

Lake Michigan, or his or her on-scene designated representative.

Dated: February 3, 2012.

M.W. Sibley,

Captain, U.S. Coast Guard, Captain of the Port, Sector Lake Michigan.

[FR Doc. 2012-5330 Filed 3-5-12; 8:45 am]

BILLING CODE 9110-04-P

DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 17

RIN 2900-AO27

Exempting In-Home Video Telehealth From Copayments

AGENCY: Department of Veterans Affairs.

ACTION: Proposed rule.

SUMMARY: The Department of Veterans Affairs (VA) is proposing to amend its regulation that governs VA services that are not subject to copayment requirements for inpatient hospital care or outpatient medical care. Specifically, the regulation would be amended to exempt in-home video telehealth care from having any required copayment. This would remove a barrier that may have previously discouraged veterans from choosing to use in-home video telehealth as a viable medical care option. In turn, VA hopes to make the home a preferred place of care, whenever medically appropriate and possible.

DATES: Written comments must be received on or before April 5, 2012.

ADDRESSES: Written comments may be submitted through www.Regulations.gov; by mail or hand-delivery to the Director, Regulations Management (02REG), Department of Veterans Affairs, 810 Vermont Ave. NW., Room 1068, Washington, DC 20420; or by fax to (202) 273-9026. Comments should indicate that they are submitted in response to "RIN 2900-AO27"—Exempting In-home Video Telehealth from Copayments." Copies of comments received will be available for public inspection in the Office of Regulation Policy and Management, Room 1063B, between the hours of 8 a.m. and 4:30 p.m. Monday through Friday (except holidays). Please call (202) 461-4902 for an appointment (this is not a toll-free number). In addition, during the comment period, comments may be viewed online through the Federal Docket Management System (FDMS) at www.Regulations.gov.

FOR FURTHER INFORMATION CONTACT: Kristin J. Cunningham, Director

Business Policy, Chief Business Office, Department of Veterans Affairs, 810 Vermont Ave. NW., Washington, DC 20420; (202) 461-1599. (This is not a toll-free number.)

SUPPLEMENTARY INFORMATION: Many of our nation's veterans must travel great distances in order to obtain health care at a VA hospital or medical center. To improve veterans' access to VA health care, VA established community-based outpatient clinics (CBOCs) located in local communities. VA has continued its efforts to improve veterans' access to VA medical care by establishing "telehealth" services. Telehealth allows VA to provide certain medical care without requiring the veteran to be physically present with the examining or treating medical professional. Telehealth helps ensure that veterans are able to get their care in a timely and convenient manner, by reducing burdens on the patient as well as appropriately reducing the utilization of VA resources without sacrificing the quality of care provided. The benefits of using this technology include increased access to specialist consultations, improved access to primary and ambulatory care, reduced waiting times, and decreased veteran travel.

VA provides various telehealth services, including clinical video telehealth and in-home video telehealth care. Clinical video telehealth, as the name implies, occurs between two clinical settings, such as two VA Medical Centers (VAMCs), a VAMC and a CBOC, or two CBOCs. Clinical video telehealth may also connect patient and provider between VAMCs and VA Centers of Specialized Care, such as those established for Spinal Cord Injury (SCI), Traumatic Brain Injury (TBI) and Multiple Sclerosis (MS). Clinical video telehealth uses real-time interactive video conferencing, sometimes with supportive peripheral devices, such as a camera to closely examine skin. This allows a specialist located in another facility to assess and treat a veteran by providing care remotely.

Like clinical video telehealth, in-home video telehealth care is used to connect a veteran to a VA health care professional using real-time videoconferencing, and other equipment as necessary, as a means to replicate aspects of face-to-face assessment and care delivery that do not require the health care professional to make an examination requiring physical contact. However, in-home video telehealth care is provided in a veteran's home, eliminating the need for the veteran to travel to a clinical setting. Using telehealth capabilities, a VA clinician

can assess elements of a patient's care, such as wound management, psychiatric or psychotherapeutic care, exercise plans, and medication management. The clinician may also monitor patient self-care by reviewing vital signs and evaluating the patient's appearance on video.

Prior to this proposed rulemaking, veterans have been required to pay a copayment for in-home video telehealth care. We believe that VA has authority by statute to discontinue charging copayments for these services.

Section 1710(g)(1) of 38 U.S.C. states:

The Secretary may not furnish medical services (except if such care constitutes hospice care) under subsection (a) of this section (including home health services under section 1717 of this title) to a veteran who is eligible for hospital care under this chapter by reason of subsection (a)(3) of this section unless the veteran agrees to pay to the United States in the case of each outpatient visit the applicable amount or amounts established by the Secretary by regulation.

VA has interpreted section 1710(g)(1) to mean that VA has the discretion to establish the applicable copayment amount in regulation, even if such amount is zero. One such implementing regulation is 38 CFR 17.108.

Generally, VA calculates the amount of a copayment based on the complexity of care provided and the resources needed to provide that care. In addition, VA may exempt certain care from the copayment requirement in an effort to make health care more accessible to veterans, or to encourage veterans to become more actively involved in their medical care, and thereby improve health care outcomes (which, in turn, lowers overall health care costs). VA proposes to make in-home video telehealth care exempt from copayments because it is not used to provide complex care and its use significantly reduces impact on VA resources compared to an in-person, outpatient visit. It also reduces any potential negative impact on the veteran's health that might be incurred if the veteran were required to travel to a VA hospital or medical center to obtain the care that would be provided via in-home video telehealth. VA also wants to encourage veterans to use the in-home video telehealth care option when their provider finds it appropriate because we believe that it would help ensure that veterans comply with outpatient treatment plans by regularly following up with physicians and medical professionals, taking medication in appropriate doses on a regular basis, and generally being more engaged with their VA health care providers.

As previously stated in this rulemaking, in-home video telehealth allows a VA clinician to assess the elements of a veteran's care, while the veteran remains at home. Conversely, clinical video telehealth assess the veteran's medical condition in a clinical setting using resources and technology that allows a medical specialist, who may be hundreds of miles away, to interact with the veteran and provide the level of care needed to treat the medical condition. VA would not exempt clinical video telehealth services from the copayment requirement because the type of care a veteran receives in clinical video telehealth requires not just the use of CBOC's technological resources, but also patient interaction between the attending physician that may be hundreds of miles away, and the medical staff in the CBOC. The attending medical staff in the CBOC follows the attending physician's instructions in the placement of the adapted equipment that is used in clinical video telehealth in order to assess the veteran's medical condition, to include the set up of the conference, use of the teleconference room, etc. All of these additional services provide a veteran a higher level of care than the level of care that the veteran receives through in-home video telehealth.

Paragraph (e) of § 17.108 contains a list of services that are not subject to copayment requirements for inpatient hospital care or outpatient medical care.

Based on the rationale set forth in this preamble, VA proposes to amend § 17.108(e) by adding a new paragraph (e)(16) to include in-home video telehealth care as exempt from copayment requirements.

Administrative Procedure Act

Concurrent with this proposed rule, we also are publishing a separate, substantively identical direct final rule in the "Rules and Regulations" section of this **Federal Register**. The simultaneous publication of these documents will speed notice and comment rulemaking under section 553 of the Administrative Procedure Act should we have to withdraw the direct final rule due to receipt of significant adverse comments.

For purposes of the direct final rulemaking, a significant adverse comment is one that explains why the rule would be inappropriate, including challenges to the rule's underlying premise or approach, or why it would be ineffective or unacceptable without change. If significant adverse comments are received, VA will publish a notice of receipt of significant adverse

comments in the **Federal Register** withdrawing the direct final rule.

Under direct final rule procedures, unless significant adverse comments are received within the comment period, the regulation will become effective on the date specified above. After the close of the comment period, VA will publish a document in the **Federal Register** indicating that no adverse comments were received and confirming the date on which the final rule will become effective. VA will also publish a notice withdrawing this proposed rule.

In the event the direct final rule is withdrawn because of significant adverse comments, VA can proceed with the rulemaking by addressing the comments received and publishing a final rule. The comment period for the proposed rule runs concurrently with that of the direct final rule. Any comments received under the direct final rule will be treated as comments regarding the proposed rule. VA will consider such comments in developing a subsequent final rule. Likewise, significant adverse comments submitted to the proposed rule will be considered as comments regarding the direct final rule.

Effect of Rulemaking

The Code of Federal Regulations, as proposed to be revised by this proposed rulemaking, would represent 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 rulemaking if possible or, if not possible, such guidance would be superseded by this rulemaking.

Paperwork Reduction Act

This document contains no provisions constituting a collection of information under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3521).

Regulatory Flexibility Act

The Secretary hereby certifies that this proposed regulatory amendment would 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 rulemaking would not directly affect any small entities. Only VA beneficiaries would be directly affected. Therefore, pursuant to 5 U.S.C. 605(b), this amendment would be exempt from the initial and final regulatory flexibility analysis requirements of sections 603 and 604.

Executive Orders 12866 and 13563

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 this Executive Order."

The economic, interagency, budgetary, legal, and policy implications of this regulatory action 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 proposed rule would have no such effect on State, local, or tribal governments, or on the private sector.

Catalog of Federal Domestic Assistance

The Catalog of Federal Domestic Assistance program number and title for this proposed rule are as follows: 64.007 Blind Rehabilitation Centers; 64.008, Veterans Domiciliary Care; 64.009, Veterans Medical Care Benefits; 64.010, Veterans Nursing Home Care; 64.014,

Veterans State Domiciliary Care; 64.015, Veterans State Nursing Home Care; 64.018, Sharing Specialized Medical Resources; 64.019, Veterans Rehabilitation Alcohol and Drug Dependence; and 64.022, Veterans Home Based Primary 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 February 28, 2012, for publication.

List of Subjects in 38 CFR Part 17

Administrative practice and procedure, Health care, Health facilities, Mental health programs, Nursing homes, Veterans.

Dated: March 1, 2012.

Robert C. McFetridge,

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

For the reasons set forth in the preamble, we propose to amend 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.

2. Amend § 17.108 by adding paragraph (e)(16) to read as follows:

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

* * * * *

(e) * * *

(16) In-home video telehealth care.

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[FR Doc. 2012-5355 Filed 3-5-12; 8:45 am]

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ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[EPA-R10-OAR-2012-0112, FRL-9643-5]

Partial Approval and Promulgation of Implementation Plans; Washington: Infrastructure Requirements for the 1997 8-Hour Ozone National Ambient Air Quality Standards

AGENCY: Environmental Protection Agency (EPA).

ACTION: Proposed rule.

SUMMARY: EPA is proposing to partially approve the State Implementation Plan (SIP) submittal from the Washington State Department of Ecology (Ecology) to demonstrate that the SIP meets the requirements of section 110(a)(1) and (2) of the Clean Air Act (CAA) for the National Ambient Air Quality Standards (NAAQS) promulgated for ozone on July 18, 1997. EPA is proposing to find that the current Washington SIP meets the following 110(a)(2) infrastructure elements for the 1997 8-hour ozone NAAQS: (A), (B), (C), (D)(ii), (E), (F), (G), (H), (J), (K), (L), and (M), except for portions related to the major source Prevention of Significant Deterioration (PSD) permitting program which is implemented under a Federal Implementation Plan.

DATES: Comments must be received on or before April 5, 2012.

ADDRESSES: Submit your comments, identified by Docket ID No. EPA-R10-OAR-2012-0112, by any of the following methods:

- *www.regulations.gov*: Follow the on-line instructions for submitting comments.
- *Email: R10-Public Comments@epa.gov.*
- *Mail:* Jeff Hunt, EPA Region 10, Office of Air, Waste and Toxics (AWT-107), 1200 Sixth Avenue, Suite 900, Seattle, WA 98101.
- *Hand Delivery/Courier:* EPA Region 10, 1200 Sixth Avenue, Suite 900, Seattle, WA 98101. Attention: Jeff Hunt, Office of Air, Waste and Toxics, AWT-107. Such deliveries are only accepted during normal hours of operation, and special arrangements should be made for deliveries of boxed information.

Instructions: Direct your comments to Docket ID No. EPA-R10-OAR-2012-0112 EPA's policy is that all comments received will be included in the public docket without change and may be made available online at *www.regulations.gov*, including any personal information provided, unless the comment includes information claimed to be Confidential Business Information (CBI) or other information whose disclosure is restricted by statute. Do not submit information that you consider to be CBI or otherwise protected through *www.regulations.gov* or email. The *www.regulations.gov* Web site is an "anonymous access" system, which means EPA will not know your identity or contact information unless you provide it in the body of your comment. If you send an email comment directly to EPA without going through *www.regulations.gov* your email address will be automatically captured

and included as part of the comment that is placed in the public docket and made available on the Internet. If you submit an electronic comment, EPA recommends that you include your name and other contact information in the body of your comment and with any disk or CD-ROM you submit. If EPA cannot read your comment due to technical difficulties and cannot contact you for clarification, EPA may not be able to consider your comment. Electronic files should avoid the use of special characters, any form of encryption, and be free of any defects or viruses.

Docket: All documents in the docket are listed in the *www.regulations.gov* index. Although listed in the index, some information is not publicly available, e.g., CBI or other information whose disclosure is restricted by statute. Certain other material, such as copyrighted material, is not placed on the Internet and will be publicly available only in hard copy. Publicly available docket materials are available either electronically in *www.regulations.gov* or in hard copy during normal business hours at the Office of Air, Waste and Toxics, EPA Region 10, 1200 Sixth Avenue, Seattle, WA 98101.

FOR FURTHER INFORMATION CONTACT: Jeff Hunt at telephone number: (206) 553-0256, email address: *hunt.jeff@epa.gov*, or the above EPA, Region 10 address.

SUPPLEMENTARY INFORMATION: Throughout this document wherever "we", "us" or "our" are used, we mean EPA. Information is organized as follows:

Table of Contents

- I. What action is EPA proposing?
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I. What action is EPA proposing?

EPA is proposing to partially approve the State Implementation Plan (SIP) submittal from the State of Washington to demonstrate that the SIP meets the requirements of section 110(a)(1) and (2) of the Clean Air Act (CAA) for the National Ambient Air Quality Standards (NAAQS) promulgated for ozone on July 18, 1997. EPA is proposing to find that the current Washington SIP, as codified at 40 CFR Part 52 Subpart WW meets