Custom Federal Regulations Service™

This is supplemental material for Book I of your set of Federal Regulations

Title 38, Parts 17, 46, 47, 51–53, 58–62, 70, 71, and 200

Medical

Veterans Benefits Administration

Supplement No. 74

Covering period of *Federal Register* issues through January 1, 2013

Need Assistance?

Questions concerning **MISSING SUPPLEMENTS**, need for **ADDITIONAL BOOKS**, and other **DISTRIBUTION LIST** issues for this loose-leaf service should be directed to:

Department of Veterans Affairs
Veterans Benefits Administration
Administration
Mail Code: 20M33
810 Vermont Avenue, N.W.
Washington DC 20420
Telephone: 202/273-7588
Fax: 202/275-5947
E-mail: coarms@vba.va.gov

Questions concerning the **FILING INSTRUCTIONS** for this loose-leaf service, or the reporting of **SUBSTANTIVE ERRORS** in the text, may be directed to:

Jonathan Publishing
660 Laurel Street, B-103
Baton Rouge LA 70802
Telephone: 225-205-5873
Fax: 702-993-6003
E-mail: info@jonpub.com

GENERAL INSTRUCTIONS

Custom Federal Regulations Service™

Supplemental Materials for *Book I*

Code of Federal Regulations
Title 38, Parts 17, 46, 47, 51–53, 58–62, 70, 71, and 200

Medical

Veterans Benefits Administration

Supplement No. 74

5 January 2013

Covering the period of Federal Register issues
through January 1, 2013

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

To ensure accuracy and timeliness of your materials, it is important that you follow these simple procedures:

1. Always file your supplemental materials immediately upon receipt.

2. Before filing, always check the Supplement Filing Record (page I-8) to be sure that all prior supplements have been filed. If you are missing any supplements, contact the Veterans Benefits Administration at the address listed on page I-2.

3. After filing, enter the relevant information on the Supplement Filing Record sheet (page I-8)—the date filed, name/initials of filer, and date through which the *Federal Register* is covered.

4. If as a result of a failure to file, or an undelivered supplement, you have more than one supplement to file at a time, be certain to file them in chronological order, lower number first.

5. Always retain the filing instructions (simply insert them at the back of the book) as a backup record of filing and for reference in case of a filing error.

6. Be certain that you *permanently discard* any pages indicated for removal in the filing instructions in order to avoid confusion later.

To execute the filing instructions, simply remove *and throw away* the pages listed under *Remove These Old Pages,* and replace them in each case with the corresponding pages from this supplement listed under *Add These New Pages*. Occasionally new pages will be added without removal of any old material (reflecting new regulations), and occasionally old pages will be removed without addition of any new material (reflecting rescinded regulations)—in these cases the word *None* will appear in the appropriate column.

FILING INSTRUCTIONS

Book I, Supplement No. 74
January 5, 2013

Remove these old pages	*Add these new pages*	*Section(s) Affected*
Do not file this supplement until you confirm that all prior supplements have been filed		
INDEX-11 to INDEX-12	INDEX-11 to INDEX-12	Book I Index
17.52-1 to 17.54-1	17.52-1 to 17.54-1	§17.52
17.110-1 to 17.110-2	17.110-1 to 17.110-2	§17.110
51.INDEX-1 to 51.INDEX-2	51.INDEX-1 to 51.INDEX-2	Part 51 Index
51.41-1 to 51.41-**2**	51.41-1 to 51.41-**4**	§51.41
53.10-1 to 53.41-2	53.10-1 to 53.41-2	§§53.10, 53.11, 53.20, 53.30, 53.40 and 53.41

Be sure to complete the *Supplement Filing Record* (page I-9) when you have finished filing this material.

HIGHLIGHTS

Book I, Supplement No. 74
January 5, 2013

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

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

Modifications in this supplement include the following:

1. On 28 November 2012 the VA published a direct final rule effective 28 January 2013, to amend its regulation governing payment by VA for non-VA outpatient care under VA's statutory authority to provide non-VA care. Change:

- In §17.52, revised paragraph (a)(2)(ii).

2. On 6 December 2012 the VA published an interim final rule effective 2 February 2013, to amend its regulations to allow VA to enter into contracts or provider agreements with State homes for the nursing home care of certain disabled veterans. Change:

- Revised §51.41.

3. On 10 December 2012 the VA published a final rule effective that same day, to amend its regulations governing VA assistance in hiring and retaining nurses in State Veterans Homes. These regulations must be updated because of recent changes to the Veterans Health Administration (VHA) organizational structure, which reassigned certain administrative duties of the Chief Consultant of the Office of Geriatrics and Extended Care to the Director of the Office of Geriatrics and Extended Care Operations. Changes:

- Revised §53.10,
- In §53.11, revised paragraph (a)(5),
- In §53.20, revised paragraph (a),
- In §53.30, revised paragraph (b),
- Revised §53.40, and
- Revised §53.41.

4. On 31 December 2012 the VA published an interim final rule effective that same day, to amend its regulations concerning the copayment required for certain medications. Change:

- In §17.110, revised paragraphs (b)(1)(ii), (b)(1)(iii), (b)(1)(iv) and (b)(2).

☼

Health Care Benefits for Certain Children of Vietnam Veterans and Veterans with Covered Service in Korea—Spina Bifida and Covered Birth Defects

Payment or Reimbursement for Emergency Services for Nonservice-Connected Conditions in Non-VA Facilities

Part 46 — Policy Regarding Participation in National Practitioner Data Bank

Subpart A — General Provisions

Subpart B — National Practitioner Data Bank Reporting

Subpart C — National Practitioner Data Bank Inquiries

Part 47 — Policy Regarding Reporting Health Care Professionals to State Licensing Boards

Part 51—Per Diem for Nursing Home Care of Veterans In State Homes

Use of Public or Private Hospitals

§17.52 Hospital care and medical services in non-VA facilities.

(a) When VA facilities or other government facilities are not capable of furnishing economical hospital care or medical services because of geographic inaccessibility or are not capable of furnishing care or services required, VA may contract with non-VA facilities for care in accordance with the provisions of this section. When demand is only for infrequent use, individual authorizations may be used. Care in public or private facilities, however, subject to the provisions of §§17.53, 17.54, 17.55 and 17.56, will only be authorized, whether under a contract or an individual authorization, for:

(1) Hospital care or medical services to a veteran for the treatment of:

(i) A service-connected disability; or

(ii) A disability for which a veteran was discharged or released from the active military, naval, or air service or

(iii) A disability of a veteran who has a total disability permanent in nature from a service-connected disability, or

(iv) For a disability associated with and held to be aggravating a service-connected disability, or

(v) For any disability of a veteran participating in a rehabilitation program under 38 U.S.C. ch. 31 and when there is a need for hospital care or medical services for any of the reasons enumerated in §17.48(j). (Authority: 38 U.S.C. 1703, 3104; sec. 101, Pub. L. 96-466; sec. 19012, Pub. L. 99-272)

(2) Medical services for the treatment of any disability of:

(i) A veteran who has a service-connected disability rated at 50 percent or more,

(ii) A veteran who has been furnished hospital care, nursing home care, domiciliary care, or medical services, and requires medical services to complete treatment incident to such care or services (each authorization for non-VA treatment needed to complete treatment may continue for up to 12 months, and new authorizations may be issued by VA as needed), and

(iii) A veteran of the Mexican border period or World War I or who is in receipt of increased pension or additional compensation based on the need for aid and attendance or housebound benefits when it has been determined based on an examination by a physician employed by VA (or, in areas where no such physician is available, by a physician carrying out such function under a contract or fee arrangement), that the medical condition of such veteran precludes appropriate treatment in VA facilities; (Authority: 38 U.S.C. 1703; sec. 19012, Pub. L. 99-272)

(3) Hospital care or medical services for the treatment of medical emergencies which pose a serious threat to the life or health of a veteran receiving hospital care or medical services in a facility over which the Secretary has direct jurisdiction or government facility with which the Secretary contracts, and for which the facility is not staffed or equipped to perform.

and transfer to a public or private hospital which has the necessary staff or equipment is the only feasible means of providing the necessary treatment, until such time following the furnishing of care in the non-VA facility as the veteran can be safely transferred to a VA facility; (Authority: 38 U.S.C. 1703; sec. 19012, Pub. L. 99-272)

(4) Hospital care for women veterans; (Authority: 38 U.S.C. 1703; sec. 19012, Pub. L. 99-272)

(5) Through September 30, 1988, hospital care or medical services that will obviate the need for hospital admission for veterans in the Commonwealth of Puerto Rico, except that the dollar expenditure in Fiscal year 1986 cannot exceed 85% of the Fiscal year 1985 obligations, in Fiscal year 1987 the dollar expenditure cannot exceed 50% of the Fiscal year 1985 obligations and in Fiscal year 1988 the dollar expenditure cannot exceed 25% of the Fiscal year 1985 obligations. (Authority: 38 U.S.C. 1703; sec. 102, Pub. L. 99-166; sec. 19012, Pub. L. 99-272)

(6) Hospital care or medical services that will obviate the need for hospital admission for veterans in Alaska, Hawaii, Virgin Islands and other territories of the United States except that the annually determined hospital patient load and incidence of the furnishing of medical services to veterans hospitalized or treated at the expense of VA in government and non-VA facilities in each such State or territory shall be consistent with the patient load or incidence of the provision of medical services for veterans hospitalized or treated by VA within the 48 contiguous States. (Authority: 38 U.S.C. 1703; sec. 19012, Pub. L. 99-272)

(7) Outpatient dental services and treatment, and related dental appliances, for a veteran who is a former prisoner of war and was detained or interned for a period of not less that 181 days. (Authority: 38 U.S.C. 1703; sec. 19012, Pub. L. 99-272)

(8) Hospital care or medical services for the treatment of medical emergencies which pose a serious threat to the life or health of a veteran which developed during authorized travel to the hospital, or during authorized travel after hospital discharge preventing completion of travel to the originally designated point of return (and this will encompass any other medical services necessitated by the emergency, including extra ambulance or other transportation which may also be furnished at VA expense. (Authority: 38 U.S.C. 1701(5))

(9) Diagnostic services necessary for determination of eligibility for, or of the appropriate course of treatment in connection with, furnishing medical services at independent VA outpatient clinics to obviate the need for hospital admission. (Authority: 38 U.S.C. 1703; sec. 19012, Pub. L. 99-272)

(10) For any disability of a veteran receiving VA contract nursing home care. The veteran is receiving contract nursing home care and requires emergency treatment in non-VA facilities. (Authority: 38 U.S.C. 1703(a))

(11) For completion of evaluation for observation and examination (O&E) purposes, clinic directors or their designees will authorize necessary diagnostic services at non-VA facilities (on an inpatient or outpatient basis) in order to complete requests from VA Regional Offices for O&E of a person to determine eligibility for VA benefits or services.

(b) The Under Secretary for Health shall only furnish care and treatment under paragraph (a) of this section to veterans described in §17.47(d).

(1) To the extent that resources are available and are not otherwise required to assure that VA can furnish needed care and treatment to veterans described in §17.47(a) and (c), and

(2) If the veteran agrees to pay the United States an amount as determined in §17.48(e). (Authority: 38 U.S.C. 1703, 1710 and 1712; sec. 19011-19012, Pub. L. 99-272)

[51 FR 25066, July 10, 1986, as amended at 53 FR 32391, Aug. 25, 1988; 54 FR 53057, Dec. 27, 1989; 58 FR 32446, June 10, 1993. Redesignated and amended at 61 FR 21965, 21966, May 13, 1996; 62 FR 17072, Apr. 9, 1997; 75 FR 78915, Dec. 17, 2010; 77 FR 70895, Nov. 28, 2012]

Supplement *Highlights* references: 59(1), 74(1).

§17.53 Limitations on use of public or private hospitals.

The admission of any patient to a private or public hospital at Department of Veterans Affairs expense will only be authorized if a Department of Veterans Affairs medical center or other Federal facility to which the patient would otherwise be eligible for admission is not feasibly available. A Department of Veterans Affairs facility may be considered as not feasibly available when the urgency of the applicant's medical condition, the relative distance of the travel involved, or the nature of the treatment required makes it necessary or economically advisable to use public or private facilities. In those instances where care in public or private hospitals at Department of Veterans Affairs expense is authorized because a Department of Veterans Affairs or other Federal facility was not feasibly available, as defined in this section, the authorization will be continued after admission only for the period of time required to stabilize or improve the patient's condition to the extent that further care is no longer required to satisfy the purpose for which it was initiated.

[39 FR 17223, May 14, 1974, as amended at 47 FR 58248, Dec. 30, 1982. Redesignated at 61 FR 21965, May 13, 1996]

§17.54 Necessity for prior authorization.

(a) The admission of a veteran to a non-Department of Veterans Affairs hospital at Department of Veterans Affairs expense must be authorized in advance. In the case of an emergency which existed at the time of admission, an authorization may be deemed a prior authorization if an application, whether formal or informal, by telephone, telegraph or other communication, made by the veteran or by others in his or her behalf is dispatched to the Department of Veterans Affairs (1) for veterans in the 48 contiguous States and Puerto Rico, within 72 hours after the hour of admission, including in the computation of time Saturday, Sunday and holidays, or (2) for veterans in a noncontiguous State, territory or possession of the United States (not including Puerto Rico) if facilities for dispatch of application as described in this section are not available within the 72-hour period, provided the application was filed within 72 hours after facilities became available.

(b) When an application for admission by a veteran in one of the 48 contiguous States in the United States or in Puerto Rico has been made more than 72 hours after admission, or more than 72 hours after facilities are available in a noncontiguous State, territory of possession of the United States, authorization for continued care at Department of Veterans Affairs expense shall be effective as of the postmark or dispatch date of the application, or the date of any telephone call constituting an informal application.

[42 FR 55212, Oct. 14, 1977. Redesignated at 61 FR 21965, May 13, 1996]

§17.110 Copayments for medication.

(a) *General*. This section sets forth requirements regarding copayments for medications provided to veterans by VA.

(b) *Copayments*.

(1) *Copayment amount*. Unless exempted under paragraph (c) of this section, a veteran is obligated to pay VA a copayment for each 30-day or less supply of medication provided by VA on an outpatient basis (other than medication administered during treatment).

(i) For the period from January 1, 2010, through June 30, 2010, the copayment amount is $8.

(ii) For the period from July 1, 2010, through December 31, 2013, the copayment amount for veterans in priority categories 2 through 6 of VA's health care system (see §17.36) is $8.

(iii) For veterans in priority categories 7 and 8 of VA's health care system (see §17.36), the copayment amount from July 1, 2010, through December 31, 2013, is $9.

(iv) The copayment amount for all affected veterans for each calendar year after December 31, 2013, will be established by using the prescription drug component of the Medical Consumer Price Index as follows: For each calendar year, the Index as of the previous September 30 will be divided by the Index as of September 30, 2001 which was 304.8. The ratio so obtained will be multiplied by the original copayment amount of $7. The copayment amount for the new calendar year will be this result, rounded down to the whole dollar amount.

Note to Paragraph (b)(1)(iv): Example for determining copayment amount. The ratio of the prescription drug component of the Medical Consumer Price Index for September 30, 2005, to the corresponding Index for September 30, 2001 (304.8) was 1.1542. This ratio, when multiplied by the original copayment amount of $7 equals $8.08, and the copayment amount beginning in calendar year 2006, rounded down to the whole dollar amount, was set at $8.

(2) The total amount of copayments in a calendar year for a veteran enrolled in one of the priority categories 2 through 6 of VA's health care system (see §17.36) shall not exceed the cap established for the calendar year. During the period from January 1, 2010 through December 31, 2013, the cap will be $960. If the copayment amount increases after December 31, 2012, the cap of $960 shall be increased by $120 for each $1 increase in the copayment amount.

(3) *Information on copayment/cap amounts*. Current copayment and cap amounts are available at any VA Medical Center and on our Web site, *http://www.va.gov*. Notice of any increases to the copayment and corresponding increases to annual cap amount will be published in the *Federal Register*.

(c) *Medication not subject to the copayment requirements*. The following are exempt from the copayment requirements of this section:

(1) Medication for a veteran who has a service-connected disability rated 50% or more based on a service-connected disability or unemployability.

(2) Medication for a veteran's service-connected disability.

(3) Medication for a veteran whose annual income (as determined under 38 U.S.C. 1503) does not exceed the maximum annual rate of VA pension which would be payable to such veteran if such veteran were eligible for pension under 38 U.S.C. 1521.

(4) Medication authorized under 38 U.S.C. 1710(e) for Vietnam-era herbicide-exposed veterans, radiation-exposed veterans, Persian Gulf War veterans, or post-Persian Gulf War combat-exposed veterans.

(5) Medication for treatment of sexual trauma as authorized under 38 U.S.C. 1720D.

(6) Medication for treatment of cancer of the head or neck authorized under 38 U.S.C. 1720E.

(7) Medications provided as part of a VA approved research project authorized by 38 U.S.C. 7303.

(8) Medication for a veteran who is a former prisoner of war.

(9) A veteran who VA determines to be catastrophically disabled, as defined in 38 CFR 17.36(e). (Authority: 38 U.S.C. 501, 1710, 1720D, 1722A, 1730A)

[66 FR 63451, Dec. 6, 2001, as amended at 74 FR 69285, Dec. 31, 2009; 75 FR 32670, June 9, 2010; 75 FR 32672, June 9, 2010; 75 FR 54030, Sept. 3, 2010; 76 FR 9646, Feb. 22, 2011; 76 FR 52274, Aug. 22, 2011; 76 FR 78826, Dec. 20, 2011; 77 FR 76867, Dec. 31, 2012]

Supplement *Highlights* references: 53(1), 55(1), 57(1), 64(1), 66(2), 74(4).

51.INDEX-1

Part 51

Per Diem for Nursing Home Care of Veterans in State Homes

Authority: 38 U.S.C. 101, 501, 1710, 1741–1743, 1745.

Source: 65 Fed. Reg. 968, January 6, 2000, unless otherwise indicated.

— Section Title Index —

- o -

§51.41 Contracts and provider agreements for certain veterans with service-connected disabilities.

(a) *Contract or VA provider agreement required.* VA and State homes may enter into both contracts and provider agreements. VA will pay for each eligible veteran's care through either a contract or a provider agreement (called a "VA provider agreement"). Eligible veterans are those who:

(1) Are in need of nursing home care for a VA adjudicated service-connected disability, or

(2) Have a singular or combined rating of 70 percent or more based on one or more service-connected disabilities or a rating of total disability based on individual unemployability and are in need of nursing home care.

(b)*Payments under contracts.* Contracts under this section will be subject to this part to the extent provided for in the contract and will be governed by federal acquisition law and regulation. Contracts for payment under this section will provide for payment either:

(1) At a rate or rates negotiated between VA and the State home; or

(2) On request from a State home that provided nursing home care on August 5, 2012, for which the State home was eligible for payment under 38 U.S.C. 1745(a)(1), at a rate that reflects the overall methodology of reimbursement for such care that was in effect for the State home on August 5, 2012.

(c)*Payments under VA provider agreements.*

(1) State homes must sign an agreement to receive payment from VA for providing care to certain eligible veterans under a VA provider agreement. VA provider agreements under this section will provide for payments at the rate determined by the following formula. For State Homes in a metropolitan statistical area, use the most recently published CMS Resource Utilization Groups (RUG) case-mix levels for the applicable metropolitan statistical area. For State Homes in a rural area, use the most recently published CMS Skilled Nursing Prospective Payment System case-mix levels for the applicable rural area. To compute the daily rate for each State home, multiply the labor component by the State home wage index for each of the applicable case-mix levels; then add to that amount the non-labor component. Divide the sum of the results of these calculations by the number of applicable case-mix levels. Finally, add to this quotient the amount based on the CMS payment schedule for physician services. The amount for physician services, based on information published by CMS, is the average hourly rate for all physicians, with the rate modified by the applicable urban or rural geographic index for physician work, then multiplied by 12, then divided by the number of days in the year.

Note to paragraph (c)(1): The amount calculated under this formula reflects the prevailing rate payable in the geographic area in which the State home is located for nursing home care furnished in a non-Department nursing home (a public or private institution not under the direct jurisdiction of VA which furnishes nursing home care). Further, the formula for establishing

these rates includes CMS information that is published in the *Federal Register* every year and is effective beginning October 1 for the entire fiscal year. Accordingly, VA will adjust the rates annually.

(2) The State home shall not charge any individual, insurer, or entity (other than VA) for the nursing home care paid for by VA under a VA provider agreement. Also, as a condition of receiving payments under paragraph (c) of this section, the State home must agree not to accept drugs and medicines from VA provided under 38 U.S.C. 1712(d) on behalf of veterans covered by this section and corresponding VA regulations (payment under paragraph (c) of this section includes payment for drugs and medicines).

(3) Agreements under paragraph (c) of this section will be subject to this part, except to the extent that this part conflicts with this section. For purposes of this section, the term "per diem" in part 51 includes payments under provider agreements.

(4) If a veteran receives a retroactive VA service-connected disability rating and becomes a veteran identified in paragraph (a) of this section, the State home may request payment under the VA provider agreement for nursing home care back to the retroactive effective date of the rating or February 2, 2013, whichever is later. For care provided after the effective date but before February 2, 2013, the State home may request payment at the special per diem rate that was in effect at the time that the care was rendered.

(d) *VA signing official.* VA provider agreements must be signed by the Director of the VA medical center of jurisdiction or designee.

(e) *Forms.* Prior to entering into a VA provider agreement, State homes must submit to the VA medical center of jurisdiction a completed VA Form 10-10EZ, Application for Medical Benefits (or VA Form 10-10EZR, Health Benefits Renewal Form, if a completed VA Form 10-10EZ is already on file at VA), and a completed VA Form 10-10SH, State Home Program Application for Care—Medical Certification, for the veterans for whom the State home will seek payment under the provider agreement. After VA and the State home have entered into a VA provider agreement, forms for payment must be submitted in accordance with paragraph (a) of this section. VA Forms 10-10EZ and 10-10EZR are set forth in full at § 58.12 of this chapter and VA Form 10-10SH is set forth in full at § 58.13 of this chapter.

(The Office of Management and Budget has approved the information collection requirements in this section under control numbers 2900-0091 and 2900-0160.)

(f) *Termination of VA provider agreements.*

(1) A State home that wishes to terminate a VA provider agreement with VA must send written notice of its intent to the Director of the VA medical center of jurisdiction at least 30 days before the effective date of termination of the agreement. The notice shall include the intended date of termination.

(2) VA provider agreements will terminate on the date of a final decision that the home is no longer recognized by VA under § 51.30.

(g) *Compliance with Federal laws.* Under provider agreements entered into under this section, State homes are not required to comply with reporting and auditing requirements imposed under the Service Contract Act of 1965, as amended (41 U.S.C. 351,*et seq.*); however, State homes must comply with all other applicable Federal laws concerning employment and hiring practices including the Fair Labor Standards Act, National Labor Relations Act, the Civil Rights Acts, the Age Discrimination in Employment Act of 1967, the Vocational Rehabilitation Act of 1973, Worker Adjustment and Retraining Notification Act, Sarbanes-Oxley Act of 2002, Occupational Health and Safety Act of 1970, Immigration Reform and Control Act of 1986, Consolidated Omnibus Reconciliation Act, the Family and Medical Leave Act, the Americans with Disabilities Act, the Uniformed Services Employment and Reemployment Rights Act, the Immigration and Nationality Act, the Consumer Credit Protection Act, the Employee Polygraph Protection Act, and the Employee Retirement Income Security Act. (Authority: 38 U.S.C. 101, 501, 1710, 1720, 1741-1745; 42 U.S.C. 1395cc)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900-0160.)

[74 FR 19432, Apr. 29, 2009; as amended at 77 FR 72742, Dec. 6, 2012]

Supplement *Highlights* references: 47(1), 74(2).

Reserved

§53.10 Decision makers, notifications, and additional information.

The Director, Geriatrics and Extended Care Operations, will make all determinations regarding payments under this part, and will provide written notice to affected State representatives of approvals, denials, or requests for additional information under this part. (Authority: 38 U.S.C. 101, 501, 1744)

[73 FR 73561, Dec. 3, 2008, as amended at 77 FR 73313, Dec. 10, 2012]

Supplement *Highlights* reference: 74(3).

§53.11 General requirements for payments.

(a) VA will make payment under this part to a State for an employee incentive program to reduce the shortage of nurses at the SVH, when the following conditions are met:

(1) The State representative applies for payment in accordance with the provisions of §53.20;

(2) The SVH receives per diem payments from VA under the provisions of 38 U.S.C. 1741 for one or more of the following: Adult day health care, domiciliary care, hospital care, or nursing home care;

(3) The SVH has a nursing shortage that is documented by credible evidence, including but not limited to SVH records showing nursing vacancies, SVH records showing nurse overtime use, and reports documenting that nurses are difficult to hire in the local area and difficult to retain as employees at the SVH;

(4) The SVH does not use payments under this part to pay for all or part of a nurse's standard employee benefits, such as salary, health insurance, or retirement plan;

(5) The SVH provides to the Chief Director, Geriatrics and Extended Care Operations, documentation establishing that it has an employee incentive program that:

(i) Is likely to be effective in promoting the hiring and retention of nurses for the purpose of reducing nursing shortages at that home, and

(ii) Is in operation or ready for immediate implementation if VA payments are made under this part;

(6) The payment amount applied for by the State is no more than 50 percent of the funding for the employee incentive program during the Federal fiscal year;

(7) The SVH employee incentive program includes a mechanism to ensure that an individual receiving benefits under the program works at the SVH as a nurse for a period commensurate with the benefits provided, and, insofar as possible, the program is designed to eliminate any nursing shortage at the SVH within a 3-year period from the initiation of VA payments;

(8) The SVH, if it received payments under this part during a previous Federal fiscal year, has met the reporting requirements of §53.31(a) regarding such payments;

(9) The SVH credits to its employee incentive program any funds refunded to the SVH by an employee because the employee was in breach of an agreement for employee assistance funded with payments made under this part and the SVH credits the amount returned as a non-Federal funding source; and

(10) The project does not involve the construction, acquisition, expansion, remodeling or alteration of the SVH.

(b) VA intends to allow flexibility and innovation in determining the types of employee incentive programs at SVHs eligible for payments. Programs could include such things as the provision of short-term scholarships for continuing nursing education, sign-on bonuses for nurses, student loan forgiveness programs, and improvements to working conditions. In determining whether an employee incentive program is likely to be effective, VA will consider any information available, including past performance of the SVH's program funded by payments made under this part. (Authority: 38 U.S.C. 101, 501, 1744)

(The Office of Management and Budget has approved the information collection provisions in this section under control number 2900-0709.)

[73 FR 73561, Dec. 3, 2008, as amended at 77 FR 73313, Dec. 10, 2012]

Supplement *Highlights* reference: 74(3).

Next Section is §53.20

§53.20 Application requirements.

(a) To apply for payments during a Federal fiscal year, a State representative must submit to VA, in accordance with §53.40, a completed VA Form 10-0430 and documentation specified by the form (VA Form 10-0430 is available at VA medical centers and on the Internet at *http://www1.va.gov/geriatricsshg/* or may be obtained by contacting the Geriatrics and Extended Care Office at 202-461-6750, VHA Headquarters, 810 Vermont Avenue, NW., Washington, DC 20420). The submission for payments for a fiscal year must be received by VA during the last quarter (July 1–September 30) of the preceding fiscal year. The State must submit a new application for each fiscal year that the State seeks payments for an incentive program.

(b) As part of the application, the State representative must submit to VA evidence that the State has sufficient funding, when combined with the VA payments, to fully operate its employee incentive program through the end of the fiscal year. To meet this requirement, the State representative must provide to VA a letter from an authorized State official certifying that, if VA were to approve payments under this part, the non-VA share of the funds for the program would be by a date or dates specified in the certification, available for the employee incentive program without further State action to make such funds available. If the certification is based on a State law authorizing funds for the employee incentive program, a copy of the State law must be submitted with the certification.

(c) If an application does not contain sufficient information for a determination under this part, the State representative will be notified in writing (electronically and by mail) of any additional submission required and that the State has 30 calendar days from the date of the notice to submit such additional information or no further action will be taken. If the State representative does not submit all of the required information or demonstrate that he or she has good cause for failing to provide the information within 30 calendar days of the notice (which may extend beyond the last quarter of the preceding Federal fiscal year), then the State applicant will be notified in writing that the application for VA assistance will be deemed withdrawn and no further action will be taken. (Authority: 38 U.S.C. 101, 501, 1744)

(The Office of Management and Budget has approved the information collection provisions in this section under control number 2900-0709.)

[73 FR 73561, Dec. 3, 2008, as amended at 77 FR 73313, Dec. 10, 2012]

Supplement *Highlights* reference: 74(3).

Next Section is §53.30

§53.30 Payments.

(a) The amount of payments awarded under this part during a Federal fiscal year will be the amount requested by the State and approved by VA in accordance with this part. Payments may not exceed 50 percent of the cost of the employee incentive program for that fiscal year and may not exceed 2 percent of the amount of the total per diem payments estimated by VA to be made under 38 U.S.C. 1741 to the State for that SVH during that fiscal year for adult day health care, domiciliary care, hospital care, and nursing home care.

(b) Payments will be made by lump sum or installment as deemed appropriate by the Director, Geriatrics and Extended Care Operations.

(c) Payments will be made to the State or, if designated by the State representative, the SVH conducting the employee incentive program.

(d) Payments made under this part for a specific employee incentive program shall be used solely for that purpose. (Authority: 38 U.S.C. 101, 501, 1744)

[73 FR 73562, Dec. 3, 2008, as amended at 77 FR 73313, Dec. 10, 2012]

Supplement *Highlights* reference: 74(3).

§53.31 Annual report.

(a) A State receiving payment under this part shall provide to VA a report setting forth in detail the use of the funds, including a descriptive analysis of how effective the employee incentive program has been in improving nurse staffing in the SVH. The report shall be provided to VA within 60 days of the close of the Federal fiscal year (September 30) in which payment was made and shall be subject to audit by VA.

(b) A State receiving payment under this part shall also prepare audit reports as required by the Single Audit Act of 1984 (see 38 CFR part 41) and submit them to VA. (Authority: 38 U.S.C. 101, 501, 1744)

(The Office of Management and Budget has approved the information collection provisions in this section under control number 2900-0709.)

§53.32 Recapture provisions.

If a State fails to use the funds provided under this part for the purpose for which payment was made or receives more than is allowed under this part, the United States shall be entitled to recover from the State the amount not used for such purpose or the excess amount received. (Authority: 38 U.S.C. 101, 501, 1744)

Next Section is §53.40

§53.40 Submissions of information and documents.

All submissions of information and documents required to be presented to VA must be made to the Director, Geriatrics and Extended Care Operations, VHA Headquarters, 810 Vermont Avenue, NW., Washington, DC 20420. (Authority: 38 U.S.C. 101, 501, 1744)

(The Office of Management and Budget has approved the information collection provisions in this section under control number 2900-0709.)

[73 FR 73562, Dec. 3, 2008, as amended at 77 FR 73313, Dec. 10, 2012]

Supplement *Highlights* reference: 74(3).

§53.41 Notification of funding decision.

If the Director, Geriatrics and Extended Care Operations, determines that a submission from a State fails to meet the requirements of this part for funding, the Director shall provide written notice of the decision and the reasons for the decision. (Authority: 38 U.S.C. 101, 501, 1744)

[73 FR 73562, Dec. 3, 2008, as amended at 77 FR 73313, Dec. 10, 2012]

Supplement *Highlights* reference: 74(3).

End of Part 53

Reserved