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Medical

Book I

Title 38, Parts 17, 46, 47, 51–53,
58–64, 70, 71, and 200

Supplement No. 121

Covering period of *Federal Register* issues
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GENERAL INSTRUCTIONS

Custom Federal Regulations Service™

Supplemental Materials for *Book I*

Code of Federal Regulations

Title 38, Parts 17, 46, 47, 51–53, 58–64, 70, 71, and 200

Medical

Supplement No. 121

5 June 2019

Covering the period of Federal Register issues
through June 1, 2019

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FILING INSTRUCTIONS

**Book I, Supplement No. 121
June 5, 2019**

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(none)	17.4100-1 to 17.4135-2 (add immediately after §17.3130)	§§17.4100 through 17.4135

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HIGHLIGHTS

Book I, Supplement No. 121 June 5, 2019

Supplement Highlights references: Where substantive changes are made in the text of regulations, the paragraphs of *Highlights* sections are cited at the end of the relevant section of text. Thus, if you are reading §17.100, you will see a note at the end of that section which reads: “Supplement *Highlights* references—37(1).” This means that paragraph 1 of the *Highlights* section in Supplement No. 37 contains information about the changes made in §17.100. By keeping and filing the *Highlights* sections, you will have a reference source explaining all substantive changes in the text of the regulations.

Supplement frequency: Beginning 1 January 2000, supplements for this Book I will be issued *every month* during which a final rule addition or modification is made to the parts of Title 38 covered by this book. Supplements will be numbered consecutively as issued.

Modifications in this supplement include the following:

1. On 14 May 2019, the VA published an interim final rule effective that same day, to implement its authority to furnish necessary care to covered individuals through certain agreements. Section 102 of the John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 authorizes VA to enter into agreements to furnish required care and services when such care and services are not feasibly available to certain individuals through a VA facility, a contract, or a sharing agreement. This interim final rule establishes the parameters of those agreements, to include: Establishing a certification process for providers who will furnish such care or services; establishing a methodology by which rates will be calculated for payment of care or services under an agreement; and establishing an administrative process for adjudicating disputes arising under or related to such agreements, including those pertaining to claims for payment for care or services provided under an agreement. Changes:

- Added §§17.4100 through 17.4135.

2. On 24 May 2019, the VA published a final rule effective 24 June 2019, to remove the regulatory provisions regarding the veteran's net worth as a factor in determining the veteran's eligibility for VA health care. Prior to January 1, 2015, VA considered a veteran's net worth and annual income when determining a veteran's assignment to an enrollment priority group for VA health care. Reporting net worth information imposed a significant burden on veterans and VA dedicated substantial administrative resources to verify the reported information. VA changed its policy regarding net worth reporting in order to improve access to VA health care to lower-income veterans and to remove the reporting burden from veterans by discontinuing collection of net worth information. As VA no longer considers net worth in making eligibility determinations, this final rule amends the regulation to remove reference to VA's discretionary statutory authority to consider a veteran's net worth as a factor in determining eligibility for VA health care. Because of the net worth reporting requirement, certain veterans who would have been eligible to receive VA health care based on their annual income were ineligible for such care, or they were placed in a lower priority category, because their net worth was too high. Changes:

- In §17.47, removed paragraph (d)(5) and re-designated paragraph (d)(6) as (d)(5).

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[Reserved]

Part 17 — Medical

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

Section 17.35 is also issued under 38 U.S.C. 1724

Section 17.38 is also issued under 38 U.S.C. 101, 501, 1701, 1705, 1710, 1710A, 1721, 1722, 1782, and 1786.

Section 17.125 is also issued under 38 U.S.C. 7304

Section 17.169 is also issued under 38 U.S.C. 1712C.

Sections 17.380, 17.390 and 17.412 are also issued under sec. 260, Pub. L. 114-223, 130 Stat. 857 and §236, div. J, Pub. L 115-141, 132 Stat. 348.

Section 17.410 is also issued under 38 U.S.C. 1787.

Section 17.415 is also issued under 38 U.S.C. 7301, 7304, 7402, and 7403.

Sections 17.640 and 17.647 are also issued under sec. 4, Pub. L. 114-2, 129 Stat. 30.

Sections 17.641 through 17.646 are also issued under 38 U.S.C. 501(a) and sec. 4, Pub. L. 114-2, 129 Stat. 30.

Section 17.417 also issued under 38 U.S.C. 1701 (note), 1709A, 1712A (note), 1722B, 7301, 7330A, 7401-7403, 7406 (note).

Section 17.655 also issued under 38 U.S.C. 501(a), 7304, 7405.

Section 17.4100 et seq. is also issued under 38 U.S.C. 1703A.

Ed. Note: Nomenclature changes to Part 17 appear at 61 FR 7216, Feb. 27, 1996

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(4) Determinations with respect to attributable income made under paragraph (d)(1) and (2) of this section, shall be made in the same manner, including the same sources of income and exclusions from income, as determinations with respect to income are made for determining eligibility for pension under §§3.271 and 3.272 of this title. The term attributable income means income of a veteran for the calendar year preceding application for care, determined in the same manner as the manner in which a determination is made of the total amount of income by which the rate of pension for such veteran under 38 U.S.C. 1521 would be reduced if such veteran were eligible for pension under that section. (Authority: 38 U.S.C. 1722; sec. 19011, Pub. L. 99-272)

(5) In order to avoid hardship VA may determine that a veteran is eligible for care notwithstanding that the veteran does not meet the income requirements established in paragraph (d)(1)(iii) or (d)(2) of this section, if projections of the veteran's income for the year following application for care are substantially below the income requirements established in paragraph (d)(1)(iii) or (d)(2) of this section. (Authority: 38 U.S.C. 1722; sec. 19011, Pub. L. 99-272)

(e) (1) If VA determines that an individual was incorrectly charged a copayment, VA will refund the amount of any copayment actually paid by that individual . (Authority: 38 U.S.C. 501; sec. 19011, Pub. L. 99-272)

(2) In the event a veteran provided inaccurate information on an application and is incorrectly deemed eligible for care under 38 U.S.C. 1710(a)(1) or (a)(2) rather than 38 U.S.C. 1710(a)(3), VA shall retroactively bill the veteran for the applicable copayment. (Authority: 38 U.S.C. 501 and 1710; sec. 19011, Pub. L. 99-272)

(f) If a veteran who receives hospital care, medical services, nursing home care, or outpatient care under 38 U.S.C. 1710(a)(3) by virtue of the veteran's eligibility for hospital care and medical services under 38 U.S.C. 1710(a), fails to pay to the United States the amounts agreed to under those sections shall be grounds for determining, in accordance with guidelines promulgated by the Under Secretary for Health, that the veteran is not eligible to receive further care under those sections until such amounts have been paid in full. (Authority: 38 U.S.C. 1710, 1721; sec. 19011, Pub. L. 99-272)

(g) (1) Persons hospitalized and/or receiving medical services who have no service-connected disabilities pursuant to §17.47, and/or persons receiving outpatient medical services pursuant to §17.93 who have no service-connected disabilities who it is believed may be eligible for hospital care and/or medical services, or reimbursement for the expenses of care or services for all or part of the cost thereof by reason of the following:

(i) Membership in a union, fraternal or other organization, or

(ii) Coverage under an insurance policy, or contract, medical, or hospital service agreement, membership, or subscription contract or similar arrangement under which health services for individuals are provided or the expenses of such services are paid, will not be furnished hospital care or medical services without charge therefore to the extent of the amount for which such parties referred to in paragraphs (g)(1)(i) or (g)(1)(ii) of this section, are, will become, or may be liable. Persons believed entitled to care under any of the plans discussed above will be required to provide such information as the Secretary may require. Provisions of this paragraph are effective April 7, 1986, except in the case of a health care policy or contract that was entered into before that date, the effective date shall be the day after the plan was modified or renewed or on which there was any change in premium or coverage and will apply only to care and services provided by VA after the date the plan was modified, renewed, or on which there was any change in premium or coverage. (Authority: 38 U.S.C. 1729; sec. 19013, Pub. L. 99-272)

(2) Persons hospitalized and/or receiving medical services for the treatment of nonservice-connected disabilities pursuant to §17.47, or persons receiving outpatient medical services pursuant to §17.93, and who it is believed may be entitled to hospital care and/or medical services or to reimbursement for all or part of the cost thereof from any one or more of the following parties:

(i) *Workers' Compensation* or employer's liability statutes, State or Federal;

(ii) By reason of statutory or other relationships with third parties, including those liable for damages because of negligence or other legal wrong;

(iii) By reason of a statute in a State, or political subdivision of a State;

(A) Which requires automobile accident reparations or;

(B) Which provides compensation or payment for medical care to victims suffering personal injuries as the result of a crime of personal violence;

(iv) Right to maintenance and cure in admiralty;

will not be furnished hospital care or medical services without charge therefore to the extent of the amount for which such parties are, will become, or may be liable. Persons believed entitled to care under circumstances described in paragraph (g)(2)(ii) of this section will be required to complete such forms as the Secretary may require, such as a power of attorney and assignment. Notice of this assignment will be mailed promptly to the party or parties believed to be liable. When the amount of charges is ascertained, a bill therefore will be mailed to such party or parties. Persons believed entitled to care under circumstances described in paragraph (g)(2)(i) or

(g)(2)(iii) of this section will be required to complete such forms as the Secretary may require .
(Authority: 38 U.S.C. 1729, sec. 19013, Pub. L. 99-272)

(h) Within the limits of Department of Veterans Affairs facilities, any veteran who is receiving nursing home care in a hospital under the direct jurisdiction of the Department of Veterans Affairs, may be furnished medical services to correct or treat any nonservice-connected disability of such veteran, in addition to treatment incident to the disability for which the veteran is hospitalized, if the veteran is willing, and such services are reasonably necessary to protect the health of such veteran.

(i) *Participating in a rehabilitation program under 38 U.S.C. chapter 31* refers to any veteran

(1) Who is eligible for and entitled to participate in a rehabilitation program under chapter 31.

- (i) Who is in an extended evaluation period for the purpose of determining feasibility, or
- (ii) For whom a rehabilitation objective has been selected, or
- (iii) Who is pursuing a rehabilitation program, or
- (iv) Who is pursuing a program of independent living, or
- (v) Who is being provided employment assistance under 38 U.S.C. chapter 31, and

(2) Who is medically determined to be in need of hospital care or medical services (including dental) for any of the following reasons:

- (i) Make possible his or her entrance into a rehabilitation program; or
- (ii) Achieve the goals of the veteran's vocational rehabilitation program;
or
- (iii) Prevent interruption of a rehabilitation program; or
- (iv) Hasten the return to a rehabilitation program of a veteran in interrupted or leave status; or
- (v) Hasten the return to a rehabilitation program of a veteran placed in discontinued status because of illness, injury or a dental condition;
or
- (vi) Secure and adjust to employment during the period of employment assistance; or
- (vii) To enable the veteran to achieve maximum independence in daily living. (Authority: 38 U.S.C. 3104(a)(9); Pub. L. 96-466, sec. 101(a))

(j) Veterans eligible for treatment under chapter 17 of 38 U.S.C. who are alcohol or drug abusers or who are infected with the human immunodeficiency virus (HIV) shall not be discriminated against in admission or treatment by any Department of Veterans Affairs health care facility solely because of their alcohol or drug abuse or dependency or because of their viral infection. This does not preclude the rule of clinical judgment in determining appropriate treatment which takes into account the patient's immune status and/or the infectivity of the HIV or other pathogens (such as tuberculosis, cytomegalovirus, cryptosporidiosis, etc.). Hospital Directors are responsible for assuring that admission criteria of all programs in the medical center do not discriminate solely on the basis of alcohol, drug abuse or infection with human immunodeficiency virus. Quality Assurance Programs should include indicators and monitors for nondiscrimination. (Authority: 38 U.S.C. 7333)

(k) In seeking medical care from VA under 38 U.S.C. 1710 or 1712, a veteran shall furnish such information and evidence as the Secretary may require to establish eligibility. (Authority: 38 U.S.C. 1722; sec. 19011, Pub. L. 99-272)

[32 FR 13813, Oct. 4, 1967, as amended at 64 FR 54218, Oct. 6, 1999; 73 FR 20532, Apr. 16, 2008; 73 FR 65260, Nov. 3, 2008; 79 FR 54615, Sep. 12, 2014; 79 FR 68131, Nov. 14, 2014; 83 FR 48382, Sept. 25, 2018; 84 FR 24034, May 24, 2019]

Editorial Note: For earlier *Federal Register* citations affecting §17.47, see the List of CFR Sections Affected in the Finding Aids section of this volume.

Supplement *Highlights* references: 37(1), 40(1), 86(1), 88(1), 118(1), 121(2).

§17.3130 HISA benefits payment procedures

(a) *Advance payment.* If the beneficiary has requested advance payment of HISA benefits in VA Form 10-0103, as provided in §17.3120(a)(2), VA will make an advance payment to the beneficiary equal to 50 percent of the total benefit authorized for the improvement or structural alteration. VA will make the advance payment no later than 30 days after the HISA benefits application is approved. The beneficiary may receive only one advance payment for each approved HISA benefits application. A beneficiary must use the advance payment only for the improvement or structural alteration described in the application and must submit a final payment request, as defined in paragraph (b) of this section, to document such use after the construction is finished.

(b) *Final payment request.* No later than 60 days after the application is approved or, if VA approved an advance payment, no later than 60 days after the advance payment was made, the beneficiary must submit a complete final payment request to VA for payment. The complete final payment request must include:

(1) A statement by the beneficiary that the improvement or structural alteration, as indicated in the application, was completed;

(2) A color photograph of the completed work; and

(3) Documentation of the itemized actual costs for material, labor, permits, and inspections.

(c) *VA action on final payment request.*

(1) Prior to approving and remitting the final payment, VA may inspect (within 30 days after receiving the final payment request) the beneficiary's home to determine that the improvement or structural alteration was completed as indicated in the application. No payment will be made if the improvement or structural alteration has not been completed.

(2) No later than 30 days after receipt of a complete final payment request, or, if VA conducts an inspection of the home under paragraph (c)(1) of this section, no later than 30 days after the inspection, VA will make a determination on the final payment request. If approved, VA will remit a final payment to the beneficiary equal to the lesser of:

(i) The approved HISA benefit amount, less the amount of any advance payment, or

(ii) The total actual cost of the improvement or structural alteration, less the amount of any advance payment.

(3) If the total actual cost of the improvement or structural alteration is less than the amount paid to the beneficiary as an advance payment, the beneficiary will reimburse VA for the difference between the advance payment and the total actual costs.

(4) After final payment is made on a HISA benefits application, the application file will be closed and no future HISA benefits will be furnished to the beneficiary for that application. If the total actual cost of the improvement or structural alteration is less than the approved HISA benefit, the balance of the approved amount will be credited to the beneficiary's remaining HISA benefits lifetime balance.

(d) *Failure to submit a final payment request.*

(1) If an advance payment was made to the beneficiary, but the beneficiary fails to submit a final payment request in accordance with paragraph (b) of this section within 60 days of the date of the advance payment, VA will send a notice to remind the beneficiary of the obligation to submit the final payment request. If the beneficiary fails to submit the final payment request or to provide a suitable update and explanation of delay within 30 days of this notice, VA may take appropriate action to collect the amount of the advance payment from the beneficiary.

(2) If an advance payment was not made to the beneficiary and the beneficiary does not submit a final payment request in accordance with paragraph (b) of this section within 60 days of the date the application was approved, the application will be closed and no future HISA benefits will be furnished to the beneficiary for that application. Before closing the application, VA will send a notice to the beneficiary of the intent to close the file. If the beneficiary does not respond with a suitable update and explanation for the delay within 30 days, VA will close the file and provide a final notice of closure. The notice will include information about the right to appeal the decision.

(e) *Failure to make approved improvements or structural alterations.* If an inspection conducted pursuant to paragraph (c)(1) of this section reveals that the improvement or structural alteration has not been completed as indicated in the final payment request, VA may take appropriate action to collect the amount of the advance payment from the beneficiary. VA will not seek to collect the amount of the advance payment from the beneficiary if the beneficiary provides documentation indicating that the project was not completed due to the fault of the contractor, including bankruptcy or misconduct of the contractor.

(Authority: 38 U.S.C. 501, 1717)

(The Office of Management and Budget has approved the information collection requirement in this section under control number 2900-0188.)

[79 FR 71662, Dec. 3, 2014]

Supplement *Highlights* references: 89(2).

§17.4100 Definitions

For the purposes of §§17.4100 through 17.4135, the following definitions apply:

Contract is any of the following: Federal procurement agreements regulated by the Federal Acquisition Regulation; common law contracts; other transactions; or any other instrument. Veterans Care Agreements are excluded from this definition.

Covered individual is an individual who is eligible to receive hospital care, medical services, or extended care services from a non-VA provider under title 38 U.S.C. and title 38 CFR.

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

Hospital care is defined in 38 U.S.C. 1701(5).

Medical services is defined in 38 U.S.C. 1701(6).

Sharing agreement is an agreement, under statutory authority other than 38 U.S.C. 1703A, by which VA can obtain hospital care, medical services, or extended care services for a covered individual.

VA facility is a point of VA care where covered individuals can receive hospital care, medical services, or extended care services, to include a VA medical center, a VA community-based outpatient clinic, a VA health care center, a VA community living center, a VA independent outpatient clinic, and other VA outpatient services sites.

Veterans Care Agreement is an agreement authorized under 38 U.S.C. 1703A for the furnishing of hospital care, medical services, or extended care services to covered individuals.

[84 FR 21678, May 14, 2019]

Supplement *Highlights* references: 121(1).

§17.4105 Purpose and Scope

(a) *Purpose.* Sections 17.4100 through 17.4135 implement 38 U.S.C. 1703A, as required under section 1703A(j). Section 1703A authorizes VA to enter into and utilize Veterans Care Agreements to furnish hospital care, medical services, and extended care services to a covered individual when such individual is eligible for and requires such care or services that are not feasibly available to the covered individual through a VA facility, a contract, or a sharing agreement.

(b) *Scope.* Sections 17.4100 through 17.4135 contain procedures, requirements, obligations, and limitations for: The process of certifying entities or providers under 38 U.S.C. 1703A; entering into, administering, furnishing care or services pursuant to, and discontinuing Veterans Care Agreements; and all disputes arising under or related to Veterans Care Agreements. Sections 17.4100 through 17.4135 apply to all entities and providers, where applicable, that are parties to a Veterans Care Agreement, participate in the certification process, or furnish hospital care, medical services, or extended care services pursuant to a Veterans Care Agreement.

[84 FR 21678, May 14, 2019]

Supplement *Highlights* references: 121(1).

§17.4110 Entity or provider certification

(a) *General.* To be eligible to enter into a Veterans Care Agreement, an entity or provider must be certified by VA in accordance with the process and criteria established in paragraph (b) of this section. Additionally, an entity or provider must be actively certified while furnishing hospital care, medical services, or extended care services pursuant to a Veterans Care Agreement that the entity or provider has entered into with VA.

(b) *Process and criteria—*

(1) *Application for certification.* An entity or provider must apply for certification by submitting the following information and documentation to VA:

(i) Documentation of applicable medical licenses; and

(ii) All other information and documentation required by VA. This information and documentation may include, but is not limited to, provider first and last names, legal business names, National Provider Identifier (NPI), NPI type, provider identifier type (e.g., individual or group practice), tax identification number, specialty (taxonomy code), business address, billing address, phone number, and care site address.

(2) *Approval or denial of certification.*

(i) VA will review all information obtained by VA, including through applicable federal and state records systems and as submitted by the applicant, and will determine eligibility for certification.

(ii) An applicant must submit all information required under paragraph (b)(1) of this section.

(iii) VA will deny an application for certification if VA determines that the entity or provider is excluded from participation in a Federal health care program (as defined in section 1128B(f) of the Social Security Act (42 U.S.C. 1320a-7b(f)) under section 1128 or 1128A of such Act (42 U.S.C. 1320a-7 and 1320a-7a) or is identified as an excluded source on the System for Award Management Exclusions list described in part 9 of title 48, Code of Federal Regulations, and part 180 of title 2 of such Code, or successor regulations.

(iv) VA will deny an application for certification if VA determines that the applicant is already barred from furnishing hospital care, medical services, and extended care services under chapter 17 of title 38, U.S.C., because VA has previously determined the applicant submitted to VA a fraudulent claim, as that term is defined in 38 U.S.C. 1703D(i)(4), for payment for hospital care, medical services, or extended care services.

(v) VA may deny an application for certification if VA determines that based on programmatic considerations, VA is unlikely to seek to enter into a Veterans Care Agreement with the applicant.

(vi) VA will issue a decision approving or denying an application for certification within 120 calendar days of receipt of such application, if practicable. Notices of approval will set forth the effective date and duration of the certification. Notices of denial will set forth the specific grounds for denial and supporting evidence. A denial constitutes VA's final decision on the application.

(3) *Duration of certification and application for recertification.*

(i) An entity or provider's certification under this section lasts for a three-year period, unless VA revokes certification during that three-year period pursuant to paragraph (b)(4) of this section.

(ii) A certified entity or provider must maintain its eligibility throughout the period in which it is certified and must inform VA of any changes or events that would affect its eligibility within 30 calendar days of the change or event.

(iii) A certified entity or provider seeking certification after the end of its current three-year certification must apply for recertification at least 60 calendar days prior to the expiration of its current certification; otherwise, the procedures set forth in paragraph (b)(3)(iv) of this section will apply. Upon application for recertification by the entity or provider, including submitting any new or updated information within the scope of paragraph (b)(1) of this section that VA requests in conjunction with such application for recertification, VA will reassess the entity or provider under the criteria in paragraph (b)(2) of this section. VA will issue a decision approving or denying the application for recertification within 60 calendar days of receiving the application, if practicable. Notice of the decision will be furnished to the applicant in writing. Notices of recertification will set forth the effective date and duration of the certification. Notices of denial will set forth the specific grounds for denial and supporting evidence. A denial constitutes VA's final decision on the application for recertification.

(iv) If a certified entity or provider applies for recertification after the deadline in paragraph (b)(3)(iii) of this section, such application will constitute a new application for certification and will be processed in accordance with paragraphs (b)(1) and (2) of this section.

(4) *Revocation of certification*—

(i) *Standard for revocation.* VA may revoke an entity's or provider's certification in accordance with paragraphs (b)(2)(ii) through (v) of this section.

(ii) *Notice of proposed revocation.* When VA determines revocation is appropriate, VA will notify the entity or provider in writing of the proposed revocation. The notice of proposed revocation will set forth the specific grounds for the action and will notify the entity or provider that it has 30 calendar days from the date of issuance to submit a written response addressing either of the following:

(A) Documenting compliance and proving any grounds false, or

(B) Providing information and documentation that demonstrates the entity or provider has, subsequent to the notice of proposed revocation, achieved compliance with all criteria for certification set forth in paragraph (b)(2) of this section.

(iii) *Decision to revoke.* Following the 30-day response period, VA will consider any information and documentation submitted by the entity or provider and will, within 30 calendar days, determine whether revocation is warranted. If VA determines that revocation is not warranted, VA will notify the entity or provider of that determination in writing. If VA determines that revocation is warranted, the entity or provider will immediately lose certified status, and VA will issue a notice of revocation to the entity or provider. Notices of revocation will set forth the specific facts and grounds for, and the effective date of, such revocation. A notice of revocation constitutes VA's final decision.

(iv) *Effect of revocation.* Revocation of certification results in such status being rendered void, and the provider or entity may not furnish services or care to a covered individual under a Veterans Care Agreement prior to applying for and obtaining certified VCA status.

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

[84 FR 21678, May 14, 2019]

Supplement *Highlights* references: 121(1).

§17.4115 VA use of Veterans Care Agreements

(a) *Criteria for using.* VA may furnish hospital care, medical services, or extended care services through a Veterans Care Agreement only if:

(1) Such care or services are furnished to a covered individual who is eligible for such care or services under 38 U.S.C. chapter 17 and requires such care or services; and

(2) Such care or services are not feasibly available to that covered individual through a VA facility, contract, or sharing agreement. For purposes of this subparagraph, hospital care, medical services, or extended care services are not feasibly available through a VA facility, contract, or sharing agreement when VA determines that the medical condition of the covered individual, the travel involved, the nature of the care or services, or a combination of these factors make the use of a VA facility, contract, or sharing agreement impracticable or inadvisable.

(b) *Standards of conduct and improper business practices—*

(1) *General.*

(i) Government business shall be conducted in a manner above reproach and, except as authorized by statute or regulation, with complete impartiality and with preferential treatment for none. Transactions relating to the expenditure of public funds require the highest degree of public trust and an impeccable standard of conduct. The general rule is to avoid strictly any conflict of interest or even the appearance of a conflict of interest in Government-contractor relationships. The conduct of Government personnel must be such that they would have no reluctance to make a full public disclosure of their actions.

(ii) VA officials and employees are reminded that there are other statutes and regulations that deal with prohibited conduct, including:

(A) The offer or acceptance of a bribe or gratuity is prohibited by 18 U.S.C. 201. The acceptance of a gift, under certain circumstances, is prohibited by 5 U.S.C. 7353, and 5 CFR part 2635;

(B) (1) Certain financial conflicts of interest are prohibited by 18 U.S.C. 208 and regulations at 5 CFR part 2635.

(2) Contacts with an entity or provider that is seeking or receives certification under section 17.4110 of this part or is seeking, enters into, and/or furnishes services or care under a Veterans Care Agreement may constitute "seeking employment," (see Subpart F of 5 CFR part 2635). Government officers and employees (employees) are prohibited by 18 U.S.C. 208 and 5 CFR part 2635 from participating personally and substantially in any particular matter that would affect the financial interests of any person from whom the employee is seeking employment. An employee who engages in negotiations or is otherwise seeking employment with an offeror or who has an arrangement concerning future employment with an offeror must comply with the applicable disqualification requirements of 5 CFR 2635.604 and 2635.606. The statutory prohibition in 18 U.S.C. 208 also may require an employee's disqualification from participation in matters pertaining to the certification of an entity or

provider or a entering into and administering a Veterans Care Agreement with an entity or provider even if the employee's duties may not be considered “participating personally and substantially”;

(C) Post-employment restrictions are covered by 18 U.S.C. 207 and 5 CFR part 2641, that prohibit certain activities by former Government employees, including representation of an entity or provider before the Government in relation to any particular matter involving specific parties on which the former employee participated personally and substantially while employed by the Government. Additional restrictions apply to certain senior Government employees and for particular matters under an employee's official responsibility; and

(D) Using nonpublic information to further an employee's private interest or that of another and engaging in a financial transaction using nonpublic information are prohibited by 5 CFR 2635.703.

(2) *Standards and requirements for entities or providers that enter into Veterans Care Agreements.* An entity or provider that enters into a Veterans Care Agreement must comply with the following standards and requirements throughout the term of the Veterans Care Agreement:

(i) Must have a satisfactory performance record.

(ii) Must have a satisfactory record of integrity and business ethics.

(iii) Must notify VA within 30 calendar days of the existence of an indictment, charge, conviction, or civil judgment, or Federal tax delinquency in an amount that exceeds \$3,500.

(iv) Must not engage in any of the following:

(A) Commission of fraud or a criminal offense in connection with-

(1) Obtaining;

(2) Attempting to obtain; or

(3) Performing a public contract or subcontract, or a

Veterans Care Agreement;

(B) Violation of Federal or State antitrust statutes relating to the submission of offers;

(C) Commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, violating Federal criminal tax laws, or receiving stolen property;

(D) Delinquent Federal taxes in an amount that exceeds \$3,500. Federal taxes are considered delinquent for purposes of this provision if both of the following criteria apply:

(1) The tax liability is finally determined. The liability is finally determined if it has been assessed and all available administrative remedies and rights to judicial review have been exhausted or have lapsed.

(2) The taxpayer is delinquent in making payment. A taxpayer is delinquent if the taxpayer has failed to pay the tax liability when full payment was due and required. A taxpayer is not delinquent in cases where enforced collection action is precluded.

(E) Knowing failure by a principal, until 3 years after final payment on any Government contract awarded to the contractor (or any Veterans Care Agreement entered into with the entity or provider), to timely disclose to the Government, in connection with the award or agreement, performance, or closeout of the contract or agreement or a subcontract thereunder, credible evidence of--

(1) Violation of Federal criminal law involving fraud, conflict of interest, bribery, or gratuity violations found in Title 18 of the United States Code;

(2) Violation of the civil False Claims Act (31 U.S.C. 3729-3733); or

(3) Significant overpayment(s) on the contract or Veterans Care Agreement, other than overpayments resulting from contract financing payments. Contract financing payments means an authorized Government disbursement of monies to a contractor prior to acceptance of supplies or services by the Government; or

(F) Commission of any other offense indicating a lack of business integrity or business honesty that seriously and directly affects the present responsibility of an entity or provider.

(v) Must not submit to VA a fraudulent claim, as that term is defined in 38 U.S.C. 1703D(i)(4), for payment for hospital care, medical services, or extended care services.

[84 FR 21679, May 14, 2019]

Supplement *Highlights* references: 121(1).

§17.4120 Payment rates

The rates paid by VA for hospital care, medical services, and extended care services (hereafter in this section referred to as “services”) furnished pursuant to a Veterans Care Agreement will be the rates set forth in the price terms of the Veterans Care Agreement. Each Veterans Care Agreement will contain price terms for all services within its scope. 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 or prospective payment system amount (hereafter in this section referred to as “Medicare rate”), if any, for the period in which the service was provided (without any changes based on the subsequent development of information under Medicare authorities).

(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 rate under paragraph (a) 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.

[84 FR 21680, May 14, 2019]

Supplement *Highlights* references: 121(1).

§17.4125 Review of Veterans Care Agreements

VA will periodically review each Veterans Care Agreement that exceeds \$5,000,000 annually, to determine if it is feasible and advisable to furnish the hospital care, medical services, and extended care services that VA has furnished or anticipates furnishing under such Veterans Care Agreements through a VA facility, contract, or sharing agreement instead. If VA determines it is feasible and advisable to provide any such hospital care, medical services, or extended care services in a VA facility or by contract or sharing agreement, it will take action to do so.

[84 FR 21681, May 14, 2019]

Supplement *Highlights* references: 121(1).

§17.4130 Discontinuation of Veterans Care Agreements

(a) Discontinuation of the agreement by the entity or provider requires a written notice of request to discontinue, in accordance with the terms of the Veterans Care Agreement and the following notice requirements:

(1) Written notice must be received by VA at least 45 calendar days before the discontinuation date and must specify the discontinuation date; and

(2) Such notice must be delivered to the designated VA official to which such notice must be submitted under the terms of the Veterans Care Agreement, and the notice and delivery must comply with all terms of the Veterans Care Agreement.

(b) (1) Discontinuation of the agreement by VA requires a written notice of discontinuation to the entity or provider in accordance with the terms of the Veterans Care Agreement and the following notice standards:

(i) Written notice of discontinuation will be issued at least 45 calendar days before the discontinuation date, except as provided in subparagraph (ii).

(ii) Notice may be issued fewer than 45 calendar days before the discontinuation date, including notice that is effective immediately upon issuance, when VA determines such abbreviated or immediate notice is necessary to protect the health of covered individuals or when such abbreviated or immediate notice is permitted under the terms of the Veterans Care Agreement.

(2) Notice will be delivered to the entity or provider in accordance with the terms of the Veterans Care Agreement.

(3) VA may discontinue a Veterans Care Agreement for the following reasons:

(i) If VA determines the entity or provider failed to comply substantially with the provisions of 38 U.S.C. 1703A or 38 CFR 17.4100-17.4135

(ii) If VA determines the entity or provider failed to comply substantially with the provisions, terms, or conditions of the Veterans Care Agreement;

(iii) If VA determines the entity or provider is excluded from participation in a Federal health care program (as defined in section 1128B(f) of the Social Security Act (42 U.S.C. 1320a-7b(f)) under section 1128 or 1128A of such Act (42 U.S.C. 1320a-7 and 1320a-7a), or is identified as an excluded source on the System for Award Management Exclusions list described in part 9 of title 48, Code of Federal Regulations, and part 180 of title 2 of such Code, or successor regulations;

(iv) If VA ascertains that the entity or provider has been convicted of a felony or other serious offense under federal or state law and determines that discontinuation of the Veterans Care Agreement would be in the best interest of a covered individual or VA; or

(v) If VA determines it is reasonable to discontinue the Veterans Care Agreement based on the health care needs of a covered individual.

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

[84 FR 21678, May 14, 2019]

Supplement *Highlights* references: 121(1).

§17.4135 Disputes*(a) General.*

(1) This section establishes the administrative procedures and requirements for asserting and resolving disputes arising under or related to a Veterans Care Agreement. For purposes of this section, a dispute means a disagreement, between VA and the entity or provider that entered into the subject Veterans Care Agreement with VA, that meets the following criteria:

(i) Pertains to one of the subject matters set forth in paragraph (b) of this section;

(ii) Is not resolved informally by mutual agreement of the parties; and

(iii) Culminates in one of the parties demanding or asserting, as a matter of right, the payment of money in a sum certain under the Veterans Care Agreement, the interpretation of the terms of the Veterans Care Agreement or a specific authorization thereunder, or other relief arising under or relating to the Veterans Care Agreement. However, a dispute does not encompass any demand or assertion, as a matter of right, for penalties or forfeitures prescribed by a statute or regulation that another federal agency is specifically authorized to administer, settle, or determine.

(2) The procedures established in this section should only be used when the parties to a Veterans Care Agreement have failed to resolve an issue in controversy by mutual agreement.

(3) The procedures established in this section constitute an entity's or provider's exclusive administrative remedy for disputes under this section.

(4) Disputes under this section are not considered claims for the purposes of laws that would otherwise require the application of sections 7101 through 7109 of title 41 U.S.C.

(5) An entity or provider must first exhaust the procedures established in this section before seeking judicial review under section 1346 of title 28 U.S.C.

(b) Subject matter of disputes. Disputes under this section must pertain to:

(1) The scope of one or more specific authorizations under the applicable Veterans Care Agreement; or

(2) Claims for payment under the applicable Veterans Care Agreement.

(c) *Procedures—*

(1) Initiation of dispute. Disputes under this section must be initiated in accordance with the following procedures and requirements:

(i) Disputes must be initiated by submitting a notice of dispute, in writing, to the designated VA official to which notice must be submitted under the terms of the Veterans Care Agreement. The notice of dispute must comply with, and be submitted in accordance with, applicable terms of the Veterans Care Agreement.

(ii) The notice of dispute must contain all specific assertions or demands, all facts pertinent to the dispute, any specific resolutions or relief sought, and all information and documentation necessary to review and adjudicate the dispute.

(iii) The notice of dispute must be received by the designated VA official to which such notice must be submitted, in accordance with the terms of the Veterans Care Agreement, within 90 calendar days after the accrual of the dispute. For purposes of this paragraph, the accrual of the dispute is the date when all events, that fix the alleged liability of either VA or the entity or provider and permit the applicable demand(s) and assertion(s), were known or should have been known. The term “accrual of the dispute,” as defined, has the following meanings in each of the two specific circumstances that follow:

(A) When a dispute consists of an entity or provider asserting that VA has made payment in an incorrect amount, under circumstances where VA has issued a corresponding payment notice and the entity or provider has received such notice, the accrual of the dispute is the date such notice was received by the entity or provider.

(B) When a dispute consists of an entity or provider asserting that VA has improperly denied payment to which it is entitled, under circumstances where VA has issued a corresponding denial of payment notice and the entity or provider has received such notice, the accrual of the dispute is the date such notice was received by the entity or provider.

(2) *VA authority to decide and resolve disputes arising under or relating to Veterans Care Agreements.*

(i) A VA official acting within the scope of authority delegated by the Secretary of Veterans Affairs (hereafter referred to in this section as the “responsible VA official”) will decide and resolve disputes under this section.

(ii) The authority to decide or resolve disputes under this section does not extend to the settlement, compromise, payment, or adjustment of any claim for payment that involves fraud or misrepresentation of fact. For purposes of this paragraph, “misrepresentation of fact” means a false statement of substantive fact, or any conduct which leads to the belief of a substantive fact material to proper understanding of the matter in hand, made with intent to deceive or mislead. If the responsible VA official encounters evidence of misrepresentation of fact or fraud on the part of the entity or provider, the responsible VA official shall refer the matter to the agency official responsible for investigating fraud and may refer the matter to other federal entities as necessary.

(3) *Review of dispute and written decision.*

(i) Upon receipt of a notice of dispute, the responsible VA official will review the dispute and all facts pertinent to the dispute.

(ii) If the responsible VA official determines additional information or documentation is required for review and adjudication of the dispute, the official will, within 90 calendar days of VA's receipt of the notice of dispute, provide written notice to both parties, in accordance with the notice provisions of the Veterans Care Agreement, that additional information or documentation is required for review and adjudication of the dispute. Such notice will identify and request the additional information and documentation deemed necessary to review and adjudicate the dispute.

(iii) Upon VA receipt of a notice of dispute that conforms to the requirements of paragraph (c)(1) of this section (including containing all information and documentation necessary to review and adjudicate the dispute), the responsible VA official will take one of the following actions within 90 calendar days:

(A) Issue a written decision, in accordance with the notice provisions of the Veterans Care Agreement, to both parties. The written decision will include:

(1) A description of the dispute;

(2) A reference to the pertinent terms of the Veterans Care Agreement and any relevant authorizations;

(3) A statement of the factual areas of agreement and disagreement;

(4) A statement of the responsible official's decision, with supporting rationale; and

(5) A statement that the decision constitutes the final agency decision on the matter in dispute.

(B) Upon a determination that additional time is reasonably required to issue a decision, the responsible VA official will provide written notice to both parties, in accordance with the notice provisions of the Veterans Care Agreement, of such determination and the time within which a decision will be issued. The time within which a decision will be issued must be reasonable, taking into account the complexity of the dispute and any other relevant factors, and must not exceed 150 calendar days after receipt of a notice of dispute that conforms to the requirements of paragraph (c)(1) of this section and all information and documentation necessary to review and adjudicate the dispute. The responsible VA official will subsequently issue a written decision in accordance with paragraph (c)(3)(iii)(A) of this section.

(4) *Issuance of decision.* VA will furnish the decision to the entity or provider by any method that provides evidence of receipt.

(5) *Effect of decision.* A written decision issued by the responsible VA official constitutes the agency's final decision on the dispute.

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

[84 FR 21678, May 14, 2019]

Supplement *Highlights* references: 121(1).

End of Part 17