TABLE 1 TO § 100.801—SECTOR OHIO VALLEY ANNUAL AND RECURRING MARINE EVENTS—Continued

Date	Event/sponsor	Ohio Valley location	Regulated area
87. 1 day in October	Cumberland River Compact/Cumberland River Dragon Boat Festival.	Nashville, TN	Cumberland River, Mile 189.7–192.1 (Tennessee).
88. 1 day in October	Outdoor Chattanooga/Swim the Suck.	Chattanooga, TN	Tennessee River, Miles 452.0–454.5 (Tennessee).
89. 1 day—First or second weekend in October.	Lookout Rowing Club/Chattanooga Head Race.	Chattanooga, TN	Tennessee River, Mile 463.0–468.0 (Tennessee).
90. 1 day in October	Shoals Scholar Dollar	Florence, AL	Tennessee River 255–257 (Alabama).
91. 2 days in October	Music City Head Race	Nashville, TN	Cumberland River 190–195 (Tennessee).
92. 2 days—First or second week of October.	Head of the Ohio Rowing Race	Pittsburgh, PA	Allegheny River, Mile 0.0–3.0 (Pennsylvania).
93. 2 days—One of the first three weekends in October.	Norton Healthcare/Ironman Triathlon.	Louisville, KY	Ohio River, Mile 600.5–605.5 (Kentucky).
94. 2 days—Two days in October	Secret City Head Race Regatta	Oak Ridge, TN	Clinch River, Mile 49.0–54.0 (Tennessee).
95. 3 days—First weekend in November.	Atlanta Rowing Club/Head of the Hooch Rowing Regatta.	Chattanooga, TN	Tennessee River, Mile 463.0–468.0 (Tennessee).
96. 1 day—Second weekend in December.	Charleston Lighted Boat Parade	Charleston, WV	Kanawha River, Mile 54.3–60.3 (West Virginia).

* * * * *

Dated: March 26, 2023.

H.R. Mattern,

Captain, U.S. Coast Guard, Captain of the Port Sector Ohio Valley.

[FR Doc. 2023–06934 Filed 4–3–23; 8:45 am]

BILLING CODE 9110–04–P

DEPARTMENT OF COMMERCE

Patent and Trademark Office

37 CFR Parts 1 and 41

[Docket No. PTO–P–2023–0005]

RIN 0651–AD66

Reducing Patent Fees for Small Entities and Micro Entities Under the Unleashing American Innovators Act of 2022

Correction

In rule document 2023–05382, appearing on pages 17147–17159, in the issue of Wednesday, March 22, 2023, make the following corrections:

■ On page 17157, § 1.445 is corrected to read as set forth below.

§ 1.445 International application filing, processing and search fees. [Corrected]

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(B) For an international application having a receipt date that is on or after October 2, 2020 and before December 29, 2022:

Table 2 to Paragraph (a)(1)(i)(B)

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(C) * * *

Table 3 to Paragraph (a)(1)(i)(C)

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(ii) * * *

Table 4 to Paragraph (a)(1)(ii)

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(2) * * *

(i) For an international application having a receipt date that is on or after April 1, 2023:

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[FR Doc. C1–2023–05382 Filed 3–31–23; 8:45 am]

BILLING CODE 0099–10–D

DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 17

RIN 2900–AR48

Copayment Exemption for Indian Veterans

AGENCY: Department of Veterans Affairs.

ACTION: Final rule.

SUMMARY: The Department of Veterans Affairs (VA) adopts as final, with changes, a proposed rule to amend its medical regulations to implement a statute exempting Indian and urban Indian veterans from copayment requirements for the receipt of hospital care or medical services. This final rule also exempts such veterans from copayments for all urgent care visits.

DATES: This rule is effective April 4, 2023.

FOR FURTHER INFORMATION CONTACT: Mark Upton, Deputy to the Deputy Under Secretary for Health, Office of the Deputy Under Secretary for Health (10A), 810 Vermont Avenue NW, Washington, DC 20420, 202–461–7459. (This is not a toll-free telephone number.)

SUPPLEMENTARY INFORMATION: In a document published in the **Federal Register** (FR) on January 12, 2023, VA proposed to amend its medical regulations at §§ 17.108, 17.110, 17.111, and 17.4600 of title 38, Code of Federal Regulations (CFR) to exempt from copayments veterans who submit documentation to VA to demonstrate they are either Indian or urban Indian, as those terms are defined in section 4 of the Indian Health Care Improvement Act (further codified at 25 U.S.C. 1603(13) and (28)), for hospital care or medical services received on or after January 5, 2022. 88 FR 2038. VA also proposed retroactive reimbursement for copayments already paid by these veterans for such care provided on or after January 5, 2022. VA provided a 30-day comment period, which ended on February 13, 2023. Forty-four comments were received, of which one was a duplicate comment, for a total of forty-three unique comments. Nine commenters expressed support for the proposed rule in whole. VA appreciates these commenters' support and does not further address their comments below. The remaining commenters expressed concerns with the proposed rule in whole or in part, and their comments are addressed below by topic. As explained in more detail below, VA makes changes to the rule based on the comments.

Discrimination

VA received several comments alleging that this copayment exemption is discriminatory and unfair to those

veterans who are not Indian or urban Indian. Commenters asserted that the proposed rule gives preference based on ethnicity or race and questioned why VA is not eliminating copayments for other veterans based on race, ethnicity, or sex. One commenter was neutral on the proposed rule, but asked VA to clarify why it was providing this copayment exemption to this group of veterans over other races. Some of these commenters also alleged that this rulemaking is part of a current political agenda. VA makes no changes to the rule based on these comments.

Pursuant to section 1710(f) and (g) of title 38, United States Code (U.S.C.), VA must charge certain veterans a copayment for hospital care, nursing home care, and medical services furnished by VA, unless otherwise exempted under law. As VA explained in the proposed rule, Congress mandated that VA exempt from copayments for hospital care or medical services those veterans who are Indian or urban Indian, as such terms are defined in section 4 of the Indian Health Care Improvement Act (codified in 25 U.S.C. 1603). This mandate is codified in law at 38 U.S.C. 1730A (as amended by section 3002 of the Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020 (the ''Act''), Pub. L. 116–315).

The underlying bill, the Native American PACT Act (H.R. 4908) which became part of the Act, was separately passed by the U.S. House of Representatives on September 22, 2020. In support of this legislation, Democratic and Republican representatives explained Congress's rationale for introducing and passing this legislation. Representative Mark Takano explained, in pertinent part:

> The Federal Government has a legal and moral obligation to uphold its treaty obligations to Tribal nations, which include the provision of healthcare. Our responsibility to ensure care is compounded when American Indians and Alaska Natives serve this country in uniform . . . For far too many Native Americans, particularly those in rural areas, the copay burden is a barrier to care. These veterans, who may be unable to access specialty care from their Tribal health systems, are then unable to access VA due to cost. Eliminating the copay burden is a step toward upholding the treaties between the United States and Tribal nations while also bringing immediate relief to veterans unable to access care during these distressing times.

See House Congressional Record dated September 22, 2020, H4678–4679.

Representative David P. Roe further stated, in pertinent part:

> [A]lmost a century ago, Congress passed the Snyder Act, which guaranteed healthcare to Native Americans free of charge. In recognition of that, the Native American PACT Act would prohibit VA from charging copayments to Native American veterans regardless of whether the care they receive from the VA is for a service-connected condition or not . . . [t]his bill would increase access to care for those brave veterans and create parity between the care provided to them through the VA, the Centers for Medicare and Medicaid Services, and the Indian Health Service. It would also uphold the United States Government's longstanding trust and treaty responsibilities to the Native American community. Id. at H4679.

Thus, the Congressional record is clear that Congress's rationale for exempting Indian and urban Indian veterans from copayments was based on fulfilling the promise this country made to Tribal nations as part of its trust and treaty responsibilities to provide American Indians and Alaska Natives with free health care, increasing access to care, and supporting parity for the provision of care by VA and other Federal agencies. Furthermore, on numerous occasions, the United States Supreme Court specifically has upheld legislation that singles out American Indians or Alaska Natives for particular and special treatment. See, for example, *Morton* v. *Mancari,* 417 U.S. 535 (1974).

To comply with the mandate in 38 U.S.C. 1730A, VA proposed to revise its regulations to exempt from copayments those veterans who are Indian or urban Indian as defined in 25 U.S.C. 1603(13) and (28). Unless explicitly allowed by law, VA cannot exempt from copayments other groups of veterans. See 38 U.S.C. 1710(f) and (g). Contrary to commenters' assertions, this copayment exemption for such individuals was not based on discrimination or VA showing preference for certain races or ethnicity, it was a requirement of law.

In response to those commenters who suggest that this is part of a current political agenda, the copayment exemption mandated by section 1730A was signed into law by then President Trump on January 5, 2021. As reflected in the excerpts from the Congressional record related to H.R. 4908 discussed further above, there was also bipartisan Congressional support for exempting Indian and urban Indian veterans from copayments. See also, *Tester, Moran Introduce Bipartisan Bill to Increase Native American Veterans' Access to VA Health Care, Eliminate Copays,* Nov. 18, 2020, *https://www.veterans.senate.gov/2020/11/tester-moran-introduce-bipartisan-bill-to-increase-native-american-veterans-access-to-va-health-care-eliminate-copays*.

Trust Responsibility

Some commenters requested VA clarify in the rulemaking that the copayment exemption under 38 U.S.C. 1730A is due to the Federal government's trust responsibility. VA's specific statutory authority and mandate for the copayment exemption is 38 U.S.C. 1730A as amended by section 3002 of the Act. However, as discussed above, the Congressional history for this copayment exemption illustrates that Congress proposed this legislation in part based on a trust responsibility with American Indian and Alaska Native communities. As discussed below, VA considered this trust responsibility in the response to comments received that suggested VA exempt copayments for all urgent care visits.

Definition of Indian or Urban Indian

One commenter supported using a definition of Indian used by the Indian Health Service (IHS) as such definition is familiar to Tribal members and would provide consistency, avoid confusion, and improve the tribes' ability to notify Tribal members of changes. Another commenter suggested that American Indian and Alaska Native veterans from a federally or State recognized Tribe or a Native Nation, or who are descendants of a Tribal or Native Nation member should be eligible for this copayment exemption. VA does not make any changes to the rule based on these comments.

VA is using the definitions of Indian and urban Indian required by law for purposes of this rulemaking. Section 1730A of 38 U.S.C. was amended to add a copayment exemption for veterans who are either Indian or urban Indian, as further defined in 25 U.S.C. 1603(13) and (28). 88 FR 2038–2039. Paragraph 13 of section 1603 defines the term Indians or Indian as any person who is a member of an Indian Tribe, as that term is further defined in section 1603(14), except that, for the purpose of 25 U.S.C. 1612 and 1613, such terms shall mean any individual who: (1) irrespective of whether he or she lives on or near a reservation, is a member of a Tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member; (2) is an Eskimo or Aleut or other Alaska Native; (3) is considered by the Secretary of the Interior to be an Indian for any purpose; or (4) is determined to be an Indian pursuant to regulations

promulgated by the Secretary of Health and Human Services.

Paragraph 28 of section 1603 defines the term urban Indian as any individual who resides in an urban center (as such term is further defined in section 1603(27)) and who meets at least one or more of the four criteria in the definition of Indian in 25 U.S.C. 1603(13) (as described above in a previous paragraph regarding the definition of Indians or Indian). Thus, these definitions apply to those eligible for the provision of healthcare by IHS and include those individuals the commenter references, such as members of federally and State recognized tribes and descendants of such members.

To the extent the commenters are suggesting VA expand eligibility beyond those defined as Indian or urban Indian in 25 U.S.C. 1603(13) and (28), VA is unable to do so as the statute is clear that VA must use those definitions.

Documentation

Several commenters had a variety of concerns related to the proposed requirement that veterans submit documentation to demonstrate they meet the definition of Indian or urban Indian. These commenters suggested that instead VA allow such veterans to self-attest that they meet the definition of Indian or urban Indian. As explained in more detail below, their concerns focused on evaluating and verifying documentation, the benefits of self-attestation, the Tribal consultation process, and acceptable forms of documentation. VA makes no changes to the rule based on these comments for the reasons explained below.

Evaluating and Verifying Documentation

Some commenters were concerned that VA does not have the capability to receive, process, evaluate, and validate the documentation that VA proposes to require veterans submit in order to verify that they meet the definition of Indian or urban Indian under 25 U.S.C. 1603(13) and (28). The commenters were particularly concerned given the diversity and volume of potential documents.

VA will be able to properly evaluate the submitted documents to determine if a veteran meets the definition of Indian or urban Indian under 25 U.S.C. 1603(13) and (28). VA will have dedicated staff to perform this function who will receive robust training on the types of acceptable documentation and how to properly evaluate and verify such documentation. This will include input and guidance from VA's own Tribal experts, such as its Office of Tribal Government Relations and Office of Tribal Health. Collecting and evaluating documentation to determine an individual's membership in a Tribe is something that other agencies, such as IHS and the Bureau of Indian Affairs (BIA), as well as many American Indian and Alaska Native health organizations do. In fact, VA intends to mirror how IHS makes these determinations. VA does not believe it will be an undue burden on VA staff to perform these tasks. Other commenters were concerned that VA verifying and determining the legitimacy of the documents will usurp Tribal sovereignty. Another commenter also stated that there should not be an administrative burden put on Tribal enrollment staff to document a veteran's status as Indian or urban Indian.

While there are 574 federally recognized tribes that may have different types of documentation, VA will defer to American Indian and Alaska Native Tribal governments regarding the documentation they issue to members of their Tribe. VA will accept such documentation as proof that a veteran meets the definition of Indian or urban Indian in 25 U.S.C. 1603(13) and (28) for purposes of this copayment exemption. VA will not require American Indian and Alaska Native Tribal governments to issue specific documentation for the purpose of demonstrating that a member of the Tribe meets the definition of Indian or urban Indian. Therefore, VA will not be usurping Tribal sovereignty or imposing additional burdens on American Indian and Alaska Native Tribal governments to issue documentation other than what they already issue members of their Tribe. A Tribe's existing documentation of an individual's status as a member of a Tribe will be sufficient. Requiring submission of documentation also shows respect for American Indian and Alaska Native Tribal governments and acknowledges that the tribes determine who are members.

Benefits of Self-Attestation

Some commenters supported self-attestation because they stated that other agencies use self-attestation. VA agrees that it is important for VA to understand how other agencies determine an individual's status as an Indian or urban Indian under 25 U.S.C. 1603(13) and (28). VA learned that IHS, BIA, and other American Indian health organizations require documentation in order to be eligible for their benefits and services. Therefore, for purposes of Federal benefits and services, tribes are familiar with providing their members with documentation and their members are familiar with providing documentation to Federal agencies to receive health care benefits.

Some commenters raised concerns that some Indian and urban Indian veterans may face barriers in obtaining documentation due to homelessness, financial instability, moving during military service, and lack of resources or culturally competent representation which can discourage these veterans from seeking the copayment exemption. VA believes that submission of documentation will not be a burden on most such veterans since they already have this documentation or could easily obtain it. In addition, VA staff will be available to provide veterans with information on documentation that VA will accept for purposes of this copayment exemption and can assist veterans with reacquiring documentation they may have lost. VA will also proactively communicate with American Indian and Alaska Native veterans about this copayment exemption and how they may apply. Additionally, VA is engaged in a robust effort to educate all stakeholders about this copayment exemption and is committed to continued engagement with its stakeholders about how best to implement and educate others about the rule.

Some commenters opined that self-attestation increases access to health care without compromising the integrity of VA's services. Other commenters stated that despite VA's concern that self-attestation may present an unreasonable risk that VA would provide the copayment exemption to veterans who do not meet the definition of Indian or urban Indian under 25 U.S.C. 1603(13) and (28), self-attestation would not present an unreasonable risk and that VA failed to provide any evidence of such unreasonable risk. The commenters further stated that existing authorities, such as 38 U.S.C. 6103 and 18 U.S.C. 1035, can help minimize risk of misrepresentation of a veteran's status as Indian or urban Indian in self-attestations.

VA believes that self-attestation could result in veterans who are not eligible for the benefit erroneously receiving the benefit. VA has a responsibility to ensure that only those who are eligible for this copayment exemption receive it. As explained in the proposed rule, requiring documentation rather than self-attestation would allow VA to ensure, through audits, that it is fulfilling its duty to only exempt those veterans who are eligible pursuant to section 1730A. 88 FR 2040.

VA is unable to audit the information provided in a self-attestation without

additional documentation to support the self-attestation. Therefore would not be in a position to establish that a veteran accurately attested to being an Indian or urban Indian on the VA Forms 10–10EZ or 10–10EZR without obtaining additional information if it were to adopt self-attestation. In this regard, while VA Forms 10–10EZ and 10–10EZR previously had a question about whether a veteran meets these definitions of Indian or urban Indian, that question was removed in February 2023. The current VA Form 10–10EZ does have a question on race, which includes American Indian or Alaska Native. However, VA Form 10–10EZR does not. Regardless, if VA used either of these questions to establish a veteran met the definition of Indian or urban Indian, there would be no way to audit that attestation without requesting additional documentation. Requiring documentation allows VA to audit whether a veteran meets the definition of Indian or urban Indian in 25 U.S.C. 1603(13) and (28) without the need to later collect more information.

If VA allowed self-attestation only, it could result in those who are ineligible receiving the copayment exemption, and VA failing to fulfill its responsibilities under the law. While VA acknowledges that under certain existing authorities it is a violation of Federal law to knowingly or willingly make a false statement related to benefits, some veterans may genuinely believe they meet the definition of Indian or urban Indian under 25 U.S.C. 1603(13) and (28), but simply do not. Therefore, it would not be clear that these veterans were knowingly or willingly making a false statement or representation, and it is not certain that they would be deterred from indicating on the VA Form 10–10EZ that they meet the definition.

Several commenters recommended VA allow veterans to initially self-attest they meet the definitions of Indian or urban Indian, after which the veteran can submit necessary documentation to show they meet the definitions within a certain period of time, which, as one of the commenters opined, could be extended if there was a good faith effort on the veteran's part to acquire the documentation. These commenters opined that this will allow VA to implement a policy where it can verify or review documentation later while ensuring that American Indian and Alaska Native veterans receive this copayment exemption immediately and do not encounter a barrier to care. One of these commenters suggested that if VA needs an additional document from a veteran who self-attests, the copayment exemption should remain in place until an appeal is completed.

VA will be providing reimbursement retroactive to January 5, 2022, to eligible veterans after VA reviews the submitted documentation and updates the veteran's record to make them exempt from copayments. Therefore, VA does not believe allowing for self-attestation followed by documentation is necessary. These veterans will be reimbursed for copayments for care provided on or after January 5, 2022, regardless of when they submit their documentation. Thus, any hardship based on when they submit documentation will be reduced by VA's reimbursement once documentation is received.

As discussed above, VA also does not believe that veterans should experience undue burden submitting documentation as they likely already have it or can easily obtain it, particularly as the documentation VA will accept includes those commonly issued by American Indian and Alaska Native Tribal governments to members of their tribes and are required by IHS to receive healthcare services.

Additionally, allowing veterans to self-attest that they meet the definition of Indian or urban Indian and then provide additional documentation at a later date would create administrative and logistical challenges for VA and potential hardships for the veterans. If VA were to exempt a veteran based on self-attestation with additional documentation to follow at a later date, VA would have the added responsibility of tracking this preliminary eligibility and, in cases where a veteran did not submit the required additional documentation, VA would have to follow up with the veteran to request the documentation, potentially on several occasions. If VA ultimately does not receive acceptable documentation from the veteran, VA would have to collect from the veteran any copayments that had been inappropriately exempted, resulting in an added burden to VA and potential hardship for the veteran.

Tribal Consultation

Several commenters alleged that VA mischaracterized or misrepresented the information it requested and received during Tribal consultation related to this rulemaking. These commenters opined that the questions posed by VA as part of Tribal consultation were narrower in scope than the definitions of Indian and urban Indian in 25 U.S.C. 1603 and incorrectly framed the statutory language that authorizes the exception. These commenters also opined that VA's statement in the proposed rule that it published a notice regarding the documentation that VA can use to identify veterans who meet the definitions of Indian or urban Indian under 38 U.S.C. 1730A was inaccurate. These commenters further stated that this did not provide American Indian and Alaska Native Tribal government leaders with the opportunity to fully consider the extent of American Indian and Alaska Native veterans eligible for the copayment exemption or provide feedback on documentation that may be required to determine eligibility for the copayment exemption. The commenters were concerned that VA inappropriately and misleadingly claimed that American Indian and Alaska Native Tribal governments supported requiring all American Indian and Alaska Native veterans to submit documentation to determine eligibility for the copayment exemption although VA never posed this question during Tribal consultation. Thus, these commenters opined that VA improperly relied upon the feedback received during consultation to support its decision to require veterans submit documentation for purposes of this copayment exemption.

In the **Federal Register** Notice (FRN) dated April 1, 2021, VA referenced the definitions of Indian and urban Indian as defined in 25 U.S.C. 1603(3). Moreover, in the supplementary section of the FRN, VA explained the changes made to 38 U.S.C. 1730A by section 3002 of the Act to exempt from copayments those who are Indian or urban Indian as defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603). 86 FR 17267 (April 1, 2021). VA further stated that it was seeking input from Tribal governments, Indians, and urban Indians regarding documentation that can be used by VA's health care system to identify those veterans who are Indians or urban Indians (as defined in 25 U.S.C. 1603). Id. VA further notes that section 1603(13) defines Indian, in pertinent part, to mean any person who is a member of an Indian Tribe. Thus, with regards to information that VA was seeking to determine eligibility for this copayment exemption, the FRN was not narrower than the statutory authority.

Additionally, VA asked for input on specific documentation, as well as other information or documentation that is available for determining if a veteran is a member of an Indian Tribe, potential sources of the information or documentation, and how VA should determine whether a veteran is a member of an Indian Tribe (whether through documentation, self-certification, other methods). Id.

As VA explained in the proposed rule, the majority of comments received during the Tribal consultation session and in the 30-day period after it, in which written comments could be submitted to VA, supported documentation, with some commenters providing examples of documentation VA could use. However, several commenters supported self-attestation. To the extent that the request was not clear, VA provided an opportunity to submit comments during the April 29, 2021 Tribal consultation and for a period of 30 days after such Tribal consultation and to submit comments on the proposed rule. VA has taken all comments received into consideration when establishing the final rule.

Acceptable Documentation

One commenter appeared to oppose the submission of documentation to demonstrate a catastrophically disabled veteran meets the definition of Indian or urban Indian for purposes of copayment exemption under 38 U.S.C. 1730A.

While not entirely clear, it appears this commenter believes that VA is requiring veterans who are catastrophically disabled *and* are also Indian or urban Indian to submit documentation to show such status. VA clarifies that section 1730A requires copayment exemption for two different groups of veterans: (1) veterans who are catastrophically disabled and (2) veterans who are Indian or urban Indian as defined in 25 U.S.C. 1603. A veteran can qualify under either category for this copayment exemption, but does not need to qualify under both.

For a veteran to be eligible for this copayment exemption as a catastrophically disabled veteran under 38 U.S.C. 1730A(b)(1), they must undergo examination and be found by VA to have a permanent severely disabling injury, disorder, or disease that compromises the ability to carry out the activities of daily living to such a degree that the individual requires personal or mechanical assistance to leave home or bed or requires constant supervision to avoid physical harm to self or others. See 38 CFR 17.36(e). In order to be eligible for this copayment exemption as an Indian or urban Indian under 38 U.S.C. 1730A(b)(2), the veteran must provide documentation establishing that they meet the definition of Indian or urban Indian as defined in 25 U.S.C. 1603(13) and (28).

However, a catastrophically disabled veteran who also meets the definition of Indian or urban Indian as defined in 25 U.S.C. 1603(13) and (28) does not need to provide additional documentation that demonstrates they are Indian or urban Indian unless they are interested in a copayment exemption for more than three urgent care visits in a calendar year. This is discussed in more detail below. VA is not otherwise adding an additional requirement for catastrophically disabled veterans. Some commenters supported accepting identification and verification issued by American Indian and Alaska Native Tribal governments, such as Tribal identifications cards, for purposes of this copayment exemption. Another commenter recommended VA expand the list of acceptable documentation to include Tribal government verification, Tribal enrollment or identification cards, Tribal letters, kinship reports, and other documentation that promotes a veteran's ability to receive copayment exempt benefits.

As explained in the proposed rule, VA will defer to American Indian and Alaska Native Tribal governments with respect to the documentation they issue to show who is a member of their Tribe. 88 FR 2039. This may include some of the documents that the commenters listed such as Tribal identification and enrollment cards, Tribal letters, and other documentation issued by tribes to demonstrate an individual is a member of their Tribe. VA will issue additional communications that provide veterans with examples of acceptable documents so that veterans know the documentation they may submit to demonstrate that they meet the definition of Indian or urban Indian under 25 U.S.C. 1603(13) and (28) and are eligible for this copayment exemption. However, in this rulemaking, VA has provided a description of the types of acceptable documents rather than an enumerated list of all acceptable documents to allow for additional documents if developed by American Indian and Alaska Native Tribal governments.

While one of these commenters suggested VA accept kinship reports, VA declines to include that in the description of acceptable documents as those would not demonstrate that a veteran meets the definition of Indian or urban Indian under 25 U.S.C. 1603(13) and (28). That same commenter also suggested VA accept other documentation that promotes a veteran's ability to receive copayment exempt benefits but did not provide examples of what those other documents may be. To the extent they are suggesting VA accept documentation other than those consistent with VA's description of acceptable documentation, VA declines to do so as the categories of acceptable documentation align with the statutory definition of Indian or urban Indian in 25 U.S.C. 1603(13) and (28).

Several commenters suggested that VA accept specific documents issued by entities, such as IHS, Tribal Health Programs (THP), and Urban Indian Organizations (UIO) that provide health care to American Indians and Alaska Natives. Suggested documents include proof of prior visit, health care records, patient registration record, and other records that show eligibility status. One commenter suggested VA improve coordination and interoperability of systems to allow sharing of records between VA and IHS for purposes of determining a veteran is eligible for this copayment exemption.

As explained directly above, while VA will not include in the regulations an enumerated list of documents that may be submitted to demonstrate that a veteran meets the definition of Indian or urban Indian as defined in 25 U.S.C 1603(13) and (28), the documents suggested by these commenters also appear problematic because it appears that some individuals who are eligible to receive healthcare from IHS, THP, and UIO do not meet the definition of Indians or urban Indians in 25 U.S.C. 1603(13) and (28). See 42 CFR 136.12. Relying on documents that may be issued to individuals who received care from IHS, THP, or UIO but that do not meet the section 1603(13) and (28) definitions essentially would allow these organizations, rather than VA, to make determinations that veterans meet the definition of Indian or urban Indian when they may not.

VA makes no changes based on these comments.

Covered Services

Several commenters, including Tribal Nations, intertribal organizations, Tribal health boards, and Indian health clinics, together serving hundreds of Tribal Nations, suggested VA waive all copayments for all health care services provided to veterans who meet the definition of Indian or urban Indian in 25 U.S.C. 1603(13) and (28). VA has authority to exempt copayments of hospital care and medical services pursuant to 38 U.S.C. 1730A. VA has distinct authority related to copayments for the hospital care and medical services provided to veterans through the urgent care benefit under 38 U.S.C. 1725A. VA interprets the comments to request additional exemptions both beyond hospital care and medical services pursuant to section 1730A and section 1725A. We will address both scenarios below and will make changes to the rule based on the comments related to urgent care.

One Tribal Nation asserted that there should be no limitation on the exemption for copayments as VA should not be more restrictive than the statutory authority. Another of these commenters further noted that copayment exempt elder care services are important since obtaining such care through VA will lighten the burden on IHS and Tribal health care providers, particularly as Tribal members are having longer lifespans. VA interprets these comments to mean that VA should provide a copayment exemption for all services furnished by VA even if they are not hospital care and medical services.

Section 1730A explicitly exempts copayments for hospital care and medical services. VA has interpreted those terms consistent with their statutory definitions in 38 U.S.C. 1701(5) and (6) and in 38 CFR 17.30(a).

Section 1701(5), in pertinent part, defines hospital care to include medical services rendered in the course of the hospitalization of any veteran, and travel and incidental expenses pursuant to the provisions of 38 U.S.C. 111.

Section 1701(6) defines medical services to include, in addition to medical examination, treatment, and rehabilitative services, the following: (1) surgical services; (2) dental services and appliances as described in 38 U.S.C 1710 and 1712; (3) optometric and podiatric services; (4) preventive health services; (5) noninstitutional extended care services, including alternatives to institutional extended care that the Secretary may furnish directly, by contract, or through provision of case management by another provider or payer; (6) in the case of a person otherwise receiving care or services under chapter 17, wheelchairs, artificial limbs, trusses, and similar appliances, special clothing made necessary by the wearing of prosthetic appliances, and such other supplies or services as the Secretary determines to be reasonable and necessary; (7) travel and incidental expenses pursuant to 38 U.S.C. 111; and (8) chiropractic services.

Consistent with section 1701(6), VA has defined medical services in 38 CFR 17.30(a) to include, in addition to medical examination, treatment, and rehabilitative services: (1) surgical services, dental services and appliances as authorized in 38 CFR 17.160 through 17.166, optometric and podiatric services, (in the case of a person otherwise receiving care or services under this chapter) the preventive health care services set forth in 38 U.S.C. 1701(9), noninstitutional extended care, wheelchairs, artificial limbs, trusses and similar appliances, special clothing made necessary by the wearing of prosthetic appliances, and such other supplies or services as are medically determined to be reasonable and necessary; (2) consultation, professional counseling, marriage and family counseling, training, and mental health services for the members of the immediate family or legal guardian of the veteran or the individual in whose household the veteran certifies an intention to live, as necessary in connection with the veteran's treatment; and (3) transportation and incidental expenses for any person entitled to such benefits under the provisions of 38 CFR 70.10.

Section 3002 of Public Law 116–315 amended 38 U.S.C. 1730A to include Indian and urban Indian veterans as covered veterans who are exempted from making copayments for the receipt of hospital care or medical services. That law requires VA to apply the copayment exemption to hospital care and medical services as those terms are defined in statute; section 1701(5) and (6) of title 38 of United States Code. Thus, VA interprets 38 U.S.C. 1730A to refer only to hospital care and medical services as defined in 38 U.S.C. 1701(5) and (6) and is exempting Indian and urban Indian veterans from copayments under 17.108, 17.110, and 17.111 for inpatient hospital care, outpatient medical care, medication, noninstitutional extended care including adult day health care, noninstitutional respite care, and noninstitutional geriatric evaluation, respectively. Therefore, these veterans would still be required to pay copayments for domiciliary care, institutional respite care, institutional geriatric evaluation, and nursing home care. See 38 U.S.C. 1730B.

Several commenters expressed concern with VA's proposal to charge a copayment for urgent care after the third visit for this group of veterans. Some commenters, including Tribal Nations, intertribal organizations, Tribal health boards, and Indian health clinics, together serving hundreds of Tribal Nations, specifically recommended VA exempt all urgent care visits from copayments as they explained that charging for urgent care visits after the first three visits in a calendar year is contrary to Congressional intent and the Federal government's trust responsibility. Some of these commenters asserted that veterans may delay or forgo needed care if they are charged a copayment for urgent care visits beyond the first three visits in a calendar year, especially as primary care is often less accessible than urgent care for American Indians and Alaska Natives. Relatedly, other commenters suggested VA exempt copayments for all urgent care as such care fills gaps where primary care is scarce or nonexistent, and copayments for such care can be a barrier for those who have to travel far for needed care, such as those in Alaska. One of these commenters suggested that alternatively, VA could exempt copayments for urgent care beyond three visits in a calendar year when an American Indian or Alaska Native veteran has to travel more than 100 miles or travel more than two or three hours for urgent care. Another commenter recommended VA extend the copayment exemption for urgent care visits beyond the initial three in a calendar year if extenuating circumstances warrant additional urgent care visits, such as when a medical appointment is canceled and cannot be rescheduled within the time that the veteran may need to address their medical issue. One commenter also recommended all urgent care visits at Indian health care providers and IHS, THP, or UIO facilities be exempt from copayments.

VA considered these comments and has decided not to finalize its proposal to exempt only the first three urgent care visits from copayments for Indian or urban Indian veterans. Instead, VA will exempt all urgent care visits from copayments for such veterans. As explained in the proposed rule, VA has discretion under 38 U.S.C. 1725A to determine the appropriate copayment for urgent care visits, after the first two visits, for veterans who are otherwise exempt from copayments for VA care. Section 1725A(f)(1)(B) provides that an eligible veteran not required to pay a copayment under this title may access walk-in care (urgent care) without a copayment for the first two visits in a calendar year. For any additional visits, a copayment at an amount determined by the Secretary may be required. VA has previously utilized the authority provided under section 1725A to require copayments for all veterans, irrespective of their priority group enrollment, level of service-connected disability, or designation as catastrophically disabled, after the first three visits in a calendar year because the copayment is designed to encourage appropriate use of the benefit. 88 FR 2041. However, based on the comments received, VA has determined that eligible Indian and urban Indian veterans will not be required to pay a copayment for urgent care visits under section 1725A.

As explained above, Congress decided to adopt a copayment exemption for Indian and urban Indian veterans in

recognition of this country's promise to Tribal nations as part of its trust and treaty responsibilities to provide American Indians and Alaska Natives with free health care, to increase access to care, and to support parity for the provision of care by VA and other Federal agencies. As Representative Takano explained, the ''Federal Government has a legal and moral obligation to uphold its treaty obligations to Tribal nations, which include the provision of healthcare.'' Likewise, Representative Roe explained that the copayment exemption upholds ''the United States Government's longstanding trust and treaty responsibilities to the Native American communities.'' Our unique responsibilities to this community counsel in favor of exempting Indian and urban Indian veterans from all urgent care copayments.

In addition, as the commenters explained, primary care is often less accessible than urgent care for American Indians and Alaska Natives, who often have to travel long distances to receive primary care. As a result, Indian and urban Indian veterans in some cases may find it necessary to use urgent care more than three times in a year, including in circumstances where primary care is not a meaningfully available alternative. Charging a copayment for those visits could deter this population from seeking necessary care. VA recognizes that the current copayment rules for urgent care are designed to encourage veterans to seek care from their primary care provider first, when VA can provide the needed care, and to utilize urgent care when prompt treatment is necessary to prevent the condition from becoming emergent. But for Indian and urban Indian veterans, that is often not a reasonably available option.

Several studies document that American Indian and Alaska Native people are disproportionally affected by chronic health conditions and die at higher rates than other Americans.[1] Native Americans, particularly those living in rural areas, face significant barriers in accessing health care.[2] The United States Government has taken several steps to make health care more accessible, including strengthening the Indian health care system, granting greater management control of health care resources to Tribes, and removing cost sharing requirements for other federally delivered health care services.

This rule will also promote parity in how other Federal agencies address copayment rules for Indian and urban Indian veterans—which, as explained above, was one goal of Congress in adopting the copayment exemption. In the United States, Indians are generally exempted from all cost-sharing in health plans. This includes through the Indian Health Service (IHS), Medicare, and the Marketplace. Under section 1402 (d)(1) of the Patient Protection and Affordable Care Act Public Law 111–148, issuers of qualified plans must eliminate all cost-sharing, including copayments and deductibles for Indians if they obtain insurance through the Health Insurance Exchange. There is also no cost sharing for any Indian for any item or service obtained directly through IHS, Indian Tribe, Tribal organization, urban Indian organization or through referrals under contract health services without regard to income. Section 2902 of the Affordable Care Act also made permanent the reimbursement for all Medicare Part B services provided by IHS hospitals and clinics.

For the reasons stated above, in recognition of the Government's trust responsibility, comments received from Tribes, and to ensure parity with other Federal health plans, VA will eliminate all copayments for urgent care visits regardless of the provider of the urgent care services for Indian and urban Indian veterans under 38 U.S.C. 1725A. For these reasons VA will also reimburse these veterans copayments for all urgent care visits going back to January 5, 2022.

VA notes that we intend to conduct further consultation and to publish a public request for information to obtain additional input from veterans on topics such as primary care access, the use of urgent care under section 1725A, and its role in health care delivery for all veterans.

Effective Date

One commenter recommended the changes to the regulations take effect immediately. The Administrative Procedure Act (APA), codified in part at 5 U.S.C. 553, generally requires that agencies publish substantive rules in the **Federal Register** for notice and comment and provide not less than 30 days before the rules become effective An agency may bypass the APA's 30-day delay requirement if good cause exists, 5 U.S.C. 553(d)(3), or if the rule ''recognizes an exemption or relieves a restriction,'' 5 U.S.C. 553(d)(1). As this rule recognizes a copayment exemption, VA finds that it can publish this final rule with an immediate effective date and forgo the 30-day delay requirement. 38 U.S.C. 553(d)(1).

Cost/Unfunded Mandate

One commenter expressed concern about the cost of this rulemaking and disagreed with VA's assertion that this rule would not result in an unfunded mandate. VA makes no changes based on this comment. As stated in the proposed rule, unfunded mandates apply to any rule that may result in the expenditure by State, local, and Tribal governments, in the aggregate, or by the private sector, of $100 million or more (adjusted annually for inflation) in any one year. This rule will not result in an expenditure by State, local, and Tribal governments, or by the private sector of $100 million or more (adjusted annually for inflation) in any one year. As explained in the regulatory impact analysis accompanying the proposed rule, VA estimated a 5-year impact of a loss of revenue to VA in the amount of approximately $20.4 million dollars and a 10-year impact of a loss of revenue to VA in the amount of approximately $50 million. This rulemaking does not require any expenditures by any State, local, or Tribal governments, as this rule only waives copayments for VA health care to certain veterans. VA refers the commenter to the regulatory impact analysis accompanying this rulemaking for a detailed analysis of the estimated costs for this rule.

Comments Outside the Scope of the Rulemaking

One commenter suggested VA spend time on the Paperwork Reduction Act (PRA) rather than the proposed rule, particularly as they opined that the proposed rule is redundant, repetitive, and not concise. However, the commenter did not recommend any specific changes to the rulemaking. VA considers this comment outside the scope of the rulemaking and makes no changes based on it.

Another commenter suggested that in future rulemakings that have an associated information collection subject to PRA, VA coordinate with the Office of Management and Budget (OMB) to allow tribes and Tribal organizations to actively participate in the rulemaking process through the submission of a written comment with sufficient time and notice. As part of the proposed rule, the public, to include

[1] *Issue Brief: Health Insurance Coverage and Access to Care for American Indians and Alaska Natives: Current Trends and Key Challenges,* U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, July 22, 2021, *https://aspe.hhs.gov/sites/default/files/2021-07/aspe-aian-health-insurance-coverage-ib.pdf* (last visited Mar. 28, 2023).

[2] Kerry J. Cromer, et al., *Barriers to Healthcare Access Facing American Indian and Alaska Natives in Rural America,* Journal of Community Health Nursing; 36:4, 165–187 (2019), *https://www.tandfonline.com/doi/abs/10.1080/07370016.2019.1665320?journalCode=hchn20* (last visited Mar. 28, 2023).

tribes and Tribal organizations, had the opportunity to submit comments on the information collection associated with this rulemaking, which is the case for all proposed rules that have an associated information collection. As VA explained in the proposed rule, a comment is best assured of having its full effect if OMB receives it within 30 days of publication of the proposed rule. Additionally, VA conducted Tribal consultation prior to the proposed rule and provided American Indian and Alaska Native Tribal governments and others the opportunity to provide VA with feedback about how VA could confirm a veteran meets the definitions in 25 U.S.C. 1603(13) and (28), including documentation that could or should be submitted for purposes of this copayment exemption. Consistent with VA policy, VA will continue to conduct Tribal consultations on issues that impact veterans who are members of tribes. The commenter did not recommend any changes to the rulemaking. VA makes no changes based on this comment.

Some commenters requested that VA host an urban confer and/or an additional Tribal consultation on this rule and the documentation requirements. While we consider this comment outside the scope of the rule, VA conducted Tribal consultation prior to the proposed rule and provided American Indian and Alaska Native Tribal governments and others the opportunity to provide VA with feedback on information and documentation that VA could use to identify veterans who are members of a Tribe. Additionally, as part of the rulemaking process, VA provided the public, including American Indian and Alaska Native Tribal governments, veterans, and Indian health organizations, the opportunity to comment on its proposed rule. VA seriously considered all comments received during the consultation and public comment process and made changes to the rule based on comments received by the tribes. VA does not believe it is necessary to conduct additional Tribal consultation or an urban confer on this rulemaking. As explained earlier in this preamble, VA is engaged in a robust effort to educate all stakeholders about this copayment exemption and is committed to continued engagement with its stakeholders about how best to implement and educate others about the rule. VA makes no changes to the rule based on these comments.

Several commenters made suggestions related to VA's implementation of this rule, including ensuring staff has adequate training and expertise to review documentation; ensuring determinations on eligibility for the copayment exemption are made by those who have specialized training and requisite subject matter expertise; conducting outreach to veterans, VA facilities, community providers, and active duty servicemembers (when they leave service); providing veterans with clear guidance and assistance on acceptable documentation; providing a defined process and timeline for identifying the copayments that will be reimbursed; and sharing data with Indian country on the utilization of the copayment exemption.

While VA considers these comments outside the scope of this rulemaking since they concern internal VA processes not appropriate for regulation, VA considered them while creating the implementation plan for the copayment exemption. Initially, VA will provide information to veterans on the types of acceptable documentation that may be submitted for this copayment exemption and will communicate information on this copayment exemption to all veterans, including those who are American Indian and Alaska Native. VA will also have a website that provides information on the copayment exemption, including a list of acceptable documentation. VA will have designated staff that will have the necessary subject matter expertise and training to properly review the submitted documentation to confirm eligibility for the copayment exemption. Frontline staff at VA facilities will be expected to direct veterans to VA's website explaining the benefit and acceptable documentation as well as direct them to specific employees who can further address any questions veterans may have. VA will also work towards ensuring that active duty servicemembers transitioning out of military service are made aware of this copayment exemption. As part of implementation, VA is determining how it will collect and analyze data related to this copayment exemption. As part of that effort, VA intends to reach out to American Indian and Alaska Native Tribal governments and will consider sharing utilization with them as appropriate. VA is developing a process for issuing reimbursements to veterans who are eligible for such reimbursements retroactive for covered services provided on or after January 5, 2022. As the time for processing these reimbursements will be dependent on the volume of veterans who are determined to be eligible for this copayment exemption, VA will be unable to provide specific timeframes for reimbursement. However, VA will make every effort to process reimbursements as quickly as possible. VA makes no changes to the regulations based on these comments.

One commenter recommended that VA retain copies of the documentation once it is submitted and update its records to identify the veteran as Indian or urban Indian and exempt them from future copayments. VA considers this comment outside the scope of the rule. However, VA will retain documentation submitted by veterans and once VA receives acceptable documentation, VA will update the veteran's VA records to ensure that VA does not charge eligible veterans copayments for covered care. VA makes no changes based on this comment.

One commenter stated that veterans should have access to culturally relevant services and care, and VA should work closely with Urban Indian Health Organizations or Tribal Health Organizations. While VA considers this comment outside the scope of the rule, VA is committed to working with partner stakeholders to better serve Indians and urban Indian veterans when possible. Future engagements with these stakeholders may foster the opportunity for new and expanded partnerships. VA makes no changes to the rule based on this comment.

Some commenters raised concerns regarding lack of access to culturally competent representation to assist American Indian and Alaska Native veterans relating to their benefits claims. These commenters further alleged VA has refused to work with or accredit UIO as claims representatives. VA considers these comments outside the scope of the rule and makes no changes based on them.

Regulatory Edits

VA is making several minor technical edits to the language it previously proposed. VA is also making a substantive edit to address the exemption for all urgent care visits for Indian and urban Indian veterans.

After the proposed rule published for public comment, VA published an interim final rule that amended several of VA's medical regulations, including 38 CFR 17.110(c). 88 FR 2536 (January 17, 2023). Section 17.110 was revised by the January 17, 2023, rulemaking to include paragraph (c)(13), ''[m]edication for an individual as part of emergent suicide care as authorized under 38 CFR 17.1200–17.1230.'' Thus, in this final rule on the copayment exemption for Indian and urban Indian Veterans, VA will add paragraph (c)(14) to § 17.110 to

refer to a veteran who meets the definition of Indian or urban Indian, as defined in 25 U.S.C. 1603(13) and (28), for medications provided on or after January 5, 2022. VA will use the exact same language that it proposed as § 17.110(c)(13) in the proposed rule but it will be in paragraph (c)(14) instead and all references to paragraph (c)(13) as proposed will now reference paragraph (c)(14). VA is making no changes to the substantive language.

VA is also making minor technical edits to the language proposed in §§ 17.108(d)(14), 17.110(c)(13), 17.111(f), and 17.4600(d)(1)(ii). In those proposed paragraphs, VA explained that in order to demonstrate that a veteran meets the definition of Indian or urban Indian, the veteran must submit to VA any of the documentation listed in the subparagraphs that follow the paragraph. However, VA finds it necessary to replace the word ''listed'' with the word ''described'' to more accurately reflect that the acceptable documentation identified in these regulations is a description rather than an exhaustive list of documents. These changes have no substantive impact on provision of benefits or services to veterans.

We are also making minor revisions to the language proposed in §§ 17.108(d)(14)(ii), 17.110(c)(13)(ii), 17.111(f)(11)(ii), and 17.4600(d)(1)(ii)(B). In those proposed paragraphs, we explained that acceptable documentation includes documentation showing that the veteran, irrespective of whether they live on or near a reservation, is a member of a Tribe, band, or other organized group of Indians terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member.

However, VA now revises that language in the final rule to state that such documentation includes documentation showing that the veteran is a member of a Tribe, band, or other organized group of Indians. Thus, the language in §§ 17.108(d)(14)(ii), 17.110(c)(14)(ii) (formerly paragraph (c)(13)(ii) but revised as explained further above), 17.111(f)(11)(ii), and 17.4600(d)(1)(ii)(B) (formerly paragraph (d)(1)(ii)(B) but revised as explained further below) will read as follows: documentation showing that the veteran, irrespective of whether they live on or near a reservation, is a member of a Tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member.

The language VA proposed in §§ 17.108(d)(14)(i), 17.110(13)(i), 17.111(f)(11)(i), and 17.4600(d)(1)(ii)(A) described documentation issued by a federally recognized Indian Tribe that shows that the veteran is a member of the Tribe, which was intended to cover the part of the definition of Indian in 25 U.S.C. 1603(13)(A) regarding membership in a Tribe, band, or other organized group of Indians. Documents described in §§ 17.108(d)(14)(i), 17.110(c)(13)(i) (revised in this final rule as paragraph (c)(14)(i) per the discussion further above), 17.111(f)(11)(i), and 17.4600(d)(1)(ii)(A) (revised in this final rule as paragraph (d)(4)(i)(A) per the discussion further below) could overlap with the revised language to §§ 17.108(d)(14)(ii), 17.110(c)(14)(ii), 17.111(f)(11)(ii), and 17.4600(d)(1)(ii)(B) described above. However, to ensure VA is consistent with the language in the definition of Indian in 25 U.S.C. 1603(13)(A), VA will revise the language proposed in §§ 17.108(d)(14)(ii), 17.110(c)(13)(ii) (revised in this final rule as paragraph (c)(14)(ii) per the discussion further above), 17.111(f)(11)(ii), and 17.4600(d)(1)(ii)(B) (revised in this final rule as paragraph (d)(4)(i)(B) per the discussion further below), as explained in the previous paragraph. These changes have no substantive impact on provision of benefits or services to veterans.

Additionally, we are making minor revisions to the language proposed in §§ 17.108(d)(14)(i), 17.110(c)(13)(ii) (revised in this final rule as paragraph (c)(14)(ii) per the discussion further above), 17.111(f)(11)(i), and 17.4600(d)(1)(ii)(A) (revised in this final rule as paragraph (d)(4)(i)(A) per the discussion further below) to remove the hyphen between ''federally-recognized'' and replacing it with space so that the language in those paragraphs states ''federally recognized''. This is a minor edit to ensure the appropriate use of the term. These changes have no substantive impact on provision of benefits or services to veterans.

VA is also making minor revisions to capitalize the term ''Tribe'' throughout §§ 17.108(d)(14), 17.110(c)(14), 17.111(f)(11), and 17.4600(d)(4), as VA did not capitalize such term in the proposed regulatory text for such sections. Capitalizing the term ''Tribe'' is consistent with the Government Publishing Office Style Guide.

Finally, VA is making additional edits to the language it proposed as part of the urgent care regulation in 38 CFR 17.4600(d) to accommodate comments and expand the copayment exemption to all urgent care visits. The language in paragraph (d)(1) is amended so that it states, ''Except as provided in paragraphs (d)(2) through (4) of this section.'' This change will accommodate the new exception for Indian and urban Indian to be copayment exempt for all urgent care visits.

VA is amending the language that was proposed in paragraph (d)(1)(ii) and adding it as a new paragraph (d)(4)(i) in 38 CFR 17.4600. The language in paragraph (d)(1)(ii) of the proposed rule stated that a veteran would be required to pay a copayment for urgent care ''[a]fter three visits in a calendar year if such eligible veteran meets the definition of Indian or urban Indian, as defined in 25 U.S.C. 1603(13) and (28). To demonstrate that they meet the definition of Indian or urban Indian, the veteran must submit to VA any of the documentation listed in paragraphs (A) through (F)''. The first sentence of (d)(4)(i) will now read ''If an eligible veteran meets the definition of Indian or urban Indian, as defined in 25 U.S.C. 1603(13) and (28), they are exempt from copayments for all urgent care visits.'' In addition, we revise the second sentence in paragraph (d)(4)(i) to state ''To demonstrate that they meet the definition of Indian or urban Indian, the veteran must submit to VA any of the documentation described in paragraphs (d)(4)(i)(A) through (F) of this section:''. This change will be consistent with the language proposed in the changes to §§ 17.108, 17.110, and 17.111 and to clarify that we are referring to paragraphs (A) through (F) of paragraph (d)(4)(i) of § 17.4600. This revised language also includes the change from ''listed'' to ''described'' as explained further above as well the new paragraph designation. This change has no substantive impact on provision of benefits or services to veterans.

VA is adding this revised language as a new paragraph (d)(4)(i) instead of as proposed paragraph (d)(1)(ii) because paragraph (d)(1), except as provided in paragraph (d)(2) or (3), explains when an eligible veteran is obligated to pay a copayment of $30 to VA. Since VA is expanding the copayment exemption to all urgent care visits, the revised language is added as an exception to the copayment requirement in paragraph (d)(1).

Further, the language in paragraph (d)(4)(i) of the proposed rule is added as new paragraph (d)(4)(ii), and to be consistent with the structural changes described above, the references to paragraph (d)(1)(ii) are revised to

paragraph (d)(4)(i). This change has no substantive impact on provision of benefits or services to veterans.

Administrative Procedure Act

The Administrative Procedure Act (APA), codified in part at 5 U.S.C. 553, generally requires that agencies publish substantive rules in the **Federal Register** and provide a 30-day delay before the rule becomes effective. However, an agency may bypass the APA's 30-day delay requirement if the rule ''recognizes an exemption or relieves a restriction,'' 5 U.S.C. 553(d)(1). This rule recognizes an exemption, in particular, a copayment exemption for Indian and urban Indian veterans, and will therefore not have the 30-day delay before it becomes effective.

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. The Office of Information and Regulatory Affairs has determined that this final rule is a significant regulatory action under Executive Order 12866. The Regulatory Impact Analysis associated with this rulemaking can be found as a supporting document at *www.regulations.gov.*

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 rule will not cause a significant economic impact on small entities since this exemption is limited to individual veterans who VA determines to be Indian or urban Indian. Therefore, pursuant to 5 U.S.C. 605(b), the initial and final regulatory flexibility analysis requirements of 5 U.S.C. 603 and 604 do not apply.

Unfunded Mandates

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

Paperwork Reduction Act

The Paperwork Reduction Act of 1995 (44 U.S.C. 3507(d)) requires that VA consider the impact of paperwork and other information collection burdens imposed on the public. Government agencies must seek approval from the Office of Management and Budget (OMB), which assigns a control number for each collection of information it approves. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays currently valid OMB control number (5 CFR 1320.8(b)(3)(vi)).

This final rule includes provisions constituting new collections of information under the Paperwork Reduction Act of 1995 that require approval by OMB. Accordingly, under 44 U.S.C. 3507(d), VA has submitted a copy of this rulemaking action to OMB for review.

Sections 17.108, 17.110, 17.111, and 17.4600 contain new collections of information. OMB has filed a comment on these information collections that were submitted in conjunction with the proposed rule. OMB requested that VA develop a cover form as part of these information collections. Such cover form would accompany the veteran's documentation demonstrating that they meet the definition of Indian or urban Indian and would include the veteran's name and contact information. VA has developed such cover form and submitted it to OMB for review and approval as part of these information collections. VA anticipates these information collections to be approved 30 days after publication of the final rule.

This information will be collected from veterans to determine if they meet the definition of Indian or urban Indian as defined in 25 U.S.C. 1603(13) and (28) for purposes of exempting such veterans from copayments for certain health care. Veterans will submit documentation that demonstrates that they meet these definitions of Indian or urban Indian. VA estimates that 25,000 veterans will submit their documentation one time. The estimated average burden per response is 15 minutes. VA estimates the annual cost to all respondents will be $175,062.50 per year (6,250 burden hours × $28.01 per hour). To estimate the total information collection burden cost, VA used the Bureau of Labor Statistics mean hourly wage for hourly wage for ''00–0000 All Occupations'' of $28.01 per hour. This information is available at *https://www.bls.gov/oes/current/oes.nat.htm.*

If OMB does not approve the collections of information as requested, VA will immediately remove the provisions containing the collections of information or take such other action as directed by OMB. Notice of such OMB approval will be published in a future **Federal Register** document.

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).

List of Subjects in 38 CFR Part 17

Administrative practice and procedure, Claims, Day care, Government programs—veterans, Health care, Health facilities, Health records, Medical devices, Mental health programs, Veterans.

Signing Authority

Denis McDonough, Secretary of Veterans Affairs, approved this document on March 29, 2023, 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.

Consuela Benjamin,

Regulations Development Coordinator, Office of Regulation Policy & Management, Office of General Counsel, Department of Veterans Affairs.

For the reasons stated in the preamble, the Department of Veterans Affairs amends 38 CFR part 17 as set forth below:

PART 17—MEDICAL

■ 1. The authority citation for part 17 is amended by adding entries for §§ 17.111 and 17.4600 in numerical order to read in part as follows:

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

* * * * *

Section 17.111 is also issued under 38 U.S.C. 101(28), 501, 1701(7), 1703, 1710, 1710B, 1720B, 1720D, 1722A, and 1730A.

* * * * *

Section 17.4600 is also issued under 38 U.S.C. 1725A and 1730A.

* * * * *

■ 2. Amend § 17.108 by adding paragraphs (d)(14) and (g) and the

information collection control number to the end of the section to read as follows:

§ 17.108 Copayments for inpatient hospital care and outpatient medical care.

* * * * *

(d) * * *

(14) A veteran who meets the definition of Indian or urban Indian, as defined in 25 U.S.C. 1603(13) and (28), for inpatient hospital care or outpatient medical care provided on or after January 5, 2022. To demonstrate that they meet the definition of Indian or urban Indian, the veteran must submit to VA any of the documentation described in paragraphs (d)(14)(i) through (vi) of this section:

(i) Documentation issued by a federally recognized Indian Tribe that shows that the veteran is a member of the Tribe;

(ii) Documentation showing that the veteran, irrespective of whether they live on or near a reservation, is a member of a Tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member;

(iii) Documentation showing that the veteran is an Eskimo or Aleut or other Alaska Native;

(iv) Documentation issued by the Department of Interior (DOI) showing that the veteran considered by DOI to be an Indian for any purpose;

(v) Documentation showing that the veteran is considered by the Department of Health and Human Services (HHS) to be an Indian under that Department's regulations; or

(vi) Documentation showing that the veteran resides in an urban center and meets one or more of the following criteria:

(A) Irrespective of whether they live on or near a reservation, is a member of a Tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member;

(B) Is an Eskimo or Aleut or other Alaska Native;

(C) Is considered by the Department of Interior to be an Indian for any purpose; or

(D) Is considered by HHS to be an Indian under that Department's regulations.

* * * * *

(g) *Retroactive copayment reimbursement.* After VA determines that the documentation submitted by the veteran meets the criteria in paragraph (d)(14) of this section and VA updates the veteran's record to reflect the veteran's status as an Indian or urban Indian, VA will reimburse veterans exempt under paragraph (d)(14) for any copayments that were paid to VA for inpatient hospital care and outpatient medical care provided on or after January 5, 2022 if they would have been exempt from making such copayments if paragraph (d)(14) had been in effect.

(The Office of Management and Budget has approved the information collection provisions in this section under control number 2900–TBD.)

■ 3. Amend § 17.110 by adding paragraphs (c)(14) and (d) and the information collection control number to the end of the section to read as follows:

§ 17.110 Copayments for medication.

* * * * *

(c) * * *

(14) A veteran who meets the definition of Indian or urban Indian, as defined in 25 U.S.C. 1603(13) and (28), for medications provided on or after January 5, 2022. To demonstrate that they meet the definition of Indian or urban Indian, the veteran must submit to VA any of the documentation described in paragraphs (c)(14)(i) through (vi) of this section:

(i) Documentation issued by a federally recognized Indian Tribe that shows that the veteran is a member of the Tribe;

(ii) Documentation showing that the veteran, irrespective of whether they live on or near a reservation, is a member of a Tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member;

(iii) Documentation showing that the veteran is an Eskimo or Aleut or other Alaska Native;

(iv) Documentation issued by the Department of Interior (DOI) showing that the veteran is considered by DOI to be an Indian for any purpose;

(v) Documentation showing that the veteran is considered by the Department of Health and Human Services (HHS) to be an Indian under that Department's regulations; or

(vi) Documentation showing that the veteran resides in an urban center and meets one or more of the following criteria:

(A) Irrespective of whether they live on or near a reservation, is a member of a Tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member;

(B) Is an Eskimo or Aleut or other Alaska Native;

(C) Is considered by DOI to be an Indian for any purpose; or

(D) Is considered by HHS to be an Indian under that Department's regulations.

(d) *Retroactive copayment reimbursement.* After VA determines the submitted documentation meets paragraph (c)(14) of this section and updates the veteran's record to reflect the veteran's status as an Indian or urban Indian, VA will reimburse veterans exempt under paragraph (c)(14) for any copayments that were paid to VA for medications provided on or after January 5, 2022, if they would have been exempt from making such copayments if paragraph (c)(14) had been in effect.

(The Office of Management and Budget has approved the information collection provisions in this section under control number 2900–TBD.)

■ 4. Amend § 17.111 by adding paragraphs (f)(11) and (g) and the information collection control number to the end of the section to read as follows:

§ 17.111 Copayments for extended care services.

* * * * *

(f) * * *

(11) A veteran who meets the definition of Indian or urban Indian, as defined in 25 U.S.C. 1603(13) and (28), is exempt from copayments for noninstitutional extended care including adult day health care, noninstitutional respite care, and noninstitutional geriatric evaluation provided on or after January 5, 2022. To demonstrate that they meet the definition of Indian or urban Indian, the veteran must submit to VA any of the documentation described in paragraphs (f)(11)(i) through (vi) of this section:

(i) Documentation issued by a federally recognized Indian Tribe that shows that the veteran is a member of the Tribe;

(ii) Documentation showing that the veteran, irrespective of whether they live on or near a reservation, is a member of a Tribe, band, or other organized group of Indians, including

those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member;

(iii) Documentation showing that the veteran is an Eskimo or Aleut or other Alaska Native;

(iv) Documentation issued by the Department of Interior (DOI) showing that the veteran is considered by DOI to be an Indian for any purpose;

(v) Documentation showing that the veteran is considered by the Department of Health and Human Services (HHS) to be an Indian under that Department's regulations; or

(vi) Documentation showing that the veteran resides in an urban center and meets one or more of the following criteria:

(A) Irrespective of whether they live on or near a reservation, is a member of a Tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member;

(B) Is an Eskimo or Aleut or other Alaska Native;

(C) Is considered by DOI to be an Indian for any purpose; or

(D) Is considered by HHS to be an Indian under that Department's regulations.

(g) *Retroactive copayment reimbursement.* After VA determines the submitted documentation meets paragraph (f)(11) of this section and updates the veteran's record to reflect the veteran's status as an Indian or urban Indian, VA will reimburse veterans exempt under paragraph (f)(11) for any copayments that were paid to VA for adult day health care, non-institutional respite care, and non-institutional geriatric evaluation provided on or after January 5, 2022, if they would have been exempt from making such copayments if paragraph (f)(11) had been in effect.

(The Office of Management and Budget has approved the information collection provisions in this section under control number 2900–TBD.)

■ 5. Amend § 17.4600 by revising paragraph (d)(1) and adding paragraph (d)(4) and the information collection control number to the end of the section to read as follows:

§ 17.4600 Urgent care.

* * * * *

(d) * * *

(1) Except as provided in paragraphs (d)(2) through (4) of this section, an eligible veteran, as a condition for receiving urgent care provided by VA under this section, must agree to pay VA (and is obligated to pay VA) a copayment of $30:

* * * * *

(4)(i) If an eligible veteran meets the definition of Indian or urban Indian, as defined in 25 U.S.C. 1603(13) and (28), they are exempt from copayments for all urgent care visits. To demonstrate that they meet the definition of Indian or urban Indian, the veteran must submit to VA any of the documentation described in paragraphs (d)(4)(i)(A) through (F) of this section:

(A) Documentation issued by a federally recognized Indian Tribe that shows that the veteran is a member of the Tribe;

(B) Documentation showing that the veteran, irrespective of whether they live on or near a reservation, is a member of a Tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member;

(C) Documentation showing that the veteran is an Eskimo or Aleut or other Alaska Native;

(D) Documentation issued by the Department of Interior (DOI) showing that the veteran is considered by DOI to be an Indian for any purpose;

(E) Documentation showing that the veteran is considered by the Department of Health and Human Services (HHS) to be an Indian under that Department's regulations; or

(F) Documentation showing that the veteran resides in an urban center and meets one or more of the following criteria:

(*1*) Irrespective of whether they live on or near a reservation, is a member of a Tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member;

(*2*) Is an Eskimo or Aleut or other Alaska Native;

(*3*) Is considered by DOI to be an Indian for any purpose; or

(*4*) Is considered by HHS to be an Indian under that Department's regulations.

(ii) After VA determines the submitted documentation meets paragraph (d)(4)(i) of this section and updates the veteran's record to reflect the veteran's status as an Indian or urban Indian, VA will reimburse eligible veterans exempt under paragraph (d)(4)(i) for any copayments that were paid to VA for urgent care visits provided on or after January 5, 2022, if they would have been exempt from making such copayments if paragraph (d)(4)(i) had been in effect.

* * * * *

(The Office of Management and Budget has approved the information collection provisions in this section under control number 2900–TBD.)

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ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 180

[EPA–HQ–OPP–2022–0671; FRL–10568–01–OCSPP]

Deltamethrin; Pesticide Tolerances

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final rule.

SUMMARY: This regulation establishes tolerances for residues of deltamethrin in or on the raw agricultural commodities, Vegetable, legume, pulse, bean, dried shelled, except soybean, subgroup 6–22E and Vegetable, legume, pulse, pea, dried shelled, subgroup 6–22F. Bayer CropScience requested these tolerances under the Federal Food, Drug, and Cosmetic Act (FFDCA).

DATES: This regulation is effective April 4, 2023. Objections and requests for hearings must be received on or before June 5, 2023, and must be filed in accordance with the instructions provided in 40 CFR part 178 (see also Unit I.C. of the **SUPPLEMENTARY INFORMATION**).

ADDRESSES: The docket for this action, identified by docket identification (ID) number EPA–HQ–OPP–2022–0671, is available at *https://www.regulations.gov* or at the Office of Pesticide Programs Regulatory Public Docket (OPP Docket) in the Environmental Protection Agency Docket Center (EPA/DC), West William Jefferson Clinton Bldg., Rm. 3334, 1301 Constitution Ave. NW, Washington, DC 20460–0001. The Public Reading Room is open from 8:30 a.m. to 4:30 p.m., Monday through Friday, excluding legal holidays. The telephone number for the Public Reading Room and the OPP Docket is (202) 566–1744. For the latest status information on EPA/DC services, docket access, visit *https://www.epa.gov/dockets.*