their bicycle and pedestrian facilities.[4] The average number of miles of existing shared use paths per city was 70 miles, and ranged from 3.1 miles in Milwaukee to 328 miles in New York City. The cities used federal funds to construct many of the shared use paths.

As discussed above, the proposed technical provisions applicable to shared use paths are consistent with the AASHTO Guide. State and local government entities that design and construct shared use paths generally use the AASHTO Guide. The SNPRM is not expected to increase the costs of constructing shared use paths for state and local government entities that use the AASHTO Guide.

We request comments on the following to assess the impacts of the SNPRM:

- The extent to which the AASHTO Guide, or other design guides and standards are used for shared use paths.
- Whether any of the proposed provisions applicable to shared use paths would result in additional costs for design work, materials, earthmoving, retaining structures, or other items compared to construction practices or design guides and standards currently used? Commenters are encouraged to identify the specific provisions that would result in additional costs and estimate the additional costs on a per mile basis to the extent possible.
- Whether any of the proposed provisions applicable to shared use paths would result in any additional costs, such as maintenance and operational costs, compared to current practices? Commenters are encouraged to identify the specific provisions that would result in additional costs and estimate the additional costs on a per mile basis to the extent possible.
- What are the benefits of the proposed provisions applicable to shared use paths?

List of Subjects in 36 CFR Part 1190

Buildings and facilities, Civil rights, Individuals with disabilities, Transportation.

Susan Brita,

Chair.

[FR Doc. 2013–03298 Filed 2–12–13; 8:45 am]

BILLING CODE 8150–01–P

[4] Alliance for Biking and Walking, ''Bicycling and Walking in the United States 2012 Benchmarking Report.''

The report is available at: *http://www.peoplepoweredmovement.org/site/.*

DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 17

RIN 2900–AO15

Use of Medicare Procedures To Enter Into Provider Agreements for Extended Care Services

AGENCY: Department of Veterans Affairs.

ACTION: Proposed rule.

SUMMARY: This rulemaking proposes to amend the medical regulations of the Department of Veterans Affairs (VA) to allow VA to use Medicare or State procedures to enter into provider agreements to obtain extended care services from non-VA providers. In addition, this rulemaking proposes to include home health care, palliative care, and noninstitutional hospice care services as extended care services, when provided as an alternative to nursing home care. Under this proposed rule, VA would be able to obtain extended care services for veterans from providers who are closer to veterans' homes and communities.

DATES: Comments must be received by VA on or before March 15, 2013.

ADDRESSES: Written comments may be submitted by email through *http://www.regulations.gov*; by mail or hand-delivery to Director, Regulations Management (02REG), Department of Veterans Affairs, 810 Vermont Avenue NW., Room 1068, Washington, DC 20420; or by fax to (202) 273–9026. Comments should indicate that they are submitted in response to ''RIN 2900–AO15, Use of Medicare Procedures to Enter Into Provider Agreements for Extended Care Services.'' 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. 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: Daniel Schoeps, Office of Geriatrics and Extended Care (10P4G), Department of Veterans Affairs, 810 Vermont Avenue NW., Washington, DC 20420; (202) 461–6763. (This is not a toll-free number.)

SUPPLEMENTARY INFORMATION: Subsection (a) of 38 U.S.C. 1710B authorizes VA to provide extended care services to eligible veterans, including geriatric evaluation, nursing home care, domiciliary services, and adult day health care. Subsection (a) of 38 U.S.C. 1720 authorizes VA to pay for the nursing home care in non-VA facilities of eligible veterans and eligible members of the Armed Forces. Section 1720(f) authorizes VA to furnish (in VA and non-VA facilities) adult day health care to enrolled veterans who would otherwise need nursing home care. Contracts between VA and these non-VA facilities are currently negotiated under Federal contract statutes and regulations (including the Federal Acquisition Regulation, which is set forth at 48 CFR chapter 1; and VA Acquisition Regulations, which are set forth at 48 CFR chapter 8).

We propose to establish a new 38 CFR 17.75, which would implement VA's authority to use Medicare procedures to enter into provider agreements. Section 105 of the Veterans Health Care, Capital Asset, and Business Improvement Act of 2003 (Pub. L. 108–170) amended section 1720 to authorize VA to use these procedures. This amendment, which is codified at 38 U.S.C. 1720(c)(1), authorizes VA to enter into agreements with providers of nursing home care, adult day health care, and other community-based extended care services under ''the procedures available for entering into provider agreements under section 1866(a) of the Social Security Act.'' Section 1866(a) (codified at 42 U.S.C. 1395cc(a)) authorizes the Department of Health and Human Services to enter into agreements with participating Medicare providers, and specifies the terms of those agreements.

The plain language of 38 U.S.C. 1720(c)(1)(B) authorizes VA, in its discretion, to furnish extended care services through non-VA providers using the above-described noncontractual mechanism. Moreover, the legislative history of Public Law 108–170 further shows that its purpose was to improve VA's ability to furnish eligible veterans with extended care services of non-VA providers by using a noncontractual mechanism. A Senate committee report explains that Medicare procedures are simpler and less burdensome than VA contracting procedures. The report includes the following discussion of this provision:

> Under current law, VA is authorized to enter into contractual arrangements with private providers of extended care services to serve the needs of veterans. Federal reporting requirements relating to the demographics of contractor employees and applicants are required to be submitted to the Department of Labor under these contractual arrangements. The Committee has learned that, due to these reporting requirements,

many small providers of extended care services are unable, or they are unwilling, to admit VA patients. Many such providers have apparently concluded that reimbursement from VA for caring for one or two veterans is not worth the cost of compiling and reporting the data required by general Federal contract law.

The Social Security Act allows the Centers for Medicare and Medicaid Services (hereinafter, ''CMS'') to enter into provider agreements for the provision of care to both Medicare and Medicaid beneficiaries. Such agreements require that contractors comply with Federal laws concerning hiring practices. But they do not require that providers prepare reports of such compliance. Nor do they subject providers to annual audits like most Federal contracts do. Not surprisingly, CMS is more successful than VA in inducing smaller providers to provide care to its beneficiaries.

Section 102 of the Committee bill places VA contractors in a similar position as CMS contractors with respect to Federal reporting requirements. By this action, the Committee seeks to encourage VA to bring care closer to veterans' homes and community support structures by contracting with small community-based providers. Even so, however, the Committee fully anticipates and expects that VA will require compliance with all applicable Federal laws concerning employment and hiring practices.

S. Rep. No. 108–193, at 6 (2003), as reprinted in 2003 U.S.C.C.A.N. 1783, 1788. To clarify the above quotation, the Social Security Act allows for the Centers for Medicare and Medicaid Services (CMS) to enter into provider agreements with Medicare providers only. States, not CMS, enter into provider agreements with Medicaid providers. Medicare agreements enable a provider to bill and receive reimbursement for Medicare-covered services furnished by the provider. The terms of those agreements often concern the kind and quality of care to be provided. Although those CMS and State agreements do not involve the provision of care, Congress specifically authorized VA to use provider agreements under 38 U.S.C. 1720(c)(1)(B) ''for furnishing'' care. Accordingly, we propose to establish a VA regulation regarding use of provider agreements. We believe that by using these agreements, VA would be able to obtain services from providers who are closer to veterans' homes and community support structures.

Proposed § 17.75(a) would define ''[e]xtended care services'' as ''geriatric evaluation; nursing home care; domiciliary services; adult day health care; noninstitutional palliative care, noninstitutional hospice care, and home health care when they are noninstitutional alternatives to nursing home care; and respite care.'' The proposed definition is derived from 38 U.S.C. 1710B(a), which requires VA to ''operate and maintain a program to provide extended care services,'' and requires that such extended care services include geriatric evaluation, nursing home care, domiciliary services, adult day health care, respite care, and ''[s]uch other noninstitutional alternatives to nursing home care as the Secretary may furnish as medical services under [38 U.S.C. 1701(10)].'' 38 U.S.C. 1710B(a)(1)–(6).

We propose to include home health care in the definition of ''[e]xtended care services'' as a noninstitutional alternative to nursing home care because in many circumstances it would be a noninstitutional alternative to nursing home care. For example, a veteran applying for nursing home care would receive a person-centered assessment by a VA health care team. The team, working with the veteran and caregiver, would explore care needs and how these needs could be met. In this process, they may decide that a combination of skilled nursing, home health aide, and respite services would meet the veteran's needs and allow the veteran to remain at home. In this case, home health services would avert a nursing home placement. We also propose to include noninstitutional palliative and noninstitutional hospice care in the definition because they would always be alternatives to nursing home care.

We understand that Medicare and States do not necessarily enter into provider agreements for all the services listed under the proposed definition for ''extended care services.'' We are proposing only to enter into provider agreements with providers that do have a Medicare or State provider agreement for the services listed in this proposed rule as ''extended care services.'' VA would continue to use contracts and other mechanisms to ensure that veterans receive needed health care services for which they are eligible, but for which there is no available provider agreement. Additionally, many States enter into provider agreements for a broader array of services than those listed in this proposed rule. We do not intend to enter into agreements that would expand beyond the scope of those services specifically listed in the proposed definition of extended care services.

Including home health care, noninstitutional palliative care, and noninstitutional hospice care in the definition of extended care services would not require VA to consider these services as extended care services for purposes of determining whether a copayment is required. Noninstitutional hospice care is exempt from both outpatient and extended care copayments. 38 U.S.C. 1710(g)(1), 1710B(c)(2)(B). Noninstitutional palliative care is a form of home health care, and the law currently requires VA to charge the outpatient copayment for home health care. 38 U.S.C. 1710(g)(1).

As noted above, under 38 U.S.C. 1710B(a)(5), VA is required to ''operate and maintain a program to provide extended care services'' that includes ''[s]uch * * * noninstitutional alternatives to nursing home care as the Secretary may furnish as medical services under [38 U.S.C. 1701(10)]''. 38 U.S.C. 1710B(a)(5). However, section 1701 no longer contains a subsection (10).

Prior to enactment of section 801 of Public Law 110–387, 38 U.S.C. 1701(10) defined medical services to include noninstitutional extended care services provided through December 31, 2008, and defined such services as follows: ''[T]he term 'noninstitutional extended care services' means such alternatives to institutional extended care which [VA] may furnish (i) directly, (ii) by contract, or (iii) (through provision of case management) by another provider or payer.'' See 38 U.S.C. 1710(10) (2008). With the enactment of Public Law 110–387 in 2008, section 1701 was amended to essentially move subsection (10) to subsection (6)(E) of section 1701 which provides that medical services include ''[n]oninstitutional extended care services, including alternatives to institutional extended care that [VA] may furnish directly, by contract, or through provision of case management by another provider or payer.'' Public Law 110–387, title VIII, § 801 (Oct. 10, 2008). Thus, the language of former subsection (10) and current subsection (6)(E) is virtually identical, except that subsection (6)(E) does not contain the 2008 sunset provision. We therefore believe that the reference to section 1701(10) in 38 U.S.C. 1710B(a)(5) must now be read as a reference to section 1701(6)(E).

Consistent with section 1720(c)(1), we would define ''[p]rovider'' in § 17.75(a) to mean any non-VA entity that provides extended care services and is participating in Medicare under title XVIII of the Social Security Act or a State Medicaid plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) pursuant to a valid provider agreement. This could include physicians and other providers who provide extended care services to veterans in non-VA nursing homes.

In proposed paragraph (b), we would implement VA's authority under section 1720(c)(1) to obtain extended care

services from non-VA providers, and would set forth the conditions under which such services may be obtained. Paragraph (b)(1) would prescribe that VA may enter into provider agreements for extended care services with non-VA providers who have a Medicare provider agreement with CMS. Paragraph (b)(2) would prescribe that VA may also enter into provider agreements for extended care services with non-VA providers who do not have a Medicare provider agreement with CMS if the provider is participating in a State Medicaid plan. Section 1720(c)(1) clearly authorizes VA to enter into provider agreements with non-VA providers of extended care services that participate in the Medicare program or a State Medicaid plan. A number of States enter into provider agreements related to services not otherwise covered by Medicare. For example, States often enter into provider agreements with Medicaid adult day health care providers, which are not eligible for similar agreements under Medicare.

Proposed paragraph (c)(1) would establish the procedure that VA would use to notify a provider of the agreement that VA proposes to use to obtain extended care services from the provider. The Director of the VA medical center of jurisdiction would provide written notification identifying the applicable Medicare or State Medicaid provider agreement to be used and the changes and additional terms that would apply to the agreement with VA, and would request written acceptance of the agreement from the provider. This documentation would serve as a record for both VA and the provider that an agreement is in place and of the parties' acceptance of all the terms of the adopted agreement. Therefore, VA would not attempt to obtain services under a provider agreement from the provider until after the provider's acceptance is received. For providers with both Medicare and State Medicaid agreements, the letter would clarify which of the two provider agreements would be used as the basis for VA's provider agreement.

Paragraph (c)(2) would establish that the terms and rates of a provider's agreement with VA would be the same as the terms and rates of the provider's separate Medicare provider agreement with CMS or agreement under a State Medicaid plan, or, if a provider has agreements with both Medicare and under a State Medicaid plan, the terms and rates would be the same as the agreement with the highest rates. VA's payment under the agreement with the highest rates would serve as an incentive to encourage providers to enter into agreements with VA for the care of veterans. We interpret VA's authority under section 1720(c)(1)(B) to use Medicare procedures as also authorizing the use of rates established under the appropriate Medicare fee schedule or payment system because there are no procedures for rate negotiation in obtaining Medicare provider agreements.

Although a provider's agreement with VA would generally contain the same terms as the provider's separate Medicare provider agreement or agreement under a State Medicaid plan, VA would need unique terms for purposes of identifying VA as the Government agency entering into the agreement with the provider and paying for the provider's services for veterans. Since the purpose of this proposed rule is to address the needs of specific veterans or groups of veterans based upon location and the availability of VA resources, VA might also need unique agreement terms to limit the scope of the agreement consistent with VA's authority under section 1720(c)(1)(B). Accordingly, proposed paragraph (c)(3) would clarify that a provider's agreement with VA will not be the same as the provider's agreement with CMS under Medicare or under a State Medicaid plan to the extent that the provider's agreement with VA will identify VA as the Government agency entering into the agreement and specify that the provider's services are for specific veterans or groups of veterans. It would also make clear that the provider's agreement with VA would be administered by VA according to the procedures in this proposed rule and not under the rules applicable to the administration of Medicare provider agreements with CMS or agreements under a State Medicaid plan. In all other respects, VA intends that a provider's agreement with VA will be the same as the provider's Medicare provider agreement with CMS or under a State Medicaid plan.

Proposed paragraph (d) would delegate to the Director of the VA medical center of jurisdiction (or a designee) the authority to enter into an agreement under the proposed rule. Under paragraph (d)(1), we would also establish that the criteria for whether to enter into an agreement under this section will be based on the needs of local veterans and the ability of VA to provide for those needs. For example, where VA does not provide equivalent care in a particular locality, or where providing VA care would be more expensive than providing care through a non-VA provider, VA would enter into agreements under this section. Similarly, if resources permit, wherever possible VA would enter into an agreement with a provider selected by the veteran. This is consistent with the purpose of section 1720(c)(1)(B), which is to help veterans receive the care that they require from providers in their own communities, as well as to improve the efficiency of care delivery from an economic perspective. However, we do not interpret section 1720(c)(1) as creating any right to care pursuant to a provider agreement or any right to enter into a provider agreement with VA. We interpret the statute as authorizing care pursuant to an agreement when a Director, based upon medical judgment and evaluation of available resources, determines that an agreement is in the best interest of the veteran under the Director's care.

Under proposed paragraph (d)(2), VA would empower the veteran to select his or her preferred provider, should more than one provider exist within a given region, subject to the provider's determination to accept the veteran, clinical appropriateness and available resources at the VA medical center of jurisdiction. VA understands the significance of placing such an important life decision in the hands of the veteran and would only intervene if a provider was not able to provide the care clinically required by the veteran, or the VA medical center of jurisdiction is simply unable to accommodate the veteran's selection due to limited resources. Foreseeable strains on resources that might prevent VA from accommodating a veteran's request could include whether the veteran has special needs that can be addressed by resources in that region or whether VA has sufficient staff to monitor the veteran in a particular facility due to the facility being remote or because VA is monitoring several veterans at another facility that is distant from the veteran's preferred provider. The decision to approve or deny a particular provider for an agreement with VA would be made by the Director (or designee) according to the criteria prescribed in paragraphs (d)(2)(A), (B), and (C).

Proposed paragraph (d)(3) would establish that the factual determination of whether a provider is eligible to enter into an agreement with VA to provide extended care services for veterans will be made based on evidence of an existing Medicare provider agreement or agreement under a State Medicaid plan as verified through Web sites maintained by CMS or the appropriate State office.

Proposed paragraph (e) would govern termination of a VA provider agreement. Under paragraph (e)(1), we would allow

a provider to voluntarily terminate an agreement but we would require the provider to notify VA at least 15 days in advance of the planned termination and provide the intended date of termination. The 15-day requirement would provide VA with a reasonable amount of time to secure alternative arrangements for affected veterans. VA would require 15 days to find an arrangement that is suitable for the veteran and provides a potential for long-term care. We determined that a notice of termination period of less than 15 days would likely require an unsatisfactory short-term solution. Such a solution might require multiple relocations of, or multiple caregiver changes for, an affected veteran in order to meet their immediate health care needs. We have determined that the 15-day notice requirement would allow VA to protect veterans from the physical, mental, and emotional health risks caused by multiple changes in their care plan and/or living arrangement.

Proposed paragraph (e)(2) would set forth when VA may terminate an agreement. VA would also be required to give providers at least 15 days notice before terminating an agreement. If, however, VA finds that the health of the veteran is in immediate jeopardy, VA would be authorized to terminate the agreement with only 2 days notice. The termination of the agreement should not be confused with VA's ability to physically remove the veteran from a dangerous situation, which can be done as soon as necessary in order to protect the health of the veteran. Proposed paragraph (e)(2) thus would assert VA's right to remove a veteran from a dangerous situation prior to terminating the applicable provider agreement.

Proposed paragraph (f) would establish procedures for appeal of a Director's decision not to enter into a VA provider agreement or to terminate an agreement. A provider may appeal a decision issued by the Director by filing a written request for review with the Chief Consultant, Office of Geriatrics and Extended Care. An appeal must be filed in writing within 90 days after the date of the Director's decision. The Chief Consultant would provide written notice of the determination, which would constitute the final agency decision regarding eligibility for or termination of a VA provider agreement. The notice would explain why the decision is appropriate.

Proposed paragraph (g) would state that providers need not comply with the Service Contract Act of 1965 (set forth at 41 U.S.C. 351, et seq.). This is the law referred to in the legislative history that requires contractors to report to the Department of Labor. While this Act applies to contracts entered into by the United States for services through the use of service employees, it does not apply to Medicare providers because they do not enter into contracts with the United States—Medicare provider agreements with CMS are used instead of contracts. However, proposed paragraph (g) would require that providers comply with all other applicable Federal laws concerning employment and hiring practices including the Fair Labor Standards Act, National Labor Relations Act, the Civil Rights Acts, the Age Discrimination in Employment Act of 1967, the Vocational Rehabilitation Act of 1973, Worker Adjustment and Retraining Notification Act, Sarbanes-Oxley Act of 2002, Occupational Health and Safety Act of 1970, Immigration Reform and Control Act of 1986, Consolidated Omnibus Reconciliation Act, the Family and Medical Leave Act, the Americans with Disabilities Act, the Uniformed Services Employment and Reemployment Rights Act, the Immigration and Nationality Act, the Consumer Credit Protection Act, the Employee Polygraph Protection Act, and the Employee Retirement Income Security Act. This is consistent with the legislative history set forth above.

We would rescind all conflicting internal VA guidance that could be interpreted as providing an alternate benefit pertaining to extended care services. Specifically, we would rescind Veterans Health Administration (VHA) Handbooks 1143.2, ''VHA Community Nursing Home Oversight Procedures''; 1140.6, ''Purchased Home Health Care Services Procedures''; and 1140.5, ''Community Hospice Care: Referral and Purchase Procedures''; and VHA Manual M–5 Part III, Chapter 6, pertaining to Community Residential Care. This policy guidance would be reissued in connection with the final rule.

Executive Orders 12866 and 13563

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 to be a significant regulatory action under the Executive Order.

Comment Period

Although under the rulemaking guidelines in Executive Order 12866, VA ordinarily provides a 60-day comment period, the Secretary has determined that there is good cause to limit the public comment period on this proposed rule to 30 days. VA does not expect to receive a large number of comments on this proposed rule, particularly comments that are negative or that oppose this rule, because it would increase the opportunity for veterans to obtain non-VA extended care services from local providers that furnish vital and often life-sustaining medical services. Accordingly, VA has provided that comments must be received within 30 days of publication in the **Federal Register**.

Paperwork Reduction Act

The proposed rule does not contain any collections of information under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3521).

Regulatory Flexibility Act

The Secretary hereby certifies that the provisions of this proposed rule would not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act, 5 U.S.C. 601–612. The proposed rule would not have a significant economic impact on any small entities because such entities would obtain only an insignificant

portion of their business from VA. Therefore, pursuant to 5 U.S.C. 605(b), this rulemaking is exempt from the initial and final regulatory flexibility analysis requirements of sections 603 and 604.

Unfunded Mandates

The Unfunded Mandates Reform Act 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 an expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of $100 million or more (adjusted annually for inflation) in any one year. This proposed rule would have no such effect on State, local, and tribal governments, or on the private sector.

Catalog of Federal Domestic Assistance

The Catalog of Federal Domestic Assistance program numbers and titles affected by this rulemaking are 64.007, Blind Rehabilitation Centers; 64.009, Veterans Medical Care Benefits; 64.010, Veterans Nursing Home Care; 64.011, Veterans Dental Care; 64.013, Veterans Prosthetic Appliances; 64.018, Sharing Specialized Medical Resources; 64.019, Veterans Rehabilitation Alcohol and Drug Dependence; and 64.022, Veterans Home Based Primary Care.

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. John R. Gingrich, Chief of Staff, Department of Veterans Affairs, approved this document on February 5, 2013, for publication.

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 record-keeping requirements, Scholarships and fellowships, Travel and transportation expenses, Veterans.

Dated: February 6, 2013.

Robert C. McFetridge,

Director of Regulation Policy and Management, Office of the General Counsel, Department of Veterans Affairs.

For the reasons set forth in the preamble, VA proposes to amend 38 CFR Part 17 as follows:

PART 17—MEDICAL

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

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

■ 2. Add an undesignated center heading and § 17.75 immediately after § 17.74 to read as follows:

Agreements for Extended Care Services

§ 17.75 Agreements for extended care services.

(a) *Definitions.* For purposes of this section:

Extended care services means geriatric evaluation; nursing home care; domiciliary services; adult day health care; noninstitutional palliative care, noninstitutional hospice care, and home health care when they are noninstitutional alternatives to nursing home care; and respite care.

Provider means any non-VA entity that provides extended care services and is participating in Medicare or a State plan under title XIX of the Social Security Act pursuant to a valid provider agreement.

(b) *Eligible providers from whom VA may obtain extended care services.* Subject to paragraph (d) of this section, VA may obtain extended care services from providers under this section only if:

(1) The provider has entered into a Medicare provider agreement under 42 U.S.C. 1395cc(a) with the Centers for Medicare & Medicaid Services (''CMS agreement''); or

(2) If the provider has not entered into a Medicare provider agreement, but the provider is participating in an agreement under a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(c) *Terms of agreements.* (1) The Director of the VA medical center of jurisdiction, or designee, will send to a provider written notification that identifies the Medicare provider agreement or agreement under a State Medicaid plan that VA proposes to use as the basis for its agreement to obtain extended care services, identifies the changes and any additional terms that would apply to the provider agreement, and requests written acceptance from the provider of that agreement. VA will not obtain extended care services from the provider through a provider agreement until such acceptance is received.

(2) Provider agreements with VA under this section must reflect the following:

(i) For a provider with a valid Medicare provider agreement, the terms of the provider's agreement with VA, including the payment rates, will be the same as the terms of the provider's agreement with CMS pursuant to the Medicare Enrollment Application for Institutional Providers (OMB No. 0938–0685).

(ii) For providers with no Medicare provider agreement but one or more agreements under a State plan, the terms of the provider's agreement with VA, including the payment rates, will be the same as the terms of the provider's agreement with the State that pays the highest rates.

(iii) For providers with both a Medicare provider agreement and an agreement under a State Medicaid plan, the terms of the provider's agreement with VA, including the payment rates, will be the same as the CMS or State agreement that provides for the higher rates.

(iv) The provider shall not charge any individual, insurer, or entity (other than VA) for the items or services obtained by VA under this section.

(3) The terms of the provider's agreement with VA will be different from the provider's separate agreement with CMS or a State only to the extent that the non-VA agreement prescribes terms or procedures inconsistent with this section and that it is necessary to identify VA as the Government agency entering into the agreement with the provider and paying for the provider's services for veterans.

(d) *Decisions regarding agreements.* (1) The Director of the VA medical center of jurisdiction, or designee, will decide, based upon medical judgment regarding the health care needs of veterans in the community and the availability and feasibility of VA or local resources to efficiently provide for those needs, whether it is necessary to enter into provider agreements for extended care services.

(2) If there is more than one provider in a given region, the veteran will select his or her preferred provider, subject to:

(i) The provider's determination to accept the veteran;

(ii) The availability and feasibility of resources at the VA medical center of jurisdiction; and

(iii) The determination of the Director of the VA medical center of jurisdiction, or designee, that the services offered by

the provider would be clinically appropriate for the care of the veteran.

(3) Factual determination of whether a provider has a Medicare provider agreement or an agreement under a State Medicaid plan will be based on verification of an existing agreement. Medicare provider agreements will be verified using CMS Web sites, which list providers with agreements. State agreements will be verified using appropriate State Web sites, which list providers with agreements, or using records maintained by the appropriate State office.

(e) *Termination of agreements.* (1) A provider that wishes to terminate its agreement with VA must send written notice of its intent at least 15 days before the effective date of termination of the agreement. The notice shall include the intended date of termination.

(2) VA may terminate an agreement with any provider if the Director of the VA medical center of jurisdiction, or designee, determines that the provider's service is no longer required or that the provider is not complying with a provision of the provider agreement, and must terminate an agreement with a provider that no longer has a Medicare provider agreement with CMS or no longer participates under a State Medicaid plan. VA will provide written notice of termination at least 15 days before the effective date of termination of the provider agreement. If the Director of the VA medical center of jurisdiction, or designee, determines the health of the veteran to be in immediate jeopardy, VA will provide notice of termination at least 2 days before the effective date of termination of the provider agreement. VA may physically remove a veteran from a dangerous situation at any time in order to protect the health of the veteran prior to terminating the applicable provider agreement.

(f) *Appeals.* Appeals of a determination by the Director of the VA medical center of jurisdiction, or designee, not to enter into or to terminate a VA provider agreement must be made in writing to the Chief Consultant, Office of Geriatrics and Extended Care, no later than 90 days after the date of the decision being appealed. The decision of the Chief Consultant will constitute a final agency decision.

(g) *Compliance with Federal laws.* Under agreements entered into under this section, providers are not required to comply with reporting and auditing requirements imposed under the Service Contract Act of 1965, as amended (41 U.S.C. 351, et seq.); however, providers must comply with all other applicable Federal laws concerning employment and hiring practices including the Fair Labor Standards Act, National Labor Relations Act, the Civil Rights Acts, the Age Discrimination in Employment Act of 1967, the Vocational Rehabilitation Act of 1973, Worker Adjustment and Retraining Notification Act, Sarbanes-Oxley Act of 2002, Occupational Health and Safety Act of 1970, Immigration Reform and Control Act of 1986, Consolidated Omnibus Reconciliation Act, the Family and Medical Leave Act, the Americans with Disabilities Act, the Uniformed Services Employment and Reemployment Rights Act, the Immigration and Nationality Act, the Consumer Credit Protection Act, the Employee Polygraph Protection Act, and the Employee Retirement Income Security Act.

(Authority: 38 U.S.C. 501, 1720; 42 U.S.C. 1395cc)

[FR Doc. 2013–02993 Filed 2–12–13; 8:45 am]

BILLING CODE 8320–01–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 622

[Docket No. 130207066–3066–01]

RIN 0648–BC66

Fisheries of the Caribbean, Gulf of Mexico, and South Atlantic; Reef Fish Fishery of the Gulf of Mexico; Amendment 37

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

ACTION: Proposed rule; request for comments.

SUMMARY: NMFS proposes to implement management measures described in Amendment 37 to the Fishery Management Plan for the Reef Fish Resources of the Gulf of Mexico (FMP) prepared by the Gulf of Mexico Fishery Management Council (Council). If implemented, this rule would revise the commercial and recreational sector's annual catch limits (ACLs) and annual catch targets (ACTs) for gray triggerfish; revise the recreational sector accountability measures (AMs) for gray triggerfish; revise the gray triggerfish recreational bag limit; establish a commercial trip limit for gray triggerfish; and establish a fixed closed season for the gray triggerfish commercial and recreational sectors. Additionally, Amendment 37 would modify the gray triggerfish rebuilding plan. The intent of this rule is to end overfishing of gray triggerfish and help achieve optimum yield (OY) for the gray triggerfish resource in accordance with the requirements of the Magnuson-Stevens Fishery Conservation and Management Act (Magnuson-Stevens Act).

DATES: Written comments must be received on or before March 15, 2013.

ADDRESSES: You may submit comments on this document, identified by ''NOAA–NMFS–2012–0199'', by any of the following methods:

- *Electronic Submission:* Submit all electronic public comments via the Federal e-Rulemaking Portal. Go to *www.regulations.gov/#!docketDetail;D=NOAA-NMFS-2012-0199,* click the ''Comment Now!'' icon, complete the required fields, and enter or attach your comments.
- *Mail:* Submit written comments to Rich Malinowski, Southeast Regional Office, NMFS, 263 13th Avenue South, St. Petersburg, FL 33701.

Instructions: Comments sent by any other method, to any other address or individual, or received after the end of the comment period, may not be considered by NMFS. All comments received are a part of the public record and will generally be posted for public viewing on *www.regulations.gov* without change. All personal identifying information (*e.g.,* name, address, etc.), confidential business information, or otherwise sensitive information submitted voluntarily by the sender will be publicly accessible. NMFS will accept anonymous comments (enter ''N/A'' in the required fields if you wish to remain anonymous). Attachments to electronic comments will be accepted in Microsoft Word, Excel, or Adobe PDF file formats only.

Electronic copies of Amendment 37, which includes a draft environmental assessment and a regulatory impact review, may be obtained from the Southeast Regional Office Web site at *http://sero.nmfs.noaa.gov.*

FOR FURTHER INFORMATION CONTACT: Rich Malinowski, Southeast Regional Office, telephone 727–824–5305, email *rich.malinowski@noaa.gov.*

SUPPLEMENTARY INFORMATION: The reef fish fishery of the Gulf is managed under the FMP. The FMP was prepared by the Council and is implemented through regulations at 50 CFR part 622 under the authority of the Magnuson-Stevens Act. All gray triggerfish weights discussed in this proposed rule are in round weight.