effects of this rule elsewhere in this preamble.

F. Environment

We have analyzed this proposed rule under Department of Homeland Security Management Directive 023–01, which guides the Coast Guard in complying with the National Environmental Policy Act of 1969 (42 U.S.C. 4321–4370f), and have made a preliminary determination that this action is one of a category of actions that do not individually or cumulatively have a significant effect on the human environment. This proposed rule involves two safety zones lasting one hour that would prohibit entry within a one-mile section of the Lower Mississippi River. They are categorically excluded from further review under paragraph L60(a) of Appendix A, Table 1 of DHS Instruction Manual 023–01–001–01, Rev. 01. A preliminary Record of Environmental Consideration supporting this determination is available in the docket where indicated under **ADDRESSES**. We seek any comments or information that may lead to the discovery of a significant environmental impact from this proposed rule.

G. Protest Activities

The Coast Guard respects the First Amendment rights of protesters. Protesters are asked to contact the person listed in the **FOR FURTHER INFORMATION CONTACT** section to coordinate protest activities so that your message can be received without jeopardizing the safety or security of people, places, or vessels.

V. Public Participation and Request for Comments

We view public participation as essential to effective rulemaking, and will consider all comments and material received during the comment period. Your comment can help shape the outcome of this rulemaking. If you submit a comment, please include the docket number for this rulemaking, indicate the specific section of this document to which each comment applies, and provide a reason for each suggestion or recommendation.

We encourage you to submit comments through the Federal eRulemaking Portal at *http://www.regulations.gov.* If your material cannot be submitted using *http://www.regulations.gov,* contact the person in the **FOR FURTHER INFORMATION CONTACT** section of this document for alternate instructions.

We accept anonymous comments. All comments received will be posted without change to *http://www.regulations.gov* and will include any personal information you have provided. For more about privacy and the docket, visit *http://www.regulations.gov/privacyNotice.*

Documents mentioned in this NPRM as being available in the docket, and all public comments, will be in our online docket at *http://www.regulations.gov* and can be viewed by following that website's instructions. Additionally, if you go to the online docket and sign up for email alerts, you will be notified when comments are posted or a final rule is published.

List of Subjects in 33 CFR Part 165

Harbors, Marine safety, Navigation (water), Reporting and recordkeeping requirements, Security measures, Waterways.

For the reasons discussed in the preamble, the Coast Guard proposes to amend 33 CFR part 165 as follows:

PART 165—REGULATED NAVIGATION AREAS AND LIMITED ACCESS AREAS

■ 1. The authority citation for part 165 continues to read as follows:

Authority: 33 U.S.C. 1231; 50 U.S.C. 191; 33 CFR 1.05–1, 6.04–1, 6.04–6, and 160.5; Department of Homeland Security Delegation No. 0170.1.

■ 2. Add § 165.T08–1058 to read as follows:

§ 165.T08–1058 Safety Zones; Lower Mississippi River, New Orleans, LA

(a) *Safety Zones.* The following areas are a safety zone:

(1) Bayou Country Music Fest, New Orleans, LA.

(i) *Location:* All navigable waters of the Lower Mississippi River between mile marker (MM) 95.4 and MM 96.4, above Head of Passes.

(ii) *Effective Period:* This rule is effective from 7:45 p.m. through 8:45 p.m. on May 25, 2018.

(2) NOLA Tricentennial 2018 Jazz and Heritage Fest.

(i) *Location:* All navigable waters of the Lower Mississippi River between mile marker (MM) 94 and MM 95, above Head of Passes.

(ii) *Effective Period:* This rule is effective from 8 p.m. through 9 p.m. on May 6, 2018.

(b) *Regulations.* (1) In accordance with the general regulations in § 165.23 of this part, entry into these zones is prohibited unless specifically authorized by the Captain of the Port Sector New Orleans (COTP) or a designated representative. A designated representative is a commissioned, warrant, or petty officer of the U.S. Coast Guard assigned to units under the operational control of USCG Sector New Orleans.

(2) Vessels requiring entry into this safety zone must request permission from the COTP or a designated representative. They may be contacted on VHF–FM Channel 16 or 67.

(3) Persons and vessels permitted to enter these safety zones must transit at their slowest safe speed and comply with all lawful directions issued by the COTP or the designated representative.

(c) *Information broadcasts.* The COTP or a designated representative will inform the public through Broadcast Notices to Mariners of any changes in the planned schedule.

Dated: January 11, 2018.

Wayne R. Arguin,

Captain, U.S. Coast Guard, Captain of the Port Sector New Orleans.

[FR Doc. 2018–00652 Filed 1–16–18; 8:45 am]

BILLING CODE 9110–04–P

DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 17

RIN 2900–AP02

Civilian Health and Medical Program of the Department of Veterans Affairs

AGENCY: Department of Veterans Affairs.

ACTION: Proposed rule.

SUMMARY: The Department of Veterans Affairs (VA) proposes to amend its regulations governing the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). The proposed revisions would clarify and update these regulations to conform to changes in law and policy that control the administration of CHAMPVA and would include details concerning the administration of CHAMPVA that are not reflected in current regulations. The proposed revisions would also expand covered services and supplies to include certain preventive services and eliminate cost-share amounts and deductibles for certain covered services.

DATES: Written comments must be received on or before March 19, 2018.

ADDRESSES: Written comments may be submitted through *http://www.Regulations.gov;* by mail or hand-delivery to the Director, Regulation and Policy Management (00REG), Department of Veterans Affairs, 810 Vermont Avenue NW, Room 1068, Washington, DC 20420; or by fax to (202) 273–9026. Comments should indicate that they are submitted in

response to ''RIN 2900–AP02, Civilian Health and Medical Program of the Department of Veterans Affairs.'' 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 *http://www.Regulations.gov.*

FOR FURTHER INFORMATION CONTACT: Joseph Duran, Director, Policy and Planning, Office of Community Care (OCC), 3773 Cherry Creek North Drive, Denver, Colorado 80209, *Joseph.Duran2@va.gov,* (303) 370–1637. (This is not a toll-free number.)

SUPPLEMENTARY INFORMATION: The Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) is a health benefits program in which the Department of Veterans Affairs (VA) shares the cost of covered medical care services and supplies with spouses, children, survivors, and certain caregivers of veterans who meet eligibility criteria under 38 U.S.C. 1781. CHAMPVA beneficiaries must not be eligible for TRICARE, a health care program administered by the Department of Defense (DoD) that is also authorized to provide health care to certain family members of veterans. Certain Primary Family Caregivers designated under 38 U.S.C. 1720G(a)(7)(A) are eligible under section 1781 as long as they are not entitled to services under a health-plan contract as that term is defined in 38 U.S.C. 1725(f).

Under section 1781, VA ''shall provide for medical care in the same or similar manner and subject to the same or similar limitations as medical care is furnished to certain dependents and survivors of active duty and retired members of the Armed Forces under chapter 55 of title 10 [United States Code] (CHAMPUS).'' 38 U.S.C. 1781(b). CHAMPUS was the original program administered by DoD to provide civilian health benefits for active duty military personnel, military retirees, and their dependents. 32 CFR 199.1. Although the CHAMPUS program is still referenced in DoD regulations, DoD effectively replaced the CHAMPUS program with what is commonly known as the ''TRICARE Standard'' plan (''TRICARE''). See 32 CFR 199.1(r), 199.17(a)(6)(ii)(C) (identifying ''TRICARE Standard'' as the basic CHAMPUS program). TRICARE's current benefit structure offers varying degrees of medical benefits under multiple plan options beyond its Standard plan, but we administer CHAMPVA in the same or similar manner as TRICARE Standard only, because that basic program is the one that is referenced by the CHAMPUS authority. Thus, all references in this rulemaking to ''TRICARE'' are to the TRICARE Standard plan, which we refer to simply as ''TRICARE'' throughout most of this rulemaking for ease of reference.

VA interprets the mandate in 38 U.S.C. 1781(b) to administer CHAMPVA in the ''same or similar manner . . . as medical care is furnished . . . under title 10 chapter 55 (CHAMPUS)'' to mean that we must generally administer CHAMPVA in a ''same or similar manner'' as the TRICARE Standard plan. The phrase ''same or similar manner'' does not require the programs to be administered in an identical manner. Rather, we broadly interpret this language as affording us needed flexibility to administer the program for CHAMPVA beneficiaries. For this reason, not every aspect of CHAMPVA will find a corollary in the TRICARE Standard Plan.

TRICARE has undergone changes in legal authority and policy that have prompted these proposed revisions to our CHAMPVA regulations. This rulemaking is intended to ensure that our regulations continue to be, again broadly speaking, the same or similar to the regulations and policies governing TRICARE. As noted throughout this proposed rule, there are necessary variations from TRICARE, particularly due to TRICARE's current benefit structure with varying degrees of medical benefits under multiple plan options, but we believe these variations satisfy the same or similar requirement in 38 U.S.C. 1781(b).

This rulemaking also proposes clarifications and revisions that will improve our ability to effectively administer CHAMPVA, as well as technical revisions to make our regulations more understandable.

17.270 General Provisions and Definitions

Current § 17.270(a) broadly discusses general administrative provisions of CHAMPVA, and current § 17.270(b) establishes certain definitions for the CHAMPVA regulations. We would revise the title of § 17.270 to clearly indicate that it contains both general provisions as well as definitions and would revise and reorganize the current definitions as well as add new definitions. Finally, we would add a new paragraph (c) to permit VA to waive, under certain circumstances, any requirements in the CHAMPVA regulations that are not otherwise required by statute, as is allowed under TRICARE. See 32 CFR 199.1(n). Waiver would be limited to very unusual and limited circumstances when waiver was determined to be in the best interests of VA; would not set a precedent for future decisions; and would not be used to deny any individual any right, benefit, or privilege provided to him or her by statute or these regulations.

Proposed § 17.270(a) would continue to provide an overview of CHAMPVA, including a general summary of the manner in which CHAMPVA is administered. We would refer to CHAMPUS, as we do in the current regulation, but would also reference TRICARE because the reference to CHAMPUS is outdated, as explained above, and may be misunderstood by CHAMPVA beneficiaries. Current § 17.270(a) states that CHAMPVA is administered by the ''Health Administration Center'' (HAC) (referred to now as the Office of Community Care (OCC)), which is located in Denver, Colorado. We propose to delete this statement because that fact is not substantively relevant to the regulations. These revisions are not substantively different from current § 17.270(a).

Proposed § 17.270(a)(1) would state that an authorized non-VA provider may provide medical services and supplies that are covered by CHAMPVA. This is current practice and would reflect in regulation VA's authority to provide CHAMPVA-covered services and supplies under 38 U.S.C. 1781(b)(2). As explained in greater detail below in connection with proposed § 17.272(b)(3), CHAMPVA-covered services and supplies are those provided by authorized non-VA providers who agree to provide covered services and supplies to CHAMPVA beneficiaries in exchange for payment of the CHAMPVA determined allowable amount. Proposed § 17.270(a)(2) would also reference VA's alternate authority under section 1781(b) to provide medical care to CHAMPVA beneficiaries through VA medical facilities equipped to provide the care and services if such resources are not being used for the care of eligible veterans. This initiative is called the CHAMPVA In-house Treatment Initiative (CITI) and would be referenced as such in proposed § 17.270(a)(2). CITI affords beneficiaries the same medical services available to veterans. CITI claims submitted to OCC are processed in the same manner as all other CHAMPVA claims. However, a monthly transfer of funds, or Transfer

Dispersing Authority (TDA), from OCC to the providing VA facility is used to reimburse CITI claims whereas electronic funds transfer or paper checks are used to reimburse beneficiaries and providers for non-CITI claims.

With regards to CHAMPVA beneficiaries receiving care in VA medical facilities through CITI, we have historically interpreted section 1781(b) to mean that such care may be provided only if the CHAMPVA beneficiary is not also eligible for Medicare benefits. We base this interpretation on the fact that CHAMPVA has always been the last payer for CHAMPVA-covered medical services and supplies when a CHAMPVA beneficiary has Medicare (included in this rulemaking's definition of ''other health insurance'' (OHI), see 38 U.S.C. 1781(d)(2)). The mandated coordination of benefits found in section 1781(d)(2) is essentially the same as the requirement in TRICARE codified at 32 CFR 199.8, which provides that if a TRICARE beneficiary is eligible for both Medicare and TRICARE, Medicare is the primary payer and TRICARE is the secondary payer. In addition, this policy limitation for CITI is reasonable because VA is a publicly funded health care system that cannot bill Medicare (see section 1814(c) and section 1835(d) of the Social Security Act, codified at 42 U.S.C. 1395f(c) and 1395n(d)). Moreover, Medicare is an entitlement program, whereas the provision of CHAMPVA medical benefits is subject to the availability of appropriations which, for any given time period, might or might not be sufficient to cover all CHAMPVA-covered medical services and supplies in a VA medical facility. Requiring beneficiaries to use their Medicare benefits first accomplishes our goal of protecting all patients' access to care. Therefore, we would further clarify in proposed § 17.270(a)(2) that any CHAMPVA beneficiary who is also eligible for Medicare benefits may not receive medical services and supplies through CITI.

Proposed § 17.270(a)(3) would newly indicate in regulation that outpatient prescription medications may be provided to certain CHAMPVA beneficiaries through Medications by Mail (MbM), administered by VA. Proposed paragraph (a)(3)(i) would further provide that VA's MbM provides prescription medications through the mail to CHAMPVA beneficiaries who do not have any OHI that pays for prescriptions, including Medicare Part D. This restriction largely is consistent with TRICARE policy on the provision of medications by mail, except that TRICARE covers prescribed medications for beneficiaries with OHI in two instances: When the prescribed medication is not covered by the OHI or when the beneficiary's OHI prescription benefit has been exhausted. See TRICARE Pharmacy Program Handbook (October 2015), pages 18–19. CHAMPVA is unable to duplicate these two exceptions due to system limitations, meaning that CHAMPVA will only provide prescription medications through the mail to beneficiaries who do not have any OHI prescription coverage. Despite this, CHAMPVA's inclusion of prescription medications is, broadly speaking, sufficiently similar to TRICARE that VA remains in substantial compliance with the requirements of section 1781(b).

Proposed paragraph (a)(3)(ii) would provide that smoking cessation pharmaceutical supplies are available only through MbM. Section 713 of the Duncan Hunter National Defense Authorization Act for Fiscal Year 2009, Public Law 110–417 (October 14, 2008) (''2009 NDAA'') required DoD to establish a smoking cessation program under TRICARE under which specified smoking cessation benefits are to be made available to beneficiaries who are not also eligible for Medicare. This TRICARE benefit is codified at 32 CFR 199.4(e)(30). As to the pharmaceutical component of this TRICARE benefit, smoking cessation pharmaceutical agents (which VA refers to as pharmaceutical supplies) are available only through Military Treatment Facility (MTF) pharmacies or the TRICARE Mail Order Program. See 32 CFR 199.4(e)(30)(ii)(A) and 199.21(h)(2)(iii). Similar to 32 CFR 199.4(e)(30)(i), proposed § 17.270(a)(3)(ii) would provide that the same smoking cessation supplies will be made available to CHAMPVA beneficiaries who are not eligible for Medicare. Additionally, smoking cessation pharmaceutical supplies would be available only through MbM. For purposes of CITI, we would not provide smoking cessation pharmaceutical supplies through VA facility pharmacies because it is administratively more efficient for CHAMPVA to provide these through MbM, and because, in complying with the requirements of section 1781(b), as discussed above, VA facility pharmacies would be required to administer any needed smoking cessation pharmaceutical supplies first to veterans before providing them to CHAMPVA beneficiaries. We would also remove the restriction on smoking cessation services and supplies in current § 17.272(a)(57), as discussed later in this proposed rule.

For clarity, we would establish abbreviations for the Civilian Health and Medical Program of the Department of Veterans Affairs as ''CHAMPVA'' and the Department of Veterans Affairs as ''VA.'' The current regulations refer to the part of VA that administratively handles CHAMPVA claims as the ''Center'' in several places (see current §§ 17.275–17.277), and to the ''Health Administration Center'' in other places (see current §§ 17.270, 17.275–17.276), and we believe that referring to ''VA'' is more appropriately descriptive and would eliminate ambiguity.

Proposed § 17.270(b) would establish definitions for the CHAMPVA regulations. We would define ''accepted assignment'' as the action of an authorized non-VA provider who accepts responsibility for the care of a CHAMPVA beneficiary and thereby agrees to accept the CHAMPVA determined allowable amount as full payment for services and supplies rendered to the beneficiary. This extinguishes the beneficiary's payment liability to the provider with the exception of applicable cost shares and deductibles. This definition is consistent with our explanation for proposed § 17.272(b)(3), which further outlines the necessity for defining ''accepted assignment.'' Our current regulations do not define the term ''authorized provider,'' but the term ''authorized provider'' (and variations thereof) is used throughout current § 17.272 to refer to an institutional or individual provider of CHAMPVA-covered services and supplies. The term is used to describe persons or institutions that are considered appropriately licensed or credentialed to competently provide medical services and supplies to CHAMPVA beneficiaries and that VA will pay to provide such services and supplies. In addition, an ''authorized provider'' has historically been interpreted in CHAMPVA to be a non-VA medical provider. To capture this historical interpretation in full, we would define an ''authorized non-VA provider'' to mean an individual or institutional non-VA provider of CHAMPVA-covered medical services and supplies who is licensed or certified by a State to provide the covered medical services and supplies, or is otherwise certified by an appropriate national or professional association that sets standards for the specific medical provider. This requirement for State licensure or other certification would be similar to TRICARE, which requires that its providers be either licensed or

certified by a State, or, where States do not offer licensure or certification, be otherwise certified by an appropriate national or professional association that sets standards for the specific medical provider. See TRICARE Policy Manual 6010.60–M, Chapter 11 (''Providers''), section 3.2 (''State Licensure And Certification''). (For general operational-type information, one can also refer to TRICARE Operations Manual 6010.59–M, Chapter 4, (''Provider Certification And Credentialing'') (April 1, 2015).)

We would define ''calendar year'' as the period of time between and including January 1 through December 31. This is plain language and is consistent with the generally understood meaning of the phrase ''calendar year.''

The term ''CHAMPVA beneficiary'' would be defined as a person enrolled for CHAMPVA under § 17.271. This would be a program-specific definition, but it is in plain language and is consistent with the generally understood meaning of the word ''beneficiary.'' To clarify, an individual is enrolled in CHAMPVA only after the individual has successfully completed the application process (*i.e.,* where the individual submits a completed VA Form 10–10d to VA, and VA has confirmed the individual's eligibility).

We would define ''CHAMPVA-covered services and supplies'' to mean those medical services and supplies that are medically necessary and appropriate for the treatment of a condition and that are not specifically excluded from coverage under proposed § 17.272(a)(1) through (84) (current § 17.272(a)(1) through (86)).

We would define ''CHAMPVA determined allowable amount'' by referencing the proposed paragraph that would relate to this term, proposed § 17.272(b)(1).

We would define ''CHAMPVA In-house Treatment Initiative (CITI)'' to mean the initiative under section 1781(b) under which participating VA medical facilities provide medical services and supplies to CHAMPVA beneficiaries who are not also eligible for Medicare, subject to availability of space and resources.

We would define the term ''child'' consistent with 38 U.S.C. 101, as we do in the current regulation at § 17.270(b).

We would define the term ''claim'' consistent with the current use and understanding of the term in the context of CHAMPVA, as a request by an authorized non-VA provider or CHAMPVA beneficiary for payment or reimbursement for medical services and supplies provided to a CHAMPVA beneficiary.

We would define ''fiscal year'' as the period of time starting on October 1 and ending on September 30. This is plain language and is consistent with the generally understood meaning of the phrase ''fiscal year'' as used within the Federal Government.

We would define ''Medications by Mail (MbM)'' to mean the initiative under which VA provides outpatient prescription medications through the mail to CHAMPVA beneficiaries.

We would define ''other health insurance'' (OHI) as a health insurance plan or program (to include Medicare) or third-party coverage that provides coverage to a CHAMPVA beneficiary for expenses incurred for medical services and supplies. The inclusion of Medicare is consistent with the TRICARE regulation related to double coverage. See 32 CFR 199.8(d)(1).

We would define the term ''payer'' to mean OHI, as defined in this rulemaking, that is obligated to pay for CHAMPVA-covered medical services and supplies. In a situation in which more than one insurer is responsible to pay for such services and supplies (*e.g.,* a ''double coverage'' situation), there would be a primary payer (*i.e.,* the payer obligated to pay first), a secondary payer (*i.e.,* the payer obligated to pay after the primary payer), etc. In double coverage situations, CHAMPVA would be the last payer, after payment by the primary payer and all other secondary payers.

Defining a ''payer'' and designating different payer types would not affect the administration of CHAMPVA because these concepts of relative payment responsibility are all accepted and understood by the insurance industry and current CHAMPVA beneficiaries and are an essential part of current CHAMPVA billing practices. For instance, Medicare would be the primary payer in situations governed by current § 17.271(b) (which remains unchanged by this proposed rulemaking). See 38 U.S.C. 1781(d)(2).

The definition of ''service-connected'' in current § 17.270(b) would be unchanged and given the same meaning as that term in 38 U.S.C. 101. However, the terms ''spouse'' and ''surviving spouse'' would no longer have the definitions of these same terms in 38 U.S.C. 101(31) and (3), respectively, as those definitions are outdated; instead, these terms would both be determined by operation of 38 U.S.C. 103(c).

Consistent with the waiver provisions of TRICARE, see 32 CFR 199.1(n), new proposed paragraph (c) would establish the discretionary authority of VA to waive, when it is deemed to be in the best interest of VA, any regulatory requirement of this part that is not required by 38 U.S.C. 1781 or otherwise imposed by statute. This discretionary waiver authority would be limited to very unusual and limited circumstances and would not set a precedent for future decisions. In addition, it would not be used to deny any individual any right, benefit, or privilege provided by statute or these regulations. This new provision would enable VA to allow payment under CHAMPVA in cases, for example, where, by operation of CHAMPVA rules, the claim is subject to complex administrative or accounting procedures that ultimately result in determination of the claim's technical noncompliance when the underlying claim is otherwise appropriate. Where a claimant's non-compliance with a purely policy or administrative-based technical requirement is both unintentional and harmless, we believe it would be in VA's best interest to have the authority to waive the regulatory requirement and allow payment.

17.271 Eligibility

Current § 17.271 identifies persons who may be eligible for CHAMPVA benefits. We would revise § 17.271(a) to recognize as CHAMPVA beneficiaries those individuals designated as Primary Family Caregivers under 38 CFR 71.25(f). This substantive addition to the eligibility criterion would be made pursuant to the Caregivers and Veterans Omnibus Health Services Act of 2010, Public Law 111–163, section 102, which amended 38 U.S.C. 1781(a) by adding a new subsection (a)(4) authorizing VA to provide CHAMPVA benefits to ''an individual designated as a primary provider of personal care services under [38 U.S.C. 1720G(a)(7)(A)] who is not entitled to care or services under a health-plan contract (as defined in [38 U.S.C. 1725(f)]).'' We amend CHAMPVA eligibility criteria to recognize these Primary Family Caregivers as CHAMPVA beneficiaries but not to establish substantive eligibility rules in the CHAMPVA regulations to determine whether an individual is a Primary Family Caregiver. (VA's regulations governing the Caregivers Benefits Program established by 38 U.S.C. 1720G are codified at 38 CFR part 71, and the specific rules governing the identification of such individuals are found at 38 CFR 71.15 through 71.25.) We would redesignate current § 17.271(a)(4) as § 17.271(a)(5) and add a new proposed § 17.271(a)(4) to state that a Primary Family Caregiver is eligible for CHAMPVA benefits if they are not entitled to care or services under a health-plan contract (as defined in 38 U.S.C. 1725(f)(2)). We note that VA is already providing CHAMPVA services

and supplies to these individuals pursuant to the statutory mandate in section 1720G(a)(3)(A)(ii)(IV) and under the Caregivers Benefits Program regulations. This revision would simply update the CHAMPVA regulations to conform to these laws.

17.272 Benefits Limitations/Exclusions

Current § 17.272 provides general information about what medical services and supplies are covered by CHAMPVA and lists coverage limitations along with the exclusions. The general information concerning coverage in current § 17.272(a) continues to be accurate, and we do not propose any changes to paragraph (a). Some of the coverage limitations and exclusions listed in the numbered paragraphs under § 17.272(a) require revision due to either changed standards in clinical practice or changes in TRICARE coverage.

Current § 17.272(a)(2) excludes the provision of services and supplies required as a result of an occupational disease or injury for which benefits are payable under workers' compensation or a similar protection plan. We propose to update the verbiage to clarify the exclusion for the reader.

Current § 17.272(a)(3) excludes the provision of services and supplies that are paid directly or indirectly by local, State, or Federal government agencies, with certain exceptions listed in § 17.272(a)(3)(i) and (ii) where CHAMPVA assumes primary payer status. We propose to add Indian Health Service and CHAMPVA supplemental policies as exceptions where CHAMPVA assumes primary payer status. This would be consistent with current CHAMPVA practice as well as the TRICARE regulation related to double coverage. See 32 CFR 199.8(b)(4)(ii) and (iv). We also propose to remove the ''(Medicaid excluded)'' parenthetical language in current § 17.272(a)(3), because § 17.272(a)(3)(i) already expressly excepts ''Medicaid'' from the general exclusion in § 17.272(a)(3).

Current § 17.272(a)(21) excludes dental care generally, with exceptions to such exclusion listed in paragraphs (a)(21)(i) through (xii). We would amend paragraph (a)(21)(ix) to clarify that the provision of initial imaging services for the treatment of temporomandibular joint disorder (TMD) could specifically include Computed Tomography (CT) and Magnetic Resonance Imaging (MRI) services. We believe the sole reference to ''initial radiographs'' in current § 17.272(a)(21)(ix) is outdated and that modern industry standards include the use of CT scans as well as MRIs for diagnosing TMD. A CT scan provides a more detailed image of the bones in the joint, and an MRI provides a more detailed image of the soft tissue to determine proper positioning as the jaw moves. We would also update § 17.272(a)(21)(ix) to refer to the more updated and clinically appropriate terminology ''temporomandibular joint disorder (TMD).'' These revisions would update CHAMPVA regulations with current standards of clinical practice for the benefit of CHAMPVA beneficiaries.

A majority of the remaining proposed changes to CHAMPVA coverage exclusions in proposed § 17.272(a)(1) through (82) are based on changes to TRICARE coverage and policy. Virtually all coverage limitations and exclusions in current § 17.272(a)(1)–(86), as shown in the chart below, are substantially identical to services and supplies excluded from, or limited under, TRICARE coverage under 32 CFR 199.4(g), or as otherwise noted in the chart.

LIST OF COMPARABLE CHAMPVA AND TRICARE EXCLUSIONS

CHAMPVA provision (identified paragraphs are from 38 CFR 17.272(a))	TRICARE provision (identified paragraphs are from 32 CFR 199.4(g), or as otherwise noted)
(1)	(11).
(2)	(23).
(3)	(13).
(4)	(1).
(5)	(2).
(6)	(3).
(7)	(4).
(8)	(5).
(9)	(6).
(10)	(7).
(11)	(8).
(12)	(9).
(13)	(14).
(14), (81)	(15).
(15)	(16).
(16)	(17).
(17)	(19).
(18)	(21).
(19), (82)	(24).
(20)	(26).
(21)	(27).
(22)	(28).
(23)	(29).
(24)	(30).
(25)	(31).
(27)	(33).
(28)	(34).
(29)	(35).
(30)	(36).
(31)	(37).
(32)	(38).
(33)	(39).
(34)	(40).
(35)	(41).
(36)	(20), (42).
(37)	(43).
(38)	(44).
(40)	(46).
(41)	(47).
(42)	(50).
(43)	(51).
(44)	(48).
(45)	(49).
(46)	(52).
(47)	(53).
(48)	(54).
(49)	(55).
(50)	(56).
(51)	(57).
(52)	(58).
(53)	(60).
(54)	(61).
(55), (57)	(62).
(56)	(64).
(57)	(65).
(58)	(66).
(59)	(67).
(60)	(72).
(62)	32 CFR 199.4(a)(12) and (b)(10)(iv).
(63) through (65)	32 CFR 199.4(e)(4) and (h).
(66)	(73).
(67), (68)	32 CFR 199.2(b) and 199.4(e)(2).
(69)	32 CFR 199.4(c)(3)(ix) and 199.4(e)(4).
(70), (71)	32 CFR 199.4(e)(17).
(73)	32 CFR 199.4(g)(15)(iv).
(74)	(69).
(75)	32 CFR 199.4(a)(1).
(76)	32 CFR 199.4(g)(74).
(77)	(39), (42).
(78)	(25).
(79)	32 CFR 199.4(g)(15).
(80)	32 CFR 199.2(b) and 199.4(b)(2)(v), (b)(3)(iii), (b)(5)(v), (d)(3)(vi), (e)(11)(i).
(83)	32 CFR 199.4(c)(2), (c)(3), (e)(8)(i)(E).
(84)	32 CFR 199.4(e)(8).
(85), (86)	32 CFR 199.2(b), 199.4(e)(8), (g)(24).

We note that even where our current provisions are not identical to a TRICARE provision, our intent has consistently been to apply CHAMPVA comparable exclusions or limitations in the same or similar manner to their TRICARE counterpart in accordance with 38 U.S.C. 1781(b). The same is true for our proposed revisions below, which are consistent with changes in DoD's administration of TRICARE.

The first change we would make to our limitations and exclusions based on TRICARE regulatory and policy changes concerns current § 17.272(a)(26), which is not addressed in the chart above because it correlates with a provision that has been removed from TRICARE regulations. See 60 FR 12419 (March 7, 1995). Therefore, we propose to remove this exclusion from our regulations as well. Paragraph (a)(26) in current § 17.272 excludes coverage for services and supplies, including psychological testing, provided in connection with a specific developmental disorder. By removing this exclusion, CHAMPVA would now cover this service, and we would redesignate current

§ 17.272(a)(27) through (38) as § 17.272(a)(26) through (37), respectively.

Under section 711 of the 2009 NDAA, TRICARE must waive all beneficiary costs associated with certain preventive services, unless the beneficiary is also Medicare-eligible. TRICARE regulations were revised to delete from 32 CFR 199.4(g)(37) the list of preventive services not excluded from coverage, and these services were moved to new § 199.4(e)(28) so that they instead would be reflected as preventive services under TRICARE for which out-of-pocket costs are eliminated. See 76 FR 81368 (December 28, 2011). We would revise our current exclusion of preventive care in § 17.272(a)(31) (proposed to be redesignated as § 17.272(a)(30)) to except the same preventive services identified in paragraphs (d)(1)(A) through (F) of section 711 of the 2009 NDAA and, further, do so in a manner that, on the whole, reflects the manner in which these services are provided under TRICARE. Section 711 of the 2009 NDAA sets forth the following preventive services for which beneficiaries shall pay no associated costs: Colorectal cancer screening; breast cancer screening; cervical cancer screening; prostate cancer screening; annual physical exam; vaccinations. Current § 17.272(a)(31)(i) through (x) set forth exceptions to the general exclusion of certain specific preventive care. Respectively, the terms of current paragraphs (a)(31)(v) and (vi) already except ''[p]ap smears'' and ''[m]ammography tests'' and so effectively capture ''cervical cancer screening'' and ''breast cancer screening'' as referred to in the 2009 NDAA. However, because the singular terms ''mammography test'' and ''pap smear'' are outdated, we are updating to ''breast cancer screening'' and ''cervical cancer screening.'' Therefore, proposed § 17.272(a)(30) would revise the exceptions to the general exclusion of preventive care to include the four remaining preventive services specified in the 2009 NDAA, namely colorectal cancer screening; prostate cancer screening; annual physical examination; and vaccinations/immunizations.

We note that the TRICARE final rule that implemented the amendments made by section 711 of the 2009 NDAA does not include an annual physical exam benefit for all TRICARE beneficiaries; instead, such benefit is limited to certain dependents of Active Duty military personnel who are traveling outside the United States and for beneficiaries ages 5 through 11 who require such exams for school enrollment. This benefit is also not exempt from cost sharing requirements. See 76 FR 81368, and 32 CFR 199.4(e)(29). Broadly interpreting our mandate in section 1781(b), VA proposes to modify the current exclusion of preventive care in current § 17.272(a)(31) insofar as it defines that term to include annual physical examinations and create an exception permitting such exams. Despite the limited availability of such examinations under TRICARE, it is noteworthy that TRICARE nonetheless covers some preventive services that are typically provided as part of an annual physical examination such as blood pressure screening, cholesterol testing, and body measurements. See TRICARE Policy Manual 6010.60–M (''Medicine''), Chapter 7, section 2.1 (''Clinical Preventive Services-TRICARE Standard'') (April 1, 2015). To be paid for by TRICARE, however, these types of health promotion and disease prevention services must be billed in connection with another preventive service delineated in TRICARE's policy manual. Id. We do not believe limiting the provision of annual physical examinations to only a few select groups is appropriate from a clinical perspective. Further, in the exercise of our discretion, when broadly interpreting the mandate of section 1781(b), we conclude it lies within our discretion to determine that this benefit should be made available to all CHAMPVA beneficiaries. This is particularly the case given that some individual health promotion and disease prevention services that are typically provided as part of an annual physical examination would eventually be approved by TRICARE as long as they are coupled or associated with billing submitted for a covered service. (The nature and delivery of those services remains the same whether delivered as part of an annual examination or under the umbrella of another service for which TRICARE billing is permitted.) Furthermore, VA finds that annual physical examinations are beneficial for both CHAMPVA beneficiaries and VA, by serving to identify serious medical issues before they progress and their clinical management becomes more difficult and resource-intensive. Even though our proposed approach would include elements of an annual physical examination not otherwise included as an adjunct service provided under a covered benefit as described above, we believe our approach is sufficiently ''similar'' to TRICARE. Therefore, we propose to create an exception to the exclusion of preventive care, permitting an annual physical examination to be among the benefits available to all CHAMPVA beneficiaries.

We also note that we would except ''[v]accinations/immunizations'' from the general exclusion of preventive services. Although subsection (d)(1)(F) of section 711 of the 2009 NDAA exempts ''vaccination'' only, TRICARE's guidance on this issue additionally exempts immunizations. See TRICARE Reimbursement Manual 6010.61–M Chapter 2 (''Beneficiary Liability''), section 1 (''Cost-Shares And Deductibles'') (April 1, 2015). We believe these terms have identical meanings and would use both terms just to be clear that this preventive service is covered regardless of whether it is called an ''immunization'' or a ''vaccination.''

Current § 17.272(a)(39) excludes coverage for audiological services or speech therapy, except when prescribed by a physician and rendered as part of a treatment addressing a physical defect, which correlates with a provision not addressed in the chart above because it has been removed from TRICARE regulations. See 75 FR 50880 (August 18, 2010). Therefore, we propose to remove this exclusion from our regulations as well. By removing this exclusion, CHAMPVA would now cover this service, and we would redesignate current § 17.272(a)(40) through (56) as § 17.272(a)(38) through (54), respectively.

As stated earlier in this rulemaking, pursuant to section 713 of the 2009 NDAA, TRICARE must make available smoking cessation benefits, as specified in the law, to beneficiaries who are not also eligible for Medicare. The four categories of smoking cessation benefits available to these beneficiaries are set forth in TRICARE's regulations under 32 CFR 199.4(e)(30)(ii)(A)–(D). Hence, we would revise our regulations by removing our correlate restriction on smoking cessation services and supplies in current § 17.272(a)(57). In removing current § 17.272(a)(57), current paragraphs (a)(58) through (71) would be redesignated as paragraphs (a)(55) through (68), respectively.

Redesignated paragraphs (a)(57) through (59) would be revised to reference coverage of mental health benefits in a ''calendar year'' versus the current reference to ''fiscal year.'' We propose to change the yearly basis of this coverage because our beneficiaries and providers are more familiar with calendar year events, and the impact of the change from fiscal to calendar on the functioning of CHAMPVA would be minimal.

With the proposed removal of § 17.272(a)(57) and subsequent redesignations of paragraphs noted above, current paragraph (a)(67) would be redesignated as paragraph (a)(64). CHAMPVA would continue to exclude the performance of abortions, except when a physician certifies that the life of the mother would be endangered if the fetus were carried to term. This is the same restriction in current TRICARE regulations (see 32 CFR 199.4(e)(2)), although statute and TRICARE policy statements recently established an additional exception to the general ban on abortions. Specifically, section 704 of the National Defense Authorization Act for Fiscal Year 2013, Public Law 112–239 (2013 NDAA), amended 10 U.S.C. 1093(a) and (b) to expand the circumstances under which funds available to DoD and MTFs may be used to provide and perform abortions in cases of pregnancy resulting from an act of rape or incest. Despite the recent amendments to section 1093 of title 10 and TRICARE policy, we do not propose same or similar changes to CHAMPVA's current exclusion at this time because TRICARE regulations do not provide for it. Additionally, such changes would create an even greater disparity between the women's health care benefits afforded veterans and CHAMPVA beneficiaries.

Current § 17.272(a)(72) excludes from coverage drug maintenance programs where one addictive drug is substituted for another such as methadone substituted for heroin. A TRICARE final rule published on October 22, 2013, and effective November 21, 2013, removes a correlate restriction from TRICARE regulations, and so we propose to similarly remove § 17.272(a)(72). See 78 FR 62427 (October 22, 2013); 32 CFR 199.4(e)(4)(ii). We agree with the stated rationale in the related TRICARE proposed rule that the current restriction fails to recognize the accumulated medical evidence supporting certain maintenance programs as one component of the continuum of care necessary for the effective treatment of substance use disorders. See 76 FR 81899 (December 29, 2011). In removing current § 17.272(a)(72), current paragraphs (a)(73) through (86) would be redesignated as paragraphs (a)(69) through (82), respectively.

Current § 17.272(a)(80), as proposed to be redesignated as paragraph (a)(76), excludes from CHAMPVA benefits medications not requiring a prescription, except for insulin and related diabetic testing supplies and syringes. We would revise redesignated paragraph (a)(76) to instead exclude ''over-the-counter products'' and would additionally expand the exception to this exclusion to cover over-the-counter smoking cessation pharmaceutical supplies that are approved by the U.S. Food and Drug Administration (FDA), prescribed, and provided through MbM. These changes would be consistent with TRICARE regulations, which require a prescription from an authorized provider for smoking cessation pharmaceutical agents (even for FDA-approved over-the-counter smoking cessation agents). See 32 CFR 199.4(e)(30)(ii)(A).

Section 702 of the 2013 NDAA grants the Secretary of Defense the authority to add certain over-the-counter medications to the TRICARE formulary so that such medications may be administered as if they were prescription medications. CHAMPVA does not have a same or similar uniform formulary as DoD that could be altered to include certain over-the-counter medications, and we do not interpret section 702 as granting authority to alter VA's uniform formulary. Therefore, we would not amend our regulations in response to section 702 of the 2013 NDAA. Our regulation as revised and redesignated § 17.272(a)(76) would permit CHAMPVA to provide the same over-the-counter smoking cessation supplies as permitted in TRICARE policy.

Lastly, we would add two new exclusions to § 17.272. Proposed paragraph (a)(83) would exclude medications that are not approved by the FDA, excluding FDA exceptions to the approval requirement. Current CHAMPVA regulations are silent regarding the need for medications to meet FDA approval requirements; however, this has not been a problem as a matter of practice because applicable standards of care generally require prescribed medications to be FDA-approved or excluded as an exception from the approval requirement. Still, we wish to formally and expressly exclude medications that do not meet these requirements. In addition, to provide benefits in the same or similar manner and subject to the same or similar limitations as TRICARE, paragraph (a)(84) would establish exclusions for services and supplies related to the treatment of dyslexia. See 38 CFR 199.4(g)(32). This change merely reflects in regulation current CHAMPVA practice and policy.

Due to the multiple proposed deletions and additions in § 17.272(a)(1)–(86), we reiterate that we would redesignate most of the current paragraphs under § 17.272(a). With the proposed removal of current paragraph (a)(26), current paragraphs (a)(27) through (38) would be redesignated as (a)(26) through (37), respectively, with the substantive changes to redesignated (a)(30) as noted above. With the proposed removal of current paragraph (a)(39), current paragraphs (a)(40) through (56) would be redesignated as (a)(38) through (54), respectively, with no substantive changes. With the deletion of the current paragraphs (a)(57) and (72), current paragraphs (a)(58) through (86) would be redesignated as (a)(55) through (82), respectively, with the minor substantive changes as noted above to redesignated paragraphs (a)(57) through (59) and (a)(76). Lastly, we would add new paragraphs (a)(83) and (84).

Current § 17.272(b) establishes the ''CHAMPVA determined allowable amount,'' and paragraph (b)(1) states that the term ''allowable amount'' is the maximum amount that CHAMPVA will pay an authorized provider for a covered benefit, which is determined prior to cost sharing and the application of deductibles or OHI. (This means, for instance, that the cost-share would be a percentage of the entire CHAMPVA determined allowable amount.) However, this is merely a definition and not a statement of coverage limitation or exclusions. We would revise paragraph (b) to clearly indicate that amounts above the CHAMPVA determined allowable amount are excluded from CHAMPVA coverage. The actual payment methodology—the amount to which cost sharing and deductibles will be applied—is addressed in proposed § 17.274(e) and is discussed below.

Proposed § 17.272(b)(1) would explain that the CHAMPVA determined allowable amount is the maximum level of payment to an authorized non-VA provider for CHAMPVA-covered services and supplies and that this allowable amount is determined before cost sharing and the application of deductibles or OHI is considered. This is a restatement of current § 17.272(b)(1), except that we would use the term ''authorized non-VA provider'' to encompass all those providers listed in current § 17.272(b)(1) and include the term ''supplies'' after ''covered services'' to underscore they too can be covered. See current 38 CFR 17.272(b)(1) (referencing ''a hospital or other authorized institutional provider, a physician or other authorized individual professional provider, or other authorized provider for covered services''). We believe use of the one term ''authorized non-VA provider'' as defined in proposed § 17.270(b) properly captures all provider types now listed in § 17.272(b)(1) and

simplifies the regulatory reference to providers for the benefit of CHAMPVA beneficiaries. Proposed § 17.272(b)(1) would also clearly state that the CHAMPVA determined allowable amount is payment made by VA to an authorized non-VA provider for the provision of CHAMPVA-covered services and supplies to a CHAMPVA beneficiary.

Current § 17.272(b)(2) states that a Medicare-participating hospital must accept the CHAMPVA determined allowable amount for inpatient services as payment in full and references 42 CFR parts 489 and 1003. While this is a true statement of law under 42 CFR 489.25, the references to 42 CFR parts 489 and 1003 are vague, and part 1003 is not relevant to the issue of what amounts Medicare-participating hospitals must accept as payment in full from CHAMPVA. See 42 CFR part 1003 (describing civil money penalties, assessments, and exclusions generally for individuals who violate provisions of or agreements with Federal health care programs). Proposed § 17.272(b)(2) would state that inpatient services are ''provided to a CHAMPVA beneficiary'' and use a single, clarifying reference to 42 CFR 489.25.

Section 503 of The Caregivers and Veterans Omnibus Health Services Act of 2010, Public Law 111–163, revised 38 U.S.C. 1781 by adding new subsection (e), which states: ''Payment by the Secretary under this section on behalf of a covered beneficiary for medical care shall constitute payment in full and extinguish any liability on the part of the beneficiary for that care.'' Current § 17.272(b)(3) states that: ''An authorized provider of covered medical services or supplies must accept the CHAMPVA determined allowable amount as payment in full.'' Proposed § 17.272(b)(3) would state more clearly that ''accepted assignment'' refers to the action of an authorized non-VA provider who accepts responsibility for the care of a CHAMPVA beneficiary and thereby agrees to accept the CHAMPVA determined allowable amount as full payment for services and supplies rendered to the beneficiary. The provider's acceptance of the CHAMPVA determined allowable amount extinguishes the beneficiary's payment liability to the provider with the exception of applicable cost shares and deductibles. Proposed § 17.272(b)(3) would not be substantively different than current paragraph (b)(3) but would clarify that the action of accepting payment is the equivalent of accepting assignment. The term ''accepted assignment'' is used currently in the administration of CHAMPVA payments, and we believe using it in this regulation as described would increase clarity in payment practices for both CHAMPVA beneficiaries and authorized non-VA providers.

Current § 17.272(b)(4) provides that a provider who has collected and not made an appropriate refund, or attempts to collect from the beneficiary any amount in excess of the CHAMPVA determined allowable amount may be subject to exclusion from Federal benefit programs. The underlying authority for this rule is 42 CFR 1003.105, which establishes the terms for a health care provider's permissive or mandatory exclusion from participation in the Medicare program and other Federal health care programs. Exclusion may result, for instance, if a provider files false claims under these programs. We would move this information to proposed § 17.272(b)(3) for increased clarity and would remove mention of providers not making an appropriate refund of amounts collected from beneficiaries, as the purpose of 38 U.S.C. 1781(e) and proposed § 17.272(b)(3) is for these amounts to never be collected by the provider. By moving this information to proposed paragraph (b)(3), we would also remove current paragraph (b)(4).

17.273 Preauthorization

CHAMPVA preauthorization requirements for certain medical care and services are based on CHAMPVA needs and are substantially the same or similar as those required by TRICARE. See 32 CFR 199.4 *passim.* We propose to revise the preauthorization requirements by adding language to indicate when a beneficiary has ''other health insurance'' that provides primary coverage for the benefit, preauthorization requirements will not apply. TRICARE waives preauthorization requirements in all instances when OHI, to include Medicare, is the primary payer. See TRICARE Policy Manual 6010.60–M, Chapter 1 (''Administration''), section 6.1 (''Special Authorization Requirements'') (April 1, 2015). To provide benefits in a similar fashion, we would waive any requirement for preauthorization where OHI (as defined by this rulemaking) covers the benefit. We would also revise current § 17.273(d) to refer to dental coverage limitations in § 17.272(a)(21)(i)–(xii) to avoid a potential misconception that preauthorization is generally required for dental services. CHAMPVA clearly excludes all dental services, except for those listed in current § 17.272(a)(21)(i)–(xii). We would remove current § 17.273(e) and not require preauthorization for durable medical equipment as a covered service or supply. Removal of § 17.273(e) would be consistent with TRICARE policy. See TRICARE Policy Manual 6010.60–M, Chapter 8 (''Other Services''), section 2.1 (''Durable Medical Equipment: Basic Program'') (April 1, 2015). Based on this removal, we would redesignate current § 17.273(f) as § 17.273(e).

Finally, we would add new proposed § 17.273(f) to detail the reviews of medical necessity. Since CHAMPVA is a secondary payer, VA would be required to perform reviews of medical necessity on a retrospective basis. If during the coordination of benefits process it is determined that CHAMPVA would be the responsible payer for the services and supplies but CHAMPVA preauthorization was not obtained prior to delivery of the services or supplies, we would obtain the necessary information and perform a retrospective medical necessity review. We would also propose that any claims, where a retrospective review occurs, are filed within the appropriate one-year period.

17.274 Cost Sharing

Current § 17.274(a) provides in general that CHAMPVA is a cost sharing program in which the cost of CHAMPVA-covered services and supplies is shared with the beneficiary, with the exception of services obtained through VA medical facilities. This provision would remain substantively the same, but we would add new paragraphs (a)(1)(i) and (ii) to explicate, respectively, that the former language ''services obtained through VA facilities'' refers to services and supplies provided both through MbM and through CITI. That is, the exception to this cost-share requirement would extend specifically to each of these initiatives (as these initiatives would be defined by this proposed rulemaking).

Subsections (d)(1)(A) through (d)(1)(F) of section 711 of the 2009 NDAA, as discussed earlier, set forth certain preventive services for which TRICARE waives all out-of-pocket costs, even if the beneficiary has not paid the amount necessary to cover the beneficiary's deductible requirement for the year. We propose to revise § 17.274(a) to make clear that there will be no associated cost share for CHAMPVA beneficiaries for such services. (We address waiving the associated deductible requirement later in the discussion of proposed § 17.274(b)). We would add new paragraphs (a)(1)(iii)(A)–(G) to § 17.274 to waive CHAMPVA beneficiary cost-share requirements for the same preventive services identified in paragraphs (d)(1)(A) through (F) of

section 711 of the 2009 NDAA. Section 711 also authorizes, but does not require, the Secretary of Defense to extend the waiver of beneficiary costs to other preventive services. As such, we state in regulation that the list of services is not all-inclusive, enabling us to add supplemental items to the list in the future if needed, while enabling us to be sufficiently similar to TRICARE. See Public Law 110–417, section 711(d)(1)(G). TRICARE regulations and policy guidance extend this waiver to well-child visits for children under 6 years of age. See 32 CFR 199.4(e)(28)(iv), (f); TRICARE Reimbursement Manual 6010.61–M, Chapter 2 (''Beneficiary Liability''), section 1 (''Cost-Shares and Deductibles), 1.3.3.10.1.6 (Preventive Services''). We would include this same waiver in proposed paragraph (a)(1)(iii)(G) of § 17.274. We would waive any cost-share requirement for hospice services in proposed § 17.274(a)(1)(iv). This waiver is similar to the cost-share waiver for hospice services in TRICARE regulation. See 32 CFR 199.14(g)(9). Lastly, to remain similar to TRICARE, in § 17.274(a)(1)(v), we would add a waiver for other services as determined by the Secretary of Veterans Affairs.

For TRICARE, the waiver of beneficiary costs associated with preventive services in proposed § 17.274(a)(1)(iii)(A) through (G) do not apply to any TRICARE beneficiary who is also Medicare-eligible. See Public Law 110–417, section 711(b). We would not exclude Medicare-eligible beneficiaries from cost sharing waivers for preventive services as this would unfairly disadvantage them as compared to other CHAMPVA beneficiaries with OHI. By not including this waiver, CHAMPVA will treat all beneficiaries with OHI the same. Additionally, we believe most preventive services provided to Medicare-eligible beneficiaries will be paid in full by Medicare, and, therefore, CHAMPVA will not assume any payment responsibility. In the event a cost share or deductible is applied for preventive services, CHAMPVA will treat those claims as it would the claims for any other beneficiary with OHI.

The general provisions in current § 17.274(b) related to establishing an annual deductible requirement (in addition to beneficiary cost share) would remain substantively the same. We would move the exception to this general requirement in current § 17.274(b) (last sentence) for services obtained through VA facilities to a new § 17.274(b)(1) and also explain that it refers to services and supplies provided through MbM or CITI under the same rationale as expressed above for proposed new § 17.274(a)(1)(i) and (ii), respectively. We would also move the exception to the deductible requirement in current § 17.274(b) (last sentence) for any inpatient services to a new § 17.274(b)(2). Proposed § 17.274(b)(3) would except the listed preventive services in proposed § 17.274(a)(1)(iii)(A)–(G) from the general deductible requirement in current and proposed § 17.274(b), in accordance with the mandate in section 711 of the 2009 NDAA. See Public Law 110–417, section 711(a)(2) (mandating that a beneficiary not be charged for preventive services during a year even if the beneficiary has not paid the amount necessary to cover the beneficiary's deductible for the year. See 32 CFR 199.4(f)(12)). Proposed § 17.274(b)(4) would waive the CHAMPVA beneficiary deductible requirement for hospice services, as is done similarly under TRICARE regulations. See 32 CFR 199.14(g)(9). Lastly, to remain similar to TRICARE, in § 17.274(b)(5), we would add a waiver for other services as determined by the Secretary of Veterans Affairs.

Current § 17.274(c) establishes a calendar year limit on the ''cost-share amount'' incurred by a CHAMPVA beneficiary through the payment of both cost-shares and deductible amounts (See current 38 CFR 17.274(c), indicating that the cap is ''limited to the applied annual deductible(s) and the beneficiary cost-share amount.''). Proposed § 17.274(c) would retain this basic information but would refer instead to a cap on ''out-of-pocket costs'' instead of ''cost-share amounts'' so that it is clear that both cost share and deductible amounts apply to this cap. Current § 17.274(c)(i) establishes an annual cap of cost sharing of $7,500 per CHAMPVA eligible family ''through December 31, 2001'', which is an outdated provision. Current § 17.274(c)(ii) further establishes a current cap of $3000 per CHAMPVA eligible family, which was ''[e]ffective January 1, 2002.'' Under proposed § 17.274(c), we would establish an annual (calendar year) cap on out-of-pocket costs of $3,000 per CHAMPVA eligible family. The annual cap amount would be unchanged from what currently exists but would use the new terminology proposed above for the sake of clarity. We would also remove current § 17.274(c)(i) and (ii).

We do not propose any substantive changes to current § 17.274(d) as this provision is legally adequate, and we are not proposing to revise policies related to it. However, we are adding a subject heading in an effort to mirror the cost share calculation in proposed paragraph (e) to § 17.274.

We propose to add a new paragraph (e) to § 17.274 which would set forth the principles found in current policy manuals that VA uses to establish CHAMPVA beneficiary cost-share amounts. The calculation methodologies that would be described in proposed § 17.274(e) represent current CHAMPVA practice and therefore would not increase or decrease the out-of-pocket costs for CHAMPVA beneficiaries. The methodologies described in proposed § 17.274(e) are also consistent with TRICARE cost-share calculation methodologies for the same or similar types of care, except as indicated below.

In accordance with current practice, and as proposed in § 17.274(e), the CHAMPVA beneficiary's cost-share amount, if applicable, is 25 percent of the CHAMPVA determined allowable amount in excess of the annual calendar year deductible for most CHAMPVA-covered services and supplies. This calculation is similar to that used in TRICARE to determine cost-share amounts for a majority of TRICARE covered services. See 32 CFR 199.4(f)(3)(ii)(C) and (f)(3)(iii). Proposed § 17.274(e)(1) and (2) would establish the services for which the general rule of a 25 percent cost share does not always apply. Proposed paragraph (e)(1) would establish in regulation the current calculation VA uses to determine CHAMPVA beneficiary cost share for inpatient facility services and supplies that are subject to the CHAMPVA Diagnosis Related Group (DRG) payment system. The CHAMPVA DRG system, like that used by TRICARE under 32 CFR 199.14, is based on the Centers for Medicare and Medicaid Services (CMS) prospective payment system for hospital services, as set forth in 42 CFR part 412. For services based on the CHAMPVA DRG system, the CHAMPVA beneficiary cost share would be the lesser of the per diem rate multiplied by the number of inpatient days; or, 25 percent of the hospital's billed amount; or, the base CHAMPVA DRG rate. This calculation is similar to that used in TRICARE regulation. See 32 CFR 199.4(f)(3)(ii)(A) and (f)(8)(ii).

Proposed § 17.274(e)(2) would establish the CHAMPVA beneficiary cost share for covered inpatient facility services and supplies that are subject to the CHAMPVA mental health low volume per diem reimbursement methodology. This methodology covers mental health inpatient services for lower volume hospitals and units (less than 25 mental health discharges per federal fiscal year). For these services, the CHAMPVA beneficiary cost share

would be the lesser of a fixed per diem amount multiplied by the number of inpatient days or 25 percent of the hospital's billed charges. This calculation is similar to that used in TRICARE regulations. See 32 CFR 199.4(f)(3)(ii)(B) and (f)(8)(ii).

Although, as noted above, a majority of the CHAMPVA cost-share methodologies are the same or similar as TRICARE's, we would not adopt a recent TRICARE exception to its general 25 percent cost-share rule for prescription medications. Section 712 of the 2013 NDAA requires the Secretary of DoD, through regulations, to establish specified fixed dollar amounts for cost shares for pharmacy benefits (*e.g.,* generic, formulary, and non-formulary agents or medications). We would not establish similar fixed cost-share amounts because CHAMPVA does not have an established uniform formulary and, therefore, is unable to identify all medications which may be prescribed or approximate their standard retail pricing to determine, with certainty, that a fixed dollar amount would satisfy beneficiaries' cost-share liability. Generally, CHAMPVA coverage of medications depends upon whether medications are approved by the FDA for the indications for which they are prescribed (as explained above in connection with new proposed § 17.272(a)(83)). Additionally, the fixed cost-share amounts required by section 712 of the 2013 NDAA would apply even to medications administered through TRICARE's mail order service; whereas, under proposed § 17.274(a)(1), as revised for clarity, cost-sharing requirements would not apply to services and supplies provided through VA's MbM. As a matter of policy, VA does not wish to apply a cost share for mail order pharmacy supplies provided to CHAMPVA beneficiaries. We believe that this departure from TRICARE is necessary to ensure the most appropriate care for CHAMPVA beneficiaries. Although we would not establish fixed cost-share amounts for medications similar to those set forth in section 712 of the 2013 NDAA, we would revise our regulations to clarify the methodology CHAMPVA uses to determine allowable amounts paid for outpatient medications obtained in the community (explained later in the discussion of proposed § 17.275(f)), upon which the 25 percent CHAMPVA beneficiary cost share is based. We believe these clarifications would provide more transparency related to pharmacy costs and subsequent CHAMPVA beneficiary cost-share amounts for pharmaceutical supplies obtained in the community, which we believe is a reasonable interpretation of the goals of section 712 of the 2013 NDAA in establishing fixed cost-share amounts.

17.275 CHAMPVA Determined Allowable Amount Calculation

We propose to add a new § 17.275 to describe the various payment methodologies used by CHAMPVA to calculate the CHAMPVA determined allowable amount for covered services and supplies. CHAMPVA uses the same or similar payment methodologies to establish allowable reimbursement amounts for providers as TRICARE. See 32 CFR 199.14. As with the cost-share methodologies that would be described in § 17.274(e), proposed § 17.275 represents current practice except as noted below and would not cause changes for CHAMPVA beneficiaries. The reason that § 17.274(e) (regarding cost share) and § 17.275 (regarding CHAMPVA determined allowable amount) would be separated is to clarify for CHAMPVA beneficiaries how much of the CHAMPVA determined allowable amount they are responsible for as a cost share (*e.g.,* 25 percent) and additionally to provide beneficiaries and providers with an idea of how such allowable amounts are calculated.

Proposed § 17.275(a) would establish in regulation the CHAMPVA determined allowable amount for reimbursement of inpatient hospital services based on the CHAMPVA DRG-based payment system. Proposed paragraph (a) would explain that, unless exempt or subject to a methodology in proposed paragraph (b) or (c), hospital services provided in the 50 States, the District of Columbia, and Puerto Rico are subject to the CHAMPVA DRG-based payment system. The CHAMPVA DRG system, similar to that used by TRICARE under 32 CFR 199.14, is also based on the CMS prospective payment system as set forth in 42 CFR part 412. Certain services provided in a DRG reimbursed facility will be reimbursed under the CHAMPVA Cost-to-Charge (CTC) payment method. See, *e.g.,* 32 CFR 199.14(c). However, we will not list these specifically in regulations as the list of services may change more often than regulations can be updated.

Proposed § 17.275(b) would establish in regulation the current CHAMPVA inpatient mental health per diem payment system used to calculate reimbursement for inpatient mental health hospital care in specialty psychiatric hospitals and psychiatric units of general acute hospitals that are exempt from the CHAMPVA DRG-based payment system. The per diem rate would be calculated based on the daily rate times the number of days (length of stay). CHAMPVA's mental health per diem rates are updated each fiscal year for both high volume hospitals (25 or more discharges per fiscal year) and low volume hospitals (less than 25 discharges per fiscal year). The per diem rates used by CHAMPVA are determined by TRICARE per diem rates. See 32 CFR 199.14(a).

Proposed § 17.275(c) would establish in regulation the CHAMPVA CTC payment system that is used to calculate the CHAMPVA determined allowable amount for inpatient services furnished by hospitals or facilities that are exempt from the CHAMPVA DRG-based payment system or the CHAMPVA inpatient mental health per diem payment system. TRICARE establishes an alternate methodology to calculate payments for inpatient services that are exempt from its DRG and inpatient mental health per diem payment systems. See 32 CFR 199.14(a)(4). Proposed § 17.275(c)(1) would establish the CHAMPVA CTC methodology used to calculate costs for hospitals or facilities by multiplying a CTC ratio by billed charges. We would further propose that the billed charges from the applicable hospitals and facilities must be customary and not in excess of rates or fees the hospital or facility charges the general public for similar services in a community. This requirement that the applicable billed charges not be in excess of what is charged of the general public is similar to TRICARE's requirements. See 32 CFR 199.14(a)(4)(i). Proposed § 17.275(c)(2)(i) through (x) would establish the types of hospitals and services subject to the CHAMPVA CTC methodology, similar to TRICARE at 32 CFR 199.14(a)(1)(ii)(D)(1) through (10) and (a)(1)(ii)(E). We would also add in proposed § 17.275(c)(2)(xi) that hospitals and services as determined by the Secretary of Veterans Affairs may be subject to the CHAMPVA CTC methodology.

Proposed § 17.275(d) would establish in regulation the CHAMPVA outpatient prospective payment system (OPPS) used to calculate the allowable amount for outpatient services provided in a hospital subject to Medicare OPPS. This will include the utilization of TRICARE's reimbursement methodology to include specific coding requirements, ambulatory payment classifications (APCs), nationally established APC amounts, and associated adjustments (*e.g.,* discounting for multiple surgery procedures, wage adjustments for variations in labor-related costs across geographical regions, and outlier

calculations). The CHAMPVA OPPS is the same as that utilized by TRICARE under 32 CFR 199.14, which is similar to Medicare's basic OPPS methodology. There are differences between TRICARE's OPPS methodology and Medicare's basic OPPS methodology due to variations in benefit structure and beneficiary population. CHAMPVA is adopting TRICARE's OPPS because the CHAMPVA beneficiary population is more similar to the TRICARE beneficiary population than to the Medicare beneficiary population. See 32 CFR 199.14(a)(6)(ii).

Proposed § 17.275(e) would establish in regulation the reimbursement methodology for services and supplies provided by authorized non-VA providers on an outpatient or inpatient basis where the services are distinct from facility-type charges in proposed § 17.275(a) through (d). Proposed § 17.275(e) would explain that the CHAMPVA determined allowable amount paid to authorized non-VA providers (not hospitals) for services and supplies provided on an outpatient or inpatient basis is the lesser of: The CHAMPVA maximum allowable charge (equivalent to the maximum allowable charge for similar services provided by other than hospitals and skilled nursing facilities under TRICARE, see 32 CFR 199.14(c)); the prevailing amount, which is the amount equal to the maximum reasonable amount allowed providers for a specific procedure in a specific locality; or the billed amount. Certain services that typically may be provided within a hospital setting, but not billed as a facility-type charge under proposed paragraphs (a) through (d), would be included as examples in proposed paragraph (e), namely anesthesia services; laboratory services; and other professional services associated with individual authorized non-VA providers. These examples are not all-inclusive.

Proposed § 17.275(f) would establish in regulation the current payment methodology for outpatient CHAMPVA pharmacy points of service. CHAMPVA negotiates rates with retail pharmacies through its contract with the pharmacy benefit manager. For services and supplies obtained from a retail ''in-network'' pharmacy, proposed § 17.275(f)(1) would establish that VA pays the lesser of the billed amount or the contracted rate. For supplies from a retail ''out-of-network'' pharmacy, proposed § 17.275(f)(2) would establish that VA pays the lesser of the billed amount plus a dispensing fee or the average wholesale price plus a dispensing fee.

Proposed § 17.275(g) would set forth in regulation the current CHAMPVA reimbursement methodology for the provision of services in a Skilled Nursing Facility (SNF). This methodology is based on the CMS prospective payment system for SNFs under 42 CFR part 413, subpart J (Medicare Resource Utilization Group (RUG) rates), which is the same methodology used in TRICARE regulations to calculate SNF payments. See 32 CFR 199.14(b).

Proposed § 17.275(h) would set forth in regulation the current reimbursement methodology for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). Reimbursement of DMEPOS would be based on the same amounts established under the CMS DMEPOS fee schedule under 42 CFR part 414, subpart D, which is the same methodology used in TRICARE regulations to calculate DMEPOS payments. See 32 CFR 199.14(k). The allowed amount would be that which is in effect in the specific geographic location at the time CHAMPVA-covered services and supplies are provided to a CHAMPVA beneficiary.

Proposed § 17.275(i) would establish in regulation the current payment methodology for all ambulance services. CHAMPVA adopts Medicare's Ambulance Fee Schedule (AFS) for ambulance services, which is based on the same methodology used by TRICARE. See TRICARE Reimbursement Manual 6010.61–M, Chapter 1 (''General''), section 14 (''Ambulance Services'') (April 1, 2015). Ambulance services are paid based on the lesser of the Medicare AFS or the billed amount. Payments for ambulance services furnished by a Critical Access Hospital (CAH) are paid on the same basis as the CTC method under paragraph (c) of this section.

Proposed § 17.275(j) would establish in regulation the current reimbursement methodology for hospice care. This methodology uses rates in the CMS hospice per diem rate payment system, which is the same methodology used in TRICARE regulations to calculate hospice payments. See 32 CFR 199.14(g)(9).

Proposed § 17.275(k) would establish in regulation a reimbursement methodology for intermittent or part-time home health services similar to the methodology used in TRICARE, which is based on Medicare's payment methods and rates. See 32 CFR 199.14(h). Under this methodology, a fixed case-mix and wage-adjusted national 60-day episode payment amount will act as payment in full for costs associated with furnishing home health services with exceptions allowing for additional payment to be established. This would be a new limitation in payments for services but is in line with the 60-day episode amount specified in the TRICARE regulation. See 32 CFR 199.14(h).

Proposed § 17.275(l) would establish in regulation the current reimbursement methodology for facility charges associated with procedures performed in a freestanding surgery center, which is the basis of a prospectively determined amount, similar to that used by TRICARE. See 32 CFR 199.14(d). These facility charges would not include physician fees, anesthesiologist fees, or fees of other authorized non-VA providers; such independent professional fees would be submitted separately from facility fees and calculated under the methodology in proposed § 17.275(e). Ambulatory surgery procedures performed in CAHs or in hospital outpatient departments are to be reimbursed in accordance with the provisions of paragraph (c) or (d) respectively of this section.

Proposed § 17.275(m) states that VA shall determine the appropriate reimbursement method or methods to be used in the extension of CHAMPVA benefits for otherwise covered medical services and supplies provided by hospitals or other institutional providers, physicians or other individual professional providers, or other providers outside the United States. The authority to establish these reimbursement methods is similar to that in TRICARE regulation. See 32 CFR 199.14(n).

Proposed § 17.275(n) would establish in regulation the reimbursement methodology for inpatient services provided in a Sole Community Hospital (SCH). TRICARE reimbursement approximates Medicare reimbursement for SCHs. TRICARE reimburses on a two-step process. TRICARE makes an initial payment based upon multiplying the billed amount by the applicable TRICARE percentage, which is the greater of the SCH's most recently available cost-to-charge ratio from the CMS inpatient Provider Specific File or the TRICARE allowed-to-billed ratio. The second step is a year-end adjustment to compare the aggregate allowable cost under the first method to the aggregate amount that would have been allowed for the same care using the DRG method. In the event that the DRG method amount is the greater, the year-end adjustment will be the amount by which it exceeds the aggregate allowable costs. See 32 CFR 199.14(a)(7). Due to certain limitations, CHAMPVA cannot be the same as TRICARE but can be

similar. CHAMPVA would compare the cost-to-charge ratio reimbursement amount versus the DRG reimbursement amount and then pay the higher of the two methods.

17.276 Claim-Filing Deadlines

Proposed § 17.276 is a revision and renumbering of current § 17.275. First, we propose to remove the reference to ''the Center'' and ''[t]he Director, Health Administration Center, or his or her designee'' in § 17.276(a) and (b), as renumbered by this rulemaking. Our intent is to indicate that VA is responsible for administering CHAMPVA and has discretion to assign claims processing responsibility within the Department.

Proposed § 17.276(c) would clarify that claims for services and supplies provided to an individual before the date of the event that qualifies the individual as eligible under § 17.271 are not reimbursable.

We further propose to add new paragraph (d) to proposed § 17.276 to clarify CHAMPVA policy concerning double coverage situations. We would clearly state that CHAMPVA is the last payer to all OHI, with the exceptions noted previously, which would mean that in cases of double coverage, any CHAMPVA benefits would generally not be paid until the claim has first been filed with the OHI and a final payment determination or explanation of benefits has been issued by the other insurer or payer. This is consistent with the purpose of TRICARE's double coverage provisions in 32 CFR 199.8, which address double coverage situations with OHI. Once CHAMPVA, as the last payer, makes its payment to the authorized non-VA provider, the CHAMPVA beneficiary's personal liability for the cost of care is then fully extinguished, as discussed earlier. However, TRICARE has special rules for double coverage situations involving TRICARE beneficiaries who also have Medicare benefits. See 32 CFR 199.8(e)(1). In the case of double coverage based on the availability of both CHAMPVA and Medicare benefits, the provisions of current § 17.271(b) would still apply and be unchanged by this proposed rulemaking. Under current § 17.271(b), VA is the secondary payer to Medicare, as required under 38 U.S.C. 1781(d)(2).

17.277 Appeals

Proposed § 17.277 is a revision and renumbering of current § 17.276. We would make two minor revisions to current § 17.276. First, we would remove references to ''Director, Health Administration Center, or his or her designee'' (an outdated reference within the current Office of Community Care) and replace it with a reference to ''VA.'' This is necessary to ensure that VA is effectively put forth as the general administrator of CHAMPVA. In addition, we would clarify when a beneficiary has OHI, an appeal must first be filed with the OHI, and a determination made, before submitting an appeal to CHAMPVA. We would also like to note that there may be instances where we would not require a beneficiary to appeal with their OHI first, such as when the OHI deems the issue non-appealable. Neither of these revisions are substantive changes. We will also keep the note located in current § 17.276, relocating it to the body of new § 17.277.

We propose to renumber current §§ 17.277–17.278 to §§ 17.278–17.279. Additionally, as with proposed § 17.277, we would remove reference to ''the Center'' in current § 17.277 and in its place insert ''VA.'' This revision would clarify that it is VA, and not HAC independently, that has the authority to pursue medical care cost recovery in accordance with applicable law. We would also remove the reference to third-party liability in proposed § 17.278 because it is unnecessary. VA's specific authority to recover for medical care costs applies to responsible third parties. We would not make any substantive changes to proposed § 17.279.

Effect of Rulemaking

The Code of Federal Regulations, as proposed to be revised by this proposed rulemaking, would represent the exclusive legal authority on this subject. No contrary rules or procedures would be authorized. All VA guidance would be read to conform with this proposed rulemaking if possible or, if not possible, such guidance would 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. The new proposed payment methods in this rulemaking will include new reimbursement rates for the Outpatient Prospective Payment System (OPPS), Home Health Prospective Payment System (HH PPS), and Sole Community Hospitals (SCHs) reimbursement methodologies. These revised methodologies would not significantly affect small businesses due to the following reasons: (1) The health care industry, to include Medicare and TRICARE, is currently using these payment methods and most providers are used to these reimbursement rates, if not expecting to receive them; (2) CHAMPVA's beneficiary population is relatively small compared to these other health care payers. Further support and data can also be found in VA's impact analysis as a supporting document at *http://www.regulations.gov,* usually within 48 hours after the rulemaking document is published. Additionally, a copy of this 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.'' Therefore, pursuant to 5 U.S.C. 605(b), this amendment would be exempt from the initial and final regulatory flexibility analysis requirements of 5 U.S.C. 603 and 604.

Executive Orders 12866, 13563 and 13771

Executive Orders 12866 and 13563 direct agencies to assess the costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, and other advantages; distributive impacts; and equity). Executive Order 13563 (Improving Regulation and Regulatory Review) emphasizes the importance of quantifying both costs and benefits, reducing costs, harmonizing rules, and promoting flexibility. Executive Order 12866 (Regulatory Planning and Review) defines a ''significant regulatory action,'' which requires review by the Office of Management and Budget (OMB), as ''any regulatory action that is likely to result in a rule that may: (1) Have an annual effect on the economy of $100 million or more or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities; (2) Create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; (3) Materially alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) Raise novel legal or policy

issues arising out of legal mandates, the President's priorities, or the principles set forth in this Executive Order.''

The economic, interagency, budgetary, legal, and policy implications of this regulatory action have been examined and OMB has determined the regulatory action to be economically significant, because it will have an annual effect on the economy of $100 million or more. As noted above, VA's impact analysis is available as a supporting document at *http://www.regulations.gov,* usually within 48 hours after the rulemaking document is published. Additionally, a copy of this 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 subject to the requirements of EO13771 because this proposed rule is expected to result in no more than de minimis costs.

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, or 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, or 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 64.009, Veterans Medical Care Benefits; 64.010, Veterans Nursing Home Care; and 64.011, Veterans Dental Care; 64.012, Veterans Prescription Service; 64.013, Veterans Prosthetic Appliances; and 64.019, Veterans Rehabilitation Alcohol and Drug Dependence.

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 October 2, 2017, for publication.

List of Subjects in 38 CFR Part 17

Administrative practice and procedure, Archives and records, Claims, Dental health, Drug abuse, Health care, Health facilities, Health professions, Health records, Medical devices, Mental health programs, Nursing homes, Veterans.

Dated: January 5, 2018.

Michael Shores,

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

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

PART 17—MEDICAL

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

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

* * * * *

■ 2. Revise § 17.270 to read as follows:

§ 17.270 General provisions and definitions.

(a) *Overview of CHAMPVA.* CHAMPVA is the Civilian Health and Medical Program of the Department of Veterans Affairs (VA). Generally, CHAMPVA furnishes medical care in the same or similar manner, and subject to the same or similar limitations, as medical care furnished to certain dependents and survivors of active duty and retired members of the Armed Forces under chapter 55 of title 10, United States Code (CHAMPUS), commonly referred to as the TRICARE Standard plan. Under CHAMPVA, VA shares the cost of medically necessary services and supplies with eligible beneficiaries within the 50 United States, the District of Columbia, the U.S. territories, and abroad. Under CHAMPVA, medical services and supplies may be provided as follows:

(1) By an authorized non-VA provider.

(2) By a VA provider at a VA facility, on a resource-available basis through the CHAMPVA In-house Treatment Initiative (CITI) only to CHAMPVA beneficiaries who are not also eligible for Medicare.

(3) Through VA Medications by Mail (MbM).

(i) Only CHAMPVA beneficiaries who do not have any other type of health insurance that pays for prescriptions, including Medicare Part D, may use MbM.

(ii) Smoking cessation pharmaceutical supplies will only be provided through MbM and only to CHAMPVA beneficiaries that are not also eligible for Medicare.

(b) *Definitions.* The following definitions apply to CHAMPVA (§§ 17.270 through 17.278):

Accepted assignment refers to the action of an authorized non-VA provider who accepts responsibility for the care of a CHAMPVA beneficiary and thereby agrees to accept the CHAMPVA determined allowable amount as full payment for services and supplies rendered to the beneficiary. (The provider's acceptance of the CHAMPVA determined allowable amount extinguishes the beneficiary's payment liability to the provider with the exception of applicable cost shares and deductibles.)

Authorized non-VA provider means an individual or institutional non-VA provider of CHAMPVA-covered medical services and supplies that meets any of the following criteria:

(i) Is licensed or certified by a State to provide the medical services and supplies; or

(ii) Where a State does not offer licensure or certification, is otherwise certified by an appropriate national or professional association that sets standards for the specific medical provider.

Calendar year means January 1 through December 31.

CHAMPVA beneficiary means a person enrolled under § 17.271.

CHAMPVA-covered services and supplies mean those medical services and supplies that are medically necessary and appropriate for the treatment of a condition and that are not specifically excluded under § 17.272(a)(1) through (84).

CHAMPVA determined allowable amount has the meaning set forth in § 17.272(b)(1).

CHAMPVA In-house Treatment Initiative (CITI) means the initiative under 38 U.S.C. 1781(b) under which participating VA medical facilities provide medical services and supplies to CHAMPVA beneficiaries who are not also eligible for Medicare, subject to availability of space and resources.

Child has the definition established in 38 U.S.C. 101.

Claim means a request by an authorized non-VA provider or by a CHAMPVA beneficiary for payment or reimbursement for medical services and supplies provided to a CHAMPVA beneficiary.

Fiscal year means October 1 through September 30.

Medications by Mail (MbM) means the initiative under which VA provides outpatient prescription medications

through the mail to CHAMPVA beneficiaries.

Other health insurance (OHI) means health insurance plans or programs (including Medicare) or third-party coverage that provide coverage to a CHAMPVA beneficiary for expenses incurred for medical services and supplies.

Payer refers to OHI, as defined in this section, that is obligated to pay for CHAMPVA-covered medical services and supplies. In a situation in which, in addition to CHAMPVA, one or more payers is/are responsible to pay for such services and supplies (*i.e.,* a ''double coverage'' situation), there would be a primary payer (*i.e.,* the payer obligated to pay first), secondary payer (*i.e.,* the payer obligated to pay after the primary payer), etc. In double coverage situations, CHAMPVA would be the last payer.

Service-connected has the definition established in 38 U.S.C. 101.

Spouse refers to a person who is married to a veteran and whose marriage is valid as determined under 38 U.S.C. 103(c).

Surviving spouse refers to a person who was married to and is the widow(er) of a veteran as determined under 38 U.S.C. 103(c).

(c) *Discretionary authority.* When it is determined to be in the best interest of VA, VA may waive any requirement in §§ 17.270 through 17.278, except any requirement specifically set forth in 38 U.S.C. 1781, or otherwise imposed by statute. It is VA's intent that such discretionary authority would be used only under very unusual and limited circumstances and not to deny any individual any right, benefit, or privilege provided to him or her by statute or these regulations. Any such waiver shall apply only to the individual circumstance or case involved and will in no way be construed to be precedent-setting.

(Authority: 38 U.S.C. 501, 1781)

■ 3. Amend § 17.271 by:
■ a. Removing the word ''and'' at the end of paragraph (a)(3).
■ b. Redesignating paragraph (a)(4) as paragraph (a)(5).
■ c. Adding a new paragraph (a)(4).
■ d. Revising the authority citation following paragraph (a).

The addition and revision read as follows:

§ 17.271 Eligibility.

(a) * * *

(4) An individual designated as a Primary Family Caregiver, under 38 CFR 71.25(f), who is not entitled to care or services under a health-plan contract (as defined in 38 U.S.C. 1725(f)(2)); and

* * * * *

(Authority: 38 U.S.C. 501, 1720G(a)(7)(A), 1781)

* * * * *

■ 4. Amend § 17.272 by:
■ a. Revising paragraph (a)(2).
■ b. In paragraph (a)(3) introductory text, removing the phrase ''(Medicaid excluded)''.
■ c. Adding paragraphs (a)(3)(iii) and (iv).
■ d. Revising paragraph (a)(21)(ix).
■ e. Removing paragraph (a)(26).
■ f. Redesignating paragraphs (a)(27) through (38) as paragraphs (a)(26) through (37), respectively.
■ g. In newly redesignated paragraph (a)(30), revising the introductory text and paragraphs (a)(30)(v) and (vi) and adding paragraphs (a)(30)(xi) through (xiv).
■ h. Removing paragraph (a)(39).
■ i. Redesignating paragraphs (a)(40) through (56) as paragraphs (a)(38) through (54), respectively.
■ j. In newly redesiganted paragraph (a)(40)(iv), removing ''(a)(42)(iii)(A)'' and adding in its place ''(a)(40)(iii)(A).''
■ k. Removing paragraph (a)(57).
■ l. Redesignating paragraphs (a)(58) through (71) as paragraphs (a)(55) through (68), respectively.
■ m. Revising newly redesignated paragraphs (a)(57) through (59).
■ n. Removing paragraph (a)(72).
■ o. Redesignating paragraphs (a)(73) through (86) as paragraphs (a)(69) through (82), respectively.
■ p. Revising newly redesignated paragraph (a)(76).
■ q. Adding paragraphs (a)(83) and (84).
■ r. Revising paragraph (b).

The revisions and additions read as follows:

§ 17.272 Benefits limitations/exclusions.

(a) * * *

(2) Services and supplies required as a result of an occupational disease or injury for which benefits are payable under workers' compensation or similar protection plan (whether or not such benefits have been applied for or paid) except when such benefits are exhausted and the services and supplies are otherwise not excluded from CHAMPVA coverage.

(3) * * *

(iii) Indian Health Service.

(iv) CHAMPVA supplemental policies.

* * * * *

(21) * * *

(ix) Treatment for stabilization of myofascial pain dysfunction syndrome, also referred to as temporomandibular joint disorder (TMD). Authorization is limited to initial imaging such as radiographs, Computed Tomography, or Magnetic Resonance Imaging; up to four office visits; and the construction of an occlusal splint.

* * * * *

(30) Preventive care (such as employment-requested physical examinations and routine screening procedures). The following exceptions apply, including but not limited to:

* * * * *

(v) Cervical cancer screening.

(vi) Breast cancer screening.

* * * * *

(xi) Colorectal cancer screening.

(xii) Prostate cancer screening.

(xiii) Annual physical examination.

(xiv) Vaccinations/immunizations.

* * * * *

(57) Unless a waiver for extended coverage is granted in advance: Inpatient mental health services in excess of 30 days in any calendar year (or in an admission), in the case of a patient 19 years of age or older; 45 days in any calendar year (or in an admission), in the case of a patient under 19 years of age; or 150 days of residential treatment care in any calendar year (or in an admission).

(58) Outpatient mental health services in excess of 23 visits in a calendar year unless a waiver for extended coverage is granted in advance.

(59) Institutional services for partial hospitalization in excess of 60 treatment days in any calendar year (or in an admission) unless a waiver for extended coverage is granted in advance.

* * * * *

(76) Over-the-counter products except for pharmaceutical smoking cessation supplies that are approved by the U.S. Food and Drug Administration, prescribed, and provided through MbM, and insulin and related diabetic testing supplies and syringes.

* * * * *

(83) Medications not approved by the U.S. Food and Drug Administration (FDA), excluding FDA exceptions to the approval requirement.

(84) Services and supplies related to the treatment of dyslexia.

(b) Costs of services and supplies to the extent such amounts are billed over the CHAMPVA determined allowable amount are specifically excluded from coverage.

(1) The CHAMPVA determined allowable amount is the maximum level of payment by CHAMPVA to an authorized non-VA provider for the provision of CHAMPVA-covered services and supplies to a CHAMPVA

beneficiary. The CHAMPVA determined allowable amount is determined before consideration of cost sharing and the application of deductibles or OHI.

(2) A Medicare-participating hospital must accept the CHAMPVA determined allowable amount for inpatient services provided to a CHAMPVA beneficiary as payment in full. See 42 CFR 489.25.

(3) An authorized non-VA provider who accepts responsibility for the care of a CHAMPVA beneficiary thereby agrees to accept the CHAMPVA determined allowable amount as full payment for services and supplies rendered to the beneficiary (*i.e.,* accepted assignment). The provider's acceptance of the CHAMPVA determined allowable amount extinguishes the beneficiary's payment liability to the provider. Any attempts to collect any additional amount from the CHAMPVA beneficiary may result in the provider being excluded from Federal benefits programs. See 42 CFR 1003.105.

* * * * *

■ 5. Amend § 17.273 by:

■ a. Revising the introductory text and paragraph (d).

■ b. Removing paragraph (e).

■ c. Redesignating paragraph (f) as paragraph (e).

■ d. Adding new paragraph (f).

The revisions and addition read as follows:

§ 17.273 Preauthorization.

Preauthorization or advance approval is required for any of the following, except when the benefit is covered by the CHAMPVA beneficiary's other health insurance (OHI):

* * * * *

(d) Dental care. For limitations on dental care, see § 17.272(a)(21)(i) through (xii).

* * * * *

(f) CHAMPVA will perform a retrospective medical necessity review during the coordination of benefits process if:

(1) It is determined that CHAMPVA is the responsible payer for services and supplies but CHAMPVA preauthorization was not obtained prior to delivery of the services or supplies; and,

(2) The claim for payment is filed within the appropriate one-year period.

* * * * *

■ 6. Amend § 17.274 by:

■ a. Revising paragraphs (a), (b), and (c).

■ b. Adding a heading for paragraph (d).

■ c. Adding paragraph (e).

The revisions and additions read as follows:

§ 17.274 Cost sharing.

(a) *Cost sharing generally.* CHAMPVA is a cost sharing program in which the cost of covered services is shared with the CHAMPVA beneficiary. CHAMPVA pays the CHAMPVA determined allowable amount less the CHAMPVA deductible, if applicable, and less the CHAMPVA beneficiary cost share.

(1) CHAMPVA beneficiary cost-share requirements do not apply to the following:

(i) Supplies provided through VA MbM.

(ii) Any medical services and supplies provided to a CHAMPVA beneficiary through CITI.

(iii) The following services, even if not provided through CITI:

(A) Colorectal cancer screening.

(B) Breast cancer screening.

(C) Cervical cancer screening.

(D) Prostate cancer screening.

(E) Annual physical exams.

(F) Vaccinations/immunizations.

(G) Well child care from birth to age six, as described in § 17.272(a)(30)(i).

(iv) Hospice services.

(v) Or other services as determined by the Secretary of Veterans Affairs.

(2) [Reserved]

(b) *Deductibles.* In addition to the CHAMPVA beneficiary cost share, an annual (calendar year) outpatient deductible requirement ($50 per beneficiary or $100 per family) must be satisfied prior to VA payment of outpatient benefits. The deductible requirement is waived for:

(1) CHAMPVA-covered services and supplies provided through VA MbM or through CITI.

(2) Inpatient services.

(3) Preventive services listed in paragraph (a)(1)(iii) of this section.

(4) Hospice services.

(5) Or other services as determined by the Secretary of Veterans Affairs.

(c) *Cost sharing limitations.* To provide financial protection against the impact of a long-term illness or injury, there is a $3,000 calendar year limit or ''catastrophic cap'' per CHAMPVA eligible family on the CHAMPVA beneficiary's out-of-pocket costs for allowable services and supplies. After a family has paid $3,000 in out-of-pocket costs, to include both cost share and deductible amounts, in a calendar year, CHAMPVA will pay the full allowable amounts for the remaining CHAMPVA-covered services and supplies through the end of that calendar year. Credits to the annual catastrophic cap are limited to the applied annual deductible(s) and the CHAMPVA beneficiary cost-share amount. Costs above the CHAMPVA determined allowable amount, as well as costs associated with non-covered medical services and supplies, are not credited toward the catastrophic cap calculation.

(d) *Non-payment.* * * *

(e) *Cost share calculation.* The CHAMPVA beneficiary's cost-share amount, if not waived under paragraph (a)(1) of this section, is 25 percent of the CHAMPVA determined allowable amount in excess of the annual calendar year deductible (see § 17.275 for procedures related to the calculation of the allowable amount for CHAMPVA-covered services and supplies), except for the following:

(1) For inpatient services subject to the CHAMPVA Diagnosis Related Group (DRG) payment system, the cost share is the lesser of:

(i) The per diem rate multiplied by the number of inpatient days;

(ii) 25 percent of the hospital's billed amount; or

(iii) The base CHAMPVA DRG rate.

(2) For inpatient mental health low volume hospitals and units (less than 25 mental health discharges per federal fiscal year), the cost share is the lesser of:

(i) The fixed per diem rate multiplied by the number of inpatient days; or

(ii) 25 percent of the hospital's billed charges.

* * * * *

§§ 17.275 through 17.278 [Redesignated as §§ 17.276 through 17.279]

■ 7. Redesignate §§ 17.275 through 17.278 as §§ 17.276 through 17.279.

■ 8. Add new § 17.275 to read as follows:

§ 17.275 CHAMPVA determined allowable amount calculation.

CHAMPVA calculates the allowable amount in the following ways, for the following covered services and supplies:

(a) *Inpatient hospital services (non-mental health).* Unless exempt or subject to a methodology under paragraph (b) or (c) of this section, inpatient hospital services provided in the 50 States, the District of Columbia, and Puerto Rico are subject to the CHAMPVA Diagnosis Related Group (DRG)-based reimbursement methodology. Under the CHAMPVA DRG-based payment system, hospitals are paid a predetermined amount per discharge for inpatient hospital services, which will not exceed the billed amount. Certain inpatient services will be reimbursed under the CHAMPVA Cost-to-Charge (CTC) reimbursement methodology.

(b) *Inpatient hospital services (mental health).* The CHAMPVA inpatient mental health per diem reimbursement methodology is used to calculate

reimbursement for inpatient mental health hospital care in specialty psychiatric hospitals and psychiatric units of general acute hospitals that are exempt from the CHAMPVA DRG-based payment system. The per diem rate is calculated by multiplying the daily rate by the number of days (length of stay). The daily rate is updated each fiscal year for both high volume hospitals (25 or more discharges per fiscal year) and low volume hospitals (fewer than 25 discharges per fiscal year).

(c) *Other inpatient hospital services.* (1) The CHAMPVA CTC reimbursement methodology is used to calculate reimbursement for inpatient care furnished by hospitals or facilities that are exempt from either of the methodologies in paragraph (a) or (b) of this section. Such hospitals or facilities will be paid at the CHAMPVA CTC ratio times the billed charges that are customary and not in excess of rates or fees the hospital or facility charges the general public for similar services in a community.

(2) The following hospitals and services are subject to the CHAMPVA CTC payment methodology:

(i) Any hospital that qualifies as a cancer hospital under Medicare standards and has elected to be exempt from the Centers for Medicare and Medicaid Services (CMS) prospective payment system.

(ii) Christian Science sanatoriums.

(iii) Critical Access Hospitals.

(iv) Any hospital outside the 50 States, the District of Columbia, or Puerto Rico.

(v) Hospitals within hospitals.

(vi) Long-term care hospitals.

(vii) Non-Medicare participating hospitals.

(viii) Non-VA Federal Health Care Facilities (*e.g.,* military treatment facilities, Indian Health Service).

(ix) Rehabilitation hospitals.

(x) Hospital or hospital-based services subject to State waiver in any State that has implemented a separate DRG-based payment system or similar payment system in order to control costs.

(xi) Hospitals and services as determined by the Secretary of Veterans Affairs.

(d) *Outpatient hospital services.* The CHAMPVA outpatient prospective payment system (OPPS) is used to calculate the allowable amount for outpatient services provided in hospitals subject to Medicare OPPS. This will include the utilization of TRICARE's reimbursement methodology to include specific coding requirements, ambulatory payment classifications (APCs), nationally established APC amounts, and associated adjustments.

(e) *Outpatient and inpatient non-hospital services.* Payments to individual authorized non-VA providers (not hospitals) for CHAMPVA-covered medical services and supplies provided on an outpatient or inpatient basis, including but not limited to, anesthesia services, laboratory services, and other professional fees associated with individual authorized non-VA providers, are reimbursed based on the lesser of:

(1) The CHAMPVA Maximum Allowable Charge;

(2) The prevailing amount, which is the amount equal to the maximum reasonable amount allowed providers for a specific procedure in a specific locality; or,

(3) The billed amount.

(f) *Pharmacy services and supplies.* The CHAMPVA pharmacy services and supplies payment methodology is based on specific CHAMPVA pharmacy points of service, which dictate the amounts paid by VA. VA pays:

(1) For services and supplies obtained from a retail in-network pharmacy, the lesser of the billed amount or the contracted rate; or

(2) For supplies obtained from a retail out-of-network pharmacy, the lesser of the billed amount plus a dispensing fee or the average wholesale price plus a dispensing fee.

(g) *Skilled Nursing Facility (SNF) care.* The CHAMPVA SNF reimbursement methodology is based on the CMS prospective payment system for SNFs under 42 CFR part 413, subpart J (Medicare Resource Utilization Group (RUG) rates).

(h) *Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS).* The CHAMPVA DMEPOS reimbursement methodology is based on the same amounts established under the CMS DMEPOS fee schedule under 42 CFR part 414, subpart D. The CHAMPVA determined allowable amount for DMEPOS is the amount in effect in the specific geographic location at the time CHAMPVA-covered medical services and supplies are provided to a CHAMPVA beneficiary.

(i) *Ambulance services.* CHAMPVA adopts Medicare's Ambulance Fee Schedule (AFS) for ambulance services, with the exception of services furnished by a Critical Access Hospital (CAH). Ambulance services are paid based on the lesser of the Medicare AFS or the billed amount. Ambulance services provided by a CAH are paid on the same bases as the CTC method under paragraph (c) of this section.

(j) *Hospice care.* CHAMPVA hospice reimbursement methodology uses Medicare per diem hospice rates.

(k) *Home health care (intermittent or part-time).* CHAMPVA home health care reimbursement methodology, based on Medicare's home health prospective payment system, uses a fixed case-mix and wage-adjusted national 60-day episode payment amount to act as payment in full for costs associated with furnishing home health services with exceptions allowing for additional payment to be established.

(l) *Ambulatory surgery.* The CHAMPVA reimbursement methodology for facility charges associated with procedures performed in a freestanding ambulatory surgery center is based on a prospectively determined amount, similar to that used by TRICARE. These facility charges do not include physician fees, anesthesiologist fees, or fees of other authorized non-VA providers; such independent professional fees must be submitted separately from facility fees and are calculated under the methodology in paragraph (e) of this section.

(m) *CHAMPVA-covered medical services and supplies provided outside the United States.* VA shall determine the appropriate reimbursement method(s) for CHAMPVA-covered medical services and supplies provided by authorized non-VA providers outside the United States.

(n) *Sole Community Hospitals.* The CHAMPVA reimbursement methodology for inpatient services provided in a Sole Community Hospital (SCH) will be the greater of: The allowable amount determined by multiplying the billed charges by the SCH's most recently available cost-to-charge ratio from the CMS Inpatient Provider Specific File or the DRG reimbursement rate.

(Authority: 38 U.S.C. 501, 1781)

■ 9. Amend newly redesignated § 17.276 by:

■ b. Revising paragraphs (a) introductory text and (b).

■ c. Adding paragraphs (c) and (d).

The revisions and additions read as follows:

§ 17.276 Claim-filing deadlines.

(a) Unless an exception is granted under paragraph (b) of this section, claims for medical services and supplies must be filed no later than:

* * * * *

(b) Requests for an exception to the claim filing deadline must be submitted in writing and include a complete explanation of the circumstances resulting in late filing along with all available supporting documentation. Each request for an exception to the

claim filing deadline will be reviewed individually and considered on its own merit. VA may grant exceptions to the requirements in paragraph (a) of this section if it determines that there was good cause for missing the filing deadline. For example, when dual coverage exists, CHAMPVA payment, if any, cannot be determined until after the primary insurance carrier has adjudicated the claim. In such circumstances an exception may be granted provided that the delay on the part of the primary insurance carrier is not attributable to the beneficiary. Delays due to provider billing procedures do not constitute a valid basis for an exception.

(c) Claims for CHAMPVA-covered services and supplies provided before the date of the event that qualifies an individual under § 17.271 are not reimbursable.

(d) CHAMPVA is the last payer to OHI, as that term is defined in § 17.270(b). CHAMPVA benefits will generally not be paid until the claim has been filed with the OHI and the OHI has issued a final payment determination or explanation of benefits. CHAMPVA is secondary payer to Medicare per the terms of § 17.271(b).

* * * * *

■ 10. Revise newly redesignated § 17.277 to read as follows:

§ 17.277 Appeals.

Notice of the initial determination regarding payment of CHAMPVA benefits will be provided to the CHAMPVA beneficiary on a CHAMPVA Explanation of Benefits (EOB) form. The EOB form is generated by the CHAMPVA automated payment processing system. If a CHAMPVA beneficiary or provider disagrees with the determination concerning CHAMPVA-covered services and supplies or calculation of benefits, he or she may request reconsideration. Such requests must be submitted to VA in writing within one year of the date of the initial determination. The request must state why the CHAMPVA claimant believes the decision is in error and must include any new and relevant information not previously considered. Any request for reconsideration that does not identify the reason for dispute will be returned to the claimant without further consideration. After reviewing the claim and any relevant supporting documentation, VA will issue a written determination to the claimant that affirms, reverses, or modifies the previous decision. If the claimant is still dissatisfied, within 90 days of the date of the decision he or she may make a written request for review by VA. After reviewing the claim and any relevant supporting documentation, VA will issue a written determination to the claimant that affirms, reverses, or modifies the previous decision. The decision of VA with respect to benefit coverage and computation of benefits is final. When a CHAMPVA beneficiary has other health insurance (OHI), an appeal must first be filed with the OHI, and a determination made, before submitting the appeal to CHAMPVA with limited exceptions such as if the OHI deems the issue non-appealable. Denial of CHAMPVA benefits based on legal eligibility requirements may be appealed to the Board of Veterans' Appeals in accordance with 38 CFR part 20. Medical determinations are not appealable to the Board. 38 CFR 20.101.

(Authority: 38 U.S.C. 501, 1781)

■ 11. Revise newly redesignated § 17.278 to read as follows:

§ 17.278 Medical care cost recovery.

VA will actively pursue medical care cost recovery in accordance with applicable law.

(Authority: 42 U.S.C. 2651; 38 U.S.C. 501, 1781)

[FR Doc. 2018–00332 Filed 1–16–18; 8:45 am]

BILLING CODE 8320–01–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 54

[WC Docket No. 17–310; FCC 17–164]

Promoting Telehealth in Rural America; Correction

AGENCY: Federal Communications Commission.

ACTION: Notice; correction.

SUMMARY: The Federal Communications Commission (Commission) published a document in the **Federal Register** of January 3, 2018 seeking comment on how to strengthen the Rural Health Care Program and improve access to telehealth in rural America. The document contained an incorrect reply comment date.

FOR FURTHER INFORMATION CONTACT: Radhika Karmarkar, Wireline Competition Bureau, (202) 418–7400 or TTY: (202) 418–0484.

Correction

In the **Federal Register** of January 3, 2018, in FR Doc. 2017–28298, on page 303, in the first column, correct the **DATES** caption to read:

DATES: Comments are due on or before February 2, 2018, and reply comments are due on or before March 5, 2018. If you anticipate that you will be submitting comments, but find it difficult to do so within the period of time allowed by this document, you should advise the contact listed below as soon as possible.

Federal Communications Commission.

Katura Jackson,

Federal Register Liaison Officer.

[FR Doc. 2018–00451 Filed 1–16–18; 8:45 am]

BILLING CODE 6712–01–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 300

[Docket No. 161228999–7867–01]

RIN 0648–BG51

Commerce Trusted Trader Program

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Proposed rule; request for comments.

SUMMARY: The National Marine Fisheries Service is proposing this Commerce Trusted Trader Program (CTTP) as part of an effective seafood traceability process to combat Illegal, Unreported, and Unregulated (IUU) fishing and seafood fraud. The voluntary CTTP supplements the Seafood Import Monitoring Program (SIMP), recently implemented under the Magnuson-Stevens Fishery Conservation and Management Act. Qualified importers who choose to participate in the CTTP would benefit from reduced reporting and recordkeeping requirements, and streamlined entry into U.S. commerce for seafood imports subject to the SIMP.

DATES: Written comments must be received by March 19, 2018.

ADDRESSES: Written comments on this action, identified by NOAA–NMFS–2016–0165, may be submitted by either of the following methods:

- *Federal eRulemaking Portal:* Go to *http://www.regulations.gov/#!docketDetail;D=NOAA-NMFS-2016-0165,* click the ''Comment Now!'' icon, complete the required fields, and enter or attach your comments.
- *Mail:* Melissa Beaudry, Office of International Affairs and Seafood Inspection, NOAA Fisheries, 1315 East-West Highway, Silver Spring, MD 20910.