

TABLE 1 OF § 165.801—SECTOR OHIO VALLEY ANNUAL AND RECURRING SAFETY ZONES—Continued

Date	Sponsor/name	Sector Ohio Valley location	Safety zone
93. 1 day—One weekend in August.	Parkersburg Homecoming Festival-Fireworks.	Parkersburg, WV	Ohio River mile 183.5–185.5 (West Virginia).

* * * * *

Dated: May 7, 2018.

M.B. Zamperini,*Captain, U. S. Coast Guard, Captain of the Port Sector Ohio Valley.*

[FR Doc. 2018–10088 Filed 5–10–18; 8:45 am]

BILLING CODE 9110–04–P

DEPARTMENT OF VETERANS AFFAIRS**38 CFR Part 17****RIN 2900–AP60****Expanded Access to Non-VA Care Through the Veterans Choice Program****AGENCY:** Department of Veterans Affairs.**ACTION:** Final rule.

SUMMARY: The Department of Veterans Affairs (VA) adopts as final, with no change, an interim final rule revising its medical regulations that implement section 101 of the Veterans Access, Choice, and Accountability Act of 2014, as amended, (hereafter referred to as “the Choice Act”), which requires VA to establish a program (hereafter referred to as the “Veterans Choice Program” or the “Program”) to furnish hospital care and medical services through eligible non-VA health care providers to eligible veterans who either cannot be seen within the wait-time goals of the Veterans Health Administration (VHA) or who qualify based on their place of residence or face an unusual or excessive burden in traveling to a VA medical facility. Those revisions contained in the interim final rule, which is now adopted as final, were required by amendments to the Choice Act made by the Construction Authorization and Choice Improvement Act of 2014, and by the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015. VA published an interim final rule on December 1, 2015, implementing those regulatory revisions, and we received seven public comments. This final rule responds to those public comments and does not make any further regulatory revisions.

DATES: *Effective date:* This rule is effective on May 11, 2018.

FOR FURTHER INFORMATION CONTACT: Joseph Duran, Director, Policy and

Planning, Office of Community Care (10D1A1), Veterans Health Administration, Department of Veterans Affairs, 810 Vermont Avenue NW, Washington, DC 20420, (303) 372–4629. (This is not a toll-free number.)

SUPPLEMENTARY INFORMATION: The Choice Act, Public Law 113–146, was enacted on August 7, 2014. Further amendments to the Choice Act were made by Public Laws 113–175, 113–235, 114–19, 114–41, and 115–26. Under these authorities, VA established the Veterans Choice Program and published regulations at 38 CFR 17.1500 through 17.1540. This final rule revises VA regulations in accordance with the amendments to the Choice Act made by Public Laws 114–19 and 114–41. Public Law 114–19, the Construction Authorization and Choice Improvement Act, amended the Choice Act to define additional criteria that VA may use to determine that a veteran’s travel to a VA medical facility is an “unusual or excessive burden.” Public Law 114–41, the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015, amended the Choice Act to expand eligibility for the Veterans Choice Program to all veterans enrolled in the VA health care system, to remove the 60-day limit on an episode of care, modify the wait-time and 40-mile distance eligibility criteria, and expand provider eligibility based on criteria as determined by VA. VA published an interim final rule on December 1, 2015, to implement these amendments to the Choice Act. 80 FR 74991. We received seven comments on the interim final rule and respond to those comments in the discussion below. We are adopting as final the interim final rule with no revisions.

Comments regarding changes in Public Law 114–19 related to the “unusual or excessive burden” standard.

Section 3(a)(2) of Public Law 114–19 amended section 101(b)(2)(D)(ii)(II) of the Choice Act by defining additional criteria that could be the basis for finding that a veteran faced an “unusual or excessive burden” in traveling to receive care in a VA medical facility, including environmental factors such as roads that are not accessible to the general public, traffic, or hazardous weather; a medical condition that affects

the ability to travel; or other factors, as determined by the Secretary. The interim final rule revised § 17.1510(b)(4)(ii) to include environmental factors such as roads that are not accessible to the general public, traffic, or hazardous weather, or a medical condition that affects the ability to travel. The interim final rule also added three “other factors” to § 17.1510(b)(4)(ii)(A) through (C): The nature or simplicity of the hospital care or medical services the veteran requires; how frequently the veteran needs such hospital care; or medical services, and the need for an attendant, which is defined as a person who provides required aid and/or physical assistance to the veteran, for a veteran to travel to a VA medical facility for hospital care or medical services. VA received one positive comment in support of the revisions to § 17.1510(b)(4)(ii), and we thank the commenter for this feedback. VA did not receive any comments that suggested changes to the revisions to § 17.1510(b)(4)(ii), and therefore does not make further regulatory revisions.

Comments regarding changes in Public Law 114–41 related to veteran eligibility, periods of follow up care, wait times, distance requirements, and provider eligibility.

Section 4005(b) of Public Law 114–41 amended section 101 of the Choice Act to remove the August 1, 2014, enrollment date restriction, thereby making all veterans enrolled in the VA health care system under § 17.36 potentially eligible for the Program if they meet its other eligibility criteria. Section 17.1510 was therefore revised in the interim final rule to codify this expanded eligibility for the Program. VA implemented this change ahead of the § 17.1510 revision, as this change was not subject to notice and comment because it had an immediate effective date and VA did not need to interpret the language of the public law to give it effect. VA also did not receive any comments on this revision, and does not make any further regulatory revisions.

Section 4005(a) of Public Law 114–41 amended section 101(h) of the Choice Act by removing the 60-day limitation on an “episode of care.” Sec. 4005(a), Public Law 114–41, 129 Stat. 443. The definition of “episode of care” in § 17.1505 was therefore revised in the interim final rule by removing the

phrase “which lasts no longer than 60 days from the date of the first appointment with a non-VA health care provider,” and the 60-day limitation was replaced with a 1-year limitation, consistent with VA’s authority in section 101(c)(1)(B)(i) of the Choice Act to establish a timeframe for authorization of care. VA received one comment in support of this change, but this comment also suggested that VA make exceptions to the 1-year limitation, particularly for chronic conditions, to avoid the possibility of the unnecessary cessation of care due to reauthorization requirements. The comment further suggested that VA should provide more specific information regarding what a community provider would need to submit to VA to obtain a broader authorization beyond 1-year, and that VA should provide more details on the process community providers may follow to “provide additional care outside the scope of the authorized course of treatment.” We agree that veterans should not experience cessations of treatment for an ongoing condition if they require care beyond one year; the regulations do therefore allow reauthorization for additional episodes of care as needed. However, we believe that it is important that VA reauthorize an episode of care annually even in those instances where it is apparent at the time of the initial authorization that the condition is chronic and care will be required for greater than one year. A chronic medical condition may change over time, resulting in a need to reexamine the authorized scope of care. Annual reauthorization of an episode of care provides an opportunity for VA to review the scope of the episode of care with the healthcare provider and make necessary revisions to meet the needs of the veteran. Care may only be provided within the scope of the authorized episode of care, as defined in § 17.1505 as a “necessary course of treatment, including follow-up appointments and ancillary and specialty services” for identified health care needs. If a community provider believes that a veteran needs additional care outside the scope of the authorized course of treatment, the health care provider must contact VA prior to administering such care to ensure that this care is authorized and therefore will be paid for by VA. Details regarding what specific information must be submitted or what processes must be followed to obtain authorizations for additional episodes of care, or for an authorization to provide care not authorized as part of the

episode of care, is too specific for a regulation, but information is available from the contractors that administer the Choice program and from VA when the care is authorized under a Choice provider agreement. VA continually works with the contractors and with community providers to improve education and processes under the Program. VA does not make any further regulatory revisions based on this comment.

Section 4005(d) of Public Law 114–41 amended section 101(b)(2)(A) of the Choice Act to create eligibility for veterans that are unable to be scheduled for an appointment within “the period determined necessary for [clinically necessary] care or services if such period is shorter than” VHA’s wait time goals. Section 4005(d), Public Law 114–41, 129 Stat. 443. This new wait-times based criterion was added as paragraph (b)(1)(ii) of § 17.1510, and created eligibility when a veteran is unable to schedule an appointment within a period of time that VA determines is clinically necessary and which is shorter than VHA’s wait time goals. VA received one positive comment in support of this revision, and we thank the commenter for this feedback. VA did not receive any comments that suggested changes to this revision, and therefore does not make further regulatory revisions.

Section 4005(e) of Public Law 114–41 amended section 101(b)(2)(B) of the Choice Act to modify the 40-mile distance eligibility criterion to provide that veterans may be eligible if they reside more than 40 miles from “(i) with respect to a veteran who is seeking primary care, a medical facility of the Department, including a community-based outpatient clinic, that is able to provide such primary care by a full-time primary care physician; or (ii) with respect to a veteran not covered under clause (i), the medical facility of the Department, including a community-based outpatient clinic, that is closest to the residence of the veteran.” VA found that it would be impracticable and not veteran centric to apply a “seeking primary care” eligibility criterion, and therefore did not revise the general 40-mile requirement in § 17.1510(b)(1) in the interim final rule to reflect such a strict reading of the public law. However, VA did revise § 17.1505 to add a definition of “full-time primary care physician,” as well as amend the definition of “VA medical facility” to require that such a facility have a full-time primary care physician, so that for purposes of determining distance-related eligibility for the Program, VA considered a qualifying VA medical

facility to include only those facilities with at least a full-time primary care physician. VA received one positive comment in support of this revision, and we thank the commenter for this feedback. VA did not receive any comments that suggested changes to this revision, and therefore does not make further regulatory revisions.

Section 4005(c) of Public Law 114–41 amended sections 101(a)(1)(B) and 101(d) of the Choice Act to permit VA to expand provider eligibility beyond those providers expressly listed in section 101(a)(1)(B) of the Choice Act, in accordance with criteria as established by VA. In the interim final rule, VA revised § 17.1530(a) to refer to a new paragraph (e) that established eligibility for these other providers, and added a new paragraph (e) to § 17.1530 to list these providers specifically. VA also revised § 17.1530(d) to reorganize current requirements and add new requirements for these providers, in accordance with section 101(d)(5) of the Choice Act. VA received two positive comments in support of this revision, and we thank the commenters for this feedback. VA received one comment that inquired whether, given the expansion of eligible providers, such providers were required to be Medicare-participating providers. We clarify that eligible providers in the Program include but are not limited to Medicare-participating providers, as established in § 17.1530(a) and (e). With this clarification, and because VA did not receive any comments that suggested changes to this revision, we therefore do not make further regulatory revisions.

Miscellaneous Comments

The remaining five comments do not specifically pertain to the regulatory changes in the interim final rule, and are addressed here in turn.

One commenter requested that the end date of August 7, 2017, for the Choice Act be removed and the program made permanent. The Choice Act, which was enacted on August 7, 2014, in Public Law 113–146, specifically prescribed that the Choice Program would be temporary, operating for 3 years or until the funding was exhausted, whichever came first. The 3-year sunset date was removed by Public Law 115–26, and so the Choice Program is authorized until the amounts appropriated in the Choice Fund are exhausted. Current regulations do not discuss the termination date of the Program, and VA does not make any regulatory changes based on Public Law 115–26 or this comment.

Another commenter expressed a generalized concern that the Choice

Program created additional barriers to access healthcare as well as expressed specific concerns about the Choice Program. To address the commenter's generalized concern related to barriers to access, we acknowledge the difficulties that some veterans have experienced and expressed since the inception of the Choice Program in August 2014, and we are similarly sympathetic to the commenter's expressed experiences. Congress mandated that VA implement the Choice Program in 90 days, and implementing such an unprecedented program in terms of VA care in the community on a nationwide basis, in 90 days, resulted in growing pains for veterans, community providers, and VA. During the initial year of the Choice Program, VA met with veterans, community providers, leading healthcare experts, and staff across the country to hear concerns and identify solutions. In order to immediately implement changes to the Choice Program, VA brought in new leadership to oversee all Community Care Programs. Under this new leadership, VA quickly began to improve the Choice Program and laid out a plan to drive towards a future that delivers the best of VA and the community. VA has earnestly tried to implement the Choice Program in accord with legal requirements while being mindful of veteran concerns and administrative realities, and VA will continue to strive to reduce any barriers communicated to us by veterans. VA does not make any regulatory changes to address the commenter's generalized concerns about the Choice Program.

As to the commenter's specific concerns, the commenter stated that there are no clear channels for resolution of complaints or problems when authorization for care has been delayed. The commenter further elaborated that it is difficult to access the Choice Program call centers and, once contact is made with the call center, it is difficult to receive answers from the employees working in the call centers. The commenter suggested that a process be put in place to address complaint resolution. We interpret these concerns to be limited to issues that arise administratively when the veteran is already enrolled in the Choice Program, such as delays in authorization, and not concerns regarding eligibility to participate in the Choice Program or concerns with clinical decisions throughout the course of treatment. Therefore, we further interpret these concerns to relate to the internal processes relating to

administration of the program and do not make any regulatory changes. However, we describe below processes and improvements that both VA and the contractors that administer the Choice Program have undertaken and which we believe obviate the need for more formal processes in regulation.

VA has taken affirmative steps to decrease administrative burdens such as delays in authorization and has improved access to VA staff through the VA call centers and the internet. For instance, VA has reduced the administrative burden for medical record submission for community providers by streamlining the documents required. We also have strived to improve veterans' experience with the call centers throughout the past year. More specifically, in May 2015, it took approximately 11 days to contact the veteran, obtain their provider and appointment preference, and work with the community provider to schedule an appointment; by May 2016, the average number of days to accomplish those tasks decreased to only 6. The Choice Program call centers have also continued to improve with a call abandon rate of less than 2 percent; a call hold time of no more than 7 seconds; and first-time call resolution over of 96 percent. In addition, Veterans are able to contact VA directly through this website that is available to the public: <http://www.va.gov/opa/choiceact/>. The website contains information about the program, a phone number that veterans can call in order to speak to a person directly, and also contains a live chat option that is available to veterans Monday through Friday from 8 a.m. to 8 p.m., eastern standard time. The vendors who administer the Choice Program additionally have processes in place for veterans who experience delays when receiving care in the community. The complaints and grievance processes for the contractors, TriWest and Health Net, are available at their public websites, respectively: http://www.triwest.com/globalassets/documents/veteran-services/complaint-grievance_form.pdf and <https://www.hnfs.com/content/hnfs/home/va/provider/resources/resources/grievances.html>.

The commenter next expressed the specific concern that rural veterans are disproportionately negatively impacted by barriers created by the Choice Act and VA and that such veterans' feedback is not heard by VA as a result of their disability status and geographic location. We first clarify that VA strives to gain feedback from all veterans, including those who live in rural areas, about their experiences with the Choice

Program. To obtain feedback from all veterans, regardless of their geographic location, VA developed a Survey of Healthcare Experiences of Patients (SHEP) for veterans to complete after receiving Choice care. We further acknowledge that there are unique problems that affect rural veterans and that it may be more difficult for rural veterans to obtain health care near their residence. In this regard, the 40-mile distance criterion in the Choice Program regulations at § 17.1510(b)(2) is designed to address accessibility issues that affect rural Veterans. Particularly, the 40-mile criterion has been interpreted by VA to consider driving distance and not straight line distance (see 80 FR 22906, April 24, 2015), and to further interpret that this distance must be from a Veteran's residence to a VA medical facility that has at least one full time equivalent primary care physician (see 80 FR 74991, December 1, 2015). Both of these interpretations we believe increase the number of rural veterans eligible for the program, and VA otherwise actively seeks and documents the concerns of rural veterans that participate in the Choice program with its SHEP survey as described above. Therefore, we make no regulatory changes based on this comment.

The commenter also stated that the Choice Program has created coordination of care issues for non-VA providers who administer health care for veterans. The commenter did not elaborate on what those issues are or how the Choice Program created them, or whether the interim final rule exacerbated the issues, and the commenter also did not suggest any changes to alleviate the issues. We do acknowledge that there may have been difficulty with coordination of care at the inception of the Choice Program, and, to enhance coordination of care for veterans, we have embedded Choice contractor staff with VA staff at 14 VA facilities, and continue to increase the number of embedded Choice contractor staff locations. As the commenter did not provide enough specificity for suggested regulatory changes, and we believe VA has undertaken efforts to mitigate coordination of care issues, we do not make any regulatory revisions based on this comment.

Finally, the commenter explained that it was easier to seek care prior to the Choice Program and that, even though the Program is voluntary, veterans are being told that they must use the Choice Program over VA care and other VA care in the community permitted by legal authorities other than the Choice Act. We first clarify that the Choice Program

is voluntary and veterans are provided the option of obtaining care solely at VA medical facilities. Significantly, the Choice Program is designed to respect and guarantee a veteran's choice to see a VA provider or a non-VA provider if they meet Choice Program criteria. In fact, if an eligible veteran elects to receive covered care through the Choice Program, VA is required by the Choice Act to furnish the care through the Program. In addition, the Choice Act authorized VA to purchase care through Choice provider agreements, which gives VA greater flexibility when furnishing care through the Choice Program. VA recognizes that some veterans faced administrative barriers and hurdles while seeking care through the Choice Program and that some veterans may have found it was easier in the past to seek VA care in the community under legal authorities other than the Choice Act. To ensure the Choice Program provides high quality and accessible care, VA has made and will continue to make improvements by working with Congress, our community providers, our Choice Program contractors and within VA. Therefore, we do not make any further regulatory revisions based on this comment.

The final three comments are beyond the scope of the interim final rule and we will not make any regulatory changes based on the comments. One commenter expressed concern about the recertification process to become a vendor and contract with VA through "*vetbiz.gov*." The process of vendorization on *vetbiz.gov* does not apply for clinical providers under the Choice Act. As the commenter did not otherwise reference the interim final rule or the Choice Program regulations generally, nor did the commenter state how the ability to recertify as a vendor was affected by the interim final rule or Choice regulations, we find that the comment is beyond the scope of the rulemaking.

Another commenter supported the interim final rule because it would enable the commenter to access community care near the commenter's residence in Panama. Care under the Choice Program is not provided outside of the United States. VA's only authority to provide care abroad is through the foreign medical care provisions in 38 U.S.C. 1724, and the Choice Act did not affect this limitation.

Another commenter expressed a concern over the potentially burdensome nature of the administrative requirements to participate in the Choice Program. Specifically, the commenter requested that VA be mindful that an overly

complicated process to apply to participate in the Choice Program may deter people who are eligible and entitled to participate in the Program. The commenter did not specify what these burdens are or if they were made worse by revisions in the interim final rule. Therefore, we interpret the comment to be general in scope. Although the interim final rule and the Choice regulations contain eligibility criteria, they do not contain any requirements or guidance for how to apply to participate in the Choice Program. Therefore, we find that the comment is not within the scope of the rulemaking and we will not make any regulatory changes based on this comment.

Effect of Rulemaking

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

Paperwork Reduction Act

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

Executive Orders 12866, 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 it has been determined that this is an economically significant regulatory action under Executive Order 12866. VA's regulatory impact analysis can be found as a supporting document at <http://www.regulations.gov>, usually within 48 hours after the rulemaking document is published. Additionally, a copy of the rulemaking and its regulatory impact analysis are available on VA's website at <http://www.va.gov/orpm/>, by following the link for "VA Regulations Published From FY 2004 Through Fiscal Year to Date." 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.

Congressional Review Act

This regulatory action is a major rule under the Congressional Review Act, 5 U.S.C. 801–08, because it may result in an annual effect on the economy of \$100 million or more. Although this regulatory action constitutes a major rule within the meaning of the Congressional Review Act, 5 U.S.C. 804(2), it is not subject to the 60-day delay in effective date applicable to major rules under 5 U.S.C. 801(a)(3) because the Secretary finds that good cause exists under 5 U.S.C. 808(2) to make this regulatory action effective on the date of publication, consistent with

the reasons given for the publication of the interim final rule. In accordance with 5 U.S.C. 801(a)(1), VA will submit to the Comptroller General and to Congress a copy of this regulatory action and VA's Regulatory Impact Analysis.

Unfunded Mandates

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

Regulatory Flexibility Act

The Secretary hereby certifies that this final rule will not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act, 5 U.S.C. 601–612. This final rule will not have a significant economic impact on participating eligible entities and providers who enter into agreements with VA. To the extent there is any such impact, it will result in increased business and revenue for them. We also do not believe there will be a significant economic impact on insurance companies, as claims will only be submitted for care that will otherwise have been received whether such care was authorized under this Program or not. Therefore, pursuant to 5 U.S.C. 605(b), this rulemaking is exempt from the initial and final regulatory flexibility analysis requirements of 5 U.S.C. 603 and 604.

Catalog of Federal Domestic Assistance

The Catalog of Federal Domestic Assistance numbers and titles for the programs affected by this document are as follows: 64.008—Veterans Domiciliary 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; 64.024—VA Homeless Providers Grant and Per Diem Program; 64.026—Veterans State Adult Day Health Care; 64.029—Purchase Care Program; 64.035—Veterans Transportation Program; 64.038—Grants for the Rural Veterans Coordination Pilot; 64.039—CHAMPVA; 64.040—VHA Inpatient Medicine; 64.041—VHA Outpatient Specialty Care; 64.042—VHA Inpatient Surgery; 64.043—VHA Mental Health Residential; 64.044—VHA Home Care;

64.045—VHA Outpatient Ancillary Services; 64.046—VHA Inpatient Psychiatry; 64.047—VHA Primary Care; 64.048—VHA Mental Health Clinics; 64.049—VHA Community Living Center; 64.050—VHA Diagnostic Care.

List of Subjects in 38 CFR Part 17

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

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 January 12, 2018, for publication.

Dated: May 8, 2018.

Consuela Benjamin,

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

PART 17—MEDICAL

■ Accordingly, the interim rules amending 38 CFR part 17 which were published at 80 FR 74991 on December 1, 2015, and 81 FR 24026 on April 25, 2016, are adopted as final without change.

[FR Doc. 2018–10054 Filed 5–10–18; 8:45 am]

BILLING CODE 8320–01–P

DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 17

RIN 2900–AQ06

Authority of Health Care Providers To Practice Telehealth

AGENCY: Department of Veterans Affairs.
ACTION: Final rule.

SUMMARY: The Department of Veterans Affairs (VA) is amending its medical regulations by standardizing the delivery of care by VA health care providers through telehealth. This rule ensures that VA health care providers can offer the same level of care to all

beneficiaries, irrespective of the State or location in a State of the VA health care provider or the beneficiary. This final rule achieves important Federal interests by increasing the availability of mental health, specialty, and general clinical care for all beneficiaries.

DATES: This final rule is effective June 11, 2018.

FOR FURTHER INFORMATION CONTACT:

Kevin Galpin, MD, Executive Director Telehealth Services, Veterans Health Administration Office of Connected Care, 810 Vermont Avenue NW, Washington, DC 20420, (404) 771–8794, (this is not a toll-free number), Kevin.Galpin@va.gov.

SUPPLEMENTARY INFORMATION: In a document published in the **Federal Register** on October 2, 2017, VA proposed to amend its medical regulations by standardizing the delivery of health care by VA health care providers through telehealth. 82 FR 45756. VA provided a 30-day comment period, which ended on November 1, 2017. We received 75 comments on the proposed rule.

Section 7301 of title 38, United States Code (U.S.C.), establishes the general functions of the Veterans Health Administration (VHA) within VA, and establishes that its primary function is to “provide a complete medical and hospital service for the medical care and treatment of veterans, as provided in this title and in regulations prescribed by the Secretary [of Veterans Affairs (Secretary)] pursuant to this title.” See 38 U.S.C. 7301(b). The Secretary is responsible for the proper execution and administration of all laws administered by the Department and for the control, direction, and management of the Department, including agency personnel and management matters. See 38 U.S.C. 303. To this end, Congress authorized the Secretary “to prescribe all rules and regulations which are necessary or appropriate to carry out the laws administered by the Department and are consistent with those laws.” See 38 U.S.C. 501(a). The Under Secretary for Health is directly responsible to the Secretary for the operation of VHA. See 38 U.S.C. 305(b). Unless specifically otherwise provided, the Under Secretary for Health, as the head of VHA, is authorized to “prescribe all regulations necessary to the administration of the Veterans Health Administration,” subject to the approval of the Secretary. See 38 U.S.C. 7304.

To allow VA to carry out its medical care mission, Congress also established a comprehensive personnel system for certain VA health care providers, independent of the civil service rules.