DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 17

RIN 2900–AQ45

Veterans Care Agreements

AGENCY: Department of Veterans Affairs.

ACTION: Interim final rule.

SUMMARY: The Department of Veterans Affairs (VA) amends its medical regulations 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.

DATES: *Effective date:* This rule is effective on May 14, 2019.

Comment date: Comments must be received on or before July 15, 2019.

ADDRESSES: Written comments may be submitted by email through *http://www.regulations.gov;* by mail or hand-delivery to Director, Office of Regulation Policy and Management (00REG), Department of Veterans Affairs, 810 Vermont Avenue NW, Room 1064, Washington, DC 20420; or by fax to (202) 273–9026. (This is not a toll-free number.) Comments should indicate that they are submitted in response to ''RIN 2900–AQ45, Veterans Care Agreements.'' Copies of comments received will be available for public inspection in the Office of Regulation Policy and Management, Room 1064, between the hours of 8:00 a.m. and 4:30 p.m. Monday through Friday (except holidays). Please call (202) 461–4902 for an appointment. (This is not a toll-free number.) In addition, during the comment period, comments may be viewed online through the Federal Docket Management System (FDMS) at *http://www.regulations.gov.*

FOR FURTHER INFORMATION CONTACT: Joseph Duran, Office of Community Care (10D), Veterans Health Administration, Department of Veterans Affairs, Ptarmigan at Cherry Creek, Denver, CO, 80209; *Joseph.Duran2@va.gov,* (303) 372–4629. (This is not a toll-free number.)

SUPPLEMENTARY INFORMATION: The John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (hereafter referred to as the ''MISSION Act'') includes five titles containing more than 60 substantive provisions, many of which amend existing law or create new law that affects the way VA furnishes necessary care and services to covered individuals. This interim final rule will implement section 102 of the MISSION Act, which creates a new 38 U.S.C. 1703A to authorize VA to enter into agreements to furnish required care and services when such care and services are not feasibly available 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. Section 1703A(k) requires VA to promulgate regulations to carry out section 1703A.

This interim final rule will not implement section 101 of the MISSION Act, which creates a new VA Community Care Program to furnish care to eligible veterans through non-VA providers. The VA Community Care Program will be implemented in a separate rulemaking (2900–AQ46), however, we provide here a brief explanation regarding the need to implement the agreements authorized by section 1703A ahead of the community care program itself. In accordance with section 101(c)(1) of the MISSION Act, VA is required to promulgate regulations to carry out Veterans Community Care Program by June 6, 2019. Concurrent with this statutory deadline, section 143 of the MISSION Act amended section 101(p) of the Veterans Access, Choice, and Accountability Act of 2014 (the Choice Act) to state that VA may not use the Choice Act to furnish care and services after June 6, 2019. As a result, after June 6, 2019, VA will no longer be able to use Veterans Choice Program provider agreements. The agreements authorized by this rulemaking will essentially replace the Veterans Choice Program provider agreements as a method for purchasing community care through instruments other than conventional procurement contracts that are subject to the Federal Acquisition Regulation (FAR) and all other Federal procurement laws. VA needs the regulations governing these new agreements to be legally effective before June 6, 2019, so that VA has time to establish new purchasing relationships with community providers, because VA's contractual network of community providers as required by the new section 1703(h), as amended by section 101(a) of the MISSION Act, may not be at full coverage by June 6, 2019. Additionally, in VA's experience, certain care and services (such as home health services) have been procured from sources that are unwilling, or unable, to enter into conventional procurement contracts subject to the FAR, and VA expects this will continue to be true after June 6, 2019. If the agreements that will be promulgated by this rulemaking are not in effect with enough time to provide VA and community providers an opportunity to transition away from the current Veterans Choice Program provider agreements before June 6, 2019, there is risk of disruptions to veterans receiving community care (see the section that discusses the Administrative Procedure Act for more specific information regarding disruption to care). To ensure the transition from the current Veterans Choice Program to the Veterans Community Care Program occurs without such disruption, VA requires this interim final rule to establish the parameters of agreements and other related authorities so that VA may legally order care and services under them by June 6, 2019.

§ 17.4100 Definitions

Section 17.4100 will establish definitions for §§ 17.4100–17.4135, which are promulgated to implement the agreements authorized by 38 U.S.C. 1703A.

The term covered individual is defined to mean 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. This definition is consistent with the definition of covered individual in section 1703A(l) and will be used throughout §§ 17.4100–17.4135 to indicate who may be furnished care

or services under a Veterans Care Agreement (VCA). This definition further clarifies that the covered individual must separately be eligible under laws administered by VA to receive care from a non-VA provider. Section 1703A is strictly an authority related to how VA may purchase care and services in the community; it does not establish eligibility to receive such care or services from a non-VA provider at VA expense. Such authority must exist elsewhere in title 38 U.S.C. (*e.g.,* 38 U.S.C. 1703). The definition of covered individual in § 17.4100 further references ''title 38 CFR,'' to ensure any implementing regulatory criteria related to the receipt of care or services from non-VA providers at VA expense also apply (more specific applicable regulatory criteria in title 38 CFR will not be cited, as such references may not be exhaustive or accurate should VA revise its regulations in the future).

The term contract is defined to mean any of the following: Federal procurement agreements regulated by the Federal Acquisition Regulation; common law contracts; other transactions; or any other instrument. However, Veterans Care Agreements are expressly excluded from the definition. This definition relates to the assessment by VA in § 17.4115 of whether care and services are feasibly available from a VA facility or through a contract or sharing agreement.

Extended care services is defined as the services described in 38 U.S.C. 1710B(a); this definition of ''extended care services'' is sufficiently broad to capture all extended care services offered by VA.

The terms hospital care and medical services are similarly defined by cross reference to the applicable statutory definitions at 38 U.S.C. 1701(5) and (6), respectively, to sufficiently capture those types of care furnished by VA.

The term sharing agreement is defined to mean 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.

The term VA facility is defined to mean 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, an VA independent outpatient clinic, and other VA outpatient services sites. This definition relates to the assessment by VA in § 17.4115 of whether care and services are feasibly available from a VA facility or through a contract or sharing agreement. We have defined this term in accordance with the types of care and services that a VA facility provides, and we have provided a non-exhaustive list of examples of designations of such facilities (*e.g.,* VA medical center, VA community-based outpatient clinic, etc.) to ensure that any future changes to descriptions or designations of VA facilities would not result in a gap in our regulations.

The term Veterans Care Agreement is defined to mean an agreement authorized by 38 U.S.C. 1703A. We note that we are using the term veterans care agreement, although individuals other than veterans may receive care under an agreement authorized by section 1703A (*see* the definition of covered individual). We additionally note that, throughout the remainder of the preamble, we may refer more simply to agreement rather than veterans care agreement.

§ 17.4105 Purpose and Scope

Section 17.4105 will establish purpose and scope paragraphs. The purpose in paragraph (a) will state that §§ 17.4100–17.4135 implement 38 U.S.C. 1703A, as required under section 1703A(j). Paragraph (a) will further state that 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.

The scope in paragraph (b) will state that §§ 17.4100–17.4135 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. Paragraph (b) will further state that §§ 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, and/or furnish hospital care, medical services, or extended care services pursuant to a Veterans Care Agreement.

§ 17.4110 Entity or Provider Certification

Section 17.4110 will implement the certification process required by 38 U.S.C. 1703A(c), by establishing the standards and process VA will use to certify entities or providers that are interested in entering into agreements with VA and furnishing care and services through such agreements. Generally, section 1703A(c) requires VA to establish procedures for application for certification, criteria to approve or deny certification and recertification, and criteria to revoke certification.

Paragraph (a) of § 17.4110 will establish the general requirement that 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 § 17.4110. Paragraph (a) will also establish that 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. We believe this meets the intent of section 1703A(c), to ensure that entities or providers must meet and maintain VA's certification requirements to be considered eligible to furnish care or services under a Veterans Care Agreement.

Paragraph (b) of § 17.4110 will establish the process and criteria for entity and provider certification. Paragraph (b)(1) will establish that an entity or provider must apply for certification, by submitting the following information to VA: (i) Documentation of applicable medical licenses, and (ii) all other information and documentation that is required by VA. This additional information may include (but is not limited to): A provider's first and last names; legal business names, National Provider Number (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. We interpret section 1703A(c) as requiring an application for certification (as section 1703A(c)(1) requires VA to establish through regulation a timeframe by which VA must act upon such application), and we are implementing that requirement by establishing that application occurs with the entity or provider submitting information as required by VA in § 17.4010(b)(1)(i)–(ii). This information is what VA presently requires providers to submit to be considered eligible to provide community care under Choice Provider Agreements, and we believe providers are familiar with this information. Although providers who will furnish services through a VCA will be familiar with submitting this information, the information collection burden will not be grandfathered from the Choice

Provider Agreements to the VCA program, because the certification process required by section 1703A(c) is new and therefore will be accounted for as a new information collection as described later in this rule. Because this collection is supporting a new statutory process VA must account for it as a new collection, which will include submission by providers of all new information.

Paragraph (b)(2) of § 17.4110 will establish the process and criteria for approval or denial of an application for certification, as required by section 1703A(c)(2). Paragraph (b)(2)(i) will first establish that VA will review all information it obtains including through applicable federal and state records systems and as submitted by the applicant, and will determine eligibility for certification. These federal and state records systems would be those that VA accesses presently to conduct its certification processes for providers. Paragraph (b)(2)(ii) will then establish that an applicant must submit all information required under paragraph (b)(1) of this section. VA will then review all applicable documentation received to determine whether all requirements are met.

Paragraph (b)(2)(iii) of § 17.4110 will establish the first mandatory basis for denial of certification, which is established in section 1703A(c), whereby VA must deny an application for certification if VA determines that the entity or provider is excluded from participating in a Federal health care program, or is identified as an excluded source on the System for Award Management Exclusions list. This mandatory denial is consistent with section 1703A(c)(3).

The second mandatory basis for denial of certification that VA is establishing is under § 17.4110(b)(2)(iv), whereby 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. We believe this basis of denial is reasonable and consistent with the purposes of section 1703A(c) because it would allow VA to deny an application based on a separate, previous determination by VA that the applicant is barred from furnishing care and services due to submitting a fraudulent claim.

Paragraph (b)(2)(v) of § 17.4110, establishes a discretionary standard that would allow VA to deny an application for certification if VA determines that, based on programmatic considerations, VA is unlikely to enter into a Veterans Care Agreement with the applicant. We believe this basis of denial is reasonable because section 1703A is a permissive procurement authority that allows (but does not require) VA to enter into and use Veterans Care Agreements. Therefore, there is little or no benefit to a provider or entity, or to VA, from proceeding with the certification process in section 1703A(c), including obtaining and monitoring certified status, when VA, in the exercise of its programmatic judgment, determines it is unlikely to enter into a VCA with the entity or provider. Under those circumstances, in order to avoid unnecessary expenditure of resources by the entity or provider, and by VA, VA may deny the application. VA's determination that the basis of denial in § 17.4110(b)(2)(v) has been met will be assessed on a case by case basis. We will not regulate more specific circumstances under which VA might apply this basis of denial, although such circumstances would generally exist when VA would not likely enter into a VCA with an entity or provider because the care or services required by a covered individual are instead feasibly available through a VA facility, a contract, or a sharing agreement (*see* 38 U.S.C. 1703A(a)(1)). For instance, if an entity or provider were already a participant in VA's contractual community care network, or if VA's contractual community care network in a certain locality already had adequate coverage of the services the entity or provider furnishes, VA would be unlikely to seek to enter into a VCA with that entity or provider.

As required by section 1703A(c)(1), § 17.4110(b)(2)(vi) will establish a deadline for VA to act on an application for certification, to require that within 120 days of VA receiving an application, VA will issue a written decision approving or denying certification, if practicable. We believe 120 days is a reasonable amount of time to make such a determination, and we include the if practicable language only to provide for limited exceptions where the 120 days may not be met (for instance, if a very large quantity of applications is received by VA at the same time or within a short timeframe). Section 17.4110(b)(2)(vi) will further establish that notices of approval will set forth the effective date and duration of the certification, while notices of denial will set forth the specific grounds for denial and supporting evidence. We believe this will provide entities and providers adequate notice of their relative certification status. Lastly, § 17.4110(b)(2)(vi) will establish that a denial constitutes VA's final decision on an application.

Paragraph (b)(3) of § 17.4110 will establish the duration of the certification, in accordance with the requirement to regulate such duration in section 1703A(c)(2). Paragraph (b)(3)(i) will provide that an entity or provider's certification will last for a three-year period, unless VA revokes such certification within that period under the standards established in § 17.4110(b)(4) (this revocation is discussed further below). This three-year certification period is reasonable for VA to administer and should not create any undue burden for entities or providers. Paragraph (b)(3)(ii) of § 17.4110 will further establish that an entity or provider must maintain certification throughout the three-year period and must inform VA of any changes or events that would affect its eligibility within 30 calendar days of the change or event. We believe this maintenance of certification is consistent with the intent of section 1703A(c).

Paragraph (b)(3)(iii) of § 17.4110 will establish that 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 § 17.4110 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 § 17.4110 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 § 17.4110. 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. We believe the processes established in § 17.4105(b)(3)(iii) provide an entity or provider with adequate notice to begin and complete the process of

recertification, as well as notice that VA will assess for recertification under the criteria established in § 17.4110(b)(2), as VA is required to regulate recertification under section 1703A(c)(2). As with initial certification, we find that written notice is adequate to communicate to entities and providers their relative recertification status, and that VA's denial notice for recertification constitutes VA's final decision on application for recertification. Paragraph (b)(3)(iv) of § 17.4110 will lastly establish that if a certified entity or provider applies for recertification after the deadline in paragraph (b)(3)(iii) of § 17.4110 (fewer than 60 days prior to their three-year period lapsing), such application will constitute a new application for certification and will be processed in accordance with paragraphs (b)(1)–(2) of § 17.4110.

Paragraph (b)(4) of § 17.4110 will establish the process for revocation of certification, in accordance with the requirement to regulate such revocation in section 1703A(c)(2). Paragraph (b)(4)(i) will establish that VA may revoke an entity's or provider's certification in accordance with § 17.4010(b)(2)(ii)–(v). Paragraph (b)(4)(ii) will establish that when VA determines revocation is appropriate, VA will notify the entity or provider in writing of the proposed revocation. The notice of 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 § 17.4110(b)(2). Paragraph (b)(4)(iii) will establish that 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. Lastly, paragraph (b)(4)(iv) will establish that revocation of certification results in such status being rendered void, and the provider or entity may not furnish services or care under a VCA prior to applying for and obtaining certified VCA status.

We believe that the processes established in § 17.4110(b)(4) provide adequate notice in both timeframes and format to providers and entities of VA's decision to revoke to then permit providers and entities with an opportunity to respond and potentially remediate circumstances that could result in VA not revoking certification. As with approvals of initial certification or recertification, VA's decision to revoke certification will constitute VA's final decision.

§ 17.4115 VA Use of Veterans Care Agreements

Section 17.4115 will establish basic parameters regarding the use of agreements. Paragraph (a)(1) of § 17.4115 will establish that VA may furnish hospital care, medical services, or extended care services through a VCA only if 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. The requirement in § 17.4115(a)(1) that individuals be eligible for care or services is consistent with section 1703A(a)(1)(A). Paragraph (a)(2) of § 17.4115 will restate the general requirement in section 1703A(a)(1)(A) that VA may use agreements to furnish care or services only if such care or services are not feasibly available to the covered individual through a VA facility, contract, or a sharing agreement. Paragraph (a) of § 17.4115 essentially restates language from section 1703A(a), but modifies it to include that agreements may ''only'' be considered for use after considering those other means of furnishing care and services. We believe this reflects the clear intent of section 1703A(a), which only authorizes VA to use agreements to purchase care in the community when such care is not feasibly available from a VA facility or through a contract or sharing agreement. Paragraph (a)(2) of § 17.4115 will also include the express qualifying language from section 1703A(a)(1)(C) that VA may consider the medical condition of the individual, the travel involved, the nature of the care or services, or a combination of these factors when determining if the furnishing of care and services through a contract or sharing agreement would be impracticable or inadvisable, thereby warranting use of an agreement instead.

Paragraph (b) of § 17.4115 will establish standards of conduct, as well as indicate improper business practices, for VA officials and for entities and providers. We note that we will not be restating the regulatory text verbatim below to explain its inclusion in regulations, to avoid unnecessary duplication and because such regulation text is predominantly self-explanatory. Paragraph (b)(1)(i) of § 17.4115 will establish general parameters that 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. Paragraph (b)(1)(ii) of § 17.4115 will memorialize that certain other statutes and regulations address prohibited conduct for VA officials and employees. Examples of such authorities are identified in paragraphs (b)(1)(ii)(A)–(D). Paragraph (b)(2) of § 17.4115 will establish more specific standards and requirements for entities and providers that enter into Veterans Care Agreements, to require such an entity or provider to: (i) Have a satisfactory performance record; (ii) have a satisfactory record of integrity and business ethics; (iii) 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) not engage in a fraudulent or criminal activity or offense (such prohibited activities or offenses are more specifically listed in the regulation text under § 17.4115(b)(2)(iv)); and (v) 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.

§ 17.4120 Payment Rates

Section 17.4120 will establish that the rate structure for payment for hospital care, medical services, and extended care services furnished pursuant to an agreement authorized by section 1703A of this title will be the rates set forth in the terms of such agreement. Each such agreement will contain price terms for all services within its scope. Payment rates will comply with the parameters defined in § 17.4120(a)–(e), as described below. To be consistent with section 1703A(d), payment rates will be analogous to the parameters established in section 1703(i) as amended by section 101 of the MISSION Act. For the sake of convenience and understanding, we refer to provisions of section 1703, as section 101 of the MISSION Act will amend it, although we recognize that section 1703 as so amended is not

legally effective until VA has published a final rule implementing the Veterans Community Care Program (the proposed rule RIN 2900–AQ46, Veterans Community Care Program, was published on February 22, 2019, see 84 FR 5629). Until section 1703(i) as amended is effective, VA exercises its general authority in this interim final rule to establish the rates paid for care and services provided through an agreement, and such rates will be consistent with section 1703(i) when it comes into effect.

Paragraph (a) of § 17.4120 will establish that, except as otherwise provided in § 17.4120, payment rates will not exceed the applicable Medicare fee schedule or prospective payment system amount (hereafter 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). This will be analogous to the general provision in section 1703(i)(1), that, with certain exceptions, the rates paid for care and services may not exceed the applicable Medicare rate. The parenthetical language in § 17.4120(a), to indicate that VA's rates would be based on Medicare rates without any changes based on the subsequent development of information under Medicare authorities, is intended to limit VA's rate adjustments to an annual basis in line with Medicare's annual payment update, versus other adjustments that Medicare may make to its rates throughout any given year that is typically provider-specific and is based on provider and other reporting.

Paragraph (b) of § 17.4120 will establish that, 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. This is consistent with section 1703(i)(4).

Paragraph (c) of § 17.4120 will establish that payment rates for services furnished in a highly rural area may exceed the limitations set forth in § 17.4120(a)–(b). VA will use the authority in section 1703(i)(1) to establish rates for highly rural areas, versus the authority in section 1703(i)(2)A. Section 17.4120(c) will further establish that 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, consistent with the definition of ''highly rural area'' in section 1703(i)(2)(B). Section 17.4120(c) will reflect VA's interpretation that imposing the limitations set forth in § 17.4120(a)–(b) may not be practicable for all services furnished in highly rural areas. VA's assessment of practicability in § 17.4120(c) is consistent with the authority in section 1703(i)(1), which expressly provides that the payment limitations of that section only apply ''to the extent practicable.'' VA may find that it is not practicable to impose the payment limitations in § 17.4120(a)–(b) for services furnished in highly rural areas primarily because the typical laws of supply and demand dictate that in highly rural areas, the scarcity of health care providers and other health care resources tends to create increased prices for delivery of health care services. VA will not implement the more express statutory payment exception in section 1703(i)(2)(A) for services furnished to individuals residing in highly rural areas, because it would not be practicable to tie payment rates to the location of a patient's residence as set forth in section 1703(i)(2)(A). We reiterate from above that a driver of increased cost of services in highly rural areas relates to the location where the services are provided, not necessarily to the location from which the patient travels to receive the services. Indeed, it may not be accurate that, in all cases, individuals who reside in highly rural areas are receiving care and services in those same areas. Accordingly, VA does not want to adopt a payment methodology that relies on the authority in section 1703(i)(2)(A), as that that can universally permit payment of higher rates to certain health care providers furnishing services in other than highly rural areas. Attempting to tie payment rates to particular patients, rather than setting general rates for particular health care providers, would be administratively cumbersome and could lead to selective acceptance of patients that would adversely affect other patients. Using the authority in section 1703(i)(1) to establish rates for highly rural areas, versus the authority in section 1703(i)(2)A), provides for more consistent and fair rate setting for these areas.

Paragraph (d) of § 17.4120 will establish that VA may deviate from the parameters set forth in § 17.4120(a)–(c) when VA determines that, based on patient needs, market analyses, health care provider qualifications, or other factors, it is not practicable to limit payments as will be dictated by application of § 17.4120(a)–(c). This general exception will be consistent with the provision in section 1703(i)(1) that authorizes VA to pay at rates not to exceed the Medicare rate ''to the extent practicable.'' Paragraph (d) will afford VA the flexibility to ensure it can reach agreement with entities or providers to furnish necessary services when factors that drive costs may shift faster than established Medicare rates. This flexibility will not be a guarantee of payments above applicable Medicare rates because the introductory language in § 17.4120 will establish that payment rates are ultimately set forth in the terms of the agreement under which the care and services are furnished. Such agreements will provide for the relevant procedures and review process for any payments that might utilize the exception in § 17.4120(d), to ensure a consistent level of VA oversight.

Finally, paragraph (e) of § 17.4120 will establish, consistent with section 1703(i)(3), that payment rates for services furnished in Alaska will not be subject to paragraphs (a) through (d).

§ 17.4125 Review of Veterans Care Agreements

Section 17.4125 will establish basic parameters for VA to review certain agreements that have been formed to determine if care and services should be furnished through a contract or sharing agreement instead, in accordance with the requirements in 38 U.S.C. 1703A(a)(2) and (a)(3). Under § 17.4125, 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. The $5,000,000 amount is established in section 1703A(a)(3) for extended care services, and we believe that amount is reasonable to consider for agreements for hospital care and medical services as well.

§ 17.4130 Discontinuation of Veterans Care Agreements

Section 17.4130 will establish parameters for the discontinuation of agreements, consistent with 38 U.S.C. 1703A(f). Paragraph (a) of § 17.4130 will establish that discontinuation of an agreement by an entity or provider requires a written notice of request to discontinue to be submitted to VA, in accordance with the terms of the VCA

and additional terms as established in § 17.4130(a)(1) and (a)(2). Paragraph (a)(1) will establish that the written notice must be received by VA at least 45 calendar days before the intended discontinuation date and must specify the discontinuation date, and paragraph (a)(2) will state that the 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 in accordance with the terms of the Veterans Care Agreement. Paragraphs (a)(1)–(2) will implement section 1703A(f)(1), which requires VA to establish, through regulations, time and notice requirements for an entity or provider to discontinue an agreement. The 45-day notice requirement in advance of discontinuation under § 17.4130(a)(1) is consistent with the discontinuation notice in current Choice Program provider agreements and is familiar to entities and providers, and otherwise necessary to ensure continuity of care should VA need to secure other health care resources prior to an agreement being discontinued.

Paragraph (b)(1) of § 17.4130 will establish the parameters under which VA may discontinue an agreement with an entity or provider, to require a written notice of discontinuation to be submitted by VA to the entity or provider, in accordance with the terms of the VCA and additional terms as established in paragraphs (b)(1)(i) and (b)(1)(ii). Paragraph (b)(1)(i) will establish that the written notice will be issued by VA at least 45 calendar days before the intended discontinuation date except as provided in paragraph (b)(1)(ii). Paragraph (b)(1)(ii) will establish that 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. Paragraph (b)(1)(ii) of § 17.4130 would provide for fewer than 45 days' notice prior to discontinuation in certain circumstances, for two reasons. First, VA must be able to discontinue an agreement without advance notice in circumstances where doing so is necessary to protect the health of covered individuals. Second, VA wants to retain the right to discontinue with fewer than 45 days' notice under other circumstances if the parties to an agreement negotiate terms permitting such an approach. Paragraph (b)(2) of § 17.4130 will establish that the written notice will be delivered to the entity or provider in accordance with the terms of the Veterans Care Agreement.

Paragraph (b)(3) of § 17.4130 will provide that VA may discontinue an agreement for any reason that is expressly enumerated in section 1703A(f)(2). These reasons are: (i) If the entity or provider fails to comply substantially with the provisions of 38 U.S.C. 1703A or 38 CFR 17.4100–17.4135; (ii) if the entity or provider fails to comply substantially with a provision of the agreement; (iii) if the entity or provider is excluded from participating in a Federal health care program or is identified on the System for Award Management exclusions list; (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 their continued participation would be detrimental to the best interest of the individuals receiving care or of VA; and (v) if VA determines it is reasonable to terminate the agreement based on the health care needs of the individual receiving care or services.

§ 17.4135 Disputes

Section 17.4135 will establish administrative procedures and requirements for eligible entities and providers to present disputes arising under agreements, in accordance with 38 U.S.C. 1703A(h)(1). Paragraph (a) of § 17.4135 will generally establish the parameters of these administrative procedures, consistent with section 1703A(h)(2)–(h)(4). Paragraph (a)(1) will more specifically establish that, for purposes of § 17.4135, 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 § 17.4135(b) (which, as explained later, are limited to claims for payment or scope of authorizations); (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. Paragraph (a)(1)(iii) will also clarify that 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.

Paragraph (a)(2) of § 17.4135 will establish that the procedures in § 17.4135 should only be used when the parties to a Veterans Care Agreement have failed to resolve an issue in controversy by mutual agreement. This language will reinforce the characterization in § 17.4135(a)(1)(ii) that when the parties to an agreement are working to informally resolve a matter by mutual agreement, those actions and that process do not constitute a dispute within the meaning of this section. In other words, the existence of this disputes process does not preclude the parties to an agreement from working together to mutually resolve any issues arising under or related to the agreement, including issues pertaining to claims for payment, the scope of authorizations, receipt or non-receipt of medical documentation by VA, or simple clerical errors (such as a miscoding of a procedure by an entity or provider).

Paragraph (a)(3) of § 17.4135 will establish that the dispute procedures in § 17.4135 constitute an entity or provider's exclusive administrative remedies for disputes arising under agreements, consistent with section 1703A(h)(2). We interpret section 1703A(h)(2) to shield disputes under agreements from the application of any other administrative remedies that VA may use to adjudicate and/or resolve disputes in other contexts, including application of administrative requirements and procedures under 38 U.S.C. chapter 71 and 38 CFR part 19.

Paragraph (a)(4) of § 17.4135 will provide that disputes under § 17.4135 are not considered claims for purposes of such laws that would otherwise require the application of 41 U.S.C. 7101–7109, also known as the Contract Disputes Act of 1978, which is consistent with 38 U.S.C. 1703A(h)(4).

Paragraph (a)(5) of § 17.4135 will establish that an eligible entity or provider must first exhaust the procedures further established in § 17.4135 before seeking judicial review under 28 U.S.C. 1346, consistent with 38 U.S.C. 1703A(h)(3).

Paragraph (b) of § 17.4135 will provide that disputes arising under agreements may only 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. These limitations as to what may be disputed are consistent with section 1703A(h)(4).

Paragraph (c) of § 17.4135 will establish procedures for disputes arising

under agreements, specifically related to initiation and review of the dispute, as well as issuance and effect of VA's decision. Paragraph (c)(1) of § 17.4135 will provide that (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 and in accordance with the terms of the Veterans Care Agreement, and (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. The information in § 17.4135(c)(ii) is what is minimally required by VA to assess the matter in dispute and issue a decision.

Paragraph (c)(1)(iii) of § 17.4135 will establish that the notice of dispute must be received by the designated VA official to which such notice must be submitted under the terms of the Veterans Care Agreement and in accordance with the terms of the Veterans Care Agreement, within 90 calendar days after the accrual of the dispute. For purposes of § 17.4135(c)(1)(iii), 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. We believe 90 days is a reasonable timeframe for entities or providers to submit disputes to VA regarding claims for payment or scope of authorizations (based on VA's experience, we believe entities or providers will seek to resolve any disagreements regarding payment amounts much sooner). To clarify when VA would determine a date certain to start the 90-day timeframe under this accrual of dispute standard, § 17.4135(c)(1)(iii) would further establish that the term accrual of the dispute has the following meanings in each of the two specific circumstances: (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; and (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. We believe that these two circumstances will cover a vast majority of disputes, because, under section 1703A(h)(4), disputes must pertain to claims for payment or the scope of authorizations.

Paragraph (c)(2) of § 17.4135 will establish the scope of VA's authority to decide and resolve disputes. Paragraph (c)(2)(i) will establish that 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. We believe that it is adequate to reference such a VA official, versus a more specific job title or position, to avoid a gap in our regulations should such titles or positions be renamed or restructured in the future. Paragraph (c)(2)(ii) will establish that 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 § 17.4135(c)(2)(ii), 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 appropriate.

Paragraph (c)(3) of § 17.4135 will establish procedures related to review of disputes and VA's decision in resolving disputes. Paragraph (c)(3)(i) will establish that upon receipt of a notice of dispute, the responsible VA official will review the dispute and all facts pertinent to the dispute. Paragraph (c)(3)(ii) will further establish that 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.

Paragraph (c)(3)(iii) of § 17.4135 will establish that upon VA receipt of a notice of dispute that conforms to the requirements of § 17.4135(c)(1), the responsible VA official will take one of the following actions within 90 calendar days, either: (A) Issue a written decision, in accordance with the notice provisions of the Veterans Care Agreement, that will include all information further described in § 17.4135(c)(3)(iii)(A)*(1)–(5);* or (B) upon a determination that additional time is required to issue a decision, provide written notice in accordance with the notice provisions of the Veterans Care Agreement of the time within which the decision will be issued. The determination of the appropriate amount of additional time must be reasonable and will take into account the complexity of the dispute and any other relevant factors, and the total time will not exceed 150 calendar days. Under § 17.4135(c)(3)(iii)(B), if additional time is needed, the responsible VA official will subsequently issue a written decision in accordance with paragraph (c)(3)(iii)(A) of this section. Under 38 U.S.C. 1703(A)(h)(4), disputes must pertain to claims for payment or the scope of authorizations. With regards to these timeframes of 90 days and 150 days that will be established in § 17.4134(c)(3) as described above, VA has extensive experience dealing with non-VA providers regarding both payment and scope of authorizations, including resolving discrepancies and disagreements outside of the new process in section 1703(A)(h)(4) regarding amounts of payment, nonpayment, and scope of authorizations. Based on that experience, VA is familiar with the types of information and documentation necessary to resolve these matters, and we have found that we can generally identify all such information and documentation in fewer than 60 days after an issue is first identified. However, to ensure we cover the potential for unforeseen delays that may arise given the more formal nature of this new disputes process (relative to how VA currently resolves similar matters with non-VA community providers) VA has established a 90-day timeframe. We believe 90 days is a prudent timeframe for VA to commit to identifying information and documentation necessary to adjudicate most disputes under this section. Section 17.4135(c)(3) will then further provide for an additional 60 days, for a

total of 150 days, in what we expect to be the rare occurrence when the 90 days would not be sufficient. We determined that the 90 days and 150 days were reasonable by balancing uncertainties that may increase the timeframe for VA to identify information under this process against the interests of providers and entities that enter into VCAs in expeditious processing and resolution of formal disputes under this section.

Paragraph (c)(4) of § 17.4135 will establish that VA will furnish its decision on the dispute to the entity or provider by any method that provides evidence of receipt. Such methods can include electronic means.

Paragraph (c)(5) of § 17.4135 will establish that the written decision issued by the responsible VA official constitutes VA's final decision on the dispute. This language serves to clarify that VA maintains no administrative process to appeal such a decision and to emphasize the reality that, under section 1703A(h)(2), this disputes process constitutes entities' and providers' exhaustive and exclusive administrative remedy.

Administrative Procedure Act

The Secretary of Veterans Affairs finds that there is good cause under 5 U.S.C. 553(b)(B) and (d)(3) to dispense with the opportunity for advance notice and opportunity for public comment and to publish this rule with an immediate effective date. As previously stated in this rulemaking, VA's contractual network of community providers as will be required under section 1703(h), as added by section 101 of the MISSION Act, will not be fully operational by June 6, 2019. Further, section 143 of the MISSION Act amended section 101(p) of the Choice Act to state that VA may not use the Choice Act to furnish care and services after June 6, 2019. As a result, on that date, VA will no longer be able to use Veterans Choice Program provider agreements. If these regulations governing Veterans Care Agreements (VCAs) are not legally effective prior to June 6, 2019, VA will not be able to use such agreements to replace the Choice Program provider agreements. If VA cannot use VCAs to replace Choice Program provider agreements, VA will not be able to: (1) Fill gaps in coverage for the furnishing of general care and services until the contractual network of community providers is fully established, and (2) furnish certain specific care and services that VA does not anticipate being secured through the contractual network of community providers at least in the near future.

Concerning gaps in coverage for general care and services until the contractual network of community providers is fully established, VA has been able to modify some of its current community care contracts for expansion until the new network is fully functional. However, even these expansions have not been able to absorb all existing Choice Program provider agreements that are used within each of the 21 Veterans Integrated Service Networks (VISN) to secure care and services outside of VA's community care contracts. Using data from April 2019, there were over 22,000 Choice Program provider agreements still in place across all VISNs. There is some disparity between VISNs regarding use of Choice Program provider agreements, for instance VISN 8 had 3,809 outstanding Choice Provider Agreements while VISN 17 had only 71.

Although continued efforts under current contract expansions as well as continued development of the new contractual network might be expected to absorb some of this outstanding volume of Choice Program provider agreements, there will be coverage gaps across all VISN areas nationwide if VCAs are not in place by June 6, 2019. VA uses Choice Program provider agreements to purchase a myriad of care and services for veterans in the community, all of which are clinically necessary. If VCAs are not in place to furnish these care and services when the authority for these provider agreements lapses, this care will not be furnished and veterans could be harmed. This would be especially true for treatment of certain diseases such as cancer that require continuous and uninterrupted care and monitoring on an immediate and stringent schedule upon diagnosis. Similarly, the health and safety of individuals receiving mental health treatment would be at risk if continuity of care were not maintained to ensure, for instance, retention of current mental health professionals already providing these services.

In addition to the general gaps in coverage as described above as VA works to expand its contracted network of care, there are specific care and services that are explicitly excluded from VA's current community care contracts that are in place as of the date of publication of this rulemaking (to include the expansions mentioned above) and that will not be covered by the new contracted network immediately after June 6, 2019. These services include unskilled home health services as well as dental care, and these services would simply stop being furnished to affected veterans on June 6, 2019 unless a VCA was in place to furnish them. Based on VA's experience, home health providers that are parties to the Choice Program provider agreements are typically unwilling to enter into a conventional procurement contract subject to the Federal Acquisition Regulation (FAR). For instance, home health care services are typically furnished by small providers serving a limited number of individuals, and it is VA's understanding in dealing with such providers for many years that being subject to Federal contractor obligations dis-incentivizes their participation in VA community care, resulting in the possibility of significant disruptions in the provision of home health care services to VA beneficiaries.

Veterans in receipt of these services represent a vulnerable population because they require assistance to retain their highest level of functioning in the least restrictive environment (their home) as possible, often avoiding a higher level of institutionalized care that is not yet needed by the veteran. Should such home health services stop, then VA could reasonably expect the health conditions of affected veterans to worsen, which could more rapidly necessitate the veteran requiring institutionalized care. For instance, veterans often receive home health aide services to assist them to properly take their prescribed medications. Should these services cease, there would be clear and unavoidable negative health outcomes for these veterans. Because institutionalized care in this type of scenario would be required due to an absence of home health care, and not necessarily due to the veteran's otherwise progressive and actual need for a higher level of service, such institutionalized care would not likely be supporting optimal clinical outcomes and would also be furnished at a much greater cost to VA.

Using dental services as another example, VCAs are needed to ensure there are not lapses in the provision of medically necessary dental care that is furnished under Choice Program provider agreements. Without proper oral hygiene and dental care, bacteria in the mouth can reach levels that might lead to oral infections, such as tooth decay and gum disease. In addition, certain medications—such as decongestants, antihistamines, painkillers, diuretics and antidepressants—can reduce saliva flow, where saliva washes away food and neutralizes acids produced by bacteria in the mouth and helps protect from microbial invasion or overgrowth that might lead to gum disease. Dental

care is critical to ensure monitoring or treatment of oral inflammation or infection that can be associated with overgrowth of oral bacterial, where this inflammation or infection can negatively impact a person's overall health and has been linked to specific diseases. For instance, endocarditis is an infection of the inner lining of your heart (endocardium), which typically occurs when bacteria or other germs from another part of your body, such as your mouth, spread through your bloodstream and attach to damaged areas in your heart. More generally, heart disease, clogged arteries and stroke might be linked to the inflammation and infections that oral bacteria can cause. Lastly, periodontitis (severe gum disease) has been linked to premature birth and low birth weight.

The lack of full coverage for general care and services that cannot be absorbed under the current contract expansions until the contractual network of providers is fully functional, and the lack of coverage for certain specific services that are excluded under VA's current community care contracts (to include expansions) and where some providers may not enter into the new contractual network of providers in the future, will create disruptions in the provision of care and services if VCAs are not in place prior to June 6, 2019. VA reviewed data from October 2017 through August 2018 and determined that there were more than 183,000 unique patients that were furnished VA community care under Choice provider agreements. Two predominant categories of care that have briefly been discussed for which these provider agreements have been used are home health services (with roughly 53,659 unique patients affected) and dental care (with roughly 24,846 unique patients affected). Although VA cannot predict with certainty that this same number of individuals will continue to require care under a Veterans Care Agreement, VA expects that a significant number of patients will require care and services under such agreements. Considering the risk to disrupting the furnishing of care for individuals who will need to receive care and services under VCAs, it is impracticable and contrary to the public interest to provide advance notice and opportunity to comment on these regulations, as this would considerably reduce the likelihood that VA will successfully transition away from the use of the current Choice provider agreements ahead of June 6, 2019.

The Secretary of Veterans Affairs finds there is good cause under 5 U.S.C. 553(b)(B) and (d)(3) to publish this rule with an immediate effective date, prior to the usual 30-day delay for an interim final rule to allow VA to begin entering into agreements immediately. This timeline is necessary to avoid potential gaps in community care because, for the reasons discussed above, entering into a broad array of agreements authorized under section 1703A, in advance of June 6, 2019, will be critical for the purposes of filling gaps in care coverage until the new contractual network is fully functional and ensuring VA has replacement instruments in place for specific care and services currently provided under Choice provider agreements with those entities and providers that are unwilling or unable to enter into conventional procurement contracts. Any further delay in the effective date of this rulemaking would substantially increase the risk that VA will be unable to enter into agreements in the timeframes necessary to fully achieve those purposes and mitigate or eliminate risk of significant disruptions to eligible individuals receiving community care.

For the above reasons, the Secretary issues this rule as an interim final rule with an immediate effective date. However, VA will consider and address comments that are received within 60 days of the date this interim final rule is published in the **Federal Register**.

Effect of Rulemaking

The Code of Federal Regulations, as revised by this rulemaking, will represent 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(d)) requires that VA consider the impact of paperwork and other information collection burdens imposed on the public. Except for emergency approvals under 44 U.S.C. 3507(j), VA may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. VA has requested that OMB approve the collection of information on an emergency basis. This interim final rule includes provisions constituting new collections of information under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3521) that require approval by the Office of Management and Budget (OMB). Accordingly, under 44 U.S.C. 3507(d), VA has submitted a copy of this rulemaking to OMB for review.

OMB assigns control numbers to collections of information it approves. VA may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Proposed §§ 17.4110, 17.4130, and 17.4135 contain collections of information under the Paperwork Reduction Act of 1995. If OMB does not approve the collections of information as requested, VA will immediately remove the provisions containing a collection of information or take such other action as is directed by OMB.

Comments on the collections of information contained in this interim final rule should be submitted to the Office of Management and Budget, Attention: Desk Officer for the Department of Veterans Affairs, Office of Information and Regulatory Affairs, Washington, DC 20503, with copies sent by mail or hand delivery to the Director, Office of Regulation Policy and Management (00REG), Department of Veterans Affairs, 810 Vermont Avenue NW, Room 1063B, Washington, DC 20420; fax to (202) 273–9026; or through www.*Regulations.gov*. Comments should indicate that they are submitted in response to ''RIN 2900–AQ45 Veterans Care Agreements.''

OMB is required to make a decision concerning the collections of information contained in this proposed rule between 30 and 60 days after publication of this document in the **Federal Register**. Therefore, a comment to OMB is best assured of having its full effect if OMB receives it within 30 days of publication. This does not affect the deadline for the public to comment on the proposed rule.

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

- Evaluating whether the proposed collections of information are necessary for the proper performance of the functions of VA, including whether the information will have practical utility;
- Evaluating the accuracy of VA's estimate of the burden of the proposed collections of information, including the validity of the methodology and assumptions used;
- Enhancing the quality, usefulness, and clarity of the information to be collected; and
- Minimizing the burden of the collections of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology,

e.g., permitting electronic submission of responses.

The collections of information contained in the amendments to title 38 CFR part 17 are described immediately following this paragraph, under their respective titles. As discussed in the regulatory impact analysis, VA believes that the net impact of the reorganization of the collections of information is likely to be regulatory under E.O. 13771. For each of the new or proposed collections of information below, VHA used general wage data from the Bureau of Labor Statistics (BLS) to estimate the respondents' costs associated with completing the information collection. According to the latest available BLS data, the mean hourly wage of full-time wage and salary workers was $15.57 based on the BLS wage code—''31–1000 Healthcare Support Occupations.'' This information was taken from the following website: *https://www.bls.gov/oes/current/oes_nat.htm* (May 2018). This wage code was chosen because it represents most closely the types of providers likely to submit this information themselves, or those support occupations that will submit the information for such providers.

Title: Submission of information for application for certification.

OMB Control No.: 2900–xxxx (New).

CFR Provision: 38 CFR 17.4110.

Summary of collection of information: Proposed § 17.4110 requires eligible entities and providers to submit to VA information concerning applicable medical licenses, as well as other information as requested by VA to evaluate eligibility for certification.

Description of the need for information and proposed use of information: The information collection is authorized under 38 U.S.C. 1703A(c) and is necessary for and would be used to verify that non-VA entities and providers that are applying for certification—and, hence, the opportunity to furnish hospital care and medical services to covered veterans under a Veterans Care Agreement—meet basic standards to ensure patient safety.

Description of likely respondents: Eligible entities or providers furnishing care and services through the Veterans Community Care Program.

Average estimated number of respondents per year: (32,181 eligible entities or providers in year 1; 8,850 eligible entities or providers in year 2; 4,425 eligible entities or providers in year 3)/3 = 15,152.

Estimated frequency of responses per year: 1 time annually.

Estimated average burden per response: 5 minutes.

Estimated total annual reporting and recordkeeping burden: 1,263 hours.

Estimated cost to respondents per year: VHA estimates the total cost to all respondents to be $19,664.91 per year (1,263 burden hours × $15.57 per hour).

Title: Submission of notice to discontinue a Veterans Care Agreement.

OMB Control No.: 2900–xxxx (New).

CFR Provision: 38 CFR 17.4130.

Summary of collection of information: Proposed § 17.4130 requires eligible entities and providers to submit to VA a written notice of intent to discontinue a Veterans Care Agreement prior to the date of such discontinuation.

Description of the need for information and proposed use of information: The information collection is authorized under 38 U.S.C. 1703A(f)(1) and is necessary for and would be used to provide VA with adequate advance notice when an entity or provider intends to discontinue an agreement, for purposes of ensuring continuity of care.

Description of likely respondents: Eligible entities or providers furnishing care and services through the Veterans Community Care Program.

Estimated number of respondents per year: 152 eligible entities or providers (1% of average annual number of entities and providers estimated to be certified per year).

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

Estimated average burden per response: 10 minutes.

Estimated total annual reporting and recordkeeping burden: 25 hours.

Estimated cost to respondents per year: VHA estimates the total cost to all respondents to be $389.25 per year (25 burden hours × $15.57 per hour).

Title: Submission of notices of dispute.

OMB Control No.: 2900–xxxx (New).

CFR Provision: 38 CFR 17.4135.

Summary of collection of information: Proposed § 17.4135 requires eligible entities and providers to submit to VA written notices of dispute that contain specific information to allow VA to assess and resolve the matter in dispute.

Description of the need for information and proposed use of information: The information collection is authorized under 38 U.S.C. 1703A(h) and is necessary for and would be used to permit VA to collect the minimally necessary information to assess and resolve matters in dispute.

Description of likely respondents: Eligible entities or providers furnishing care and services through the Veterans Community Care Program.

Estimated number of respondents per year: 803 eligible entities or providers (5% of average annual number of entities and providers estimated to be certified per year).

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

Estimated average burden per response: 20 minutes.

Estimated total annual reporting and recordkeeping burden: 268 hours.

Estimated cost to respondents per year: VHA estimates the total cost to all respondents to be $4,172.76 per year (268 burden hours × $15.57 per hour).

Regulatory Flexibility Act

The Regulatory Flexibility Act, 5 U.S.C. 601–612, is not applicable to this rulemaking because notice of proposed rulemaking is not required. 5 U.S.C. 601(2), 603(a), 604(a).

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 this Executive Order.''

VA has examined the economic, interagency, budgetary, legal, and policy implications of this regulatory action and determined that the action is a significant regulatory action under Executive Order 12866, because it raises novel legal or policy issues arising out

of legal mandates, the President's priorities, or the principles set forth in this Executive Order. VA's 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 interim final rule is considered an E.O. 13771 regulatory action. Details on the estimated costs of this interim final rule can be found in the rule's economic analysis. VA has determined that the net costs are $7.4 million over a five-year period (FY2019–FY2023) and $656,053.56 per year on an ongoing basis discounted at 7 percent relative to year 2016, over a perpetual time horizon.

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 interim 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: 64.009, Veterans Medical Care Benefits; and 64.018, Sharing Specialized Medical Resources.

List of Subjects in 38 CFR Part 17

Administrative practice and procedure, Alcohol abuse, Alcoholism, Claims, Day care, Dental health, Drug abuse, Foreign relations, Government contracts, Grant programs-health, Grant programs-veterans, Health care, Health facilities, Health professions, Health records, Homeless, Medical and dental schools, Medical devices, Medical research, Mental health programs, Nursing homes, Philippines, Reporting and recordkeeping requirements, Scholarships and fellowships, Travel and transportation expenses, 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 March 7, 2019, for publication.

Dated: May 10, 2019.

Consuela Benjamin,

Regulations Development Coordinator, 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 general authority citation for part 17 continues, and an authority for section 17.4100 *et seq.* is added, to read as follows:

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

* * * * *

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

■ 2. Add an undesignated center heading and §§ 17.4100 through 17.4135 to read as follows:

Veterans Care Agreements

Sec.

§ 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.

§ 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.

§ 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.)

§ 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.

§ 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.

§ 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.

§ 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.)

§ 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.)

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