

AIRAC date	State	City	Airport	FDC No.	FDC date	Subject
18-Jun-20	OK	Duncan	Halliburton Field	0/4845	4/17/20	RNAV (GPS) RWY 17, Amdt 2.
18-Jun-20	OK	Duncan	Halliburton Field	0/4846	4/17/20	RNAV (GPS) RWY 35, Amdt 2A.
18-Jun-20	SC	Greenville	Greenville Downtown	0/5525	4/22/20	RNAV (GPS) RWY 1, Orig-C.
18-Jun-20	SC	Greenville	Greenville Downtown	0/5526	4/22/20	NDB RWY 1, Amdt 22C.
18-Jun-20	OH	Columbus	Ohio State University	0/5532	4/21/20	RNAV (GPS) RWY 27L, Orig-A.
18-Jun-20	OH	Columbus	Ohio State University	0/5533	4/21/20	RNAV (GPS) RWY 9R, Amdt 1A.
18-Jun-20	OH	Columbus	Ohio State University	0/5534	4/21/20	ILS OR LOC RWY 9R, Amdt 5A.
18-Jun-20	OH	Columbus	Ohio State University	0/5535	4/21/20	NDB RWY 9R, Amdt 3A.
18-Jun-20	WY	Hulett	Hulett Muni	0/5954	4/24/20	RNAV (GPS) RWY 13, Orig.
18-Jun-20	WY	Hulett	Hulett Muni	0/5955	4/24/20	RNAV (GPS)-A, Amdt 1.
18-Jun-20	MT	Plentywood	Sher-Wood	0/6195	4/24/20	RNAV (GPS) RWY 12, Orig-B.
18-Jun-20	MT	Plentywood	Sher-Wood	0/6196	4/24/20	RNAV (GPS) RWY 30, Orig-B.
18-Jun-20	GA	Reidsville	Swinton Smith Fld At Reidsville Muni.	0/6247	4/24/20	RNAV (GPS) RWY 11, Amdt 1A.
18-Jun-20	NJ	Pittstown	Sky Manor	0/6255	4/24/20	RNAV (GPS) RWY 7, Amdt 1A.
18-Jun-20	NJ	Pittstown	Sky Manor	0/6256	4/24/20	RNAV (GPS) RWY 25, Orig-B.
18-Jun-20	NJ	Pittstown	Sky Manor	0/6257	4/24/20	VOR RWY 7, Amdt 3B.
18-Jun-20	IN	Muncie	Delaware County Rgnl	0/6957	4/27/20	VOR RWY 21, Amdt 14.
18-Jun-20	IA	Belle Plaine	Belle Plaine Muni	0/7297	3/18/20	VOR-A, Amdt 1A.
18-Jun-20	IL	Rochelle	Rochelle Muni Airport-Koritz Field.	0/7299	3/18/20	VOR-A, Amdt 8A.
18-Jun-20	WA	Yakima	Yakima Air Terminal/Mcallister Field.	0/7314	4/13/20	LOC/DME BC-B, Amdt 3.
18-Jun-20	WA	Yakima	Yakima Air Terminal/Mcallister Field.	0/7315	4/13/20	VOR-A, Amdt 7.
18-Jun-20	WA	Yakima	Yakima Air Terminal/Mcallister Field.	0/7316	4/13/20	VOR/DME OR TACAN RWY 27, Amdt 8A.

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DEPARTMENT OF DEFENSE**Office of the Secretary****32 CFR Part 199**

[Docket ID: DOD-2020-HA-0040]

RIN 0720-AB81

TRICARE Coverage and Payment for Certain Services in Response to the COVID-19 Pandemic**AGENCY:** Office of the Secretary, Department of Defense.**ACTION:** Interim final rule with request for comments.

SUMMARY: The Assistant Secretary of Defense for Health Affairs (ASD(HA)) issues this interim final rule with comment to: Provide an exception to the prohibition on telephone, audio-only telehealth services; to authorize reimbursement for interstate or international practice by TRICARE-

authorized providers when such authority is consistent with governing state, federal, or host nation licensing requirements; and to eliminate copayments and cost-shares for telehealth services. The changes in this rule will be effective for the period of the coronavirus 2019 (COVID-19) pandemic. These changes will reduce the spread of COVID-19 among TRICARE beneficiaries by incentivizing use of telehealth services, and will aid providers in caring for TRICARE beneficiaries by temporarily waiving some licensure requirements.

DATES: *Effective date:* This interim final rule is effective on May 12, 2020 through the end of the President's national emergency (Proclamation 9994 of March 13, 2020 (85 FR 15337)). ASD(HA) will publish a document announcing the expiration date. See the **SUPPLEMENTARY INFORMATION** section for more information.

Comment date: Comments are invited and must be submitted on or before June 11, 2020.

ADDRESSES: You may submit comments, identified by docket number and/or

Regulation Identification Number (RIN) number and title, by any of the following methods:

- *Federal Rulemaking Portal:* <http://www.regulations.gov>. Follow the instructions for submitting comments.
- *Mail:* DoD cannot receive written comments at this time due to the COVID-19 pandemic. Comments should be sent electronically to the docket listed above.

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

FOR FURTHER INFORMATION CONTACT:

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SUPPLEMENTARY INFORMATION:

Expiration Date of the Interim Final Rule

Unless extended after consideration of submitted comments, this interim final rule will cease to be in effect upon termination of the President's declared national emergency, in accordance with applicable law and regulation (e.g., 50 U.S.C. 1622(a)). Because TRICARE operates both in the United States and in overseas locations, the ASD(HA), or designee, may determine that it is appropriate to continue exemptions to permanent regulation provisions for some or all of TRICARE's overseas locations serviced by the TRICARE Overseas Program contractor under 32 CFR 199.1(b) beyond termination of the President's declared national emergency based on the status of COVID–19 community spread in those locations. Such continuation of these provisions for overseas locations will be published in TRICARE's implementing instructions (TRICARE manuals), available at <http://manuals.health.mil>.

If the ASD(HA) determines it would be appropriate to make these changes permanent, the ASD(HA) will follow-up with final rulemaking.

I. Executive Summary

A. Purpose of the Interim Final Rule

A novel coronavirus (SARS-CoV–2), which causes Coronavirus Disease 2019 (COVID–19), was first detected in December 2019 and has spread rapidly throughout the world. On January 31, 2020, the Secretary of Health and Human Services determined that a public health emergency existed since 27 January, 2020.¹ On March 13, 2020, the President declared a national emergency due to COVID–19. Proclamation 9994 of March 13, 2020, titled “Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID–19) Outbreak” published in the **Federal Register** on March 18, 2020 (85 FR 15337–15338). This proclamation is available at <https://www.govinfo.gov/content/pkg/FR-2020-03-18/pdf/2020-05794.pdf>. According to WHO data on March 25, 2020, there were 416,686 cases of COVID–19 worldwide (18,589 deaths), with 51,914 in the United States (673 deaths), with the number of cases rapidly expanding each day. Medical experts from the National Institute of Allergy and

Infectious Disease anticipate more cases in the United States and overseas in the coming months.²

In light of the rapid spread of COVID–19, the Centers for Disease Control and Prevention (CDC) has urged Americans to work and engage in schooling from home whenever possible as well as to avoid congregating in groups. Various States (e.g., Washington, New York) and various cities (e.g., Los Angeles) have imposed more rigid restrictions on gatherings requiring many businesses to restrict or close their operations, all to prevent further spread of the disease.

Pursuant to the President's emergency declaration and as a result of the worldwide COVID–19 pandemic, the ASD(HA) hereby modifies the following regulations, but in each case, only to the extent necessary, as determined by the Director, Defense Health Agency (DHA), to encourage social distancing and prevent the spread of COVID–19 by incentivizing the use of telehealth services, and to allow TRICARE–authorized providers to care for TRICARE beneficiaries wherever there is need as a result of the consequences of the COVID–19 pandemic. The following regulations are temporarily modified:

a. 32 CFR 199.4(g)(52) Telephone Services: Existing regulations exclude TRICARE coverage of telephone services (audio-only) except for biotelemetry. Given the current CDC guidelines for social distancing and some states' governors' orders for residents to stay at home, it is imperative that an exception to the regulatory exclusion be permitted to allow TRICARE–authorized providers to render medically necessary care and treatment to beneficiaries over the telephone, when in-person treatment is not required. Telephone calls of an administrative nature (e.g., appointment scheduling) are not medical services and are not reimbursable. The exception to the exclusion is warranted now during the COVID–19 pandemic and the DoD may follow up with final rulemaking to make the removal of the exclusion a permanent change in Program regulations, if appropriate, after a thorough review of costs, benefits, risks, patient privacy, and other considerations. However, while the DoD conducts this review, it is prudent to permit telephone services more expansively during this emergency period. This change will apply to all geographic areas where TRICARE beneficiaries reside.

b. 32 CFR 199.6(c)(2) Conditions of authorization—(i) Professional license requirement: Existing regulations require TRICARE–authorized providers to be licensed in the state where practicing, even if such a license is optional. Anticipating that practitioners may be asked to surge to areas of high medical need, the federal government (through the Department of Health and Human Services (HHS)) and some states (e.g., California, Florida, Louisiana) have proposed suspending interstate license requirements or otherwise making it easier for providers to treat patients beyond the state where the provider holds a license. If the federal or state government permits providers to operate within a jurisdiction without obtaining a license in that state, TRICARE would be unable to cost-share services provided to in-state beneficiaries by out-of-state licensed providers due to the existing regulatory licensure requirements. For telehealth, the provider license requirement has long been interpreted to mean that the provider must be licensed in the state where practicing and in the state where the beneficiary resides. This regulation change would allow for reimbursement of an otherwise–authorized TRICARE provider if, under applicable federal or state law, that individual holds an equivalent license from any state in the United States, complies with any provisions for interstate practice in that state, and is not affirmatively barred or restricted from practicing in any state in the United States. This change does not supplant state authority to regulate licensure, but assures that if licensure requirements are relaxed by any state or the federal government during the period of the COVID–19 pandemic, that providers caring for TRICARE beneficiaries in compliance with state or federal law will be eligible for reimbursement under TRICARE.

Implementing this regulatory change resolves an issue of particular concern where TRICARE has military installations near the border between states and patients may have their primary care or other regular provider based in another state (e.g., the patient lives in Kentucky but sees a mental health professional in Virginia). Without this change, the provider would not be able to be reimbursed for services provided to that beneficiary via telehealth unless the provider was also licensed in the adjoining state.

Services provided to TRICARE beneficiaries overseas would be eligible for reimbursement when performed by a provider outside of the nation in which they are licensed and normally practice if allowed by the host country in which

¹ <https://www.phe.gov/emergency/news/healthactions/phe/Pages/2019-nCoV.aspx>.

² <https://www.niaid.nih.gov/news-events/covid-19-reminder-challenge-emerging-infectious-diseases>.

they are practicing and so long as they hold an equivalent licensure in the nation in which they normally provide services. The provider would be required to meet all requirements for practice under the host nation.

Providers listed on the HHS sanction list are ineligible to receive reimbursement under the TRICARE program, and would remain ineligible under this provision.

c. *32 CFR 199.17(l)(3) Special cost-sharing rules:* Existing regulations require copayments and cost-sharing for telehealth services to be the same as if the service was provided in person. TRICARE's cost-shares and copayments are set by law. However, Section 718(d) of the National Defense Authorization Act of 2017 authorized the Secretary of Defense to reduce or eliminate copayments or cost-shares when deemed appropriate for covered beneficiaries in connection with the receipt of telehealth services under TRICARE. Given the current environment where community-spread of COVID-19 is evident and the CDC has recommended social distancing, we find it appropriate to remove copayments and cost-shares for TRICARE Prime and Select beneficiaries utilizing telehealth services provided by network providers as a necessary incentive to prevent further spread of COVID-19 during this emergency. The waiving of copayments and cost-shares (including deductibles) for in-network telehealth services will apply to all otherwise-covered services delivered via telehealth, not just those related to COVID-19, and will apply to all TRICARE beneficiaries in all geographic regions for the duration of this emergency. TRICARE program rules still apply, for example, TRICARE Prime beneficiaries must have a referral from their Primary Care Manager (PCM) for a specialty care visit, however, under this rule modification, both the PCM visit and the specialty care visit (if performed via in-network telehealth) have no cost-share or copay. There are no changes to cost-shares and copays for ancillary services, durable medical equipment, prescriptions, or other referrals or care that are ordered due to or result from the telehealth service.

d. *Dates:* These modifications will become effective on May 12, 2020 and will cease to be in effect upon termination of the President's declared national emergency. With TRICARE beneficiaries located worldwide, the ASD(HA), or designee, may allow the provisions of this interim final rule (IFR) to continue after termination of the President's national emergency for some or all of TRICARE's overseas locations

based on the status of COVID-19 community transmission in those locations. Such continuation of these provisions for overseas locations will be published in TRICARE's implementing instructions (TRICARE manuals), available at <http://manuals.health.mil>.

Certain provisions of this IFR may be made permanent (e.g., the elimination of the audio-only telehealth exclusion) while others are anticipated to be removed when the COVID-19 pandemic has concluded (e.g., waiver of telehealth cost-shares and licensure of authorized providers). The DoD may issue a final rule to make permanent changes.

B. Interim Final Rule Justification

Agency rulemaking is governed by section 553 of the Administrative Procedure Act (APA), 5 U.S.C. 551 *et seq.* Section 553(b) requires that, unless the rule falls within one of the enumerated exemptions, the DoD must publish a notice of proposed rulemaking in the **Federal Register** that provides interested persons an opportunity to submit written data, views, or arguments, prior to finalization of regulatory requirements. Section 553(b)(B) of the APA authorizes a department or agency to dispense with the prior notice and opportunity for public comment requirement when the agency, for "good cause," finds that notice and public comment thereon are impracticable, unnecessary, or contrary to the public interest. Section 553(d)(3) requires that an agency must include an explanation of such good cause with the publication of the new rule.

As noted in this preamble, the United States, as well as numerous other countries, have taken unprecedented measures to try to contain or slow the spread of COVID-19. The CDC has recommended that individuals remain at home unless their occupations are essential, *e.g.*, health care workers, and various states and locales have instituted more stringent requirements discouraging travel. As a result, ensuring that patients receive testing and care as warranted will require robust telehealth (including audio-only services) and coverage of providers rendering services in different locations from where they are licensed.

Given the national emergency caused by COVID-19, it would be impracticable and contrary to the public health—and, by extension, the public interest—to delay these implementing regulations until a full public notice-and-comment process is completed.

Pursuant to 5 U.S.C. 553(b)(B), and for the reasons stated in this preamble, the ASD(HA), therefore, concludes that there is good cause to dispense with

prior public notice and the opportunity to comment on this rule before finalizing this rule. For the same reasons, the ASD(HA) has determined, consistent with section 553(d) of the APA, that there is good cause to make this IFR effective immediately upon publication in the **Federal Register**.

C. Summary of Major Provisions of the Interim Final Rule

This provision, 32 CFR 199.4(g)(52) currently excludes telephone services when they are audio-only. However, biotelemetry for patient monitoring and synchronous two-way audio interactions that are enhanced with video or similar kinds of data transmissions are covered under the TRICARE Program. This IFR temporarily revises the regulation to provide an exception to the prohibition for telephonic services (audio-only) for the duration of the COVID-19 pandemic. The exception to the prohibition is warranted now during the pandemic to permit beneficiaries to have their symptoms (which include COVID-19 symptoms, or symptoms of other covered illness or injury) evaluated by a provider over the telephone before, or in lieu of, obtaining an in-person appointment; which may ultimately not be necessary. This practice supports containment of the disease and decreases the opportunity for exposing others.

Consistent with existing TRICARE policy, all audio-only telehealth encounters must be medically necessary, appropriate, and be rendered by a TRICARE-authorized provider acting within the scope of their licensure, as defined by TRICARE statute, regulation, and policy. This regulatory modification does not expand the services available to TRICARE beneficiaries; instead, it makes otherwise-covered services, when rendered via telephone (audio-only), eligible for reimbursement and cost-sharing when care is medically necessary and appropriate, and meets all other provisions of TRICARE policy. While existing telehealth platforms that incorporate both audio and video/visual two-way communication is preferred, there may be instances when this is not possible within the context of this public health emergency. For example, a rural provider may not have access to broadband capability, or a beneficiary may not have in-home technology to support two-way audio/video communication. For the purposes of this public health emergency, and to support clinical guidelines regarding social distancing, audio-only visits (if appropriate) are an acceptable

alternative to other, preferred, telehealth platforms. The rendering provider will be expected to utilize their judgment of clinical necessity, within their licensure and scope of practice, to differentiate services provided via audio and video (traditional telehealth platforms) or audio-only services. The use of audio-only telehealth should be for the purpose of providing assessment, diagnosis, clinical care, or formal patient education from an authorized provider to a patient, or for providing clinical consultation between providers that directly impacts upon a particular patient's care. The authorized provider should determine that a phone call is appropriate for accomplishing the clinical goals of the encounter and document appropriately. If the decision to provide care via a traditional audio/visual method is chosen, the reasons for that decision should be documented as well. For recurring care, the rationale for choosing audio-only or audio and visual should be documented only at the initiation of remote care, or upon any change in modality.

Care that normally requires a physical examination (including a remote physical examination requiring a telepresenter such as a nurse) is not appropriate for audio-only telehealth encounters. Administrative services (for example, making appointments or verifying prescriptions) are not separately reimbursed services. Following publication of this IFR, the agency will provide additional parameters and policy regarding audio-only telehealth encounters in the implementing instructions consistent with this IFR and other provisions of TRICARE policy.

The Agency may follow up with final rulemaking to make the removal of the exclusion for telephonic services (audio-only) a permanent change in Program regulation, if appropriate, after a thorough review of costs, benefits, risks, patient privacy, and other considerations. However, while the agency conducts this review, it is prudent to permit telephone services more expansively during this emergency period. This temporary change will apply to all geographic areas where TRICARE beneficiaries reside.

This provision, 32 CFR 199.6(c)(2)(i), requires providers to be licensed in the state in which they practice when such a license is offered, even if such a license is not required. The requirement has not changed over the years; however, the global pandemic has created a situation where flexibility is required in order to allow providers to (1) deliver care in areas of need without the additional time and cost of re-

licensure, when permitted by state and federal law, and (2) provide services via telehealth to beneficiaries wherever they are located. This temporary rule change will make it easier for TRICARE beneficiaries to access telehealth services, and will ensure providers are able to treat beneficiaries in areas of high need without worrying about not being reimbursed for doing so. Nothing in TRICARE's provision supplants the authority of states to manage the licensing of providers in their jurisdictions, and this modification would only apply in those areas that have opted to relax interstate licensing requirements or where the Federal Government has preempted state licensing requirements. In doing so, it would ensure that providers continue to be reimbursed during the highly-fluid global pandemic. It will still require providers to have an equivalent license in any state, to meet the requirements for the state where they are practicing, and forbid reimbursement of services by a provider who is affirmatively barred or restricted from practice in any state.

This modification would also apply to providers treating beneficiaries outside of the United States by allowing the provider to practice in a nation other than the one in which they are licensed and normally provide services so long as the host nation permits such practice and the provider is not on the HHS sanctions list. The ability of the provider to practice in the host nation remains the province of the host nation; this modification would ensure that services provided within the licensure requirements of the host nation would be reimbursable under TRICARE.

This provision, 32 CFR 199.17(l)(3), delineates requirements for cost-shares and copayments under the TRICARE program. This IFR would amend the regulation to add a new provision waiving cost-shares and copayments (including deductibles) for all in-network authorized telehealth services for the duration of the COVID-19 pandemic (ending when the President's state of emergency declaration is suspended or terminated, in accordance with applicable law and regulation). This will incentivize TRICARE beneficiaries to utilize telehealth services and avoid unnecessary in-person TRICARE-authorized provider visits, which could potentially bring them into contact with or inadvertently aid in the spread of COVID-19. This will apply to TRICARE Prime and Select beneficiaries in all geographic areas.

D. Legal Authority for This Program

This rule is issued under 10 U.S.C. 1073(a)(2) giving authority and

responsibility to the Secretary of Defense to administer the TRICARE program. The text of 10 U.S.C. chapter 55 can be found at <https://manuals.health.mil/>.

II. Regulatory History

Each of the sections being modified by this rule are revised every few years to ensure requirements continue to align with the evolving health care field. Title 32 CFR Section 199.4 was most recently updated on September 29, 2017, with an IFR (82 **Federal Register** (FR) 45438) that implemented the Congressionally-mandated TRICARE Select benefit plan. Its revision to 32 CFR 199.4 included the addition of medically necessary foods as a benefit under the TRICARE Basic Program. No revisions have been made to the telehealth services paragraph being revised by this IFR, § 199.4(g)(52), in at least 20 years.

The most recent update to 32 CFR 199.6 was on March 17, 2020 (85 FR 15061), which added physical therapist assistants and occupational therapy assistants as TRICARE-authorized providers. Six hundred eighty-one comments, none of which were substantial, were received on the proposed rule associated with that change, and all were resolved in the final rule. The particular provision being modified by this IFR regarding provider licensure, Section 199.6(c)(2)(i) is a long-standing requirement of the TRICARE program, and has not been revised in over 20 years.

Title 32 CFR Section 199.17 was last revised on February 15, 2019 (84 FR 4333), as part of the final rule implementing the TRICARE Select benefit plan. The revisions to Section 199.17 included adding high-value services as a benefit under the TRICARE program, as well as copayment requirements for Group B beneficiaries. The 32 CFR 199.17(l) paragraph being modified by this IFR was created as part of the IFR that established the TRICARE Select benefit (82 FR 45438) during which a comprehensive revision of Section 199.17 occurred. This paragraph did not exist prior to that revision and has not been modified since.

III. Regulatory Analysis

A. Regulatory Planning and Review

a. Executive Orders

Executive Order 12866, "Regulatory Planning and Review" and Executive Order 13563, "Improving Regulation and Regulatory Review"

Executive Orders 13563 and 12866 direct agencies to assess all costs and benefits of available regulatory

alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility.

Accordingly, the rule has been reviewed by the Office of Management and Budget (OMB) under the requirements of these Executive Orders. This rule has been designated a “significant regulatory action,” and determined to be not economically significant, under section 3(f) of Executive Order 12866. This rule is not expected to have a significant impact on the economy; however, the urgency of the change due to the global pandemic makes it a significant regulatory action.

b. Summary

The modifications to Section 199.4(g)(52) in this IFR will allow TRICARE beneficiaries to obtain telephonic (audio) office visits with TRICARE-authorized providers for otherwise-covered, medically necessary care and treatment and allow reimbursement to those providers during the COVID–19 pandemic. It provides an exception to the regulatory exclusion prohibiting audio-only telephone services.

The modifications to Section 199.6(c)(2)(i) in this IFR will allow providers to be reimbursed for interstate practice, both in person and via telehealth, during the global pandemic so long as the provider meets the

requirements for practicing in that state or under federal law. It removes the requirement that the provider must be licensed in the state where practicing, even if that license is optional. For providers overseas, this will allow providers, both in person and via telehealth, to practice outside of the nation where licensed when permitted by the host nation.

The modifications to Section 199.17(l)(3) will remove cost-shares and copayments for telehealth services for TRICARE Prime and Select beneficiaries utilizing telehealth services with an in-network, TRICARE-authorized provider during the global pandemic. It adds in-network telehealth services as a special cost-sharing rule to waive the beneficiary copay.

c. Affected Population

This rule impacts all 9.5 million TRICARE beneficiaries, TRICARE-authorized providers, the TRICARE Program, and its contractors, both in the United States and overseas. TRICARE beneficiaries will be impacted through increased access to telehealth services and to providers who might surge to help with areas of high medical need. Providers will be impacted by being able to provide services in any state or nation that allows them to do so without risking loss of reimbursement for those services. TRICARE’s health care contractors will be impacted by being required to implement the provisions of this regulatory change. While states will not be directly impacted by this change, this change will support efforts by states to ensure enough providers are available to provide services to TRICARE beneficiaries within their jurisdictions

when those states relax licensing requirements for interstate practice.

d. Costs

The cost estimates related to the changes discussed in this IFR include health care and administrative costs to the government and beneficiary cost impact. The duration of the COVID–19 emergency is uncertain, therefore estimated three-, six-, and nine-month scenarios for the impact of this IFR are presented.

Health Care Costs Associated With Removing Copays for Telehealth

There are three factors that would increase DoD health care costs due to this rule. First, the government would lose cost-sharing revenue paid by beneficiaries on the existing level of telehealth visits. Second, there would be induced demand costs, as removal of patient costs will increase patient demand for these services. Finally, there would be a substitution effect, as the COVID–19 pandemic and removal of telehealth cost-shares would encourage a shift from in-person visits, for which beneficiaries would pay a copay, to telehealth visits, which would be free to beneficiaries. The estimated direct loss of copay revenue is estimated at: \$156,949.00 for three-month waiver; \$313,897.00 for six months; and \$470,846.00 for nine months. The projected induced demand due to zero cost-sharing for telehealth visits, (relative to existing utilization) per 3 months is estimated at \$117,772.00. Regarding the estimated cost associated with the substitution effect, see Table 1. Assumed Shifts of Historical Visits from In-Person to Telehealth.

TABLE 1—ASSUMED SHIFTS OF HISTORICAL VISITS FROM IN-PERSON TO TELEHEALTH

	Non-preventive primary care and urgent care (%)	Mental health (%)	Government cost increase
During months 1–3	25	90	\$26,673,895
During months 4–6	20	75	21,937,107
During months 7–9	10	67	16,848,793
3-month scenario overall	25	90	26,673,895
6-month scenario overall	23	83	48,611,002
9-month scenario overall	18	77	65,459,795

Administrative Costs

The estimated total contractor start-up administrative costs to implement this change is approximately \$67,000. This includes a one-time change to the

contractors’ claims processing systems and education of network providers.

Combined Health Care and Administrative Costs

Table 2 provides a summary of the combined government health care and administrative costs of the IFR.

TABLE 2—SUMMARY OF GOVERNMENT COSTS OF THE PROPOSED COVID-19 TELEHEALTH IFR

	3-month scenario	6-month scenario	9-month scenario
Government Health care Cost (HC):			
Loss of copays on existing telehealth	\$156,949	\$313,897	\$470,846
Induced demand	117,772	235,544	353,316
Loss of copays on in-person shifting to Telehealth	26,673,895	48,611,002	65,459,795
Subtotal, Government HC cost	26,948,616	49,160,443	66,283,957
Start-up administrative cost	67,494	67,494	67,494
Total Government Cost increase	27,016,110	49,227,937	66,351,451

Beneficiary Cost Impact

There are two types of savings for beneficiaries estimated here. First, beneficiaries would avoid the cost-sharing they otherwise would have paid on existing telehealth visits and on in-person visits that would shift to telehealth. It is estimated the cost-sharing savings to beneficiaries would be: \$26,830,844.00 for a three-month scenario; \$48,924,899.00 for a six-month

scenario; and \$65,930,641.00 for a nine-month scenario. Second, for the share of historical visits that is estimated would shift from in-person to telehealth, beneficiaries would avoid travel time and time spent in the provider's waiting room. Two parameters were considered in developing the estimate of the value of time saved for TRICARE beneficiaries: (1) The average amount of time saved per visit, and (2) a monetized estimate of the value of the time saved,

based on the opportunity cost of that time. We estimated that beneficiaries would save an average of 60 minutes per visit for avoided travel and time waiting at the provider's office. We converted this average time saved per visit to a monetized value to the beneficiary at \$20 per hour as the average after-tax wage rate. See Table 3 Estimated Value to Beneficiaries for the combined results of avoided cost-sharing and dollar value of saved time.

TABLE 3—ESTIMATED VALUE TO BENEFICIARIES

	3-month scenario	6-month scenario	9-month scenario
Avoided cost-sharing	\$26,830,844	\$48,924,899	\$65,930,641
Dollar value of time saved	17,085,995	31,089,668	41,384,466
Total estimated value to beneficiaries	43,916,839	80,014,567	107,315,107

Another important value to beneficiaries that is not feasible to estimate but worth noting is the possibility that shifting visits from in-person to telehealth might reduce the risk of COVID-19 exposure, with all the potential benefits that could accompany that reduced exposure risk. This reduced risk of COVID-19 exposure will likely result in downstream reductions in costs to the TRICARE Program in avoided COVID-19 diagnostics and treatment, although it is also not feasible to estimate these cost savings.

e. Benefits

This change will have a positive impact on beneficiaries by incentivizing the use of telehealth while reducing their cost to do so. This change will have a positive impact on providers, who will be able to serve TRICARE beneficiaries where they are and increase their ability to reach beneficiaries through telehealth. Further, this change will have a positive societal impact by inducing demand for telehealth services and reducing the number of TRICARE beneficiaries seeking in-person health care services and potentially reducing the spread of

COVID-19. Finally, though we are unable to quantify, the Department may have some reduced costs due to reduced spread and exposure of TRICARE beneficiaries to COVID-19, partially offsetting some of the costs associated with expansion of benefits and copayment waivers.

f. Alternatives

The DoD considered several alternatives to this IFR. The first alternative involved taking no action. Although this alternative would be the most cost neutral for DHA, it was rejected as not addressing the urgent medical needs of the beneficiary population in response to the COVID-19 pandemic.

The second alternative DoD considered was to only apply the regulatory modifications to COVID-19-related diagnoses. This was rejected because the effects of the COVID-19 pandemic are causing stress on the entire health care system. The regulatory modifications in this IFR will take the pressure off of the health care system by: (1) Covering telephonic office visits with a TRICARE-authorized provider and thereby supporting social

distancing recommendations; (2) covering TRICARE-authorized providers practicing across state lines, thereby increasing the overall access to medical care and treatment; and (3) waiving all copayments for in-network telehealth services for TRICARE Prime and Select beneficiaries, thereby removing the potential cost barrier to obtaining medical services remotely and inducing demand for these services, reducing potential person-to-person transmission of COVID-19 during medical appointments.

B. Public Law 96-354, “Regulatory Flexibility Act” (5 U.S.C. 601)

The Department of Defense certifies that this IFR is not subject to the Regulatory Flexibility Act (5 U.S.C. 601) because it would not, if promulgated, have a significant economic impact on a substantial number of small entities. Therefore, the Regulatory Flexibility Act, as amended, does not require us to prepare a regulatory flexibility analysis.

C. Congressional Review Act

Pursuant to the Congressional Review Act (5 U.S.C. 801 *et seq.*), the Office of Information and Regulatory Affairs

designated this rule as not a major rule, as defined by 5 U.S.C. 804(2).

D. Sec. 202, Public Law 104-4, “Unfunded Mandates Reform Act”

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) (2 U.S.C. 1532) requires agencies to assess anticipated costs and benefits before issuing any rule whose mandates require spending in any one year of \$100 million in 1995 dollars, updated annually for inflation. This IFR will not mandate any requirements for State, local, or tribal governments, nor will it affect private sector costs.

E. Public Law 96-511, “Paperwork Reduction Act” (44 U.S.C. Chapter 35)

It has been determined that 32 CFR part 199 does not impose reporting or recordkeeping requirements under the Paperwork Reduction Act of 1995.

F. Executive Order 13132, “Federalism”

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

List of Subjects in 32 CFR Part 199

Administrative practice and procedure, Claims, Fraud, Health care, Health insurance, Individuals with disabilities, Mental health programs, and Military personnel.

Accordingly, 32 CFR part 199 is amended to read as follows:

PART 199—CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES (CHAMPUS)

■ 1. The authority citation for part 199 continues to read as follows:

Authority: 5 U.S.C. 301; 10 U.S.C. chapter 55.

■ 2. Section 199.4 is amended by revising paragraph (g)(52) to read as follows:

§ 199.4 Basic program benefits.

* * * * *

(g) * * *

(52) *Telephone services.* Services or advice rendered by telephone are excluded, except that: (i) Telephone services (audio-only) are not excluded when otherwise covered TRICARE services are provided to a beneficiary through this modality during the coronavirus 2019 (COVID-19) public health national emergency, if the

services are medically necessary and appropriate, and

(ii) A diagnostic or monitoring procedure which incorporates electronic transmission of data or remote detection and measurement of a condition, activity, or function (biotelemetry) is not excluded when:

(A) The procedure without electronic transmission of data or biotelemetry is otherwise an explicit or derived benefit of this section;

(B) The addition of electronic transmission of data or biotelemetry to the procedure is found by the Director, CHAMPUS, or designee, to be medically necessary and appropriate medical care which usually improves the efficiency of the management of a clinical condition in defined circumstances; and

(C) The each data transmission or biotelemetry devices incorporated into a procedure that is otherwise an explicit or derived benefit of this section, has been classified by the U.S. Food and Drug Administration, either separately or as a part of a system, for consistent use with the defined circumstances in paragraph (g)(52)(ii) of this section.

* * * * *

■ 3. Section 199.6 is amended by revising paragraph (c)(2)(i) to read as follows:

§ 199.6 TRICARE-authorized providers.

* * * * *

(c) * * *

(2) * * *

(i) *Professional license requirement.*

The individual must be currently licensed to render professional health care services in each state in which the individual renders services to CHAMPUS beneficiaries. Such license is required when a specific state provides, but does not require, license for a specific category of individual professional provider. The license must be at full clinical practice level to meet this requirement. A temporary license at the full clinical practice level is acceptable. During the period of national emergency for the global coronavirus 2019 (COVID-19) pandemic, a license is not required in the United States for each state in which the provider practices, so long as the provider holds an equivalent license in another state, the state in which the provider is practicing permits such practice under its interstate licensing requirements or the state licensing requirements have been preempted by Federal law, and the provider is not affirmatively barred or restricted from practicing in any state. During the COVID-19 pandemic, providers overseas are not required to be licensed

in each nation in which the provider operates, so long as the provider holds an equivalent license in another nation, the host nation permits such practice under its licensing requirements, and the provider is not on the Department of Health and Human Services sanction list.

* * * * *

- 4. Amend § 199.17 by:
 - a. Redesignating paragraph (l)(3)(A) and (B) as (l)(3)(i) and (ii).
 - b. Adding paragraph (l)(3)(iii).
 - c. Redesignating paragraphs (l)(4)(A) and (B) as (l)(4)(i) and (ii).

The addition reads as follows:

§ 199.17 TRICARE program.

* * * * *

(l) * * *

(3) * * *

(iii) Cost-sharing and copayments (including deductibles) shall be waived for in-network telehealth services during the national emergency for the global coronavirus 2019 (COVID-19) pandemic.

* * * * *

Dated: May 6, 2020.

Morgan E. Park,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 2020-10042 Filed 5-8-20; 4:15 pm]

BILLING CODE 5001-06-P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[EPA-R01-OAR-2019-0695; FRL-10009-41-Region 1]

Air Plan Approval; Massachusetts; Infrastructure State Implementation Plan Requirements for the 2015 Ozone Standard; Withdrawal of Direct Final Rule

AGENCY: Environmental Protection Agency (EPA).

ACTION: Withdrawal of direct final rule.

SUMMARY: Due to the receipt of an adverse comment, the Environmental Protection Agency (EPA) is withdrawing the March 13, 2020 direct final rule approving a State Implementation Plan (SIP) revision submitted by the Commonwealth of Massachusetts. Massachusetts' SIP revision approved the infrastructure requirements to demonstrate the Commonwealth has the necessary resources to comply with the 2015 ozone National Ambient Air Quality Standard. This action is being taken in accordance with the Clean Air Act.