121°02′00″ W.; to lat. 41°41′00″ N., long. 120°41′04″ W.; to lat. 41°41′00″ N., long. 120°20′00″ W.; to lat. 41°14′00″ N., long. 120°15′00″ W., to lat. 41°02′00″ N., long. 120°39′30″ W.; to lat. 41°05′00″ N., long. 121°03′00″ W.; to lat. 41°22′00″ N., long. 121°15′00″ W., thence to the point of beginning.

Issued in Seattle, Washington, on May 12, 2011.

John Warner,

Manager, Operations Support Group, Western Service Center.

[FR Doc. 2011–12360 Filed 5–18–11; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 17

RIN 2900–AN80

Medical Foster Homes

AGENCY: Department of Veterans Affairs.

ACTION: Proposed rule.

SUMMARY: This document proposes to amend the Department of Veterans Affairs (VA) "Medical" regulations to add rules relating to medical foster homes. Currently, VA's medical foster home program, whenever possible and appropriate, relies upon existing regulations that govern community residential care facilities; however, these existing regulations do not adequately or appropriately cover all aspects of medical foster homes, which provide community based care in a smaller, residential facility and to a more medically complex and disabled population. The proposed rules reflect current VA policy and practice, and generally conform to industry standards and expectations.

DATES: Comments on the proposed rule must be received by VA on or before July 18, 2011.

ADDRESSES: Written comments may be submitted through *http://www.Regulations.gov;* by mail or hand-delivery to the 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–AN80, Medical Foster Homes." 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 a.m. and 4:30 p.m., Monday through Friday (except holidays). Please call (202) 461–4902 for an appointment. This is not a toll-free number. In addition, during the comment period, comments may be viewed online at *http://www.Regulations.gov* through the Federal Docket Management System (FDMS).

FOR FURTHER INFORMATION CONTACT: Rick Greene, Office of Patient Care Services (114), Veterans Health Administration, Department of Veterans Affairs, 810 Vermont Avenue, NW., Washington, DC 20420, (202) 461–6786. (This is not a toll free number.)

SUPPLEMENTARY INFORMATION:

General Background

Many veterans who are disabled due to complex chronic disease or traumatic injury may be unable to live safely and independently, or may have health care needs that exceed the capabilities of their families. Many of these veterans are placed in nursing homes. However, with the proper support, many veterans who previously would have been placed in nursing homes can continue to live in a home and delay, or totally avoid, the need for nursing home care. VA's community residential care program, specifically authorized by 38 U.S.C. 1730 and implemented at 38 CFR 17.61 through 17.72, has provided health care supervision to eligible veterans who are not able to live independently and have no suitable family or significant others to provide needed supervision and supportive care.

A medical foster home is a specific type of community residential care facility that provides home-based care to a small number of residents with serious chronic disease and disability. Under 38 U.S.C. 1730 as implemented by 38 CFR 17.61(b), community residential care is not a substitute for nursing home care. A medical foster home provides a greater level of care than a community residential care facility (and in this respect a medical foster home is more analogous to nursing home care), while allowing veterans to live in a home-like setting and maintain a greater degree of independence. VA interprets 38 U.S.C. 1730 as authorizing a medical foster home program, as a subset of the community residential care program. In particular, we believe medical foster homes fit within the type of facility authorized by section 1730(f), since they provide "room and board and * * * limited personal care." The medical foster home program is targeted to the needs of veterans who meet the eligibility criteria, which we would establish in proposed 38 CFR 17.73(c).

Through the medical foster home program, VA recognizes and approves certain medical foster homes for the placement of veterans. When a veteran is placed in an approved medical foster home, VA will provide inspections of the home, oversight, and medical foster home caregiver training. If a medical foster home does not meet our criteria for approval, VA will not provide these benefits and services, which, in turn, may discourage veterans from seeking to be placed in that home. Thus, the process of obtaining and maintaining VA approval has a substantial and vital impact on the lives of veterans, and is useful to medical foster homes.

Currently, VA does not have regulations specifically targeted at governing medical foster homes, and, when necessary and appropriate, we have relied upon the regulations that govern all community residential care facilities, industry standards, and VA policy and practice to ensure the safety and quality of approved VA medical foster homes. However, many of our current regulations governing community residential care cannot or should not apply to medical foster homes. For example, the life safety provisions in 38 CFR 17.63 refer to industry standards that specifically govern facilities with four or more residents, while medical foster homes, by definition, provide care to three or fewer residents. By establishing these regulations, we intend to make clear to the public the criteria which VA will use when deciding whether to approve a medical foster home. Moreover, our current regulations applicable to community residential care facilities do not adequately protect bedridden patients. The current regulations are only intended to address homes where personal care services are provided to veterans and are not intended to address bedridden patients.

This proposed rule would reflect current practice and policy and would require approved facilities to conform with applicable state and local regulations. The proposed rule is also based, as much as possible, on our current regulations governing community residential care. Because the proposed rule would reflect industry standards and current VA policy and procedures, we do not expect that it would have a significant or adverse impact on medical foster homes that are currently approved by VA, or on those that are not approved but who would seek approval under the proposed rule.

Section 17.73 Medical Foster Homes—General

Proposed § 17.73(a) would briefly describe the purpose of the medical foster home program, and clarify that a choice to become a resident in a medical foster home is a voluntary decision on

the part of the veteran. The proposed regulation would note that VA's role is limited to referring veterans to approved medical foster homes, and that only veteran residents placed in approved homes can depend on VA to provide ongoing oversight and inspections of the home.

Proposed § 17.73(b) would contain definitions applicable to the medical foster homes program. These proposed definitions are consistent with current practice and policy.

"Labeled" would have a definition consistent with the definition established in the 2009 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code, Chapter 3, 3.2.4. Although proposed § 17.74(a)(3) would make chapter 3 of the NFPA 101 applicable to medical foster homes, we believe it would be useful to include a definition of this term in our regulations. Defining "labeled" this way would ensure that medical foster homes adhere to certain standards when utilizing equipment.

We would define "medical foster home" as "a private home in which a medical foster home caregiver provides care to a veteran resident and: (1) The medical foster home caregiver lives in the medical foster home; (2) the medical foster home caregiver owns or rents the medical foster home; and (3) there are not more than three residents receiving care (including veteran and non-veteran residents)." This definition would adequately identify and distinguish medical foster homes from other types of community residential care facilities that are governed by current §§ 17.61 through 17.72. In addition, this definition reflects the intended purpose of a medical foster home, which is to provide care in a small, privately owned, residential-type facility.

The proposed definition of "medical foster home caregiver" would be "the primary person who provides care to a veteran resident." This would typically entail providing a safe environment, room and board, supervision, and personal assistance, as appropriate for each veteran. We would use the phrase "primary person" because relief caregivers may assist the medical foster home caregiver, as noted in the proposed definition.

We would include a definition of "placement" that clarifies that VA does not "place" veterans in medical foster homes; rather, placement "refers to the voluntary decision by a veteran to become a resident in an approved medical foster home."

We would define a "veteran resident" to be an eligible veteran residing in an approved medical foster home. This definition is necessary to clarify that only veterans placed in approved homes can depend on VA to provide ongoing oversight and inspections of the home.

Proposed § 17.73(c) would outline eligibility criteria that must be met before VA will refer a veteran to a medical foster home. We propose to condition eligibility on three criteria.

In proposed § 17.73(c)(1), we would condition eligibility on the veteran being unable to live independently safely, or being in need of nursing home level care. These alternate criteria are necessary because medical foster homes are intended to provide a higher level of care than most community residential care facilities. Medical foster homes are designed to be alternatives to nursing home care, or to provide support for veterans who do not live with a family member who is able to provide needed care and assistance. These alternate criteria will ensure that the medical foster home program reaches these types of veterans.

In proposed § 17.73(c)(2), we would condition eligibility on enrollment in either a VA Home Based Primary Care or VA Spinal Cord Injury Homecare program. VA Home Based Primary Care (HBPC) is a home care program designed to meet the longitudinal, primary care needs of an aging veteran population with complex, chronic, disabling disease. In contrast to the episodic, time-limited and focused skilled-care services reimbursed by other funding mechanisms such as Medicare, HBPC provides comprehensive longitudinal care of patients often for the remainder of their lives. HBPC provides cost effective primary care services in the home and includes palliative care, rehabilitation, disease management, and coordination of care. One of the principle requirements of VA HBPC program is an interdisciplinary team that includes a physician medical director, a program director, and staff from nursing, social work, rehabilitation, dietetics, and pharmacy. Other services frequently needed include pastoral care and mental health.

Similar to the HBPC, the Spinal Cord Injury (SCI) Homecare program consists of interdisciplinary services as an integral part of SCI outpatient services. The SCI Homecare program supports the transition and medical needs of patients in the home setting, decreasing the need for hospitalization when possible. The program provides a full range of care for all enrolled veterans who have sustained a spinal cord injury or have a stable neurologic impairment of the spinal cord.

Requiring participation in either HBPC or SCI Homecare Program is necessary because these are currently the only two VA programs through which we can use an interdisciplinary medical team to treat, or supervise the treatment of, medically complex veterans placed in the community. The criterion is consistent with current practice; currently, any veteran who wishes to be placed in a medical foster home must enroll in either a VA Home Based Primary Care or VA Spinal Cord Injury Homecare program. Similarly, when VA identifies veterans who might benefit from placement in a medical foster home, we require them first to enroll in one of these care programs, and then refer them to an approved medical foster home for placement. Again, as of the publication of this proposed rule, all veterans placed in medical foster homes are enrolled in one of the two programs identified in proposed paragraph (c)(2), and these are currently the only two VA programs that service the population of veterans who could benefit from medical foster home placement. Because VA may establish programs similar to the HBPC or SCI Homecare program in the future, we would also include as part of the eligibility criteria "similar VA interdisciplinary program designed to assist medically complex veterans living in the home." Such programs would have similar missions (*i.e.,* offering clinically sufficient care in a secure home environment) to HBPC and SCI Homecare program, and similar clinical staff dedicated to fulfill that mission.

In proposed § 17.73(c)(3) we would require VA approval of the medical foster home in accordance with proposed § 17.73(d). This would premise eligibility on the medical foster home having met the standards in proposed § 17.74.

Proposed § 17.73(d) would make the procedures for approving medical foster homes identical to the procedures for approving community residential care facilities. We have determined that current approval procedures for community residential care facilities would be adequate, irrespective of the smaller, less institutionalized nature of medical foster homes and the differing criteria for approval. This is because the salient concerns in the approval of medical foster homes are very similar to the factors to be considered in the approval of community residential care facilities, namely, the fitness of the facility for providing a safe and comfortable environment for veteran residents. Accordingly, proposed paragraph (d) is substantively identical to the first (undesignated) paragraph of

current § 17.63. Additionally, proposed § 17.73(d) would prescribe that the approval process is governed by the approval process for community residential care facilities in current §§ 17.65 through 17.72.

Proposed § 17.73(e) would establish the duties of medical foster home caregivers. We propose to require that the medical foster home caregiver, with assistance from relief caregivers, provide a safe environment, room and board, supervision, and personal assistance, as appropriate for each veteran.

Section 17.74 Standards Applicable to Medical Foster Homes

Due to the fact that the Medical Foster Home program pre-dates this proposed rule, and that proposed §§ 17.73 and 17.74 conform to current practice and enforcement policy, VA does not believe there are any approved medical foster homes that are not presently in compliance with the requirements of this proposed rule.

Proposed § 17.74(a) is based on current § 17.63(a). Proposed § 17.74(a)(1) and (2) are substantively identical to § 17.63(a)(1) and (3), except that we would add in proposed paragraph (a)(2) that "[v]entilation for cook stoves is not required." We have determined that it is not necessary to impose this requirement on these smaller, home-based facilities that provide food for a small number of residents. Proposed § 17.74(a)(3) is similar to current § 17.63(a)(2), except that it would make chapters 1 through 11, 24, and section 33.7 of the NFPA 101 applicable to medical foster homes.

Proposed § 17.74(b) would prescribe the community residential care facility standards that also would be applicable to medical foster homes. We note that we would make current § 17.63(k), regarding the cost of community residential care, applicable to medical foster homes, but the reference would be to § 17.63(k) as it is proposed to be amended.

Beginning with proposed § 17.74(c), we would set forth unique standards applicable to medical foster homes. Proposed paragraph (c), and most of the paragraphs that follow, would adopt and/or modify existing regulatory or NFPA standards to make them appropriate for medical foster homes, or would address safety standards imposed by VA because we believe that they are appropriate for such homes. We believe that the standards set forth in the proposed rule are clear and straightforward, and plainly necessary for the safety and comfort of medical foster home residents, but a few of these paragraphs warrant specific discussion. Moreover, all medical foster homes currently recognized by VA conform to these NFPA standards.

Proposed paragraph (c) would require the medical foster home to plan and facilitate appropriate recreational and leisure activities because this requirement will help ensure the quality of life of the veteran resident(s). It is consistent with the current practice of all medical foster homes currently recognized by VA.

Proposed § 17.74(d) would contain standards for bedrooms in medical foster homes, just as current § 17.63(e) establishes such standards for other community residential care facilities. We propose to require each veteran resident to have a bedroom (1) with a door that closes and latches; (2) that contains a suitable bed and appropriate furniture; and (3) that is single occupancy, unless the veteran agrees to a multi-occupant bedroom. We have determined that these requirements are necessary for the comfort of those who reside in medical foster homes, but due to the size of most medical foster homes, ordinarily a single family dwelling, we decline to set a minimum bedroom size as in § 17.63(e).

Proposed § 17.74(e) would establish a temporary exception to chapter 24 of the NFPA 101, which is made applicable by paragraph (a)(3), concerning windows used as a secondary means of escape. Due to their small size and residential character, we expect some medical foster homes may not initially have windows that are in compliance with the requirements of chapter 24. Rather than failing to approve an otherwise acceptable medical foster home on this basis, we propose to provisionally approve a medical foster home, provided that the secondary means of escape is brought into compliance no later than 60 days after a veteran resident is placed in the home. While current § 17.65 provides for a 12-month provisional approval period, or such time as the parties determine is reasonably necessary for correcting deficiencies in community residential care facilities, that section provides a maximum length of time for all potential deficiencies, including deficiencies more problematic than issues with windows. We have determined that 60 days is a reasonable period of time to achieve compliance with this important, but relatively straightforward, requirement.

Proposed § 17.74(f) would permit special locking devices that do not conform to section 7.2.1.5 of NFPA 101 where the clinical needs of the veteran require specialized security measures, so long as there is written approval for the alternate device from both the VA clinician, as well as the VA fire/safety specialist or the Director of the VA Medical Center of jurisdiction. Nonstandard locking devices might be used for patient safety—particularly, to address concerns caused by "wandering" patients. The Life Safety Code does not allow such locking devices, which is why we need to establish this exception.

Proposed § 17.74(g) would concern smoke and carbon monoxide (CO) detectors. Due to their small size and residential character, some medical foster homes may not have detection systems that specifically meet the requirements of the proposed paragraph. We therefore propose to allow a 60-day provisional approval period for a medical foster home that mitigates risk through the use of battery-operated single station alarms for smoke and CO detection. In proposed paragraph (g)(1), we would require that homes install smoke detectors or smoke alarms in accordance with sections 24.3.4.1 or 24.3.4.2 of NFPA 101. We recognize that a UL985-listed household fire warning system or a UL864-listed fire alarm system would be permissible in these facilities, and note that the cited NFPA 101 sections are consistent with this recognition.

Proposed § 17.74(h) concerns sprinkler systems. Sprinkler systems would not be required in all medical foster homes. Rather, we would require sprinkler systems only when they are required by the NFPA, which only requires sprinkler systems for new construction pursuant to NFPA 13. However, when a medical foster home contains a sprinkler system, whether it was installed to comply with NFPA 13 or simply due to the wishes of the medical foster home caregiver, we would require it to be inspected, tested, and maintained in accordance with NFPA 25. This is to ensure that sprinkler systems in medical foster homes are in good working order and can safely be relied upon.

In § 17.74(o)(1), we would prescribe that "[u]se of extension cords must be limited" without prescribing any specific standard. It is not possible to prescribe a specific requirement, such as limiting the use to four or less extension cords, because different facilities will have different needs. By stating that the use must be limited, we intend to discourage the use of extension cords and to allow our field inspectors to use their expertise to determine whether a particular medical foster home is relying inappropriately on the use of extension cords. Extension cords could become

overloaded if users attach equipment that draws more amperage (current) than the amperage for which the cord is rated. Drawing more current than the cord is rated for could result in overheating of the cord and presents a fire hazard. Extension cords should not be used as a branch circuit of the home electrical system. Rather, fixed circuits should be installed. If the extension cords are run through doorways, the action of the door over time could wear off the outer insulation of the cord, resulting in a shock hazard. The insulation could also become worn off if the extension cord is run under the carpeting. Extension cords could also create a tripping hazard.

In proposed § 17.74(o)(2), we would require that flammable or combustible liquids and other hazardous material be safely and properly stored in either the original, labeled container, or in a safety can as defined by NPFA 30 (2008 edition). This is to ensure that dangerous materials are only kept in containers that are specifically designed to store them as safely as possible, rather than in ordinary household containers which might increase fire risk associated with those materials.

In proposed § 17.74(p), we would prescribe special requirements for emergency egress and relocation drills in order to ensure that medical foster homes have a workable plan to be able to evacuate all residents in case of an emergency. In particular, in paragraph (p)(2), we would require that the medical foster home caregiver "demonstrate the ability to evacuate all occupants within three minutes to a point of safety outside of the medical foster home that has access to a public way." The term "all occupants" means every person in the home at the time of the emergency egress and relocation drill, including non-residents. Although the purpose of the proposed rule is to establish requirements for the approval of medical foster homes for use by veteran residents, we do not believe that it is realistic merely to demonstrate the ability to evacuate all veteran-residents. In a real emergency, the medical foster home caregiver will need to ensure the timely evacuation of up to three residents and any other persons inside the home. As such, we would require a demonstration of such ability. For any home that fails to meet the evacuation requirements of proposed paragraph (p)(2), we would in paragraph (p)(3) allow a 60-day provisional approval during which time the medical foster home must establish an alternative to such evacuation. During that provisional approval period, VA inspectors would be authorized to require the home to increase its fire protection measures. Facilities that are unable to comply with paragraph (p)(2) would be required to implement one of the remedial options outlined in paragraph (p)(3), both of which are reasonable ways to ensure the safety of veteran residents in the event of a fire at the home.

In proposed § 17.74(q), we would incorporate all records requirements contained in current § 17.63(i), except for the "statement of needed care" requirement, because no such statement is required for medical foster homes. The statement is not needed because interdisciplinary VA clinical teams provide direct assistance to the veteran and medical foster home caregiver pursuant to the requirement that the veteran be enrolled in one of the programs identified in the proposed definition of veteran resident in § 17.73.

In proposed § 17.74(s), we would authorize approval of equivalencies in extremely rare circumstances, and only when the equivalencies are in accordance with NFPA 101, section 1.4.3, and with the approval of the appropriate Veterans Health Administration, Veterans Integrated Service Network (VISN) Director. These criteria are designed to ensure that equivalencies are only granted when the equivalency will not endanger resident safety, the medical foster home cannot comply with all requirements of this part without prohibitive expense, and when VA's decision not to approve the medical foster home in question would lead to a shortage of approved medical foster homes in a given area. Further, we would require that a veteran placed in the home be given notice of the equivalencies and the reasons for them. This notice would describe the equivalency with particularity, including identifying the exempted requirement and explaining why the exemption is necessary. We intend that veterans would make informed choices when they decide to live in a medical foster home that has been granted an equivalency. We would limit the authority to grant an equivalency to circumstances where the technical requirements of the proposed rule would cause an undue expense, there is no other nearby home to provide an adequate alternative, and the equivalency is in the best interest of the veteran. This might occur, *e.g.,* when a veteran wishes to be placed in a home located near his or her family's residence, but that home fails to meet a requirement such as that the windows are a quarter of an inch too small to meet the proposed § 17.74(e) standard. If such a defect can be remedied without imposing a cost on the medical foster home that the VISN Director considers undue expense, an equivalency would not be authorized. If there is no adequate alternative to the equivalency and the VISN Director determines the equivalency is in the best interest of the veteran, it would be authorized.

Proposed § 17.74(u)(1) would clarify that payment for the charges to veterans for the cost of medical foster home care is not the responsibility of the U.S. Government. However, paragraphs (u)(2) and (3) would prescribe requirements designed to ensure that medical foster homes approved by VA do not charge usurious rates or rates that are not comparable to the rates charged to non-veterans in the same or comparable medical foster homes. We also want to ensure that we do not approve a home that dramatically increases the rates charged to a veteran resident after the veteran has moved into the home, without a reasonable basis for such increase (such as a worsening of the veteran's condition requiring an increased level of care). These provisions are designed to allow the medical foster home to charge an appropriate rate based on the level of care and supervision required by the particular veteran, but are also designed to ensure that VA does not approve a home that charges unfair rates. They are also designed to be flexible, based on the resources of the particular medical foster home. We note that it is only in very rare cases that VA would use costs as a reason to not approve a medical foster home. We also note that this "costs" paragraph is significantly different from the one applicable to other community residential care facilities, *i.e.,* current § 17.63(k), because of the higher degree of medical complexity and care required by medical foster home residents. It is not feasible to apply an across-the-board base rate for each facility as we did with Community Residential Care facilities in § 17.63(k) because the higher degree of medical complexity associated with each veteran means that appropriate levels of care and therefore costs will vary widely between medical foster home patients.

Incorporations by Reference

Proposed § 17.74(t) would incorporate by reference the NFPA standards identified in proposed §§ 17.73 and 17.74. Because of the unique nature of medical foster homes, we cannot rely solely on particular, existing NFPA publications, as we do with other community residential care and housing regulations. On February 24, 2011, VA published in the **Federal Register**, at 76

FR 10246, a final rule to establish a centralized regulation (38 CFR 17.1) for incorporations by reference in part 17 of title 38 CFR. This proposed rule would incorporate by reference the versions of the NFPA standards that are current as of the date of publication of the proposed rule. In the future, we will amend this regulation if and when the incorporated NFPA standards are changed in a way that we believe is relevant to medical foster homes. We believe that this will assist medical foster homes in clearly identifying whether any changes are required based on changes to the NFPA codes cited herein.

Approval of Incorporations by Reference

We propose to amend our regulations to require medical foster homes seeking VA approval to meet the requirements of the following NFPA codes and standards: NFPA 10, Standard for Portable Fire Extinguishers (2010 edition); NFPA 13, Standard for the Installation of Sprinkler Systems (2010 edition); NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes (2010 edition); NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies Up To and Including Four Stories in Height (2010 edition); NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems (2008 edition); NFPA 30, Flammable and Combustible Liquids Code (2008 edition); NFPA 72, National Fire Alarm and Signaling Code (2010 edition); and NFPA 720, Standard for the Installation of Carbon Monoxide (CO) Detection and Warning Equipment (2009 edition). We also propose to amend our regulations to require medical foster homes seeking VA approval to meet the requirements of the following chapters and/or sections of NFPA 101, National Fire Protection Association's Life Safety Code (NFPA 101) (2009 edition): Chapters 1 through 11, 24, and section 33.7.

This action is necessary to ensure that medical foster homes meet current industry-wide safety standards. We will request that the Office of the Federal Register approve our incorporation by references.

These materials for which we are seeking incorporation by reference are available for inspection at the Department of Veterans Affairs, Office of Regulations Management (02REG), 810 Vermont Avenue, NW., Room 1068, Washington, DC 20420, or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call (202) 741–6030, or go to: *http://www.archives.gov/federal--register/code--of--federal--regulations/ibr--locations.html*. Copies may be obtained from the National Fire Protection Association, Battery March Park, Quincy, MA 02269. (For ordering information, call toll-free 1–800–344–3555.)

Currently § 17.1 contains the materials that are incorporated by reference (IBR) for part 17. The Office of the Federal Register requires that if an agency has established an IBR section, then all approvals must be listed in that part. We, therefore, propose to amend § 17.1(b) to add the new IBR approvals contained in this proposed rulemaking.

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 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 given year. The proposed rule would have no such effect on state, local, and Tribal governments, or on the private sector.

Paperwork Reduction Act

This proposed rule includes a collection of information under the Paperwork Reduction Act (44 U.S.C. 3501–3521) that requires approval by the Office of Management and Budget (OMB). Accordingly, under section 3507(d) of the Act, VA has submitted a copy of this rulemaking to OMB for review. OMB assigns a control number for each collection of information it approves. Except for emergency approvals under 44 U.S.C. 3507(j), VA may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Proposed § 17.74(q) contains a collection of information under the Paperwork Reduction Act (44 U.S.C. 3501–3521). If OMB does not approve the collection of information as requested, VA will immediately remove the provisions containing a collection of information or take such other action as is directed by OMB.

Comments on the collection of information contained in this proposed rule should be submitted to the Office of Management and Budget, Attention: Desk Officer for the Department of Veterans Affairs, Office of Information and Regulatory Affairs, Washington, DC 20503, with copies sent by mail or hand delivery to: Director, Office of Regulation Policy and Management (02REG), Department of Veterans Affairs, 810 Vermont Ave., NW., Room 1068, Washington, DC 20420; fax to (202) 273–9026; or through *http://www.Regulations.gov*. Comments should indicate that they are submitted in response to "RIN 2900–AN80–Medical Foster Homes."

OMB is required to make a decision concerning the collections of information contained in this proposed rule between 30 and 60 days after publication of this document in the **Federal Register**. Therefore, a comment to OMB is best assured of having its full effect if OMB receives it within 30 days of publication. This does not affect the deadline for the public to comment on the proposed rule.

VA considers comments by the public on proposed collections of information in—

- Evaluating whether the proposed collections of information are necessary for the proper performance of the functions of VA, including whether the information will have practical utility;
- Evaluating the accuracy of VA's estimate of the burden of the proposed collections of information, including the validity of the methodology and assumptions used;
- Enhancing the quality, usefulness, and clarity of the information to be collected; and
- Minimizing the burden of the collections of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, *e.g.,* permitting electronic submission of responses.

The proposed amendments to title 38 CFR chapter 17 contain collections of information under the Paperwork Reduction Act for which we are requesting approval by OMB.

Title: Medical Foster Homes.

Summary of collection of information: Paragraph (q) would require medical foster homes to comply with the recordkeeping requirements of 38 CFR 17.63(i) regarding facility records, and must document all inspection, testing, drills and maintenance activities required by this section. Such documentation must be maintained for 3 years or for the period specified by the applicable NFPA standard, whichever is longer. Documentation of emergency egress and relocation drills must include the date, time of day, length of time to evacuate the home, the name of each medical foster home caregiver who participated, the name of each resident,

whether the resident participated, and whether the resident required assistance.

Description of the need for information and proposed use of information: The information is needed to ensure the safety of veteran residents because medical foster homes operate in a residential setting in the community.

Description of likely respondents: Medical foster homes who seek to be approved by VA.

Estimated number of respondents per year: 300 medical foster homes.

Estimated frequency of responses per year: 6 times per year.

Estimated total annual reporting and recordkeeping burden: 600 hours.

Executive Order 12866

Executive Order 12866 directs agencies to assess all 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, and other advantages; distributive impacts; and equity). The Executive Order classifies a "significant regulatory action," requiring review by OMB unless OMB waives such review, 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 planned or taken 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 the Executive Order.

The economic, interagency, legal, and policy implications of this proposed rule have been examined, and it has been determined not to be a significant regulatory action under Executive Order 12866.

Regulatory Flexibility Act

The Secretary hereby certifies that 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. In addition to having an effect on individuals (veterans), the proposed rule would have an insignificant economic impact on a few small entities. Most of the minimum standards that would be established by this rulemaking are already required by state and local regulations, and medical foster homes should already be in compliance with those regulations or with the current NFPA codes. Any additional costs for compliance with the proposed rule would constitute an inconsequential amount of the operational costs of such facilities. Accordingly, pursuant to 5 U.S.C. 605(b), this rule is exempt from the initial and final regulatory flexibility analysis requirements of sections 603 and 604.

Catalog of Federal Domestic Assistance

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

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 May 11, 2011, 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, Incorporation by reference, Medical and dental schools, Medical devices, Medical research, Mental health programs, Nursing homes, Philippines, Reporting and recordkeeping requirements, Scholarships and fellowships, Travel and transportation expenses, Veterans.

Dated: May 13, 2011.

Robert C. McFetridge,

Director, Regulations Policy and Management, Department of Veterans Affairs.

For the reasons set forth in the preamble, the Department of Veterans Affairs 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, 1721, and as noted in specific sections.

2. Revise § 17.1(b) to read as follows:

§ 17.1 Incorporation by reference.

* * * * *

(b) The following materials are incorporated by reference into this part.

(1) NFPA 10, Standard for Portable Fire Extinguishers (2010 edition), Incorporation by Reference (IBR) approved for §§ 17.63, 17.74, and 17.81.

(2) NFPA 101, Life Safety Code (2009 edition), IBR approved for §§ 17.63, 17.74 (chapters 1 through 11, 24, and section 33.7), 17.81, and 17.82.

(3) NFPA 101A, Guide on Alternative Approaches to Life Safety (2010 edition), IBR approved for § 17.63.

(4) NFPA 13, Standard for the Installation of Sprinkler Systems (2010 edition), IBR approved for § 17.74.

(5) NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes (2010 edition), IBR approved for § 17.74.

(6) NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies Up To and Including Four Stories in Height (2010 edition), IBR approved for § 17.74.

(7) NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems (2008 edition), IBR approved for § 17.74.

(8) NFPA 30, Flammable and Combustible Liquids Code (2008 edition), IBR approved for § 17.74.

(9) NFPA 72, National Fire Alarm and Signaling Code (2010 edition), IBR approved for § 17.74.

(10) NFPA 720, Standard for the Installation of Carbon Monoxide (CO) Detection and Warning Equipment (2009 edition), IBR approved for § 17.74.

(Authority: 5 U.S.C. 552(a), 38 U.S.C. 501, 1721)

3. Sections 17.73 and 17.74 are added to read as follows:

§ 17.73 Medical foster homes—general.

(a) *Purpose.* Through the medical foster home program, VA recognizes and approves certain medical foster homes

for the placement of veterans. The choice to become a resident of a medical foster home is a voluntary one on the part of each veteran. VA's role is limited to referring veterans to approved medical foster homes. When a veteran is placed in an approved home, VA will provide inspections to ensure that the home continues to meet the requirements of this part, as well as oversight and medical foster home caregiver training. If a medical foster home does not meet VA's criteria for approval, VA will not refer any veteran to the home or provide any of these services. VA may also provide certain medical benefits to veterans placed in medical foster homes, consistent with the VA program in which the veteran is enrolled.

(b) *Definitions.* For the purposes of this section and § 17.74:

Labeled means that the equipment or materials have attached to them a label, symbol, or other identifying mark of an organization recognized as having jurisdiction over the evaluation and periodic inspection of such equipment or materials, and by whose labeling the manufacturer indicates compliance with appropriate standards or performance.

Medical foster home means a private home in which a medical foster home caregiver provides care to a veteran resident and:

(1) The medical foster home caregiver lives in the medical foster home;

(2) The medical foster home caregiver owns or rents the medical foster home; and

(3) There are not more than three residents receiving care (including veteran and non-veteran residents).

Medical foster home caregiver means the primary person who provides care to a veteran resident in a medical foster home.

Placement refers to the voluntary decision by a veteran to become a resident in an approved medical foster home.

Veteran resident means a veteran residing in an approved medical foster home who meets the eligibility criteria in paragraph (c) of this section.

(c) *Eligibility.* VA health care personnel may assist a veteran by referring such veteran for placement in a medical foster home if:

(1) The veteran is unable to live independently safely or is in need of nursing home level care;

(2) The veteran must be enrolled in, or agree to be enrolled in, either a VA Home Based Primary Care or VA Spinal Cord Injury Homecare program, or a similar VA interdisciplinary program designed to assist medically complex veterans living in the home; and

(3) The medical foster home has been approved in accordance with paragraph (d) of this section.

(d) *Approval of medical foster homes.* Medical foster homes will be approved by a VA Medical Foster Homes Coordinator based on the report of a VA inspection and on any findings of necessary interim monitoring of the medical foster home, if that home meets the standards established in § 17.74. The approval process is governed by the process for approving community residential care facilities under §§ 17.65 through 17.72 except as follows:

(1) Where §§ 17.65 through 17.72 reference § 17.63.

(2) Because VA does not physically place veterans in medical foster homes, VA also does not assist veterans in moving out of medical foster homes as we do for veterans in other community residential care facilities under § 17.72(d)(2); however, VA will assist such veterans in locating an approved medical foster home when relocation is necessary.

(e) *Duties of Medical foster home caregivers.* The medical foster home caregiver, with assistance from relief caregivers, provides a safe environment, room and board, supervision, and personal assistance, as appropriate for each veteran.

(Authority: 38 U.S.C. 501, 1730)

§ 17.74 Standards applicable to medical foster homes.

(a) *General.* A medical foster home must:

(1) Meet all applicable state and local regulations, including construction, maintenance, and sanitation regulations.

(2) Have safe and functioning systems for heating, hot and cold water, electricity, plumbing, sewage, cooking, laundry, artificial and natural light, and ventilation. Ventilation for cook stoves is not required.

(3) Except as otherwise provided in this section, meet the applicable provisions of chapters 1 through 11 and 24, and section 33.7 of NFPA 101, National Fire Protection Association's Life Safety Code (NFPA 101) (2009 edition) (incorporated by reference, see § 17.1), and the other codes and chapters identified in this section, as applicable.

(b) *Community residential care facility standards applicable to medical foster homes.* Medical foster homes must comply with § 17.63(c), (d), (f), (h), (j) and (k).

(c) *Activities.* The facility must plan and facilitate appropriate recreational and leisure activities.

(d) *Residents' bedrooms.* Each veteran resident must have a bedroom:

(1) With a door that closes and latches;

(2) That contains a suitable bed and appropriate furniture; and

(3) That is single occupancy, unless the veteran agrees to a multi-occupant bedroom.

(e) *Windows.* VA may grant provisional approval for windows used as a secondary means of escape that do not meet the minimum size and dimensions required by chapter 24 of NFPA 101 (incorporated by reference, see § 17.1) if the windows are a minimum of 5.0 square feet (and at least 20 inches wide and at least 22 inches high). The secondary means of escape must be brought into compliance with chapter 24 no later than 60 days after a veteran resident is placed in the home.

(f) *Special locking devices.* Special locking devices that do not comply with section 7.2.1.5 of NFPA 101 (incorporated by reference, see § 17.1) are permitted where the clinical needs of the veteran resident require specialized security measures and with the written approval of:

(1) The responsible VA clinician; and

(2) The VA fire/safety specialist or the Director of the VA Medical Center of jurisdiction.

(g) *Smoke and carbon monoxide (CO) detectors and smoke and CO alarms.* Medical foster homes must comply with this paragraph (g) no later than 60 days after the first veteran is placed in the home. Prior to compliance, VA inspectors will provisionally approve a medical foster home for the duration of this 60-day period if the medical foster home mitigates risk through the use of battery-operated single station alarms, provided that the alarms are installed before any veteran is placed in the home.

(1) Smoke detectors or smoke alarms must be provided in accordance with sections 24.3.4.1 or 24.3.4.2 of NFPA 101 (incorporated by reference, see § 17.1); section 24.3.4.3 of NFPA 101 will not be used. In addition, smoke alarms must be interconnected so that the operation of any smoke alarm causes an alarm in all smoke alarms within the medical foster home. Smoke detectors or smoke alarms must not be installed in the kitchen or any other location subject to causing false alarms.

(2) CO detectors or CO alarms must be installed in any medical foster home with a fuel-burning appliance, fireplace, or an attached garage, in accordance with NFPA 720, Standard for the Installation of Carbon Monoxide (CO) Detection and Warning Equipment (2009 Edition) (NFPA 720) (incorporated by reference, see § 17.1).

(3) Combination CO/smoke detectors and combination CO/smoke alarms are permitted.

(4) Smoke detectors and smoke alarms must initiate a signal to a remote supervising station to notify emergency forces in the event of an alarm.

(5) Smoke and/or CO alarms and smoke and/or CO detectors, and all other elements of a fire alarm system, must be inspected, tested, and maintained in accordance with NFPA 72, National Fire Alarm and Signaling Code (2010 edition) (incorporated by reference, see § 17.1) and NFPA 720 (incorporated by reference, see § 17.1).

(h) *Sprinkler systems.* (1) If a sprinkler system is installed, it must be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems (2008 edition) (incorporated by reference, see § 17.1), unless the sprinkler system is installed in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes (2010 Edition) (NFPA 13D) (incorporated by reference, see § 17.1). If a sprinkler system is installed in accordance with NFPA 13D (incorporated by reference, see § 17.1), it must be inspected annually by a competent person.

(2) If sprinkler flow or pressure switches are installed, they must activate notification appliances in the medical foster home, and must initiate a signal to the remote supervising station.

(i) *Fire extinguishers.* At least one 2–A:10–B:C rated fire extinguisher must be visible and readily accessible on each floor, including basements, and must be maintained in accordance with the manufacturer's instructions. Portable fire extinguishers must be inspected, tested, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers (2010 edition) (incorporated by reference, see § 17.1).

(j) *Emergency lighting.* Each occupied floor must have at least one plug-in rechargeable flashlight, operable and readily accessible, or other approved emergency lighting. Such emergency lighting must be tested monthly and replaced if not functioning.

(k) *Fireplaces.* A non-combustible hearth, in addition to protective glass doors or metal mesh screens, is required for fireplaces. Hearths and protective devices must meet all applicable state and local fire codes.

(l) *Portable heaters.* Portable heaters may be used if they are maintained in good working condition and:

(1) The heating elements of such heaters do not exceed 212 degrees Fahrenheit (100 degrees Celsius);

(2) The heaters are labeled; and

(3) The heaters have tip-over protection.

(m) *Oxygen safety.* Any area where oxygen is used or stored must not be near an open flame and must have a posted "No Smoking" sign. Oxygen cylinders must be adequately secured or protected to prevent damage to cylinders. Whenever possible, trans-filling of liquid oxygen must take place outside of the living areas of the home.

(n) *Smoking.* Smoking must be prohibited in all sleeping rooms, including sleeping rooms of non-veteran residents. Ashtrays must be made of noncombustible materials.

(o) *Special/other hazards.* (1) Extension cords must be three-pronged, grounded, sized properly, and not present a hazard due to inappropriate routing, pinching, damage to the cord, or risk of overloading an electrical panel circuit.

(2) Flammable or combustible liquids and other hazardous material must be safely and properly stored in either the original, labeled container or a safety can as defined by section 3.3.44 of NFPA 30, Flammable and Combustible Liquids Code (2008 edition) (incorporated by reference, see § 17.1).

(p) *Emergency egress and relocation drills.* Operating features of the medical foster home must comply with section 33.7 of NFPA 101 (incorporated by reference, see § 17.1), except that section 33.7.3.6 of NFPA 101 does not apply. Instead, VA will enforce the following requirements:

(1) Before placement in a medical foster home, the veteran will be clinically evaluated by VA to determine whether the veteran is able to participate in emergency egress and relocation drills. Within 24 hours after arrival, each veteran resident must be shown how to respond to a fire alarm and evacuate the medical foster home, unless the veteran resident is unable to participate.

(2) The medical foster home caregiver must demonstrate the ability to evacuate all occupants within three minutes to a point of safety outside of the medical foster home that has access to a public way, as defined in NFPA 101 (incorporated by reference, see § 17.1).

(3) If all occupants are not evacuated within three minutes or if a veteran resident is either permanently or temporarily unable to participate in drills, then the medical foster home will be given a 60-day provisional approval, after which time the home must have established one of the following remedial options or VA will terminate the approval in accordance with § 17.65.

(i) The home is protected throughout with an automatic sprinkler system in accordance with section 9.7 of NFPA 101 (incorporated by reference, see § 17.1) and whichever of the following apply: NFPA 13, Standard for the Installation of Sprinkler Systems (2010 edition) (incorporated by reference, see § 17.1); NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies Up To and Including Four Stories in Height (2010 edition) (incorporated by reference, see § 17.1); or NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes (2010 edition) (incorporated by reference, see § 17.1).

(ii) Each veteran resident who is permanently or temporarily unable to participate in a drill or who fails to evacuate within three minutes must have a bedroom located at the ground level with direct access to the exterior of the home that does not require travel through any other portion of the residence, and access to the ground level must meet the requirements of the Americans with Disabilities Act. The medical foster home caregiver's bedroom must also be on ground level.

(4) The 60-day provisional approval under paragraph (p)(3) of this section may be contingent upon increased fire prevention measures, including but not limited to prohibiting smoking or use of a fireplace. However, each veteran resident who is temporarily unable to participate in a drill will be permitted to be excused from up to two drills within one 12-month period, provided that the two excused drills are not consecutive, and this will not be a cause for VA to not approve the home.

(5) For purposes of paragraph (p), the term *all occupants* means every person in the home at the time of the emergency egress and relocation drill, including non-residents.

(q) *Records of compliance with this section.* The medical foster home must comply with § 17.63(i) regarding facility records, and must document all inspection, testing, drills and maintenance activities required by this section. Such documentation must be maintained for 3 years or for the period specified by the applicable NFPA standard, whichever is longer. Documentation of emergency egress and relocation drills must include the date, time of day, length of time to evacuate the home, the name of each medical foster home caregiver who participated, the name of each resident, whether the resident participated, and whether the resident required assistance.

(r) *Local permits and emergency response.* Where applicable, a permit or license must be obtained for occupancy or business by the medical foster home caregiver from the local building or business authority. When there is a home occupant who is incapable of self-preservation, the local fire department or response agency must be notified by the medical foster home within 7 days of the beginning of the occupant's residency.

(s) *Equivalencies.* Any equivalencies to VA requirements must be in accordance with section 1.4.3 of NFPA 101 (incorporated by reference, see § 17.1), and must be approved in writing by the appropriate Veterans Health Administration, Veterans Integrated Service Network (VISN) Director. A veteran living in a medical foster home when the equivalency is granted or who is placed there after it is granted must be notified in writing of the equivalencies and that he or she must be willing to accept such equivalencies. The notice must describe the exact nature of the equivalency, the requirements of this section with which the medical foster home is unable to comply, and explain why the VISN Director deemed the equivalency necessary. Only equivalencies that the VISN Director determines do not pose a risk to the health or safety of the veteran may be granted. Also, equivalencies may only be granted when technical requirements of this section cannot be complied with absent undue expense, there is no other nearby home which can serve as an adequate alternative, and the equivalency is in the best interest of the veteran.

(t) *Incorporation by reference.* The standards required in this section are incorporated by reference into this section with the approval of the Director of the Federal Register under 5 U.S.C. 552(a) and 1 CFR part 51. To enforce any edition other than that specified in this section, VA will publish a notice of proposed rulemaking regarding the change in the **Federal Register** and the material will be made available to the public. All approved material is available for inspection at the Department of Veterans Affairs, Office of Regulation Policy and Management (02REG), Room 1068, 810 Vermont Avenue, NW., Washington, DC 20420, or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call (202) 741–6030, or go to: *http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.* Copies may be obtained from the National Fire Protection Association, Battery March Park, Quincy, MA 02269. (For ordering information, call toll-free 1–800–344–3555). The NFPA home page is: *http://www.nfpa.org/.* For information on NFPA codes or standards see the NFPA Web site at: *http://www.nfpa.org/aboutthecodes/list_of_codes_and_standards.asp.* The VA-controlled Web site that provides access to all NFPA codes and standards is: *http://vaww.ceosh.med.va.gov/01FS/pages/NFPAWarning.shtml.*

(u) *Cost of medical foster homes.* (1) Payment for the charges to veterans for the cost of medical foster home care is not the responsibility of the United States Government.

(2) The resident or an authorized personal representative and a representative of the medical foster home facility must agree upon the charge and payment procedures for medical foster home care.

(3) The charges for medical foster home care must be comparable to prices charged by other assisted living and nursing home facilities in the area based on the veteran's changing care needs and local availability of medical foster homes.

(Authority: 38 U.S.C. 501, 1730)

[FR Doc. 2011–12253 Filed 5–18–11; 8:45 am]

BILLING CODE 8320–01–P

DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 39

RIN 2900–AN90

Tribal Veterans Cemetery Grants

AGENCY: Department of Veterans Affairs.

ACTION: Proposed rule.

SUMMARY: The Department of Veterans Affairs (VA) is proposing to amend its regulations governing Federal grants for the establishment, expansion, and improvement of veterans cemeteries. We propose to implement through regulation new statutory authority to provide grants for the establishment, expansion, and improvement of Tribal Organization veterans cemeteries, as authorized by Section 403 of the "Veterans Benefits, Health Care, and Information Technology Act of 2006" (the Act). The Act requires VA to administer grants to Tribal Organizations in the same manner and under the same conditions as grants to States. The proposed rule would make non-substantive changes to the part heading of part 39 and the name of the State Cemetery Grants Service to more accurately reflect that VA awards veteran cemetery grants to States and Tribal Organizations. The proposed rule would establish criteria to guide VA's decisions on granting Tribal Organization requests to obtain grants for establishing, expanding, and improving veterans cemeteries that are or will be owned and operated by a Tribal Organization. The proposed rule would also expand VA's preapplication requirement to all veterans cemetery grants as a means to promote consistency and communication in the grant application process. Further, the proposed rule would revise VA regulations to address structural differences between Tribal Organizations and States.

DATES: Comments must be received by VA on or before July 18, 2011.

ADDRESSES: Written comments may be submitted 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 (this is not a toll free number). Comments should indicate that they are submitted in response to "RIN 2900–AN90—Tribal Veterans Cemetery Grants." 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 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: For grant issues, contact Frank Salvas, Director of Veterans Cemetery Grants Service, National Cemetery Administration (41E), Department of Veterans Affairs, 810 Vermont Avenue, NW., Washington, DC 20420. *Telephone:* (202) 461–8947 (this is not a toll-free number). For regulatory issues, contact Jane Kang, Program Analyst, Legislative and Regulatory Division, National Cemetery Administration, Department of Veterans Affairs, 810 Vermont Avenue, NW., Washington, DC 20420. *Telephone:* (202) 461–6216 (this is not a toll-free number).

SUPPLEMENTARY INFORMATION: The goal of the National Cemetery Administration (NCA) is to ensure that the burial needs of veterans and eligible family members are met by providing a burial opportunity in veterans cemeteries. In the past, NCA has done