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**DEPARTMENT OF VETERANS AFFAIRS****38 CFR Part 17****RIN 2900-AQ08****Reimbursement for Emergency Treatment****AGENCY:** Department of Veterans Affairs.**ACTION:** Interim final rule.

**SUMMARY:** The Department of Veterans Affairs (VA) revises its regulations concerning payment or reimbursement for emergency treatment for non-service-connected conditions at non-VA facilities to implement the requirements of a recent court decision. Specifically, this rulemaking expands eligibility for payment or reimbursement to include veterans who receive partial payment from a health-plan contract for non-VA emergency treatment and establishes a corresponding reimbursement methodology. This rulemaking also expands the eligibility criteria for veterans to receive payment or reimbursement for emergency transportation associated with the emergency treatment, in order to ensure that veterans are adequately covered when emergency transportation is a necessary part of their non-VA emergency treatment.

**DATES:**

*Effective Date:* This rule is effective on January 9, 2018.

*Comment Date:* Comments must be received on or before March 12, 2018.

**ADDRESSES:** Written comments may be submitted by email through <http://www.regulations.gov>; by mail or hand-delivery to Director, Regulations Management (00REG), Department of Veterans Affairs, 810 Vermont Avenue NW, Room 1063B, Washington, DC 20420; or by fax to (202) 273-9026. (This is not a toll-free number.)

Comments should indicate that they are submitted in response to “RIN 2900-AQ08, Reimbursement for Emergency Treatment.” 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 (FDMS) at <http://www.regulations.gov>.

**FOR FURTHER INFORMATION CONTACT:**

Joseph Duran, Director, Policy and Planning VHA Office of Community Care (10D1A1), Veterans Health Administration, Department of Veterans Affairs, 810 Vermont Avenue NW, Washington, DC 20420, (303-370-1637). (This is not a toll-free number.)

**SUPPLEMENTARY INFORMATION:** 38 U.S.C. 1725 authorizes VA to reimburse veterans for the reasonable value of emergency treatment for non-service connected conditions furnished in a non-VA facility, if certain criteria are met. One requirement is that the veteran must be personally liable for the emergency treatment. As originally enacted in 1999, the statute provided that a veteran is personally liable if the veteran “has no entitlement to care or services under a health-plan contract,” and “no other contractual or legal recourse against a third party that would, in part or in whole, extinguish such liability to the provider.” 38 U.S.C. 1725(b)(3)(B) and (C) (1999). VA interpreted that version of the statute as barring reimbursement for veterans with any coverage from either a health-plan contract or a third party because those veterans did not satisfy the requirement to have “no entitlement . . . under a health-plan contract” and “no other . . . recourse against a third party.”

In addition, the 1999 version of the statute distinguished “health-plan contract” and “third party” by separately defining them. 38 U.S.C. 1725(f)(2)–(3)(1999).

On February 1, 2010, Congress enacted the Expansion of Veteran Eligibility for Reimbursement Act, Public Law 111-137 (2010 Act), which amended section 1725. The legislative history of the 2010 Act provided:

The Committee has learned that under current law the VA does not pay for emergency treatment for non-service connected conditions in non-VA facilities if the veteran has third-party insurance that pays any portion of the costs associated with such emergency treatment. This situation can inadvertently arise if a veteran has minimal health insurance coverage through a state-mandated automobile insurance policy. Consequently, if an emergency does occur, and the veteran has a policy containing such minimal coverage, the veteran may be responsible for essentially the full cost of emergency treatment. While some veterans are able to negotiate payment plans and debt forgiveness of a portion of their medical bills with the non-VA hospital where they received the emergency treatment, many veterans are without the financial resources to shoulder such a cost and are unaware that the VA would not be responsible for such emergency care. H.R. Rep. No. 111-55.

The 2010 Act amended section 1725 by striking the phrase “in part” from

section 1725(b)(3)(C). It also removed state-mandated automobile insurance policies from the definition of “health-plan contract.” In chief, the effect of the 2010 amendments is that partial payment from a third party is not a bar to reimbursement under section 1725, assuming all of the other eligibility criteria are met; the third-party payment is only a bar to reimbursement if it fully extinguishes the veteran’s personal liability. Thus, eligible veterans who receive only partial payment by the third party, including state-mandated automobile insurance, are eligible for VA payment or reimbursement of the unpaid portion of their emergency medical expenses, subject to the payment limitations added by that same law.

VA amended its regulations to comply with the 2010 Act. Relevant to this rulemaking, VA revised 38 CFR 17.1001(a)(5), 17.1002(g), and 17.1005(e) and (f). Section 17.1001(a)(5) was amended to remove state-mandated automobile insurance from the definition of “health-plan contract.” Section 17.1002(g) was amended to only prohibit reimbursement from VA if a third party extinguished the liability in whole. § 17.1005(e) was amended to establish a methodology to reimburse veterans when a third-party payment partially extinguished the veteran’s liability, and § 17.1005(f) was promulgated to implement the limitation in 38 U.S.C. 1725(c)(4)(D) that VA may not reimburse any deductible, copayment, or similar payment that veterans owe to third parties. However, because the 2010 Act did not amend section 1725(b)(3)(B), pertaining to health-plan contracts, VA did not amend its corresponding regulation at § 17.1002(f) that bars reimbursement from VA if the veteran is entitled to either partial or full payment from a health-plan contract. Similarly, VA did not specify in § 17.1005(f) that it would not reimburse amounts for which the veteran is responsible under a health-plan contract because it was unnecessary to do so; consistent with VA’s interpretation of the 2010 Act, reimbursement or payment continued to be barred if the veteran had coverage under a health-plan contract.

In *Staab v. McDonald*, 28 Vet. App. 50 (2016), the U.S. Court of Appeals for Veterans Claims (the Court) reversed a Board of Veterans’ Appeals (the Board) decision denying a claim under section 1725. The Board had applied § 17.1002(f) to conclude that partial payment of the emergency treatment by the veteran’s health-plan contract barred VA reimbursement. On appeal, the veteran challenged § 17.1002(f) as

inconsistent with section 1725. The Court agreed, and in a precedential decision, held invalid and set aside § 17.1002(f) and remanded the case.

In so doing, the Court interpreted section 1725(b)(3)(B) to bar reimbursement only if a veteran's health-plan contract would wholly extinguish the veteran's liability. In other words, the Court interpreted the 2010 amendments relating to payment by a third party to also apply to section 1725(b)(3)(B) relating to payment by health-plan contracts.

To reach this conclusion, the Court gave particular weight to sections 1725(c)(4) and (f)(3), which, in the Court's words, "more broadly include health-plan contracts, including Medicare, in the category of a 'third party.'" In addition, the Court reasoned that its interpretation was consistent with the overall purpose of section 1725, as amended, *i.e.*, to permit reimbursement when a veteran is personally liable to the provider of emergency treatment for the costs of such care. The purpose of this rulemaking is to amend the pertinent VA regulations to comply with the holding of this Court decision.

First, this interim final rule revises 38 CFR 17.1002(f). Section 17.1002 establishes the criteria that must be met for veterans to receive payment or reimbursement under 38 U.S.C. 1725 for emergency treatment for non-service-connected conditions at non-VA facilities. Specifically, current § 17.1002(f) bars reimbursement unless the veteran has, "no coverage under a health-plan contract for payment or reimbursement, in whole or in part, for the emergency treatment." This rule revises the regulation to state that a veteran may be eligible for payment or reimbursement as long as the veteran does not have coverage under a health-plan contract that will fully extinguish the veteran's liability to the provider. This change reflects the Court's interpretation that partial coverage for the emergency treatment under a veteran's health-plan contract is not a bar to reimbursement under section 1725. Reimbursement is only barred if coverage under the health-plan contract wholly extinguishes the veteran's liability. We believe that this change comports with the holding of *Staab*. Because, in accordance with the Court's decision, VA will now provide payment or reimbursement on claims involving partial payment by a health-plan contract, we also amend § 17.1005 to specifically clarify that VA does not have authority to reimburse copayments or similar payment the veteran owes under a health-plan contract. As noted,

in implementing the 2010 Act, we did not address specifically VA's authority to reimburse such amounts owed under a health-plan contract, because payment or reimbursement in that circumstance was wholly barred. We do so now, based on the Court's decision in *Staab* that a veteran is eligible for payment or reimbursement when there is a partial payment by a health-plan contract, to make clear that the prohibition in 38 U.S.C. 1725(c)(4)(D) (on VA reimbursing a veteran for any copayment or similar payment that the veteran owes a third party) applies to amounts owed by a veteran under a health-plan contract.

To clarify the applicability of this regulation change, judicial decisions invalidating a statute or regulation, or VA's interpretation of a statute or regulation, cannot affect prior final VA decisions. *See, Jordan v. Nicholson*, 401 F.3d 1296 (Fed. Cir. 2005); *Disabled American Veterans v. Gober*, 234 F.3d 682, 697–98 (Fed. Cir. 2000). Therefore, VA will not retroactively pay benefits for claims filed under § 17.1002(f) that were finally denied before April 8, 2016, the date of the *Staab* decision. In other words, VA can only apply the new § 17.1002(f) to claims pending on or after April 8, 2016. We note that all claims under § 17.1002(f) involving partial payment from a health-plan contract pending on April 8, 2016, or filed on or after April 8, 2016, have been held in abeyance pending the publication of this interim final rule. Therefore, all such § 17.1002(f) claims will be processed using the regulatory revisions published in this rule.

Second, this interim final rule revises 38 CFR 17.1003 related to emergency transportation to be consistent with our interpretation that the exercise of VA's authority under 38 U.S.C. 1725 should result in veterans' liability to providers of emergency treatment being extinguished, except for deductibles, copayments, coinsurance, or other similar payments owed by the veteran for which VA is barred from reimbursing under 38 U.S.C. 1725(c)(4)(D), as described above. Although section 1725 does not specifically authorize payment for emergency transportation, it authorizes payment for "emergency treatment" as defined in section 1725(f)(1). VA has interpreted the phrase "emergency treatment" in section 1725(f)(1) to include emergency transportation if the transportation is provided as part of the emergency medical treatment administered at the non-VA facility. Current § 17.1003 authorizes VA to provide payment or reimbursement under 38 U.S.C. 1725 for ambulance services (including air ambulance

services) for transporting a veteran to a non-VA facility if certain criteria are met. We amend § 17.1003(a), (c), and (d) and create a new paragraph (e) for the following reasons.

The current regulation states that VA will pay for emergency transportation if "[p]ayment or reimbursement is authorized under 38 U.S.C. 1725 for emergency treatment provided at [a non-VA] facility (or payment or reimbursement could have been authorized under 38 U.S.C. 1725 for emergency treatment if death had not occurred before emergency treatment could be provided)." We have historically interpreted this paragraph to authorize reimbursement for emergency transportation only if VA approves and makes actual payment on the claim for the emergency treatment provided at the non-VA facility. The reason for this interpretation was that the emergency transportation was considered part of (not apart or distinct from) the claim for emergency treatment. If VA reimbursement was not authorized for the emergency treatment, reimbursement was not authorized separately for the emergency transportation (in other words, payment on the main treatment claim was essentially a condition precedent).

Under current § 17.1003(a), this results in denials of claims for reimbursement for the costs of emergency transportation when a third-party payment satisfies the claim for emergency medical treatment, despite the transportation claim meeting the other criteria for reimbursement by VA under 38 U.S.C. 1725. So if the veteran does not have any remaining liability for the treatment provided at the non-VA facility due to satisfaction of the treatment claim by a third party, VA denies that veteran's claim for reimbursement of the emergency treatment and, in turn, reimbursement is not be authorized for their emergency transportation. In practice then, application of VA's existing regulations is in tension with VA's view that emergency transportation is part of emergency treatment. If VA's sole basis to deny a transportation claim is satisfaction by a third party of the related emergency treatment claim, even if that transportation claim meets all of the other requirements for reimbursement under 38 U.S.C. 1725, VA is, in effect, treating the emergency transportation claim differently than the related emergency treatment claim.

To address this, we now revise § 17.1003(a). As amended, § 17.1003(a) authorizes reimbursement for emergency transportation even if the veteran is ineligible to receive

reimbursement or payment for the emergency treatment, if the reason for that ineligibility is that the veteran is not personally liable for the emergency treatment due to satisfaction of the treatment claim by a third party, including a health-plan contract. We note that the veteran is still required to be personally liable for the emergency transportation as established in paragraphs (b)–(e) of the regulation. For example, if a veteran has Medicare insurance and the Medicare payment fully extinguishes the veteran's liability for the emergency treatment but does not cover the costs of emergency transportation, under the prior regulation, VA was not permitted to reimburse or pay for the emergency transportation because there was no remaining liability for the treatment. However, under the revised regulation, the veteran will be eligible to receive reimbursement or payment for the emergency transportation, aside from deductibles, copayments, or other similar payments owed by the veteran, as described above, assuming all the other eligibility criteria of that section are met.

Therefore, we amend § 17.1003(a) by retaining the general criteria that payment or reimbursement must be authorized under section 1725 for emergency treatment provided at a non-VA facility, but we remove the parenthetical and instead list out the two exceptions for when payment does not have to be authorized in order for the veteran to be eligible for reimbursement: Paragraph (a)(1) says that payment does not have to be authorized for the emergency treatment if the veteran has no remaining liability for the emergency treatment because prior payment by non-VA, third party, sources extinguished the veteran's liability, and paragraph (a)(2) contains the language in the current parenthetical that authorization is not required if death occurred prior to when the treatment could have been provided.

While not directly compelled by the Court's decision, this interim final rule also amends paragraphs (c) and (d) of § 17.1003. These changes are necessitated by the Court's holding when read in concert with VA's longstanding unchanged regulatory interpretation that emergency transportation is an integral part of emergency treatment, as discussed above. Otherwise, current § 17.1003 would operate in a manner that counteracts the changes to § 17.1002(f) made by this rulemaking. Paragraphs (c) and (d) are therefore revised to allow veterans to receive reimbursement or payment for emergency transportation

even if they receive partial payment under a health-plan contract or from a third party for the emergency transportation. We revise paragraph (c) to state that a veteran may be eligible for payment or reimbursement if the veteran does not have coverage under a health-plan contract that will fully extinguish the veteran's liability to the provider. Similarly, we revise paragraph (d) by stating that the veteran may be eligible if the veteran has no contractual or legal recourse against a third party that could reasonably be pursued for the purpose of fully extinguishing the veteran's liability to the provider.

We also amend § 17.1003 by creating a new paragraph (e). Paragraph (e) states separately the requirement that was formerly in paragraph (c) that to be eligible for reimbursement or payment for emergency transportation, the veteran cannot be eligible for reimbursement for emergency treatment under 38 U.S.C. 1728. This requirement was moved for clarity so that each distinct requirement is located in a separate paragraph.

Third, this interim final rule revises § 17.1005 pertaining to the payment methodologies and limitations used to calculate payment and reimbursement for claims filed under section 1725. Currently, § 17.1005(e) sets forth VA's payment methodology when a veteran has contractual or legal recourse against a third party whose payment only partially extinguishes the veteran's liability to the provider of emergency treatment. This provision was originally drafted to address only third party situations described in section 1725(b)(2)(C), as interpreted before the Court decision. If VA applies the methodology in current § 17.1005(e) to claims involving partial payments under a health-plan contract, it is likely that partial payment under a veteran's health-plan contract will exceed the maximum amount that VA can pay based on the current payment limitation. (Section 1725(c)(1) requires VA to establish the maximum amount that can be paid on claims under section 1725(a); for eligible claims where a third party has already or will make partial payment, the law still requires the VA payment not to exceed that maximum amount.) For this reason, these veterans would in most cases be liable to the provider for the remaining charges.

We underscore that the payment limitation in § 17.1005 was derived based on an understanding of how payers in the health care industry establish payment rates and then VA deliberately reduced the maximum payable amount to reflect Congress' original purpose in enacting section

1725(c)(1), ensuring that providers had incentive to seek other sources of payment before pursuing payment from the government. The limitation, which remains today, was not intended to apply to claims involving partial payments made under a health-plan contract because current § 17.1002(f) bars reimbursement in that circumstance. This is why partial payments made under a health-plan contract will exceed VA's current maximum payment limitation and why applying the current maximum in all instances would result in VA not making payments in most cases where there is payment under a health-plan contract. Applying the current maximum in all cases would thus be at cross purposes with the other proposed amendments requiring VA to exercise its authority under 38 U.S.C. 1725 when there is partial payment by a health-plan contract.

(This is not to say that this cannot, or has not, occurred in connection with claims involving partial payment by a third party other than a health-plan contract. In those cases, however, the amount of the partial payment typically does not exceed the amount that VA can pay under the statute and § 17.1005(e), *e.g.*, partial payments made by state-mandated automobile reparations insurance carriers, and so VA's authorized payments generally succeed in extinguishing these veterans' remaining personal liability to their providers. In cases where the third-party payment exceeded VA's payment limits, VA believes that veterans with remaining liability simply declined to file claims with VA.)

VA believes that claims properly authorized for payment or reimbursement under 38 U.S.C. 1725 should invariably extinguish the veterans' liability to the provider, aside from any deductibles, copayments, or other similar payments owed by the veteran to a third party or under a health-plan contract as required by law. This includes claims where partial payment is made by a third-party under a health-plan contract. This is why amending the methodology in § 17.1005(e) to ensure VA can make a payment on claims involving partial payment under a health-plan contract is an essential logical outgrowth of the Court's decision and consistent with the other amendments made by this rulemaking. Otherwise, this rulemaking will merely amend § 17.1002(f), in accordance with the Court decision, without providing an effective mechanism to ensure its complete, successful, timely, and practical application. As explained below, any

payment by VA, if accepted by the provider and not rejected and refunded within 30 days from the date of receipt, extinguishes the remainder of the veteran's liability, thereby ensuring VA is responsible for the remainder of the veteran's liability instead of the veteran.

We revise paragraph (a) and remove paragraphs (e) and (f) so that paragraph (a) now addresses, in one place, all reimbursement and payment methodologies applicable to claims approved under section 1725.

As revised, paragraph (a)(1) establishes the payment methodology to be used when VA is the sole payer on the claim. This includes situations when a veteran does not have coverage for the treatment under a health-plan contract and does not have any other legal or contractual recourse against a third party for payment of the emergency treatment expenses. Historically, this payment methodology was established in paragraph (a) and provided that VA would pay the lesser of the amount for which the veteran is personally liable or 70 percent of the amount under the applicable Medicare fee schedule rate, an amount that VA and Congress believed would ensure providers still had sufficient incentive to pursue reimbursement from other liable parties before seeking reimbursement from VA. This paragraph is revised merely to clarify that it is applicable when the veteran is the sole payer and is not eligible to receive partial payment from a third party, to include under a health-plan contract. Paragraph (a)(1) now states that where an eligible veteran has personal liability to a provider of emergency treatment and has no contractual or legal recourse against a third party, to include under a health-plan contract, VA will pay the lesser of the amount for which the veteran is personally liable or 70 percent of the applicable Medicare fee schedule rate.

New paragraph (a)(2) applies in cases where VA will be the secondary payer because the veteran is entitled to partial payment under a health-plan contract or has other legal or contractual recourse against a third party that results in partial payment of the emergency treatment costs. Paragraph (a)(2)(i) requires VA to pay according to the current methodology, which is the difference between the amount VA would have paid under paragraph (a)(1) for the cost of the emergency treatment and the amount paid or payable by the third party. However, that provision will apply only when the amount calculated under paragraph (a)(2)(i) is greater than zero, meaning that VA is authorized to make a payment to

extinguish the veteran's liability. If the payment amount calculated under paragraph (a)(2)(i) would be zero and the veteran has remaining liability to the provider, VA is adopting an alternative method to ensure we can make payment and extinguish each veteran's personal liability. If the amount paid under paragraph (a)(2)(i) would be zero, therefore, the payment method in paragraph (a)(2)(ii) will apply. Paragraph (a)(2)(ii) requires VA to pay the lesser of the remainder of the veteran's personal liability after payment is made by the third party (or health-plan contract) or 70 percent of the applicable Medicare fee schedule amount for the care provided. Similar to paragraph (a)(1), if the veteran's remaining liability under paragraph (a)(2)(ii) is less than the 70 percent of the applicable Medicare fee schedule amount, VA's payment will equal the amount of the veteran's liability, and the veteran will have no personal liability for the treatment expenses. If the lesser amount is the applicable Medicare rate, VA will pay that rate, even if the amount billed by the provider is higher, and acceptance of the VA payment by the provider will extinguish the remainder of the veteran's liability. This methodology sets an appropriate "cap" on VA's payment to ensure providers have sufficient incentive to pursue the primary sources of payment while also ensuring that VA has an opportunity to make a payment which, if accepted by the provider, extinguishes the veteran's liability. This is consistent with section 1725(a)(1), which requires VA to reimburse a veteran for the reasonable value of the emergency treatment furnished to the veteran, and section 1725(c)(1)(A), which requires VA to establish the maximum amount payable under subsection (a); the application of the Medicare fee schedule represents the Federal government's standard for what constitutes appropriate payment amounts under the law.

Paragraph (a)(3) establishes an alternative methodology to use when there is no applicable Medicare Fee Schedule rate for the emergency services provided. In such cases, we will use the amount already established in our own fee schedule, under 38 CFR 17.56(a)(2)(i)(B). This is necessary to ensure that all potential emergency services are covered by this rule.

Paragraph (a)(4) is similar to current paragraph (e)(3). It states that the provider will consider payments under this section as payment in full and extinguish the veteran's liability to the provider. In other words, if the provider accepts and does not timely refund VA's payment, under either paragraph (a)(1),

(a)(2), or (a)(3), the provider must consider the payment as payment in full and the provider cannot submit additional charges to the veteran for payment. 38 U.S.C. 1725(c)(4)(C). In addition, paragraph (a)(4) includes a parenthetical that explains that neither the absence of a contract or agreement between the Secretary and the provider nor any provision of a contract, agreement, or assignment to the contrary shall operate to modify, limit, or negate the requirement in the paragraph. The ability of the provider to reject and refund VA payment within 30 days from the date of receipt and the parenthetical at the end of the paragraph are both included in order to clarify the rights and responsibilities under this paragraph which are established in section 1725(c)(3).

Paragraph (a)(5) restates current paragraph (f), clarifying that VA will not reimburse a claimant under this section for any deductible, copayment, coinsurance, or similar payment that the veteran owes the third party or is obligated to pay under a health-plan contract. This is consistent with 38 U.S.C. 1725(c)(4)(D), which, as noted above prohibits VA from reimbursing a veteran for any copayment or similar payment that the veteran owes a third party or for which the veteran is responsible under a health-plan contract.

### Effect of Rulemaking

Title 38 of the Code of Federal Regulations, as revised by this interim final rulemaking, represents VA's implementation of its legal authority on this subject. Other than future amendments to this regulation or governing statutes, no contrary guidance or procedures are authorized. All existing or subsequent VA guidance must be read to conform with this rulemaking if possible or, if not possible, such guidance is superseded by this rulemaking.

### Administrative Procedure Act

In accordance with 5 U.S.C. 553(b)(3)(B) and (d)(3), the Secretary of Veterans Affairs has concluded that there is good cause to publish this rule without prior opportunity for public comment and to publish this rule with an immediate effective date. As explained above, in a precedential decision, the Court invalidated 38 CFR 17.1002(f), holding that partial payment from a health-plan contract was not a bar to reimbursement by VA for emergency treatment rendered for a non-service-connected condition at a non-VA facility. This means VA is required to process all pending, non-

final claims where veterans receive(d) partial payment from health-plan contracts, assuming all the other requirements of 38 U.S.C. 1725 are met.

VA initially disagreed with the Court's decision. It unsuccessfully sought reconsideration of the decision in 2016 and ultimately the Government appealed the Court decision to the U.S. Court of Appeals for the Federal Circuit (Court of Appeals). At the start of VA's efforts to obtain reversal of the decision in 2016, VA necessarily starting holding in abeyance all affected claims. As of September 29, 2017, VA is holding almost 822,000.

While the appeal was pending before the Court of Appeals, VA made the decision in 2017 to withdraw its appeal and to proceed with rulemaking and then the processing of claims being held in abeyance. The Government's appeal unavoidably delayed processing of these claims, and the additional time associated with a public comment period would cause further delay, which VA believes would cause hardship to veterans and is contrary to the public interest.

As explained above, VA's current payment methodology would typically result in partial payments under health-plan contracts exceeding VA's maximum allowable amount, leaving many, if not most, veterans' still financially liable to their providers for the remaining costs of their emergency treatment. Merely revising § 17.1002(f) to implement the Court decision without, at the same time, amending the payment methodology to avoid this undesired result would, for all practical purposes, result in unsound, ineffective, incomplete rulemaking. We would provide the right to payment without the means by which to achieve the goal in practice. Public interest therefore compels concomitant revisions be made to the payment methodology.

Similarly, as explained above, under current regulations, there are circumstances wherein VA must deny otherwise eligible claims for reimbursement solely because of satisfaction of the related treatment claim by a third-party payer. VA believes this is inconsistent with our interpretation of 38 U.S.C. 1725, particularly our view that emergency transportation is part and parcel of emergency treatment, and VA believes that failing to remedy that would be contrary to the public interest because it would also result in veterans receiving no reimbursement, causing financial hardship for veterans.

During recent confirmation hearings for the Secretary of the Department, Senator Rounds expressed frustration

that VA had not originally complied with the amendments to section 1725 made by the Emergency Care Fairness Act (ECFA) (2010), and he criticized VA for waiting for 6 years until it received the adverse Court decision to change its interpretation of section 1725 to accord with the Congressional drafters original intent. See Congressional Record, November 30, 2016, pages S6609–S6610. As part of his comments, the Senator noted that most affected by VA's failure to implement the ECFA amendments as originally intended (and confirmed by the Court decision) mostly affected elderly veterans, many of whom live on fixed incomes and have limited financial resources to pay medical bills. *Id.* He provided anecdotal evidence of veterans being pursued for payment of these expenses by collection agencies while these claims have been held in abeyance. *Id.* He also expressed additional concern that this situation may be playing into the high rate of veteran suicide among elderly veterans and so simply found VA's holding of claims to be unacceptable. *Id.* In response, the Secretary assured the Senator, the Committee, and the general public at large that VA would act quickly to rectify this situation and get these claims processed.

Even before this, in December 2016, Senator Rounds and 21 other Senators wrote the Department expressing these same concerns, with the additional concern that these veteran-claimants may not seek needed care in the future out of fear of incurring additional medical bills.

In addition, the public record, *e.g.*, articles by USA Today, Stars and Stripes, etc., Veterans Service Organizations, and social media, includes reports readily available on the internet about the Court decision as well as follow-up stories tracking VA's actions. They convey a collective sense of concern for claimants who are still experiencing continued delays in getting their claims processed.

For these reasons, good cause exists to publish this rule without prior opportunity for public comment and to publish this rule with an immediate effective date. Thus, the Secretary issues this rule as an interim final rule. VA will consider and address comments that are received within 60 days of the date this interim final rule is published in the **Federal Register**.

#### **Paperwork Reduction Act**

This interim final 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 the adoption of this interim final rule will not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act, 5 U.S.C. 601–612. It will not directly affect any small entities as they are defined under the Act. Therefore, pursuant to 5 U.S.C. 605(b), this interim final rule will be exempt from the initial and final regulatory flexibility analysis requirements of sections 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 to be an economically significant regulatory action because it will have an annual effect on the economy of \$100 million or more. VA's impact analysis can be found as a supporting document at <http://www.regulations.gov>, usually within 48

hours after the rulemaking document is published. Additionally, a copy of the rulemaking and its impact analysis are available on VA's website at <http://www.va.gov/orpm> by following the link for VA Regulations Published from FY 2004 through FYTD. This rule is not subject to the requirements of E.O. 13771 because this rule results 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, and tribal governments, in the aggregate, or by the private sector, of \$100 million or more (adjusted annually for inflation) in any one year. This interim final rule will have no such effect on State, local, and tribal governments, or on the private sector.

#### Catalog of Federal Domestic Assistance Numbers

The Catalog of Federal Domestic Assistance numbers and titles for the programs affected by this document are 64.005, Grants to States for Construction of State Home Facilities; 64.007, Blind Rehabilitation Centers; 64.008, Veterans Domiciliary Care; 64.009, Veterans Medical Care Benefits; 64.010, Veterans Nursing Home Care; 64.011, Veterans Dental Care; 64.012, Veterans Prescription Service; 64.013, Veterans Prosthetic Appliances; 64.014, Veterans State Domiciliary Care; 64.015, Veterans State Nursing Home Care; 64.016, Veterans State Hospital Care; 64.018, Sharing Specialized Medical Resources; 64.019, Veterans Rehabilitation Alcohol and Drug Dependence; 64.022, Veterans Home Based Primary Care.

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

Administrative practice and procedure, Alcohol abuse, Alcoholism, Claims, Day care, Dental health, Drug abuse, Foreign relations, Government contracts, Grant programs-health, Grant programs-veterans, Health care, Health facilities, Health professions, Health records, Homeless, Medical and dental schools, Medical devices, Medical research, Mental health programs, Nursing homes, Philippines, Reporting and recordkeeping requirements, Scholarships and fellowships, Travel and transportation expenses, Veterans.

#### Signing Authority

The Secretary of Veterans Affairs, or designee, approved this document and authorized the undersigned to sign and submit the document to the Office of the

Federal Register for publication electronically as an official document of the Department of Veterans Affairs. Gina S. Farrissee, Deputy Chief of Staff, Department of Veterans Affairs, approved this document on July 14, 2017, for publication.

Dated: January 4, 2018.

**Michael Shores,**

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

For the reasons set out in the preamble, VA amends 38 CFR part 17 as set forth below:

#### PART 17—MEDICAL

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

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

\* \* \* \* \*

■ 2. Amend § 17.1002 by revising paragraph (f) to read as follows:

#### § 17.1002 Substantive conditions for payment or reimbursement.

\* \* \* \* \*

(f) The veteran does not have coverage under a health-plan contract that would fully extinguish the medical liability for the emergency treatment (this condition cannot be met if the veteran has coverage under a health-plan contract but payment is barred because of a failure by the veteran or the provider to comply with the provisions of that health-plan contract, e.g., failure to submit a bill or medical records within specified time limits, or failure to exhaust appeals of the denial of payment);

\* \* \* \* \*

■ 3. Amend § 17.1003 by:

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

■ b. Adding paragraph (e).

The revisions and addition read as follows:

#### § 17.1003 Emergency transportation.

\* \* \* \* \*

(a) Payment or reimbursement is authorized under 38 U.S.C. 1725 for emergency treatment provided at a non-VA facility, or payment or reimbursement would have been authorized under 38 U.S.C. 1725 for emergency treatment had:

(1) The veteran's personal liability for the emergency treatment not been fully extinguished by payment by a third party, including under a health-plan contract; or

(2) Death had not occurred before emergency treatment could be provided;

\* \* \* \* \*

(c) The veteran does not have coverage under a health-plan contract that would fully extinguish the medical liability for the emergency transportation (this condition is not met if the veteran has coverage under a health-plan contract but payment is barred because of a failure by the veteran or the provider to comply with the provisions of that health-plan contract);

(d) If the condition for which the emergency transportation was furnished was caused by an accident or work-related injury, the claimant has exhausted without success all claims and remedies reasonably available to the veteran or provider against a third party for payment of such transportation; and the veteran has no contractual or legal recourse against a third party that could reasonably be pursued for the purpose of fully extinguishing the veteran's liability to the provider; and

(e) If the veteran is not eligible for reimbursement for any emergency treatment expenses under 38 U.S.C. 1728.

\* \* \* \* \*

■ 4. Amend § 17.1005 by:

■ a. Revising paragraph (a).

■ b. Removing paragraph (e).

■ c. Removing paragraph (f).

The revisions read as follows:

#### § 17.1005 Payment limitations.

(a) Payment or reimbursement for emergency treatment (including emergency transportation) under 38 U.S.C. 1725 will be calculated as follows:

(1) If an eligible veteran has personal liability to a provider of emergency treatment and no contractual or legal recourse against a third party, including under a health-plan contract, VA will pay the lesser of the amount for which the veteran is personally liable or 70 percent of the applicable Medicare fee schedule amount for such treatment.

(2) If an eligible veteran has personal liability to a provider of emergency treatment after payment by a third party, including under a health-plan contract, VA will pay:

(i) The difference between the amount VA would have paid under paragraph (a)(1) of this section for the cost of the emergency treatment and the amount paid (or payable) by the third party, if that amount would be greater than zero, or;

(ii) If applying paragraph (a)(2)(i) of this section would result in no payment by VA, the lesser of the veteran's remaining personal liability after such third-party payment or 70 percent of the applicable Medicare fee schedule amount for such treatment.

(3) In the absence of a Medicare fee schedule rate for the emergency treatment, VA payment will be the lesser of the amount for which the veteran is personally liable or the amount calculated by the VA Fee Schedule in § 17.56 (a)(2)(i)(B).

(4) Unless rejected and refunded by the provider within 30 days from the date of receipt, the provider will consider VA's payment made under paragraphs (a)(1), (a)(2), or (a)(3) of this section as payment in full and extinguish the veteran's liability to the provider. (Neither the absence of a contract or agreement between the Secretary and the provider nor any provision of a contract, agreement, or assignment to the contrary shall operate to modify, limit, or negate the requirement in the preceding sentence.)

(5) VA will not reimburse a veteran under this section for any copayment, deductible, coinsurance, or similar payment that the veteran owes the third party or is obligated to pay under a health-plan contract.

\* \* \* \* \*

[FR Doc. 2018-00232 Filed 1-8-18; 8:45 am]

BILLING CODE 8320-01-P

## POSTAL SERVICE

### 39 CFR Part 111

#### **eInduction Option, Seamless Acceptance Program, and Full-Service Automation Option, Verification Standards**

**AGENCY:** Postal Service™.

**ACTION:** Final rule.

**SUMMARY:** The Postal Service is amending *Mailing Standards of the United States Postal Service*, Domestic Mail Manual (DMM®), to add verification standards for the *eInduction Option*, *Seamless Acceptance Program*, and *Full-Service Automation Option*.

**DATES:** Effective: March 5, 2018.

**FOR FURTHER INFORMATION CONTACT:** Heather Dyer at (207) 482-7217, or Garry Rodriguez at (202) 268-7281.

**SUPPLEMENTARY INFORMATION:** The Postal Service published a notice of proposed rulemaking on October 31, 2017, (82 FR 50346-50348) to add the verification standards for the *eInduction Option*, *Seamless Acceptance Program*, and *Full-Service Automation Option*, which included a 30-day comment period.

The Postal Service received 2 formal responses on the proposed rule, both of which included multiple comments.

#### **Comments From the First Responder**

*Comment:* When measuring compliance against the “active version of the Mail Direction File” during eInduction verifications, does a 30-day grace period apply?

*Response:* Yes. The effective Mail Direction File (MDF) is distributed among the industry and *PostalOne!* applications at the beginning of each month to ensure valid container entry acceptance. Each effective MDF also observes a 30 day grace period allowing consumers to confirm mail prepared for the subsequent mailing period. For mail that is prepared in the current mailing period, the effective MDF will provide a source of valid entry facilities that will accept mail within the prepared mailing period. For mail that is prepared in the subsequent mailing period, the effective MDF's grace period observations will provide a source of valid entry facilities that will accept mail with the prepared mailing period. At this time the USPS does not plan on changing any system processes with regards to logging errors for eInduction. If mailers believe that invalid errors are being logged they may be researched through the review process.

*Comment:* The Postal Service should consider removing eInduction assessment on undocumented containers for mailers that do not participate in Seamless Acceptance.

*Response:* At this time, the USPS does not plan on changing any system processes, including postage assessment for eInduction. If mailers believe that they have proof of payment for a container that received an undocumented error they may request a review.

#### **Comments From the Second Responder**

*Comment:* In reviewing the proposed DMM updates, there are several documents that are cross-referenced; these documents are not up to date.

*Response:* The recommended changes to USPS Publication 685 have been noted and will be addressed through a separate forum. Changes to DMM Section 602.5.2 were published in the Address Quality Census Measurement and Assessment Process final rule of October 24, 2017 (82 FR 49123-49128), and take effect on January 21, 2018. The USPS is working to update “Publication 804—Drop Shipment Procedures for Destination Entry” and “Guide for Streamlined Mail Acceptance for Letters and Flats Reporting.”

*Comment:* We disagree with the method USPS has adopted to assess additional postage charged for logical mailers in the Full-Service Intelligent

Mail program. Please explain why the method is not consistent across all Streamlined programs.

*Response:* At this time the USPS does not plan on changing the Full-Service assessment process for logical mailings. If a mailer is able to provide documentation supporting a reduction in assessment due to evidence of physical mailings during the review process it will be taken into consideration.

*Comment:* The Appeals Process outlined in the DMM Section 604.10.1.2 does not appear to be consistent with the process outlined in Publication 685.

*Response:* The Appeals Process for the eInduction, Full-Service, and Seamless Acceptance, programs are outlined in Section 6-3.3.3 PCSC Appeals of Publication 685. These programs are not covered by the timeline outlined in DMM Section 604.10.1.2. Mailers should work with their assessment reviewer to discuss the findings of the review and what type of documentation will be needed to file an appeal.

*Comment:* We have outlined the differences between the DMM and Publication 685; please utilize the same language for consistency.

*Response:* For each difference noted, changes to the DMM sections were made when applicable and appropriate. The recommended changes to Publication 685 have been noted and will be addressed through a separate forum.

In addition, the second responder had numerous comments that were determined to be beyond the scope of this final rule. The Postal Service will review and address these comments in a separate forum with the responder.

The Postal Service is amending DMM sections 705.20, *eInduction Option*, 705.22, *Seamless Acceptance Program*, and 705.23, *Full-Service Automation Option*, to add the applicable verification descriptions, error thresholds, and postage assessments, standards. These standards have been made available to the public via Publication 685, *Publication for Streamlined Mail Acceptance for Letters and Flats*, available at <https://postalpro.usps.com>, which also contains additional information on the verification processes.

#### **List of Subjects in 39 CFR Part 111**

Administrative practice and procedure, Postal Service.

The Postal Service adopts the following changes to *Mailing Standards of the United States Postal Service*, Domestic Mail Manual (DMM),