

**DEPARTMENT OF VETERANS
AFFAIRS**

38 CFR Part 17

RIN 2900-AN55

**Reimbursement Offsets for Medical
Care or Services**

AGENCY: Department of Veterans Affairs.

ACTION: Final rule.

SUMMARY: This document amends the regulations of the Department of Veterans Affairs (VA) concerning the reimbursement of medical care and services delivered to veterans for nonservice-connected conditions. This rule applies in situations where third-party payers are required to reimburse VA for costs related to care provided by VA to a veteran covered under the third-party payer's plan. This final rule adds a new section barring offsets by third-party payers and requires that third-party payers submit a request for a refund for claims when there is an alleged overpayment.

DATES: *Effective Date:* July 25, 2011.

FOR FURTHER INFORMATION CONTACT: Anthony Norris, Program Analyst, Business Operations, Chief Business Office (168), Veterans Health Administration, Department of Veterans Affairs, 810 Vermont Avenue, NW., Washington, DC 20420, (202) 461-1593. (This is not a toll free number.)

SUPPLEMENTARY INFORMATION: Pursuant to 38 U.S.C. 1729, a third-party payer, such as a private medical insurer, has an obligation to pay the United States reasonable charges for the cost of medical care or services furnished to a veteran for a nonservice-connected disability when the veteran or the provider of the care or services would otherwise be eligible to receive payment for such medical care from the third-party payer. The obligation to pay is to the extent that the beneficiary would be eligible to receive such reimbursement or indemnification from the third-party payer if the beneficiary were to incur the costs on the beneficiary's own behalf. VA's authority under section 1729 is generally implemented in 38 CFR 17.101 through 17.105.

As a matter of common business practice, third-party payers who are (or who believe that they are) owed a refund from VA based on an overpayment often recoup such money by unilaterally offsetting a future payment amount to VA. As a purchaser and provider of care, VA medical centers incur these unilateral offsets in the ordinary course of their business. An offset occurs when the payer,

alleging that it made an earlier overpayment to VA, reduces or takes back the alleged overpayment by withholding payment owed to VA on an unrelated debt transaction. In an attempt to recoup the overpayment, the payer seldom associates the reduced payment with the alleged overpaid claim. These unilateral offsets by third-party payers disrupt VA accounting practices and present certain challenges to VA in managing third-party collections and evaluating account receivables for deficient payments. Further, such practices eliminate VA's opportunity to validate the alleged overpayment and pursue proper review, if deemed appropriate given the circumstances.

In a document published in the **Federal Register** on October 8, 2010 (75 FR 62348), we proposed to amend VA's regulations concerning the reimbursement of medical care and services delivered to veterans for nonservice-connected conditions to address reimbursement offsets. In the proposed rule we explained that the changes are consistent with regulations promulgated by the Department of Defense (DoD) in 32 CFR Part 220. DoD's collection statute, 10 U.S.C. 1095, is similar to VA's collection statute, 38 U.S.C. 1729. We intended that the proposed rule would clarify VA's interpretation of the statute. The purpose of the proposed rule is to proscribe offsetting by third-party payers, provide clarity and uniformity in how third-party payers interact with both VA and DOD, and eliminate disruptions to VA accounting, collections, and account receivables. We provided a 60-day comment-period, which ended on December 7, 2010. We received 3 comments, one from the general public and two from within the health insurance industry.

One commenter agreed with our proposed rule and suggested that addressing third-party recovery of costs in this rule is an appropriate response to third-parties unilaterally offsetting payments. This commenter stated that the proposed rule would allow VA to efficiently track accounts without the complications caused by third-party offsets. The commenter asked whether the "system will work in reverse" if the third-party owes VA money. The commenter also asked whether third-party payers will be able to check the status of a request for reimbursement based upon an alleged overpayment. Finally, the commenter asked how long the process would take from the third party's submission of the claim seeking reimbursement from VA for alleged

overpayments to receipt of reimbursement.

Although the time to process third-party claims seeking reimbursement from VA for alleged overpayments will vary based on numerous factors such as the complexity of the claim and the sufficiency of the information submitted with the claim, most claims will be processed within 90 days. Our 90-day estimate is based upon current VA practice and claim-processing times. The third-party payer will have a payee address on file for each VA facility or Consolidated Patient Account Center (CPAC), and would use that contact information for written follow-up inquiries, or the third-party payer may communicate with the VA facility or CPAC through more direct means, such as telephone or e-mail.

This commenter's questions suggest a possible misunderstanding concerning the scope of our proposal. We did not propose to establish an entirely new process for third parties seeking reimbursement from VA for alleged overpayments. Rather, we proposed to clarify the rules regarding VA collections and to require third-party payers to present any alleged overpayment claim to VA rather than unilaterally offsetting money owed to VA. To further clarify the purpose of this rulemaking, we have changed the heading for § 17.106 from "Third-party claims for refunds based on amounts previously paid to the Department of Veterans Affairs (overpayments)" to "VA collection rules; third-party payers." We made no further changes to the rule based upon these comments.

Two commenters from within the health insurance industry asserted that the rule, in particular the language in § 17.106(a)(1), is not authorized by 38 U.S.C. 1729. The commenters' position is that VA providers must meet the same timely filing rules insurers require of commercial or other providers or members in their coverage contracts, and argue that the rule would override insurers own time limits for filing claims applicable to providers. We disagree.

Although beneficiaries of health insurers generally must file a claim for reimbursement within a specified period of time in order to seek reimbursement, the statutory authority granted to VA by Congress does not place such a time limit on VA's right to seek reimbursement from third-parties. This is clearly set forth in 38 U.S.C. 1729(f), which states that "[n]o provision of any contract or other agreement, shall operate to prevent recovery or collection by the United States under this section or with respect

to care or services furnished under section 1784 of this title.” Therefore, we make no changes based on this comment.

Pursuant to 38 U.S.C. 1729(a)(1), VA’s right to recover or collect from a third-party reasonable charges for medical care or services provided to a veteran is limited “to the extent that the veteran (or the provider of the care or services) would be eligible to receive payment for such care or services from such third party if the care or services had not been furnished by [VA].” Under section 1729(b)(2)(C), the United States has the authority to institute proceedings to collect such payment within six years after the medical care or services were provided. We do not interpret these statutory provisions to be inconsistent. As reflected in the proposed and final rule text, we interpret the “extent” language in paragraph (a)(1) to refer to the amount for which VA may seek payment. In other words, VA cannot seek payment from the third-party that would be greater than what would be provided to another health care provider. This is consistent with the other provisions in both the statute and the regulation. For example, both the statute and the regulation preclude VA from collecting the amount of any applicable deductibles (38 U.S.C. 1729(a)(3); 38 CFR 17.106(b)(2)); and both the statute and regulation limit the amount subject to collection to “reasonable charges,” which are defined by statute as “the amount that [the] third party demonstrates * * * it would pay for the care or services if provided by [non-VA] facilities in the same geographic area” (38 U.S.C. 1729(c)(1)(B)), and which VA calculates using 38 CFR 17.101. Thus, the restriction on when VA can collect the amount due is not limited by the “extent” language in 38 U.S.C. 1729(a)(1). We do not interpret section 1729(a)(1) as binding VA to the internal processing rules of third parties.

The commenters argue that the right of the United States to institute a collection action within six years applies only to lawsuits that the United States may bring against the third-party payer, but does not purport to allow VA to disregard insurers’ timely filing rules applicable to providers. In response, we first point out that 38 U.S.C. 1729(f) prescribes that “[n]o law of any State or of any political subdivision of a State, and no provision of any contract or other agreement, shall operate to prevent recovery or collection by the United States under this section or with respect to care or services furnished under [38 U.S.C. 1784].” This means that the United States is not bound by

third-parties’ rules and policies. Indeed, third-party rules on timely filing differ within individual insurance plans, and may be changed by the third-party without VA’s consent and without notice to Congress. Congress did not intend to bind VA to varying, unpredictable policies over which VA has no control or input.

The commenters’ objections also seem to be that the statute gives the right of a cause of action to the “United States” and not specifically to VA. We disagree. We interpret “United States” as used by Congress in section 1729 to mean an action by the Federal government on behalf of a Federal department or agency. This final rule implements that interpretation in § 17.106(c)(1).

We also note that VA will make every effort to collect payments from a third-party in a timely manner, and has no intention of waiting six years to do so. However, there may be occasions when VA will be unable to do so within a particular time limitation established by a particular third-party. The imposition of a timely filing requirement by third parties is inconsistent with 38 U.S.C. 1729(f), which proscribes contract provisions that would operate to prevent VA collections. If a third-party denies payment on such a ground, the United States is then authorized to institute legal proceedings—so long as the proceeding is instituted within the six-year limit. Thus, the assignment of the right to the United States, rather than to VA, to institute a cause of action is a distinction without a difference. Any legal action to collect payments would be instituted by VA, and such action would be instituted only after the third-party has denied payment.

One commenter requested that VA revise § 17.106(c)(4), which prohibits a third-party payer from offsetting other claims due to the VA in order to recover an overpayment. The commenter recommended instead that the rule state that VA facilities and insurers may agree to permit offsets in lieu of a separate appeal and adjudication process. Similarly, another commenter stated that when a third-party offsets overpayments against amounts otherwise due a VA facility, the third-party is treating the VA facility like any other health care provider. The commenter asserted that VA has no legal right to seek a higher standing. We do not agree.

As stated in the preamble to the proposed rule, one of the primary goals of this rulemaking is to prohibit a third-party payer from offsetting payments to VA. Under 38 U.S.C. 1729(a)(1), VA has the right to recover or collect reasonable charges for care or services from third-

party payers. The right to collect reasonable charges is not dependent upon a third-party payer’s contention regarding a previous alleged overpayment. It is consistent with the statute to bar a third-party payer from offsetting a claim based on a different, disputed transaction. Moreover, under 38 U.S.C. 1729(c)(1), the authority to compromise a claim rests with the government, not with the payer. Without the consent of the government, a third-party payer cannot compromise a claim premised on some separate disputed transaction. Therefore, a third-party payer must submit a claim for a refund of monies allegedly owed to it and with sufficient specificity for VA to determine whether a third-party is due a refund. In doing so, VA will improve its accountability of payments and provide uniformity throughout the VA medical system. We make no changes based on this comment.

Two commenters also requested that we delete proposed paragraph (f)(2)(iv), which reads “[t]he lack of a participation agreement or the absence of privity of contract between a third-party payer and VA is not a permissible ground for refusing or reducing third-party payment.” One commenter stated that under the proposed rule, preferred provider organization (PPO) plans would be required to reimburse VA facilities as preferred providers even if they have not entered into the same preferred provider agreement. The other industry commenter stated that since a PPO would not reimburse a non-preferred private provider as if it were preferred, the PPO need not treat a VA facility with which it does not have a preferred provider agreement as if it were a preferred provider. To the extent that the commenters appear to be disputing the amounts of payments owed to VA under this rule, there is simply no difference between the types of third-parties involved. The “reasonable charges” calculation will be made regardless of whether the payment is owed by a health maintenance organization (HMO), PPO, or any other type of health plan, for the reasons explained above. As previously stated, VA does not expect payment from a third-party, regardless of whether the payment is owed by a HMO, PPO, or any other type of third-party payer, that is greater than what the third-party would pay to a non-federal health care provider in the same geographic area. We make no changes based on this comment.

Similar comments on this topic appear to dispute the range of services for which VA may seek reimbursement. A commenter argued that since an

exclusive provider organization (EPO) would not generally pay claims submitted by an out-of-network private provider, the EPO is not required under the statute to pay an out-of-network VA facility. The commenter asserted that the proposed rule, which noted that a third-party payer must pay only to the extent covered by the payer's plan, supported the commenter's view.

The full discussion of this matter in the proposed rule clearly indicates that we expect HMOs not to exclude claims or refuse to certify emergent care that would otherwise be covered by the plan, and that opt-out or point-of-service options also may not be used to exclude such services. See 75 FR 62351. However, if the HMO bars coverage for services provided by facilities not associated with the HMO, we would not expect the HMO to reimburse VA for those services. The extent of a HMO-like limitation would depend on the provisions in the EPO's specific plan and such provisions may not seek to only exclude payment of claims for medical care and services furnished by a department or agency of the United States. Moreover, we note that Congress clearly expressed its intent in 38 U.S.C. 1729(f) that "[n]o provision of any contract or other agreement, shall operate to prevent recovery or collection by the United States." In 38 U.S.C. 1729(i)(1)(a), Congress clearly defined a "health-plan contract" and only excluded Medicare and Medicaid from the definition as beyond VA's collection authority. We make no changes based on this comment.

Based on the rationale set forth in the preamble to the proposed rule and in this preamble, VA is adopting the proposed rule as a final rule with the minor change noted above.

Effect of Rulemaking

Title 38 of the Code of Federal Regulations, as revised by this final rule, represents VA's implementation of its legal authority on this subject. Other than future amendments to this regulation or governing statutes, no contrary rules or procedures are authorized. All existing or subsequent VA guidance must be read to conform with this final rule if possible or, if not possible, such guidance is superseded by this rulemaking.

Executive Order 12866

Executive Order 12866 directs agencies to assess all 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, and other advantages; distributive impacts; and equity). The Executive Order classifies a regulatory action as a "significant regulatory action," requiring review by the Office of Management and Budget (OMB) unless OMB waives such review, 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.

The economic, interagency, budgetary, legal, and policy implications of this final rule have been examined and it has been determined not to be a significant regulatory action under Executive Order 12866.

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 expenditure by State, local, or tribal governments, in the aggregate, or by the private sector, of \$100 million or more (adjusted annually for inflation) in any given year. This final rule will have no such effect on State, local, and tribal governments, or on the private sector.

Paperwork Reduction Act

The document contains no provisions constituting a collection of information under the Paperwork Reduction Act (44 U.S.C. 3501–3520).

Regulatory Flexibility Act

The Secretary hereby certifies that this final rule will 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 will have an insignificant impact on large insurance companies and other large entities. Therefore, pursuant to 5 U.S.C. 605(b), this proposed amendment is exempt from the initial and final regulatory flexibility analysis requirements of sections 603 and 604.

Catalog of Federal Domestic Assistance Numbers

The Catalog of Federal Domestic Assistance numbers and titles are 64.009 Veterans Medical Care Benefits, 64.010 Veterans Nursing Home Care and 64.011 Veterans Dental Care.

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. John R. Gingrich, Chief of Staff, Department of Veterans Affairs, approved this document on June 9, 2011, for publication.

List of Subjects in 38 CFR Part 17

Administrative practice and procedure, Alcohol abuse, Alcoholism, Claims, Day care, Dental health, Drug abuse, Foreign relations, Government contracts, Grant programs-health, Government programs-veterans, Health care, Health facilities, Health professions, Health records, Homeless, Medical and dental schools, Medical devices, Medical research, Mental health programs, Nursing home care, Veterans.

Dated: June 21, 2011.

Robert C. McFetridge,

Director, Office of Regulation Policy and Management, Office of the General Counsel, Department of Veterans Affairs.

For the reasons stated in the preamble, VA amends 38 CFR part 17 as follows:

PART 17—MEDICAL

■ 1. The authority citation for part 17 continues to read as follows:

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

§ 17.106 [Redesignated as § 17.107]

■ 2. Redesignate § 17.106 as § 17.107.

■ 3. Add new § 17.106 before the undesignated center heading "Disciplinary Control of Beneficiaries Receiving Hospital, Domiciliary or Nursing Home Care" to read as follows:

§ 17.106 VA collection rules; third-party payers.

(a)(1) *General rule.* VA has the right to recover or collect reasonable charges from a third-party payer for medical care and services provided for a nonservice-connected disability in or through any VA facility to a veteran who is also a beneficiary under the third-party payer's plan. VA's right to recover or collect is limited to the extent

that the beneficiary or a nongovernment provider of care or services would be eligible to receive reimbursement or indemnification from the third-party payer if the beneficiary were to incur the costs on the beneficiary's own behalf.

(2) *Definitions.* For the purposes of this section:

Automobile liability insurance means insurance against legal liability for health and medical expenses resulting from personal injuries arising from operation of a motor vehicle.

Automobile liability insurance includes:

(A) Circumstances in which liability benefits are paid to an injured party only when the insured party's tortious acts are the cause of the injuries; and

(B) Uninsured and underinsured coverage, in which there is a third-party tortfeasor who caused the injuries (i.e., benefits are not paid on a no-fault basis), but the insured party is not the tortfeasor.

Health-plan contract means any plan, policy, program, contract, or liability arrangement that provides compensation, coverage, or indemnification for expenses incurred by a beneficiary for medical care or services, items, products, and supplies. It includes but is not limited to:

(A) Any plan offered by an insurer, reinsurer, employer, corporation, organization, trust, organized health care group or other entity.

(B) Any plan for which the beneficiary pays a premium to an issuing agent as well as any plan to which the beneficiary is entitled as a result of employment or membership in or association with an organization or group.

(C) Any Employee Retirement Income and Security Act (ERISA) plan.

(D) Any Multiple Employer Trust (MET).

(E) Any Multiple Employer Welfare Arrangement (MEWA).

(F) Any Health Maintenance Organization (HMO) plan, including any such plan with a point-of-service provision or option.

(G) Any individual practice association (IPA) plan.

(H) Any exclusive provider organization (EPO) plan.

(I) Any physician hospital organization (PHO) plan.

(J) Any integrated delivery system (IDS) plan.

(K) Any management service organization (MSO) plan.

(L) Any group or individual medical services account.

(M) Any participating provider organization (PPO) plan or any PPO provision or option of any third-party payer plan.

(N) Any Medicare supplemental insurance plan.

(O) Any automobile liability insurance plan.

(P) Any no fault insurance plan, including any personal injury protection plan or medical payments benefit plan for personal injuries arising from the operation of a motor vehicle.

Medicare supplemental insurance plan means an insurance, medical service or health-plan contract primarily for the purpose of supplementing an eligible person's benefit under Medicare. The term has the same meaning as "Medicare supplemental policy" in section 1882(g)(1) of the Social Security Act (42 U.S.C. 1395, *et seq.*) and 42 CFR part 403, subpart B.

No-fault insurance means an insurance contract providing compensation for medical expenses relating to personal injury arising from the operation of a motor vehicle in which the compensation is not premised on who may have been responsible for causing such injury. No-fault insurance includes personal injury protection and medical payments benefits in cases involving personal injuries resulting from operation of a motor vehicle.

Participating provider organization means any arrangement in a third-party payer plan under which coverage is limited to services provided by a select group of providers who are members of the PPO or incentives (for example, reduced copayments) are provided for beneficiaries under the plan to receive health care services from the members of the PPO rather than from other providers who, although authorized to be paid, are not included in the PPO. However, a PPO does not include any organization that is recognized as a health maintenance organization.

Third-party payer means an entity, other than the person who received the medical care or services at issue (first party) and VA who provided the care or services (second party), responsible for the payment of medical expenses on behalf of a person through insurance, agreement or contract. This term includes, but is not limited to the following:

(A) State and local governments that provide such plans other than Medicaid.

(B) Insurance underwriters or carriers.

(C) Private employers or employer groups offering self-insured or partially self-insured medical service or health plans.

(D) Automobile liability insurance underwriter or carrier.

(E) No fault insurance underwriter or carrier.

(F) Workers' compensation program or plan sponsor, underwriter, carrier, or self-insurer.

(G) Any other plan or program that is designed to provide compensation or coverage for expenses incurred by a beneficiary for healthcare services or products.

(H) A third-party administrator.

(b) *Calculating reasonable charges.*

(1) The "reasonable charges" subject to recovery or collection by VA under this section are calculated using the applicable method for such charges established by VA in 38 CFR 17.101.

(2) If the third-party payer's plan includes a requirement for a deductible or copayment by the beneficiary of the plan, VA will recover or collect reasonable charges less that deductible or copayment amount.

(c) *VA's right to recover or collect is exclusive.* The only way for a third-party payer to satisfy its obligation under this section is to pay the VA facility or other authorized representative of the United States. Payment by a third-party payer to the beneficiary does not satisfy the third-party's obligation under this section.

(1) Pursuant to 38 U.S.C. 1729(b)(2), the United States may file a claim or institute and prosecute legal proceedings against a third-party payer to enforce a right of the United States under 38 U.S.C. 1729 and this section. Such filing or proceedings must be instituted within six years after the last day of the provision of the medical care or services for which recovery or collection is sought.

(2) An authorized representative of the United States may compromise, settle or waive a claim of the United States under this section.

(3) The remedies authorized for collection of indebtedness due the United States under 31 U.S.C. 3701, *et seq.*, 4 CFR parts 101 through 104, 28 CFR part 11, 31 CFR part 900, and 38 CFR part 1, are available to effect collections under this section.

(4) A third-party payer may not, without the consent of a U.S. Government official authorized to take action under 38 U.S.C. 1729 and this part, offset or reduce any payment due under 38 U.S.C. 1729 or this part on the grounds that the payer considers itself due a refund from a VA facility. A written request for a refund must be submitted and adjudicated separately from any other claims submitted to the third-party payer under 38 U.S.C. 1729 or this part.

(d) *Assignment of benefits or other submission by beneficiary not necessary.* The obligation of the third-party payer to pay is not dependent

upon the beneficiary executing an assignment of benefits to the United States. Nor is the obligation to pay dependent upon any other submission by the beneficiary to the third-party payer, including any claim or appeal. In any case in which VA makes a claim, appeal, representation, or other filing under the authority of this part, any procedural requirement in any third-party payer plan for the beneficiary of such plan to make the claim, appeal, representation, or other filing must be deemed to be satisfied. A copy of the completed VA Form 10-10EZ or VA Form 10-10EZR that includes a veteran's insurance declaration will be provided to payers upon request, in lieu of a claimant's statement or coordination of benefits form.

(e) *Preemption of conflicting State laws and contracts.* Any provision of a law or regulation of a State or political subdivision thereof and any provision of any contract or agreement that purports to establish any requirement on a third-party payer that would have the effect of excluding from coverage or limiting payment for any medical care or services for which payment by the third-party payer under 38 U.S.C. 1729 or this part is required, is preempted by 38 U.S.C. 1729(f) and shall have no force or effect in connection with the third-party payer's obligations under 38 U.S.C. 1729 or this part.

(f) *Impermissible exclusions by third-party payers.* (1) *Statutory requirement.* Under 38 U.S.C. 1729(f), no provision of any third-party payer's plan having the effect of excluding from coverage or limiting payment for certain care if that care is provided in or through any VA facility shall operate to prevent collection by the United States.

(2) *General rules.* The following are general rules for the administration of 38 U.S.C. 1729 and this part, with examples provided for clarification. The examples provided are not exclusive. A third-party payer may not reduce, offset, or request a refund for payments made to VA under the following conditions:

(i) Express exclusions or limitations in third-party payer plans that are inconsistent with 38 U.S.C. 1729 are inoperative. For example, a provision in a third-party payer's plan that purports to disallow or limit payment for services provided by a government entity or paid for by a government program (or similar exclusion) is not a permissible ground for refusing or reducing third-party payment.

(ii) No objection, precondition or limitation may be asserted that defeats the statutory purpose of collecting from third-party payers. For example, a provision in a third-party payer's plan that purports to disallow or limit payment for services for which the patient has no obligation to pay (or similar exclusion) is not a permissible ground for refusing or reducing third-party payment.

(iii) Third-party payers may not treat claims arising from services provided in or through VA facilities less favorably than they treat claims arising from services provided in other hospitals. For example, no provision of an employer sponsored program or plan that purports to make ineligible for coverage individuals who are eligible to receive VA medical care and services shall be permissible.

(iv) The lack of a participation agreement or the absence of privity of contract between a third-party payer and VA is not a permissible ground for refusing or reducing third-party payment.

(v) A provision in a third-party payer plan, other than a Medicare supplemental plan, that seeks to make Medicare the primary payer and the plan the secondary payer or that would operate to carve out of the plan's coverage an amount equivalent to the Medicare payment that would be made if the services were provided by a provider to whom payment would be made under Part A or Part B of Medicare is not a permissible ground for refusing or reducing payment as the primary payer to VA by the third-party payer unless the provision expressly disallows

payment as the primary payer to all providers to whom payment would not be made under Medicare (including payment under Part A, Part B, a Medicare HMO, or a Medicare Advantage plan).

(vi) A third-party payer may not refuse or reduce third-party payment to VA because VA's claim form did not report hospital acquired conditions (HAC) or present on admission conditions (POA). VA is exempt from the Medicare Inpatient prospective payment system and the Medicare rules for reporting POA or HAC information to third-party payers.

(vii) Health Maintenance Organizations (HMOs) may not exclude claims or refuse to certify emergent and urgent services provided within the HMO's service area or otherwise covered non-emergency services provided out of the HMO's service area. In addition, opt-out or point-of-service options available under an HMO plan may not exclude services otherwise payable under 38 U.S.C. 1729 or this part.

(g) *Records.* Pursuant to 38 U.S.C. 1729(h), VA shall make available for inspection and review to representatives of third-party payers, from which the United States seeks payment, recovery, or collection under 38 U.S.C. 1729, appropriate health care records (or copies of such records) of patients. However, the appropriate records will be made available only for the purposes of verifying the care and services which are the subject of the claim(s) for payment under 38 U.S.C. 1729, and for verifying that the care and services met the permissible criteria of the terms and conditions of the third-party payer's plan. Patient care records will not be made available under any other circumstances to any other entity. VA will not make available to a third-party payer any other patient or VA records. (Authority: 31 U.S.C. 3711, 38 U.S.C. 501, 1729, 42 U.S.C. 2651)

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