veterans to enable them to make informed choices of whether to elect to receive community care. These comments primarily stated that comparisons between VA care and community care were not apparent at the point veterans might elect to receive community care, and that veterans needed access to more timely comparisons between: VA and non-VA wait times; distances from a veteran's residences to VA and non-VA providers; and relative competency of VA and non-VA providers (particularly, for care to treat conditions such as posttraumatic stress disorder and traumatic brain injury). Some of these comments suggested specific improvements (such as ensuring non-VA provider directories are updated and available to veterans), where other comments requested VA clarify how relevant comparative information will be provided to veterans to elect to receive community care as required by section 1703B(b). VA understands the desire for more information so covered veterans can make informed choices regarding providers. VA has included community provider information in the VA facility locator on www.va.gov that shows both VA and community providers. This will allow covered veterans to see the locations of specific community providers in relation to VA providers. As VA begins to implement the new CCN contracts, appointment availability timeframes will also be available for the VA to share with covered veterans to assist them in making a decision on providers.

Implementation of VA's Average Drive Time Standard

VA received comments that requested clarification on how VA will calculate average drive times. We note that some detailed information regarding average drive time calculations and algorithms is proprietary. At a general level, VA's

calculation of average drive times between the veteran's residence and an applicable VA facility will take into consideration a variety of factors, including: Distance, route options, and speed limits. In its current configuration, VA's geographic information system tool bases these calculations on historical data, rather than real-time traffic information. As VA gains more experience with VCCP and receives feedback from veterans regarding their experiences with the program, we anticipate refining this tool and our systems to improve our consideration of actual conditions that affect travel to receive care and services and to provide more information to veterans regarding calculation of average drive times.

We received a comment that urged VA to publish a report every six months regarding the outcome of VA using an average drive time standard versus a mileage standard, to include a total number of individuals qualifying under the average drive time standards. We do not make changes to the regulation based on this comment, and do not commit to publishing such a report, although we note that VA will monitor use of the VCCP care and services by covered veterans, to include use that qualifies under the designated access standards. VA will report regularly to Congress on utilization of the VCCP, as required by section 1703(m).

Claims Adjudication and Payments

We received comments related to administrative procedures for VA's processing of claims for payments for hospital care, medical services, or extended care services furnished through the VCCP. These comments essentially stated that claims and payment procedures need to be clear and minimally burdensome and that VA must ensure it applies the prompt payment provisions that are required under section 1703D to ensure providers are paid on timely (particularly, as noted by one comment, to include provisions that cover interest on overdue claims). Some of these comments further urged VA to confirm its plans to publish future regulations to implement the prompt payment provisions in section 1703D, with some requests that VA provide a more specific timeframe in which it expects to promulgate such regulations. Another comment urged that VA should consider establishing a maximum timeframe to pay electronic claims within 14 days, and to pay paper claims within 30 days, when VA does promulgate regulations to implement section 1703D. Lastly, multiple comments generally asserted

that appeals procedures for adjudication of claims or payment-related disputes should be comprehensive and timely.

We first confirm that VA will be undertaking future rulemaking to implement the prompt pay provisions of section 1703D, which will include provisions to implement the requirements under section 1703D (such as establishing timeframes in which to pay clean electronic and clean paper claims, addressing interest on overdue claims, and appeals procedures). We cannot provide an exact timeframe in which VA can expect such regulations to be promulgated, and we will not discuss specifics here of any policy development regarding such regulations, although we generally note that two-stage rulemaking can typically require 18–24 months to complete. We received some related comments regarding claims and payments processing that asserted the compensation options for eligible entities or providers are difficult to understand and that providers are not paid timely as a result, but these comments urged VA to publish a comprehensive policy for eligible entities and providers to resolve misunderstandings. We clarify that the compensation options are part of the contract between VA and the TPA. VA will work with the TPAs to ensure they have appropriate information regarding claims submission and processing that will assist in preventing untimely payments. Section 122 of the MISSION Act requires VA to develop and implement a training program for employees and contractors on how to administer non-Department health care programs. As required by section 122 of the VA MISSION Act, VA is providing training to the TPAs regarding administrative processes.

One comment indicated that on July 31, 2018, the Centers for Medicare and Medicaid Services (CMS) published the Prospective Payment System (PPS) and Consolidated Billing for Skilled Nursing Facilities (SNF) Final Rule for Fiscal Year (FY) 2019. The comment further noted that in this rule, CMS finalized a proposal to replace the current Skilled Nursing Facility Prospective Payment System Resource Utilization Group (RUGs) payment model with a new per diem payment system called the Patient-Driven Payment Model (PDPM) beginning on October 1, 2019. This comment ultimately urged that CMS and VA communicate how the PDPM reimbursement structures and VA's reimbursement structures will work together. Because reimbursement is included in the contracts with the TPAs, VA will ensure that the payment

methodology used is clearly explained to the contractors so that eligible entities and providers understand how VA's benchmark of using applicable Medicare rates may shift with the publication or annual or major Medicare rate shifts.

Improve Procedures and Practices of VA's Third-Party Administrators

We received many comments that identified both general and specific administrative improvements that could be made by the third-party administrators (TPA) with whom VA contracts to generally administer the VCCP. Most of these comments identified the desired administrative improvements by providing examples of TPA deficiencies as experienced under Choice, but we address these comments here in relation to the VCCP. The most general concerns expressed in these comments related to a lack of timeliness, accuracy, and follow-up regarding TPA practices in referring and scheduling care in the community. These comments generally urged that improvements were needed to streamline scheduling, where specific suggestions to achieve improvements ranged from simplifying communications systems (e.g., consolidating various call center numbers to create a one-call/one-stop experience for covered veterans to interact with TPAs) to creating more comprehensive guidance on how TPAs obtain timely eligibility determinations and authorizations from VA. VA is generally responsible for scheduling appointments for veterans in most markets and will work with its TPAs to improve administrative processes to assist in streamlining scheduling in other cases, particularly where VA can improve its processes to verify eligibility and communicate authorizations of care.

Other comments indicated a need for clearer policies and processes to ensure that non-VA providers and covered veterans understand what care is and is not authorized, and a few comments deemed that VA's review of authorizations for care were not timely or consistent. One comment further urged VA to adopt a more robust and transparent process to ensure each authorization for care includes: A binding determination regarding the scope of issues that might be raised for coverage and payment purposes; a plan to transfer a covered veteran back to VA after conclusion of the treatment authorized; prompt decisions to grant or deny authorizations; and a statement that clarifies non-VA providers will receive payment for services provided due to error on VA's part or on the

covered veteran's part. Much of what is specifically raised by this comment is contemplated in the contracts VA forms with TPAs or directly with eligible entities and providers to furnish care and services through the VCCP, and VA will work to improve consistency in its authorization processes. Related comments urged VA to develop guidance to address oversight of its TPAs that would include metrics to measure effective communications between the TPAs and eligible entities or providers, and a process for such entities or providers to contact VA for dispute resolution regarding TPA performance. We similarly respond that much of what these comments raise is contemplated in the contracts VA forms with eligible entities and providers, and VA will work to ensure appropriate monitoring of TPAs as identified in the contract.

We received some comments related to VA's processes in credentialing non-VA entities or providers to find them eligible to furnish care and services through the VCCP. Specifically, these comments urged VA to reduce potential duplication of credentialing processes between VA and the TPAs with whom VA contracts to administer community care. One comment further urged VA to maintain its recognition of a current administrative process adopted by some non-VA hospitals (particularly, academic medical centers) to have the TPA delegate provider credentialing to the non-VA hospital, where such hospital agrees to meet the credentialing requirements through their own in-house process and be audited as necessary. We clarify that the credentialing process to determine whether non-VA entities or providers are eligible to participate in the VCCP will be conducted by the TPAs with whom VA contracts and not by VA, so we do not believe there is cause to be concerned about duplicative credentialing processes. For this same reason, VA cannot respond to clarify how a TPA's credentialing processes may be conducted, but VA would support any TPA processes to continue or establish credentialing that reduces delays, so long as VA's credentialing requirements are met.

Some comments urged improvements to administrative processes for particular groups of covered veterans. For instance, with regard to pregnant veterans and veterans in need of maternity care, one comment urged VA to: Establish a more streamlined process for prior authorizations for pregnant veterans (to include priority access to treatment of substance use disorder); require authorization by VA of required

episodes of care no more than seven days after pregnancy is diagnosed; make Maternity Care Coordinators (MCC) a full-time position in VA facilities as needed; and ensure that pregnant veterans receiving non-VA care are put in contact with MCCs to assist navigating non-VA care. One commenter urged VA to require eligible entities and providers in the community to use VA's universal housing instability screener to ensure that homeless veterans who may elect to receive care in the community are aware of VA's homeless assistance programs. We appreciate these comments and agree it is important to maintain awareness if certain veteran populations may require particular VA assistance to navigate community care or assistance to access VA resources that do not necessarily pertain to healthcare matters. VA will ensure it maintains its focus to assist in care coordination for all veterans who elect to receive care in the community.

Lastly, we received a few comments that stated that VA should not use TPAs generally, as this creates an unnecessary layer of administrative bureaucracy. A few comments indicated more specifically that VA should not use a specific TPA with which it has previously contracted to provide care in the community, and instead should use veteran contractors. Currently, VA's utilization of TPAs to perform certain functions is important to ensuring VA optimizes its provision of care in the community. For instance, use of a TPA provides VA an accredited network of providers as well as claims processing that is standardized in the health care industry, which are two areas that VA does not have the required infrastructure or expertise to administer directly at this time. With regard to the comments that VA should not use a specific TPA and should use veteran contractors instead, we note that VA is subject to, and abides by, the comprehensive set of laws governing Federal procurement. Those laws do not permit indiscriminate awarding of contracts to groups of individuals, as we believe is suggested by the commenter.

Information Technology and Information Sharing

We received multiple comments that expressed concerns regarding VA's information technology (IT) infrastructure and capabilities to enable the level of information sharing required to ensure smooth administration of the VCCP. The general thrust of these comments asserted that VA's IT systems, particularly its electronic medical record system, required improvements to ensure the timely and

seamless exchange of clinical information between VA and non-VA sources. More specifically, some commenters urged VA to acquire and use a single electronic system that would be accessible 24 hours a day/7 days a week by non-VA entities and providers, and that could be integrated with VA's electronic medical record to assist with confirming VCCP eligibility and otherwise to communicate all clinical and administrative information necessary to participate in VCCP (*e.g.* eligible entities and providers would submit and receive referrals or authorizations, medical records, claims forms, etc.). Other comments further urged VA, whether it would adopt new IT systems or modify its existing systems, to allow non-VA providers (specifically the large academic medical centers and faculty practice plans) to designate multiple staff members who would have access to those systems. We clarify that VA has been steadily working on improvements for sharing of medical information. VA participates in standardized health information exchanges in the health care industry, and this summer is deploying a commercial referral management system, Healthshare Referral Manager, which will be used to share authorizations with community providers and exchange medical information. VA has already deployed community viewer, which allows community providers secure, web-based access to medical information and VirtruPro, which allows secure, encrypted email exchange between the VA and community providers. VA also encourages all providers to submit claims electronically using industry standard transactions to ensure prompt payment of claims.

We received one comment that urged VA to modernize its IT systems as an attempt to move away from the administration of paper claims and eventually require the submission of electronic claims. VA will consider addressing the submission of paper claims and electronic claims in any future rulemaking to implement the prompt payment provisions of section 1703D. VA is also undertaking efforts to modernize its IT systems for claims processing. As noted above, VA encourages all providers to submit claims electronically using industry-standard transactions. VA is additionally deploying an industry-standard claims processing system this year that includes auto-adjudication and will improve timeliness of claims processing.

We received one comment that expressed concerns that VA's decision

support tool to determine whether a covered veteran was eligible to participate in VCCP (particularly with regard to eligibility based on VA's designated access standards), will not be ready for timely implementation on June 6, 2019. VA expects the tool will be ready by June 6, 2019. This tool will assist with eligibility determinations by displaying, documenting, and storing relevant information related to eligibility determinations in a standardized and reportable manner. In the event that the tool was not at full functionality for any reason, VA can also look to other systems to gather and assess information related to eligibility (such as VA's Computerized Patient Record System) as a contingency.

Emergency Care

We received comments related to the administrative practices of VA in reviewing and approving emergency care. These comments generally relayed concerns that covered veterans were unduly subject to cost liabilities for emergency treatment because the administrative requirements VA imposes were unclear or inefficient and lead to VA failing to approve or pay for the emergency care in a timely manner. These comments suggested multiple improvements, primarily comprised of requests for VA to: Increase education for providers and covered veterans (to ensure the nearest VA facility is well known for purposes of the 72-hour notification, who is the appropriate VA official at that facility to receive the notice, etc.); and establish a single, nationwide system (such as an online portal and national call center) where all emergency care matters under the VCCP would be administered. The administrative rules in place regarding notice to the nearest local VA facility are required to ensure that emergency care can be authorized and claims can be considered under all available authorities for emergency care. The local facility is in the best position (and in many ways, the only position) to actually assess criteria related to the appropriateness of authorizing emergency care (for instance, whether a patient could be transferred to a nearby VA facility). VA will work to improve education and messaging to non-VA providers and veterans concerning how and where to submit timely notice of use of emergency care to assist with timely approvals.

Prescriptions

We received comments regarding VA's administrative practices in reviewing and approving prescriptions issued by non-VA providers. These

comments primarily voiced concerns that VA's practices were unnecessary or unduly burdensome and either created delays in getting prescriptions filled, or created unnecessary administrative costs for VA. Some comments further suggested alternatives to VA's current practice of VA providers reviewing and approving prescriptions from non-VA providers, such as allowing non-VA providers to fill prescriptions directly with VA pharmacies through the TPA that VA utilizes to administer its community care programs. VA's current practices of reviewing and approving prescriptions issued by non-VA providers are in place to ensure appropriate prescription monitoring, care coordination, and cost and quality controls. VA does not believe that this review creates unnecessary administrative costs for VA, but VA can work to improve its internal review and approval processes to reduce or eliminate delays in getting non-VA prescriptions filled.

Eligible Entities and Providers

We received comments related to VA's practices in disseminating information to non-VA providers who could potentially participate in VCCP, for the purpose of maintaining and increasing provider participation. These comments generally called for improvements in VA's communicating such information to providers and suggested improvements ranged from offering a webinar specifically on the implementation of contracts or agreements (particularly for Veterans Care Agreements authorized under section 1703A and §§ 17.4100 through 17.4135), to developing or improving policies related to approving providers to participate in the VCCP. VA will examine its current outreach and education efforts in maintaining and increasing (as needed) provider participation in the VCCP and will be open to all options of communicating with non-VA providers to ensure that provider requirements to participate in the VCCP are well understood.

We received one comment that urged VA to clarify whether non-VA providers who would furnish care and services under the VCCP are considered Federal contractors or subcontractors to be subject to Federal contractor requirements, including, but not limited to Executive Order 11246, as amended, Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended, and the McNamara-O'Hara Service Contract Act of 1965, as amended, and any other Federal contractor obligations, such as

those related to Federal minimum wage and sick leave. This comment urged that non-VA providers participating in the VCCP should not be considered Federal contractors or subcontractors to avoid application of Federal contractor obligations imposed under the jurisdiction of the Department of Labor's Office of Federal Contract Compliance Programs (OFCCP). We clarify that section 107 of the MISSION Act states that Directive 2014-01 of the Office of Federal Contract Compliance Programs (OFCCP) of the Department of Labor (effective as of May 7, 2014) applies to any entity entering into an agreement under section 1703A or section 1745 of title 38 in the same manner as such Directive applies to subcontractors under the TRICARE program for the duration of the moratorium established by that Directive. VA has consulted with the Department of Labor regarding this provision, and we understand that OFFCP intended, through a Directive 2018-02, to extend the moratorium from OFCCP's jurisdiction concerning Executive Order 11246, section 503 of the Rehabilitation Act, and the Vietnam Era Veterans' Readjustment Assistance Act to cover health care providers in all VA programs under which VA has statutory authority to provide care to veterans by contracting with private, non-VA providers. Specifically, we understand OFCCP to consider the following categories of providers to be within the scope of the 2018 Directive's moratorium: Independent contractors operating in VA facilities, contract community-based outpatient clinics, and providers who are part of a network and furnishing services pursuant to a contract between VA and the network administrator, contracts and agreements directly between VA and providers (*i.e.*, Federal Acquisition Regulation (FAR)-based contracts subject to all procurement laws, Choice provider agreements, Veterans Care Agreements, and agreements with State Veterans Homes). We further note that the Department of Labor is working to establish the Directive's moratorium through a regulation, and we appreciate their efforts in that effort.

Congressional Review Act

The Secretary of Veterans Affairs finds that there is good cause under the provisions of 5 U.S.C. 808(2) to make the rule effective on June 6, 2019. Specifically, the Secretary finds that it would be contrary to the public interest to delay the date this rule could be operative and effective because any delay in implementing the rule would have a severe detrimental impact on veterans' health care.

Section 143 of the MISSION Act of 2018 amended section 101(p) of the Veterans Access, Choice, and Accountability Act of 2014 (Pub. L. 113–146; 38 U.S.C. 1701 note, as amended, hereafter referred to as the Choice Act) to state that VA may not use the Choice Act to furnish care and service after June 6, 2019. As a result, on that date, VA will no longer be able to use the Veterans Choice Program to furnish care or services in the community. Section 101 of the MISSION Act will amend 38 U.S.C. 1703 to permit VA to administer a new Veterans Community Care Program, which will replace the Veterans Choice Program. However, section 1703 will not be so amended until VA promulgates regulations under section 101(c) of the VA MISSION Act of 2018 by its own terms, which is the function of this final rule. Therefore, if this final rule is not effective on June 6, 2019, VA would not have the Choice Act authority or the MISSION Act authority under which to administer care in the community; the only authority VA would have to administer such care would section 1703 as it exists unamended by the MISSION Act.

The provisions of section 1703 as unamended by the MISSION Act, as well as its implementing regulations at 38 CFR 17.52, do not provide a sufficient legal basis to meet the requirements of section 101 of the MISSION Act in areas such as eligibility, appeals, and payment rates, nor do they provide for the same levels of community care that have been received by veterans under the Veterans Choice Program through June 6, 2019.

If this final rule to implement the new Veterans Community Care Program, and to replace Veterans Choice Program, is not effective on June 6, 2019, the approximately 2 million veterans who have received care under the Veterans Choice Program (for over 46 million appointments since inception) will be forced to find alternative pathways to care. These veterans will either be: (1) Absorbed by existing VA facilities, (2) sent out into the community under VA's more limited section 1703 authority, or (3) might forego care all together. As indicated below, all of these pathways would result in delays in care, lack of continuity in care, and absence of care that would be significantly detrimental to veteran's health.

Absorbing the Veterans Choice Program's share of care for 2 million veterans into existing VA facilities would significantly strain VA's resources and cause problems impacting veterans' health. It would interrupt continuity of care, pose significant

delays for scheduling care, and would lead to long wait times. The VA system is simply not capable of accommodating this amount of care without causing delays in access to care.

Some care, therefore, would need to remain in the community. But with neither the Veterans Choice Program nor the new Veterans Community Care Program in place, VA would have no universally applicable eligibility criteria for community care. Without such national, clear, and consistent criteria in place, individual VA facilities or VA Health Care Systems may adopt local criteria that do not support standardized decisions regarding when veterans may be eligible to receive VA community care, and VA could return to the same non-standardized community care environment that led to the wait-time issues in 2014, such as when access barriers adversely affected the quality of primary and specialty care at the Phoenix VA Health Care System. After the wait-time issues of the Phoenix VA Health Care System were made public, VA's Office of Inspector General examined the electronic health records and other information from more than 3,000 veteran patients and identified 28 instances of clinically significant delays in care associated with access to care or patient scheduling. The Office of the Inspector General (OIG) found that the majority of the veteran patients reviewed were on official or unofficial wait lists and experienced delays accessing primary care—in some cases, pressing clinical issues required specialty care, which some patients were already receiving through VA or non-VA providers. OIG further found that some veterans on unofficial wait lists were at risk of never obtaining their requested or necessary appointments. As OIG stated, inappropriate scheduling practices were a nationwide systemic problem. OIG identified multiple types of scheduling practices in use that did not comply with VHA's scheduling policy. We believe these deviations from scheduling policy were due in part to limited and inconsistently applied criteria by which veterans may receive community care.

By way of example, section 1703 as unamended by the MISSION Act provides VA authority to contract for hospital care and medical services when VA facilities are not capable of furnishing economical care due to geographic inaccessibility or are not capable of furnishing care. However, our implementing regulations at 38 CFR 17.52 generally establish eligibility criteria based on type of care needed and whether or not the veteran is service-connected, and do not provide

additional clarity on what geographic inaccessibility means. Nothing in § 17.52 or section 1703 as unamended by the MISSION Act approximates the specific eligibility criteria available under the Veterans Choice Program or contemplated under the MISSION Act related to distance-related access criteria. As such, the criterion of geographic inaccessibility under section 1703 as unamended by the MISSION Act can be interpreted many ways, leading to inequitable eligibility decisions for community care and bad scheduling practices based on such decisions.

A delay in the effective date of this rule would result in a lack of consistently applicable community care criteria, which would create significant disruptions for even a limited period of time such as sixty days. Continuity of care could particularly be disrupted, and patient safety and health would be in jeopardy, for any veterans who would not be authorized to seek care from a health care provider that has been treating them for years under the Veterans Choice Program. This could be particularly harmful for veterans who have mental health conditions and are only comfortable seeking treatment from their current mental health care professional.

Such veterans may opt to simply forego care from a different provider for a delay of sixty days until this rule is effective. Similarly, a sixty-day delayed effective date could increase confusion for even for new veteran users, new and existing providers in the community, as well as employees at VA, if VA were to go from administering community care under Veterans Choice Program criteria, to then under significantly more limited criteria of section 1703 as unamended by the MISSION Act for a very limited period of time, and then to implementation of what are now publicly vetted and broader criteria under the new Veterans Community Care Program. To avoid this confusion, some veterans may simply choose not to receive care until the new Veterans Community Care Program is in place, or providers may simply not participate, or even VA may be at risk for administering community care incorrectly. This places veterans' health and safety at risk, particularly for continuous and periodic care or treatment that may be occurring under the Veterans Choice Program through June 6, 2019, and that must typically occur on an immediate and stringent schedule upon diagnosis (such as treatment for cancer, or maternity care).

Accordingly, the Secretary finds it would be contrary to the public interest

to delay the effective date of AQ46 and that there is good cause to dispense with the opportunity for a 60-day period of prior Congressional review and to publish this final rule with an operative and effective date of June 6, 2019.

Administrative Procedure Act

For the reasons set forth in the preceding section, the Secretary finds that there is good cause under 5 U.S.C. 553(d)(3) to publish this rule with an effective date that is less than 30 days from the date of publication.

Effect of Rulemaking

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

Paperwork Reduction Act

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

This final rule will amend information collection requirements currently approved under control number 2900-0823 and will impose new collections of information requirements and burden. Notice of OMB approval for this information collection will be published in the **Federal Register**.

Regulatory Flexibility Act

The Secretary hereby certifies that this final rule will not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act, 5 U.S.C. 601-612. Although some eligible entities or providers that will furnish care and services to veterans under this rule might be considered small entities, there will be no significant adverse economic impact. To the extent there is any impact on small entities and given the lapse in statutory authority for the Veterans Choice Program, it will be a potential increase in business due to proposed expanded eligibility for non-VA care. While this rulemaking defines payment rates and eligible entities and providers, it does so

in a way that is consistent with VA's current authorities. We note that separate regulations at 38 CFR 17.4100 through 17.4135, authorizes VA to enter into agreements with eligible providers, many of whom will likely be small businesses. We also do not believe there will be a significant economic impact on any insurance companies that might be considered small businesses, as claims would only be submitted for care that would otherwise have been received whether such care was authorized under VCCP; the need for the care itself is not generated by the VCCP, merely furnished under the VCCP versus another program. Therefore, pursuant to 5 U.S.C. 605(b), the Secretary has determined that an initial and a final regulatory flexibility analysis are not needed.

Executive Orders 12866, 13563 and 13771

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

The total estimated budget impact (both transfers and costs) is projected to be \$346.3 million in FY 2019 and \$17.9 billion over a 5-year period. Transfers are estimated to be \$15.6 billion over a 5-year period and costs are estimated to be \$2.2 billion over a 5-year period. These transfer impacts are from the federal government to eligible Veterans. The cost impacts are administrative fees, claim fees and other non-provider payment costs.

Benefits of the rulemaking will strengthen the access to VA health care overall by increasing the choices Veterans have for their health care and complementing the increasingly timely, high-quality care provided by VA medical facilities. Veterans will continue to have the option to choose whether to receive care at a VA medical facility or a community provider. Furthermore, the access expansion will allow Veterans to receive care in the community through a network of providers when VA does not provide the required care or services, wait times do not conform with VA access standards, service line does not meet VA quality standards, the referring clinician determines it is in the best medical interest of the Veteran to receive care or services in the community. Additionally, Veterans will be able to access community care when the Veteran was eligible to receive care under certain grandfathering provisions or VA does not operate a full-service medical facility in the State in which the veteran resides.

VA's regulatory impact analysis can be found as a supporting document at <http://www.regulations.gov>, usually within 48 hours after the rulemaking document is published. Additionally, a copy of the rulemaking and its impact analysis are available on VA's website at <http://www.va.gov/orpm> by following the link for VA Regulations Published from FY 2004 through FYTD. This final rule is an E.O. 13771 regulatory action. VA has determined that the net costs are \$2.2 million over a five-year period (FY2019-FY2023) and \$429 million per year on an ongoing basis discounted at 7 percent relative to year 2016, over a perpetual time horizon. Details on the estimated costs of this final rule can be found in the rule's economic 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 one year. This final rule will have no such effect on State, local, and tribal governments, or on the private sector.

Catalog of Federal Domestic Assistance

The Catalog of Federal Domestic Assistance numbers and titles for the programs affected by this document are as follows: 64.007, Blind Rehabilitation Centers; 64.008, Veterans Domiciliary Care; 64.009, Veterans Medical Care Benefits; 64.010, Veterans Nursing Home Care; 64.011, Veterans Dental Care; 64.012, Veterans Prescription Service; 64.013, Veterans Prosthetic Appliances; 64.014, Veterans State Domiciliary Care; 64.015, Veterans State Nursing Home Care; 64.016, Veterans State Hospital Care; 64.018, Sharing Specialized Medical Resources; 64.019, Veterans Rehabilitation Alcohol and Drug Dependence; 64.022, Veterans Home Based Primary Care; and 64.024, VA Homeless Providers Grant and Per Diem Program.

List of Subjects in 38 CFR Part 17

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

Signing Authority

The Secretary of Veterans Affairs, or designee, approved this document and authorized the undersigned to sign and submit the document to the Office of the Federal Register for publication electronically as an official document of the Department of Veterans Affairs. Robert L. Wilkie, Secretary, Department of Veterans Affairs, approved this document on April 23, 2019, for publication.

Dated: May 30, 2019.

Michael P. Shores,

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

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

PART 17—MEDICAL

■ 1. The authority citation for part 17 is amended by revising the entry for § 17.38 and adding entries for §§ 17.46, 17.52, 17.55, 17.56, 17.108, 17.110, and 17.111 and §§ 17.4000 through 17.4040

in numerical order to read in part as follows:

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

* * * * *

Section 17.38 is also issued under 38 U.S.C. 1703.

Section 17.46 is also issued under 38 U.S.C. 1710.

Section 17.52 is also issued under 38 U.S.C. 1701, 1703, 1710, 1712, and 3104.

Section 17.55 is also issued under 38 U.S.C. 513, 1703, and 1728.

Section 17.56 is also issued under 38 U.S.C. 1703 and 1728.

Section 17.108 is also issued under 38 U.S.C. 501, 1703, 1710, 1725A, and 1730A.

Section 17.110 is also issued under 38 U.S.C. 501, 1703, 1710, 1720D, 1722A, and 1730A.

Section 17.111 is also issued under 38 U.S.C. 101(2B), 501, 1701(7), 1703, 1710, 1710B, 1720B, 1720D, and 1722A.

* * * * *

Sections 17.4000 through 17.4040 also issued under 38 U.S.C. 1703, 1703B, and 1703C.

* * * * *

§ 17.38 [Amended]

■ 2. Amend § 17.38(a)(1)(iv) by removing “§§ 17.52(a)(3), 17.53, 17.54, 17.120–132” and adding in its place “§ 17.52(a)(3), § 17.53, § 17.54, §§ 17.120 through 17.132, or §§ 17.4000 through 17.4040.”

§ 17.46 [Amended]

- 3. Amend § 17.46:
 - a. In paragraph (a) introductory text by adding the phrase “on or before June 6, 2019,” after the phrase “In furnishing hospital care”; and
 - b. Removing the authority citations at the ends of paragraphs (a) and (b).
- 4. Amend § 17.52 by removing the authority citations at the ends of paragraphs (a)(1) through (10) and paragraph (b) and adding paragraph (c) to read as follows:

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

* * * * *

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

§ 17.54 [Removed and Reserved]

- 5. Remove and reserve § 17.54.
- 6. Amend § 17.55 by revising the introductory text and removing the authority citation at the end of the section to read as follows:

§ 17.55 Payment for authorized public or private hospital care.

Except as otherwise provided in this section, payment for public or private hospital care furnished on or before

June 6, 2019, under 38 U.S.C. 1703 and § 17.52, or at any time under 38 U.S.C. 1728 and §§ 17.120 and 17.128 or under 38 U.S.C. 1787 and § 17.410, shall be based on a prospective payment system similar to that used in the Medicare program for paying for similar inpatient hospital services in the community. Payment shall be made using the Centers for Medicare & Medicaid Services (CMS) PRICER for each diagnosis-related group (DRG) applicable to the episode of care.

* * * * *

■ 7. Amend § 17.56 by adding paragraph (e) and removing the authority citation at the end of the section to read as follows:

§ 17.56 VA payment for inpatient and outpatient health care professional services at non-departmental facilities and other medical charges associated with non-VA outpatient care.

* * * * *

(e) Except for payments for care furnished under 38 U.S.C. 1725 and § 17.1005, under 38 U.S.C. 1728 and §§ 17.120 and 17.128, or under 38 U.S.C. 1787 and § 17.410, the provisions of this section shall not apply to care furnished by VA after June 6, 2019, or care furnished pursuant to an agreement authorized by 38 U.S.C. 1703A.

- 8. Amend § 17.108:
 - a. In paragraph (b)(4):
 - i. By removing “§ 17.1500 through 17.1540” and adding in its place “§§ 17.1500 through 17.1540, or the Veterans Community Care Program under §§ 17.4000 through 17.4040”; and
 - ii. Removing “paragraphs (b)(2) or (b)(3)” and adding in its place “paragraph (b)(2) or (3)”;
 - b. In paragraph (c)(4), by removing “§ 17.1500 through 17.1540” and adding in its place “§§ 17.1500 through 17.1540, or the Veterans Community Care Program under §§ 17.4000 through 17.4040”; and
 - c. Removing the authority citation at the end of the section.

§ 17.110 [Amended]

- 9. Amend § 17.110:
 - a. In paragraph (b)(4):
 - i. By removing “§ 17.1500 through 17.1540” and adding in its place “§§ 17.1500 through 17.1540, or the Veterans Community Care Program under §§ 17.4000 through 17.4040”; and
 - ii. Removing “paragraphs (b)(1)(i) through (b)(1)(iii)” and adding in its place “paragraphs (b)(1)(i) through (iii)”; and
 - b. Removing the authority citation at the end of the section.

§ 17.111 [Amended]

- 10. Amend § 17.111:
 - a. In paragraph (b)(3):
 - i. By removing “§ 17.1500 through 17.1540” and adding in its place “§§ 17.1500 through 17.1540, as well as extended care services furnished through the Veterans Community Care Program under §§ 17.4000 through 17.4040”; and
 - ii. Removing “paragraphs (b)(1) or (b)(2)” and adding in its place “paragraph (b)(1) or (2)”; and
 - b. Removing the authority citation at the end of the section.

§ 17.1004 [Amended]

- 11. Amend § 17.1004 in paragraph (b) introductory text by removing the phrase “HCFA 1500” and adding in its place “CMS 1500” and removing the authority citation at the end of the section.
- 12. Add an undesignated center heading and §§ 17.4000 through 17.4040 to read as follows:

Veterans Community Care Program

Sec.

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

Veterans Community Care Program**§ 17.4000 Purpose and scope.**

(a) *Purpose.* Sections 17.4000 through 17.4040 implement the Veterans Community Care Program, authorized by 38 U.S.C. 1703.

(b) *Scope.* The Veterans Community Care Program establishes when a covered veteran may elect to have VA authorize an episode of care for hospital care, medical services, or extended care services from an eligible entity or provider. Sections 17.4000 through 17.4040 do not affect eligibility for non-VA care under sections 1724, 1725, 1725A, or 1728 of title 38, United States Code.

§ 17.4005 Definitions.

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

Appointment means an authorized and scheduled encounter, including telehealth and same-day encounters, with a health care provider for the delivery of hospital care, medical services, or extended care services.

Covered veteran means a veteran enrolled under the system of patient

enrollment in § 17.36, or a veteran who otherwise meets the criteria to receive care and services notwithstanding his or her failure to enroll in § 17.37(a) through (c).

Eligible entity or provider means a health care entity or provider that meets the requirements of § 17.4030.

Episode of care means a necessary course of treatment, including follow-up appointments and ancillary and specialty services, which lasts no longer than 1 calendar year.

Extended care services include the same services as described in 38 U.S.C. 1710B(a).

Full-service VA medical facility means a VA medical facility that provides hospital care, emergency medical services, and surgical care and having a surgical complexity designation of at least “standard.”

Note 1 to the definition of “full-service VA medical facility”: VA maintains a website with a list of the facilities that have been designated with at least a surgical complexity of “standard,” which can be accessed on VA’s website.

Hospital care has the same meaning as defined in 38 U.S.C. 1701(5).

Medical services have the same meaning as defined in 38 U.S.C. 1701(6).

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

Residence means a legal residence or personal domicile, even if such residence is seasonal. A covered veteran may maintain more than one residence but may only have one residence at a time. If a covered veteran lives in more than one location during a year, the covered veteran’s residence is the residence or domicile where they are staying at the time they want to receive hospital care, medical services, or extended care services through the Veterans Community Care Program. A post office box or other non-residential point of delivery does not constitute a residence.

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

appointment in advance of such appointment.

Note 1 to the definition of “schedule”: A VA telehealth encounter and a same-day care encounter are considered to be scheduled even if such an encounter is conducted on an ad hoc basis.

VA facility means a VA facility that offers hospital care, medical services, or extended care services.

VA medical service line means a specific medical service or set of services delivered in a VA facility.

§ 17.4010 Veteran eligibility.

Section 1703(d) of title 38, U.S.C., establishes the conditions under which, at the election of the veteran and subject to the availability of appropriations, VA must furnish care in the community through eligible entities and providers. VA has regulated these conditions under paragraphs (a)(1) through (5) of this section. If VA determines that a covered veteran meets at least one or more of the conditions in paragraph (a) of this section and has provided information required by paragraphs (b) and (c) of this section, the covered veteran may elect to receive authorized non-VA care under § 17.4020.

(a) The covered veteran requires hospital care, medical services, or extended care services and:

(1) No VA facility offers the hospital care, medical services, or extended care services the veteran requires.

(2) VA does not operate a full-service VA medical facility in the State in which the veteran resides.

(3) The veteran was eligible to receive care and services from an eligible entity or provider under section 101(b)(2)(B) of the Veterans Access, Choice, and Accountability Act of 2014 (Pub. L. 113–146, sec. 101, as amended; 38 U.S.C. 1701 note) as of June 5, 2018, and continues to reside in a location that would qualify the veteran under that provision, and:

(i) Resides in Alaska, Montana, North Dakota, South Dakota, or Wyoming; or

(ii) Does not reside in one of the States described in paragraph (a)(3)(i) of this section, but received care or services under title 38 U.S.C. between June 6, 2017, and June 6, 2018, and is seeking care before June 6, 2020.

(4) Has contacted an authorized VA official to request the care or services the veteran requires, but VA has determined it is not able to furnish such care or services in a manner that complies with designated access standards established in § 17.4040.

(5) The veteran and the veteran’s referring clinician determine it is in the best medical interest of the veteran, for the purpose of achieving improved

clinical outcomes, to access the care or services the veteran requires from an eligible entity or provider, based on one or more of the following factors, as applicable:

(i) The distance between the veteran and the facility or facilities that could provide the required care or services;

(ii) The nature of the care or services required by the veteran;

(iii) The frequency the veteran requires the care or services;

(iv) The timeliness of available appointments for the required care or services;

(v) The potential for improved continuity of care;

(vi) The quality of the care provided; or

(vii) Whether the veteran faces an unusual or excessive burden in accessing a VA facility based on consideration of the following:

(A) Excessive driving distance; geographical challenges, such as the presence of a body of water (including moving water and still water) or a geologic formation that cannot be crossed by road; or environmental factors, such as roads that are not accessible to the general public, traffic, or hazardous weather.

(B) Whether care and services are available from a VA facility that is reasonably accessible.

(C) Whether a medical condition of the veteran affects the ability to travel.

(D) Whether there is a compelling reason the veteran needs to receive care and services from a non-VA facility.

(E) The need for an attendant, which is defined as a person who provides required aid and/or physical assistance to the veteran, for a veteran to travel to a VA medical facility for hospital care or medical services.

(6) In accordance with § 17.4015, VA has determined that a VA medical service line that would furnish the care or services the veteran requires is not providing such care or services in a manner that complies with VA's standards for quality.

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

(c) A covered veteran must provide to VA information on any other health-care plan contract under which the veteran is covered prior to obtaining authorization for care and services the veteran requires. If the veteran changes such other health-care plan contract, the veteran must update VA about the change within 60 days.

(d) Review of veteran eligibility determinations. The review of any decisions under paragraph (a) of this

section are subject to VA's clinical appeals process, and such decisions may not be appealed to the Board of Veterans' Appeals.

(The information collection is pending Office of Management and Budget approval.)

§ 17.4015 Designated VA medical service lines.

(a) VA may identify VA medical service lines that are underperforming based on the timeliness of care when compared with the same medical service line at other VA facilities and based on data related to two or more distinct and appropriate quality measures of VA's standards for quality when compared with non-VA medical service lines.

(b) VA will make determinations regarding VA medical service lines under this section using data described in paragraph (a) of this section, VA standards for quality, and based on factors identified in paragraph (e) of this section.

(c) VA will announce annually any VA medical service lines identified under paragraph (a) of this section by publishing a document in the **Federal Register**. Such document will identify and describe the standards for quality VA used to inform the determination under paragraph (a), as well as how the data described in paragraph (a) and factors identified in paragraph (e) of this section were used to make the determinations. Such document will also identify limitations, if any, concerning when and where covered veterans can receive qualifying care and services at their election in the community based on this section. Such limitations may include a defined timeframe, a defined geographic area, and a defined scope of services. VA will also take reasonable steps to provide direct notice to covered veterans affected under this section.

(d) VA will identify no more than 3 VA medical services lines in a single VA facility under this section, and no more than 36 VA medical service lines nationally under this section.

(e) In determining whether a VA medical service line should be identified under paragraph (a) of this section, and to comply with paragraph (c) of this section, VA will consider:

(1) Whether the differences between performance of individual VA medical service lines, and between performance of VA medical service lines and non-VA medical service lines, is clinically significant.

(2) Likelihood and ease of remediation of the VA medical service line within a short timeframe.

(3) Recent trends concerning the VA medical service line or non-VA medical service line.

(4) The number of covered veterans served by the medical service line or that could be affected by the designation.

(5) The potential impact on patient outcomes.

(6) The effect that designating one VA medical service line would have on other VA medical service lines.

§ 17.4020 Authorized non-VA care.

(a) *Electing non-VA care.* Except as provided for in paragraph (d) of this section, a covered veteran eligible for the Veterans Community Care Program under § 17.4010 may choose to schedule an appointment with a VA health care provider, or have VA authorize the veteran to receive an episode of care for hospital care, medical services, or extended care services from an eligible entity or provider when VA determines such care or services are clinically necessary.

(b) *Selecting an eligible entity or provider.* A covered veteran may specify a particular eligible entity or provider. If a covered veteran does not specify a particular eligible entity or provider, VA will refer the veteran to a specific eligible entity or provider.

(c) *Authorizing emergency treatment.* This paragraph (c) applies only to emergency treatment furnished to a covered veteran by an eligible entity or provider when such treatment was not the subject of an election by a veteran under paragraph (a) of this section. This paragraph (c) does not affect eligibility for, or create any new rules or conditions affecting, reimbursement for emergency treatment under section 1725 or 1728 of title 38, United States Code.

(1) Under the conditions set forth in this paragraph (c), VA may authorize emergency treatment after it has been furnished to a covered veteran. For purposes of this paragraph (c), "emergency treatment" has the meaning defined in section 1725(f)(1) of title 38, United States Code.

(2) VA may only authorize emergency treatment under this paragraph (c) if the covered veteran, someone acting on the covered veteran's behalf, or the eligible entity or provider notifies VA within 72-hours of such care or services being furnished and VA approves the furnishing of such care or services under paragraph (c)(3) of this section.

(3) VA may approve emergency treatment of a covered veteran under this paragraph (c) only if:

(i) The veteran is receiving emergency treatment from an eligible entity or provider.

(ii) The notice to VA complies with the provisions of paragraph (c)(4) of this section and is submitted within 72 hours of the beginning of such treatment.

(iii) The emergency treatment only includes services covered by VA's medical benefits package in § 17.38.

(4) Notice to VA must:

(i) Be made to the appropriate VA official at the nearest VA facility;

(ii) Identify the covered veteran; and

(iii) Identify the eligible entity or provider.

(d) *Organ and bone marrow transplant care.* (1) In the case of a covered veteran described in paragraph (d)(3) of this section, the Secretary will determine whether to authorize an organ or bone marrow transplant for the covered veteran through an eligible entity or provider.

(2) The Secretary will make determinations under paragraph (d)(1) of this section, and the primary care provider of the veteran will make determinations concerning whether there is a medically compelling reason to travel outside the region of the Organ Procurement and Transplantation Network in which the veteran resides to receive a transplant, in consideration of, but not limited to, the following factors:

(i) Specific patient factors.

(ii) Which facilities meet VA's standards for quality, including quality metrics and outcomes, for the required transplant.

(iii) The travel burden on covered veterans based upon their medical conditions and the geographic location of eligible transplant centers.

(iv) The timeliness of transplant center evaluations and management.

(3) This paragraph (d) applies to covered veterans who meet one or more conditions of eligibility under § 17.4010(a) and:

(i) Require an organ or bone marrow transplant as determined by VA based upon generally-accepted medical criteria; and

(ii) Have, in the opinion of the primary care provider of the veteran, a medically compelling reason, as determined in consideration of the factors described in paragraph (d)(2) of this section, to travel outside the region of the Organ Procurement and Transplantation Network in which the veteran resides, to receive such transplant.

§ 17.4025 Effect on other provisions.

(a) *General.* No provision in this section may be construed to alter or modify any other provision of law establishing specific eligibility criteria for certain hospital care, medical services, or extended care services.

(b) *Prescriptions.* Notwithstanding any other provision of this part, VA will:

(1) Pay for prescriptions no longer than 14 days written by eligible entities or providers for covered veterans, including over-the-counter drugs and medical and surgical supplies, available under the VA national formulary system to cover a course of treatment for an urgent or emergent condition.

(2) Fill prescriptions written by eligible entities or providers for covered veterans, including over-the-counter drugs and medical and surgical supplies, available under the VA national formulary system.

(3) Pay for prescriptions written by eligible entities or providers for covered veterans that have an immediate need for durable medical equipment and medical devices that are required for urgent or emergent conditions (e.g., splints, crutches, manual wheelchairs).

(4) Fill prescriptions written by eligible entities or providers for covered veterans for durable medical equipment and medical devices that are not required for urgent or emergent conditions.

(c) *Copayments.* Covered veterans are liable for a VA copayment for care or services furnished under the Veterans Community Care Program, if required by § 17.108(b)(4) or (c)(4), § 17.110(b)(4), or § 17.111(b)(3).

§ 17.4030 Eligible entities and providers.

To be eligible to furnish care and services under the Veterans Community Care Program, entities or providers:

(a) Must enter into a contract, agreement, or other arrangement to furnish care and services under the Veterans Community Care Program under §§ 17.4000 through 17.4040.

(b) Must either:

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

(2) If the provider is an employee of VA, not be acting within the scope of such employment while providing hospital care, medical services, or extended care services through the Veterans Community Care Program under §§ 17.4000 through 17.4040.

(c) Must be accessible to the covered veteran. VA will determine accessibility by considering the following factors:

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

(2) The qualifications of the entity or provider to furnish the hospital care, medical services, or extended care services from the entity or provider; and

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

§ 17.4035 Payment rates.

The rates paid by VA for hospital care, medical services, or extended care services (hereafter referred to as "services") furnished pursuant to a procurement contract or an agreement authorized by §§ 17.4100 through 17.4135 will be the rates set forth in the terms of such contract or agreement. Such payment rates will comply with the following parameters:

(a) Except as otherwise provided in this section, payment rates will not exceed the applicable Medicare fee schedule (including but not limited to allowable rates under 42 U.S.C. 1395m) or prospective payment system amount (hereafter "Medicare rate"), if any, for the period in which the service was provided (without any changes based on the subsequent development of information under Medicare authorities).

(b) With respect to services furnished in a State with an All-Payer Model Agreement under section 1814(b)(3) of the Social Security Act (42 U.S.C. 1395f(b)(3)) that became effective on or after January 1, 2014, the Medicare payment rates under paragraph (a) of this section will be calculated based on the payment rates under such agreement.

(c) Payment rates for services furnished in a highly rural area may exceed the limitations set forth in paragraphs (a) and (b) of this section. The term "highly rural area" means an area located in a county that has fewer than seven individuals residing in that county per square mile.

(d) Payment rates may deviate from the parameters set forth in paragraphs (a) through (c) of this section when VA determines, based on patient needs, market analyses, health care provider qualifications, or other factors, that it is not practicable to limit payment for services to the rates available under paragraphs (a) through (c).

(e) Payment rates for services furnished in Alaska are not subject to paragraphs (a) through (d) of this section and will be set forth in the terms of the procurement contract or agreement authorized by §§ 17.4100 through 17.4135, pursuant to which such services are furnished. If no payment rate is set forth in the terms of such a contract or agreement pursuant to which such services are furnished, payment rates for services furnished in Alaska will follow the Alaska Fee Schedule of the Department of Veterans Affairs.

§ 17.4040 Designated access standards.

(a) The following access standards have been designated to apply for purposes of eligibility determinations to access care in the community through the Veterans Community Care Program under § 17.4010(a)(4).

(1) *Primary care, mental health care, and non-institutional extended care services.* VA cannot schedule an appointment for the covered veteran with a VA health care provider for the required care or service:

(i) Within 30 minutes average driving time of the veteran's residence; and

(ii) Within 20 days of the date of request unless a later date has been agreed to by the veteran in consultation with the VA health care provider.

(2) *Specialty care.* VA cannot schedule an appointment for the covered veteran with a VA health care provider for the required care or service:

(i) Within 60 minutes average driving time of the veteran's residence; and

(ii) Within 28 days of the date of request unless a later date has been agreed to by the veteran in consultation with the VA health care provider.

(b) For purposes of calculating average driving time from the veteran's residence in paragraph (a) of this section, VA will use geographic information system software.

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