created electronically using word processing software must be filed in native applications or print-to-PDF format and not in a scanned format. Commenters filing electronically do not need to make a paper filing.

62. Commenters that are not able to file comments electronically may file an original of their comment by USPS mail or by courier-or other delivery services. For submission sent via USPS only, filings should be mailed to: Federal Energy Regulatory Commission, Office of the Secretary, 888 First Street NE, Washington, DC 20426. Submission of filings other than by USPS should be delivered to: Federal Energy Regulatory Commission, 12225 Wilkins Avenue, Rockville, MD 20852.

VII. Document Availability

63. In addition to publishing the full text of this document in the **Federal Register**, the Commission provides all interested persons an opportunity to view and/or print the contents of this document via the internet through the Commission's Home Page (*https://www.ferc.gov*). From the Commission's Home Page on the internet, this information is available on eLibrary. The full text of this document is available on eLibrary in .pdf and Microsoft Word format for viewing, printing, and/or downloading. To access this document in eLibrary, type the docket number excluding the last three digits of this document in the docket number field.

64. User assistance is available for eLibrary and the Commission's website during normal business hours from FERC Online Support at (202) 502–6652 (toll free at 1–866–208–3676) or email at *ferconlinesupport@ferc.gov,* or the Public Reference Room at (202) 502–8371, TTY (202)502–8659. Email the Public Reference Room at *public.referenceroom@ferc.gov.*

By direction of the Commission.

Dated: September 19, 2024.

Debbie-Anne A. Reese,

Acting Secretary.

[FR Doc. 2024–22230 Filed 9–30–24; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF DEFENSE

Office of the Secretary

32 CFR Part 220

[Docket ID: DoD–2022–HA–0054]

RIN 0720–AB87

Medical Billing for Healthcare Services Provided by Department of Defense Military Medical Treatment Facilities to Civilian Non-Beneficiaries

AGENCY: Defense Health Agency (DHA), Department of Defense (DoD).

ACTION: Proposed rule.

SUMMARY: As required by the James M. Inhofe National Defense Authorization Act for Fiscal Year 2023 (NDAA–23), this document proposes to reduce financial harm to civilians who are not covered beneficiaries of the Military Health System (MHS), and who receive healthcare services at DoD military medical treatment facilities (MTF). The rulemaking, once finalized, will implement the MHS Modified Payment and Waiver Program (MPWP) through which the DoD will apply a sliding fee scale and/or a catastrophic fee waiver to medical invoices of certain non-beneficiaries and will accept payments from health insurers of non-beneficiaries as full payment except for copays, coinsurance, deductibles, nominal fees and non-covered services.

DATES: This rulemaking, once finalized, will apply to non-beneficiary patient medical care provided on or after June 21, 2023. Comments to this proposed rule are being accepted and must be received by December 2, 2024.

ADDRESSES: You may submit comments, identified by docket number and/or Regulation Identifier Number (RIN) number and title, by any of the following methods:

- *Federal eRulemaking Portal: https://www.regulations.gov.* Follow the instructions for submitting comments.
- *Mail:* Department of Defense, Office of the Assistant to the Secretary of Defense for Privacy, Civil Liberties, and Transparency, Regulatory Directorate, 4800 Mark Center Drive, Attn: Mailbox 24, Suite 08D09, Alexandria, VA 22350–1700.

Instructions: All submissions received must include the agency name and docket number or RIN. The general policy for comments is to make these submissions available for public viewing at *https://www.regulations.gov* as they are received without change, including any personal identifiers or contact information.

FOR FURTHER INFORMATION CONTACT: Ms. Merlyn Jenkins, phone number: (703) 681–7346, mailing address: Office of the Secretary of Defense for Health Affairs, Health Resources Management and Policy, 1200 Defense Pentagon, Washington, DC 20301–1200; email address: *mailto:merlyn.jenkins.civ@health.mil.*

SUPPLEMENTARY INFORMATION: The NDAA–23 also grants the Director of DHA discretionary authority to waive assessment of medical fees of non-beneficiaries when the healthcare provided enhances the knowledge, skills, and abilities (KSAs) of healthcare providers, as determined by the Director of DHA. The DHA is proposing to implement the amendments to 10 U.S.C. 1079b enacted through the NDAA–23. By statute (Pub. L. 117–263, div. A, title VII, § 716(c), Dec. 23, 2022, 136 Stat. 2661), the sliding fee scale and/or catastrophic fee waivers apply to bills for healthcare services provided at MTFs on or after June 21, 2023.

I. Background and Authority

Title 10, United States Code (U.S.C.), section 1073d requires the Department of Defense (DoD) to maintain MTFs for the purposes of supporting the medical readiness of the armed forces and the readiness of deployable medical personnel. To maintain medical currency and bolster the KSAs of DoD healthcare providers, the DoD renders emergency, trauma, and other medical services to beneficiaries of the MHS which consist of service members and former service members, and their dependents. The MHS may provide healthcare services to other individuals who are not eligible beneficiaries, in certain circumstances, as authorized by law, and typically on a reimbursable basis (Pub. L. 114–328, 717(c), Dec. 23, 2016, as amended (10 U.S.C. 1071 note); and § 1074(c)).

Proposed rules implementing DoD's authority under 10 U.S.C. 1095 and related provisions of law to compute reasonable charges for inpatient and ambulatory (outpatient) care provided by MTFs, including charges for pharmaceuticals, durable medical equipment, supplies, immunizations, injections, or other medications, are at 32 CFR part 220, last updated on August 20, 2020 (55 FR 21742–21750). Medical billing is structured under three existing healthcare cost recovery programs: Third Party Collections (10 U.S.C. 1095); Medical Services Account (10 U.S.C. 1079b, 1085, and 1104); and Medical Affirmative Claims (42 U.S.C. 2651–2653). The rates used for billing are modeled after the rates published by

the Centers for Medicare & Medicaid Services. The rates are approved annually by the Assistant Secretary of Defense for Health Affairs (ASD(HA)) and published on the DoD Comptroller's website at *https://comptroller.defense.gov/Financial-Management/Reports/rates2023/*. Funds collected through the healthcare cost recovery programs are used to enhance healthcare delivery at MTFs.

In carrying out the DoD's healthcare cost recovery programs, charges and fees for care provided are assessed, as applicable, to civilian non-beneficiary patients who receive treatment at MTFs. When medical care is provided, such individuals become indebted to the United States. The DoD has authority under the Debt Collection Improvement Act of 1996 (DCIA) (Pub. L. 104–134) to compromise, or terminate the collection of, claims involving monetary indebtedness to the United States. The Federal Claims Collection Standards (FCCS) promulgated at 31 CFR parts 900through 904, which implement the DCIA, require that Federal agencies aggressively collect all debts arising out of activities of that agency. Collection activities must be undertaken promptly with follow-up action taken as necessary. Although an individual's financial circumstances are considered in applying the FCCS, the relevance of such information in determinations concerning debt compromise or termination concerns the likelihood of repayment or successful enforced collection within a reasonable period of time, rather than the impact on or financial harm to an individual that is consequential to being indebted. Accordingly, DoD MTFs have generated medical claims and invoices for care to civilian non-beneficiaries rendered within MTFs and have administered delinquent accounts consistent with the FCCS.

Title 10 U.S.C. 1079b, as amended by section 716 of NDAA–23, establishes financial harm to certain individual civilian non-beneficiaries as a statutory factor used in setting the amount of fees and charges assessed.

II. Problem Being Addressed Through This Rulemaking

Due to the high cost of healthcare in the United States and the mandate for Federal agencies to aggressively pursue collection of debts under FCCS, civilian non-beneficiaries who were provided emergency or trauma healthcare services in DoD MTFs have experienced financial harm after receiving substantial medical bills from MTFs. The DoD does not have authority to forgive indebtedness for MTF charges outside of the FCCS and has not had authority to discount charges and fees for medical care, in contrast to for-profit and non-profit hospitals that offer various financial assistance policies (FAPs). In consequence, Congress wholly amended 10 U.S.C. 1079b via section 716 of NDAA–23. Section 716 directs DoD to apply a sliding fee and/or a catastrophic fee waiver when assessing fees and charges to non-beneficiaries. For non-beneficiaries with health insurance, Section 716 directs DoD to accept payments from health insurers as full payment and to not balance bill non-beneficiaries except for copays, coinsurance, deductibles, nominal fees, and non-covered services. It also provides the Director of DHA conditional, discretionary authority to waive the assessment of fees that otherwise would be charged to non-beneficiaries when the healthcare provided enhances the KSAs of healthcare providers, as determined by the Director of DHA. The NDAA for FY 2017 (NDAA–17) authorizes provision of such care on a reimbursable basis to civilians who are not covered beneficiaries. Public Law 114–328, § 717(c), Dec. 23, 2016, as amended, 10 U.S.C. 1071 note.

III. Alternatives Considered

Section 716(c) of NDAA–23 mandates that DoD implement the amendments to 10 U.S.C. 1079b within 180 days of enactment. With this constrained timeline, the DoD undertook expedited research efforts to ascertain whether private sector hospitals offered programs similar to what the statute mandates and which might serve as a model for the DoD. Research conducted indicated that while there is financial reporting of charitable care and FAPs by non-Federal entities that provide medical care, there is no single accessible and authoritative source which outlines the content and structure of those programs. Programs vary widely across the researched entities. The market research also included a review of the rules pertaining to eligibility for Federal and State programs such as Medicaid. The research provided a few alternative models for consideration in establishing the MHS MPWP, including:

- Alternative #1: Although charity care policies vary by state, generally, for-profit and non-profit hospitals determine a patient's eligibility for their FAPs by comparing the applicant's annual household income against the Federal Poverty Guidelines (FPGs). The FPGs are published annually by the Department of Health and Human Services pursuant to 42 U.S.C. 9902(2). There are separate FPGs for the contiguous 48 states and Washington DC, for Alaska, and for Hawaii. The Census Bureau annually publishes FPG thresholds. The threshold is a statistical calculation used to identify the number of people living in poverty. There is no geographic variation; the same figures are used for all 50 states and Washington DC. The Office of Management and Budget (OMB) designates the Census Bureau poverty thresholds as the Federal Government's official statistical definition of poverty. The FPGs are also used by State and Federal agencies for determining an individual's eligibility for programs such as Medicaid.
- Alternative #2: Both for-profit and non-profit hospitals often offer discounted charges and fees on a sliding scale based upon the patient's household income when compared to the FPGs. Predominantly, discounts are offered to individuals whose household income falls within the range of 125 percent to 400 percent of the FPGs, with most hospitals offering discounts to patients whose income is at or below 200 percent of the FPGs.
- Alternative #3: Most private sector hospitals do not offer programs, additional to their needs-based FAPs for further waiver of charges or fees, that are analogous to § 1079b(c)(3)'s mandate for a DoD catastrophic fee waiver program, but a few will limit a patient's bill to a maximum percentage of the patient's household income (range of 10 to 20 percent of monthly income). In addition, we examined the maximum percentage that agencies generally can administratively garnish from an individual's monthly income (generally 15 percent of monthly income). See 31 U.S.C. 3720D(b)(1); 31 CFR 285.11.

IV. Recommended Proposed Policy

The three alternative models identified through market research represent fair and reasonable approaches that could readily be adopted for use in the administration of the MHS MPWP, with some modifications, and without incurring significant costs to implement. This regulation's proposed way forward is a combination of all three alternatives that make up the recommended policy. Specifically:

- Alternative #1: Since 10 U.S.C. 1079b mandates the application of a sliding scale and catastrophic fee waivers, the FPGs will be used as the measure to determine a patient's eligibility for these discounts. Alternative #2: The FPG range for eligibility for the sliding scale discount set by the ASD(HA) will be published

annually on the DoD Comptroller's Reimbursement Rates website available at *https://comptroller.defense.gov/Financial-Management/Reports/rates2024/.* The ASD(HA) may revise the range, when appropriate, to mitigate financial harm. Alternative #3: Eligibility for a catastrophic fee waiver will be limited based on a maximum percentage of a patient's monthly household income determined by the ASD(HA) and published annually on the DoD Comptroller's Reimbursement Rates website. The ASD(HA) may revise the percentage applied to household income, when appropriate, to mitigate financial harm.

In summary, the DoD proposes to adopt and implement fair and reasonable application of a sliding scale and catastrophic fee waivers in accordance with precedent and market best practices. The FPGs will be used as the definitive measure to determine a patient's eligibility for discounts and waivers.

The FPG range of eligibility for the sliding scale discount will be published annually on the DoD Comptroller's Reimbursement Rates website, giving DoD maximum flexibility to mitigate financial harm.

The catastrophic percentage will be published annually on the DoD Comptroller's Reimbursement Rates website, giving DoD maximum flexibility to mitigate financial harm.

V. Other Applicable Authority

Section 717 of NDAA–17 conditionally authorizes DoD to evaluate and treat civilian non-beneficiaries at MTFs if the evaluation and treatment is necessary to maintain medical readiness skills and competencies of healthcare providers. Section 717(c) mandates that DoD bill such individuals for the costs of such healthcare services provided. By amending 10 U.S.C. 1079b, section 716 of NDAA–23 has provided discretionary authority to waive an individual's responsibility to pay those statutorily mandated charges if the provision of care enhances the KSAs of healthcare providers, as determined by the DHA. If, under 10 U.S.C. 1079b(b), DoD elects to waive charges it is otherwise statutorily required to collect from an individual, any resulting discharge of indebtedness may need to be reported to the Internal Revenue Service (IRS) in accordance with the reporting requirements at 26 U.S.C. 6050P. DoD may also be required to issue a Form 1099–C, ''Cancellation of Debt'' (OMB Control Number 1545–1424), available at *https://www.irs.gov/pub/irs-pdf/f1099c.pdf,* to the patient in accordance with the same reporting requirements. This discharge of indebtedness could result in gross income being attributed to the patient under 26 U.S.C. 61. Authority provided by § 1079b(c) to adjust or waive assessment of fees and charges for medical care will be exercised by applying criteria applicable to civilian non-beneficiaries, rather than by exercising discretion to discharge indebtedness with respect to non-beneficiaries. Consequently, to reduce avoidable gross income to a patient under 26 U.S.C. 61, DoD will consider a waiver under 10 U.S.C. 1079b(b) of an individual's responsibility to pay charges only after any sliding scale discounts and catastrophic cap on charges have been applied.

VI. Summary of Current Billing and Collection Processes Involving Non-Beneficaries

For non-beneficiary medical encounters occurring prior to June 21, 2023, an MTF processes a bill to either the patient, the patient's third-party insurance, or to another guarantor. The current legal framework to process non-beneficiary bills is established under 10 U.S.C. 1079b (Procedures for Charging Fees to Civilians). Collection of medical debt resulting from medical bills is subject to the DCIA.

Title 10 U.S.C. 1079b directs the Secretary of Defense to implement procedures by which a non-beneficiary will be billed. The ASD(HA) publishes medical rates packages that are updated annually. The ASD(HA) rates reflect the full cost to the Government of providing care to a non-beneficiary patient; the rates generally reflect the same amounts that DoD reimburses to civilian healthcare providers when care is rendered outside of an MTF to a beneficiary patient, and they are also the same rates that DoD uses to bill third-party health insurers (under 10 U.S.C. 1095) when a beneficiary patient receives care in an MTF.

A bill generated for care at an MTF must be paid in full, whether by the patient, medical insurer, or other guarantor. The full amount is pursued against the patient and/or the patient's guarantor. If the debt is not paid within 180 days of the due date (or an installment plan due date), the debt is transferred to the Cross-Servicing Program (''Cross-Servicing'') of the Department of the Treasury, Bureau of the Fiscal Service, for collection. Agencies may also refer eligible debts that are less than 180 days delinquent to the Cross-Servicing program.

Under the current legal framework there is no authority to reduce the amount of a debt owed by a patient who received care at an MTF. There is an ability to compromise a balance that cannot be paid by the non-beneficiary. However, the FCCS governing a compromise requires that a debtor reasonably demonstrate the inability to pay the debt balance, which entails evaluation of a debtor's current financial condition, and obtaining a credit report or other financial information in order to evaluate the debtor's assets, liabilities, income, and expenses.

VII. Changes With This Rulemaking

A. MHS Modified Payment and Waiver Program

Under title 10 U.S.C. 1079b, as amended by NDAA–23, the DoD is required to apply a sliding scale and/or catastrophic fee waivers to medical invoices generated by MTFs in certain instances. The statute also gives the Director of DHA discretionary authority to waive charges mandated by section 717 of NDAA–17, when the care provided enhances the medical KSAs of MHS healthcare providers, as determined by the Director of DHA. Consequently, the DoD proposes to implement § 1079b authorities with the objective of mitigating financial harm to civilian non-beneficiaries. The MHS MPWP will be applied uniformly to all civilian non-beneficiary patients who apply to the program. Applicable discounts will be based only on household income and family size. All patients will be eligible to apply for the MHS MPWP in order to mitigate financial harm.

The MHS MPWP will involve a cascading, sequential process that begins with collecting health insurance information from all patients. For patients with health insurance, the patient must agree to allow DoD to file medical claims on the patient's behalf. Patients with health insurance who do not consent to allowing DoD to file insurance claims on their behalf will not be eligible for the MHS MPWP. By allowing DoD to file insurance claims on the patient's behalf, the DoD will be assured that insurance remittances and Explanation of Benefits (EOB) documents are properly sent to the DoD. This will enable the DoD to adjust balances on the patient's account inclusive of the amount paid by the insurance carrier, amounts disallowed, and amounts that are the patient's responsibility as determined by the insurance carrier (*i.e.,* copays, coinsurance, deductibles, nominal fees and non-covered services). Once the patient's account is properly adjusted in accordance with the EOB, the DoD will bill insured patients only for portions of

the bill that are their responsibility. For patients without health insurance, DoD will bill the patient.

Patients who are uninsured, underinsured and/or who have a remaining balance for copay, coinsurance, deductible, nominal fee, or non-covered services may apply to the MHS MPWP for application of the sliding scale discounts and catastrophic fee waiver discounts.

Patients unable to pay the remaining balance after the application of the sliding scale and catastrophic fee waiver may also apply for a waiver of their medical fees under 10 U.S.C. 1079b(b), by submitting a completed DD Form 3201–1, ''Request for Medical Debt Waiver, Military Health System Modified Payment and Waiver Program'' (*https://www.esd.whs.mil/Directives/forms/dd3000_3499/*). Waivers may be approved when—at the discretion of the DHA Director, the care rendered to the patient enhanced the KSAs of the healthcare providers. KSAs are a set of clinical skill requirements a provider needs in order to provide medical care/treatment in the deployed environment. Additionally, waivers will be used sparingly and generally only in instances where severe financial harm cannot be reasonably mitigated through application of discounts. Waivers may result in financial reporting to the IRS and issuance of an IRS Form 1099–C to the patient. Generally, waivers may be granted if: (a) The patient has completed a DD Form 2569, ''Third Party Collection Program/Medical Services Account/Other Health Insurance'' (OMB Control Number 0720–0055), available at *https://www.esd.whs.mil/Directives/forms/dd2500_2999/;* (b) the patient has submitted a completed application for the MHS MPWP via the DD Form 3201 and any and all appropriate discounts have been applied; (c) DHA competent medical authority confirms in writing on the DD Form 3201–1 that the care provided to the patient enhanced the KSAs of the DoD healthcare provider; and (d) the DHA determines that a waiver is necessary to mitigate severe financial harm. If the above conditions are met, the Director of DHA may exercise discretionary authority to waive the medical invoice.

B. Collection of Health Insurance Information

All patients receiving healthcare services at a DoD MTF are asked to complete a DD Form 2569 to collect health insurance information along with the patients' consent for the DoD to file a claim on their behalf. The form advises patients that their ''records may be disclosed outside of DoD to healthcare clearinghouses, commercial insurance providers, and other third parties in order to collect amounts owed to the Department of Defense.''

C. Billing Insurance

For non-beneficiaries with health insurance who complete the DD Form 2569, the DHA will bill the non-beneficiary's health insurance and accept remittances. When payment or an EOB is received from the insurance company, the DoD will not bill the patient except for copays, coinsurance, deductibles, nominal fees, and amounts for non-covered services. The DoD will suspend collection against the patient for up to 120 days to allow the patient's insurance to process the claim. The DoD will not bill the patient until a determination on payment and/or an EOB is received from the insurance company, or 120 days has lapsed, whichever comes first. If the DoD receives an insurance remittance after 120 days have elapsed, the DoD will deposit the check, adjust the patient's account in accordance with the EOB, and issue the patient a refund for overpayments, if any have been received. The DoD will ensure that medical invoices sent to the patient reflect information about the MHS MPWP, including instructions for applying to the program.

D. Delinquent Accounts

Delinquent accounts will be processed in accordance with the DCIA as implemented by the FCCS.

E. Applications for MHS MPWP Received for Delinquent Accounts Transferred to the Department of the Treasury

Individuals may still submit an application for the MHS MPWP even if their account has been transferred to Cross-Servicing; however, any reductions to the medical invoice from the MPWP may be subject to interest, penalties, and costs. For patients who apply and are eligible for a reduction under the MHS MPWP, the DoD will recall the debt from Cross-Servicing. For patients who apply and are ineligible for a reduction under the MHS MPWP, the debt will remain at Cross-Servicing. Patients may request reconsideration for the MHS MPWP when their financial circumstances appear to have significantly changed.

F. Income Verification and Collection of Income Information

Required MHS MPWP application documentation. Patients who desire to apply for the MHS MPWP must do so by completing a DD Form 3201, ''Application for Military Health System Modified Payment and Waiver Program'' (OMB Control Number PENDING), available at *https://www.esd.whs.mil/Directives/forms/dd3000_3499/,* and submitting the requisite documents. All DoD patient invoices will include a description of the documents that patients must submit together with DD Form 3201 in order to demonstrate their eligibility for the MHS MPWP. To demonstrate eligibility for a sliding fee/catastrophic fee waiver, the patient must first complete a DD Form 2569 (even in cases where the patient possesses no health insurance). Patients must also attach a copy of their most recent filed Federal income tax return and the patient's (or guarantor's if the patient is a minor) last two pay stubs. Patients who did not file a Federal income tax return for the preceding year, must certify that they did not file an income tax return on the DD Form 3201. Additionally, when the patient has no verifiable income, the patient must provide a certification to that effect on the DD Form 3201. The last two pay stubs or disability check stubs may be used if no Federal income tax return is provided in conjunction with the patient's certification of annual income on the DD Form 3201 to determine the patient's income. Finally, when the patient has certified to having no verifiable income and has neither a tax return nor pay stubs, other information may be used to validate the patient's lack of income including, but not limited to, the last two bank statements (savings and checking), or a Social Security benefits letter.

For patients with health insurance, the patient must agree to allow DoD to file medical claims on the patient's behalf.

G. Application for MHS MPWP Discounts and Waivers

Consideration for sliding scale and catastrophic fee waiver requires evaluation of the patient's household income. To receive consideration for the sliding fee discount or catastrophic fee waiver, or to be considered for a full waiver of fees under 10 U.S.C. 1079b(b), the patient must apply to the MHS MPWP after receiving the MTF medical invoice by completing and submitting the DD Form 3201 (OMB Control Number PENDING). Applications can be made by: (1) patients with a remaining balance after insurance has been billed by the DoD and the insurance remittance and/or EOB has been received by the DoD; (2) by patients without insurance who have a balance; and (3) by patients with a remaining balance after recovery from tortfeasors is

made. Application instructions will be printed on the DoD invoice. Applicants to the MHS MPWP will be notified of the status of their application via the following methods: (1) For approved applications, the DoD will issue to the patient a modified medical invoice reflecting the balance due after applying the sliding fee and/or catastrophic fee waiver; (2) for disapproved applications, the DoD will issue a letter reflecting the reason why the application was disapproved. The letter will inform the patient of the right to reapply should the patient's financial circumstances change.

H. Sliding Fee Discount

Applicants to the MHS MPWP will first be considered for a sliding fee discount, and then for a catastrophic fee waiver. The threshold for the sliding fee discount will be set to a 100 percent medical bill discount and no nominal fee for applicants whose annual household income is at or below 100 percent of the applicable year's FPGs; and a 100 percent medical bill discount plus a stratified nominal fee for applicants whose annual household income is greater than 100 percent and up to 400 percent of the applicable year's FPGs. The ASD(HA) may periodically adjust the threshold limits by issuing policy to be published on the DoD Reimbursement Rates website (*https://comptroller.defense.gov/Financial-Management/Reports/*). Stratified nominal fees are generally established in a manner that is equitable with what military retirees enrolled in the TRICARE program would be required to pay in the private sector for comparable services. The ASD(HA) will annually set the stratified nominal fees for outpatient and inpatient care and may periodically adjust the nominal fee by issuing policy to be published on the DoD Reimbursement Rates website (available at *https://comptroller.defense.gov/Financial-Management/Reports/*). The initial nominal stratified fees are as follows:

Household income falls within the below federal poverty guidelines (%)	Inpatient fee	Outpatient fee
0–100	$0	$0
101–120	750	50
121–140	1,250	50
141–160	2,000	50
161–180	3,000	50
181–200	4,000	50
201–220	5,000	50
221–240	6,000	50
241–260	7,000	50
261–280	8,000	50
281–300	9,000	50
301–320	10,000	50
321–340	11,000	50
341–360	12,000	50
361–380	13,000	50
381–400	14,000	50

Applicants with annual household income of greater than 400 percent of the applicable year's FPGs will not be eligible for a sliding fee discount but may be eligible for a catastrophic fee waiver.

I. Catastrophic Fee Waiver

The catastrophic fee waiver is based on a formula for adjusting the medical invoice over a 36-month period. The catastrophic fee waiver consists of limiting the patient's medical bill to a maximum percentage of the patient's monthly household income multiplied by 36 months and waiving fees associated with the balance of the medical bill that exceeds the calculation. If the calculation yields an amount greater than the original medical bill, then the catastrophic fee waiver will not be applicable. The maximum percentage will be set to 5 percent of the patient's monthly household income multiplied by 36 months. The ASD(HA) will annually set the catastrophic fee waiver percentage and may periodically adjust the percentage by issuing policy to be published on the DoD Reimbursement Rates website.

J. Collection in Installments

As part of the implementation of the sliding fee and catastrophic fee waiver protections to prevent severe financial harm, patients eligible for the MHS MPWP may have amounts collected in installments for a term not to exceed 72 months. Additionally, patients may request to pay their balance by lump sum. The minimum amount that may be paid by installment per month is $25.

K. Alternative Authority for Waiver of Medical Fees Based on KSA Enhancement

In accordance with 10 U.S.C. 1079b(b), the Director of DHA may issue a full waiver of fees for care provided to civilian non-beneficiaries if determined by the Director of DHA to be appropriate. Accordingly, consideration of a waiver of medical fees will occur on a case-by-case basis and only after application for the MHS MPWP has occurred. A waiver under 10 U.S.C. 1079b(b) of $600 or more will result in reporting to the IRS and issuance of a Form 1099–C to the non-beneficiary for the amount waived. Waivers under 10 U.S.C. 1079b(b) shall be used sparingly and only when the Director of DHA determines that the MHS MPWP did not sufficiently mitigate severe financial harm and receives certification from competent medical authority that the care provided to the patient enhanced the KSAs of the treating healthcare provider(s). All patient invoices will include a statement that the patient may apply for a waiver based on 10 U.S.C. 1079b(b) and 32 CFR 220.12(n) and include information on how to submit a waiver request.

L. Applicability of the MHS MPWP to Tortfeasors and Third-Party Payers

No discount or waiver of fees under 10 U.S.C. 1079b shall be interpreted to be applicable to tortfeasors under the Federal Medical Care Recovery Act (FMCRA), 42 U.S.C. 2651 or to third-party payers under 10 U.S.C. 1095. Patients treated at DoD MTFs are responsible to identify on the DD Form 3201 whether their injury/disease was caused by a third party. To be eligible to obtain any discounts or waivers

under the MHS MPWP, the patient must consent and agree to cooperate with the United States to recover the cost of care against any liable tortfeasor or insurance under the FMCRA. Patients who have a remaining balance after recoveries from third-party tortfeasors or their insurers, may apply for relief of any remaining medical debt or may be refunded amounts already paid toward their medical debt if no balance is owed.

VIII. Expected Impact of This Rulemaking

DoD anticipates that section 716 of the NDAA–23 will substantially mitigate serious financial harm to non-beneficiaries through application of a sliding fee and/or a catastrophic fee waiver to medical invoices generated by MTFs. DoD anticipates that the Director of DHA's discretionary authority to waive fees for non-beneficiaries will also contribute to reducing severe financial harm.

The anticipated costs for the MHS MPWP include only the time required for a patient's application to be completed (see Paperwork Reduction Act section of this preamble) and reviewed. This includes time required for civilian non-beneficiary patients to complete the associated DD Form 3201 declaring their income, DoD to receive and assess the application, followed by the determination of the eligibility for a sliding scale discount, catastrophic fee waiver, or waiver under 10 U.S.C. 1079b(b) by the Director of DHA, and the response time for the decision. The total estimated time is less than 90 days. In addition, costs may be incurred for patients who desire to apply for a waiver of their medical debt (via a DD Form 3201–1) after they have been approved for the MHS MPWP.

(1) Government Burden Related to the DD Form 3201, ''Application for Military Health System Modified Payment and Waiver Program'':

TABLE A—GOVERNMENT BURDEN RELATED TO THE DD FORM 3201, ''APPLICATION FOR MILITARY HEALTH SYSTEM MODIFIED PAYMENT AND WAIVER PROGRAM''

Part A: Labor cost to the Federal government	Part B: Operational and maintenance costs
(1) Collection Instrument: DD Form 3201	(1) Cost Categories.
(a) Number of Total Annual Responses: 2,160	(a) Equipment: $0.
(b) Processing Time for each Response: 10 minutes	(b) Printing: $0.15/printing adjusted medical bills * 2,160 = $324.
(c) Hourly Wage of Worker(s) Processing Responses: $17.28	(c) Postage: $0.66 * 2,160 = $1,425.60.
(d) Cost to Process Each Response: $2.88	(d) Software Purchases: $0.
(e) Total Cost to Process Responses: $6,220.80	(e) Licensing Costs: $0.
(2) Overall Labor Burden to the Federal Government	(f) Other (Envelope): $0.24 * 2,160 = $518.40.
(a) Total Number of Annual Responses: 2,160	(2) Total Operational and Maintenance Cost: $2,268.00.
(b) Total Labor Burden: $6,220.80.	

Source: 2023 GS Pay Scale at GS–06, Step 1 (*https://federaljobs.net/salarybase/#Base_Rate_Chart*).
Source: Printing page cost (*https://www.ecfr.gov/current/title-32/subtitle-A/chapter-I/subchapter-N/part-286/subpart-E/section-286.12*). Postage costs: United States Postal Service, https://store.usps.com/store/results/shipping-supplies/_/N-7d0v8v#content.

Part C: Total cost to the Federal government
(1) Total Labor Cost to the Federal Government: $6,220.80.
(2) Total Operational and Maintenance Costs: $2,268.00.
(3) Total Cost to the Federal Government: $8,488.80.

(2) Government Burden Related to the DD Form 3201–1, ''Request for a Medical Debt Waiver, Military Health System Modified Payment and Waiver Program'':

TABLE B—GOVERNMENT BURDEN RELATED TO THE DD FORM 3201–1, ''REQUEST FOR A MEDICAL DEBT WAIVER, MILITARY HEALTH SYSTEM MODIFIED PAYMENT AND WAIVER PROGRAM''

Part A: Labor cost to the Federal government	Part B: Operational and maintenance costs
(1) Collection Instrument: DD Form 3201–1	(1) Cost Categories.
(a) Number of Total Annual Responses: 1,080	(a) Equipment: $0.
(b) Processing Time per Response: 4 minutes	(b) Printing: $0.15/printing adjusted medical bills * 1,080 = $162.
(c) Hourly Wage of Worker(s) Processing Responses: $17.28	(c) Postage: $0.66 * 1,080 = $712.80.
(d) Cost to Process Each Response: $1.15	(d) Software Purchases: $0.
(e) Total Cost to Process Responses: $1,244.16	(e) Licensing Costs: $0.
(2) Overall Labor Burden to the Federal Government	(f) Other (Envelope): $0.24 * 1,080 = $259.20.
(a) Total Number of Annual Responses: 1,080	(2) Total Operational and Maintenance Cost: $1,134.00.
(b) Total Labor Burden: $1244.16.	

Source: 2023 GS Pay Scale at GS–06, Step 1 (*https://federaljobs.net/salarybase/#Base_Rate_Chart*).

Part C: Total cost to the Federal government
(1) Total Labor Cost to the Federal Government: $1,244.16.
(2) Total Operational and Maintenance Costs: $1,134.00.
(3) Total Cost to the Federal Government: $2,378.16.

IX. Regulatory Compliance Analysis

A. Executive Order 12866, ''Regulatory Planning and Review,'' as Amended by Executive Order 14094, ''Modernizing Regulatory Review'' and Executive Order 13563, ''Improving Regulation and Regulatory Review''

Executive Order 12866, as amended by 14094 (88 FR 21879, April 11, 2023), and Executive Order 13563 direct agencies to assess all costs, benefits and available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health, safety effects, distributive impacts, and equity). These Executive Orders emphasize the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility. This proposed rule has been designated significant, under section 3(f) of Executive Order 12866, as amended by Executive Order 14094.

B. Public Law 118–15, Div. B, Title III, ''Administrative Pay-As-You-Go Act of 2023''

Per the Administrative Pay-As-You-Go Act of 2023 (Fiscal Responsibility Act of 2023 (Pub. L. 118–5, div. B, title III)), agencies are required to submit certain information regarding the direct spending effects of their rules to OMB. Accordingly, the DoD does not anticipate an increase to direct spending, *i.e.,* mandatory net outlays, stemming from the implementation of this proposed rule. This proposed rule affects only DoD's annually appropriated (discretionary) salaries and expenses resources and does not affect direct spending. Healthcare services provided by MTFs are funded by discretionary appropriations. Generally, when MTFs render healthcare services to non-beneficiaries of the Department of Defense, such as those that will be covered by implementation of this proposed rule, the care is provided on a reimbursable basis. On average from 2019–2020, MTFs generated $235.6 million annually in medical bills for healthcare services rendered to non-beneficiaries. Of that amount, an average of 29 percent is reimbursed by the third-party health insurance plans of insured patients, while another 30 percent is written off in accordance with agreed upon terms of coverage. An average of 6 percent is collected from uninsured patients and those who are insured but have remaining coinsurance and co-pays; and an average of 35 percent is transferred to the Department of the Treasury for collection actions due to an individual's unresponsiveness to due process billing activity. Of the 35 percent transferred to the Treasury, many are undocumented individuals without Social Security Numbers. The Treasury has historically recovered approximately 1 percent of the amount transferred by MTFs. All amounts recovered are deposited to the discretionary appropriation that funds MTF operations.

TABLE D—HISTORICAL ACTIVITY
[FY 2019–2020]

		Percent
Average Non-beneficiary Healthcare Billed by MTFs Annually	$235,618,719	
Average Paid by Third-Party Insurance	68,473,042	29
Insurance Write-off	70,685,616	30
Average Paid by Patients	13,160,172	6
Transferred to Treasury	82,621,796	35
Collected by Treasury	2,478,654	1

Uninsured non-beneficiary patients and those who are insured but have high coinsurance and co-pays will benefit most from implementation of this proposed rule. Of these uninsured and underinsured, we estimate a minimum of 50 percent will be eligible for a 100 percent discount of their MTF medical bill. From Calendar Years (CY) 2018 through 2021, the average inpatient medical bill for this patient population was $47,009; and the average outpatient medical bill was $150. In Bexar County, Texas, where most of these costs were incurred (*i.e.,* Brooke Army Medical Center in San Antonio, Texas), the median household income is $67,275 (per the 2020 U.S. Census Bureau) and the same source reports cite that the average number of persons living in each household in Bexar County is 2.71. Consequently, we estimate that this patient population will significantly benefit from this program. For example, using the 2020 U.S. Census Bureau data for Bexar County and the average inpatient and outpatient medical bill amounts for CYs 2018–2021, applying the MHS MPWP discounts would yield a reduction of 83 percent to the average inpatient medical bill (decreasing it from $47,009 to $8,000) and a 67 percent reduction to the average outpatient medical bill (decreasing it from $150 to $50).

CY 2018–2021	Average medical bill	MHS MPWP discount	% Discount	New bill
Inpatient	$47,009	$39,009	83	$8,000
Outpatient	150	100	67	50

Notes: Based on 2020 U.S. Census Bureau data for Bexar County, Texas, where median household income is $67,275 and the average number of persons living in each household is 2.71.

With the implementation of the MHS MPWP, we anticipate the percentage of cases being transferred to the Treasury for collection activity, and the average amounts paid for by uninsured and underinsured patients, being substantially decreased. While this may cause an increase in discretionary spending of the Defense Health Program appropriation; it will not cause an increase in mandatory net outlays (direct spending). The Administrative Pay-As-You-Go Act of 2023 is available at *https://www.whitehouse.gov/wp-content/uploads/2023/09/M-23-21-Admin-PAYGO-Guidance.pdf.*

C. Congressional Review Act (5 U.S.C. 801 et seq.)

Pursuant to Subtitle E of the Small Business Regulatory Enforcement Fairness Act of 1996 (also known as the Congressional Review Act), OMB's Office of Information and Regulatory Affairs has determined that this proposed rule does not meet the criteria set forth in 5 U.S.C. 804(2).

D. Public Law 96–354, ''Regulatory Flexibility Act'' (5 U.S.C. 601)

The ASD(HA) certified that this proposed rule is not subject to the Regulatory Flexibility Act (5 U.S.C. 601) because it would not, if promulgated, have a significant economic impact on a substantial number of small entities. The Regulatory Flexibility Act aims at taking into account the impact of regulations on small businesses, small organizations, small governmental jurisdictions, and small entities. More specifically, the law states ''. . . agencies shall endeavor . . . to fit regulatory and informational requirements to the scale of the business, organizations, and governmental jurisdictions subject to regulation.'' (Pub. L. 96–354, September 19, 1980; section 2 (b)) The proposed amendments to 32 CFR part 220 do not impact the small entities referenced in this paragraph. Therefore, the Regulatory Flexibility Act, as amended, does not require us to prepare a regulatory flexibility analysis.

E. Section 202, Public Law 104–4, ''Unfunded Mandates Reform Act''

Section 202 of the Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1532) requires agencies to assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2024, that threshold is approximately $183 million. This proposed rule will not mandate any requirements for State, local, or tribal governments, and will not affect private sector costs. An unfunded mandate occurs when a State, local, or tribal government must perform certain actions or offer certain programs but does not receive any Federal funds to make it happen. The Federal Government passes legislation requiring the program, but the law does not include any funding. This proposed rule will only affect a very narrow category of the public and it will not impact State, local, or tribal governments. Additionally, it will not affect private sector costs as all proposed actions would be completed by Federal agencies.

F. Public Law 96–511, ''Paperwork Reduction Act'' (44 U.S.C. Chapter 35)

It has been determined that this proposed rule contains information collection requirements. DoD has submitted the following proposal to OMB under the provisions of the Paperwork Reduction Act (44 U.S.C. chapter 35). Comments are invited on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of DoD, including whether the information will have practical utility; (b) the accuracy of the estimate of the burden of the proposed information collection; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the information collection on respondents, including the use of automated collection techniques or other forms of information technology.

(1) Respondent Burden Related to DD Form 3201, ''Application for Military Health System Modified Payment and Waiver Program.'' This is a new collection. Using the information collected on the form, DoD medical billing offices will determine whether the patient is eligible for the medical discount/waiver program. If the patient is eligible, the billing office will generate an adjusted medical bill and send it to the patient. If the patient is not eligible, the billing office will send written correspondence to the patient, informing them that they are not eligible for the discount program and of their right to reapply should their financial circumstances change. Processing of the application will be annotated on the last page of the application. The application will be filed in the billing office's official records.

	Part A: Estimation of respondent burden		Part B: Labor cost of respondent burden
(1)	Collection Instrument: DD Form 3201	(1)	Collection Instrument: DD Form 3201.
(a)	Number of Respondents: 2,160	(a)	Number of Total Annual Responses: 2,160.
(b)	Number of Responses Per Respondent: 1	(b)	Response Time: 4 minutes.
(c)	Number of Total Annual Responses: 2,160	(c)	Respondent Hourly Wage: $33.58.*
(d)	Response Time: 4 minutes	(d)	Labor Burden per Response: $2.24.
(e)	Respondent Burden Hours: 144 hours	(e)	Total Labor Burden: $4,835.52.
(2)	Total Submission Burden	(2)	Overall Labor Burden.
(a)	Total Number of Respondents: 2,160	(a)	Total Number of Annual Reponses: 2,160.
(b)	Total Number of Annual Responses: 2,160	(b)	Total Labor Burden: $4,835.52.
(c)	Total Respondent Burden Hours: 144 hours.		

Approximately 8,000 civilian non-beneficiary patients are treated at DoD MTFs annually. The U.S. Census Bureau estimates that 27 percent of Americans are uninsured. Based on that estimate, we anticipate that 2,160 (or 27 percent of 8,000) patients will not have insurance and may face serious financial harm stemming from MTF medical bills. We anticipate that those uninsured individuals will apply for the MHS MPWP each year.

* **Source:** *http://www.bls.gov/web/empsit/ceseesummary.htm* (Bureau of Labor Statistics national average hourly wage for all employees June 2023)

(2) Respondent Burden Related to DD Form 3201–1, ''Request for Waiver of Medical Debt, Military Health System Modified Payment and Waiver Program''. This is a new collection. The 10 U.S.C. 1079b statute grants the Director of the Defense Health Agency discretionary authority to grant waivers to medical bills in certain instances. Accordingly, the DD Form 3201–1 may be used by non-beneficiary patients to apply for a waiver. For patients who are approved for waivers (not discounts) under the Director of the Defense Health Agency's discretionary authority, the waived amount, along with the patient's SSN and address, will be relayed to the IRS.

	Part A: Estimation of respondent burden		Part B: Labor cost of respondent burden
(1)	Collection Instrument: DD Form 3201–1	(1)	Collection Instrument: DD Form 3201–1.
(a)	Number of Respondents: 1,080	(a)	Number of Total Annual Responses: 1,080.

	Part A: Estimation of respondent burden		Part B: Labor cost of respondent burden
(b)	Number of Responses Per Respondent: 1	(b)	Response Time: 4 minutes.
(c)	Number of Total Annual Responses: 1,080	(c)	Respondent Hourly Wage: $33.58.
(d)	Response Time: 4 minutes	(d)	Labor Burden per Response: $2.24.
(e)	Respondent Burden Hours: 72 hours	(e)	Total Labor Burden: $2,417.76.
(2)	Total Submission Burden	(2)	Overall Labor Burden.
(a)	Total Number of Respondents: 1,080	(a)	Total Number of Annual Reponses: 1,080.
(b)	Total Number of Annual Responses: 1,080	(b)	Total Labor Burden: $2,417.76.
(c)	Total Respondent Burden Hours: 72 hours.		

Of the 2,160 anticipated applicants to the program, we anticipate that most will receive a substantially discounted medical bill. However, this estimate is prepared with a worst-case scenario in which half of the applicants desire to apply for a waiver.

Written comments and recommendations on the proposed information collection should be sent to Mr. Matt Eliseo at the Office of Management and Budget, DoD Desk Officer, Room 10102, New Executive Office Building, Washington, DC 20503, with a copy to Ms. Merlyn Jenkins at the Office of the Secretary of Defense for Health Affairs, Health Resources Management and Policy, 1200 Defense Pentagon, Washington, DC 20301–1200. Comments can be received from 30 to 60 days after the date of this notice, but comments to OMB will be most useful if received by OMB within 30 days after the date of this notice.

You may also submit comments identified by docket number and title through the Federal eRulemaking Portal at *http://www.regulations.gov.* Follow the instructions for submitting comments.

All submissions received must include the agency name, docket number and title for this **Federal Register** document. The general policy for comments and other submissions from members of the public is to make these submissions available for public viewing on the internet at *http://www.regulations.gov* as they are received without change, including any personal identifiers or contact information.

To request more information on this proposed information collection or to obtain a copy of the proposal and associated collection instruments, please write to Ms. Merlyn Jenkins at the Office of the Secretary of Defense for Health Affairs, Health Resources Management and Policy, 1200 Defense Pentagon, Washington, DC 20301–1200, (703) 681–7346.

G. Executive Order 13132, ''Federalism''

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a rule that imposes substantial direct requirement costs on State and local governments, preempts state law, or otherwise has federalism implications. This proposed rule will not have a substantial effect on State and local governments.

H. Executive Order 13175, ''Consultation and Coordination with Indian Tribal Governments''

Executive Order 13175 establishes certain requirements that an agency must meet when it promulgates a rule that imposes substantial direct compliance costs on one or more Indian tribes, preempts tribal law, or effects the distribution of power and responsibilities between the Federal Government and Indian tribes. This proposed rule will not have a substantial effect on Indian tribal governments.

List of Subjects in 32 CFR Part 220

Accounts receivable, Civilian medical debt, Claims, Healthcare, Health insurance, Medical billing, Medical debt, Medical debt waiver, Military medical treatment facilities, Military personnel, and Third party collections.

Accordingly, the DoD proposes to amend 32 CFR part 220 to read as follows:

PART 220—MEDICAL BILLING FOR HEALTHCARE SERVICES PROVIDED BY DEPARTMENT OF DEFENSE MILITARY MEDICAL TREATMENT FACILITIES TO CIVILIAN NON–BENEFICIARIES

■ 1. The authority citation for part 220 is revised to read as follows:

Authority: 5 U.S.C. 301; 10 U.S.C. 1095, 1097b(b), 1079b; 31 U.S.C. 3711, 3717; and 42 U.S.C. 2651.

■ 2. The part heading is revised to read as set forth above.

■ 3. Add § 220.12 to reads as follows:

§ 220.12 Medical billing for healthcare services provided by DoD Military Medical Treatment Facilities to civilian non-beneficiaries.

(a) *Applicability.* (1) This section applies to all persons who receive reimbursable care in a military medical treatment facility (MTF) who are not covered beneficiaries of the Department of Defense (DoD) as defined in § 220.14, other than persons who receive care in an MTF pursuant to an agreement between the United States and a foreign government or other entity.

(2) This section does not apply to third persons (or their insurers) with a tort liability under the Federal Medical Care Recovery Act (FMCRA) (42 U.S.C. 2651) or third-party payers under 10 U.S.C. 1095. The discounts and waivers implemented by this section may not be used to reduce the value of the care and treatment that is recoverable from those third persons (or their insurers) under the FMCRA or 10 U.S.C. 1095.

(b) *Definitions.* (1) *Military Health System (MHS) Modified Payment and Waiver Program (MPWP).* The MHS MPWP is a DoD program to implement an enacted Fiscal Year 2023 National Defense Authorization Act (2023–NDAA) amendment to section 1079b of title 10, United States Code (U.S.C.). Section 716 of the 2023–NDAA amended 10 U.S.C. 1079b to require, inter alia, the Director of the Defense Health Agency to reduce fees that would otherwise be charged to civilian non-beneficiaries for medical care according to a sliding scale and to implement a catastrophic fee waiver to prevent severe financial harm. It also granted the Director of the Defense Health Agency with discretionary authority to issue waivers of fees for medical care if the provision of such care enhances the knowledge, skills, and abilities of healthcare providers.

(2) *Covered payer.* A third-party payer or other insurance, medical service, or health plan.

(3) *Covered by a covered payer.* A medical item or service is deemed to be covered by a covered payer when:

(i) The patient possesses health insurance that is in effect on the date(s) that the item or service was provided;

(ii) The health insurance plan provides coverage for the geographic area where the care was delivered;

(iii) The care provided to the patient is an item or service covered by the terms of the insurance plan, and;

(iv) The health insurance plan provides coverage for care rendered in a U.S. Government/DoD facility;

(v) The insurer agrees to pay the facility directly;

(vi) The insurer agrees to provide the facility with an Explanation of Benefits (EOB) that details how the insurer processed the claims according to the insurance plan; and

(vii) The patient authorizes the DoD to file insurance claims against the insurance policy.

(4) *Non-covered item or service.* A medical item or service that is not covered by the terms of the insurance plan.

(5) *Third-party payer* and *insurance, medical service, or health plan* have the meaning given those terms in 10 U.S.C. 1095(h).

(6) *Knowledge, skills, and abilities (KSAs).* KSAs are a set of clinical skill requirements that a healthcare provider needs in order to provide medical care or treatment in the deployed environment.

(7) *Reasonable value of medical care.* Reasonable value of medical care is defined in § 220.8. The reasonable value of medical care is based on the amount billed by the MTF before application of any sliding scale discount, catastrophic fee waiver discount, or other discount or waiver under this section.

(c) *Notifications concerning MHS MPWP.* The Assistant Secretary of Defense for Health Affairs (ASD(HA)) will maintain a public website containing information about the MHS MPWP, applicable forms (with links to the forms), and a fee discount calculator. The DoD will notify non-beneficiary patients of the availability of the MHS MPWP. Information about the MHS MPWP will be posted in MTFs (*e.g.,* in waiting rooms and information desks) and included in DoD patient invoices.

(d) *Requirement to complete a DD Form 2569.* MTFs will present the DD Form 2569, ''Third Party Collection Program/Medical Services Account/Other Health Insurance'' to all patients. It will also be available at *https://www.esd.whs.mil/Directives/forms/dd2500_2999/.* All patients (regardless of insurance status) must complete the DD Form 2569.

(1) Before applying for the MHS MPWP, all patients (regardless of health insurance status) must fully complete (including by signing) the DD Form 2569 and ensure that a current and accurate DD Form 2569 is on file with the applicable MTF. Successful completion of these steps is a condition of eligibility for the MHS MPWP.

(2) For patients with health insurance, the DoD will file insurance claims on behalf of the patient. Patients with health insurance who do not consent to allowing the DoD to file health insurance claims on their behalf will not be eligible for the MHS MPWP.

(3) *Updating the DD Form 2569.* The DoD may use a completed DD Form 2569 for multiple episodes of care. Unless a DD Form 2569 completed within the preceding 12 months for the patient is available, the DoD will solicit an updated DD Form 2569 from patients who receive a subsequent episode of care from the MTF. However, the lack of an updated form will not preclude the DoD from filing additional claims against encounters for the patient.

(e) *Notifications on Medical Invoices.* In addition to any notifications otherwise already required by law, regulation, or DoD policy, all DoD invoices will notify patients that–

(1) Patients must consent to DoD filing insurance claims on their behalf to be eligible for the MHS MPWP;

(2) The DoD will suspend fee assessment and patient billing actions against the debtor for up to 120 days while the DoD is pursuing an insurance claim or claim against a third-party payer;

(3) For patients who are covered by a covered payer, the DoD will only bill the patient for the insurer-assigned copays, coinsurance, deductibles, nominal fees, and non-covered services;

(4) The patient demonstrates potential eligibility for the MHS MPWP fee discounts and catastrophic fee waivers by completing and submitting DD Form 2569 and DD Form 3201, which may result in a discount of their medical invoice after pursuit or recovery of claims against third party payers (instructions for demonstrating eligibility, including deadline, will also be included);

(5) In addition to fee discounts and catastrophic fee waivers, patients may request a full waiver under 10 U.S.C. 1079b(b) by submitting a DD Form 3201–1, Request for Medical Debt Waiver, Military Health System Modified Payment and Waiver Program. Patients may be considered for a full waiver if they previously applied to the MHS MPWP and it did not sufficiently mitigate financial harm and if the applicable care provided is determined to enhance the KSAs of DoD healthcare providers. Waivers under 10 U.S.C. 1079b(b) may result in information reporting to the Internal Revenue Service and issuance of a Form 1099–C, Cancellation of Debt, and the waived amount(s) may constitute gross income to the patient under 26 U.S.C. 61;

(6) If fees or charges (including those reduced under the MHS MPWP) become delinquent due to non-payment, the DoD will establish a debt for the delinquent amount and commence efforts to collect the established debt, which may include transfer to the Department of the Treasury in accordance with applicable authority; and

(7) That invoices issued after reduction or waiver of charges under the MHS MPWP will reflect the date by which an unpaid account will become delinquent.

(f) *DoD medical billing rates.* Annually, the ASD(HA) publishes the rates that DoD uses for medical billing. Except for reasons listed in 32 CFR 220.8(f) or (g), the DoD rate will be used for all non-beneficiary billing, including billing to either the insurer or patient.

(g) *For non-covered items or services.* In any instance where an item or service is not covered by a covered payer, the DoD will bill the patient for the full amount of the service.

(h) *For patients who are potentially covered by a covered payer.* In any instance where a patient submits a DD Form 2569 that indicates that the patient possesses valid health insurance, the DoD will suspend any collections against the patient to allow time for the claim remittance to be processed by the insurer and for a valid EOB to be received, or until 120 days have passed since filing for payment from the insurance company, whichever comes first. Upon receipt of an EOB, the DoD will bill the patient only for those amounts that are designated by the insurance company as a copay, coinsurance, deductible, nominal fee, or non-covered service. If insurance remittance and an EOB are not received within 120 days of filing of a claim, the DoD will deem the item or service to be a non-covered service. If insurance remittance and an EOB are received after 120 days have elapsed, the DoD will deposit the remittance and adjust the patient's account accordingly. The DoD will issue to the patient a revised medical invoice reflecting updated balances.

(i) *Actions when an insurance payment and/or EOB is received.* When the DoD receives an insurance payment and/or an EOB, the DoD will post all payments and adjustments for those items or services that are deemed as covered by a covered payer against the bill in the manner prescribed by the EOB. The DoD will bill the patient for any remaining copays, co-insurance, deductibles, nominal fees and non-covered services.

(j) *Application for the MHS MPWP (DD Form 3201).* All DoD invoices generated for non-covered beneficiaries will include a statement that all patients applying for the MHS MPWP must

complete DD Form 3201 and must include instructions on how to apply (*i.e.,* the deadline and where to submit the application). Processing of the application will be logged on the last page of the DD Form 3201. Applicants to the MHS MPWP will be notified of the status of their application via the following methods:

(1) For approved applications, the DoD will issue to the patient a modified medical invoice reflecting the adjusted balance due after applying the sliding fee and/or catastrophic fee waiver. The invoice modified to reflect fee adjustments or waiver under the MHS MPWP will include notification of the requirement to transfer delinquent debts to the Department of the Treasury if, after any modification under the MHS MPWP, an unpaid invoice becomes delinquent.

(2) For disapproved applications, the DoD will issue a letter reflecting the reason why the application was disapproved. The letter will inform the patient of their right to reapply should their financial circumstances change.

(k) *Requirements to apply to the MHS MPWP.* (1) To apply to the MHS MPWP all patients must:

(i) Complete a DD Form 2569 (even in cases where the patient possesses no health insurance). Insurance remittances must be applied before the patient can be considered for the MHS MPWP.

(ii) Complete a DD Form 3201, ''Application for Military Health System Modified Payment and Waiver Program.''

(iii) Attach a copy of the patient's (or guarantor's if the patient is a minor) most recently filed Federal Income Tax Return to the DD Form 3201.

(iv) Attach a copy of the patient's (or guarantor's if the patient is a minor) last two pay stubs.

(v) Indicate whether their injury/disease was caused by a third party and provide explanatory information.

(2) Required certifications.

(i) If the patient did not file a Federal Income Tax Return for the preceding year, the patient must certify this on the DD Form 3201.

(ii) If the patient has no verifiable income, the patient must certify this and provide a certification of their current annual income amount on the DD Form 3201.

(iii) If the patient believes that hospitalization/care occurred as the result of an action for which another party may be responsible, then to be eligible for the MHS MPWP, the patient must agree to cooperate and assist the United States to recover the cost of care from said party.

(l) *Basis to assign a Sliding Fee Discount/Catastrophic Fee Waiver*—(1) *MHS Discount Calculator.* Once a year, the ASD(HA) will promulgate an MHS Discount Calculator. The initial calculator will assign a 100 percent sliding fee discount and no stratified nominal fee to applicants to the MHS MPWP whose annual household income is at or below 100 percent of the applicable year's Federal Poverty Guidelines; and a 100 percent sliding fee discount plus a stratified nominal fee to applicants whose annual household income is greater than 100 percent and at or below 400 percent of the Federal Poverty Guidelines current at the time of application. Applicants with annual household income of greater than 400 percent of the applicable year's Federal Poverty Guidelines will not be eligible for a sliding fee discount; but may be eligible for a catastrophic fee waiver.

(2) *Catastrophic Fee Waiver.* For applicants who exceed the 400 percent threshold, the calculator will assign an ASD(HA)-approved maximum percentage that may be charged monthly based on the patient's monthly household income. The maximum percentage will be set to 5 percent. The monthly household income will be multiplied by 5 percent and the result will be multiplied by 36 months to derive the amount of downward adjustment to the patient's bill. Amounts that exceed the recalculated amount will be waived. If the original bill is less than the recalculated bill, the original bill will remain as the balance owed.

(3) *Nominal fee.* Once a year, the ASD(HA) will publish a stratified nominal inpatient and outpatient fee. The nominal fee will be assigned in any case where the sliding fee results in a 100 percent discount of the medical invoice and the patient's income is above 100 percent and up to 400 percent of the applicable year's Federal Poverty Guidelines. Stratified nominal fees are generally established in a manner that is equitable with what military retirees enrolled in the TRICARE program would be required to pay in the private sector for comparable services. The initial nominal stratified fees are as follows:

Household income falls within the below Federal poverty guidelines	Inpatient fee	Outpatient fee
0%–100%	$0	
101%–120%	$750	$50
121%–140%	1,250	50
141%–160%	2,000	50
161%–180%	3,000	50
181%–200%	4,000	50
201%–220%	5,000	50
221% –240%	6,000	50
241%–260%	7,000	50
261%–280%	8,000	50
281%–300%	9,000	50
301%–320%	10,000	50
321%–340%	11,000	50
341%–360%	12,000	50
361%–380%	13,000	50
381%–400%	14,000	50

(m) *Notification of approved/disapproved MHS MPWP applications.* Unless additional time is needed (*e.g.,* to verify a patient's documentation), the DoD shall determine whether a patient has demonstrated eligibility for the MHS MPWP within 30 days of receipt of the complete application. If a decision cannot be made in 30 days, the DoD shall provide the patient with an interim written response. The DoD may suspend DoD collection actions against the patient during the review.

(1) For approved applications, the DoD will issue to the patient a modified

medical invoice reflecting the adjusted balance due after applying the sliding fee and/or catastrophic fee waiver. The invoice modified to reflect fee adjustments or waiver under the MHS MPWP will include notification of the requirement to transfer delinquent debts to the Department of the Treasury if, after any modification under the MHS MPWP, an unpaid invoice becomes delinquent.

(2) For disapproved applications, the DHA will issue a letter by U.S. mail to the patient's last known address reflecting the reason why the application was disapproved. The letter will inform the patient of the right to reapply should the patient's financial circumstances change.

(n) *Collection in installments.* Patients approved for a sliding scale fee reduction or catastrophic fee waiver shall have amounts collected in installments for a term not to exceed 72 months. Patients may choose to pay their balance in a lump sum payment.

(o) *Application for a 10 U.S.C. 1079b(b) waiver.* (1) *Basis for a waiver.* Waivers may be granted when—

(i) The patient has provided the DoD with a completed DD Form 2569 (even for patients who possess no valid health insurance) and applicable insurance payments have been applied;

(ii) The patient has previously submitted a completed application to the MHS MPWP (32 CFR 220.12(k)) and was provided any applicable discounts;

(iii) The patient provided additional information indicating that the MHS MPWP did not sufficiently mitigate severe financial harm; and

(iv) A DoD competent medical authority confirms in writing (on the DD Form 3201) that the care provided to the patient enhanced the KSAs of the DoD healthcare provider.

(v) If the above conditions are met, the Director of DHA may exercise discretionary authority to waive the medical invoice.

(2) *Method to request a waiver.* Patients must submit a completed DD Form 3201–1, ''Request for Medical Debt Waiver Military Health System Modified Payment and Waiver Program.'' All DoD invoices will include the address where a patient may submit a waiver request.

(3) *Response to a request for waiver.* Unless additional time is needed (*e.g.,* to verify a patient's documentation), the DoD shall make a decision on the request within 90 days. The DoD will provide a response in writing to the patient, as well as a copy of the medical invoice reflecting the balance due. Waivers that are approved under 10 U.S.C. 1079b(b) may require reporting to the IRS and issuance of a IRS Form 1099–C.

(p) *Debts transferred to Treasury that are subsequently processed through insurance.* In any instance where a debt is transferred to Treasury and a lower balance is assigned to a Treasury-managed debt due to a claim being subsequently processed through insurance, the DoD shall recall the debt back to the DoD for management actions and notify Treasury to delete the debt from its systems and reverse any adverse reporting that occurred against the debt.

(q) *Delinquent Accounts.* Delinquent accounts will be processed in accordance with the Debt Collection Improvement Act of 1996 and its implementing regulation 31 CFR parts 900–904 (Federal Claims Collection Standards).

(r) *Applications for MHS MPWP Received for Delinquent Accounts Transferred to the Department of the Treasury.* Individuals may still submit an application for the MHS MPWP after their account has been transferred to the Cross-Servicing Program (''Cross-Servicing'') of the Department of the Treasury, Bureau of the Fiscal Service; however, any reductions to the medical invoice from the MPWP may be subject to interest, penalties, and costs. When patients apply to the MHS MPWP after their accounts were transferred to Cross-Servicing, their debts will remain at Cross-Servicing unless and until the DoD determines that they are eligible for a reduction under the MHS MPWP. The DoD may recall the debt from Cross-Servicing after it determines that the debt is eligible for a reduction under the MHS MPWP. Patients may request reconsideration for the MHS MPWP when their financial circumstances appear to have significantly changed.

(s) *Reporting to IRS and Furnishing of IRS Forms 1099–C (Cancellation of Debt).* The DoD will report to IRS, and furnish to patients, IRS Forms 1099–C for all 10 U.S.C. 1079b(b) waivers issued during the previous calendar year where required by 26 U.S.C. 6050P. IRS reporting will not be done for portions of a bill which have been adjusted downwards due to insurance processing, or by assignment of a sliding fee/catastrophic fee waiver to the debt. The IRS Forms 1099–C will reflect amounts waived under the DHA Director's discretionary authority.

(t) *Refunds not permitted for amounts previously paid.* Except for circumstances specified in §§ 220.12(p) and 220.12(u)(3), financial relief under the MHS MPWP may only be granted for amounts still due by the patient; an application for financial relief cannot be used to obtain a refund for any amounts previously paid.

(u) *Claims involving tortfeasors and third-party payers.* No discount or waiver of fees under 10 U.S.C. 1079b shall be interpreted to be applicable to tortfeasors under the FMCRA, 42 U.S.C. 2651, or third-party payers under 10 U.S.C. 1095.

(1) For patients who indicate that their injury/disease was caused by a third party, DoD MTFs will follow procedures established under the Medical Affirmative Claims program.

(2) Patients who have a remaining balance after insurance remittances or recoveries from third-party tortfeasors may apply for relief of any remaining medical debt.

(3) Payments toward the medical debt that were made by the patient prior to settlement of the claim with the tortfeasor will be offset against any balances owed by the patient or may be refunded to the patient if no balance is owed.

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[FR Doc. 2024–22584 Filed 9–30–24; 8:45 am]

BILLING CODE 6001–FR–P

DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 3

RIN 2900–AR75

VA Adjudication Regulations for Disability or Death Benefit Claims Based on Toxic Exposure

AGENCY: Department of Veterans Affairs.

ACTION: Proposed rule.

SUMMARY: The Department of Veterans Affairs (VA) is proposing to amend its adjudication regulations to implement provisions of the Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act of 2022 (PACT Act or Act). The statute amended procedures applicable to claims based on toxic exposure and modified or established presumptions of service connection related to toxic exposure. Pursuant to the Act, VA is proposing to remove the manifestation period requirement and the minimum compensable evaluation requirement from Persian Gulf War claims based on undiagnosed illness and medically unexplained chronic multisymptom illnesses. VA is also proposing to expand the definition of a Persian Gulf veteran; update the list of locations eligible for a presumption of exposure to