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Medical

Book I

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

Supplement No. 92

Covering period of *Federal Register* issues
through May 1, 2015

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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. 92

5 May 2015

Covering the period of Federal Register issues
through May 1, 2015

When **Book I** was originally prepared, it was current through final regulations published in the *Federal Register* of 15 January 2000. These supplemental materials are designed to keep your regulations up to date. You should file the attached pages immediately, and record the fact that you did so on the *Supplement Filing Record* which is at page I-8 of Book I, *Medical*.

**To ensure accuracy and timeliness of your materials,
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1. Always file your supplemental materials immediately upon receipt.
2. Before filing, always check the Supplement Filing Record (page I-8) to be sure that all prior supplements have been filed. If you are missing any supplements, contact the Veterans Benefits Administration at the address listed on page I-2.
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4. If as a result of a failure to file, or an undelivered supplement, you have more than one supplement to file at a time, be certain to file them in chronological order, lower number first.
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FILING INSTRUCTIONS

**Book I, Supplement No. 92
May 5, 2015**

<i>Remove these old pages</i>	<i>Add these new pages</i>	<i>Section(s) Affected</i>
Do not file this supplement until you confirm that all prior supplements have been filed		
17.102-3 to 17.105-1	17.102-3 to 17.105-1	§§17.103, 17.104 & 17.105
17.1505-2 to 17.1515-1	17.1505-2 to 17.1515-1	§17.1510
63.INDEX-1 to 63.15-3 <i>(Mistakenly reads 61.INDEX currently)</i>	63.INDEX-1 to 63.15-3	§§63.1, 63.2, 63.3 63.10 & 63.15

**Be sure to complete the
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HIGHLIGHTS

Book I, Supplement No. 92 May 5, 2015

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 24 April 2015, the VA published an interim final rule effective that same day, to amend its medical regulations to modify how VA measures the distance from a veteran’s residence to the nearest VA medical facility. This modified standard will consider the distance the veteran must drive to the nearest VA medical facility, rather than the straight-line or geodesic distance to such a facility. Change:

- In §17.1510, revised paragraph (e).

2. On 27 April 2015, the VA published a final rule effective that same day, to make technical amendments to its medical regulations by updating certain delegations of authority to be consistent with the statutory authority that established the Consolidated Patient Account Centers (CPACs). VA is, through this final rule, specifying delegations of authority for the collection of debts owed VA to the Chief Financial Officers of the CPACs. Change:

- In §17.103, revised paragraph (a),
- In §17.104, revised paragraph (a), and
- In §17.105, revised paragraph (c).

3. On 1 May 2015, the VA published a final rule effective 1 June 2015, to amend its medical regulations concerning eligibility for the Health Care for Homeless Veterans (HCHV) program. The rule modifies the requirement that homeless veterans be diagnosed with a serious mental illness or substance use disorder to qualify for the HCHV program. The rule also updates the definition of homeless to match in part the one used by HUD. The rule further clarifies that the services provided by the HCHV program through non-VA community-based providers must include case management services, including non-clinical case management, as appropriate. Changes:

- Revised §63.1,
- In §63.2, revised definitions,
- In §63.3, revised paragraph (a),
- In §63.10, revised paragraph (a), and
- In §63.15, revised paragraph (b).

Reserved

§17.103 Referrals of compromise settlement offers.

Any offer to compromise or settle any charges or claim for \$20,000 or less asserted by the Department of Veterans Affairs in connection with the medical program shall be referred as follows:

(a) *To Chief Financial Officers of the Consolidated Patient Account Centers.* If the debt represents charges made under §§17.108, 17.110, or 17.111, the compromise offer shall be referred to the Chief Financial Officer of the Consolidated Patient Account Center (CPAC) for application of the collection standards in §1.900, *et seq.* of this chapter, provided:

- (1) The debt does not exceed \$1,000, and
- (2) There has been a previous denial of waiver of the debt by the CPAC Committee on Waivers and Compromises.

(b) *To Regional Counsel.* If the debt in any amount represents charges for medical services for which there is or may be a claim against a third party tort-feasor or under workers' compensation laws or Pub. L. 87-693; 76 Stat. 593 (see §1.903 of this chapter) or involves a claim contemplated by §1.902 of this chapter over which the Department of Veterans Affairs lacks jurisdiction, the compromise offer (or request for waiver or proposal to terminate or suspend collection action) shall be promptly referred to the field station Regional Counsel having jurisdiction in the area in which the claim arose, or

(c) *To Committee on Waivers and Compromises.* If one of the following situations contemplated in paragraph (c)(1) through (3) of this section applies

(1) If the debt represents charges made under §17.101(a), but is not of a type contemplated in paragraph (a) of this section, or

(2) If the debt represents charges for medical services made under §17.101(b), or

(3) A claim arising in connection with any transaction of the Veterans Health Administration for which the instructions in paragraph (a) or (b) of this section or in §17.105(c) are not applicable, then, the compromise offer should be referred for disposition under §1.900, *et seq.* of this chapter to the field station Committee on Waivers and Compromises which shall take final action.

[39 FR 26403, July 19, 1974, as amended at 47 FR 58250, Dec. 30, 1982. Redesignated and amended at 61 FR 21966, 21967, May 13, 1996; 62 FR 17072, Apr. 9, 1997; 80 FR 23241, April 27, 2015]

Supplement *Highlights* References: 92(2).

§17.104 Terminations and suspensions.

Any proposal to suspend or terminate collection action on any charges or claim for \$20,000 or less asserted by the Department of Veterans Affairs in connection with the medical program shall be referred as follows;

(a) *Of charges for medical services.* If the debt represents charges made under §§ 17.108, 17.110, or 17.111 questions concerning suspension or termination of collection action shall be referred to the Chief Financial Officer of the Consolidated Patient Account Center for application of the collection standards in §1.900, *et seq.* of this chapter, or

(b) *Of other debts.* If the debt is of a type other than those contemplated in paragraph (a) of this section, questions concerning suspension or termination of collection action shall be referred in accordance with the same referral procedures for compromise offers (except the Fiscal activity shall make final determinations in terminations or suspensions involving claims of \$150 or less pursuant to the provisions of §1.900, *et seq.* of this chapter.)

[34 FR 7807, May 16, 1969, as amended at 39 FR 26403, July 19, 1974. Redesignated and amended at 61 FR 21966, 21967, May 13, 1996; 80 FR 23241, April 27, 2015]

Supplement *Highlights* References: 92(2).

§17.105 Waivers.

Applications or requests for waiver of debts or claims asserted by the Department of Veterans Affairs in connection with the medical program generally will be denied by the facility Fiscal activity on the basis there is no legal authority to waive debts, unless the question of waiver should be referred as follows:

(a) *Of charges for medical services.* If the debt represents charges made under §17.102, the application or request for waiver should be referred for disposition under §1.900, *et seq.* of this chapter to the field facility Committee on Waivers and Compromises which shall take final action, or

(b) *Of claims against third persons and other claims.* If the debt is of a type contemplated in §17.103(b), the waiver question should be referred in accordance with the same referral procedures for compromise offers in such categories of claims, or

(c) *Of charges for copayments.* If the debt represents charges for outpatient medical care, inpatient hospital care, medication or extended care services copayments made under §§17.108, 17.110, or 17.111, the claimant must request a waiver by submitting VA Form 5655 (Financial Status Report) to the Consolidated Patient Account Center (CPAC) Chief Financial Officer. The claimant must submit this form within the time period provided in §1.963(b) of this chapter and may request a hearing under §1.966(a) of this chapter. The CPAC Chief Financial Officer may extend the time period for submitting a claim if the Chairperson of the Committee on Waivers and Compromises could do so under §1.963(b) of this chapter. The CPAC Chief Financial Officer will apply the standard “equity and good conscience” in accordance with §§1.965 and 1.966(a) of this chapter, and may waive all or part of the claimant’s debts. A decision by the CPAC Chief Financial Officer under this provision is final (except that the decision may be reversed or modified based on new and material evidence, fraud, a change in law or interpretation of law, or clear and unmistakable error shown by the evidence in the file at the time of the prior decision as provided in §1.969 of this chapter) and may be appealed in accordance with 38 CFR parts 19 and 20.

(d) *Other debts.* If the debt represents any claim or charges other than those contemplated in paragraphs (a) and (b) of this section, and is a debt for which waiver has been specifically provided for by law or under the terms of a contract, initial action shall be taken at the station level for referral of the request for waiver through channels for action by the appropriate designated official. If, however, the question of waiver may also involve a concurrent opportunity to negotiate a compromise settlement, the application shall be referred to the Committee on Waivers and Compromises.

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900-0165.)

(Authority: 38 U.S.C. 501, 1721, 1722A, 1724)

[39 FR 26403, July 19, 1974. Redesignated and amended at 61 FR 21966, 21967, May 13, 1996; 69 FR 62204, Oct. 25, 2004; 80 FR 23241, April 27, 2015]

Supplement Highlights References: 92(2).

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

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

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

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

[79 FR 65585, Nov. 5, 2014]

Supplement *Highlights* references: 88(2).

§ 17.1510 Eligible veterans.

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

(a) A veteran must:

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

(2) Be eligible for hospital care and medical services under 38 U.S.C. 1710(e)(1)(D) and be a veteran described in 38 U.S.C. 1710(e)(3).

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

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

(2) The veteran's residence is more than 40 miles from the VA medical facility that is closest to the veteran's residence.

(3) The veteran's residence is both:

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

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

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

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

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

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

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

(e) For purposes of calculating the distance between a veteran's residence and the nearest VA medical facility under this section, VA will use the driving distance between the nearest VA medical facility and a veteran's residence. VA will calculate a veteran's driving distance using geographic information system software.

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

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

[79 FR 65585, Nov. 5, 2014; as amended at 80 FR 22909, April 24, 2015]

Supplement *Highlights* references: 88(2), 92(1).

§ 17.1515 Authorizing non-VA care.

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

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

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

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

[79 FR 65586, Nov. 5, 2014]

Supplement *Highlights* references: 88(2).

Part 63

Health Care for Homeless Veterans (HCHV) Program

Authority: Authority: 38 U.S.C. 501, 2031, and as noted in specific sections.

Source: 76 Fed. Reg. 52578, August 23, 2011, unless otherwise indicated.

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§63.1 Purpose and scope.

This part implements the Health Care for Homeless Veterans (HCHV) program. This program provides per diem payments to non-VA community-based facilities that provide housing, outreach services, case management services, and rehabilitative services, and may provide care and/or treatment to all eligible homeless veterans.

(Authority: 38 U.S.C. 501, 2031(a)(2))

[76 FR 52578, Aug. 23, 2011; as amended at 80 FR 24821, May 1, 2015]

Supplement *Highlights* references: 64(3), 92(3).

§ 63.2 Definitions.

For the purposes of this part:

Case management means arranging, coordinating, or providing direct clinical services and support; referring and providing linkage to VA and non-VA resources, providing crisis management services and monitoring; and intervening and advocating on behalf of veterans to support transportation, credit, legal, and other needs.

Clinician means a physician, physician assistant, nurse practitioner, psychiatrist, psychologist, or other independent licensed practitioner.

Homeless has the meaning given that term in paragraphs (1) through (3) of the definition of homeless in 24 CFR 576.2.

Non-VA community-based provider means a facility in a community that provides temporary, short-term housing (generally up to 6 months) for the homeless, as well as community outreach, case management, and rehabilitative services, and, as needed, basic mental health services.

Participant means an eligible veteran under § 63.3 for whom VA is paying per diem to a non-VA community-based provider.

(Authority: 38 U.S.C. 501, 2002, 2031)

[76 FR 52578, Aug. 23, 2011; as amended at 80 FR 24821, May 1, 2015]

Supplement *Highlights* references: 64(3), 92(3).

§ 63.3 Eligible veterans.

(a) *Eligibility.* In order to serve as the basis for a per diem payment through the HCHV program, a veteran served by the non-VA community-based provider must be:

(1) Enrolled in the VA health care system, or eligible for VA health care under 38 CFR 17.36 or 17.37; and

(2) Homeless.

(b) *Priority veterans.* In allocating HCHV program resources, VA will give priority to veterans, in the following order, who:

(1) Are new to the VA health care system as a result of VA outreach efforts, and to those referred to VA by community agencies that primarily serve the homeless population, such as shelters, homeless day centers, and soup kitchens.

(2) Have service-connected disabilities.

(3) All other veterans.

(c) VA will refer a veteran to a non-VA community-based provider after VA determines the veteran's eligibility and priority.

(Authority: 38 U.S.C. 501, 2031)

[76 FR 52578, Aug. 23, 2011; as amended at 80 FR 24821, May 1, 2015]

Supplement *Highlights* references: 64(3), 92(3).

Next Section is §63.10

§ 63.10 Selection of non-VA community-based providers.

(a) *Who can apply.* VA may award per diem contracts to non-VA community-based providers who provide temporary residential assistance homeless persons, including but not limited to persons with serious mental illness, and who can provide the specific services and meet the standards identified in §63.15 and elsewhere in this part.

(b) *Awarding contracts.* Contracts for services authorized under this section will be awarded in accordance with applicable VA and Federal procurement procedures in 48 CFR chapters 1 and 8. Such contracts will be awarded only after the quality, effectiveness and safety of the applicant's program and facilities have been ascertained to VA's satisfaction, and then only to applicants determined by VA to meet the requirements of this part.

(c) *Per diem rates and duration of contract periods.*

(1) Per diem rates are to be negotiated as a contract term between VA and the non-VA community-based provider; however, the negotiated rate must be based on local community needs, standards, and practices.

(2) Contracts with non-VA community-based providers will establish the length of time for which VA may pay per diem based on an individual veteran; however, VA will not authorize the payment of per diem for an individual veteran for a period of more than 6 months absent extraordinary circumstances.

(Authority: 38 U.S.C. 501, 2031)

[76 FR 52578, Aug. 23, 2011; as amended at 80 FR 24821, May 1, 2015]

Supplement *Highlights* references: 64(3), 92(3).

Next Section is §63.15

§ 63.15 Duties of, and standards applicable to, non-VA community-based providers.

A non-VA community-based provider must meet all of the standards and provide the appropriate services identified in this section, as well as any additional requirements set forth in a specific contract.

(a) *Facility safety requirements.* The facility must meet all applicable safety requirements set forth in 38 CFR 17.81(a).

(b) *Treatment plans, therapeutic/rehabilitative services, and case management.* Individualized treatment plans are to be developed through a joint effort of the veteran, non-VA community-based provider staff, and VA clinical staff. Therapeutic and rehabilitative services, as well as case management and outreach services, must be provided by the non-VA community-based provider as described in the treatment plan. In some cases, VA may complement the non-VA community-based provider's program with added treatment or other services, such as participation in VA outpatient programs or counseling. In addition to case management services, for example, to coordinate or address relevant issues related to a veteran's homelessness and health as identified in the individual treatment plan, services provided by the non-VA community-based provider should generally include, as appropriate:

(1) Structured group activities such as group therapy, social skills training, self-help group meetings, or peer counseling.

(2) Professional counseling, including counseling on self-care skills, adaptive coping skills, and, as appropriate, vocational rehabilitation counseling, in collaboration with VA programs and community resources.

(c) *Quality of life, room and board.*

(1) The non-VA community-based provider must provide residential room and board in an environment that promotes a lifestyle free of substance abuse.

(2) The environment must be conducive to social interaction, supportive of recovery models and the fullest development of the resident's rehabilitative potential.

(3) Residents must be assisted in maintaining an acceptable level of personal hygiene and grooming.

(4) Residential programs must provide laundry facilities.

(5) VA will give preference to facilities located close to public transportation and/or areas that provide employment.

(6) The program must promote community interaction, as demonstrated by the nature of scheduled activities or by information about resident involvement with community activities, volunteers, and local consumer services.

(7) Adequate meals must be provided in a setting that encourages social interaction; nutritious snacks between meals and before bedtime must be available.

(d) *Staffing.* The non-VA community-based provider must employ sufficient professional staff and other personnel to carry out the policies and procedures of the program. There will be at a minimum, an employee on duty on the premises, or residing at the program and available for emergencies, 24 hours a day, 7 days a week. Staff interaction with residents should convey an attitude of genuine concern and caring.

(e) *Inspections.*

(1) VA must be permitted to conduct an initial inspection prior to the award of the contract and follow-up inspections of the non-VA community-based provider's facility and records. At inspections, the non-VA community-based provider must make available the documentation described in paragraph (e)(3) of this section.

(2) If problems are identified as a result of an inspection, VA will establish a plan of correction and schedule a follow-up inspection to ensure that the problems are corrected. Contracts will not be awarded or renewed until noted deficiencies have been eliminated to the satisfaction of the inspector.

(3) Non-VA community-based providers must keep sufficient documentation to support a finding that they comply with this section, including accurate records of participants' lengths of stay, and these records must be made available at all VA inspections.

(4) Inspections under this section may be conducted without prior notice.

(f) *Rights of veteran participants.* The non-VA community-based provider must comply with all applicable patients' rights provisions set forth in 38 CFR 17.33.

(g) *Services and supplies.* VA per diem payments under this part will include the services specified in the contract and any other services or supplies normally provided without extra charge to other participants in the non-VA community-based provider's program.

(Authority: 38 U.S.C. 501, 2031)

[76 FR 52578, Aug. 23, 2011; as amended at 80 FR 24821, May 1, 2015]

Supplement *Highlights* references: 64(3), 92(3).

Reserved

End of Part 63