DATES: Nominations for membership on the HICPAC should be received no later than September 17, 2022. Packages received after this time will not be considered for the current membership cycle.

ADDRESSES: All nominations should be mailed to HICPAC, Division of Healthcare Quality Promotion, NCEZID, CDC, 1600 Clifton Road NE, Mailstop H16–3, Atlanta, Georgia 30329–4027, emailed (recommended) to hicpac@cdc.gov, or faxed to (404) 639–4043.

FOR FURTHER INFORMATION CONTACT: Sydnee Byrd, MPA, HICPAC, Division of Healthcare Quality Promotion, NCEZID, CDC, 1600 Clifton Road NE, Mailstop H16–3, Atlanta, Georgia 30329–4027; Telephone: (404) 718–8039. Email: hicpac@cdc.gov.

SUPPLEMENTARY INFORMATION: The U.S. Department of Health and Human Services policy stipulates that committee membership be balanced in terms of points of view represented, and the committee’s function. Appointments shall be made without discrimination on the basis of age, race, ethnicity, gender, sexual orientation, gender identity, HIV status, disability, and cultural, religious, or socioeconomic status. Nominees must be U.S. citizens and cannot be full-time employees of the U.S. Government. Current participation on federal workgroups or prior experience serving on a federal advisory committee does not disqualify a candidate; however, it is HHS policy to avoid excessive individual service on advisory committees and multiple committee memberships. Committee members are Special Government Employees (SGEs), requiring the filing of financial disclosure reports at the beginning and annually during their terms. CDC reviews potential candidates for HICPAC membership each year and provides a slate of nominees for consideration to the Secretary of HHS for final selection. HHS notifies selected candidates of their appointment near the start of the term in July 2023, or as soon as the SGE selection process is completed. Note that the need for different expertise varies from year to year and a candidate who is not selected in one year may be reconsidered in a subsequent year. Candidates should submit the following items:

- Current curriculum vitae, including complete contact information (telephone numbers, mailing address, email address)
- At least one letter of recommendation from person(s) not employed by the U.S. Department of Health and Human Services. (Candidates may submit letter(s) from current HHS employees if they wish, but at least one letter must be submitted by a person not employed by an HHS agency (e.g., CDC, NIH, FDA, etc.).

Nominations may be submitted by the candidate him- or herself, or by the person/organization recommending the candidate.

The Director, Strategic Business Initiatives Unit, Office of the Chief Operating Officer, Centers for Disease Control and Prevention, has been delegated the authority to sign Federal Register notices pertaining to announcements of meetings and other committee management activities, for both the Centers for Disease Control and Prevention and the Agency for Toxic Substances and Disease Registry.

Kalwant Smagh, Director, Strategic Business Initiatives Unit, Office of the Chief Operating Officer, Centers for Disease Control and Prevention.

[FR Doc. 2022–07236 Filed 4–5–22; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Public Health Determination and Order Regarding Suspending the Right To Introduce Certain Persons From Countries Where a Quarantinable Communicable Disease Exists

AGENCY: Centers for Disease Control and Prevention (CDC), Department of Health and Human Services (HHS).

ACTION: General notice.

SUMMARY: The Centers for Disease Control and Prevention (CDC), a component of the U.S. Department of Health and Human Services (HHS), is hereby issuing this Public Health Determination and Order Regarding Suspending the Right to Introduce Certain Persons from Countries Where a Quarantinable Communicable Disease Exists (Public Health Determination and Termination). This Public Health Determination and Termination terminates the Order Suspending the Right to Introduce Certain Persons from Countries Where a Quarantinable Communicable Disease Exists, issued on August 2, 2021 (August Order), and all related prior orders issued pursuant to the authorities in sections 362 and 365 of the Public Health Service (PHS) Act and implementing regulations. This Termination will be implemented on May 23, 2022.

DATES: The Termination issued in this Order will be implemented on May 23, 2022.

FOR FURTHER INFORMATION CONTACT: Candice Swartwood, Division of Global Migration and Quarantine, National Center for Emerging and Zoonotic Infectious Diseases, Centers for Disease Control and Prevention, 1600 Clifton Road NE, MS H16–4, Atlanta, GA 30329. Telephone: 404–498–1600. Email: dgmqpolicyoffice@cdc.gov.

SUPPLEMENTARY INFORMATION:

Background

Coronavirus disease 2019 (COVID–19) is a quarantinable communicable disease caused by the SARS–CoV–2 virus. As part of U.S. government efforts to mitigate the introduction, transmission, and spread of COVID–19, CDC issued the August Order, replacing a prior order issued on October 13, 2020, which continued a series of orders issued pursuant to 42 U.S.C. 265, 268 and the implementing regulation at 42 CFR 71.40, suspending the right to introduce certain persons into the United States from countries or places where the quarantinable communicable disease exists in order to protect the public health from an increased risk of the introduction of COVID–19 (CDC Orders).

The CDC Orders issued under 42 U.S.C. 265, 268 and 42 CFR 71.40 were intended to reduce the risk of COVID–19 introduction, transmission, and spread at ports of entry (POE) and U.S. Border Patrol stations by significantly reducing the number and density of covered noncitizens held in these congregate settings, thereby reducing risks to U.S. citizens and residents, Department of Homeland Security and U.S. Customs and Border Patrol personnel and noncitizens at the facilities, and local healthcare systems. CDC deemed the measures included in the CDC Orders necessary for the protection of public health during the ongoing COVID–19 pandemic.

The August Order applied specifically to “covered noncitizens,” defined as “persons traveling from Canada or Mexico (regardless of their country of origin) who would otherwise be introduced into a congregate setting in a POE or U.S. Border Patrol station at or near the U.S. land and adjacent coastal borders subject to certain exceptions detailed below; this includes noncitizens who do not have proper travel documents, noncitizens whose entry is otherwise contrary to law, and noncitizens who are apprehended at or near the border seeking to unlawfully enter the United States between POE.”
Three groups typically make up covered noncitizens—single adults (SA), individuals in family units (FMU), and unaccompanied noncitizen children (UC).

In the August Order, CDC committed to reassessing the public health circumstances necessitating the Order at least every 60 days by reviewing the latest information regarding the status of the COVID–19 public health emergency and associated public health risks, including migration patterns, sanitation concerns, and any improvement or deterioration of conditions at the U.S. borders. On March 11, 2022, CDC fully terminated the August Order and all previous orders issued under 42 U.S.C. 265, 268 and 42 CFR 71.40 with respect to UC based on a thorough determination of the status of the COVID–19 pandemic, an analysis of the specific care available to UC, and the absence of legitimate countervailing reliance interests on the CDC Orders.

The instant Public Health Determination and Termination considers the current status of the pandemic, including the receding numbers of COVID–19 cases, hospitalizations, and deaths most recently related to the Omicron variant, and constitutes the reassessment concluding on March 30, 2022.

Based on this analysis, the CDC Director finds that, pursuant to 42 U.S.C. 265 and 42 CFR 71.40, there is no longer a serious danger that the entry of covered noncitizens, as defined by the August Order, into the United States will result in the introduction, transmission, or spread of COVID–19 and that a suspension of the introduction of covered noncitizens is no longer required in the interest of public health. While the introduction, transmission, and spread of COVID–19 into the United States is likely to continue to some degree, the cross-border spread of COVID–19 due to covered noncitizens does not present the serious danger to public health that it once did, given the range of mitigation measures now available, CDC continues to stress the need for robust COVID–19 mitigation measures at the border, including vaccination and continued masking in congregate settings. CDC has determined that the extraordinary measure of an order under 42 U.S.C. 265 is no longer necessary, particularly in light of less burdensome measures that are now available to mitigate the introduction, transmission, and spread of COVID–19. Therefore, CDC is terminating the August Order and all related prior orders issued pursuant to 42 U.S.C. 265 and 42 CFR 71.40. This Termination will be implemented on May 23, 2022, to enable the Department of Homeland Security (DHS) time to implement appropriate COVID–19 protocols, such as scaling up a program to offer COVID–19 vaccinations to migrants, and prepare for full resumption of regular migration under Title 8 authorities.

**Legal Authority**

CDC is hereby immediately terminating the August Order and all prior orders issued pursuant to sections 362 and 365 of the PHS Act (42 U.S.C. 265, 268) and the implementing regulation at 42 CFR 71.40.

**Referenced Order**

A copy of the Order is provided below, and a copy of the signed Order can be found at https://www.cdc.gov/coronavirus/2019-ncov/cdcresponse/Final-CDC-Order-Prohibiting-Introduction-of-Persons.pdf.

**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**

Centers for Disease Control and Prevention (CDC)

Order Under Sections 362 & 365 of the Public Health Service Act (42 U.S.C. 265, 268) and 42 CFR 71.40

Public Health Determination and Order Regarding the Right To Introduce Certain Persons From Countries Where a Quarantinable Communicable Disease Exists

**Executive Summary**

The Centers for Disease Control and Prevention (CDC), a component of the U.S. Department of Health and Human Services (HHS), is hereby issuing this Public Health Determination and Order Regarding the Right To Introduce Certain Persons From Countries Where a Quarantinable Communicable Disease Exists (Public Health Determination and Termination). This Public Health Determination and Termination terminates the Order Suspending the Right to Introduce Certain Persons From Countries Where a Quarantinable Communicable Disease Exists, issued on August 2, 2021 (August Order), and all related prior orders issued pursuant to the authorities in sections 362 and 365 of the Public Health Service (PHS) Act (42 U.S.C. 265, 268) and the implementing regulation at 42 CFR 71.40 (CDC Orders); this Termination will be implemented on May 23, 2022. The August Order continued a suspension of the right to introduce “covered noncitizens,” as defined in the Order, into the United States along the U.S. land and adjacent coastal borders. The August Order states that CDC will reassess at least every 60 days whether the Order remains necessary to protect the public health. Based on the public health landscape, the current status of the COVID–19 pandemic, and the procedures in place for the processing of covered noncitizens, taking into account the inherent risks of transmission of SARS–CoV–2 in congregate settings, CDC has determined that a suspension of the right to introduce such covered noncitizens is no longer necessary to protect U.S. citizens, U.S. nationals, lawful permanent residents, personnel and noncitizens at the ports of entry (POE) and U.S. Border Patrol stations, and destination communities in the United States. This Termination will be implemented on May 23, 2022, to enable the Department of Homeland Security (DHS) to implement appropriate COVID–19 mitigation protocols, such as scaling up a program to provide COVID–19 vaccinations to migrants, and prepare for full resumption of regular migration processing under Title 8 authorities. Until that date, it is CDC’s expectation that DHS will continue to apply exceptions outlined in the August Order to covered noncitizens as appropriate, including the exception based on the totality of an individual’s circumstances on a case-by-case basis.

**Outline of Determination and Order**

I. Background

A. Evolution of the COVID–19 Pandemic and the U.S. Government Response

1. First Wave—January to June 2020
2. Second Wave—June to August 2020

3. See infra I.

5. See supra I.


7. See infra I.

introduce certain persons into the United States from countries or places where the quarantinable communicable disease exists in order to protect the public health from an increased risk of the introduction of COVID–19. The August Order applied specifically to “covered noncitizens,” defined as “persons traveling from Canada or Mexico (regardless of their country of origin) who would otherwise be introduced into a congregate setting in a POE or U.S. Border Patrol station at or near the U.S. land and adjacent coastal border subject to certain exceptions detailed below; this includes noncitizens who do not have proper travel documents, noncitizens whose entry is otherwise contrary to law, and noncitizens who are apprehended at or near the border seeking to unlawfully enter the United States between POE.”

Three groups typically make up covered noncitizens: single adults (SA), individuals in family units (FMU), and unaccompanied noncitizen children (UC). UC were specifically excepted from the August Order based on its explicit incorporation by reference of CDC’s July Exception of UC. On March 11, 2022, CDC fully terminated the August Order and all previous orders issued under 42 U.S.C. 265, 268 and 42 CFR 71.40 with respect to UC. This termination with respect to UC was based on a thorough determination of the current status of the COVID–19 pandemic as well as an analysis of the specific care available to UC and the absence of legitimate countervailing reliance interests, and was prioritized ahead of CDC’s reassessment for SA and FMU in light of the entry of a preliminary injunction by the U.S. District Court for the Northern District of Texas that was to go into effect on March 11, 2022, enjoining CDC from excepting UC from the August Order based solely on their status as UC.

The CDC Orders issued under 42 U.S.C. 265, 268 and 42 CFR 71.40 were intended to reduce the risk of COVID–19 introduction, transmission, and spread at POE and U.S. Border Patrol stations by significantly reducing the number and density of covered noncitizens held in these congregate settings, thereby reducing risks to U.S. citizens, U.S. nationals, lawful permanent residents, DHS and U.S. Customs and Border Protection (CBP) personnel and noncitizens at the facilities, and local healthcare systems. The measures included in the CDC Orders were deemed necessary for the protection of public health. In the August Order, CDC committed to reassessing the public health circumstances necessitating the Order at least every 60 days by reviewing the latest information regarding the status of the COVID–19 public health emergency and associated public health risks, including migration patterns, sanitation concerns, and any improvement or deterioration of conditions at the U.S. borders. CDC conducted its most recent reassessment on January 28, 2022; in addition, a reassessment specific to UC was completed on March 11, 2022. The Instant Public Health Determination and Termination considers the current status of the COVID–19 pandemic as well as an analysis of the specific care available to UC and the absence of legitimate countervailing reliance interests, and was prioritized ahead of CDC’s reassessment for SA and FMU in light of the entry of a preliminary injunction by the U.S. District Court for the Northern District of Texas that was to go into effect on March 11, 2022, enjoining CDC from excepting UC from the August Order.
pandemic, including the recording numbers of COVID–19 cases, hospitalizations, and deaths most recently related to the Omicron variant, and constitutes the reassessment concluding on March 30, 2022. This Determination and Termination also reflects the recent issuance of CDC’s COVID–19 Community Levels framework. Additionally, the National COVID–19 Preparedness Plan was recently updated to provide a roadmap to help the nation continue fighting COVID–19, while also allowing resumption of more normal routines.

Based on the analysis below, the CDC Director finds that, pursuant to 42 U.S.C. 265 and 42 CFR 71.40, there is no longer a serious danger that the entry of covered noncitizens, as defined by the August Order, into the United States will result in the introduction, transmission, and spread of COVID–19 and that a suspension of the introduction of covered noncitizens is no longer required in the interest of public health. While the introduction, transmission, and spread of COVID–19 into the United States is likely to continue to some degree, the cross-border spread of COVID–19 due to covered noncitizens does not present the serious danger to public health that it once did, given the range of mitigation measures now available. CDC continues to stress the need for robust COVID–19 mitigation measures at the border, including vaccination and continued masking in congregate settings. CDC has determined that the extraordinary measure of an order under 42 U.S.C. 265 is no longer necessary, particularly in light of less burdensome measures that are now available to mitigate the introduction, transmission, and spread of COVID–19. Therefore, as described below, CDC is terminating the August Order and all related prior orders issued pursuant to 42 U.S.C. 265, 268 and 42 CFR 71.40. This Termination will be implemented on May 23, 2022, to enable DHS to implement appropriate COVID–19 protocols, such as scaling up a program to offer COVID–19 vaccinations to migrants, and prepare for full resumption of regular migration under Title 8 authorities.

A. Evolution of the COVID–19 Pandemic and the U.S. Government Response

Since late 2019, SARS–CoV–2, the virus that causes COVID–19, has spread throughout the world, resulting in a pandemic. As of March 30, 2022, there have been over 480 million confirmed cases of COVID–19 globally, resulting in over six million deaths. The United States has reported over 79 million cases resulting in over 975,000 deaths due to the disease and is currently averaging around 26,000 new cases of COVID–19 a day as of March 28, 2022. The U.S. government response to the COVID–19 pandemic has focused on taking actions and providing guidance based on the best available scientific information. The United States has experienced five waves of the pandemic, each with its own unique epidemiologic characteristics. As the waves of COVID–19 cases have surged and ebbed, so too have actions taken in response to the pandemic. Earlier phases of the pandemic required extraordinary actions by the U.S. government and society at large. However, epidemiologic data, scientific knowledge, and the availability of public health mitigation measures, vaccines, and therapeutics have permitted many of those early actions to be relaxed in favor of more nuanced, targeted, and narrowly tailored guidance that provides a less burdensome means of preventing and controlling the SARS–CoV–2 virus and COVID–19. Of note for this Determination are the multiple travel- and migration-related measures taken by the U.S. government in each phase.

1. First Wave—January to June 2020

SARS–CoV–2 was first identified as the cause of an outbreak of respiratory illness that began in Wuhan, Hubei Province, People’s Republic of China. The United States reported its first COVID–19 case on January 21, 2020.


25 Supra note 21.


27 Id.

and the HHS Secretary declared COVID–19 a public health emergency on January 31, 2020. Community transmission was detected in the United States in February 2020. COVID–19 cases initially spread in a small number of U.S. metropolitan areas, most notably in New York City and surrounding areas. The resulting first wave of the pandemic peaked in the United States on April 7, 2020, with two million cases (3% of cumulative cases) and over 127,000 deaths (13% of cumulative deaths). During this period, public health officials monitored the situation closely and began instituting community-level nonpharmaceutical interventions such as school closures and physical distancing, in addition to promoting respiratory and hand hygiene practices. Vaccines and approved therapeutics were not available during this time.


30 Id.


33 Id.

34 See supra note 26.
or attempted entry. And Canada and Mexico joined the United States in temporarily restricting travelers across land borders for non-essential purposes. CDC began screening travelers from certain countries at airports and issued several travel health notices and, following a series of COVID–19 outbreaks on cruise ships, issued a No Sail Order and Suspension of Further Embarkation.

It was in the context of this initial wave of the pandemic and travel- and migration-related actions that the CDC Director promulgated an interim final rule at 42 CFR 71.40 implementing his authority under 42 U.S.C. 265, 268 and issued an Order under the interim final rule suspending the introduction of certain “covered aliens” on March 20, 2020 (March Order). The March Order sought to avert the serious danger of the introduction of COVID–19 into the land POEs and Border Patrol stations at or near the United States borders with Canada and Mexico due to encountered noncitizens otherwise being held in the common areas of the facilities and in close proximity to one another as they undergo immigration processing. The March Order applied to SA, FMU, and UC and was subsequently amended and extended in April and May 2020.

2. Second Wave—June to August 2020

During the second wave of the pandemic, from approximately June to August 2020, COVID–19 spread geographically throughout the United States. Case numbers peaked on July 14, 2020, and in total the second wave resulted in approximately 2.6 million COVID–19 cases (4% of cumulative cases) and over 75,000 deaths (4% of cumulative deaths). During the second wave, public health officials and scientists learned more about COVID–19 transmission, including asymptomatic transmission, particularly in congregate, high-density settings, such as meat-packing plants and congregate facilities. The medical community learned more about potential effects of COVID–19 on specific populations, such as pregnant people, older, and immunocompromised people. In July 2020, CDC announced that cloth face coverings (masks) are a critical public health tool in reducing the spread of COVID–19, particularly when used universally within communities. As stay-at-home orders issued during the first wave were lifted, CDC continued to promote broad implementation of masking and face covering requirements. One pivotal marker of the second wave was the creation of Operation Warp Speed, a partnership between the HHS and Department of Defense (DOD) aimed to help accelerate the development of a COVID–19 vaccine.

As concerns about asymptomatic transmission grew and vaccines and therapeutics were still being developed, the U.S. government continued to take steps to protect the public health. CDC extended the No Sail Order and Suspension of Further Embarkation for cruise ships and, as the second wave was being replaced by the third, issued an Order temporarily halting evictions in the United States due to the potential for accelerated transmission in congregate settings such as shelters for displaced persons. The CDC Order under 42 U.S.C. 265, 268 and 42 CFR 71.40 issued in March 2020 and amended and extended in April and May 2020, continued to be in place throughout this period.

3. Third Wave—Alpha Variant—September 2020 to May 2021

COVID–19 variants, including the B.1.1.7 (Alpha) variant, emerged in the fall of 2020, heralding the third wave of the pandemic and resulting in 22.5 million COVID–19 cases (34% of cumulative cases) and over 398,000 deaths (21% of cumulative deaths) in the United States. The third wave lasted from approximately September 2020 to May 2021 and coincided with the initial availability of vaccines for COVID–19 and increased availability of the vaccines in the United States.
Also issued an Order requiring face masks to be worn while on conveyances traveling into, within, or out of the United States and at U.S. transportation hubs. Based on developments with respect to variants and the continued spread of COVID–19, the U.S. government expanded the list of countries from which entry into the United States was limited. CDC also announced a Conditional Sailing Order framework under which cruise ships could resume passenger operations only after meeting stringent public health mitigation measures, such as frequent testing of crew members.

In October 2021, following the promulgation of the Final Rule for 42 CFR 71.40, CDC published a new Order under 42 U.S.C. 265 and 268 and the regulation suspending the right to introduce certain covered persons into the United States. As with all prior CDC Orders, the October Order applied to “covered aliens,” which included certain SA, FMU, and UC seeking entry into the United States without valid travel documents and provided certain exceptions, including a case-by-case exception to be applied by CBP officers with supervisor approval upon a determination that an individual should be excepted from application of the Order based on the totality of the circumstances, including consideration of significant law enforcement, officer and public safety, humanitarian, and public health interests. The October Order was the subject of litigation regarding its application to both FMU and UC.

4. Fourth Wave—Delta Variant—June to October 2021

The COVID–19 pandemic’s fourth wave lasted from June to October 2021 and was characterized by the spread of the Delta variant in the United States; during this period the United States experienced 9.8 million cases (15% of cumulative cases) and over 179,000 deaths (9% of cumulative deaths). Vaccines were widely available during the fourth wave and uptake rose slightly throughout this period.

Given the predictable global spread of the virus, the effectiveness of COVID–19 vaccines, and the rising availability of COVID–19 vaccines globally, and recognizing the need to allow the U.S. economy to continue recovering from the effects of the pandemic, the President issued a Proclamation reflecting the United States’ desire to move away from the country-by-country restrictions previously applied during the COVID–19 pandemic and to adopt an air travel policy that relies primarily on vaccination to advance the safe resumption of international air travel to the United States. The Proclamation was followed by a suite of travel-related mitigation measures.
mitigation measures allowed the U.S. government to shift its pandemic approach in the travel context, the country continued to see a surge in COVID–19 cases caused by the Delta variant necessitating different measures in non-travel contexts. For example, as a result, the CDC Director extended the aforementioned eviction moratorium for persons in counties experiencing substantial or high rates of transmission.69

During the fourth wave, CDC also issued the July Exception excepting UC from the October 2020 Order, which followed CDC’s decision in January 2021 to temporarily except UC from expulsion pending a public health reassessment of the October Order.70 The October 2020 Order was subsequently replaced by the August Order under 42 U.S.C. 265 and 268 and 42 CFR 71.40, which fully incorporated the July Exception. The August Order explained why the mitigation measures specific to UC and discussed in the July Exception were not available to SA and FMU and, thus, why the August Order applied only to SA and FMU.71 As with many of the other actions taken by the U.S. government during this wave, the August Order was predicated, in part, on the significant increase in community transmission levels brought forth by the Delta variant.

5. Fifth Wave—Omicron Variant—November 2021 to March 2022

The highly infectious SARS–CoV–2 variant B.1.1.529 (Omicron) is responsible for the currently receding fifth wave of the pandemic. The fifth wave resulted in an extraordinary and unparalleled increase in COVID–19 cases around the world.72 Although the emergence of the Omicron variant resulted in the highest reported numbers of cases and hospitalizations during the pandemic, disease severity indicators, including hospital length of stay, intensive care unit admissions, and deaths, remained lower than during previous pandemic waves.73 As a result of the Omicron surge, the United States experienced almost 24 million cases (36% of cumulative cases); given this volume of cases, however, the resulting number of deaths in the United States (163,000 deaths, or 9% of cumulative deaths) was comparatively small.74 Vaccine efforts continued across the country during this fifth wave and were expanded to include children aged 5 to 11 years.75 Despite breakthrough cases due to Omicron, vaccines continued to provide substantial protection against severe illness, hospitalizations, and deaths due to COVID–19.76

Although the COVID–19 public health emergency continues,77 scientific understanding about the epidemiology of COVID–19 and its variants as well as the effectiveness of pharmaceuticals and nonpharmaceutical interventions have substantially expanded, allowing the U.S. government and CDC to transition to a more narrowly tailored set of tools to prevent and control the spread of the SARS–CoV–2 virus and COVID–19. The U.S. government has pivoted away from country-specific measures. Following the temporary issuance of country-based restrictions as Omicron emerged,78 all country-based mitigation measures were later lifted by the President, as recommended by CDC.79 Based on an increasing body of evidence, CDC recommended that everyone be vaccinated and remain up to date with vaccines, including boosters for those eligible.80 As more information about the Omicron variant and vaccine effectiveness became available, CDC calibrated its mitigation measures in accordance with the epidemiology of the virus and the different characteristics of the predominant variants. This included shortening the recommended duration of quarantine and isolation for all members of the general public in community settings81 and also shortening the timeframe for its COVID–19 testing requirements for all air passengers boarding flights to the United States.82 DHS also required that all inbound non-citizen, non-lawful permanent residents traveling to the United States via land POE—whether for essential or non-essential reasons—must provide proof of full COVID–19 vaccination status upon request.83 These refinements in policy reflect CDC’s increased understanding of the science and its desire to tailor mitigation measures so that they are no more burdensome than necessary. The ability of CDC to be responsive to the public health landscape and adjust such

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68 See 85 FR 55292 (Sept. 4, 2020).
69 See 86 FR 43244 (Aug. 6, 2021).
70 See supra note 63.
71 86 FR 42828, 42837–38.
72 Omicron was first reported to the World Health Organization (WHO) by South Africa on November 24, 2021; on November 26, 2021, WHO designated it a Variant of Concern (VOC). On November 30, 2021, the U.S. also decided to classify Omicron as a VOC. This decision was based on a number of factors, including detection of cases attributed to Omicron in multiple countries, even among persons without travel history, transmission and replacement of Delta as the predominant variant in South Africa, changes in the spike protein of the virus, and concerns about potential decreased effectiveness of vaccination and treatments.
74 Per internal CDC calculations.
78 Those restrictions included suspending entry into the United States of immigrants or nonimmigrants physically present within eight southern African countries during the 14-day period preceding their entry or attempted entry into the United States. See Proclamation 10315 (Nov. 26, 2021), 86 FR 68383 (Dec. 1, 2021).
79 Based on an increasing body of evidence, CDC recommended that everyone be vaccinated and remain up to date with vaccines, including boosters for those eligible.80 As more information about the Omicron variant and vaccine effectiveness became available, CDC calibrated its mitigation measures in accordance with the epidemiology of the virus and the different characteristics of the predominant variants. This included shortening the recommended duration of quarantine and isolation for all members of the general public in community settings81 and also shortening the timeframe for its COVID–19 testing requirements for all air passengers boarding flights to the United States.82 DHS also required that all inbound non-citizen, non-lawful permanent residents traveling to the United States via land POE—whether for essential or non-essential reasons—must provide proof of full COVID–19 vaccination status upon request.83 These refinements in policy reflect CDC’s increased understanding of the science and its desire to tailor mitigation measures so that they are no more burdensome than necessary. The ability of CDC to be responsive to the public health landscape and adjust such

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79 A person is considered up to date after receiving all recommended COVID–19 vaccines, including any booster dose(s) when eligible. Stay Up to Date with Your Vaccines, Centers for Disease Control and Prevention, https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html (issued Jan. 22, 2022, updated Mar. 22, 2022).
80 CDC Updates and Shortens Recommended Isolation and Quarantine Periods for General Population, Centers for Disease Control and Prevention, https://www.cdc.gov/media/releases/2021/s1227-isolation-quarantine-guidance.html (Dec. 27, 2021). Specifically, the length of isolation period for the general public was shortened to five days, followed by five days of wearing a well-fitting mask. See also What We Know About Quarantine and Isolation, Centers for Disease Control and Prevention, https://www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/quarantine-isolation-background.html (updated Feb. 25, 2022).
83 All air passengers two years or older with a flight departing to the United States from a foreign country starting on December 6, 2021, are required show a negative COVID–19 viral test result taken no more than one day before travel, or documentation of having recovered from COVID–19 in the past 90 days, before they board their flight. This requirement remains in place.
84 See 87 FR 3429 (Jan. 24, 2022) (applying restrictions to the U.S.-Canada border) and 87 FR 3425 (applying restrictions to the U.S.-Mexico border).
measures up and down is critical to successfully fighting the pandemic. During the fifth wave of the pandemic and as specified in the August Order, CDC reviewed the public health rationale underlying the need for the Order every 60 days. By the time of the second reassessment in late November 2021 the public health situation with respect to COVID–19 was improving. However, the sudden emergence of the Omicron variant led CDC to find that the August Order continued to be necessary. Because case numbers remained infection and society at large, epidemiologic data, scientific knowledge, and the availability of public health mitigation measures, vaccines, and therapeutics have permitted the country to safely transition to more normal routines. As part of that transition, CDC is also shifting to more nuanced and narrowly tailored guidance that provides a less burdensome means of preventing and controlling the SARS–CoV–2 virus and COVID–19.

1. Community COVID–19 Levels

During the first four waves of the pandemic, CDC relied on a formula to calculate community transmission levels and update COVID–19 prevention strategies. However, in this new phase, with widespread population immunity and a generally lower overall risk of severe disease due to the nature of the Omicron variant, CDC is reconsidering the need for the Community COVID–19 Levels framework.

**B. Current Status of the COVID–19 Pandemic**

As a result of the Omicron variant, the United States recorded its highest seven-day moving average number of cases on January 15, 2022. Following this unprecedented peak, however, the number of COVID–19 cases in the United States began to rapidly decrease, falling by over 95% as of March 30, 2022. After a brief period of continued increases, deaths and hospitalizations also reversed course and began a swift descent. Even at their peaks, however, the number of deaths and hospitalizations during Omicron were substantially lower than would have been expected from previous waves, based on the case counts. These welcomed changes were due, in part, to widespread population immunity and the accrual of high levels of immunity at the population level, and the availability of effective therapeutics, testing, and masks or respirators. As a result, CDC released a new framework in February 2022, “COVID–19 Community Levels,” reflecting a shift in focus from eliminating SARS–CoV–2 transmission toward disease control and healthcare system protection. This new framework examines three currently relevant metrics for each U.S. county: New COVID–19 hospital admissions per 100,000 population in the past seven days, the percent of staffed inpatient beds occupied by patients with COVID–19, and total new COVID–19 cases per 100,000 population in the past seven days. CDC determined that data on disease severity and healthcare system strain complement these case rates, and that these data together are more informative for assessing the public health situation with respect to COVID–19.

In September 2020, CDC released the Indicators of Community Transmission framework, which incorporated three metrics to define community transmission: Total new cases per 100,000 persons in the past seven days, and percentage of Nucleic Acid Amplification Test results that are positive for the past seven days, and percentage of Nucleic Acid Amplification Test results that are positive for COVID–19. CDC also released the framework of the “Union Address, https://www.whitehouse.gov/state-of-the-union-2022/ (Feb. 23, 2022).”


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**88 In addition to vaccine-induced immunity, studies have consistently shown that infection with SARS–CoV–2 lowers an individual’s risk of subsequent infection and an even lower risk of hospitalization and death. National estimates of both vaccine- and infection-induced antibody seroprevalence have been measured among blood donors; as of December 2021, these measures demonstrated 94.7% of persons 16 years and older showed antibody seroprevalence for COVID–19.**

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public health recommendations for individual, organizational, and jurisdictional decisions than data on community transmission rates alone. The comprehensive approach to assessing COVID–19 Community Levels can inform decisions about layered COVID–19 prevention strategies, including testing and masking to reduce medically significant disease and limit strain on the healthcare system and other societal functions. Using these data, the COVID–19 Community Levels for each county are classified as low, medium, or high. CDC recommends using county COVID–19 Community Levels to help determine which mitigation measures should be implemented within a community.

As of March 31, 2022, 94.9% of U.S. counties are classified at the low COVID–19 Community Level, 4.5% of U.S. counties are classified at the medium COVID–19 Community Level; only 0.5% of U.S. counties are classified at the high COVID–19 Community Level. Furthermore, 97.1% of the U.S. population lives in counties classified as “low,” 2.5% live in counties classified as “medium,” and 0.4% live in counties classified as “high.”

2. Healthcare Systems and Resources

With the ebb of the fifth wave, the number of new hospital admissions of patients with confirmed COVID–19 has similarly receded. Daily new hospitalization admissions peaked with 154,696 daily new admissions on January 15, 2022. The large number of cases in a very short time led to a high volume of hospitalizations that strained some local healthcare systems and, in some instances, impacted care for non-COVID–19-related concerns. Despite this high volume of COVID–19 cases and hospitalizations, COVID–19 cases caused by the Omicron variant were, on average, less severe. The observed reduction in severity of COVID–19 cases and ongoing effective use of pharmaceutical interventions make it possible to minimize medically significant disease and prevent excessive strain on the healthcare sector, even with the occurrence of SARS–CoV–2 transmission.

Accordingly, at this stage of the pandemic, data on disease severity and healthcare system strain complement case rates and result in a more comprehensive approach to assessing COVID–19 Community Levels.

3. Mitigation Measures

Effective public health mitigation measures have contributed to the vast majority of the U.S. population living in a county identified by CDC as having either a “low” or “medium” COVID–19 Community Level. In addition to earlier public health measures, such as masking and physical distancing, the development and widespread deployment of COVID–19 tests, vaccines, and therapeutics have greatly reduced the transmission of the virus and severity of the disease throughout the United States and provided a new understanding of how prevention measures may be used to minimize the impact of COVID–19 on health and society. Effective public health mitigation measures and the resulting current status of the COVID–19 pandemic are a major factor in CDC’s determination that the Orders issued under the authorities of 42 U.S.C. 265, 268 and 42 CFR 71.40 suspending the right to introduce certain persons into the United States are no longer necessary to protect the public health.

a. Test Availability

Testing continues to be an essential part of COVID–19 mitigation due to the potential for asymptomatic and pre-symptomatic transmission. Compared to earlier in the pandemic, COVID–19 tests are widely available in the United States. During January 2022, Americans had access to over 480 million at-home tests in addition to rapid point of care and laboratory tests. With the additional testing capacity available through antigen tests, rapid testing can be implemented to identify infected persons for isolation and identification of close contacts for quarantine and testing if indicated.

Testing is also particularly helpful in congregate settings, where testing facility residents and personnel can help facilitate early identification of increased infection rates and prompt mitigation actions to help avoid strain on facility operations. CDC recommends broad use of COVID–19 tests among facility workforces and within the larger community; such workforce testing may decrease the necessity for testing residents in congregate settings.

b. Vaccines and Boosters

Since August 2021, the scientific community has made significant strides in the development and distribution of COVID–19 vaccines, including booster shots. When the August Order was issued, three COVID–19 vaccines were authorized by the U.S. Food and Drug Administration (FDA) for emergency use and recommended for all people 12 years of age and up. While the daily count of total COVID–19 vaccine doses administered across the United States has plateaued, the cumulative number of people protected by COVID–19 vaccination has grown since the August Order. As of March 30, 2022, over 209 million people in the United States 12 years of age or older (73.9% of the population 12 years or older) have been fully vaccinated and over 245 million people in the United States 12 years or older (86.6%) have received at least one dose. To address concerns with potential waning immunity, booster shots are now recommended for all people 12 years of age or older. FDA has recommended that the decision about which vaccine is used as a third dose for individuals who have received a two-dose mRNA vaccine should be based on the determinations of the state or local health authorities.

Testing-related guidance and provide targeted investments to expand the available testing supply and maximize testing capacity).
adults ages 18 years and older. As of March 30, 2022, 48.3% of fully vaccinated individuals 18 years and older in the United States have also received a booster dose.

Since the August Order, eligibility for COVID–19 vaccines has expanded to include children ages five to 11. Children ages six months through four years may soon become eligible for a COVID–19 vaccine; CDC is working with state and local jurisdictions for the eventual rollout of this critical product. Improving COVID–19 vaccination coverage among children and adolescents is crucial to maintaining low rates of COVID–19-associated morbidity and mortality among these groups and ensuring a safe and expedited return to normal routines for everyone.

Vaccines, including boosters, continue to be the single most important public health tool for fighting COVID–19 and CDC recommends that all people get vaccinated as soon as they are eligible and stay up to date on vaccinations. Evidence shows that people who have completed the primary COVID–19 vaccination series, and received a booster when eligible, are at substantially reduced risk of severe illness and death from COVID–19; in contrast, the cumulative rate of COVID–19-associated hospitalizations is substantially higher in unvaccinated adults than in those who are up to date on COVID–19 vaccines. Therefore, vaccines, including booster doses when appropriate, provide a substantial measure of protection against COVID–19-associated hospitalization and severe disease, including from the Omicron variant. The increased percentage of individuals who are not only vaccinated but have also received a booster—which was not available at the time of the August Order—strengthens community protection levels and is a critical step toward resuming normal routines safely.

The availability of COVID–19 vaccines globally has also increased dramatically since the August Order. On August 2, 2021, only 29% of the world had received at least one dose of a COVID–19 vaccine, with 12% being fully vaccinated. As of March 30, 2022, 64.9% of the world population has received at least one dose of a COVID–19 vaccine and 57% of the global population is fully vaccinated with a primary vaccine series. Fighting COVID–19 abroad is key to the nation’s effort to protect people at home and stay ahead of new variants: therefore, the United States remains committed to accelerating global vaccination efforts.

Compared to August 2021, treatments for COVID–19 are more widely available. Although monoclonal antibodies were available in August 2021 and some continue to be effective and were widely used during the Omicron wave, such treatments must be administered by infusion and are cumbersome to administer. The FDA has issued emergency use authorizations (EUAs) for a number of treatments for COVID–19 for people at high risk of COVID–19 disease progression, some of which were developed after August 2021. In February 2022, FDA issued an EUA for a new monoclonal antibody that is specifically effective in combating the Omicron variant. FDA has also authorized oral antiviral medications that target the SARS-CoV-2 virus. The U.S. government has expedited the development, manufacturing, and procurement of these treatments, securing 20 million courses of antiviral pills, which have been shown to reduce the risk of hospitalization or death by 80%. The availability of efficacious and accessible treatments add a powerful layer of protection against severe COVID–19 that was not available in the summer of 2021. The U.S. government’s commitment to making such medications available and the ability to produce variant-specific treatments are critical components of the next phase of the fight against COVID–19.

4. Congregate Settings

As highlighted in the August Order, the very nature of congregate settings increases the risk for COVID–19 outbreaks. Now, however, numerous non-pharmaceutical and pharmaceutical interventions are available to decrease the spread and severity of COVID–19 in these settings.


113 See supra note 112 (citing data as of Mar. 30, 2022). Additionally, 46.5% of fully vaccinated individuals 12 years of age and older in the United States have received a booster dose.

114 See supra note 75.


117 COVID–19 Vaccines Work, Centers for Disease Control and Prevention, https://www.cdc.gov/coronavirus/2019-ncov/vaccines/effectiveness-work.html (updated Dec. 23, 2021). See also supra note 111, attributing decline of vaccine effectiveness to waning vaccine induced immunity over time, possible increased immune evasion by SARS-CoV-2 variants, or a combination of these and other factors and finding that receiving a booster shot was highly effective at preventing COVID–19-associated emergency department and urgent care department visits and preventing COVID–19-associated hospitalizations. See also Stay Up to Date with Your Vaccines, Centers for Disease Control and Prevention, https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html (updated Mar. 30, 2022), a person is considered up to date after receiving all recommended COVID-19 vaccines, including any booster dose(s) when eligible. See also infra L.B.5.

118 This pattern applies to all age groups but is most pronounced among adults aged 65 years and older, who are at increased risk for hospitalization and death.


122 Id.

123 See supra note 21.


126 See supra note 124.


128 Id. Antiviral pills will also be added to the stockpile for the first time.

129 See supra note 44, explaining preventing coronavirus disease 2019 (COVID–19) in correctional and detention facilities can be challenging because of population-dense housing, varied access to hygiene facilities and supplies, and limited space for isolation and quarantine.
pandemic, congregate settings have adapted processes to mitigate COVID–19 risk, including incorporating mask use, improving ventilation, enhancing cleaning and disinfection procedures, and connecting people to medical care. Current CDC guidance for correctional and detention facilities recommends that certain key mitigation measures, including provision of vaccinations and use of standard infection controls remain in place at all times. In addition, facilities are encouraged to identify their own risk levels and apply additional mitigation measures as necessitated by local conditions.

Rather than requiring physical distancing to be kept in place at all times, CDC’s congregate settings guidance allows such measures to be scaled up or down based on local data trends and facility characteristics. Because case counts and hospitalizations are decreasing in most areas of the country, many correctional and detention facilities are resuming certain activities that had previously been paused to facilitate physical distancing, signaling the resumption of more normal operations for many congregate settings.

5. DHS Mitigation Measures

It is CDC’s understanding that DHS facilities incorporate some of the recommended COVID–19 mitigation measures for congregate settings into their protocols. In particular, CBP continues to implement a variety of mitigation measures based on the infection prevention strategy referred to as the hierarchy of controls, which includes engineering upgrades, masking for migrants, and PPE for its workforce. Moreover, vaccine uptake among the CBP workforce has reached approximately 86% among personnel on the U.S.-Mexico border.

Of particular note, DHS has recently begun implementing a vaccination program for migrants processed under Title 8 immigration authorities and held in CBP facilities. The DHS vaccination program will apply to all age-appropriate migrants who lack legal status and are processed pursuant to Title 8 authorities; have entered the United States after crossing the Southwest Border; and are taken into DHS custody. DHS has conveyed to CDC that all such migrants who are unable to provide proof of vaccination with an FDA EUA- or WHO EUL-approved vaccine will be provided an initial dose of a COVID–19 mRNA vaccine. DHS began implementing their vaccination program at 11 sites on March 28, 2022. DHS is working to expand this program over the next two months and states that their goal is to provide vaccinations to up to 6,000 migrants a day across 27 sites across the Southwest Border by May 23, 2022.

In addition, since the August Order, the DHS Office of the Chief Medical Officer has worked with partners in local communities to move individuals safely out of CBP custody and through the appropriate Title 8 immigration procedures, as applicable to the individual noncitizens. Through these partnerships, DHS has supported state, local, tribal, and territorial partners and NGOs in developing robust COVID–19 testing and quarantine programs along the Southwest Border.

II. Public Health Determination

As the COVID–19 pandemic and public health landscape evolve, CDC reassesses the need for continued measures under 42 U.S.C. 265, 268 and 42 CFR 71.40, the authorities that support the CDC Orders. This Public Health Determination and Termination is based upon the most recent science and data available to CDC. Based upon the data, CDC has determined that, although the implementation of the CDC Orders to reduce the numbers of noncitizens held in congregate settings in POEs and Border Patrol stations has been part of the layered COVID–19 mitigation strategy used over the past two years, less burdensome measures are now available to mitigate the introduction, transmission, and spread of COVID–19 resulting from the entry of covered noncitizens.

This Public Health Determination and Termination is the most recent step in CDC’s continued efforts toward aligning the public health measures response to the COVID–19 pandemic with the best available science. Throughout the COVID–19 pandemic, CDC has taken a range of actions to help protect the public’s health. These actions have been informed by the status of the pandemic based on the scientific and epidemiological information available at the time. The actions fall along a spectrum of restrictions on movement and activities in public. Some, like the masking order for conveyances, impact individuals but do not restrict movement; others, like the No Sail Order, apply to entire industries.

The CDC Orders issued under the authorities of 42 U.S.C. 265, 268 and 42 CFR 71.40 suspending the right to introduce certain persons into the United States are among the most restrictive measures CDC has undertaken in the fight against COVID–19. The U.S. government has only used the extraordinary authority available under 42 U.S.C. 265 to restrict the introduction of persons in one instance—prior to the COVID–19 pandemic—in 1929, in response to the Spanish influenza outbreak. During the earlier periods of the COVID–19 pandemic, while scientists were still learning about its epidemiology and developing therapeutics and vaccines, the CDC Orders were deemed necessary due to the rapid spread of the virus. As the understanding of the virus has grown and vaccines and therapeutics for the disease have become more widely available, lower COVID–19 Community Levels have been observed.

The August Order recognized the full panoply of mitigation measures available as key to slowing the spread of the virus and protecting U.S. healthcare systems while widespread vaccination efforts continued. Like other COVID–19 mitigation measures issued by CDC, the August Order was always intended as a temporary measure as understanding of the virus evolved. The scientific knowledge, availability of vaccines and
therapeutics, and high percentage of the U.S. population living in a county identified as having “low” or “medium” COVID–19 Community Levels have permitted CDC to carefully step-down the various public health mitigation measures used. This step-down involves purposeful narrowing of some restrictions while terminating others when the public health need for and efficacy of the measures no longer outweigh the severity of the restriction. For example, CDC took the unprecedented step of halting cruise ship operations in July 2021 and was allowed to expire on January 31, 2022). Furthermore, CDC concluded that although there is still a risk of COVID–19 transmission in crowded congregate settings, including nursing homes, that risk does not present a sufficiently serious danger to public health to necessitate maintaining the August Order. Therefore, the mitigation measures available will help reduce severe outcomes and reduce the serious risk of introduction, transmission, and spread of COVID–19 into the United States by covered noncitizens.

Both at home and abroad, vaccination rates are increasing. Vaccination among the American public and the DHS workforce in particular has been largely successful and, as stated in the August Order, widespread vaccination of federal employees and personnel in congregate settings at POE and Border Patrol stations demonstrates important progress toward the normalization of border operations. Since August 2021, vaccination rates in the countries of origin for the current majority of incoming noncitizens have also increased dramatically. Such global increases in vaccination rates and infection-induced immunity provide additional layers of protection. As noted above, DHS is currently scaling up a program that provides vaccines to encountered noncitizens taken into CBP custody along the Southwest Border.

The August Order also highlighted the threat posed by emerging variants and the potential for a future, vaccine-resistant variant, either of which could negatively impact U.S. communities and local healthcare resources. Based in part on these threats, CDC concluded that time that SA and FMU should continue to be subject to the August Order, pending further improvements in the public health situation and subject to continual reassessment. Since the August Order was implemented, public health officials have learned a great deal about variants and how best to respond to them. In response to Omicron, the U.S. government updated the National COVID–19 Preparedness Plan for monitoring COVID–19 to swiftly adapt tools to combat a new variant and deploy emergency resources to help communities. The Plan includes steps to ensure that variant surveillance, countries of origin for covered noncitizens. Rates of vaccination for each country are as follows: Cuba: 88% fully vaccinated, 94% only partly vaccinated; Guatemala: 33% fully vaccinated, 9.8% only partly vaccinated; Honduras: 71% fully vaccinated, 6% only partly vaccinated; Mexico: 61% fully vaccinated, 4.5% only partly vaccinated; Nicaragua: 61% fully vaccinated, 82% only partly vaccinated. Coronavirus (COVID–19) Vaccinations, Our World in Data, https://ourworldindata.org/covid-vaccinations (last visited Mar. 31, 2022).

As demonstrated by the U.S. government’s experience with Operation Artemis and Operation Allies Welcome, a COVID–19 vaccination program helps protect noncitizens, as well as personnel serving these populations and American communities. Vaccination of all encountered noncitizens aligns with larger U.S. government pandemic efforts and safe travel policies.
vaccines, tests, and treatments can be updated and deployed quickly.150

At this point in the pandemic, the United States has high rates of vaccine and infection-induced immunity in the population, as well as availability of effective therapeutics, testing, and well-fitting masks. These tools, which have been developed and distributed over the past two years, help minimize medically significant disease and prevent excessive strain on the healthcare sector even while SARS-CoV-2 virus continues to circulate. As noted above, 97.1% of the U.S. population is currently living in an area classified as having a “low” COVID–19 Community Level, meaning most of the population can operate under more relaxed COVID–19 mitigation strategies.151 Noteworthy for purposes of this Determination, as of March 31, 2022, all 24 U.S. counties along the U.S.-Mexico border are classified as having a “low” COVID–19 Community Level.152 Like prior CDC Orders, the August Order, issued during the fourth wave of the pandemic, noted the goal of slowing the introduction, transmission, and spread of SARS-CoV-2 into the United States by covered noncitizens.153 With the ebb of the Omicron surge across the United States, however, the public health findings underlying the August Order have changed. Although COVID–19 remains a concern, the readily available and less burdensome public health mitigation tools to combat the disease render an order under 42 U.S.C. 265 to prevent a serious danger to the public health unnecessary. At the present point in the pandemic, the previously identified public health risk is no longer commensurate with the extraordinary measures instituted by the CDC Orders. As the pandemic evolves, CDC will continue to monitor the situation with respect to COVID–19 at U.S. borders and will continue to consult with DHS on combating COVID–19 in DHS facilities following the Termination of the August Order.

III. Legal Considerations

A. Temporary Nature of Orders Under 42 U.S.C. 265 and Absence of Reliance Interests

In issuing this Public Health Determination and Termination, CDC has considered whether state or local governments, or their subdivisions, have any “legitimate reliance”154 interests in the continued expulsion of covered noncitizens pursuant to 42 U.S.C. 265 (Section 265). CDC has determined that no state or local government could be said to have legitimately relied on the CDC Orders issued under 42 U.S.C. 265, 268 and 42 CFR 71.40 to implement long-term or permanent changes to its operations because those orders are, by their very nature, short-term orders, authorized only when specified statutory criteria are met, and subject to change at any time in response to an evolving public health crisis. Section 265 may be invoked only if CDC determines that there is a “serious danger of the introduction of [a communicable] disease into the United States, and that this danger is so increased by the introduction of persons or property from such country [where the communicable disease exists] that a suspension of the right to introduce such persons and property is required in the interest of the public health.”155 Moreover, the statute may be invoked only “for such period of time as [CDC] may deem necessary” to avert such a danger.156 As HHS’s implementing regulation further recognizes, in prohibiting the introduction of covered persons “in whole or in part,”157 a CDC Order is effective “only for such period of time that the Director deems necessary to avert the serious danger of the introduction of a quarantinable communicable disease.”158

For these reasons, the CDC Orders have consistently been subject to periodic reviews to ensure their continued necessity. CDC’s initial order issued in March 2020 made clear that the Order represented a “temporary suspension of the introduction of [covered] persons into the United States”159 and that the order would remain effective only for “30 days, or until [CDC] determine[s] that the danger of further introduction of COVID–19 into the United States has ceased to be a serious danger to the public health, whichever is shorter.”160 The March 2020 Order was subsequently extended on April 20, 2020, and then amended on May 19, 2020. The fact that the policy was frequently reviewed should have underscored that CDC’s use of its authority under 42 U.S.C. 265 was a temporary measure subject to change at any time. The October 2020 Order again confirmed this understanding of CDC’s authority, noting the “temporary” nature of the suspension of the introduction of covered persons, as well as the facts that the Order would be reviewed every 30 days based on “the latest information regarding the status of the COVID–19 pandemic and associated public health risks,” and that CDC “retain[ed] the authority to extend, modify, or terminate the Order, or implementation of [the] Order, at any time as needed to protect public health.”161

In addition, CDC’s ability to exercise its authority under Section 265 as to certain groups of covered noncitizens should have further discouraged reliance on temporary CDC orders. For example, in November 2020, the United States District Court for the District of Columbia enjoined the expulsion of UC on the basis that Section 265 likely did not authorize such expulsions.162 Although the government obtained a stay of the injunction in January 2021,163 the extent of the government’s authority under Section 265 remained contested. In addition, in September 2021, the United States District Court for the District of Columbia similarly enjoined the expulsion of FMU, again on the basis that Section 265 likely did not authorize such expulsions.164 The U.S. Court of Appeals for the D.C. Circuit recently upheld the government’s authority under 42 U.S.C. 265 to expel FMU, but the court held

156 140 S. Ct. 1891, 1913 (2020).
157 42 CFR 71.40(a).
158 42 CFR 71.40(a).
159 85 FR at 17061 (emphasis added).
160 86 FR 42828, 42834 and 42838.
that such expulsions cannot be to places where the noncitizen are likely to be persecuted or tortured. Although the decision will not take effect until the mandate issues in late April 2022, the decision should have put any state or local government on notice that there might be significant practical constraints on the government’s ability to expel covered FMU quickly.

Moreover, by August 2021, state and local governments were on notice that the federal government would be taking steps towards the resumption of normal border operations. In the August 2021 Order, CDC stated that it “view[ed] this public health reassessment as setting forth a roadmap toward the safe resumption of normal processing of arriving noncitizens, taking into account COVID–19 concerns and immigration facilities’ ability to implement mitigation measures.” Accordingly, state and local governments could not have reasonably relied on CDC’s indefinite use of its expulsion authority under Section 265. As a factual matter, CDC is of any reasonable or legitimate reliance on the continued expulsion of covered noncitizens under 42 U.S.C. 265 beyond potentially local healthcare systems’ allocation of resources, which CDC has considered in this Order.

Even if a state or local government had relied on the continued existence of a CDC order under this authority, 42 U.S.C. 265 only authorizes CDC to prevent the introduction of noncitizens when it is required in the interest of public health. No state or local government could reasonably rely on CDC’s continued application of Section 265 once CDC determined that there is no longer sufficient public health risk present with respect to the introduction of covered noncitizens. Therefore, CDC’s considered judgment is that any reliance interest that might be said to exist in connection with the continued suspension of the right to introduce covered noncitizens under 42 U.S.C. 265 is not weighty enough to displace CDC’s determination that there is no public health justification for such a suspension at this time. To the extent that any state or local government did rely on the expulsion of noncitizens for purposes of resource allocation despite the reasons cautioning against such reliance, CDC concludes that resource allocation concerns do not outweigh CDC’s determination that the suspension of the right to introduce covered noncitizens is not required to avert a serious danger to public health.

CDC has also considered whether there may be any short-term reliance on the continued expulsion of noncitizens under the August 2021 Order. CDC concludes that any short-term reliance interests should be limited for all the reasons explained above, and particularly in light of the expressly temporary nature of the Order. For the same reasons, CDC concludes that any such reliance does not outweigh CDC’s determination that the expulsion of covered noncitizens is not required to avert a serious danger to public health. Moreover, to the extent that any state or local government has made any short-term plans based on the existence of the August Order, the effective date of this Termination has been set for 52 days from the date of issuance, thus providing state and local governments time to adjust to the resumption of regular Title 8 immigration processing.

Finally, the CDC Orders issued under 42 U.S.C. 265, 268 and 42 CFR 71.40 are not, and do not purport to be, policy decisions about controlling immigration; rather, as explained, CDC’s exercise of its authority under Section 265 depends on the existence of a public health need. Thus, to the extent that state and local governments along the border or elsewhere were relying on an order under 42 U.S.C. 265 as a means of controlling immigration, such reliance would not be reasonable or legitimate. And even if such reliance were reasonable or legitimate, that reliance would not outweigh CDC’s conclusion that expulsions are not necessary under the terms of 42 U.S.C. 265 or warrant disruption of ordinary processing of covered noncitizens.

B. Basis for Termination Under 42 U.S.C. 265, 268 and 42 CFR 71.40

CDC is hereby terminating the August Order and all prior orders issued pursuant to sections 362 and 365 of the PHS Act (42 U.S.C. 265, 268) and the implementing regulation at 42 CFR 71.40. This Termination will be implemented on May 23, 2022, for the operational reasons outlined herein, including to give DHS time to implement additional COVID–19 mitigation measures. The statutory and regulatory authorities permit the CDC Director to issue Orders prohibiting, in whole or in part, the introduction into the United States of persons from designated foreign countries (or one or more political subdivisions or regions thereof) or places, only for such period of time that the Director deems necessary to avert the serious danger of the introduction of a quarantinable contagious disease, based on a determination by the Director that:

(1) By reason of the existence of any quarantinable communicable disease in a foreign country (or one or more political subdivisions or regions thereof) or place there is serious danger of the introduction of such quarantinable communicable disease into the United States; and

(2) This danger is so increased by the introduction of persons from such country (or one or more political subdivisions or regions thereof) or place that a suspension of the right to introduce such persons into the United States is required in the interest of public health.

Pursuant to 42 U.S.C. 265 and the implementing regulation, the CDC Director has the authority to issue orders to mitigate the introduction and further spread of COVID–19 disease. In recognition of the extraordinary nature of these emergency public health powers, section 265 and its implementing regulation contemplate that the exercise of these authorities will be temporally and geographically limited in scope as described below. Critically, these authorities also require that any orders issued will be terminated when they are no longer necessary to protect the public health. The authority to make this determination has been delegated to the CDC Director.
CDC explained in the preamble to the Final Rule for 42 CFR 71.40 that, in issuing an Order under these authorities, it may “consider a wide array of facts and circumstances when determining what is required in the interest of public health in a particular situation . . . including: the overall number of cases of disease; any large increase in the number of cases over a short period of time; the geographic distribution of cases; any sustained (generational) transmission; the method of disease transmission; morbidity and mortality associated with the disease; the effectiveness of contact tracing; the adequacy of state and local healthcare systems; and the effectiveness of state and local public health systems and control measures.”

Other factors noted in the Final Rule are the potential for disease spread among persons held in congregate settings, the potential for disease spread to the community at large, and strain on healthcare systems.

CDC is committed to avoiding the imposition of unnecessary burdens in exercising its communicable disease authorities. This aligns with the underlying legal authority in 42 U.S.C. 265, which makes clear that this authority extends only for such period of time deemed necessary to avert the serious danger of the introduction of a quarantinable communicable disease into the United States.

Such an order must also be predicated, in part, upon a determination that the danger of such introduction is so increased that a suspension of the right to introduce such persons into the United States is required in the interest of public health.

CDC has considered these and other relevant factors in the foregoing determination, including the overall shift in the U.S. government response to the pandemic, and has determined that less restrictive means are available to avert the public health risks associated with the introduction, transmission, and spread of COVID–19 into the United States due to the entry of covered noncitizens. Although COVID–19 continues to spread within the United States, as a result of the numerous tools for disease prevention, mitigation, and treatment which have become available over the past two years, and the other considerations explained above, an order suspending the right to introduce covered noncitizens under 42 U.S.C. 265 is no longer required in the interest of public health.

IV. Issuance and Implementation

Based on the foregoing Public Health Determination, I hereby Terminate the August Order and all previous orders issued pursuant to Sections 362 and 365 of the PHS Act (42 U.S.C. 265, 268), and their implementing regulations under 42 CFR 71.40. This Termination will be implemented on May 23, 2022.

Following a shift in the U.S. government response to the current epidemiologic status of the COVID–19 pandemic and the U.S. government’s ongoing response efforts, I find there is no longer a public health justification for the August Order and previous Orders issued under these authorities; employing such a broad restriction to preserve the health and safety of U.S. citizens, U.S. nationals, and lawful permanent residents, and personnel and noncitizens in POE and U.S. Border Patrol stations is no longer necessary to protect the public health.

Other current public health mitigation measures sufficiently reduce the serious danger of introduction, transmission, and spread of the virus that causes COVID–19 as a result of the entry of covered noncitizens, including in congregate settings where such noncitizens would otherwise be held while undergoing immigration processing, including at POE and U.S. Border Patrol stations at or near the U.S. land and adjacent coastal borders.

Termination of the August Order is based on the current status of the COVID–19 pandemic and the available public health mitigation measures. In making this determination, I have considered myriad facts, including epidemiological information such as the viral transmissibility and asymptomatic transmission of COVID–19, the epidemiology and spread of SARS–CoV–2 variants, the morbidity and mortality associated with the disease for individuals in certain risk categories, COVID–19 Community Levels, national levels of transmission and immunity, the availability and efficacy of vaccination and treatments, as well as public health concerns with congregate settings at border facilities. While holding noncitizens in congregate settings with limited options for COVID–19 mitigation is accompanied by inherent risk, the overall public health landscape in the United States has changed such that the justification for the August Order is no longer sustained.

The COVID–19 pandemic is ongoing and appropriate public health mitigation measures must continue to be applied. Although it cannot be known how the spread of SARS–CoV–2 will change in the future (e.g., due to the emergence of a new variant), CDC plans to rely on COVID–19 Community Levels, among other factors, to inform how prevention measures may be used to minimize the impact of COVID–19 on health and society. Including at the U.S. borders. To that end, CDC will continue to assess the public health situation at the U.S. borders even after this Termination as part of its comprehensive COVID–19 response. If, for example, there is a substantial change in the public health situation with respect to the pandemic, such as due to new and particularly concerning SARS–CoV–2 variants, CDC could determine a new order under 42 U.S.C. 265, 268 and 42 CFR 71.40 is necessary. Any such determination would be based on the public health needs identified at that time.

A. Implementation of This Termination

CDC is required by the Final Rule to consult with “all Federal departments or agencies whose interests would be impacted by this order,” “as practicable under the circumstances.” CDC recognizes that resumption of border operations under Title 8 authorities, and the need to put additional appropriate COVID–19 mitigation measures in place, requires time to operationalize in a manner that protects the health and safety of the migrants, workforce, and American communities. Based on DHS’ recommendation and in order to provide DHS time to implement operational plans for fully resuming Title 8 processing, including incorporating appropriate COVID–19 measures, this Termination will be implemented on May 23, 2022.

DHS has represented that over the next several weeks it is taking important steps to implement processes in preparation for the full resumption of border operations pursuant to Title 8 authorities, in a manner that promotes the health and safety of migrants, CBP employees, and the local communities. Most recently, DHS has initiated a vaccination program for all age-eligible migrants who lack legal status and are processed pursuant to Title 8.
authorities; this program will be scaled up over the next two months.\textsuperscript{181} As stated above, CDC recognizes vaccination as the single most important public health tool for fighting COVID–19 and recommends that all eligible persons, regardless of citizenship, be vaccinated and remain up to date with boosters.\textsuperscript{182} The implementation timeline of this Termination will provide DHS with time to scale its vaccination program, as well as ready its operational capacity, implement appropriate COVID–19 protocols, and prepare for resumption of regular migration under Title 8.

CDC recognizes that the Termination of the August Order will lead to an increase in the number of noncitizens being processed in DHS facilities which could result in overcrowding in congregate settings. Moreover, DHS projects, based on available intelligence as well as seasonal migration patterns, an increase in encounters in the coming months, which could lead to further overcrowding in DHS facilities. DHS reports that it is taking steps to plan for such increases, including by readying decompression plans, deploying additional personnel and resources to support U.S. Border Patrol, and enhancing its ability to safely hold noncitizens it encounters. Putting such plans in place, ensuring that the workforce is adequately and appropriately trained for their shifting roles, and deploying critical resources require time. This Termination will be implemented on May 23, 2022, to provide DHS with additional time to ready such operational plans and prepare for full resumption of regular migration under Title 8.

For the foregoing reasons, this Termination will be implemented on May 23, 2022. To the extent that any state or local government has a misplaced reliance interest on the August Order, the timeline for implementation of the Termination also allows time for such entities to adjust their planning in anticipation of the full resumption of Title 8 border processing. During this temporary period of continued application of the August Order, DHS will continue to exercise its discretion to issue case-by-case exceptions based on the totality of the circumstances as set forth in the August Order.\textsuperscript{183} DHS has represented that it will continue to make use of this exception where, for example, a noncitizen may suffer particular harms associated with expulsion (e.g., vulnerable and medically fragile persons) until the Termination is effective.

\textbf{B. APA Review}

This Termination shall be implemented on May 23, 2022. I consulted with DHS and other federal departments as required by the Final Rule before I issued this Order and requested that DHS aid in the implementation of this Termination.\textsuperscript{184} DHS is developing operational plans for implementing this Termination. CDC will review these plans and ensure that they are consistent with the language of this Termination and public health best practices.

This Termination, like the preceding Orders issued under this authority, is not a rule subject to notice and comment under the Administrative Procedure Act (APA).\textsuperscript{185} Even if it were, notice and comment are not required because there is good cause to dispense with prior public notice and the opportunity to comment on this Termination.\textsuperscript{186} Given the extraordinary nature of an order under Section 265, the resultant restrictions on application for asylum and other immigration processes under Title 8, and the statutory and regulatory requirement that an OCD order under the authority last no longer than necessary to protect public health, it would be impracticable and contrary to the public interest and immigration laws that apply in the absence of an order under 42 U.S.C. 265 to delay the effective date of this Termination beyond May 23, 2022 for the reasons outlined herein.\textsuperscript{187} As explained, DHS requires time to institute operational plans to implement this order, including COVID–19 mitigation measures, and begin regular immigration processing pursuant to Title 8. In light of the August Order’s significant disruption of ordinary immigration processing and DHS’s need for time to implement an orderly and safe termination of the order, there is good cause not to delay issuing this Termination or to delay the termination of this order past May 23, 2022. In addition, this Order concerns ongoing discussions with Canada, Mexico, and other countries regarding immigration and how best to control COVID–19 transmission over shared borders and therefore directly “involve[s] . . . a . . . foreign affairs function of the United States;”\textsuperscript{188} thus, notice and comment are not required.

With this Termination, I hereby determine that the danger of further introduction, transmission, or spread of COVID–19 into the United States from covered noncitizens, as defined in the August Order, has ceased to be a serious danger to the public health and therefore the continuation of the August Order, and all previous orders issued under the same authority, is no longer necessary to protect public health. Nothing in this Termination will prevent me from issuing a new Order under 42 U.S.C. 265, 268 and 42 CFR 71.40 based on new findings, as dictated by public health needs.

Sherri Berger,
Chief of Staff, Centers for Disease Control and Prevention.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Advisory Board on Radiation and Worker Health (ABRWH); Notice of Charter Renewal

AGENCY: Centers for Disease Control and Prevention (CDC), Department of Health and Human Services (HHS).

ACTION: Notice of charter renewal.

SUMMARY: This gives notice under the Federal Advisory Committee Act of October 6, 1972, that the Advisory Board on Radiation and Worker Health (ABRWH), Centers for Disease Control and Prevention, Department of Health and Human Services, has been renewed

\textsuperscript{181} See supra I.B.5.
\textsuperscript{182} In line with CDC’s emphasis on the importance of vaccination, CDC has kept its requirement for noncitizens to provide proof of vaccination for air travel and also supports DHS’s Order requiring the same at the land borders (see supra notes 67 and 83).
\textsuperscript{183} 5 U.S.C. 553(a)(1).
\textsuperscript{184} I.B.5.
\textsuperscript{185} 5 U.S.C. 553(a)(1).
\textsuperscript{186} Subtitle E of the Small Business Regulatory Enforcement Fairness Act of 1996, also known as the Congressional Review Act (CRA), 5 U.S.C. 804(2).
\textsuperscript{187} 5 U.S.C. 553(b)(3)(B).
\textsuperscript{188} See supra notes 67 and 83.

189 5 U.S.C. 804(2). The agency finds, for the reasons listed above, that good cause exists to make this rule effective on May 23, 2022, under 5 U.S.C. 808(2).

190 5 U.S.C. 807(b)(2).


193 "Persons whom customs officers determine, with approval from a supervisor, should be excepted from this Order based on the totality of the circumstances, including consideration of significant law enforcement, officer and public safety, humanitarian, and public health interests. DHS will consult with CDC regarding the standards for such exceptions to help ensure consistency with current CDC guidance and public health recommendations."


196 While this Termination is not a rule subject to notice and comment under the APA [5 U.S.C. 553(a)], the Office of Information and Regulatory Affairs has determined that this is a major rule as defined by Subtitle E of the Small Business Regulatory Enforcement Fairness Act of 1996, also known as the Congressional Review Act (CRA), 5 U.S.C. 804(2). The agency finds, for the reasons listed above, that good cause exists to make this rule effective on May 23, 2022, under 5 U.S.C. 808(2).
