

approaches that maximize net benefits. The Department believes that these final regulations are consistent with the principles in Executive Order 13563.

We also have determined that this regulatory action is not significant and would not unduly interfere with State, local, and Tribal governments in the exercise of their governmental functions.

In accordance with the Executive orders, the Department has assessed the potential costs and benefits, both quantitative and qualitative, of this regulatory action. The final regulations are not expected to have a significant impact.

Regulatory Flexibility Act Certification

The Regulatory Flexibility Act does not apply to this rulemaking because there is good cause to waive notice and comment under 5 U.S.C. 553.

Paperwork Reduction Act of 1995

The final regulations do not create any new information collection requirements.

Intergovernmental Review

The CSP—Grants for Credit Enhancement for Charter School Facilities are subject to Executive Order 12372 and the regulations in 34 CFR part 79.

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(Catalog of Federal Domestic Assistance Number: 84.354A CSP—Grants for Credit Enhancement for Charter School Facilities.)

List of Subjects in 34 CFR Part 225

Education, Educational facilities, Elementary and secondary education, Grant programs—education, Reporting and recordkeeping requirements, Schools.

Dated: May 30, 2019.

Betsy DeVos,
Secretary of Education.

For the reasons discussed in the preamble, the Secretary amends part 225 of title 34 of the Code of Federal Regulations as follows:

PART 225—CREDIT ENHANCEMENT FOR CHARTER SCHOOL FACILITIES PROGRAM

■ 1. The authority citation for part 225 is revised to read as follows:

Authority: 20 U.S.C. 1221e–3, 1232, and 7221c.

§§ 225.1 through 225.21 [Amended]

- 2. Sections 225.1 through 225.21 are amended by removing the authority citations at the end of each section.
- 3. Section 225.1 is further amended by adding paragraph (b)(3) to read as follows:

§ 225.1 What is the Credit Enhancement for Charter School Facilities Program?

* * * * *

(b) * * *

(3) Assist charter schools with the predevelopment costs required to assess sites for the purpose of acquiring (by purchase, lease, donation, or otherwise) an interest (including an interest held by a third party for the benefit of a charter school) in improved or unimproved real property or constructing new facilities, or renovating, repairing, or altering existing facilities, and that are necessary to commence or continue the operation of a charter school.

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§ 225.4 [Amended]

■ 4. Section 225.4 is further amended by removing the words “5210 of the Elementary and Secondary Education Act of 1965, as amended by the No Child Left Behind Act of 2001” from paragraph (a) introductory text and adding in their place the words “4310(2) of the Elementary and Secondary Education Act of 1965, as amended by the Every Student Succeeds Act”.

§ 225.11 [Amended]

■ 5. Section 225.11 is further amended by removing the words “5202(e)(3) of

the Elementary and Secondary Education Act of 1965” from paragraph (a)(7) and adding in their place the words “4303(g)(2) of the Elementary and Secondary Education Act of 1965”.

■ 6. Section 225.12 is further amended by revising paragraph (a)(1) to read as follows:

§ 225.12 What funding priority may the Secretary use in making a grant award?

(a) * * *

(1) The extent to which the applicant would target services to geographic areas in which a large proportion or number of public schools have been identified for comprehensive support and improvement or targeted support and improvement under the ESEA, as amended by the Every Student Succeeds Act;

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[FR Doc. 2019–11727 Filed 6–4–19; 8:45 am]

BILLING CODE 4000–01–P

DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 17

RIN 2900–AQ47

Urgent Care

AGENCY: Department of Veterans Affairs.
ACTION: Final rule.

SUMMARY: The Department of Veterans Affairs (VA) adopts as final a proposed rule amending its regulations that govern VA health care. This final rule grants eligible veterans access to urgent care from qualifying non-VA entities or providers without prior approval from VA. This rulemaking implements the mandates of the VA MISSION Act of 2018 and increases veterans’ ability to choose health care in the community.

DATES: This final rule is effective June 6, 2019.

FOR FURTHER INFORMATION CONTACT: Joseph Duran, Director of Policy and Planning, 3773 Cherry Creek North Drive, Denver CO 80209. Joseph.Duran2@va.gov. (303) 370–1637. (This is not a toll-free number.)

SUPPLEMENTARY INFORMATION: In a document published in the **Federal Register** on January 31, 2019, VA published a proposed rule, which proposed to amend its regulations that govern VA health care. 84 FR 627. VA provided a 30-day comment period, which ended on March 4, 2019. We received 3,285 comments on the proposed rule.

On June 6, 2018, section 105 of Public Law 115–182, the John S. McCain III,

Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018, or the VA MISSION Act of 2018, amended title 38 of the United States Code (U.S.C.) by adding a new section 1725A, Access to walk-in care. The new section 1725A was further amended through the Department of Veterans Affairs Expiring Authorities Act of 2018 (Pub. L. 115–251). This benefit is intended to offer eligible veterans convenient care for certain, limited, non-emergent health care needs. Section 1725A(a) and (g) direct the Secretary to establish procedures and regulations to ensure eligible veterans are able to access such care from qualifying non-VA entities or providers to ensure their access to care when minor injury or illness arise. VA is required to develop procedures to ensure eligible veterans can access this care from qualifying non-VA entities or providers. Eligible veterans would include any enrolled veteran who has received care under chapter 17 of title 38 U.S.C. within the 24-month period preceding the furnishing of care under this section. Care under chapter 17 of title 38, U.S.C. would include any of the following: Care provided in a VA facility, care authorized by VA performed by a community provider, emergency room care authorized by VA performed by a community provider, care furnished by a State Veterans home, or urgent care under this proposed section. Qualifying non-VA entities or providers would include any non-VA entity or provider that has entered into a contract, agreement, or other arrangement with VA to provide services under this section.

VA refers to this benefit as urgent care, instead of walk-in care. This benefit will include care provided at both urgent care facilities and walk-in retail health clinics.

This rule implements the mandates of section 1725A, as added by the VA MISSION Act of 2018 as amended, by establishing a new § 17.4600. Multiple commenters generally supported the proposed rule, but had several suggestions and concerns on various aspects of the rule, while others strongly opposed the proposed rule. We have grouped similar comments into the various sections below for ease of readability.

Positive Comments

VA received numerous comments in favor of the rule. One commenter stated that the rule would provide veterans vital services as well as provide longer hours of operation in convenient locations. Another commenter said

urgent care would bring a better sense of care to veterans in need. A commenter also stated that the proposed rule would provide access to quality accessible community care to serve the veteran community. Several commenters stated that the proposed rule would provide at lower cost many services that veterans might otherwise seek from an emergency room. Several commenters indicated that the proposed rule would save veterans time in that they would not have to travel long distances to their nearest VA medical facility to receive health care. Another commenter indicated that urgent care would free up VA medical facility resources so that VA can focus on treating service-connected conditions and managing long term care. Several commenters stated that urgent care will ensure that veterans receive timely and appropriate, immediately necessary care in a short period of time, which will save lives. Another commenter stated that the proposed rule is an important step in ensuring that veterans will receive appropriate care regardless of whether the best treatment is in VA or the private sector. Another commenter stated that the rule would alleviate the burden of disabled or elderly veterans who might face obstacles in reaching VA medical facilities. This commenter also stated that the rule would help restore trust in the VA health care system. Another commenter similarly stated that the proposed rule would benefit veterans who live in rural areas, the homeless, and those veterans who lack transportation. Several commenters supported VA's decision to call the new benefit urgent care, which is consistent with industry practice. Another commenter supported the proposed rule stating that the rule should expand community care options for veterans. Several commenters agreed that urgent care should not replace primary and specialty care coordinated through VA. One commenter also stated that urgent care would allow for better delivery of timely access for serious or life-threatening emergency situations in VA medical facilities. A commenter supported the proposed rule stating that it will widen the stream of health care and allow more veterans to get the care they need. Another commenter supported the proposed rule stating that urgent care should only be for the treatment of a single condition and that follow-up care should be managed by the VA medical facility. The commenter also agreed with the publishing of a list of the non-VA providers and entities who will provide urgent care, as well as the establishment of the \$30 copayment.

One commenter stated that urgent care has the potential for high value for veterans. We thank the commenters and make no changes based on these comments.

Comments on Copayments

We stated in the proposed rule that VA would establish a regular copayment for urgent care of \$30. An eligible veteran's liability for the \$30 regular copayment would depend on the veteran's enrollment category and the number of visits in a calendar year. Veterans enrolled in priority groups 1 through 6 (except those veterans described in § 17.36(d)(3)(iii) for all matters not covered by priority category 6), would be required to pay the \$30 copayment after their third visit in the calendar year. All other veterans would be required to pay the \$30 copayment on every visit, subject to certain exceptions explained further in the proposed rule. Most of the comments received on the proposed rule were in opposition to VA charging a copayment for urgent care for veterans enrolled in priority groups 1 through 6, service-connected veterans, or other specific subsets of veterans. The commenters' concerns are summarized as follows.

Many commenters stated charging a copayment for service-connected veterans is unreasonable and unacceptable. Some commenters had more specific concerns and suggestions about the category of veterans who should be charged copayments. For instance, some comments stated that copayments should only be charged for non-service-connected conditions, veterans who were 100 percent service-connected should not be charged a copayment, veterans who are enrolled in priority group 1 should not be charged copayments, and that veterans with a disability rating over 30 percent should not pay a copayment. Another commenter stated that subjecting American Indian and Alaska Native veterans to a copayment as a condition of health care violates the Federal trust responsibility.

VA acknowledges that veterans enrolled under priority groups 1 through 6 generally are not required to pay copayments under other health care programs administered under title 38; however, section 1725A(f)(1)(B) states that an eligible veteran not required to pay a copayment under the title may access walk-in care without a copayment for the first two visits in a calendar year. For any additional visits, a copayment at an amount determined by the Secretary may be required. VA has decided to utilize this authority to require copayments for these veterans,

including for the categories of veterans that the commenters specifically noted, because the copayment is designed to encourage appropriate use of the benefit. Collecting a copayment after the third visit will help ensure that the urgent care benefit is utilized appropriately and is not being used as a substitute for primary care. As explained in the proposed rule, copayments are a common feature of health care, including VA health care, and are an important mechanism for guiding behavior to ensure that patients receive care at an appropriate location. The copayment is designed to encourage veterans to seek care from VA first, when VA can provide the needed care, and to utilize urgent care when prompt treatment is necessary to prevent the condition from becoming emergent. Urgent care is considered to be a convenient option for care, but is not intended to be used as a substitute for traditional primary care that emphasizes longitudinal management and care coordination. Also, collecting copayments allows VA to utilize its health care resources more efficiently. Generally speaking, copayments are applicable to all similarly situated veterans and VA care is provided to eligible veterans in connection with military service. However, VA is not authorized to waive copayments for specific categories of veterans, such as American Indian or Alaskan Native veterans, as suggested by one commenter.

In addition, VA has decided to utilize this authority to require copayments for these veterans, including for the categories of veterans that the commenters specifically noted, because the copayment is designed to discourage excessive use or misuse of the benefit. VA anticipates that veterans, on average, will use this benefit fewer than three times per year. VA used Medicare sampling data, which is frequently used by health researchers and others, to estimate that 85 percent of visits are an enrollees' first or second visit. We have confidence that these data should be accurate given the similarity of the benefit (open access), the availability of multiple network providers, and the comparable morbidities between the Medicare population and the veteran population. While the Medicare data does not have the same copayment as VA's proposed rate (it assumed a higher copayment), we have adjusted for this by assuming higher utilization given the lower cost. Therefore, VA believes that the majority of service-connected veterans will not pay a copayment, as their first three visits in the calendar

year are exempt from the copayment requirement.

Many commenters were concerned that the copayment could cause a financial burden on veterans and some were further concerned that the copayment may act as a deterrent for using the urgent care benefit. In particular, one commenter suggested that there should be no copayment to encourage veterans to use the urgent care benefit instead of emergency room, which is free. Another commenter stated that veterans in priority groups 1 through 6 who are 10 percent service-connected are not required to pay a copayment, and will not be expecting a bill. In addition, the commenter stated that beneficiaries have been warned through the military health system and Medicare about providers going after patients for money they do not owe (so called balance billing schemes). The commenter added that as such, eligible veterans may have been conditioned to ignore bills they receive, which could lead to unpaid medical bills and collection actions against veterans.

VA does not believe the rule as proposed will create a copayment burden for most veterans. VA has a waiver process for copayments in place for existing copayments when these liabilities would produce a financial hardship for veterans, and this process will apply to copayments assessed under this benefit. In fiscal year (FY) 2018, VA granted approximately two-thirds of waiver requests from veterans, but only received fewer than 25,000 such requests. We interpret these data to mean that those veterans who face an actual hardship are granted relief, while the copayment liabilities are not an obstacle for most veterans. VA believes the \$30 copayment after three visits is a reasonable mechanism to help ensure that veterans are going to use urgent care appropriately. VA worked with the support of contractors to analyze different copayment structures in the context of the urgent care benefit and the impact of these copayments on utilization. Copayments are common for urgent care visits both in the private and public sectors. The analysis showed that copayments are an appropriate method to influence utilization. Also, VA has developed educational materials that will alert the public of the availability of the new urgent care benefit, the eligibility criteria, as well as the copayment obligation. VA expects that these educational materials will assist veterans in taking full advantage of the urgent care benefit while listing upfront charges for the copayment structure. We are not making any changes based on these comments.

To ensure that neither the veteran nor their insurer is billed by the provider when VA is responsible for the payment of urgent care, we are adding a new paragraph (f). This new paragraph states that payments made for urgent care constitute payment in full and extinguish the liability of the veteran. It also states the qualifying non-VA entity or provider may not impose any additional charge on a veteran or his or her health care insurer for any urgent care service for which payment is made by VA. Finally, it states that this section does not abrogate VA's right under section 1729 to recover or collect from a third party the reasonable charges of the care or services provided under this section. These provisions are consistent with current practice under other authorities for community care and should address the commenters' concerns. We are also adding a new paragraph (c)(1)(B) that states that the eligible veteran must declare at the time of the episode of care that the veteran is using the VA benefit under this section. We believe this requirement will also help reduce the potential for inadvertent billing, as the qualifying non-VA entities or providers will know in advance that this care is being furnished under the VA benefit. A collateral benefit of this change is that it should also help reduce the potential that services that are outside the scope of VA's benefit will be furnished to eligible veterans. We further make a clarifying edit to the language in paragraph (c)(1) to refer more broadly to urgent care under this section.

Some commenters suggested that a copayment be charged for veterans in priority groups 1 through 6 after a different number of visits (other than after the third visit). For instance, one commenter stated that copayments should not be imposed until after the sixth visit while another suggested that the copayment should not be imposed until after the tenth visit. As previously explained, VA determined it would be appropriate to require a copayment after the third visit for priority groups 1 through 6. VA is not limiting the total number of visits a veteran may make in a year, as VA is striving to ensure veterans will have access to convenient care when necessary. However, this urgent care benefit is not meant to supplant primary and specialty care provided by VA. VA is limiting the types of services provided to ensure that preventive care is not provided through this benefit and the veteran's primary care is managed through the veteran's primary care provider. A copayment after the third visit will encourage

veterans enrolled in these priority groups to seek only episodic urgent care from the community and direct other care to the local VA facility. VA is working to increase internal capacity at medical facilities while ensuring veterans have access to community facilities to address urgent care needs.

Many commenters suggested alternative copayment structures. For instance, one commenter suggested that veterans enrolled in priority group 1 pay no copayment; priority groups 2 through 6 pay \$30 after two visits; and priority groups 7 and 8 pay \$40 after one visit. Another commenter stated that the copayment should not be more than \$12. A commenter indicated that VA should adopt the \$8 copayment that is charged for Medicare, instead of the proposed \$30. Several commenters stated that the copayment for urgent care should be \$5 to \$10. A commenter recommended that VA apply a standard copayment rate for all beneficiaries and be consistent as to which services require a copayment. When modeling the proposed rule, VA looked at various copayment structures between \$0 and \$75, the effect of requiring copayments after a different number of visits, and considered instituting different copayments for the various priority groups. We believe that these various models reflect the general proposals that we received suggesting that VA adopt different copayment structures. We determined that the model proposed and adopted here as final is appropriate given our goals of ensuring access, reducing over-reliance, ensuring the right level of care, and being fiscally responsible. In addition, the \$30 copayment is still less than the industry average, which is \$67 based on the market average as determined by analysis conducted by VA that was published in conjunction with the proposed rule. We are not making any changes based on these comments.

Multiple commenters also suggested that the copayment structure mirror the copayment structure VA uses for care provided at VA facilities. A commenter stated that the proposed rule as drafted raises the standard copayment from \$15 to \$30 for all urgent care visits without adequate justification. The commenter indicated that currently, veterans seeking same-day services for urgent non-service connected care are required to pay a copayment amount equivalent to a primary care visit, which is \$15, not \$30. The commenter also noted that the proposed rule's cost-benefit analysis failed to provide data comparing the existing \$15 copayment to the proposed \$30 copayment to justify the increase. The comment further explained that our

MISSION Act Copayment Study Assessment Analysis (assessment) concluded this would be the least disruptive option, while new copayment levels would result in "significant disruption from a people, process, and technology perspective". The commenter added that the disparity in copayments between VA facilities and qualifying non-VA entities will punish veterans for using health facilities outside of VA for urgent care and that raising the copayment rates for urgent care will financially punish veterans for seeking routine health care.

As previously explained, section 1725A(f) allows VA to establish a copayment for each episode of care furnished under this section. In preparation for the implementation of the VA MISSION Act of 2018, VA reviewed industry copayment structures for urgent care. The assessment reviewed commercial best practices and cost sharing structures and the applicability of those structures to VA. The assessment defined several scenarios and provided analytics based on utilization data and behavior change assumptions to develop costs and benefits for each possibility to make a recommendation on how VA could structure a copayment for urgent/walk-in care. VA acknowledges that this assessment recommended a \$15 copayment for the urgent care benefit and the assessment did not provide data comparing the existing \$15 copayment to the proposed \$30 copayment to justify the increase; however, the assessment did not look at the clinical consideration to make certain that the veterans receive the right level of care, better care coordination, and patient outcomes. In this regard, the higher copayment VA proposed would encourage veterans to seek care with their primary care providers at a lower copayment. In addition, although VA's assessment did not include data using a \$30 copayment, it did analyze various different dollar amounts. In our assessment of copayments, we found that copayments ranged from \$15 to \$100, and the majority of copayments in commercial, health maintenance organization (HMO), preferred provider organization (PPO), and government plans fell between \$40 and \$70. Moreover, we considered both a \$15 copayment and an escalating copayment, both with a requirement for preauthorization beyond the second visit. However, we believe that a \$30 copayment for each visit without a preauthorization requirement is consistent with the need to ensure that veterans receive the right level of care,

better care coordination, and improved patient outcomes. This copayment is below what other commercial and government plans charge and is in line with the copayment structure used by TRICARE Prime for retirees. Regarding the technological concern stated by the commenter, VA is addressing this concern through system changes to facilitate the charging of the different copayments for urgent care. Once the system changes are in place, this will allow for automation, thereby streamlining our process and ensuring that employee workload is no greater than what it is for charging copayments for other community care claims today. We are not making any changes based on these comments.

A commenter stated that there is an exception to the copayment rule for veterans described in 38 CFR 17.36(d)(3)(iii) and questioned how the exception applies to veterans in priority group 4 based on catastrophic disability. We initially note that the exception in § 17.36(d)(3)(iii) does not affect veterans enrolled in priority group 4. Veterans who are enrolled in priority group 4 will not have a copayment for the first three urgent visits in each calendar year at an eligible facility, but they will be required to pay a \$30 copayment starting on the fourth visit of such calendar year. This copayment requirement includes veterans who are determined to be catastrophically disabled by VA under priority group 4. There is no limit on the number of urgent care visits for an eligible veteran. The \$30 copayment discourages over utilization of the benefit, while still making on-demand care accessible and without prior authorization.

A commenter stated that they do not agree with the \$30 copayment after a few urgent care visits because it will create an added burden on VA staff to manage. Although VA acknowledges that administrative actions will be required to collect the copayment, VA believes that the burden will not be unreasonable, and VA has implementation plans in place to address the administrative aspects of implementing the rule. We are not making any edits changes on this comment.

A commenter agreed with the \$30 copayment but suggested that VA periodically adjust the copayment to account for market changes in the cost of delivering health care. VA has the authority to adjust the \$30 copayment for urgent care visits through subsequent rulemaking and may choose to do so in the future. We are not making any changes based on this comment.

A commenter stated that the copayment for urgent care does not seem to control usage because a non-service connected veteran would pay \$30 for urgent care, which is less than the copayment for a specialty visit. VA acknowledges that a copayment for specialty care is \$50. Urgent care may be used for services that VA considers specialty care, for example x-rays, however, these services must be provided in a single visit. We believe that it is unlikely that veterans will be this selective in terms of only seeking specialty care services through qualifying non-VA entities or providers. Moreover, VA believes that most types of specialty care are longitudinal care, which is not covered under the section 1725A. We defined *longitudinal management of conditions* in the proposed rule to mean outpatient care that addresses important disease prevention and treatment goals and is dependent upon bidirectional communications that are ongoing over an extended period of time. For purposes of this section, the term “longitudinal management of conditions” and “longitudinal care” are synonymous.

Another commenter requested clarification that non-VA urgent care entities will not be responsible for collection of veteran copayments. We stated in the proposed rule that eligible veterans would not owe copayments at the time of service, consistent with current practice for VA and VA-authorized community care. VA finds that this language is sufficiently clear in that VA does not intend for members of the non-VA urgent care network to collect or bill veterans for copayments resulting from urgent care visits.

A commenter stated that VA should waive copayments for urgent care visits during which a flu shot is the only service provided. The proposed rule, in § 17.4600(d)(2), already provided that an urgent care visit consisting solely of an immunization against influenza (flu shot), as well as a visit consisting solely of a service VA has identified under § 17.4600(b)(5)(iii) (VA’s authority to provide additional services not typically covered by this benefit, now (b)(5)(iv)) is not subject to the \$30 copayment amount.

Several commenters were under the impression that the proposed rule would establish a new copayment for urgent care provided in a VA medical facility and opposed such change. The urgent care benefit under 38 U.S.C. 1725A will not be provided at VA medical facilities. This benefit will be provided by qualifying non-VA entities or providers. The copayment

requirements for similar care provided at VA medical facilities will not be amended by this rule. We are not making any changes based on these comments.

Several commenters indicated that instead of charging a copayment for urgent care, VA should stop collecting severance pay from their service-connected disability compensation. Section 3.700(a)(3) of 38 CFR states that where the disability or disabilities found to be service-connected are the same as those upon which disability severance pay is granted, or where entitlement to disability compensation was established on or after September 15, 1981, an award of compensation generally will be made subject to recoupment of the disability severance pay. The proposed rule only addressed urgent care authorized under section 1725A. The recoupment of disability severance pay is beyond the scope of the proposed rule. We are not making any changes based on these comments.

Several commenters stated that undocumented immigrants are afforded free health care and veterans who have served their countries are charged copayments. The proposed rule addressed urgent care authorized by 38 U.S.C. 1725A. Health care for undocumented immigrants is beyond the scope of the proposed rule. We are not making any edits based on these comments.

One commenter was concerned that the rule would destroy the priority care afforded to service-connected disabled veterans. The commenter added that when service-connected veterans are stripped of their priority status for care and placed on the same level as veterans with no service connected disability then you have created the problem of access to services. The new urgent care benefit does not change any priority status for veterans. Furthermore, we contemplate that the availability of urgent care in the community will be sufficient to provide ready access to veterans qualifying for that service. We are not making any changes based on this comment.

We are making further revisions to our amendments to § 17.108. In our proposed rule, we proposed amending paragraph (e) of that section to apply the exceptions identified in that paragraph to copayments for the urgent care benefit. Upon closer review, we have determined that applying all of the copayment exceptions under § 17.108(e) to urgent care copayments would create inequities that VA did not intend. For example, § 17.108(e)(1) provides that care for a veteran for a non-compensable zero percent service-connected

disability is not subject to an outpatient copayment. Applying this exception to the urgent care benefit would create an illogical result where treatment for zero percent service connected disabilities were not subject to a copayment, but treatment for 100 percent service connected disabilities (after a third visit by that veteran) were subject to a copayment. Similarly, subparagraphs (2), (4), and (10) apply to other care that, while not service connected, is generally treated as the equivalent of service connected, and thus would generate the same inequities. We are also omitting the exception under § 17.108(e)(14) from applying to the urgent care copayments, as this provision exempts laboratory services, flat film radiology services, and electrocardiograms from copayments. Exempting these services from copayment liabilities in the context of the urgent care benefit could create an incentive for veterans to receive these services through this benefit, but these procedures are typically necessary for the longitudinal management of conditions, and are always needed for purposes of care coordination. As we explained in the proposed rule and do so again here in further detail below, we believe that care coordination by a primary care provider is essential to overall health, and thus we seek to reduce the potential for fragmentation and duplication of care that could occur through multiple providers ordering lab services or radiology services. As a result, we are amending section 17.108(e) to state that the exceptions in subparagraphs (1), (2), (4), (10), and (14) do not apply as exceptions to the copayment obligation under the urgent care benefit in § 17.4600.

Comments on Scope of Available Services

Several commenters had questions regarding the scope of services that would be provided under the urgent care benefit. These commenters indicated that there should be clear guidance for what VA would consider episodic care and questioned what the dispute process would be if care was provided that was not considered episodic. A commenter specifically questioned what would happen if a veteran went to an urgent care clinic for care that is not considered episodic.

The urgent care benefit under 38 U.S.C. 1725A(h) is limited to eligible veterans seeking immediate, non-emergent care from a qualifying non-VA entity or provider that furnishes episodic care and not longitudinal management of conditions. VA further proposed defining the term episodic

care in § 17.4600(b)(2) as applying to a particular health condition, or a limited set of particular health conditions, without an ongoing relationship being established between the eligible veteran and the qualifying non-VA entity or provider. VA will provide educational materials to the public that will state that VA will not pay for preventive care, such as annual examinations and routine screenings, and will post such materials on VA's website at www.va.gov. VA will not provide an exhaustive list to account for the needed flexibility in administering the benefit. VA will monitor utilization of this benefit and may make further revisions to the website in the future. Any services provided that are outside of the scope of this benefit are the financial liability of the veteran. These educational materials will be provided to comply with section 121 of the VA MISSION Act of 2018. VA will educate the third-party administrators (TPA), as discussed below, on the urgent care benefit, as required by section 122 of the VA MISSION Act of 2018.

The veteran will be responsible for any urgent care medical claims that do not meet the criteria set forth in this rulemaking. Specifically, a veteran could be liable if: The veteran is not an eligible veteran (*i.e.*, the veteran is either not enrolled or has not received care under chapter 17 of title 38 within the prior 24 months); the provider is not a qualifying non-VA entity or provider (meaning it does not meet the requirements in § 17.4600(b)(4), such as having a contract, agreement, or other arrangement with VA to furnish care and services under this section); or if the care or services do not meet the definition of urgent care in § 17.4600(b)(5) (*i.e.*, the care is not care available from an entity or provider submitting claims for payment as a walk-in retail health clinic or an urgent care facility; or the care is preventive care, is dental care, or is managing a chronic disease). To reduce the potential of veterans' facing unexpected copayments, VA will be available by phone, in person, and by other means to advise veterans who are unsure of their eligibility for this benefit. VA also will make a list of qualifying non-VA entities or providers available on VA's website (www.va.gov) so that veterans know where to go and which providers can furnish this care. VA will provide information regarding the services that are generally available through this benefit on a website and will work with its contractors to educate them on the scope of services VA covers. Veterans will also have the option to contact

either a VA call center or the non-VA entity or provider to discuss urgent care benefit information including eligibility, covered services, and the nearest qualifying facility and location. Although VA does not anticipate that the urgent care providers will provide care outside of the scope of the urgent care benefit, if this does occur, the veteran would be charged for the cost of care, but both the provider and the veteran would have the ability to appeal this determination. We are not making any changes based on this comment.

Several commenters had concerns regarding follow-up care. A commenter strongly disagreed with VA's proposal that episodic care is addressed in a single visit. The commenter wants the urgent care/walk-in care benefit to be expanded to allow for follow-up care as a clinical best practice. Another commenter stated that the definition in the proposed rule fails to recognize the role of urgent care facilities in the health care delivery system and continuity of care and could create a barrier to necessary follow-up care subsequent to an urgent care encounter for illness or injury. We appreciate the commenters' perspective regarding whether or not episodic care can be furnished in a single visit; however, VA maintains that in order to ensure that care provided is not longitudinal, episodic care is care that can be furnished in a single visit. For this reason, we are amending § 17.4600(b)(2) to amend the definition of episodic care to specifically state that the care must be provided in a single visit.

Another commenter asked who will determine cases where a veteran argues that an episode of care requires several follow-up visits to ensure continuity and full treatment of an acute condition. The commenter further asked whether each visit will count against the three visits that are not subject to a copayment or if the provision regarding three visits without a copayment apply to three visits for unrelated episodes of care. Under our regulations, each visit either counts as one of the three free visits or is subject to a copayment, depending upon the eligible veteran's priority group, the number of visits, and whether the visit is exclusively for a flu shot (or a similar treatment under § 17.4600(b)(5)(iv)). Based upon this and other comments, we are amending § 17.4600(b)(5)(iii) to clarify that veterans requiring follow-up care as a result of an urgent care visit under this section must contact VA or their VA-authorized primary care provider to arrange such care. At the time that the veteran contacts VA for follow-up care, VA will schedule the necessary follow-

up care at a VA medical facility or by referral through a community provider. If a veteran instead chose to subsequently go to a qualifying non-VA entity or provider for a follow-up visit, this visit would either count as another visit or could be determined to be not covered if it constituted the longitudinal management of a condition if the encounter was not episodic. VA staff will make the determination of whether care is episodic or not, and an appeals process will be available for providers and patients as described above. VA also makes a minor clarifying edit to the language in this provision to change the conjunction.

Multiple commenters had concerns with follow-up care and one commenter indicated that the standard should be that urgent care providers are allowed to provide the same level and scope of care in that urgent care visit for the complete course of treatment that a VA operated urgent care provider would provide as part of the course of treatment in that urgent care visit. The commenter added that to require the course of treatment by the urgent care provider to be arbitrarily and prematurely terminated simply to protect some standard of separation for "longitudinal care" is not justified. The treatment that would be provided at a non-VA urgent care facility should be the same as that treatment received in a VA urgent care facility. VA believes that limiting urgent care to a single visit is appropriate because it is important that a veteran's care be provided by a primary care provider to eliminate duplicate treatment and improve health outcomes. Moreover, the separation of longitudinal care as being outside the scope of this benefit is statutorily prescribed in section 1725A(h).

A commenter questioned if a clinical determination was made before or after the fact and based on whose judgement. The commenter also questioned how the best medical interest provision would apply in cases where the veteran believes that care was urgent and not preventative. VA notes that the best medical interest provision in the MISSION Act is a specific eligibility criterion for care that is authorized under the Veterans Community Care Program under section 1703 of title 38, as modified by section 101 and as addressed in VA's separate rulemaking, RIN 2900-AQ46 (Veterans Community Care Program), which is published elsewhere in this issue of the **Federal Register**. As previously stated, this urgent care benefit provides certain veterans access to urgent and walk-in care from qualifying non-VA entities or providers without prior approval by VA.

The urgent care benefit will provide the treatment of conditions that are episodic in nature. Eligible veterans have a dedicated primary care provider and this benefit is intended only to supplement, not supplant, such providers. These dedicated primary care providers coordinate care and reduce the duplication of care to improve patient outcomes. In these cases, if follow up care is required after an urgent care visit, the veteran will need to coordinate such care with VA, as explained above. Further, and as also discussed above, determinations regarding whether services are covered within the benefit will be made by VA staff, and veterans or providers who disagree may appeal this determination.

A commenter recommends that VA publish a list of conditions and symptoms for which veterans can seek urgent care. They state that most individuals are not familiar with the names of services that are used to diagnose and treat the symptoms they may be experiencing, and they believe a list would reassure veterans their urgent care visit would be covered. While VA understands the commenter's concern, VA is not going to list symptoms because we would not want to inadvertently divert care from the appropriate level of care. For instance, pain is a symptom, and could be indicative of a minor illness that would be appropriately treated at an urgent care facility but could also be indicative of a life-threatening condition necessitating emergency treatment. VA will provide examples of care and services that are excluded from the benefit and will make that available to the public at www.va.gov. VA will consult with clinical staff, including women's health care providers, in developing the services available at the urgent care and walk-in care facilities.

The same commenter stated that VA should cover emergency contraception for women veterans who request it during an urgent care visit. Urgent care facilities generally do not administer the medication suggested by the commenter during a visit. VA encourages women veterans to use their women's health care provider as their primary care provider, who may provide these services. However, women veterans may access certain services through this benefit that might otherwise be provided by a women's health care provider, such as treatment for urinary tract infections or vaginitis.

This commenter also recommended flu shots and therapeutic vaccines in the urgent care benefit to be available for all veterans, including pregnant women. In addition, the commenter recommended

that VA waive copayments for urgent care visits during which a flu shot is the only service provided. VA agrees with the commenter. The new urgent care benefit will include immunizations against influenza (flu shots), which will be available to all veterans as clinically appropriate, including pregnant women. The proposed rulemaking provides an urgent care visit consisting solely of an immunization against influenza (flu shot) is not subject to the \$30 copayment amount. VA, in response to other comments, is amending proposed § 17.4600(d)(2) to exempt visits that consist solely of flu shots from the number of visits an eligible veteran may receive before being charged a copayment.

A commenter stated that their urgent care representative stated that veterans must have a pre-authorization to receive urgent care, and that their local VA medical facility indicated that urgent care is not covered for veterans. The commenter stated that women veterans are not receiving equal access to health care and added that VA should help all veterans have equal access to health care. We wish to clarify two points in light of this comment. First, eligible veterans will not be required to request VA authorization prior to receiving urgent care from a qualifying non-VA entity or provider under this benefit. As stated previously, VA will consult with health care providers, including women's health care providers, regarding this benefit to ensure equal access to health care. Second, the new urgent care benefit authorized under 38 U.S.C. 1725A has not been effective prior to this rulemaking, and thus the statement by the local VA medical facility was accurate at the time it was made, as all VA community care (except for emergency care provided under 38 U.S.C. 1725 or 1728) has required VA authorization prior to veterans seeing community providers. We are not making any changes based on this comment.

Another commenter had questions about prior authorization required for the urgent care visit as well as any necessary follow-up care. Urgent care benefits under section 1725A do not require authorization from VA. However, follow-up care must be coordinated by VA, and it is the veteran's responsibility to coordinate follow-up care and must contact VA or their VA-authorized primary care provider to arrange such care.

Another commenter stated that urgent care centers have a role in preventive care, ranging from influenza vaccines to diabetes and hepatitis screenings. The commenter further stated that irrational

barriers being proposed in this rule disallowing urgent care centers from providing follow-up care after an acute care visit or preventive care should be removed so urgent care facilities are not restricted from improving the health of our nation's veterans. The commenter also stated that urgent care facilities serve an essential role as part of the primary care safety net across the country. We understand the commenters point, but note that eligible veterans are not like other potential users of urgent care centers or walk-in retail health clinics, as they, by definition, are enrolled in VA health care and are receiving care and services from VA. As such, the ability of urgent care centers to serve as a primary care safety net and to provide preventive care for eligible veterans is less important because they already have means of accessing these services. Cost-free preventive care is already available to all eligible enrolled veterans at VA clinics and hospitals, usually on a walk-in or same-day basis; there is no need for a veteran to seek such care at a retail walk-in clinic or urgent care center. Veterans requiring services that are not available within walk-in retail health clinics or urgent care centers will need to contact VA, or in the case of a medical emergency, seek care at the nearest emergency room. We are, however, making one edit based on these comments. We are revising § 17.4600(b)(5)(ii)(B) to authorize specifically screenings related to the treatment of symptoms associated with an immediate illness or exposure. We believe this addresses some of the commenter's concerns and should provide additional flexibility so that patients who present for care with symptoms may receive diagnostic screenings for purposes of identifying the specific clinical need and treating it appropriately.

Several commenters encouraged VA to include preventive services generally, or at least certain preventive services (such as physical therapy services), and to cover a broader range of immunizations than influenza, not just on an as-needed or as-appropriate basis. Section 1725A(h) does not provide for urgent care to be used for the longitudinal management of health care, such as physical therapy. Preventive health services are excluded because such services are best coordinated and managed by a primary health care provider who addresses important disease prevention and treatment goals through bidirectional communication. We are clarifying that urgent care in § 17.4600(b)(5)(ii)(A) does not include

preventive care or chronic disease management. Also, physical therapy services are considered “rehabilitative services”, which are not included in the definition of preventive services in 38 U.S.C. 1701(9).

Continuous care generally reduces the risk of adverse reactions, and that is one of VA’s primary goals, but we have made an exception here for flu shots and therapeutic vaccines because there is so little risk in these areas and because they are necessary as part of treatment of certain conditions. VA considers other types of preventive care vaccines to be part of the veteran’s longitudinal care, and as such, these other vaccines should be provided by the veteran’s primary care provider and not as part of urgent care. Other vaccines may produce unique risks of adverse reaction or duplication that could potentially harm the patient. Managing these vaccines through a primary health care provider reduces these risks. In response to the example provided by the commenter, physical therapy, if not properly coordinated and performed, can lead to worse health outcomes.

One commenter stated that in the proposed rule, VA acknowledged that there may be other preventive treatments with minimal risk of adverse action; however, VA considered these preventive care treatments to be part of the veteran’s longitudinal care, and accordingly these other treatments should be provided by the veteran’s primary care provider and not as part of urgent care. The commenter questioned whether these other services would not be paid by VA and added if there would be some discussion as to paying for some services as outpatient care because urgent/walk-in care providers do not provide inpatient care or extended care services and would this result in an argument over payment. Urgent care is authorized under section 1725A and only includes the limited scope of services; however, additional care can be authorized in the community under a separate authority. This type of care is addressed under a separate rulemaking with distinct eligibility criteria, which is published elsewhere in this issue of the **Federal Register**.

Another commenter stated that they were in favor of the proposed rule, but added that for the service to be effective, urgent care should include lab tests. VA agrees with the commenter and the benefit would cover certain lab tests, such as sexually transmitted disease testing and blood tests.

A commenter stated that the rule should clearly define urgent care versus convenience care. Specifically, the

commenter stated that VA should distinguish convenience care for a veteran who goes to an urgent care clinic to refill a medication for a chronic condition or a visit strictly for obtaining a flu shot versus a flu shot given opportunistically to a veteran who is at the urgent care clinic for another purpose. The commenter also stated that the rule should specify the services provided; for example, diagnostic studies should be limited to those necessary for the acute condition that can be accomplished in that visit. VA appreciates the comment regarding refilling medication and addresses this topic below in more detail. Veterans will be permitted to refill medications, however, VA will only pay or reimburse for a 14 day supply; anything beyond that would have to be submitted to VA. Also, the visit to obtain a refill of a medication for a chronic condition may not be considered urgent care and may be considered as part of the veteran’s longitudinal care. In addition, veterans can use the benefit for obtaining a flu shot and would also be able to obtain the flu shot if the veteran was at the qualifying non-VA entity or provider for another purpose. The rule clearly provides that flu shots are available through this benefit. Similarly, VA believes the rule is clear that services provided are limited to those necessary to treat a particular health condition, or a limited set of particular health conditions, without an ongoing relationship being established between the eligible veteran and qualifying non-VA entities or providers. In this rulemaking, we further clarified that episodic care has to be addressed in a single visit.

The commenter also suggested that diagnostics requiring scheduling at a later date should be coordinated by VA, as well as prosthetic items that are not readily available in retail stores, in addition to specialty care consultations. The commenter also stated that follow-up care should also be coordinated through VA.

When a veteran has seen an urgent care provider, the veteran is responsible for contacting VA to arrange for any follow-up care that is needed. We agree with the commenter in that prosthetics that are not readily available in retail stores should not be covered under urgent care. As discussed further below, in response to comments, VA is including language in a new paragraph (e) regarding prescriptions for medications, medical equipment, and medical devices for urgent care. VA will determine whether to provide the necessary care and services, such as prosthetic items, at a VA facility or

through a community health care provider.

We are comparing the prescription of urgent care medications to the Veterans Community Care Program, under a separate rulemaking (RIN 2900-AQ46), which is published elsewhere in this issue of the **Federal Register**. We are addressing VA’s payment and fulfillment of prescriptions obtained by covered veterans from eligible entities and providers, but would clarify VA’s current practice that distinguishes circumstances under which VA pays for (versus fills) such prescriptions in new paragraph § 17.4600(e). Paragraph § 17.4600(e)(1) would match the practice proposed in § 17.4025 in RIN 2900-AQ46, and would also retain the practice in the Veterans Choice Program that VA will pay for prescriptions, including prescription drugs, over-the-counter drugs, and medical and surgical supplies available under the VA national formulary system written by non-VA health care providers furnishing services through VA community care, but would clarify that such payment would be for a course of treatment for urgent care that lasts no longer than 14 days. This current practice to limit payment for non-VA prescriptions is reasonable, as it would allow VA to ensure that any amount of medication in excess of 14 days would be filled through VA’s Consolidated Mail Order Pharmacy system to ensure cost and quality controls. VA believes that the economies of scale related to bulk purchase of medications allow for the best maximization of Federal resources. Paragraph § 17.4600(e)(2) establishes the correlate rule from the Veterans Choice Program, and the rule proposed in RIN 2900-AQ46, that VA would fill longer-term prescriptions available under the VA national formulary system for courses of treatment that exceed 14 days if they are filled through VA’s Consolidated Mail Order Pharmacy system. We note that these authorities would only be available for prescriptions furnished as part of urgent care under this section.

Paragraph § 17.4600(e)(3) further clarifies current practice under the Veterans Choice Program and would mirror provisions proposed in RIN 2900-AQ46 regarding VA paying for or filling prescriptions written by non-VA health care providers for durable medical equipment (DME) and devices. As we stated in our proposed rule for the Veterans Community Care Program (RIN 2900-AQ46), the Veterans Choice Program currently permits VA to pay for such prescriptions to be furnished by a community provider only when there is an urgent or emergent need for the

durable medical equipment or medical device, meaning the veteran has a medical condition of acute onset or exacerbation manifesting itself by severity of symptoms including pain, soft tissues symptomatology, bone injuries, etc. Urgent DME or medical devices may include, but are not limited to: Splints, crutches, canes, slings, soft collars, walkers, and manual wheelchairs. This current practice to limit payment for non-VA prescriptions of DME or medical devices to only what is immediately needed is reasonable, as VA must ensure administrative oversight as well as clinical appropriateness of all other DME and medical devices prescribed by non-VA health care providers. DME and medical devices are specific to a particular clinical need and in most cases are further specifically tailored to fit or serve an individual, and as such require direct provision by VA (except when urgently needed) to ensure clinical appropriateness and the best use of Federal resources. Paragraph § 17.4600(e)(3) establishes that VA may pay for prescriptions written by eligible entities or providers for covered veterans that have an immediate need for durable medical equipment and medical devices to address urgent conditions, and parenthetically references a non-exhaustive list of such devices to include splints, crutches, and manual wheelchairs. These provisions of the final rule are a logical outgrowth of both the proposed rule and the comments we received seeking clarification as to the scope of prescription benefits under this program.

Multiple commenters did not agree with VA changing the name of the benefit from walk-in care to urgent care. One commenter suggested that the benefit should be referred to as walk-in care with a clear distinction between retail clinics (those in pharmacies, grocery stores, and big-box stores) that are places of service code (POS) 17 and urgent care facilities recognized as places of service code (POS) 20. Another commenter stated that in calling the benefit urgent care, VA is trying to deter veterans from using it because they will not think their conditions are “urgent”. The commenter also cited to a Congressional report describing this benefit as offering non-urgent care. The comment further noted that other provisions of regulations and VA’s Community Care Network proposal use the term differently.

VA appreciates the comments, but does not believe that veterans will be deterred from using this benefit based upon the name. The lack of consistency

in defining the name both in the industry and within the comments signifies the importance that VA define its own benefit and therefore VA looks towards a name that is easy to remember and has some market relevance. VA also does not believe it is necessary to distinguish between retail clinics that are POS 17 and urgent care facilities recognized as POS 20. VA will continue to develop educational materials on the benefit that will be available to veterans. Congress provided the Secretary authority to define what walk-in care includes through section 1725A(h). VA has exercised its authority to include services that are available at walk-in retail health clinics and urgent care facilities. As noted at the beginning of § 17.4600(b), the definitions only apply to this section.

Regarding the services provided by walk-in clinics, the commenter cited several examples of major chains (CVS, Walgreens) that offer preventive services (the commenter says about half of the services they offer appear to be preventive), but these would not be included in the benefit. The commenter argued that VA’s rationale (the need to coordinate preventive care) is invalid because clinics have to provide records, and VA is required to coordinate care. Also, the commenter asked who would be liable if the veteran goes to an urgent clinic for something that VA considers preventive care and thus not within the scope of this benefit.

As we have already stated in this rulemaking, care is not just about providing the veteran’s medical record, care includes the veteran establishing a relationship with the veteran’s primary care provider, which cannot be accomplished in one urgent care visit. Regarding the exclusion of preventive services, such services are best coordinated and managed by a primary health care provider who addresses important disease prevention and treatment goals through bidirectional communication. Such a provider can also ensure that care is not duplicated, both improving patient care while reducing costs. The veteran would be liable for the cost for any care that VA determines is not within the scope of the benefit. We are not making any changes based on these comments.

A commenter asked whether the definition of urgent care would also include several key conditions or other uses of the term “urgent care” or “urgent services” in other VA regulations, specifically §§ 17.101, 17.106, and 70.71. Also, the commenter asked if the change of the statutory term walk-in care to urgent care would create confusion in the veteran community

that could lead to billing disputes. The commenter also asked what is the likelihood that any care that is provided to an eligible veteran that does not meet this definition of urgent care, whether it be that the care was provided by a non-qualifying entity or provider or that the care provided was beyond the scope of urgent care as defined in this section, will not be covered by VA. The commenter stated that in these situations, the eligible veteran would be liable for the cost of such care and questioned how this determination will be made and whether there will be any provision for review and/or appeal. As stated in the proposed rule, the urgent care definition under § 17.4600(b)(5) only applies to the mandates under 38 U.S.C. 1725A. Regarding the regulations listed by the commenter, those regulations were developed at a separate time and address other types of benefits not provided under this rulemaking. We do not believe that the change in name to urgent care would result in billing disputes, but we can amend these regulations in the future if VA encounters any confusion regarding the interaction between this rule and the ones listed by the commenter. Moreover, bills can only be submitted by parties who have a contract, agreement, or other arrangement to furnish care and services under this section. By statute and regulation, only in-network providers can furnish urgent care under this section. Urgent care provided at an out-of-network facility will not be covered, and the veteran will be responsible for the cost of that care. An eligible veteran will be responsible for the payment for any care that does not meet the definition of urgent care; a non-eligible veteran would be liable for any care provided by any provider, whether in or out of VA’s network. VA staff will determine whether the care meets the requirements of this section, and veterans and providers will be notified of their appeal rights in connection with VA’s decision.

One commenter stated that veterans enrolled in priority group 4 who are paraplegic with bladder problems should be able to see any hospital to meet their health care needs, especially if they have to drive more than 30 miles to the nearest VA medical facility. Several commenters similarly indicated that veterans should be able to go to any doctor, hospital, or clinic for all of their care and not have to drive 60 miles to receive VA care. Section 1725A does not place a mileage limit for non-VA entities or providers that would offer urgent care. The intent of the urgent care benefit is to provide care that is

accessible to eligible veterans and is within the veterans' community. The provision of any other types of health care services, such as hospital or primary care, that is not covered under section 1725A is beyond the scope of the proposed rule. We are not making any changes based on these comments.

A commenter requested that urgent care be expanded to care that is directly related to a veteran's service-connected condition, specifically for wound care. This commenter stated that there is a dividing line between ongoing care and urgent care, especially if the veteran has a chronic condition, which may be service-connected, that sometimes has urgent symptoms. The commenter questioned if such a veteran would still qualify to receive urgent care. Under this rule, urgent care may be provided for the immediate treatment of a chronic condition, including a service-connected condition, that does not address important disease prevention and treatment goals. We are not making any changes based on this comment.

One commenter stated that the proposed definition of urgent care in § 17.4600(b)(5) defines urgent care, in part, as those services being provided by walk-in retail health clinics or urgent care facilities, as designated by the Centers for Medicare & Medicaid Services (CMS). The commenter indicated that they were not aware of any process by which the CMS "designates" urgent care facilities. Rather, the link in the **SUPPLEMENTARY INFORMATION** section of the proposed rule leads to the CMS website listing of places of service codes (POS) used for billing purposes. The commenter further stated that while CMS does designate POS codes that providers must use to bill for services, this does not result in CMS designating specific facilities as specific types of providers. We appreciate the commenter's input and agree that VA's proposed rule was not sufficiently clear on this issue. We are amending the definition of urgent care in paragraph (b)(5)(i) to state that urgent care includes services available from entities or providers submitting claims for payment as a walk-in retail health clinic (CMS Place of Service code 17) or urgent care facility (CMS Place of Service code 20). This concept had previously been included in the introductory language of paragraph (b)(5), but is now, with minor revisions, being relocated to paragraph (b)(5)(i), which has subsequently resulted in a renumbering of the other clauses and conforming amendments to other provisions of the regulation citing these provisions.

The same commenter stated that relying on Medicare POS codes is not an appropriate means to define urgent care providers. The commenter suggested that VA broaden the definition of urgent care to include all providers or facilities that provide episodic walk-in or urgent care services to Medicare beneficiaries. We think that the reliance on entities or providers who furnish services and bill as POS 17 or 20 facilities is consistent with the scope of services established under section 1725A. These facilities generally offer clinically appropriate and convenient care. See S. Rpt. 115-212, page 18. We recognize that VA was not required to limit the types of services to those available from providers who submit claims for payment under POS 17 and 20, but we believe that the services available from these types of facilities would offer a clear and readily verifiable distinction between those facilities that are included and those that are not.

A commenter recommended that Congress add a new benefit similar to the commercial Silver Sneakers to provide overweight veterans with limited income assistance in weight reduction. This comment recommends action by Congress on a separate program, which is beyond the scope of this rulemaking. We are not making any changes based on this comment.

One commenter stated that VA needs to provide dental services for veterans. Although the proposed rule was silent on dental care, we are clarifying in § 17.4600(b)(5)(ii)(A) that dental care is not covered under the urgent care benefit. Eligibility for dental care is complex and a limited number of eligible veterans qualify for this benefit under 38 U.S.C. 1712. In addition, there are a limited number of urgent care facilities that provide dental care. Eligible veterans seeking dental care will need to contact their local VA Dental Service. We are not making any changes based on this comment.

Comments on Medications Prescribed in Urgent Care Visit

Several commenters questioned how veterans would fill prescriptions that were prescribed during an urgent care visit. The commenters raised the following questions: What does a veteran need to do to get a prescription filled? would a veteran submit the prescription to VA and wait another week to obtain the prescription? what is the procedure for obtaining prescriptions? and who is responsible for the cost and what is the cost? Another commenter stated that they were in favor of the proposed rule, but added that for service to be effective,

urgent care should include prescriptions. A commenter stated that the rule should specify that medications prescribed during an urgent care visit should be limited to a two-week supply. Another commenter recommended that VA address non-VA physicians' writing prescriptions for veterans eligible for non-VA care adding that those veterans should be allowed to have those prescriptions filled by a pharmacy.

As discussed above, VA is adding a new paragraph (e) to state that veterans will be allowed to have prescriptions written by the urgent care providers filled by VA. In addition, prior to the deployment of the new community care network contract, veterans who need a short-term medication (14 days or less fill) immediately may take it to any pharmacy and have it filled at their expense and be reimbursed by VA. Upon deployment of the Community Care Network contract, veterans will be able to use contracted pharmacies to fill the immediate need medications without paying out of pocket.

Long term medications must be sent to VA to be filled by VA, typically through a Consolidated Mail Outpatient Pharmacy. The copayments for medications under the new urgent care benefit follow VA's tiered medication copayment system. For more information on medication copayments see 38 CFR 17.110(b) or https://www.va.gov/COMMUNITYCARE/revenue_ops/copays.asp#Medications. We are not making any changes beyond the inclusion of paragraph (e) based on these comments.

Comments on Information Included on Website and Communications

Many commenters had concerns about how information regarding the new urgent care benefit would be disseminated to veterans and what type of information would be included on VA's website. Several commenters had suggestions on the type of information that should be provided on the website and the type of information that should be communicated to veterans on this benefit.

One commenter recommended that the rule should focus more on the importance of creating a website that outlines urgent care in an accessible way. The commenter stated that the website should include the name, locations, contact information for the qualifying non-VA entity or provider, and the type of care that a veteran is eligible to receive. Similarly, several commenters wanted to ensure that veterans would be able to see which providers would be covered, whether preauthorization would be required, and

the scope of services (what constitutes episodic care versus longitudinal care). Similarly, another commenter encouraged VA to ensure that information about available services is carefully defined, vetted, and communicated clearly to veterans. Another commenter stated that, as proposed, the information about the scope of services offered should be "site specific," and the directory of locations should be updated regularly to ensure accuracy. A commenter added that in order for the program to be successful, VA must make it easy for the veteran to identify urgent care facilities within their community. Along with information regarding scope of services and locations, the commenter urged VA to also include information about the required copay amounts that veterans will be charged when seeking urgent care. In addition, one commenter was concerned how veterans will know that they are eligible for urgent care, particularly in cases when driving time, as determined by geospatial mapping can be disputed.

VA agrees with the commenters that it is important to provide veterans with information on the new urgent care benefit. Veterans will have access to urgent care benefit information on VA's website (www.va.gov), and they can call their local VA medical facility to confirm eligibility. The website, which will be updated regularly, will include information on eligibility, examples of excluded services, copayment requirements, and a list of qualifying non-VA entities or providers. We are making one minor edit to this portion of the rule, to clarify that VA's website will provide the information described above. It is possible that in the future, much of this information will be presented on a contractor's website, so to avoid duplicating content (or potentially creating inconsistencies between two sites), we are revising the rule to not state that VA's website will contain this information, but merely provide it. If, in the future, a contractor's website is used, VA's website will provide veterans the information they need through links to these third party sites. To clarify for the commenters, any enrolled veteran who has received VA care under chapter 17 in the last 24-months is eligible for the urgent care benefit. Drive time and geospatial mapping are not a consideration for the new urgent care benefit. In addition, only urgent care received from a qualifying non-VA entity or provider will be covered under the benefit; veterans obtaining urgent

care from out-of-network providers will be responsible for the cost of the care.

Another commenter stated that VA should publish a website containing information on urgent care. However, if this website experienced technical difficulties, the commenter asked if veterans would be able to use a 24 hour a day/7 day a week/365 day a year toll-free number to verify whether a non-VA provider or entity is in VA's network. VA agrees with the need to provide this information through other means, and eligible veterans may call their nearest VA medical facility, which will have a list of authorized providers. VA fact sheets on this benefit will list both the online web address and call-in numbers. However, this is an operational matter and does not require regulation, so we are not making changes to the rule based on these comments.

Another commenter recommended that VA provide notice to veterans of the proposed rule changes upon implementation. The commenter indicated that simply providing this information on the VA website will not be sufficient notice and that VA should post this information in prominent places within each VA medical facility, including information about the location of the nearest urgent care centers. VA agrees that communication about this benefit will be crucial, and as a result, VA is developing posters, fact sheets, and other guidance that will detail what care and services are included in the urgent care benefit and will be provided when the new benefit goes into effect. The name and location of qualifying non-VA entities or providers will be available on VA's website or by contacting VA. We are not making any changes based on this comment.

A commenter stated that VA would publish a website with the information on the non-VA entities or providers but questioned how often this site would be updated to indicate additions to the list as well as deletions from the list. The commenter added that without requiring prior approval from VA, a veteran could, through no fault of his or her own, receive services from a non-VA provider who is no longer approved for the program. VA will update the list of qualifying non-VA entities and providers under this program on a regular basis. VA is not making any changes based on this comment.

A commenter recommends that preventative measures be in place to alert veterans prior to incurring charges that they will be liable for the costs of care. VA will provide urgent care benefit information on VA's website at www.va.gov, which will include

information on veteran eligibility for the benefit, available services, and qualifying non-VA entities or providers. If a veteran is not eligible, receives services that are not covered, or receives care from an out-of-network provider, the veteran may be responsible for the cost of that care.

Another commenter was concerned that the VA website will not provide sufficient information for veterans to allow them to determine whether a retail walk-in care clinic or the more extensive range of services available at an urgent care facility better suits their needs. VA will provide information on qualifying non-VA entities and providers on a website. Veterans will also be able to call the qualifying non-VA entity or provider to determine which services they provide. VA believes this will allow them to determine which qualifying non-VA entity or provider can best address their particular needs. In addition to VA's website, VA is developing posters, fact sheets, and news releases to educate and inform veterans, VSOs and community providers about the new benefit. VA will be able to update this information to reflect concerns, trends, and advances in this benefit as needed.

Another commenter stated that new rules need to be very clearly defined and that VA should post flyers in every VA medical facility as well as mail such flyers to accredited Veteran Service Offices, County Veteran Service Offices, and Tribal Veteran Service Offices. VA is developing guidance on the changes to health care and services that will be provided under 38 U.S.C. 1725A. This guidance will be widely distributed in a variety of formats to veterans, Veterans Service Organizations (VSO), and the public. We are not making any changes based on these comments.

Another commenter recommended that VA provide patient and clinician education regarding aspects of this proposed rule. VA will provide training and education on our website for both providers and veterans. In accordance with section 121 of the MISSION Act, VA will be developing and administering an education program that teaches veterans about their health care options through VA; moreover, VA will be communicating with veterans through multiple avenues, with VA's website being the most comprehensive method of obtaining information on the new urgent care benefit. Additionally, as required by section 122 of the MISSION Act, VA is developing and implementing a training program to train employees and contractors of the Department on how to administer non-VA health care programs, including the

urgent care benefit. We are not making any changes to the rule based on these comments.

One commenter stated that veterans should not have to make telephone calls to arrange for or confirm care. VA agrees with the commenter and is constantly searching for new avenues to expand veteran access for health care services. In addition to traditional in-person or telephone scheduling of appointments, veterans can communicate with their medical team using secure email via the My HealtheVet portal, and many services are now available electronically via video telehealth, allowing veterans to schedule appointments and even to receive face-to-face care from their home, office, or other location without traveling to a VA facility. We are not making any changes based on this comment.

We note here we made minor revisions to § 17.4600(a) to clarify the scope of the urgent care benefit under this rulemaking. Specifically, we emphasize that eligible veterans may obtain urgent care in accordance with the requirements and processes set forth in this section, and that qualifying non-VA entities or providers must be in VA's network and will be identified in accordance with paragraph (c)(2). We regard these as clarifying edits only. We also make minor clarifying edits to paragraph (c)(2) to note the website will provide information on urgent care, and that the contact information will be for qualifying non-VA entities or providers from which urgent care is available under this section.

Comments on Emergency Care

Many commenters had suggestions and recommendations regarding the inclusion of emergency care or emergency follow-up care as part of this benefit.

Several commenters suggested that a patient should be admitted to a local non-VA hospital at VA expense if the urgent care provider deems it necessary. Similarly, some commenters questioned what would happen if a veteran seeks care in an urgent care clinic and during this visit the health care professional determines that the veteran requires emergency care—would the veteran be billed for the subsequent emergency care visit? Another commenter requested that VA allow access to emergency care without pre-authorization. Another commenter similarly stated that they lived 45 miles from their nearest VA medical facility and that they should be able to visit their local hospital emergency room (5 miles away) in the event they encounter an emergency. Several other

commenters suggested that the rule should also include emergency room care. Another commenter also stated that veterans should have access to urgent care for the emergency treatment of conditions incurred in service.

The intent of this rulemaking is to provide eligible veterans the ability to receive treatment for certain, limited, non-emergent care from approved walk-in retail health clinics and urgent care centers. The authority for this new benefit, section 1725A, precludes the inclusion of emergent care by its definition of walk-in care in 1725A(h). Therefore, any emergent care deemed necessary by the urgent care provider will not be provided under section 1725A and the urgent care benefit. Instead, VA's authority to provide emergency treatment in the community is 38 U.S.C. 1725 and 38 U.S.C. 1728. The eligibility criteria for emergency treatment in the community are defined through these statutes and their implementing regulations and are also administered separately. Veterans seeking emergency care may be liable for the cost of such care. We are not making any changes based on these comments.

A commenter additionally stated that Congress should give VA the ability to pay copayments, even in the case of emergency. We appreciate the commenter's suggestion, but as noted in the comment itself, this would require Congressional action. As such, this is beyond the scope of the rulemaking, and we are not making any changes based on this comment.

One commenter suggested that the urgent care benefit under 38 U.S.C. 1725A meant care provided in non-VA emergency rooms and that veterans would now be charged for emergency room care. As previously stated in this rulemaking, the current regulations that address emergency room care at non-VA medical facilities will not be amended by this rule. We are not making any changes based on this comment.

Several commenters stated that patients are often confused between the definition of urgent care and emergency care and encouraged VA to clearly define what is meant by urgent care, and how this is distinguished from emergency care. The term emergency treatment is defined in statute at section 1725(f)(1)(B) as care or services rendered in a medical emergency of such nature that a prudent layperson reasonably expects that delay in seeking immediate medical attention would be hazardous to life or health. Urgent care, as defined in the proposed rule, is care that does not require immediate, emergent medical attention. If veterans

are unsure whether or not they are having a medical emergency, they should call 9–1–1 or visit their nearest emergency room. We are not making any changes to the rule based on these comments.

Comments on Contracts With Non-VA Entities or Providers and Billing

Several commenters requested that community health care providers accepting Medicare or Medicaid be required to accept veterans and that veterans be able to receive care at any facility. Health care providers are independent businesses, licensed by the State in which they are offering health care services to the public. There are no statutes or Federal regulations that require an independent business to contract with a Federal agency to provide health care services without the consent of the provider. The comment addresses VA's community care program more broadly and is thus beyond the scope of this rulemaking, which is limited just to the urgent care benefit.

One commenter questioned how the contracts between the urgent care facilities and VA would be written, specifically asking if VA or the veteran will be the payer. The commenter indicated that the veteran should not be billed when VA fails to pay the urgent care facility timely. One commenter was also concerned that the non-VA entities or providers may not accept VA patients because VA has not issued payments timely. Similarly, another commenter further questioned whether the payment to the urgent care facility will be faster than similar payments to care in the community. The commenter was concerned that if the payment to the urgent care facility takes too long, the bill for care could be sent for collection, destroying the veteran's credit rating. Also, the commenter asked what would happen if VA took too long to pay and the urgent care facility billed the veteran's Medicare or other health insurance, incurring a bill above the VA copayment saying that they gave VA a reasonable amount of time to pay. Qualifying non-VA entities or providers must have a contract, agreement, or other arrangement to furnish benefits under this section. The terms of these contracts or agreements will define the provider's ability to seek payment and VA's responsibilities for payment. VA will be administering this benefit through a managed network, where VA has a contractual relationship with a third-party administrator (TPA) that in turn has contracts or agreements with a network of providers. Payments are similarly separated—VA pays the TPA,

and the TPA pays the provider. We believe that these arrangements provide sufficient assurances that eligible veterans will not be billed for urgent care furnished by qualifying non-VA entities or providers. As we have stated previously, though, if an eligible veteran received urgent care from an entity or provider that is not a qualifying non-VA entity or provider, VA would have no contract or mechanism to prohibit that provider from billing the veteran. We recommend veterans contact VA if they have any question as to whether or not the walk-in retail health clinic or urgent care center they are planning to access is in VA's network. We are not making any changes based on this comment.

A commenter indicated that the proposed rule would increase access to much needed health care. However, the commenter was concerned that non-VA doctors would not want to enter into contracts with VA because the pay may be less than their regular fees. VA has entered into contracts with TPAs to administer this benefit, and we believe the payment rates for providers under these contracts are sufficient to maintain an adequate network of providers because they are comparable to rates negotiated by other Federal health care agencies and third-party health plan contracts. We are not making any changes based on this comment.

A commenter recommended that if an agreement currently exists with a non-VA provider or entity, VA should amend such contracts by adding an addendum to include urgent care. The commenter wanted to avoid creating a separate agreement for urgent care because it would cause an undue burden on the non-VA entity or provider and having said addendum would fast track the process and bring needed service expansion to eligible veterans. The method VA uses to procure these services is outside the scope of this rulemaking, which deals exclusively with the scope of the benefit, not how it will be purchased. We are not making any changes based on this comment.

Another commenter stated that the rule would be a huge advantage for veterans to receive timely access to urgent care services. However, the commenter cautioned that CMS should impose strict billing guidelines so that veterans do not end up with surprise bills. The commenter suggested that facilities and providers be attested with CMS and thoroughly perform Recovery Audit Contractors (RAC) audits of any facility treating veterans. Another commenter cautioned that VA must make certain that veterans are not burdened with a financial obligation

beyond the copayment. We note that CMS billing is not applicable to VA; while VA generally pays CMS rates, CMS does not pay claims on VA's behalf or audit VA's community network of providers. VA does not anticipate veterans will have surprise bills for the reasons described above concerning VA's contractual arrangements with TPAs, and the TPAs' relationships with providers. Veterans will only be charged a copayment for the services, if applicable, by VA. However, as noted, care that is provided to a non-eligible veteran or by a non-qualifying entity or provider could be billed to the veteran. We are not making any changes based on these comments.

Another commenter was concerned that VA contracts with retail walk-in clinics and urgent care centers will not adequately address the difference in the care offered by the various types of retail walk-in clinics versus urgent care centers. VA understands and appreciates the differences and similarities between the types of care offered at urgent care facilities and walk in care clinics in the private sector. VA will provide information on a website on the qualifying non-VA providers and entities. VA believes that veterans will be able to call the qualifying non-VA entity or provider would best address their needs. We are going to have TPA contracts that require the TPA to provide a network of providers to furnish these services on our behalf. VA appreciates the commenters concern and will ensure that the information available to veterans is adjusted to ensure veterans understand this benefit and can use it as intended. The veteran will be able to go to whichever contracted facility has the service that they require.

One commenter requested clarification on the process stated in proposed § 17.4600(b)(4) stating that VA will enter into an agreement with non-VA entities or providers to furnish urgent care. The commenter stated that they believed that it is in the best interest of the veteran that a streamlined process be established to ensure the availability of urgent care to veterans, particularly those who live in rural areas. The commenter also requested that VA specify that the payment for urgent care services will be at the same rates Medicare pays the specific providers for those services. VA will be contracting with TPAs to provide urgent care. The payment rate for care and services will be included in the terms of the contract. We are not making any changes based on these comments. We revise the proposed definition of a qualifying non-VA entity or provider to

recognize explicitly that VA intends to use third-party administrators to make urgent care available to veterans. In implementing this authority, VA intends to utilize contracts with non-VA entities, third-party administrators, to furnish services under this section. The third-party administrators would, in turn, have their own contracts or agreements with direct care providers in the community that furnish urgent care to veterans under this section. To remove any ambiguity as to what we mean when we refer to qualifying non-VA entities or providers in this regulation, we are recognizing this arrangement with this new language. This is consistent with both the plain language of the statute, as well as Congressional intent. In a Committee report, the Senate Veterans' Affairs Committee stated in the context of section 1725A(c) that, "It is the Committee's intent that the authority in this section be exercised nation-wide, among several types of entities or providers to ensure adequate coverage, so that all veterans have the option of utilizing this convenient, walk-in care." S. Rpt. 115-212, p. 19.

One commenter suggested that VA should consider changing its current policy to serve as the secondary payer for urgent non-service connected care delivered in the community. VA does not have authority to act as a secondary payer for urgent care; such a change would require Congress to amend VA's statutory authority. We are not making any changes based on this comment.

A commenter was concerned how VA would qualify the non-VA entities or providers as "approved" vendors. VA will be entering into contracts or agreements with TPAs to access a network of urgent care centers and walk-in retail health clinics to create a network of qualified local providers. VA defines a qualifying non-VA entity or provider to mean a non-VA entity or provider that has entered into a contract, agreement, or other arrangement with VA to furnish urgent care. We are not making any changes based on these comments.

Comments on Information Sharing With Community Providers

Multiple commenters had concerns and suggestions regarding medical record sharing with qualifying non-VA entities or providers.

One commenter indicated that strategically-placed partnerships with urgent care providers must be combined with bidirectional access to the veterans' medical data through VA provided highly secure encrypted hardware that will not locally store

personal health information (PHI). Another commenter similarly stated that VA medical records should be shared with the urgent care clinics. One commenter suggested that physicians and insurers enroll and certify in VA-mandated reporting and integration of the veterans' medical records. A commenter proposed that VA set forth the expectation that non-VA entities or providers must provide electronic interoperable visit summaries to VA so that this information can be added to the electronic health record. The commenter further stated that submission of these visit summaries should be a condition for payment. Another commenter worried that the urgent care provider would not be able to provide the veteran the best care needed because the provider does not have access to the veteran's VA health record at the time of the urgent care visit. The commenter also noted that this lack of access to medical records may, in turn, not reflect that the veteran is addicted to opioids, or the urgent care facility could dispense medication that may adversely interfere with a medication that has been prescribed by VA. Another commenter suggested that non-VA urgent care entities possess the information technology capabilities to be able to interface with VA electronic medical record system.

Section 1725A(e) of 38 U.S.C. requires VA to ensure continuity of care for this new benefit; specifically, VA is required to establish a mechanism to receive medical records from walk-in care providers and provide pertinent medical records to providers of walk-in care. VA participates in industry standard Health Information Exchanges (HIE) to share medical records, which has security measures in place to protect the veteran's medical records. If the provider does not participate in an HIE, VA can provide pertinent medical records through other means, including through requesting access to a secure web-based version of veterans' medical records (Community Viewer). Therefore, although VA acknowledges the commenter's concern about potential negative health outcomes, which include adverse reactions to medications or substance abuse of opioids, if the qualifying non-VA entity or provider is not provided access to the veteran's medical records, VA has systems in place, either through the HIE or through community viewer, to make the needed health information available to the qualifying non-VA entity or provider at the point of care.

Continuity of care will be managed because the urgent care provider must submit medical documentation back to

VA so that the veteran's VA provider has access to the information. If further treatment is required, the veteran is responsible for contacting VA to coordinate any follow-up care. We are not making any changes based on these comments.

Comments on Other VA Health Care Programs

Many commenters submitted comments related to VA's Community Care Program or Veterans Choice Program. These comments are beyond the scope of the rulemaking as this rulemaking only implements 38 U.S.C. 1725A, which is distinct from VA's authority to provide the care in the community generally under 38 U.S.C. 1703, as amended by section 101 of the MISSION Act. However, we are summarizing them here in the interest of transparency.

One commenter indicated that they wanted to comment on the first two items of the VA News Letter dated January 30, 2019. Because the commenter could not find a comment section in the VA News Letter, the commenter decided to comment on the rule. The commenter added that urgent care was the third item, for which they didn't provide a comment. Instead, the commenter requested more information on the grandfathering of the Veterans Choice Program and the qualification standards for the new access standards for the program that would replace the Veterans Choice Program. Another commenter asked if the proposed rule would mean that if a veteran lives more than 30 minutes away from their nearest VA medical facility the veteran can do all of their health care outside VA. Multiple commenters stated that they routinely had their appointments cancelled when they sought care in the community and that the average wait time for the appointment was five to six months. One commenter added that they had no choice in where to receive the care in the community because the VA physician ordered the appointment. A commenter similarly asked if the proposed rule means that since it takes a month to get a VA mental health appointment, the veteran can go to a local health care provider. Another commenter suggested that the drive distance to obtain urgent care should be 50 miles. The commenter stated that they had to receive care from emergency rooms because they were not able to obtain an appointment in a VA medical facility timely. Another commenter stated that the proposed new travel distances, travel times, and appointment wait times do nothing to improve a veteran's care. The commenter further

stated that changing from travel distance to travel time criteria will allow more veterans in metropolitan areas where there are large VA hospitals to use non-VA providers, which will deplete VA funds and deprive rural veterans of non-VA care for services not provided in smaller VA hospitals and clinics. Another commenter concurs with the proposed access standards and holds VA accountable for meeting, if not exceeding them. Another commenter also states that distance and time are major factors when someone is suffering from injury or pain and mentions that the 40 mile criterion is essential for all rural areas. Similarly, a commenter questioned if the proposed rule meant that the veteran can find a local cardiologist rather than the 75-mile drive to the nearest VA medical facility.

This rulemaking does not implement or affect eligibility under section 1703 for VA's Community Care Program of Veterans Choice Program. Travel distances are also not a consideration for urgent care. Section 1725A does not place a mileage limit for non-VA entities or providers that would offer urgent care. VA will enter into contracts or agreements with qualifying non-VA entities or providers within the community, and we believe this will expand access to care in the community (through additional locations) and in VA facilities (by freeing up some resources). These comments are beyond the scope of the rulemaking. We will not make any changes to the rule based on these comments.

One veteran was not in favor of the rule, stating that the rule morphs fee basis in name only in an attempt to convince veterans that something has changed for the better. The commenter recommends that VA replace the Choice Act with the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). The Veterans Choice Program authorizes VA to furnish hospital care and medical services to eligible veterans, as defined in § 17.1510, through agreements with eligible entities or providers, as defined in § 17.1530. See §§ 17.1500 through 17.1540. The authority for the Veterans Choice Program is Sec. 101, Public Law 113-146, 128 Stat. 1754, as amended, and VA's authority to furnish care and services under that Program will end on June 6, 2019. CHAMPVA furnishes medical care to certain dependents and survivors of active duty and retired members of the Armed Forces and is authorized under 38 U.S.C. 1781. The proposed rule did not address the Veterans Choice Program, the Veterans Community Care Program, or CHAMPVA, and any comment regarding

those programs is beyond the scope of this rulemaking.

Comments on Quality

Several commenters were concerned that the quality of providers at urgent care facilities would not be as good as the quality of care veterans receive at VA facilities. One commenter stated that VA already provides same-day access to veterans at every VA facility. The commenter stated that this is the preferred source of care in terms of quality, cost effectiveness, and coordination of care. If there are staffing or space needs to ensure same day urgent care access at every VA facility, that should be addressed first through oversight and funding to fill the over 40,000 unfilled positions in the Veterans Health Administration. Another commenter recommended that treatment for rated illnesses and complex issues should be under tighter VA control and tight certification of non-VA providers. VA agrees with the commenter that quality health care services are important; therefore, we have revised the procedures under § 17.4600(c) to add a new paragraph (4) that states that urgent care furnished under this section must meet VA's standards for quality established under 38 U.S.C. 1703C, as applicable. We note that VA's standards for quality may not be fully incorporated into the contracts or agreements by the effective date of this regulation, or some standards may refer to population-based metrics that are not relevant in individual circumstances, and therefore we have included the language "as applicable" to demonstrate that urgent care will only be required to meet the standards for quality once those standards have been articulated and are in the contracts or agreements. VA reiterates that it is solely the veteran's choice whether to seek urgent care at a qualifying non-VA entity or provider or seek care at a VA facility. VA further notes that the funding to fill the over 40,000 VA unfilled positions as stated by the commenter is beyond the scope of the proposed rule.

A commenter stated that there must be a mechanism to generate data to assess quality improvements and cost savings and accountability for the \$1.4 billion in spending for the urgent care benefit. VA is working on processes to assess quality improvements and cost savings for the benefit. We will conduct reviews once the benefit is implemented. However, as these are internal administrative matters, we are making no changes to the rule based on this comment.

A commenter questioned how the proposed rule would affect providers and what provisions are being taken to ensure there is no provider burnout as clinical roles have a high burnout rate. The commenter added that it would be unfortunate to have greater access, but poorer quality of care due to burnout. We do not expect this benefit would affect or contribute to provider burnout. If the commenter is referring to qualifying non-VA entities or providers, they are independent businesses, licensed by the individual States in which they are offering health care services to the public. It is their responsibility, and in their interest, to determine how many patients can be treated. VA agrees with the commenter that quality health care services are important; therefore, VA will require the urgent care furnished under this section to meet VA's standards for quality under section 1703C. If the commenter is referring to burnout of VA health care professionals, although the proposed rule itself does not address provider burnout, VA is using VA patient aligned care teams (PACT) help manage the flow of care and information. Several studies have shown PACTs to be associated with lower provider burnout.¹ We are not making any changes based on this comment.

A commenter stated that the proposed rule should address quality as well as access. The commenter urged VA to include in the contracts with the non-VA entity or provider a requirement that they have earned the National Committee for Quality Assurance Patient-Centered Connected Care Recognition. The commenter indicated that this program is designed to help ensure that urgent, retail, and other clinics connect and coordinate with the patient's primary care provider. The commenter further stated that Patient-Centered Connected Care Recognition creates a roadmap for how urgent care and retail clinics can fit into the medical neighborhoods of Patient-Centered Medical Homes and Patient-Centered Specialty Practices, which closely align with the VA MISSION Act of 2018's non-urgent care quality standards by avoiding re-creating the wheel and

requiring non-VA entities or providers to meet ready-made standards. The National Committee for Quality Assurance (NCQA) is a private organization that contracts its services out to the private sector and government agencies to assist them with measuring and improving quality. Another commenter suggested that non-VA entities receive Joint Commission accreditation prior to being included in the VA urgent care network of providers. The commenter also indicated that the proposed rule does not mention assessing quality metrics for the non-VA entities or providers who will provide urgent care services. The commenter recommends that every provider should be pre-screened for equivalent credentials, training, and expertise that is required of VA health care professionals. Lastly, the commenter recommended that every provider of urgent care should track and report quality processing and outcomes of the veteran patients in order to adequately assess the quality of care provided.

As stated before, VA agrees with the commenters that quality health care services are important; therefore, we have revised the procedures associated with urgent care under § 17.4600(c) to include a new paragraph (4) that states that urgent care furnished under this section must meet VA's standards for quality established under 38 U.S.C. 1703C, as applicable. We are not making any changes based on this comment.

A commenter stated that VA is the national leader in integrating primary care and mental health, and they believe that walk-in clinics will result in inferior, fragmented mental health care by providers with significantly less training and supervision. Although the majority of the care provided for mental health is generally considered longitudinal care, if a veteran has a need for urgent mental health care, they may receive such care through this benefit. VA emphasizes that long-term mental health care should be coordinated through the veteran's primary care provider and not through the urgent care benefit. VA has also been expending resources to expand access to immediate and urgent mental health care, and we believe that better patient outcomes can be achieved by furnishing such care through VA. In 2007, VA established the Veterans Crisis Line, which provides confidential support to veterans in crisis. Veterans, as well as their family and friends, can call, text, or chat online with a caring, qualified responder, regardless of eligibility for VA care or enrollment in VA's health care system. VA is committed to

¹ Karin M. Nelson, MD, MSHS; Christian Helfrich, MPH, Ph.D.; Haili Sun; et al: Implementation of the Patient-Centered Medical Home in the Veterans Health Administration Associations With Patient Satisfaction, Quality of Care, Staff Burnout, and Hospital and Emergency Department Use: JAMA Intern Med. June 23, 2014;174(8):1350-1358; Christian D. Helfrich, MPH, Ph.D., Joseph A. Simonetti, MD, MPH, Walter L. Clinton, Ph.D.; et al: The Association of Team-Specific Workload and Staffing with Odds of Burnout Among VA Primary Care Team Members: J Gen Intern Med February 23, 2017;32(7):760-6.

providing free and confidential crisis support to veterans 24 hours a day, 7 days a week. In addition, VA has implemented a “no wrong door” philosophy so that every VA employee will assist veterans in need.

Comments on VA Staffing, Hiring, and Budget

Several commenters had concerns and suggestions regarding internal VA structure, including VA’s staffing, hiring, and budget considerations. We are addressing the comments related to these subjects in this section, but because they are outside the scope of this rulemaking, we will not be making changes as a result of these comments.

Multiple commenters expressed concerns that, absent increased and dedicated funding by Congress equal to the actual costs of the new urgent care program, which they noted may be grossly underestimated by the administration and the Congressional Budget Office, funds may be diverted from traditional medical services within VA or other VA services. One commenter suggested Congress should provide funding for double the estimated usage. Another commenter strongly urged VA to work with Congress to provide the necessary additional funding to existing VA medical facilities that have the capability to provide urgent care services. VA performed an actuarial analysis to estimate the total cost of the increased reliance that would result from the new MISSION standards. We will continue to monitor resource needs and utilization and respond accordingly. The provision of funds from Congress for the urgent care benefit is beyond the scope of the proposed rule.

Several commenters stated that privatizing VA health care, or any move towards privatization, is the wrong move and will eventually harm veterans and cost taxpayers hundreds of billions of dollars in giveaways to the private sector. VA has no intention to privatize and does not believe that this benefit moves towards privatization. The purpose of this benefit is to implement section 1725A by providing veterans a convenient option for seeking episodic care.

One commenter additionally suggested that because the government already has TRICARE and Medicare, VA should authorize a special class of eligible users and provide separate funding for the anticipated impact that would allow veterans more access to civilian care, but within already established program channels. TRICARE and Medicare are not entities that are

governed by VA and, as such, the substitution of VA care for these two benefits is beyond the scope of the proposed rule and is neither authorized nor even contemplated by law. We are not making any changes based on these comments.

Multiple commenters were concerned with the rule because they believe that veterans’ care should be managed by VA. VA is the primary provider of care and services to veterans; the proposed rule will not change that. The proposed rule will increase veterans’ access to care and services available from local community providers in limited circumstances. VA believes that the implementation of this new benefit, as structured, will encourage veterans to seek care from VA facilities for primary and longitudinal care and only access urgent care when necessary and appropriate to treat an episodic condition.

One commenter suggested that VA staff VA medical facilities with medical personnel from the Reserve and National Guard to accomplish their active duty training. The commenter added that VA should incentivize civilian workers and retired medical persons to volunteer their services, possibly under the supervision of an active duty medical person. We appreciate the commenter’s suggestion; however, the appointment of health care professionals as VA employees or volunteers is beyond the scope of the proposed rule. We are not making any changes based on this comment.

One commenter suggested that VA medical facilities have longer operating hours and use local doctors and nurses to work in VA medical facilities. In doing so, VA would not have a need to use the Veterans Choice Program. The operating hours of VA medical facilities are beyond the scope of the proposed rule, but we note that VA is implementing the Improving Capacity, Efficiency, and Productivity initiative, a collaboration among VA offices focused on creating efficient practice solutions, including offering extended hours (evenings and Saturdays), using telehealth and video appointments, providing facilities with appropriate guidance for overbooking, and adopting point-of-care scheduling. We are making no changes based on this comment.

One commenter stated that VA cannot staff their VA medical facilities and questioned why VA was trying to make veterans think that VA could open walk-in clinics. Although VA provides same-day services at VA medical facilities, the urgent care benefit will not be creating new VA medical facilities to provide urgent care to eligible veterans, nor will

it impose any new obligations on VA facilities in terms of care delivery. Urgent care will be furnished through qualifying non-VA entities or providers, as stated in 38 U.S.C. 1725A. We are not making any changes based on this comment.

One commenter requested that VA fill the existing vacancies at all VA departments. The commenter added that not hiring persons for empty existing vacancies is causing problems for veterans. We presume that the commenter meant the hiring of VA health care professionals. The proposed rule addressed urgent care authorized by 38 U.S.C. 1725A. The hiring of VA health care professionals is beyond the scope of the proposed rule. We are not making any changes based on this comment.

One commenter stated that one of the most important programs within the VA system is training of residents. The commenter expressed concern that a reduction in volume at VA facilities due to reliance on the new urgent care benefit may result in a reduction in this program, or a reduction in the types of training or opportunities it could provide. The commenter states that if these training programs for residents are reduced or eliminated it could have a far-reaching downstream effect, not only on the nation’s veterans but on the nation as a whole. We do not believe that the urgent care benefit is a diversion of care away from VA medical facilities. We are not making any changes based on this comment.

Multiple commenters addressed the need for triage or a nurse line. In particular, one commenter agreed that urgent care is a nice addition to VA health care, but believed that VA should have a few checks and balances for the use of urgent care. The commenter recommended that every veteran who seeks urgent care should be required to call their VA clinic or be provided triage or VA nurse helpline prior to running out and receiving urgent care. The commenter also recommended hiring more health care staff and manning a VA urgent care clinic after hours. The commenter stated that when possible, the health care needs of the veteran should be kept in the VA health care system. Veterans always have the ability to contact a VA call center or their VA or VA-authorized primary care provider for guidance or to seek care within the VA health care system. However, pre-approval from VA is not a requirement for eligible veterans to receive urgent care, and this benefit is intended to be a supplement to existing VA services. We are not making any changes based on this comment.

One commenter recommends delaying the implementation of the proposed rule. For the reasons stated under the Congressional Review Act heading below, we do not believe it would be in the public interest to delay the effective date of this rule. We are not making any changes based on this comment.

Comments on Veteran Eligibility and Other Benefits

One commenter opposed the use of walk-in clinics to supplement the primary and specialty care provided by VA and demanded that VA place a firm limit on the number of times a patient may use these walk-in clinics and the type of services that will be provided, exercise oversight authority over these clinics as providers, and work to increase VA's ability to provide same-day access at VA facilities. VA agrees with the commenter as the urgent care benefit is not meant to supplant primary and specialty care provided by VA. VA is not limiting the number of visits, as VA is striving to ensure veterans will have access to convenient care when necessary. VA is limiting the types of services provided to ensure that preventive care is not provided through this benefit and the veteran's primary care is managed through the veteran's primary care physician. VA is working on increasing internal capacity at medical facilities while ensuring veterans have access to facilities to address urgent care needs.

Several commenters recommended that VA allow veterans to present their VA medical card as insurance to any health care facility in the community. Another commenter similarly recommended that VA provide a State and County wide database that contains all of the veterans in the VA health care system that can be accessed by the attending physician. The commenter added that the chip in the veteran's VA or Veterans Choice Program card can be used for this purpose. Similarly, one commenter recommended that VA patient identification cards contain all the data related to the veteran's status, including priority group, enrollment status for the Veterans Choice Program (40 mile rule), and disability rating. The commenter also stated that if a care center or doctor accepts Medicare or Medicaid, they should also accept any authorized care, including Veterans Choice and Tri-West. Several commenters similarly stated that veterans should automatically receive urgent care at any non-VA entity or provider in the country by simply showing the VA card with the veteran's picture on it, and getting reimbursed by

VA, rather than having to drive to the VA facility miles away. With today's technology, the commenter indicated that a veteran should not be making calls to arrange or confirm care. These comments all deal with programs or benefits that are beyond the scope of this rulemaking. While VA provides the Veteran Health Identification Card (VHIC) for veterans enrolled in the VA health care system, VA is not an insurance program and the cards do not provide proof of health insurance coverage. VA does not place the veteran's personal or medical information on electronic chips embedded in VA issued cards; instead, VA utilizes a secure national database available to VA clinicians and staff charged with the responsibility for providing care and services to eligible veterans. We are not making any changes based on these comments.

One commenter indicated that they highly recommend physical therapy assistants and occupational therapy assistants as TRICARE providers. The commenter added that both health care professionals are supervised by physical therapists and occupational therapists and are an underutilized health care resource. The use of physical therapy assistants and occupational therapy assistants as TRICARE providers is beyond the scope of the proposed rule. We are not making any changes based on this comment.

One commenter was concerned with what constitutes having received health care for purposes of meeting the 24-month eligibility requirement. Another commenter did not believe VA should limit the urgent care to veterans seen by VA within the last 24 months. The eligibility requirement is set forth in 38 U.S.C. 1725A(b), and VA cross-referenced this requirement in its proposed rule without further elaboration. However, as we explained, this provision of law requires the veteran be enrolled in VA's health care system and have received care under chapter 17 within the 24-month period preceding the furnishing of walk-in or urgent care. This latter requirement would be met in any of the following circumstances: Care provided in a VA facility, care authorized by VA performed by a community provider, care reimbursed under VA's Foreign Medical Program (38 U.S.C. 1724) or an emergency treatment authority (38 U.S.C. 1725 or 1728) care furnished by a State Veterans Home, or urgent care furnished under this authority. A commenter also questioned what does not constitute received health care for purposes of meeting the 24-month eligibility requirement. Any care

furnished to a veteran that is not furnished under a provision in chapter 17 of title 38, United States Code, would not satisfy the requirement in section 1725A(b)(2). We are not making any changes based on these comments.

Another commenter was concerned that the proposed rule would exclude veterans who receive care under the Foreign Medical Program because they might not meet the 24-month requirement. The commenter recommended that the rule be amended to specifically state that eligible veterans include those in the Foreign Medical Program. As previously stated the Foreign Medical Program is covered under the 24-month eligibility requirement stated in section 1725A. We are not making any changes based on these comments.

Another commenter stated that it would be nice if urgent care also applies to disabled veteran expatriates. The commenter added that currently even 100 percent disabled veterans not living in the United States covered by the Foreign Medical Program are not truly covered. VA currently does not have contracts in foreign countries. Section 1725A(c) requires that VA have contracts in place to provide the urgent care benefit. Consequently, without such contracts, VA cannot furnish urgent care through the Foreign Medical Program. We are not making any changes based on this comment.

One commenter stated that TRICARE and CHAMPVA require enrollment in Medicare Part B when eligible. The commenter questioned why VA did not require veterans to enroll in Medicare Part B, when eligible, and added that this would help offset the cost of non-VA provided care. Section 1725A of 38 U.S.C. provides that any enrolled veteran who has received care in the last 24-months is eligible for the new urgent care benefit. Section 1725A does not require the veteran to have other health insurance coverage, and we do not believe we have the authority to impose such a requirement under this authority. We are not making any changes based on this comment.

Another commenter stated that all veterans should be given Medicare with the Part B supplemental at no cost to allow veterans to use any private hospital in our nation. Another commenter similarly stated that VA needs to let Medicare take over billing for veterans and not have money assigned to Medicare, VA care, and then payments under contracts for such things as the Veterans Choice Program and the Veterans Community Care Program. VA does not oversee or implement the Medicare program, and

CMS does not have authority to operate programs on VA's behalf. Further these comments are beyond the scope of the proposed rule. We are not making any changes based on this comment.

One commenter suggested that travel not be paid for veterans who use urgent care. Beneficiary travel is regulated under 38 CFR 70.1 through 70.50 and the purpose of the program is to make payments for travel expenses incurred in the United States to help veterans and other persons obtain care or services from VA. Eligible veterans who seek urgent care may also qualify for beneficiary travel if they meet the requirements of § 70.10. We are not making any changes based on this comment.

Another commenter stated that VA needs to increase the rate it pays for beneficiary travel. The commenter also stated that there should be more programs for helping veterans updating their houses. The commenter also stated that they were not able to obtain an emotional support dog. The proposed rule addressed urgent care authorized by 38 U.S.C. 1725A. These concerns are beyond the scope of the proposed rule. We are not making any changes based on these comments.

One commenter stated that more information is needed to evaluate whether or not the new urgent care benefit will improve health care outcomes or inadvertently harm veterans, particularly those who are older and disabled. The commenter further stated that older adults with multiple morbidities are better served in a continuity system and use of disconnected urgent care visits should not be encouraged. Section 1725A authorizes VA to provide urgent care to eligible veterans. The scope of services available under this program, and the range of providers who can furnish this care, will necessarily be limited to some degree, and patient health will be monitored by VA clinical staff to ensure eligible veterans who use this benefit receive continuous, necessary care. We are not making any changes based on this comment.

Another commenter recommended expanding Medicare's definition of urgent care entities and including primary care clinics and emergency room departments with fast-tracks for urgent care needs. In defining qualifying non-VA entities or providers, VA is utilizing the billing codes CMS has developed for walk-in retail health clinics and urgent care centers. To the suggestion that VA include primary care clinics and emergency room departments with fast tracks for urgent care, VA may consider these facilities as

qualifying non-VA entities or providers as long as they utilize CMS billing codes 17 or 20. We are not making any changes based on this comment.

Another commenter stated that any walk-in clinic pilot or analysis should include the input of all key stakeholders, including labor representatives of frontline employees who are tasked with providing, arranging, and coordinating care as well as VSOs. The rulemaking process is meant to ensure stakeholders are allowed to provide input for the regulations of this new benefit. VA provided a 30-day comment period for this rulemaking. All interested stakeholders were able to submit a comment. VA notes that it has used caution and has thoroughly reviewed the comments we received. VA will provide educational material on the changes to health care and services under section 1725A. This material will be widely distributed in a variety of formats through an aggressive communications plan with VA's internal and external stakeholders including VA staff and Veteran Service Organizations. We are not making any changes based on this comment.

Another commenter supported the efforts to expand access for veterans to non-VA care facilities for immediate, time-sensitive care and requested that VA take this opportunity to begin the long-delayed coordination with Urban Indian Health Programs (UIHP) to address these needs. The commenter supports the inclusion of section 1725A(c)(1) to clearly define when an eligible veteran can access time-sensitive care and VA's decision to allow such care to be furnished without prior approval from VA. The commenter added that VA has never fully implemented the VA-Indian Health Service Memorandum of Understanding (MoU) for UIHPs. The commenter stated that VA must expeditiously implement this MoU so that UIHPs can be reimbursed for providing culturally competent care (including culturally competent urgent care) to the American Indian and Alaska Native veterans residing in urban areas. The commenter stated that VA should ensure that opportunities and new programs that seek to expand access to care for veterans are inclusive of UIHPs. The MoU for UIHPs is beyond the scope of the proposed rule, which only addresses urgent care authorized under section 1725A.

This commenter was concerned that the proposal to define urgent care to encompass walk-in care will hinder the ability of UIHPs to provide services under this program—again leaving

UIHPs out of the equation. The proposal to define urgent care to encompass walk-in care will have no effect if UIHPs can provide the services and qualify to be part of our contracted network. As previously explained, VA is defining urgent care to mean, in general, those services available at facilities that submit claims utilizing the Medicare Place of Service (POS) codes 17 and 20. We welcome UIHPs to apply to be part of the contracted network of care to help meet the needs of veterans. We are not making any changes to the rule based on this comment.

Comments on the Rulemaking Process

Several commenters opposed the shortened public comment period, stating that it was a devious and underhanded way to restrict the ability of the public to review and comment and to limit the number of comments received in opposition, as it is obvious this proposal would be greatly opposed. One commenter added that the sole and very obvious purpose of the shortened comments period was to make it appear that not many people actually oppose this new proposal, and thus ensure its adoption. As we explained in the proposed rule, we believe that a 30-day comment period was appropriate because it would allow the Secretary to expedite the commencement of this new benefit, thereby increasing access to health care for eligible veterans. We also note that we received more than 3,000 comments during this 30-day period, and we believe these comments came from a wide cross-section of the public. Therefore, we consider the 30-day comment period adequate and appropriate.

One commenter stated that the proposed rule was too complicated and that the rule should be simplified. VA understands that some veterans may need assistance in understanding how to obtain urgent care. As part of the implementation process of the rule, VA will establish a website that will state the locations of qualifying non-VA entities or providers where eligible veterans may receive urgent care in their community. Veterans may also call their local VA medical facility for additional assistance in obtaining information on urgent care. We are not making any changes based on this comment.

Several commenters made remarks on the proposed rule but did not provide additional information on their comment. In particular, commenters stated that they looked forward to seeing veterans get the care they deserve but provided no additional information. Other commenters opposed the rulemaking but did not explain the basis

for their opposition. Several commenters simply stated that veterans should be honored. Other commenters made non-substantive comments that VA considers inappropriate due to language and content and will not be addressed in this final rule. We are not making any changes based on these comments.

Based on the rationale set forth in the **SUPPLEMENTARY INFORMATION** to the proposed rule and in this final rule, VA is adopting the proposed rule with the edits described in this rulemaking.

Effect of Rulemaking

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

Paperwork Reduction Act

This rulemaking does not contain any provisions constituting collections of information under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3521).

Regulatory Flexibility Act

The Secretary hereby certifies that this final rule does not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act, 5 U.S.C. 601–612. This final rule does not have a significant economic impact on qualifying non-VA entities or providers. To the extent there is any such impact, it would result in increased business and revenue for them based on voluntary entry into contracts to provide care. We also do not believe there will be a significant economic impact on insurance companies, as claims would only be submitted for care that would otherwise have been received if the veteran had received this care in a primary care visit. Therefore, pursuant to 5 U.S.C. 605(b), this rulemaking is exempt from the initial and final regulatory flexibility analysis requirements of 5 U.S.C. 603 and 604.

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 the Office of Management and Budget (OMB), as any regulatory action that is likely to result in a rule that may: (1) Have an annual effect on the economy of \$100 million or more or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities; (2) Create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; (3) Materially alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) Raise novel legal or policy issues arising out of legal mandates, the President’s priorities, or the principles set forth in the Executive Order.

VA has examined the economic, interagency, budgetary, legal, and policy implications of this regulatory action and determined that the action is an economically significant regulatory action under Executive Order 12866. VA’s regulatory impact analysis can be found as a supporting document at <http://www.regulations.gov>, usually within 48 hours after the rulemaking document is published. Additionally, a copy of the rulemaking and its regulatory impact analysis are available on VA’s website at <http://www.va.gov/orpm> by following the link for VA Regulations Published from FY 2004 through FYTD. This final rule is considered an E.O. 13771 regulatory action. Details on the estimated costs of this final rule can be found in the rule’s economic analysis. VA has determined that the net costs are \$34.3 million over a five-year period (FY2019–FY2023) and \$6.8 million 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 final rule will have no such effect on State, local, and tribal governments, or on the private sector.

Congressional Review Act

The Secretary of Veterans Affairs finds that there is good cause under the provisions of 5 U.S.C. 808(2) to publish this final rule without full, prior Congressional review under 5 U.S.C. 801 and to make the rule effective on June 6, 2019. Specifically, the Secretary finds that it would be contrary to the public interest to delay the date this rule could be operative and effective because any delay in implementing the rule would have a severe and detrimental impact on eligible veterans’ health care.

This rule will grant eligible veterans access to urgent and walk-in care from qualifying non-VA entities or providers without prior approval from VA. This rulemaking will implement the mandates of 38 U.S.C. 1725A, as added by section 105 of the VA MISSION Act of 2018, and make it easier for eligible veterans to readily and quickly access health care in their communities.

The VA MISSION Act of 2018 provides that VA may not use the authority granted by section 101 of the Veterans Access, Choice, and Accountability Act of 2014 (Pub. L. 113–146; 38 U.S.C. 1701 note, as amended) to furnish care and service after June 6, 2019. And the statute defining and authorizing the new Veterans Community Care Program (38 U.S.C. 1703) will not go into effect until VA promulgates regulations under section 101(c) of the VA MISSION Act of 2018. If VA does not have regulations implementing the new Veterans Community Care Program in place on June 6, 2019, then, the only authority it would have to authorize the vast majority of care in the community would be the existing section 1703. Under this statute, VA could not furnish care as envisioned by section 101 of the VA MISSION Act of 2018. The provisions in the existing section 1703, as well as its implementing regulations, do not provide anywhere near a sufficient legal basis to meet the requirements of the VA MISSION Act of 2018, or the Veterans Choice Program, in areas such as eligibility, appeals, and payment rates. Executing a program inconsistent with both existing section 1703 and its regulations would present significant risks and challenges.

Although a separate rulemaking with distinct eligibility criteria and benefits is published elsewhere in this issue of the **Federal Register**, this rule is integral to the development of VA’s comprehensive Veterans Community

Care Program (RIN 2900–AQ46) under 38 U.S.C. 1703, as amended by section 101 of the VA MISSION Act of 2018. Taken together, these rules develop the system of access to health care in the community called for by the VA MISSION Act of 2018. The urgent care benefit will complement the new Veterans Community Care Program because the Veterans Community Care Program provides access to care generally and the urgent care benefit will allow timely access to urgent care to create a comprehensive community care program offering access to multiple levels of necessary care. In this regard, the Veterans Community Care Program requires preauthorization and referral for community care. Under the Veterans Community Care Program, VA technically can send eligible veterans to urgent care facilities, but the referral and scheduling takes time and may not be able to accommodate a same day visit on a weekend. However, the urgent care benefit will allow eligible veterans to go directly to a qualifying non-VA entity or provider to receive same-day treatment for urgent care. Therefore, the urgent care benefit is a necessary component for eligible veterans to be able to access this level of care in a timely manner as part of a comprehensive community care program. The VA MISSION Act of 2018 sets an expectation that the urgent care and traditional, routine care authorized through the Veterans Community Care Program will work together to provide eligible veterans with greater choice and access starting on June 6, 2019.

VA also believes that unacceptable risk to eligible veterans' health and well-being would be created by delaying implementation of the urgent and walk-in benefit. Approximately one third of veterans live in rural or highly rural areas, and access to local, walk-in options in urgent situations prevents care delays and detrimental health outcomes. The urgent and walk-in care benefit is an important part of the statutory scheme that Congress enacted to address this distance barrier (among other barriers to eligible veterans' care), and VA does not wish to impose a burden on veterans by delaying the availability of this care option.

Further, the message that urgent care and traditional, routine care coordinated through the Veterans Community Care Program will work together to provide eligible veterans with greater choice and access beginning on June 6, 2019 has been amplified by stakeholders, including Veterans Service Organizations. VA believes that eligible veterans understand and are relying upon this synergy. Eligible veterans'

belief that the two options for care are interconnected is evidenced by the numerous comments VA received on this rulemaking that offered suggestions and recommendations for separate rulemaking describing the general Veterans Community Care Program. Even with a comprehensive communications strategy, delaying urgent care implementation would create a risk of confusion by eligible veterans. Based on the expectation of simultaneous delivery no later than June 6, 2019, set forth in the Act and now amplified, eligible veterans may seek urgent care prior to implementation and face unexpected financial burden from the cost of urgent care visits. For those eligible veterans without insurance, this could result in serious financial hardship. Conversely, eligible veterans who learn of the delay in implementation could postpone care due to the cost and risk potentially serious health complications. Also, urgent care will be provided in locations that are convenient to the veteran, without having to solely rely on VA medical facilities to receive care. Thus, RIN 2900–AQ46 Veterans Community Care Program and RIN 2900–AQ47 Urgent Care must be implemented simultaneously to improve eligible veterans' health care, achieve Congressional objectives, and support comprehensive access to care, and it would be contrary to the public interest to delay the effective date of the final rule to allow for the Congressional review contemplated by the Congressional Review Act.

Accordingly, the Secretary finds it would be contrary to the public interest to delay the effective date of AQ47 and that there is good cause to dispense with the opportunity for a 60-day period of prior Congressional review and to publish this final rule with an operative and effective date of June 6, 2019.

Administrative Procedure Act

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

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; 64.012, Veterans Prescription Service; 64.013, Veterans Prosthetic Appliances; and 64.018, Sharing Specialized Medical Resources.

List of Subjects in 38 CFR Part 17

Administrative practice and procedure, Claims, Day care, Dental health, Government contracts, Health care, Health facilities, Health professions, Health records, Mental health programs, Nursing homes, Reporting and recordkeeping requirements, 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 April 10, 2019, for publication.

Dated: May 29, 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 are amending 38 CFR part 17 as follows:

PART 17—MEDICAL

■ 1. The authority citation for part 17 is amended by adding entries for §§ 17.105, 17.108, and 17.4600 to read in part as follows:

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

* * * * *

Section 17.105 is also issued under 38 U.S.C. 501, 1721, 1722A, 1724, and 1725A.

Section 17.108 is also issued under 38 U.S.C. 501, 1710, 1725A, 1730A, Sec. 101, Pub. L. 113–146, 128 Stat. 1754.

* * * * *

Section 17.4600 is also issued under 38 U.S.C. 1725A.

§ 17.105 [Amended]

- 2. Amend § 17.105 by:
- a. In paragraph (c), removing “or 17.111” and adding in its place “17.111, or 17.4600”.
 - b. Removing the authority citation at the end of the section.
- 3. Amend § 17.108 by:
- a. Revising paragraph (e) introductory text.
 - b. Removing the authority citation at the end of the section.

The revision reads as follows:

§ 17.108 Copayments for inpatient hospital care and outpatient medical care.

* * * * *

(e) *Services not subject to copayment requirements for inpatient hospital care, outpatient medical care, or urgent care.* The following are not subject to the copayment requirements under this section or, except for § 17.108(e)(1), (2), (4), (10), and (14), the copayment requirements under § 17.4600.

* * * * *

■ 4. Add § 17.4600 to read as follows:

§ 17.4600 Urgent care.

(a) *Purpose.* The purpose of this section is to establish procedures for accessing urgent care. Eligible veterans may obtain urgent care, in accordance with the requirements and processes set forth in this section, from qualifying non-VA entities or providers in VA's network that are identified by VA in accordance with paragraph (c)(2) of this section.

(b) *Definitions.* The following definitions apply to this section.

(1) *Eligible veteran* means a veteran described in 38 U.S.C. 1725A(b).

(2) *Episodic care* means care or services provided in a single visit to an eligible veteran for a particular health condition, or a limited set of particular health conditions, without an ongoing relationship being established between the eligible veteran and qualifying non-VA entities or providers.

(3) *Longitudinal management of conditions* means outpatient care that addresses important disease prevention and treatment goals and is dependent upon bidirectional communications that are ongoing over an extended period of time. For purposes of this section, the term "longitudinal management of conditions" and "longitudinal care" are synonymous.

(4) *Qualifying non-VA entity or provider* means a non-VA entity or provider, including Federally-qualified health centers as defined in 42 U.S.C. 1396d(l)(2)(B), that has entered into a contract, agreement, or other arrangement with the Secretary to furnish urgent care under this section, or has entered into an agreement with a third-party administrator with whom VA has a contract to furnish such care.

(5) *Urgent care* means services provided by a qualifying non-VA entity or provider, and as further defined in paragraphs (b)(5)(i) through (iv) of this section.

(i) Urgent care includes service available from entities or providers submitting claims for payment as a walk-in retail health clinic (Centers for Medicare and Medicaid Services (CMS) Place of Service code 17) or urgent care facility (CMS Place of Service code 20);

(ii)(A) Except as provided in paragraph (b)(5)(ii)(B) or (b)(5)(iv) of this

section, urgent care does not include preventive health services, as defined in section 1701(9) of title 38, United States Code, dental care, or chronic disease management.

(B) Urgent care includes immunization against influenza (flu shots), as well as therapeutic vaccines that are necessary in the course of treatment of an otherwise included service and screenings related to the treatment of symptoms associated with an immediate illness or exposure.

(iii) Urgent care may only be furnished as episodic care for eligible veterans needing immediate non-emergent medical attention, and it does not include longitudinal care. Veterans requiring follow-up care as a result of an urgent care visit under this section must contact VA or their VA-authorized primary care provider to arrange such care.

(iv) If VA determines that the provision of additional services is in the interest of eligible veterans, based upon identified health needs, VA may offer such additional services under this section as VA determines appropriate. Such services may be limited in duration and location. VA will inform the public through a **Federal Register** document, published as soon as practicable, and other communications, as appropriate.

(c) *Procedures.* (1)(i)(A) Eligible veterans may receive urgent care under this section without prior approval from VA.

(B) Eligible veterans must declare at each episode of care if they are using this benefit prior to receiving urgent care under this section.

(2) VA will publish a website providing information on urgent care, including the names, locations, and contact information for qualifying non-VA entities or providers from which urgent care is available under this section.

(3) In general, eligibility under this section does not affect eligibility for hospital care or medical services under the medical benefits package, as defined in § 17.38, or other benefits addressed in this title. Nothing in this section waives the eligibility requirements established in other statutes or regulations.

(4) Urgent care furnished under this section must meet VA's standards for quality established under 38 U.S.C. 1703C, as applicable.

(d) *Copayment.* (1) Except as provided in paragraphs (d)(2) and (3) of this section, an eligible veteran, as a condition for receiving urgent care provided by VA under this section, must agree to pay VA (and is obligated to pay VA) a copayment of \$30:

(i) After three visits in a calendar year if such eligible veteran is enrolled under § 17.36(b)(1) through (6), except those veterans described in § 17.36(d)(3)(iii) for all matters not covered by priority category 6.

(ii) If such eligible veteran is enrolled under § 17.36(b)(7) or (8), including veterans described in § 17.36(d)(3)(iii).

(2) An eligible veteran who receives urgent care under paragraph (b)(5)(iv) of this section or urgent care consisting solely of an immunization against influenza (flu shot) is not subject to a copayment under paragraph (d)(1) of this section and such a visit shall not count as a visit for purposes of paragraph (d)(1)(i) of this section.

(3) If an eligible veteran would be required to pay more than one copayment under this section, or a copayment under this section and a copayment under § 17.108 or § 17.111, on the same day, the eligible veteran will only be charged the higher copayment.

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

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

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

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

(f) *Payments.* Payments made for urgent care constitute payment in full and shall extinguish the veteran's liability to the qualifying non-VA entity or provider. The qualifying non-VA entity or provider may not impose any additional charge on a veteran or his or her health care insurer for any urgent care service for which payment is made by VA. This section does not abrogate VA's right, under 38 U.S.C. 1729, to recover or collect from a third party the reasonable charges of the care or services provided under this section.

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