

her health care insurer for any inpatient services for which payment is made by the VA.

(h) Hospitals of distinct part hospital units excluded from the prospective payment system by Medicare and hospitals that do not participate in Medicare will be paid at the national cost-to-charge ratio times the billed charges that are reasonable, usual, customary, and not in excess of rates or fees the hospital charges the general public for similar services in the community.

(i) A hospital participating in an alternative payment system that has been granted a Federal waiver from the prospective payment system under the provisions of 42 U.S.C. section 1395f(b)(3) or 42 U.S.C. section 1395ww(c) for the purposes of Medicare payment shall not be subject to the payment methodology set forth in this section so long as such Federal waiver remains in effect.

(j) Payments for episodes of hospital care furnished in Alaska that begin during the period starting on the effective date of this section through the 364th day thereafter will be in the amount determined by the HCFA PRICER plus 50 percent of the difference between the amount billed by the hospital and the amount determined by the PRICER. Claims for services provided during that period will be accepted for payment by VA under this paragraph (k) until December 31 of the year following the year in which this section became effective.

(k) Notwithstanding other provisions of this section, VA, for public or private hospital care covered by this section, will pay the lesser of the amount determined under paragraphs (a) through (j) of this section or the amount negotiated with the hospital or its agent.

(Authority: 38 USC 513, 1703, 1728; § 233 of P. L. 99-576)

[55 FR 42852, Oct. 24, 1990. Redesignated and amended at 61 FR 21965, 21966, May 13, 1996; 62 FR 17072, Apr. 9, 1997; 63 FR 39515, July 23, 1998; 65 FR 66637, Nov. 7, 2000]

§ 17.56 Payment for non-VA physician services associated with outpatient and inpatient care provided at non-VA facilities.

(a) Except for anesthesia services, payment for non-VA physician services associated with outpatient and inpatient care provided at non-VA facilities authorized under § 17.52, or made under § 17.120 of this part, shall be the lesser of the amount billed or the amount calculated using the formula developed by the Department of Health & Human Services, Health Care Financing Administration (HCFA) under Medicare's participating physician fee schedule for the period in which the service is provided (see 42 CFR Parts 414 and 415). This payment methodology is set forth in paragraph (b) of this section. If no amount has been calculated under Medicare's participating physician fee schedule or if the services constitute anesthesia services, payment for such non-VA physician services associated with outpatient and inpatient care provided at non-VA facilities authorized under § 17.52, or made under § 17.120 of this part, shall be the lesser of the actual amount billed or the amount calculated using the 75th percentile methodology set forth in paragraph (c) of this section; or the usual and customary rate if there are fewer than 8 treatment occurrences for a procedure during the previous fiscal year.

(b) The payment amount for each service paid under Medicare's participating physician fee schedule is the product of three factors: a nationally uniform relative value for the service; a geographic adjustment factor for each physician fee schedule area; and a nationally uniform conversion factor for the service. The conversion factor converts the relative values into payment amounts. For each physician fee schedule service, there are three relative values: An RVU for physician work; an RVU for practice expense; and an RVU for malpractice expense. For each of these components of the fee schedule, there is a geographic practice cost index (GPCI) for each fee schedule area. The GPCIs reflect the relative costs of practice expenses, malpractice insurance, and physician work in an

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area compared to the national average. The GPCIs reflect the full variation from the national average in the costs of practice expenses and malpractice insurance, but only one-quarter of the difference in area costs for physician work. The general formula calculating the Medicare fee schedule amount for a given service in a given fee schedule area can be expressed as: Payment = [(RVUwork × GPCIwork) + (RVUpractice expense × GPCIpractice expense) + (RVUmalpractice × GPCImalpractice)] × CF.

(c) Payment under the 75th percentile methodology is determined for each VA medical facility by ranking all occurrences (with a minimum of eight) under the corresponding code during the previous fiscal year with charges ranked from the highest rate billed to the lowest rate billed and the charge falling at the 75th percentile as the maximum amount to be paid.

(d) Payments made in accordance with this section shall constitute payment in full. Accordingly, the provider or agent for the provider may not impose any additional charge for any services for which payment is made by VA.

(e) Notwithstanding other provisions of this section, VA, for physician services covered by this section, will pay the lesser of the amount determined under paragraphs (a) through (d) of this section or the amount negotiated with the physician or the physician's agent.

(Authority: 38 U.S.C. 513, 38 U.S.C. 1703, 38 U.S.C. 1728)

[63 FR 39515, July 23, 1998, as amended at 65 FR 66637, Nov. 7, 2000]

USE OF COMMUNITY NURSING HOME CARE FACILITIES

§ 17.57 Use of community nursing homes.

(a) Nursing home care in a contract public or private nursing home facility may be authorized for the following: Any veteran who has been discharged from a hospital under the direct jurisdiction of VA and is currently receiv-

ing VA hospital based home health services.

(Authority: 38 U.S.C. 1720; sec. 108, Pub. L. 99-166)

(b) 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 38 U.S.C. 1710(a)(1), the Under Secretary for Health may furnish care under this paragraph to any veteran described in 38 U.S.C. 1710(a)(2) if the veteran agrees to pay the United States an amount as determined in 38 U.S.C. 1710(f).

(Authority: 38 U.S.C. 1710, 1720; sec. 19011, Pub. L. 99-272)

(Authority: 38 U.S.C. 1720(b))

[51 FR 25067, July 10, 1986. Redesignated and amended at 61 FR 21965, 21966, May 13, 1996 and further redesignated at 63 FR 39515, July 23, 1998]

§ 17.60 Extensions of community nursing home care beyond six months.

Directors of health care facilities may authorize, for any veteran whose hospitalization was not primarily for a service-connected disability, an extension of nursing care in a public or private nursing home care facility at VA expense beyond six months when the need for nursing home care continues to exist and

(a) Arrangements for payment of such care through a public assistance program (such as Medicaid) for which the veteran has applied, have been delayed due to unforeseen eligibility problems which can reasonably be expected to be resolved within the extension period, or

(b) The veteran has made specific arrangements for private payment for such care, and

(1) Such arrangements cannot be effectuated as planned because of unforeseen, unavoidable difficulties, such as a temporary obstacle to liquidation of property, and

(2) Such difficulties can reasonably be expected to be resolved within the extension period; or