

**§ 7.62 Lake Chelan National Recreation Area.**

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(d) *Solid waste disposal.* A solid waste transfer station located near Stehekin within the boundary of Lake Chelan National Recreation Area must comply with all provisions in 36 CFR part 6, except it may:

(1) Accept solid waste generated within the boundary of the park unit that was not generated by National Park Service activities;

(2) Be located within one mile of a campground or a residential area;

(3) Be visible by the public from scenic vistas or off-trail areas in designated wilderness areas;

(4) Be detectable by the public by sound from a campground; and

(5) Be detectable by the public by sight, sound, or odor from a road open to public travel.

Dated: November 19, 2015.

**Karen Hyun,**

*Acting Principal Deputy Assistant Secretary for Fish and Wildlife and Parks.*

[FR Doc. 2015-30349 Filed 11-30-15; 8:45 am]

BILLING CODE 4310-EJ-P

**DEPARTMENT OF VETERANS AFFAIRS****38 CFR Part 17**

RIN 2900-AP60

**Expanded Access to Non-VA Care Through the Veterans Choice Program**

**AGENCY:** Department of Veterans Affairs.

**ACTION:** Interim final rule.

**SUMMARY:** The Department of Veterans Affairs (VA) revises its medical regulations that implement section 101 of the Veterans Access, Choice, and Accountability Act of 2014 (hereafter referred to as “the Choice Act”), which requires VA to establish a program to furnish hospital care and medical services through eligible non-VA health care providers to eligible veterans who either cannot be seen within the wait-time goals of the Veterans Health Administration (VHA) or who qualify based on their place of residence (hereafter referred to as the “Veterans Choice Program” or the “Program”). These regulatory revisions are required by the most recent amendments to the Choice Act made by the Construction Authorization and Choice Improvement Act of 2014, and by the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015. The Construction Authorization and Choice Improvement Act of 2014

amended the Choice Act to define additional criteria that VA may use to determine that a veteran’s travel to a VA medical facility is an “unusual or excessive burden,” and the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015 amended the Choice Act to cover all veterans enrolled in the VA health care system, remove the 60-day limit on an episode of care, modify the wait-time and 40-mile distance eligibility criteria, and expand provider eligibility based on criteria as determined by VA. This interim final rule revises VA regulations consistent with the changes made to the Choice Act as described above.

**DATES:** *Effective date:* This rule is effective on December 1, 2015.

*Comment date:* Comments must be received on or before March 30, 2016.

**FOR FURTHER INFORMATION CONTACT:** Kristin Cunningham, Director, Business Policy, Chief Business Office (10NB), Veterans Health Administration, Department of Veterans Affairs, 810 Vermont Avenue NW., Washington, DC 20420, (202) 382-2508. (This is not a toll-free number.)

**SUPPLEMENTARY INFORMATION:** The Veterans Access, Choice, and Accountability Act of 2014 (the Choice Act, Pub. L. 113-146, 128 Stat. 1754) was enacted on August 7, 2014. Further amendments to the Choice Act were made on September 26, 2014, by the Department of Veterans Affairs Expiring Authorities Act of 2014 (Pub. L. 113-175, 128 Stat. 1901, 1906); on December 16, 2014, by the Consolidated and Further Continuing Appropriations Act of 2015 (Pub. L. 113-235, 128 Stat. 2130, 2568); on May 22, 2015, by the Construction Authorization and Choice Improvement Act (Pub. L. 114-19, 129 Stat. 215); and on July 31, 2015, by the Surface Transportation and Veterans Health Care Choice Improvement Act (Pub. L. 114-41, 129 Stat. 443). This interim final rule revises VA regulations that implement the Choice Act in accordance with the most recent amendments made by Public Laws 114-19 and 114-41. Prior to discussing the regulatory changes made in this interim final rule, a brief history of previous rulemakings that created and revised regulations that implement the Choice Act is provided below.

Section 101 of the Choice Act creates the Veterans Choice Program (the Program) and requires VA to enter into agreements with identified eligible non-Department of Veterans Affairs (VA) entities or providers to furnish hospital care and medical services to eligible veterans who elect to receive care under the Program. Sec. 101(a)(1)(A), Public

Law 113-146, 128 Stat. 1754. On November 5, 2014, VA published an interim final rule, as required by section 101(n) of the Choice Act, to implement the Veterans Choice Program through new regulations at 38 CFR 17.1500-17.1540. 79 FR 65571 (hereafter referred to as the “November interim final rule”). VA published another interim final rule on April 24, 2015, modifying § 17.1510(e) to revise the methodology for calculating distances under that section from geodesic (or “straight-line”) distance to driving distance. 80 FR 22906 (hereafter referred to as the “April interim final rule”). VA published a final rule (hereafter referred to as the “final rule”) amending the payment rates in the Program to account for two exceptions: One for Alaska, and one for states with an All-Payer Model Agreement (Maryland). These two payment rate exceptions were authorized by section 242 of Division I of Public Law 113-235. 128 Stat. 2568.

**Changes in Public Law 114-19 Related to the “Unusual or Excessive Burden” Standard**

Under the November interim final rule at § 17.1510(b)(4)(ii), veterans may be eligible to participate in the Veterans Choice Program if they live 40 miles or less from a VA medical facility but face an “unusual or excessive burden” in traveling to such medical facility based on the presence of a body of water or a geologic formation that cannot be crossed by road. As explained in the November interim final rule, this standard for “unusual or excessive burden” was VA’s interpretation of the language in the Choice Act, which at that time required the burden to be “due to geographical challenges, as determined by the Secretary.” Sec. 101(b)(2)(D)(ii)(II), Pub. L. 113-146, 128 Stat. 1754. As explained in the final rule, section 3(a)(2) of Public Law 114-19 amended section 101(b)(2)(D)(ii)(II) of the Choice Act by defining additional criteria that could be the basis for finding that a veteran faced an “unusual or excessive burden” in traveling to receive care in a VA medical facility, including environmental factors such as roads that are not accessible to the general public, traffic, or hazardous weather; a medical condition that affects the ability to travel; or other factors, as determined by the Secretary. VA implemented two of these factors, namely the environmental factors such as roads that are not accessible to the general public, traffic, or hazardous weather, or a medical condition that affects the ability to travel, ahead of these regulatory revisions. We did so because we believe these factors are

easily understood by the public and that implementation fulfilled a clear Congressional mandate that had an immediate effective date. These changes were not subject to notice and comment prior to implementation because they had an immediate effective date and VA did not need to interpret the language to give it effect. VA is now adding these criteria to § 17.1510(b)(4)(ii) and is merely restating the existing statutory law to make our regulations consistent with Congressional intent as well as consistent with our current practice. These new criteria in § 17.1510(b)(4)(ii) are a virtually verbatim copy from section 3(a)(2) of Public Law 114–19 without the addition of further clarifying criteria, although we provide some examples here for clarity. For instance, roads that are not accessible to the general public include roads through military bases or other restricted areas. If veterans are only able to access a VA medical facility that is 40 miles or less from their residence via such a restricted road, they can be considered eligible for the Program under this standard. Traffic or hazardous weather includes special traffic congestion and patterns or weather conditions that make travel of a veteran to a VA medical facility 40 miles or less from their residence excessively or unusually burdensome. A medical condition that affects the ability to travel includes a medical condition of the veteran that affects the ability of the veteran to safely travel for 40 miles or less to a VA medical facility or that otherwise makes such travel burdensome. As an example, veterans on portable ventilators or with oxygen tanks may only be able to travel for a certain amount of time before their health is in jeopardy. As another example, veterans with spinal cord injuries or other serious conditions may require the use of assistive devices or may not be able to traverse over bumpier or windier roads, and may also face an unusual or excessive burden in traveling to a VA medical facility that is 40 miles or less from their residence. If traveling to a non-VA facility would be safer for such veterans than traveling to the nearest VA medical facility, they can qualify for the Program under this standard because traveling to the VA medical facility would be unusually or excessively burdensome. These are intended to be clarifying but not exhaustive examples of medical conditions that may qualify veterans to receive care at non-VA facilities under the new medical condition criterion in § 17.1510(b)(4)(ii). VA currently makes determinations regarding eligibility

under the “unusual or excessive burden” criterion in § 17.1510(b)(4)(ii) based on the facts presented by the particular veteran’s circumstances, and will continue to do so under the new criteria in § 17.1510(b)(4)(ii). Such determinations do not need to be made in person and can instead be made based on information that is available in the veteran’s medical record or that is otherwise available to VA.

In addition to the express factors in section 3(a)(2) of Public Law 114–19 that are related to the environment or that are related to the medical condition of a veteran, we add three “other factors” to § 17.1510(b)(4)(ii)(A) through (C) that the Secretary may consider when determining whether a veteran faces an unusual or excessive burden in travelling to a VA medical facility that is 40 miles or less from their residence. These criteria are newly implemented in this interim final rule and are not intended to be an exhaustive list, although VA anticipates they will address the majority of cases that could reasonably be the basis for finding an unusual or excessive burden in travel. These other factors are the nature or simplicity of the hospital care or medical services the veteran requires, how frequently the veteran needs hospital care or medical services, and the need for an attendant, which is defined as a person who provides required aid and/or physical assistance to the veteran, for a veteran to travel to a VA medical facility for hospital care or medical services. Considering the nature or simplicity of the care or services will allow VA to determine, for example, that routine and simple procedures that do not necessarily require the expertise or best practices of VA providers (such as simple tests or treatments like an allergy test or an immunization) do not justify traveling a longer distance just to receive that care from VA. Similarly, if a veteran needs repeated appointments for a course of treatment, such as chemotherapy, the frequency of travel could become an excessive burden on the veteran that could be alleviated or lessened by receiving care closer to home. If a veteran requires an attendant to travel to a VA medical facility, this could also create an excessive or unusual burden on the veteran, as he or she may need to arrange transportation with another person. VA will define the term “attendant” to include any person who provides required aid and/or physical assistance to the veteran to travel to a VA medical facility for hospital care or medical services. This definition is consistent with the definition of this

term in VA’s beneficiary travel regulation (see 38 CFR 70.2.), but the definition at § 70.2 is dependent on separate eligibility under the beneficiary travel program, and therefore is not cross referenced in § 17.1510(b)(4)(ii)(C). The list of factors in § 17.1510(b)(4)(ii)(A) through (C) is demonstrative and not exhaustive. There may be other unique factors that create an unusual or excessive burden for a veteran, and in such cases, VA will make a determination on a case-by-case basis.

#### **Changes Made by Public Law 114–41 Related to Veteran Eligibility, Periods of Follow Up Care, Wait Times, Distance Requirements, and Provider Eligibility**

Section 4005 of the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015 amended section 101 of the Choice Act to: Remove the August 1, 2014 enrollment date restriction, thereby making all veterans enrolled in the VA health care system under § 17.36 eligible for the Program if they meet its other eligibility criteria; remove the 60-day limit on an episode of care; modify wait-time eligibility requirements; modify the 40-mile distance eligibility criterion; and expand provider eligibility based on criteria as determined by VA. Sec. 4005, Public Law 114–41, 129 Stat. 443. Paragraph (a) of § 17.1510 is therefore revised, and paragraphs (a)(1) and (2) are removed, so it is clear under revised § 17.1510(a) that all veterans enrolled under § 17.36 are potentially eligible, as required by subsection (b) of section 4005 of Public Law 114–41. VA has already implemented these changes related to removal of the August 1, 2014 enrollment date ahead of the regulatory revisions in this interim final rule. These changes were not subject to notice and comment prior to implementation because they had an immediate effective date and VA did not need to interpret the language to give it effect. These changes are merely a restatement of existing statutory law to make our regulations consistent with Congressional intent as well as consistent with our current practice. VA enrolls new veterans every day, so these changes have allowed more veterans who also meet the other eligibility requirements under § 17.1510 to be eligible for the Program.

We discuss below the remaining changes made by Public Law 114–41 to section 101 of the Choice Act that are newly implemented in this interim final rule. Section 4005(a) of Public Law 114–41 amended section 101(h) of the Choice Act by removing the 60-day

limitation on an “episode of care.” Sec. 4005(a), Public Law 114–41, 129 Stat. 443. The definition of “episode of care” in § 17.1505 is therefore revised by removing the phrase “which lasts no longer than 60 days from the date of the first appointment with a non-VA health care provider.” We replace the 60-day limitation with a 1-year limitation, consistent with VA’s authority in section 101(c)(1)(B)(i) of the Choice Act to establish a timeframe for authorization of care. This change creates a broader standard in terms of the possible duration of an episode of care, but the definition of “episode of care” in § 17.1505 still means a “necessary course of treatment, including follow-up appointments and ancillary and specialty services” for identified health care needs. VA therefore retains clinical judgment in this revised definition to determine whether ancillary and specialty care of any duration up to 1 year is actually needed in the course of a veteran’s treatment. We reiterate from the November interim final rule that while some episodes of care require only a single visit, others may require multiple visits, but in all cases VA will authorize only the care that it deems necessary as part of a course of treatment. If a non-VA health care provider believes that a veteran needs additional care outside the scope of the authorized course of treatment, the health care provider must contact VA prior to administering such care to ensure that this care is authorized and therefore will be paid for by VA. Whether additional care constitutes a new “episode of care” will continue to be a clinical determination made by VA on a case-by-case basis. VA anticipates that the vendors that administer the Choice Program will require additional time after the effective date of this interim final rule to fully integrate this revision into their administrative functions. VA will work with the vendors that administer the Choice Program to ensure that care under the Choice Program is authorized in accordance with this rulemaking, even as the administrative functions of these vendors continue to change to accommodate this revision.

Section 4005(d) of Public Law 114–41 amended section 101(b)(2)(A) of the Choice Act to create eligibility for veterans that are unable to be scheduled for an appointment within “the period determined necessary for [clinically necessary] care or services if such period is shorter than” VHA’s wait time goals. Sec. 4005(d), Public Law 114–41, 129 Stat. 443. This new wait-times based criterion is added as paragraph

(b)(1)(ii) of § 17.1510, and creates eligibility when VA clinically determines that a veteran requires care within a period of time that is shorter than 30 days from the date an appointment is deemed clinically appropriate by a VA health care provider, or shorter than 30 days from the date that a veteran prefers to be seen.

Section 4005(e) of Public Law 114–41 amended section 101(b)(2)(B) of the Choice Act to modify the 40-mile distance eligibility criterion. Section 101(b)(2)(B)(i)–(ii) of the Choice Act now provides that veterans may be eligible if they reside more than 40 miles from “(i) with respect to a veteran who is seeking primary care, a medical facility of the Department, including a community-based outpatient clinic, that is able to provide such primary care by a full-time primary care physician; or (ii) with respect to a veteran not covered under clause (i), the medical facility of the Department, including a community-based outpatient clinic, that is closest to the residence of the veteran.” We find it would be impracticable to apply a “seeking primary care” eligibility criterion as literally written in the Act. Many individuals that seek VA care generally do not specifically “seek” primary care, but rather “seek” treatment for a specific complaint, and are directed first to primary care for the very purpose of determining what health care needs must be addressed. For instance, a veteran who is eligible for the Program and who seeks VA care for a complaint of generalized back pain would in most cases be directed first to primary care and not immediately to an orthopedist or chiropractor. Under a strict reading of the phrase “seeking primary care” in section 4005(e) of Public Law 114–41, such a veteran might not be considered eligible under the new section 101(b)(2)(B)(i) criterion because they did not specifically “seek” primary care.

Rather than make this distinction, between those veterans “seeking primary care” and those not “seeking primary care,” we interpret section 4005(e) of Public Law 114–41 as a clarification of the eligibility criterion for the 40-mile distance determination. Effectively, this would raise the threshold for what constitutes a qualifying VA medical facility to include only those facilities with at least a full-time primary care physician. For instance, previously, if a veteran lived 10 miles from a VA-community based outpatient clinic (CBOC) that did not have a full-time primary care physician, but lived 50 miles from another VA medical facility that did, the veteran

would not be eligible for the Program because of their proximity to the CBOC. Under this interim final rule, however, that veteran would be eligible for the Program because the nearest VA medical facility with a full-time primary care physician is more than 40 miles away. We therefore do not revise the general 40-mile requirement in § 17.1510(b)(1), but do revise § 17.1505 to add a definition of “full-time primary care physician,” as well as amend the definition of “VA medical facility” to require that such a facility have a full-time primary care physician. We note that “full-time primary care physician” will mean at least one individual physician whose workload, or multiple physicians whose combined workload, equates to a 0.9 full time equivalent employee that works at least 36 clinical work hours per week. This definition’s requirement that 36 of the 40 hours must be clinical is reasonable to ensure that for purposes of determining eligibility for the Veterans Choice Program, we are taking into account how much clinical work, as opposed to administrative work, a physician actually performs. VA updates full-time equivalent employee data for primary care physicians on a regular basis, and will use such data when making these determinations.

Not distinguishing between those veterans that are “seeking primary care” and other veterans is additionally more veteran-centric because we find that a veteran’s access to specialty care can be as important as their access to primary care, and in a majority of cases if a veteran lives more than 40 miles from a VA medical facility with a full-time primary care physician, it is very likely that such veteran also lives more than 40 miles away from a VA medical facility that would be able to provide the vast majority of specialty care that we know our veteran population requires. Lastly, if VA did distinguish between those veterans that are “seeking primary care” versus all other veterans who otherwise live more than 40 miles from a VA facility with a full-time primary care physician, this may have the effect of creating an unintentional back door for veteran eligibility in the Program, whereby veterans might be directed to seek primary care to be determined eligible, when such veterans may not actually need primary care. This interpretation gives effect to section 4005(e) of Public Law 114–41 by accounting for those veterans that would be specifically “seeking primary care” and that live more than 40 miles from a VA facility with a full-time primary care physician, as well as for

those veterans seeking care generally that live more than 40 miles from a VA facility with a full-time primary care physician.

Section 4005(c) of Public Law 114–41 amended sections 101(a)(1)(B) and 101(d) of the Choice Act to permit VA to expand provider eligibility beyond those providers expressly listed in section 101(a)(1)(B) of the Choice Act, in accordance with criteria as established by VA. Sec. 4005(c), Public Law 114–41, 129 Stat. 443. Under the authority of sections 101(a)(1)(B)(v) and 101(d)(5) of the Choice Act, we revise § 17.1530(a) to refer to a new paragraph (e) that will establish eligibility for these other providers, and add a new paragraph (e) to § 17.1530 to list these providers specifically. We also revise paragraph (d) to reorganize current requirements and add new requirements for these providers, in accordance with section 101(d)(5) of the Choice Act. We revise paragraph (d) to retain all requirements related to provider credentialing and licensure, as well as the annual provision to VA of documentation of such requirements, in new paragraph (d)(1)(A). We add paragraph (d)(1)(B) to require that all providers not be excluded from participation in a Federal health care program, as defined in particular sections of the Social Security Act, as well as not be listed as excluded sources or excluded providers or entities in databases and lists maintained under certain Federal programs (such as the System for Award Management or the List of Excluded Individuals and Entities that is maintained by the U.S. Department of Health and Human Services). These requirements in § 17.1530(d)(1)(B) ensure that providers that would participate in the Program are not those that are otherwise excluded from participating in Federal health care programs for a number of reasons, such as being convicted of criminal Medicare or Medicaid fraud, patient abuse or neglect, or felony convictions for other health care-related fraud, theft, or other financial misconduct. Lastly, new paragraph (d)(2) maintains the current requirement that eligible entities must ensure that their providers meet the standards established in § 17.1530(d).

Paragraph 17.1530(e) will specifically add new eligible providers for the Veterans Choice Program. Paragraph (e)(1) of § 17.1530 adds to the list of eligible providers any health care provider that is participating in a State Medicaid plan under title XIX of the Social Security Act (42 U.S.C. 1396 *et seq.*), including any physician furnishing services under such program, if the provider has an agreement under

a State plan under title XIX of such Act (42 U.S.C. 1396 *et seq.*) or a waiver of such a plan. Opening eligibility to Medicaid providers will increase VA's ability to offer certain services under the Program, including dental services (for veterans otherwise eligible for VA dental care) as well as some unskilled home health services, because providers of such services are not typically one of the provider types listed in section 101(a)(1)(B)(i)–(iv) of the Choice Act. We note that these services such as dental care and certain home health services are already considered “medical services” that VA is authorized to furnish under the Choice Act as well as under other statutory authorities that permit VA to provide non-VA care to veterans. *See* 38 U.S.C. 1703 and 38 U.S.C. 8153. Making Medicaid providers eligible under the Veterans Choice Program therefore does not newly authorize the provision of services to veterans generally, but merely expands services offered under the Veterans Choice Program specifically by expanding the pool of potential Choice providers.

Paragraph (e)(2) will make certain providers of extended care services eligible, namely an Aging and Disability Resource Center, an area agency on aging, or a State agency (as defined in section 102 of the Older Americans Act of 1965 (42 U.S.C. 3002)), or a center for independent living (as defined in section 702 of the Rehabilitation Act of 1973 (29 U.S.C. 796a)). Paragraph (e)(3) of § 17.1530 will establish eligibility for any provider meeting all requirements of § 17.1530(d) that is not listed in section 101(a)(1)(B)(i)–(iv) of the Choice Act or § 17.1530(e)(1)–(e)(2). This is essentially a flexible provision for these regulations so that VA can furnish care under the Program through providers who do not fall into the specific categories listed in section 101(a)(1)(B)(i)–(iv) of the Choice Act or § 17.1530(e)(1)–(e)(2), but satisfy the requirements in § 17.1530(d) to ensure that the provider is skilled and safe to provide services to veterans. This avoids the possible scenario that future required revisions to § 17.1530(e) would create delays in care being provided to veterans under the Program.

#### Miscellaneous Changes

To ensure that VA had the resources in place to support care for eligible veterans, the November 2014 interim final rule established different start dates for eligible veterans in § 17.1525 so that implementation of the Program could be phased in. Because the start dates in § 17.1525 have already passed, we remove the language in § 17.1525 to

include the section header, but retain § 17.1525 and mark it as reserved for future use.

#### Administrative Procedure Act

The Secretary of Veterans Affairs finds under 5 U.S.C. 553(b)(B) that there is good cause that advance notice and opportunity for public comment are impracticable, unnecessary, or contrary to the public interest and under 5 U.S.C. 553(d)(3) that there is good cause to publish this rule with an immediate effective date. Section 101(n) of the Choice Act authorized VA to implement the Veterans Choice Program through an interim final rule, and provided a deadline of no later than November 5, 2014, the date that is 90 days after the date of the enactment of the law. Additionally, the Program is only authorized to run until August 7, 2017, or until funds expire, which creates a need for expedited action. The changes made by the Construction Authorization and Choice Improvement Act included an immediate effective date under section 3(b) of that Act. These provisions clearly demonstrate that Congress intended that VA act quickly in expanding access to non-VA care options.

This interim final rule changes the criteria VA may consider when determining if a veteran faces an unusual or excessive burden in traveling to the nearest VA medical facility. This interim final rule also expands eligibility for veterans in other ways (through the new criteria related to wait times and to the distance requirements), as well as expands eligibility for providers as required and permitted by the most recent amendments to the Choice Act. These changes will increase the number of veterans who are eligible for the Veterans Choice Program. In order for these veterans to have access to needed health care under the Program, it is essential that the revised criteria be made effective as soon as possible. For the above reasons, we are issuing this rule as an interim final rule. However, VA will consider and address comments that are received within 120 days of the date this interim final rule is published in the **Federal Register**.

#### Effect of Rulemaking

Title 38 of the Code of Federal Regulations, as revised by this interim 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 guidance or procedures are authorized. All existing or subsequent VA guidance must be read to conform with this

rulemaking if possible or, if not possible, such guidance is superseded by this rulemaking.

#### **Paperwork Reduction Act**

Although this action contains provisions constituting collections of information, at 38 CFR 17.1530(d), under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3521), no new or proposed revised collections of information are associated with this interim final rule. The information collection requirements for § 17.1530(d) are currently approved by the Office of Management and Budget (OMB) and have been assigned OMB control number 2900–0823.

#### **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,” requiring review by 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 this Executive Order.”

The economic, interagency, budgetary, legal, and policy implications of this regulatory action have been examined, and it has been determined that this is an economically significant regulatory action under Executive Order 12866. VA’s regulatory impact analysis can be found as a supporting document at [http://](http://www.regulations.gov)

[www.regulations.gov](http://www.regulations.gov), usually within 48 hours after the rulemaking document is published. Additionally, a copy of the rulemaking and its regulatory impact analysis are available on VA’s Web site at <http://www.va.gov/orpm/>, by following the link for “VA Regulations Published From FY 2004 Through Fiscal Year to Date.”

#### **Congressional Review Act**

This regulatory action is a major rule under the Congressional Review Act, 5 U.S.C. 801–08, because it may result in an annual effect on the economy of \$100 million or more. Although this regulatory action constitutes a major rule within the meaning of the Congressional Review Act, 5 U.S.C. 804(2), it is not subject to the 60-day delay in effective date applicable to major rules under 5 U.S.C. 801(a)(3) because the Secretary finds that good cause exists under 5 U.S.C. 808(2) to make this regulatory action effective on the date of publication, consistent with the reasons given for the publication of this interim final rule. In accordance with 5 U.S.C. 801(a)(1), VA will submit to the Comptroller General and to Congress a copy of this regulatory action and VA’s Regulatory Impact Analysis.

#### **Unfunded Mandates**

The Unfunded Mandates Reform Act of 1995 requires, at 2 U.S.C. 1532, that agencies prepare an assessment of anticipated costs and benefits before issuing any rule that may result in the expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of \$100 million or more (adjusted annually for inflation) in any 1 year. This interim final rule will have no such effect on State, local, and tribal governments, or on the private sector.

#### **Regulatory Flexibility Act**

The Secretary hereby certifies that this interim 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 interim final rule will not have a significant economic impact on participating eligible entities and providers who enter into agreements with VA. To the extent there is any such impact, it will result in increased business and revenue for them. We also do not believe there will be a significant economic impact on insurance companies, as claims will only be submitted for care that will otherwise have been received whether such care was authorized under this Program or not. Therefore, pursuant to 5 U.S.C. 605(b), this rulemaking is exempt from

the initial and final regulatory flexibility analysis requirements of 5 U.S.C. 603 and 604.

#### **Catalog of Federal Domestic Assistance**

The Catalog of Federal Domestic Assistance numbers and titles for the programs affected by this document are as follows: 64.007, Blind Rehabilitation Centers; 64.008, Veterans Domiciliary Care; 64.009, Veterans Medical Care Benefits; 64.010, Veterans Nursing Home Care; 64.011, Veterans Dental Care; 64.012, Veterans Prescription Service; 64.013, Veterans Prosthetic Appliances; 64.014, Veterans State Domiciliary Care; 64.015, Veterans State Nursing Home Care; 64.016, Veterans State Hospital Care; 64.018, Sharing Specialized Medical Resources; 64.019, Veterans Rehabilitation Alcohol and Drug Dependence; 64.022, Veterans Home Based Primary Care; and 64.024, VA Homeless Providers Grant and Per Diem Program.

#### **Signing Authority**

The Secretary of Veterans Affairs, or designee, approved this document and authorized the undersigned to sign and submit the document to the Office of the Federal Register for publication electronically as an official document of the Department of Veterans Affairs. Robert L. Nabors II, Chief of Staff, Department of Veterans Affairs, approved this document on October 9, 2015, for publication.

#### **List of Subjects in 38 CFR Part 17**

Administrative practice and procedure, Alcohol abuse, Alcoholism, Claims, Day care, Dental health, Drug abuse, Government contracts, Grant programs—health, Grant programs—veterans, Health care, Health facilities, Health professions, Health records, Homeless, Mental health programs, Nursing homes, Reporting and recordkeeping requirements, Travel and transportation expenses, Veterans.

Dated: November 19, 2015.

#### **Michael P. Shores,**

*Chief Impact Analyst, Office of Regulation Policy & Management, Office of the General Counsel, Department of Veterans Affairs.*

For the reasons set forth 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.

■ 2. Amend § 17.1505 by:

- a. Revising the definition of “episode of care”.
- b. Adding a definition of “full-time primary care physician”.
- c. Revising the definition of “VA medical facility”.
- d. Revising the authority citation.

The revisions and addition read as follows:

**§ 17.1505 Definitions.**

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*Episode of care* means a necessary course of treatment, including follow-up appointments and ancillary and specialty services, which lasts no longer than 1 calendar year from the date of the first appointment with a non-VA health care provider.

*Full-time primary care physician* means a single VA physician whose workload, or multiple VA physicians whose combined workload, equates to 0.9 full time equivalent employee working at least 36 clinical hours a week at the VA medical facility and who provides primary care as defined by their privileges or scope of practice and licensure.

\* \* \* \* \*

*VA medical facility* means a VA hospital, a VA community-based outpatient clinic, or a VA health care center, any of which must have at least one full-time primary care physician. A Vet Center, or Readjustment Counseling Service Center, is not a VA medical facility.

\* \* \* \* \*

(Authority: Sec. 101, Pub. L. 113–146, 128 Stat. 1754; Sec. 4005, Pub. L. 114–41, 129 Stat. 443)

- 3. Amend § 17.1510 by revising paragraphs (a), (b)(1), (b)(4)(ii), and the authority citation to read as follows:

**§ 17.1510 Eligible veterans.**

\* \* \* \* \*

(a) A veteran must be enrolled in the VA health care system under § 17.36.

(b) \* \* \*

(1) The veteran attempts, or has attempted, to schedule an appointment with a VA health care provider, but VA is unable to schedule an appointment for the veteran within:

(i) The wait-time goals of the Veterans Health Administration; or

(ii) With respect to such care or services that are clinically necessary, the period VA determines necessary for such care or services if such period is shorter than the wait-time goals of the Veterans Health Administration.

\* \* \* \* \*

(4) \* \* \*

(ii) Faces an unusual or excessive burden in traveling to such a VA

medical facility based on geographical challenges, such as the presence of a body of water (including moving water and still water) or a geologic formation that cannot be crossed by road; environmental factors, such as roads that are not accessible to the general public, traffic, or hazardous weather; a medical condition that affects the ability to travel; or other factors, as determined by VA, including but not limited to:

(A) The nature or simplicity of the hospital care or medical services the veteran requires;

(B) The frequency that such hospital care or medical services need to be furnished to the veteran; and

(C) The need for an attendant, which is defined as a person who provides required aid and/or physical assistance to the veteran, for a veteran to travel to a VA medical facility for hospital care or medical services.

\* \* \* \* \*

(Authority: Sec. 101, Pub. L. 113–146, 128 Stat. 1754; Section 3(a)(2) of Pub. L. 114–19, 129 Stat. 215)

**§ 17.1525 [Removed and Reserved]**

- 4. Remove and reserve § 17.1525

- 5. Amend § 17.1530 by revising paragraphs (a), and (d), adding paragraph (e), and revising the authority citation to read as follows:

**§ 17.1530 Eligible entities and providers.**

(a) *General.* An entity or provider is eligible to deliver care under the Veterans Choice Program if, in accordance with paragraph (c) of this section, it is accessible to the veteran and is an entity or provider identified in section 101(a)(1)(B)(i)–(iv) of the Veterans Access, Choice, and Accountability Act of 2014 or is an entity identified in paragraph (e) of this section, and is either:

\* \* \* \* \*

(d) *Requirements for health care providers.* (1) To be eligible to furnish care or services under the Veterans Choice Program, a health care provider must:

(i) Maintain at least the same or similar credentials and licenses as those required of VA’s health care providers, as determined by the Secretary. The agreement reached under paragraph (b) of this section will clarify these requirements. Eligible health care providers must submit verification of such licenses and credentials maintained by the provider to VA at least once per 12-month period.

(ii) Not be excluded from participation in a Federal health care program (as defined in section 1128B(f) of the Social Security Act (42 U.S.C.

1320a–7b(f)) under section 1128 or 1128A of such Act (42 U.S.C. 1320a–7 and 1320a–7a)), not be identified as an excluded source on the list maintained in the System for Award Management or any successor system, and not be identified on the List of Excluded Individuals and Entities that is maintained by the Office of the Inspector General of the U.S. Department of Health and Human Services.

(2) Any entities that are eligible to provide care through the Program must ensure that any of their providers furnishing care and services through the Program meet the standards identified in paragraph (d)(1) of this section. An eligible entity may submit this information on behalf of its providers.

(e) *Other eligible entities and providers.* In accordance with sections 101(a)(1)(B)(v) and 101(d)(5) of the Veterans Access, Choice, and Accountability Act of 2014 (as amended), the following entities or providers are eligible to deliver care under the Veterans Choice Program, subject to the additional criteria established in this section.

(1) A health care provider that is participating in a State Medicaid plan under title XIX of the Social Security Act (42 U.S.C. 1396 *et seq.*), including any physician furnishing services under such program, if the health care provider has an agreement under a State plan under title XIX of such Act (42 U.S.C. 1396 *et seq.*) or a waiver of such a plan;

(2) An Aging and Disability Resource Center, an area agency on aging, or a State agency (as defined in section 102 of the Older Americans Act of 1965 (42 U.S.C. 3002)), or a center for independent living (as defined in section 702 of the Rehabilitation Act of 1973 (29 U.S.C. 796a)).

(3) A health care provider that is not identified in paragraph (e)(1) or (2) of this section, if that provider meets all requirements under paragraph (d) of this section.

(Authority: Sec. 101, Pub. L. 113–146, 128 Stat. 1754; Sec. 4005, Pub. L. 114–41, 129 Stat. 443)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–0823.)

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