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President & CEO

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VIA ELECTRONIC FILING

Mr. Michael Shores, Director
Office of Regulation Policy and Management (00REG)
Department of Veterans Affairs
810 Vermont Avenue NW, Room 1063B
Washington, DC 20420

**Re: Veterans Community Care Program Proposed Rule (RIN 2900-AQ46,
Veterans Community Care Program)**

Dear Director Shores:

The Federation of American Hospitals (FAH) is the national representative of over 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching, short-stay acute, inpatient rehabilitation, long-term acute care, psychiatric and cancer hospitals in urban and rural America, and provide a wide range of acute, post-acute, and ambulatory services. The FAH appreciates the opportunity to submit comments to the Department of Veterans Affairs (VA) regarding the February 22, 2019 proposed rule, RIN 2900-AQ46, *Veterans Community Care Program* proposed rule (Proposed Rule).

I. General Comments

The Veterans Community Care Program, as authorized under the John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. 115-182 (the Act), establishes a referral program by which the largest integrated health care system in the United States, the Veterans Health Administration, would authorize covered veterans to receive care in the community from eligible entities or providers at VA expense. The FAH views the Veterans Community Care Program as distinct from a coverage program that might be implemented through a third-party administrator or administrative contractor. Established rules already govern

coverage of veterans through the VA, and the Veterans Community Care Program does not alter these rules. Instead, the Veterans Community Care Program enables veterans to access the care they are already entitled to receive from the VA through non-VA providers in the community pursuant to VA authorization. As such, the Veterans Community Care Program should be implemented in a manner that assures that non-VA providers can confidently provide care pursuant to a VA authorization without the risk that the authorized care will not be paid due to any re-evaluation of questions that should have been definitively decided by the VA or its agent when the non-VA care was authorized (e.g., veteran eligibility and clinical necessity).

In light of the importance of predictability for non-VA health care providers participating in the Veterans Community Care Program, ***the FAH also requests that the VA: 1) to the extent feasible, standardize the contracts and contracting process nationally; and 2) make contracts entered into under 38 U.S.C. § 1703(h) publicly available.*** Ensuring the contracts and contracting process is, to the extent possible, consistent nationally will simplify the process for eligible entities and providers, thus avoiding the regional variation in contracts and the multiple laborious contracting processes currently at play in other VA community care programs. The national standardization should apply regardless of whether the eligible entity or provider contracts directly with the VA or through a network entity that contracts with the VA.

Additionally, the rules governing any entities that contract with the VA to establish a network of health care providers for the Veterans Community Care Program should be developed by notice-and-comment rulemaking so that stakeholders can provide crucial input on the downstream impact of those rules on network providers. The agreements themselves should also be publicly available so that providers have adequate information to contract with such entities. This is particularly important in light of the VA's indication that it intends to implement certain provisions of 38 U.S.C. § 1703 by contract where appropriate. 84 Fed. Reg. 5629, 5630 (Feb. 22, 2019).

II. Appointment Definition (38 C.F.R. § 17.4005)

The proposed definitions for the Veterans Community Care Program at § 17.4005 would amend the current definition of “appointment” at § 17.1505 to include “extended care services” and remove the exclusion of emergency room visits and unscheduled visits. The amended definition would also recognize telehealth and same-day encounters (even if not scheduled in advance) by referencing the definition of “schedule,” which states “**Note:** A VA telehealth encounter and a same-day encounter are considered to be scheduled even if such an encounter is conducted on an ad hoc basis.” 84 Fed. Reg. at 5648. ***The FAH supports this amended and expanded definition of appointment and the corresponding reference in the definition of schedule. The FAH also encourages the VA to specifically include telehealth and same-day encounters in the definition of appointment.***¹

¹ *Id.* The amended regulation would read: “Appointment means an authorized and scheduled encounter with a health care provider for the delivery of hospital care, medical services, or extended care services, ***including telehealth and same-day encounters.***”

III. Veteran Eligibility (Proposed 38 C.F.R. § 17.4010)

The FAH supports the use of the Secretary’s discretion to propose two additional factors for consideration in determining whether “it is in the best medical interest of the veteran, to access the care or services the veteran requires from any eligible provider...” 84 Fed. Reg. at 5648. The FAH agrees that the proposed factors: “the potential for improved continuity of care” (§ 17.4010(a)(5)(v)) and “the quality of care provided” (§ 17.4010(a)(5)(vi)) are important considerations regarding whether a veteran already has an established care relationship with a non-VA provider and/or whether a non-VA provider can deliver higher-quality care or offers specific expertise.

IV. Service Lines Notification (Proposed 38 C.F.R. § 17.4015)

The Act requires the VA to identify service lines that do not meet the Secretary’s standards for quality and, at least annually, to “publish in the Federal Register, and...take all reasonable steps to provide direct notice to covered veterans affected...” information regarding when and where veterans can receive such services. 38 U.S.C. § 1703(e)(1). The Proposed Rule puts forth the process for the VA to annually announce the affected service lines in the Federal Register at proposed § 17.4015. While the FAH supports notification in the Federal Register, *we also encourage the VA to identify and implement additional notification methods and to ensure that veterans and non-VA health care providers are aware of the affected service lines. Specifically, the FAH recommends including “non-VA health care providers” along with “covered veterans” in the last line of § 17.4015(c)² and detailing the additional notification methods it has identified.*

V. Authorized Non-VA Care (Proposed § 17.4020)

The FAH believes that the authorization process for non-VA care is crucial to the success of the Veterans Community Care Program and *urges the VA to adopt more robust authorization rules that ensure each authorization: (1) is a binding determination of all the relevant issues for coverage and payment (e.g., eligibility, clinical necessity, and coverage); (2) includes an agreed-upon plan for transferring the patient back to VA care after the conclusion of authorized treatment; and (3) is promptly granted or denied within a clinically appropriate time period following the request for authorization.* At present, the proposed 38 C.F.R. § 17.4020 and existing 38 C.F.R. § 17.1515 fail to address these crucial elements of a reliable authorization process. An unreliable authorization system that permits the VA or its contractor to determine, after the fact, that authorized services were not clinically necessary or that the veteran was not eligible to receive those services creates unnecessary and problematic payment risks for non-VA health care providers that have already incurred large volumes of unpaid claims.³ Moreover, if authorizations are not granted on a timely basis, are not binding, and do not address

² 84 Fed. Reg. 5629, 5649 (Feb. 22, 2019). The amended regulation would read: “VA will also take reasonable steps to provide direct notice to covered veterans *and non-VA health care providers* affected under this section. *Those steps will include...*”

³ See VA, Top 20 Providers with High Dollar Value of Unpaid Claims (last updated June 26, 2018), at <https://www.va.gov/COMMUNITYCARE/providers/Top-20-list.asp>; VA Office of Inspector General, Alleged Nonacceptance of VA Authorizations by Community Care Providers, Fayetteville, North Carolina, Report No. 17-05228-279 (Sep. 20, 2018), at <https://www.va.gov/oig/pubs/VAOIG-17-05228-279.pdf>.

plans for post-treatment care, the process will create risks to veterans in terms of timely access to non-VA care and continuity of care between non-VA and VA providers.

A. Authorization Should be a Binding and Conclusive Determination of Eligibility, Clinical Necessity, and Coverage

Under the Veterans Community Care Program, a covered veteran may “only receive care or services under [38 U.S.C. § 1703] upon the authorization of such care or services by the Secretary.” The authorizations, however, should not simply be another prerequisite to payment; instead, they should function as the process by which each prerequisite to payment is evaluated and determined. ***The FAH urges the VA to revise its proposed prior authorization rule so that authorization is both comprehensive and binding.*** The authorization process should conclusively resolve questions concerning eligibility, clinical necessity, coverage, and payment obligations. Once an authorization is granted, the non-VA health care provider’s entitlement to payment should be clear and the issues determined during the authorization process should not be called into question or reevaluated. Expanding the scope and reliability of Veterans Community Care Program authorizations in this way would be consistent with the popular understanding of the prior authorization process, reduce post-claim payment delays and disputes, and protect veterans who believed their non-VA care was covered under the Program.

Authorization as an Eligibility Determination. Under the Act, 38 U.S.C. § 1703(d) establishes the six conditions under which a veteran may elect to receive (and the VA must furnish, subject to the availability of appropriations) care under the Veterans Community Care Program. The preamble concerning proposed rule 38 C.F.R. § 17.4010, confirms that “[i]t is VA’s responsibility to determine whether the veteran has met any of the conditions described here and would be eligible to make an election to have VA authorize the care in the community.” Moreover, it is the covered veteran’s obligation to furnish to the VA information that would be required by proposed 38 C.F.R. § 17.4010(b) and (c) as a condition for receiving care and services through the Veterans Community Care Program.

Because the VA is responsible for determining whether a covered veteran is eligible to receive Veterans Community Care Program services, and because the covered veteran is responsible for providing the VA necessary information to receive care (*i.e.*, changes of residence within 60 days and information on any other health care plan contract under which the veteran is covered prior to obtaining authorization for care and services that the veteran requires, as well as any changes to such coverage within 60 days of the change), the FAH strongly believes that the VA’s authorization to provide care should limit a non-VA provider’s exposure to any issues caused by either the VA’s failure to adequately determine eligibility or the veteran’s failure to provide necessary information to the VA. ***Specifically, the FAH urges the VA to clarify that non-VA providers are not responsible for any errors made by the VA or due to issues with information provided by the veteran to the VA, and that non-VA providers will still receive payment for services rendered if such issues present.***

Authorization and Clinical Necessity. Under proposed 38 C.F.R. § 17.4020(a), an eligible veteran may “have VA authorize the veteran to receive an episode of care... from an eligible entity or provider when VA determines such care or services are clinically necessary.” As such, it appears that the proposed regulation would make an authorization a determination of

clinical necessity. ***The FAH requests that the VA confirm that clinical necessity is determined at the time of authorization and is not re-determined after the service is furnished.*** Non-VA health care providers that rely on a proper authorization (which inherently constitutes a determination of clinical necessity) should not be subject to the risk of a denied claim due to a *post hoc* medical necessity review by the VA or a Veterans Community Care Program contracting entity.

Scope of Authorized Services. The FAH also urges the VA to clarify that necessary care furnished during an authorized procedure is likewise authorized. Under proposed 38 C.F.R. § 17.4020(a), it is the “episode of care” that is authorized, and proposed 38 C.F.R. § 17.4005 would define “episode of care” as “a necessary course of treatment, including follow-up appointments and ancillary and specialty services, which lasts no longer than 1 calendar year.” The FAH understands this to mean that if a particular procedure is authorized, that authorization extends to the entire episode of care, which may include unanticipated but clinically appropriate care furnished during the course of a surgical procedure. In the preamble to the proposed rule, however, the VA states that “[if] an eligible entity or provider believed that a veteran needed additional care beyond the authorized episode of care, the eligible entity or provider would be required to contact VA prior to administering or referring such care to ensure that this care was authorized and therefore would be paid for by VA.” 84 Fed. Reg. at 5633. In some circumstances (particularly during the course of a surgical procedure) it may not be practical or medically advisable to discontinue or delay care in order to obtain a second authorization. ***Therefore, the FAH requests the VA to clarify that any authorization of an episode of care that includes a surgical procedure shall automatically also cover any other care furnished during that procedure without the need for a second authorization.***

Coverage and Primary Payer. An authorization should likewise constitute a determination that the care is covered and that the VA or its agent is obligated to pay in full as the primary payer. Proposed 38 C.F.R. § 17.4025(c) provides that covered veterans may have copayment liability, but that copayment liability is to the VA, not to the non-VA health care provider. Accordingly, the FAH understands that authorized care will be paid in full (inclusive of any copayment amount) by the VA or its agent, and any copayment collection will be undertaken by the VA itself. The VA should also be a primary payer whenever care is authorized through the Veterans Community Care Program. The proposed rules do not directly address coordination of benefits issues, but the VA states that “[u]nder the Veterans Community Care Program, VA will be the primary payer[.]” 84 Fed. Reg. at 5641. The VA’s Community Care Network solicitation, however, addresses both situations where the VA would be the primary payer and situations where other health coverage would be primary (*e.g.*, for non-service connected care). ***The FAH requests that the VA clarify and confirm that the VA will always be the primary payer under the Veterans Community Care Program, and adopt regulations establishing that a Veterans Community Care Program authorization definitively establishes the VA as the primary payer for the authorized treatment.***

B. Care Coordination and Transfer Arrangements

Although the proposed rule addresses the need for additional authorizations for subsequent episodes of care, it does not address the critical process of transitioning a veteran back to VA providers at the conclusion of an episode of care. Non-VA providers that have

previously provided care to veterans through other community care programs have reported difficulties in coordinating a clinically appropriate transfer of the resident back to VA care after the emergency medical condition was stabilized or the authorized episode of care was concluded. ***Therefore, the FAH requests that the VA modify the authorization rules to ensure that a plan is in place to transfer the veteran back to VA care at the conclusion of each authorized episode of care or to otherwise establish robust care coordination and transfer processes to ensure continuity of care following treatment by a non-VA provider.*** At a minimum, where authorization for a subsequent episode of care is denied, the VA should be required to transfer the veteran's care back to VA providers in a timely fashion.

Along similar lines, the FAH requests that the VA implement HIPAA-compliant electronic transfer standards to enable medical records to be promptly and smoothly transmitted between the VA and the non-VA health care provider. Under 38 U.S.C. § 1703(a)(2), the VA is required to coordinate the furnishing of non-VA care by, among other things, “the establishment of a mechanism to receive medical records from non-Department providers.” The FAH urges the VA to use notice-and-comment rulemaking to establish such a mechanism using HIPAA-compliant electronic transfer standards so that the VA will have the benefit of stakeholder feedback from non-VA health care providers and others.

C. Timeliness of Authorization

Aside from the discussion of how the VA could authorize the provision of care after the care is provided under proposed 38 C.F.R. § 17.4020(c), the proposed rules are silent as to the timeliness standards for the authorizations. For the VA to ensure appropriate care is provided to veterans, these authorizations must be timely. ***The FAH proposes that the VA adopt a standard where for a typical service, the authorization will be provided within 24 hours and for a post-stabilization service, the authorization will be provided within one hour.*** As will be discussed at greater length below, the FAH also proposes that emergency care should be deemed to be authorized as long as the prudent layperson standard is met.

VI. Emergency Services (Proposed 38 C.F.R. § 17.4020(c))

The FAH supports the VA's conclusion that the Act permits the VA to authorize covered veterans to receive emergency care in the community from eligible entities or providers at VA expense. This approach is supported by the text of the Act, which does not exclude emergency services, and the availability of emergency care under the prior version of 38 U.S.C. § 1703. ***The FAH requests, however, that the VA clarify the relationship between the Veterans Community Care Program and 38 U.S.C. §§ 1725 and 1728, adopt an appropriate authorization process for emergency services that deems emergency services as authorized based on the prudent layperson standard and promptly addresses requests for authorization of post-stabilization services, and adopt a conforming amendment to 38 C.F.R. § 17.38(a)(1)(iv).***

A. Relationship to Sections 1725 and 1728

At present, there are a number of statutory authorities for the provision of emergency care to covered veterans in the community at VA expense, namely 38 U.S.C. §§ 1703, 1725, and 1728. The overlap between these authorities may lead to confusion amongst veterans, providers,

and other Veterans Community Care Program entities. It is the FAH's understanding that where payment may be made under the Veterans Community Care Program for emergency services, the Veterans Community Care Program should govern coverage and payment for that care notwithstanding the availability of reimbursement under 38 U.S.C. § 1725 or § 1728 and that §§ 1725 and 1728 should only apply when payment is not available through the Veterans Community Care Program. This is consistent with the VA's interpretation that proposed 38 C.F.R. § 17.4020(c) "would not affect eligibility for, or create any new rules or conditions affecting, reimbursement for emergency treatment under sections 1725 or 1728" and that "[c]are that cannot be authorized under [§ 17.4020(c)] would be considered for reimbursement under 1725 or 1728, as applicable." 84 Fed. Reg. at 5640. ***The FAH, however, urges the VA to make this relationship clear by expressly stating that the Veterans Community Care Program's rules and payment should govern where emergency care may be payable under more than one program. Moreover, the VA should note that authorizations for emergency care under the Veterans Community Care Program will not be denied based on the availability of payment under 38 U.S.C. § 1725 or § 1728.***

B. Prudent Layperson and Authorization

The FAH agrees that the statutory authorization requirement for emergency care under the Veterans Community Care Program can be met after the delivery of care. The FAH, however, urges the VA to grant such authorizations based on the prudent layperson standard and to simplify the authorization process to rely on notice to the VA or the entity contracting with the VA under 38 U.S.C. § 1703(h).

As presented, the proposed rules do not define "emergency treatment," but the VA references in the preamble the definition of emergency treatment under 38 U.S.C. § 1725(f)(1). Although this definition incorporates the prudent layperson standard, it also permits second guessing the decision to seek non-VA care because emergency treatment may only be furnished when VA facilities "are not feasibly available and an attempt to use them beforehand would not be reasonable." The Veterans Community Care Program statute, however, does not incorporate this limitation on emergency treatment, and ***the FAH urges the VA to instead adopt a definition of emergency treatment that focuses on the widely accepted prudent layperson standard.*** For example, the Public Health Services Act defines an "emergency medical condition" as "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in" (1) serious jeopardy to the health of the individual (or unborn child); (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part. 42 U.S.C. § 300gg-19a(b)(2)(A). "Emergency services" is then defined "with respect to an emergency medical condition" to include a medical screening examination to evaluate such emergency medical condition and such further medical examination and treatment as required to stabilize the patient. *Id.* at § 300gg-19a(b)(2)(B). These definitions are widely accepted and properly avoid second guessing the patient's choice of providers where a prudent layperson could reasonably expect the absence of immediate medical attention to result in serious jeopardy to health, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

The FAH also urges the VA to simplify the authorization process for emergency treatment in proposed 38 C.F.R. § 17.4020(c). First, the time for notifying the VA of emergency treatment should run from the time when a reasonably diligent provider would have obtained sufficient information to provide such notification. In some cases, a veteran may arrive at the emergency department without identification, and the provider may be unable to obtain the necessary information from the veteran (including identifying information and the existence of VA coverage) within 72 hours of the beginning of treatment. Beginning the 72-hour clock at the start of care would create situations where the facility could not timely request authorization due to circumstances beyond its control. ***Therefore, time should run from the later of the start of care or the time when a reasonably diligent provider would have information sufficient to provide a compliant notice to the VA.***

Second, the process for providing notice should be clear to the non-VA health care provider. Under proposed 38 C.F.R. § 17.4020(c)(4)(i), notice of emergency treatment must be “made to the appropriate VA official at the nearest VA facility.” In many cases, the provider may have a network agreement with an entity that has contracted with the VA under 38 U.S.C. § 1703(h). In these circumstances, the provider should only be responsible for providing notice to such entity, which would then be responsible per its VA contract to provide any direct notice to the VA. In other situations, the provider may be responsible for directly providing notice to the appropriate VA official. The VA states that, where the appropriate official is not specified in an agreement, this information would likely be available “through another means (like each VA medical facility’s website).” The FAH requests that the VA clarify that providers may rely on the VA locator tool on the VA website (<https://www.va.gov/find-locations/>) to identify a nearby VA medical facility and that the VA add contact information for the appropriate official at each VA medical facility to this website. The necessary information for notice should be readily available to providers in order to minimize uncertainty and the operational burdens associated with the Veterans Community Care Program.

Lastly, the FAH urges the VA to adopt particular authorization rules specific to post-stabilization treatment. In particular, authorization requests should be handled within one hour in order to avoid unnecessary delays in treatment, and if further care is not authorized, the VA should be responsible for expeditiously transferring the patient to a VA facility for post-stabilization care. *See* discussion of Timeliness of Authorization, *supra*.

C. Conforming Amendment to Section 17.38

The FAH requests that the VA adopting a conforming amendment to 38 C.F.R. § 17.38(a)(1)(iv) to expressly provide that emergency care provided through the Veterans Community Care Program is covered as part of the VA’s medical benefits package. Proposed § 17.4020(c)(3)(iii) would provide that the VA may only approve emergency treatment under the Veterans Community Care Program if “[t]he emergency treatment only includes services covered by VA’s medical package in § 17.38 of this part.” At present, however, § 17.38(a)(1)(iv) only provides for coverage of emergency care in non-VA facilities when it is provided “in accordance with sharing contracts or if authorized by §§ 17.52(a)(3), 17.53, 17.54, 17.120-132.” Current § 17.38(a)(1)(iv) does not address coverage for emergency care provided under the Veterans Community Care Program. A conforming amendment to § 17.38 would thus ensure

that the VA medical benefits package includes this care, consistent with the Act and proposed § 17.4020(c).

VII. Prescriptions (38 C.F.R. § 17.4025(b))

The FAH supports the VA’s payment for prescriptions, including prescription drugs, over the counter drugs, and medical and surgical supplies written by eligible entities and providers under the Veterans Community Care Program. ***The FAH, however, encourages the VA to expand the payment for prescriptions from those no longer than 14 days to those no longer than 30 days*** to ensure there is not an unnecessary gap in a veteran’s access to medication when transitioning from obtaining the prescription from the eligible entity or provider to obtaining it from the VA’s Consolidated Mail Order Pharmacy.

VIII. Payment Rates (38 C.F.R. § 17.4035)

A. Payment Rates Not Reduced by Sequestration

The FAH supports the VA’s proposed payment language, which confirms that payment rates are based on “the applicable Medicare fee schedule... or prospective payment system amount (hereinafter ‘Medicare rate’).” This language suggests what the FAH believes should be clear: The payment amount set forth in 38 U.S.C. §§ 1703(i) and 1703A(d) is the Medicare rate as set forth in the applicable fee schedule or prospective payment system without any reduction for sequestration.

Budget sequestration is an across-the-board reduction in federal spending by presidential order that is implemented through the Office of Management and Budget (OMB). Therefore, sequestration is not itself a Medicare rule and is not incorporated into the Medicare payment rules (e.g., the annual inpatient prospective payment system rule) or the resulting rates. In fact, the Centers for Medicare & Medicaid Services has explicitly stated, “sequestration is independent of Medicare payment policy.” 83 Fed. Reg. 594552, 59663 (Nov. 23, 2018). Ultimately, although sequestration reduces the amount of federal payments, it does not reduce the underlying Medicare payment rates or alter Medicare payment rules. ***Therefore, the FAH understands that the “Medicare rate” referenced in the proposed regulation (consistent with the statute) does not include any sequestration reduction and urges the VA to expressly confirm this understanding.***

B. Appropriate Medicare-Like Payment for IRF, LTCH, and Psychiatric Hospitals

Traditionally, VA community care program payment rates have fallen well below Medicare and commercial payer rates, and it is critical to remedy this situation to ensure veterans have sufficient access to care. The payment structure for health care services provided under the Veterans Community Care Program is set forth in proposed § 17.4035. As with the current Veterans Choice Program at § 17.1535, the rates for those services “would be the rates set forth in the terms of such contract or agreement” with the participating entities and providers and based on Medicare payment rates, with the flexibility to pay above Medicare rates to ensure access to care in certain geographic regions or when “patient needs, market analysis, health care provider qualifications, or other factors” necessitate higher payment rates. 84 Fed. Reg. at 5642.

As there is a clear preference for Medicare rates reflected in the statute⁴ – with the flexibility to pay above-Medicare rates when needed – ***the FAH urges the VA to ensure that the payment rates under the Veterans Community Care Program mirror Medicare rates, and do not fall below those rates. The best way to achieve that result is to ensure that entities that have a Medicare prospective payment system (PPS) rate are paid that rate (or a higher rate if warranted due to market conditions) under the Veterans Community Care Program.*** Eligible entities that have a Medicare PPS rate include acute care hospitals,⁵ psychiatric hospitals, inpatient rehabilitation hospitals (IRFs), and long-term care hospitals (LTCHs),⁶ and the VA should provide payment in accord with the respective PPS rate structure.

C. Prompt Payment

The proposed rule does not address prompt payment, but section 111 of the Act (38 U.S.C. § 1703D) sets forth prompt payment standards that apply to the Veterans Community Care Program and any other program under Chapter 17. Briefly, payment is to be made to non-VA providers within 45 days of receiving a clean paper claim or 30 days upon receipt of a clean electronic claim. If VA and/or the entity contracting with the VA under 38 U.S.C. § 1703(h) fails to pay, deny with notice, or pend with notice a clean claim in a timely manner, then the Secretary may require that interest be paid. ***The FAH urges the VA to adopt prompt payment regulations to further clarify the critical requirements of 38 U.S.C. § 1703D.***

To ensure non-VA providers will participate in the Veterans Community Care Program, the VA should make every effort to promptly pay non-VA providers and to ensure that VA contractors responsible for such payments adhere to prompt payment requirements. Failing to do so will reduce the pool of providers willing to participate in this important program for our nation’s veterans. ***To this end, the FAH urges the VA to confirm that interest will be paid on any overdue claims and to provide a process for non-VA providers to seek enforcement of the statutory prompt payment and interest requirements. Furthermore, the FAH strongly urges the VA to establish robust and appropriate notice requirements for denied or pending claims*** so that non-VA providers have sufficient information to appeal such action where warranted and so that any claim that is denied or pending without the required notice will be treated as overdue per the Act. This should be done through notice-and-comment rulemaking to assure that the VA has the benefit of adequate and appropriate stakeholder feedback on prompt pay rules.

IX. Non-VA Providers Should Not be Federal Contractors or Subject to OFCCP Jurisdiction

The FAH urges the VA to clarify that non-VA providers are not federal contractors or subcontractors and are therefore not subject to any federal contractor requirements, including, but not limited to Executive Order 11246, as amended, Section 503 of the Rehabilitation Act of

⁴ 38 U.S.C. § 1703(i)(1) and (6). Paragraph (6) reads, “With respect to hospital care, medical services, or extended care services for which there is not a rate paid under the Medicare program as described in paragraph (1), the rate paid for such care or services shall be determined by the Secretary.”

⁵ 42 CFR § 412.1(a)(1).

⁶ 42 CFR § 412.23. Psychiatric hospitals are paid under the prospective payment system as specified in §412.1(a)(2) and 42 CFR Subpart N; IRFs are paid under the prospective payment system as specified in §412.1(a)(3) if they meet the requirements under §412.29; and LTCHs are paid under the prospective payment system as specified in §412.1(a)(4) and 42 CFR Subpart O.

1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended, and the McNamara-O'Hara Service Contract Act of 1965, as amended, and any other federal contractor obligations, such as those related to federal minimum wage and sick leave.

The Act makes clear Congress' intent to shield the Veterans Community Care Program providers from federal contractor obligations and the jurisdiction of the Department of Labor's Office of Federal Contract Compliance Programs (OFCCP). Section 107 of the Act provides that the TRICARE moratorium (the Moratorium) of the OFCCP, Directive 2014-01 (effective May 7, 2014) shall apply to any entity entering into an agreement under 38 U.S.C. §§ 1703A (Veterans Care Agreements) or 1745 (State Veterans Homes). Subsequently, Directive 2018-02 extended the Moratorium to May 7, 2021 and amended it to include Veterans Affairs Health Benefits Program Providers. Notably, Section 107 of the Act expressly limits 38 U.S.C. § 1703A(i) (section 102 of the Act), which otherwise provides that providers that enter into Veterans Care Agreements are generally subject to "all laws that protect against employment discrimination or that otherwise ensure equal employment opportunities." Congress also evinced its intent that Veterans Community Care Program providers not be subject to federal contractor obligations when it stated that contracting providers "shall not be treated as a Federal contractor or subcontractor for purposes of chapter 67 of title 41 (commonly known as the 'McNamara-O'Hara Service Contract Act of 1965')."

Thus, it appears non-VA providers that enter into Veterans Care Agreements under the Veterans Community Care Program should not be subject to the affirmative action and nondiscrimination rules under OFCCP jurisdiction and other federal contractor obligations during the Moratorium and thereafter. ***The FAH strongly urges the VA and Department of Labor to clarify that even without the Moratorium, non-VA providers participating in the Veterans Community Care Program (and other programs set forth in the Act) are not federal contractors or subcontractors and will not be subject to OFCCP jurisdiction if and when the Moratorium lapses.*** The success of the Veterans Community Care Program depends on the reliable participation of high quality, non-VA health care providers, but uncertainty as to the current and future legal obligations of providers participating in the Veterans Community Care Program and their risk of exposure to OFCCP jurisdiction could significantly reduce provider participation, defeating the aims of the program. The FAH therefore strongly encourages the VA to take measures to assure non-VA providers that the OFCCP will not have jurisdiction over providers participating in the Veterans Community Care Program under the Act.

X. Living Donor Coverage

The FAH supports the Act's authorization for VA coverage of an operation on a non-VA eligible living donor to facilitate a transplant for an eligible veteran and encourages the VA to promptly issue regulations implementing this provision.

* * * * *

The FAH appreciates the opportunity to comment on the Veterans Community Care Program proposed rule. If you have any questions about our comments or need further information, please contact me or a member of my staff at 202-624-1500.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrew M. Kuntz". The signature is fluid and cursive, with a large initial "A" and "M".