

- RIN 2900–AL72, Burial Benefits (April 8, 2008)
- RIN 2900–AL74, Apportionments to Dependents and Payments to Fiduciaries and Incarcerated Beneficiaries (January 14, 2011)
- RIN 2900–AL76, Benefits for Certain Filipino Veterans and Survivors (June 30, 2006)
- RIN 2900–AL82, Rights and Responsibilities of Claimants and Beneficiaries (May 10, 2005)
- RIN 2900–AL83, Elections of Improved Pension; Old-Law and Section 306 Pension (December 27, 2004)
- RIN 2900–AL84, Special and Ancillary Benefits for Veterans, Dependents, and Survivors (March 9, 2007)
- RIN 2900–AL87, General Provisions (March 31, 2006)
- RIN 2900–AL88, Special Ratings (October 17, 2008)
- RIN 2900–AL89, Dependency and Indemnity Compensation Benefits (October 21, 2005)
- RIN 2900–AL94, Dependents and Survivors (September 20, 2006)
- RIN 2900–AL95, Payments to Beneficiaries Who Are Eligible for More than One Benefit (October 2, 2007)
- RIN 2900–AM01, General Evidence Requirements, Effective Dates, Revision of Decisions, and Protection of Existing Ratings (May 22, 2007)
- RIN 2900–AM04, Improved Pension (September 26, 2007)
- RIN 2900–AM05, Matters Affecting the Receipt of Benefits (May 31, 2006)
- RIN 2900–AM06, Payments and Adjustments to Payments (October 31, 2008)
- RIN 2900–AM07, Service-Connected Disability Compensation (September 1, 2010)
- RIN 2900–AM16, VA Benefit Claims (April 14, 2008)

VA received numerous comments to the 20 NPRMs and on November 27, 2013, proposed amendments to the 20 NPRMs in one document, RIN 2900–AO13. 78 FR at 71,042. VA received additional comments on AO13, from private individuals and several Veterans Service Organizations, and VA thanks the commenters for the time they invested and their input.

As noted in RIN 2900–AO13, in 2012, the Veterans Benefits Administration (VBA) formulated a Transformation Plan to improve the delivery of benefits to veterans and their dependents and survivors. 78 FR at 71,043. VA acknowledged that, to ensure successful implementation of the plan, a final rule with regard to the Rewrite Project would

not be published in the near future and would ultimately require an evaluation of the feasibility of a one-time implementation of proposed Part 5. Id. In the interim, VA assured, Part 3 regulations would be updated and improved as needed, to include the type of readability changes proposed for Part 5. Id.

Over the past five years, such updates have occurred, see, e.g., 79 FR 32,653 (June 6, 2014) (implementing improvements sourced in RIN 2900–AL72), and VA proposes to continue this current rulemaking approach—updating Part 3 and Part 4 as needed—but at an accelerated pace designed to also incorporate needed changes from proposed Part 5 for clarity and simplicity. Thus, it will not be adopting a one-time implementation of proposed Part 5. This will avoid the inevitable confusion caused by two co-existing sets of regulations and manuals that may or may not be applicable depending on the date of the claim. It will avoid the delays and decreases in productivity inherent in any transition where adjudicators have to familiarize themselves with all new sections and provisions. It will also ease programming complexity and allow VBA to manage the risk associated with the transition to revised regulations. VA has already undertaken a review to identify and prioritize the needs and expectations for incorporating proposed Part 5 improvements, where possible, into the current Part 3 and Part 4.

Phased implementation allows for incremental assessment and development of the required system modifications. Controlling the rate of rewrite implementation allows VBA to retain, plan for, and mitigate adverse system impacts and development needs by reordering phases as necessary. The plan also affords VBA flexibility in scaling personnel and other resource allocations to each new phase, if necessary. One-time implementation would require extensive training for personnel, as well as costs associated with IT equipment, installation, maintenance, support, and system updates. Even though the proposed rules were not intended to alter substantive law, they would alter the terminology, section numbers, and organization of the current regulations upon which current VA systems, applications, forms, and tools are based. Thus, one-time implementation would involve a rework of numerous computer-based processing applications, claims-related training tools and materials, quality assurance tools, claims-related forms, and the Adjudication Procedures Manual. It

would syphon resources from existing modernization priorities, such as improvements to the Veterans Benefits Management System and National Work Queue. This phased rollout minimizes disruption of these major IT modernization projects, as well as other VA initiatives requiring substantial personnel or training.

Changes in Part 3 and Part 4 regulations, to include incorporation of proposed Part 5 improvements, where appropriate, can be achieved over a number of years. Some of these changes are already underway, with VA's modernized Part 4, VA Schedule for Rating Disabilities, slated for publication in the near future. This multi-year approach minimizes disruption on field operations (and ultimately claim production and accuracy), as well as VBA Central Office staffing required to implement the revised regulations.

For the above reasons, VA is withdrawing RIN 2900–AO13.

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. Jacquelyn Hayes-Byrd, Deputy Chief of Staff, Department of Veterans Affairs, approved this document on April 3, 2018, for publication.

Dated: April 3, 2018.

Jeffrey M. Martin,

Impact Analyst, Office of Regulation Policy & Management, Office of the Secretary, Department of Veterans Affairs.

[FR Doc. 2018–07078 Filed 4–5–18; 8:45 am]

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DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 17

RIN 2900–AP00

Definition of Domiciliary Care

AGENCY: Department of Veterans Affairs.

ACTION: Proposed rule.

SUMMARY: The Department of Veterans Affairs (VA) proposes to amend its rule defining domiciliary care, to accurately reflect the scope of services currently provided under the Domiciliary Care Program. VA's Domiciliary Care Program provides a temporary home to certain veterans, which includes the furnishing of shelter, goods, clothing and other comforts of home, as well as

medical services. In 2005 VA designated its Mental Health Residential Rehabilitation Treatment Program (MH RRTP) as a type of domiciliary care. MH RRTP provides clinically intensive residential rehabilitative services to certain mental health patient populations. We propose to amend the definition of domiciliary care to reflect that domiciliary care includes MH RRTP. In addition, VA domiciliary care, as a matter of long-standing practice, includes non-permanent housing, but this is not clear in the regulation. The proposed rule would clarify that domiciliary care provides temporary, not permanent, residence to affected veterans.

DATES: *Comment Date:* Comments on the proposed rule must be received by VA on or before June 5, 2018.

ADDRESSES: Written comments may be submitted through <http://www.Regulations.gov>; by mail or hand delivery to the Director, Regulation Policy and Management (00REG), Department of Veterans Affairs, 810 Vermont Avenue NW, Room 1063B, Washington, DC 20420; or by fax to (202) 273-9026. Comments should indicate that they are submitted in response to “RIN 2900-AP00—Definition of Domiciliary Care.” Copies of comments received will be available for public inspection in the Office of Regulation Policy and Management, Room 1063B between the hours of 8:00 a.m. and 4:30 p.m., Monday through Friday (except holidays). Please call (202) 461-4902 for an appointment. (This is not a toll-free number.) In addition, during the comment period, comments may be viewed online through the Federal Docket Management System at www.Regulations.gov.

FOR FURTHER INFORMATION CONTACT: Jamie R. Ploppert, National Director, Mental Health Residential Treatment Programs (10P4M), Veterans Health Administration, Department of Veterans Affairs, 810 Vermont Avenue NW, Washington, DC 20420 or (757) 722-9991 extension 1123. (This is not a toll-free number.)

SUPPLEMENTARY INFORMATION: Title 38, United States Code (U.S.C.), section 1710(b)(2) authorizes VA to provide needed domiciliary care to veterans whose annual income does not exceed the applicable maximum annual rate of VA pension and to veterans who have no adequate means of support. The term “domiciliary care” is currently defined at 38 Code of Federal Regulations (CFR) 17.30(b) as the furnishing of a home to a veteran, embracing the furnishing of shelter, food, clothing and other comforts of home, including necessary

medical services, as well as travel and incidental expenses pursuant to 38 CFR 70.10. Veterans must meet eligibility criteria found in § 17.46(b) as well as § 17.47(b)(2) and (c) to receive domiciliary care.

The domiciliary program was authorized to provide eligible veterans with a home and coordinated ambulatory medical care as needed. Typically, domiciliaries are co-located with VA medical centers or exist as designated bed-settings within the centers. By law, eligible veterans include only: Those whose annual income does not exceed the maximum annual rate of pension payable to a Veteran in need of regular aid and attendance; or (2) those who have no adequate means of support, as this phrase is defined in 38 CFR 17.47(b)(2), who can perform the activities specified in 38 CFR 17.46(b) but who suffer from a chronic disability, disease, or defect that results in the veteran being unable to earn a living for a prospective period. See 38 CFR 17.47 (b)(2) and (c).

VA domiciliaries served initially as “Soldiers’ Homes” for economically-disadvantaged Veterans with chronic medical needs that can be addressed on an outpatient basis. Domiciliary care provides services to economically-disadvantaged veterans, and VA remains committed to serving that group. Historically, domiciliary care in VA has primarily been focused on delivering care to older residents who cannot live independently but who do not require admission to a nursing home. However, “domiciliary care” has expanded to also provide services to veterans who require residential rehabilitation treatment for mental health or substance use issues. While the above-referenced statutory definitions and eligibility criteria still apply as do the regulatory criteria of §§ 17.46(b) and 17.47(b)(2), the scope of services furnished under the program has evolved significantly, requiring revision of § 17.30(b) and § 17.47(c). We propose to amend the definition of domiciliary care to reflect that change.

The scope of clinical services available to VA domiciliary residents has necessarily become specialized over time due to the characteristics of the patient populations served by the residential rehabilitation treatment model. In 2005, VA administratively designated all MH RRTP facilities as domiciliary care facilities to fully integrate mental health, residential rehabilitation; and treatment and domiciliary care. VA established the first MH RRTP in 1995. MH RRTPs provide comprehensive supervised treatment and rehabilitative services to

veterans with mental health or substance use disorders, and coexisting medical or psychosocial needs such as homelessness and unemployment. MH RRTPs identify and address goals of rehabilitation, recovery, health maintenance, improved quality of life, and community integration in addition to specific treatment of medical conditions, mental illnesses, addictive disorders, and homelessness. The residential component emphasizes incorporation of clinical treatment gains into a lifestyle of self-care and personal responsibility. MH RRTPs provide a 24 hours-per-day, 7 days-per-week structured and supportive residential environment similar to that in traditional domiciliary care. However, there are differences in the type of care delivered. The goals of care for residential rehabilitation treatment reflect a stronger emphasis on rehabilitative services, including professional, counseling, and guidance services as well as treatment programs. Rehabilitative services are designed to facilitate the process of recovery from injury, illness, or disease. These services are intended to restore, to the maximum extent possible, the physical, mental, and psychological functioning of veterans receiving residential rehabilitation treatment.

Since 2010, domiciliary care has been included as part of VA’s MH RRTP, which began in 1995. VA domiciliaries are used currently for VA’s Domiciliary Residential Rehabilitation Treatment Programs; Domiciliary Care for Homeless Veterans Program; Health Maintenance Domiciliary Beds Program; General Domiciliary or Psychosocial Residential Rehabilitation Treatment Program; Domiciliary Substance Abuse Programs; and Domiciliary Post-Traumatic Stress Disorder Programs. These are the patient populations currently residing in our domiciliaries. VA therefore proposes to update the definition of domiciliary care in § 17.30(b) to reflect the scope of clinically intensive rehabilitation services included in the program.

Current § 17.30(b) defines domiciliary care as the furnishing of a home to a veteran, embracing the furnishing of shelter, food, clothing and other comforts of home, including necessary medical services. We would amend this definition by stating that domiciliary care means a “temporary home” rather than “home.” This is consistent with VA’s long-standing practice of providing domiciliary care as a non-permanent living arrangement for eligible veterans. This proposed change would not alter VA’s commitment to ensure extended or geriatric care is available to older

veterans eligible for VA domiciliary care, that is, those who cannot live independently but who do not require admission to a nursing home. These veterans receive their domiciliary care through State Veterans Homes Domiciliary Programs and VA pays half of the cost of that care through per diem payments. We would define domiciliary care to also mean a day hospital program consisting of intensive supervised rehabilitation and treatment provided in a therapeutic residential setting for residents with mental health or substance use disorders, and co-occurring medical or psychosocial needs such as homelessness and unemployment.

Current § 17.47 addresses considerations applicable in determining eligibility for hospital care, medical services, nursing home care, or domiciliary care. Current paragraph (c) clarifies that “domiciliary care, as the term implies, is the provision of a home, with such ambulant medical care as is needed.” For the reasons stated above, we would amend this paragraph to reflect that domiciliary care provides a temporary home.

Effect of Rulemaking

The CFR, as proposed to be revised by this proposed rule, would represent the exclusive legal authority on this subject. No contrary rules or procedures are authorized. All VA guidance will be read to conform with this proposed rulemaking if possible or, if not possible, such guidance will be superseded by this rulemaking.

Paperwork Reduction Act

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

Regulatory Flexibility Act

The Secretary hereby certifies that this proposed rule would not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act, 5 U.S.C. 601–612. This proposed rule would directly affect only individuals treated within VA and would not affect any small entities. Therefore, pursuant to 5 U.S.C. 605(b), this rulemaking is exempt from the initial and final regulatory flexibility analysis requirements of sections 603 and 604.

Executive Orders 12866, 13563 and 13771

Executive Orders (E.O.) 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). E.O. 13563 (Improving Regulation and Regulatory Review) emphasizes the importance of quantifying both costs and benefits, reducing costs, harmonizing rules, and promoting flexibility. E.O. 12866 (Regulatory Planning and Review) defines a “significant regulatory action” requiring review by the Office of Management and Budget (OMB), unless OMB waives such review, as “any regulatory action that is likely to result in a rule that may: (1) Have an annual effect on the economy of \$100 million or more or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities; (2) Create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; (3) Materially alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) Raise novel legal or policy issues arising out of legal mandates, the President’s priorities, or the principles set forth in this Executive Order.”

The economic, interagency, budgetary, legal, and policy implications of this regulatory action have been examined, and it has been determined not to be a significant regulatory action under E.O. 12866. VA’s impact analysis can be found as a supporting document at <http://www.regulations.gov>, usually within 48 hours after the rulemaking document is published. Additionally, a copy of the rulemaking and its impact analysis are available on VA’s website at <http://www.va.gov/orpm/>, by following the link for “VA Regulations Published From FY 2004 Through Fiscal Year to Date.”

This proposed rule is not expected to be an E.O. 13771 regulatory action because this proposed rule is not significant under E.O. 12866.

Unfunded Mandates

The Unfunded Mandates Reform Act of 1995 requires, at 2 U.S.C. 1532, that agencies prepare an assessment of anticipated costs and benefits before issuing any rule that may result in 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 one year. This proposed rule would have no such effect on State, local, and tribal governments, or on the private sector.

Catalog of Federal Domestic Assistance

The Catalog of Federal Domestic Assistance numbers and titles for the programs affected by this document are 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; 64.018, 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.

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, Medical and dental schools, Medical devices, Medical research, Mental health programs, Nursing homes, Reporting and recordkeeping requirements, Travel and transportation expenses, Veterans.

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. Gina S. Farrisee, Deputy Chief of Staff, Department of Veterans Affairs, approved this document on February 27, 2018, for publication.

Dated: April 3, 2018.

Consuela Benjamin,

Regulations Development Coordinator, Office of Regulation Policy & Management, Office of the Secretary, Department of Veterans Affairs.

For the reasons stated in the preamble, Department of Veterans Affairs proposes to amend 38 CFR part 17 as follows:

PART 17—MEDICAL

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

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

Section 17.38 also issued under 38 U.S.C. 101, 501, 1701, 1705, 1710, 1710A, 1721, 1722, 1782, and 1786.

Section 17.63 also issued under 38 U.S.C. 1730.

Section 17.169 also issued under 38 U.S.C. 1712C.

Sections 17.380 and 17.412 are also issued under sec. 260, Public Law 114–223, 130 Stat. 857.

Section 17.410 is also issued under 38 U.S.C. 1787.

Section 17.415 is also issued under 38 U.S.C. 7301, 7304, 7402, and 7403.

Sections 17.640 and 17.647 are also issued under sec. 4, Public Law 114–2, 129 Stat. 30.

Sections 17.641 through 17.646 are also issued under 38 U.S.C. 501(a) and sec. 4, Public Law 114–2, 129 Stat. 30.

■ 2. Amend § 17.30 by revising paragraph (b) to read as follows:

§ 17.30 Definitions.

* * * * *

(b) *Domiciliary care.* The term domiciliary care—

(1) Means the furnishing of:

(i) A temporary home to a veteran, embracing the furnishing of shelter, food, clothing and other comforts of home, including necessary medical services; or

(ii) A day hospital program consisting of intensive supervised rehabilitation and treatment provided in a therapeutic residential setting for residents with mental health or substance use disorders, and co-occurring medical or psychosocial needs such as homelessness and unemployment.

(2) Includes travel and incidental expenses pursuant to § 70.10 of this chapter.

* * * * *

■ 3. Amend § 17.47 by removing the word “home” in the second sentence of paragraph (c) and adding, in its place, “temporary home”.

[FR Doc. 2018–07082 Filed 4–5–18; 8:45 am]

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ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[EPA–R08–OAR–2017–0567, FRL–9975–09–Region 8]

Promulgation of State Implementation Plan Revisions; Colorado; Attainment Demonstration for the 2008 8-Hour Ozone Standard for the Denver Metro/North Front Range Nonattainment Area, and Approval of Related Revisions

AGENCY: Environmental Protection Agency (EPA).

ACTION: Proposed rule.

SUMMARY: On May 31, 2017, the State of Colorado submitted State Implementation Plan (SIP) revisions related to attainment of the 2008 8-hour ozone National Ambient Air Quality Standards (NAAQS) for the Denver Metro/North Front Range (DMNFR) Moderate nonattainment area by the applicable attainment date of July 20, 2018. The Environmental Protection Agency (EPA) proposes to approve the majority of the submittal, which includes an attainment demonstration, base and future year emission inventories, a reasonable further progress (RFP) demonstration, a reasonably available control measures (RACM) analysis, a motor vehicle inspection and maintenance (I/M) program in Colorado Regulation Number 11 (Reg. No. 11), a nonattainment new source review (NNSR) program, a contingency measures plan, 2017 motor vehicle emissions budgets (MVEBs) for transportation conformity, and revisions to Colorado Regulation Number 7 (Reg. No. 7). The EPA is also proposing to approve portions of the reasonably available control technology (RACT) analysis. Finally, the EPA proposes to approve revisions made to Colorado’s Reg. No. 7 in a May 5, 2013 SIP submission. This action is being taken in accordance with the Clean Air Act (CAA).

DATES: Comments must be received on or before May 7, 2018.

ADDRESSES: Submit your comments, identified by Docket ID No. EPA–R08–OAR–2017–0567, at <http://www.regulations.gov>. Follow the online instructions for submitting comments. Once submitted, comments cannot be edited or removed from *Regulations.gov*. The EPA may publish any comment received to its public docket. Do not submit electronically any information you consider to be Confidential Business Information (CBI) or other information whose disclosure is restricted by statute. Multimedia submissions (audio, video, etc.) must be accompanied by a written comment. The written comment is considered the official comment and should include discussion of all points you wish to make. The EPA will generally not consider comments or comment contents located outside of the primary submission (*i.e.*, on the web, cloud, or other file sharing system). For additional submission methods, the full EPA public comment policy, information about CBI or multimedia submissions, and general guidance on

making effective comments, please visit <http://www2.epa.gov/dockets/commenting-epa-dockets>.

FOR FURTHER INFORMATION CONTACT:

Abby Fulton, Air Program, U.S. Environmental Protection Agency (EPA), Region 8, Mail Code 8P–AR, 1595 Wynkoop Street, Denver, Colorado 80202–1129, (303) 312–6563, fulton.abby@epa.gov.

SUPPLEMENTARY INFORMATION:

I. What action is the Agency taking?

As explained below, the EPA is proposing various actions on Colorado’s proposed revisions to its SIP that it submitted to the EPA on May 5, 2013, and May 31, 2017. Specifically, we are proposing to approve Colorado’s 2017 attainment demonstration for the 2008 8-hour ozone NAAQS. In addition, we propose to approve the MVEBs contained in the State’s submittal. We also propose to approve all other aspects of the submittal, except for certain area source categories and major source RACT, which we will be acting on at a later date. We propose to approve the revisions to Colorado’s Reg. 11 and 7, except for Section X.E of Reg. 7, which we will be acting on at a later date. We propose to approve the revisions to Colorado Reg. 7 Sections I, II, VI, VII, VIII, and IX from the State’s May 5, 2013 submittal.

The specific bases for our proposed actions and our analyses and findings are discussed in this proposed rulemaking. Technical information that we rely upon in this proposal is contained in the docket, available at <http://www.regulations.gov>, Docket No. EPA–R08–OAR–2017–0567.

II. Background

On March 12, 2008, the EPA revised both the primary and secondary NAAQS for ozone to a level of 0.075 parts per million (ppm) (based on the annual fourth-highest daily maximum 8-hour average concentration, averaged over 3 years) to provide increased protection of public health and the environment (73 FR 16436, March 27, 2008). The 2008 ozone NAAQS retains the same general form and averaging time as the 0.08 ppm NAAQS set in 1997, but is set at a more protective level. Specifically, the 2008 8-hour ozone NAAQS is attained when the 3-year average of the annual fourth-highest daily maximum 8-hour average ambient air quality ozone concentrations is less than or equal to 0.075 ppm. *See* 40 CFR 50.15.

Effective July 20, 2012, the EPA designated as nonattainment any area that was violating the 2008 8-hour ozone NAAQS based on the three most