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The President

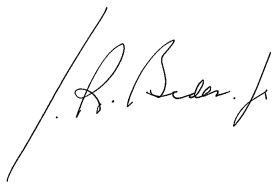
Memorandum of July 25, 2023

Delegation of Authority Under Section 506(a)(1) of the Foreign Assistance Act of 1961

Memorandum for the Secretary of State

By the authority vested in me as President by the Constitution and the laws of the United States of America, including section 621 of the Foreign Assistance Act of 1961 (FAA), I hereby delegate to the Secretary of State the authority under section 506(a)(1) of the FAA to direct the drawdown of up to $400 million in defense articles and services of the Department of Defense, and military education and training, to provide assistance to Ukraine and to make the determinations required under such section to direct such a drawdown.

You are authorized and directed to publish this memorandum in the *Federal Register*.



THE WHITE HOUSE,
Washington, July 25, 2023

[FR Doc. 2023–16585
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Billing code 4710–10–P

Presidential Documents

Executive Order 14103 of July 28, 2023

2023 Amendments to the Manual for Courts Martial, United States

By the authority vested in me as President by the Constitution and the laws of the United States of America, including chapter 47 of title 10, United States Code (Uniform Code of Military Justice, 10 U.S.C. 801–946a), and in order to prescribe additions and amendments to the Manual for Courts-Martial, United States, prescribed by Executive Order 12473 of April 13, 1984, as amended, it is hereby ordered as follows:

Section 1. Part II, Part III, Part IV, and Part V of the Manual for Courts-Martial, United States, are amended as described in Annex 1, which is attached to and made a part of this order. The amendments in Annex 1 shall take effect on the date of this order, subject to the following:

(a) Nothing in Annex 1 shall be construed to make punishable any act committed or omitted prior to the date of this order that was not punishable when committed or omitted.

(b) Nothing in Annex 1 shall be construed to invalidate any nonjudicial punishment proceeding, restraint, preliminary hearing, referral of charges, trial in which arraignment occurred, or other action begun prior to the date of this order, and any such nonjudicial punishment proceeding, restraint, preliminary hearing, referral of charges, trial in which arraignment occurred, or other action may proceed in the same manner and with the same effect as if the Annex 1 amendments had not been prescribed.

Sec. 2. Part I, Part II, Part III, Part IV, Part V, and Appendix 12A of the Manual for Courts-Martial, United States, are amended as described in Annex 2, which is attached to and made a part of this order. The amendments in Annex 2 shall apply in accordance with the effective date established by section 539C of the National Defense Authorization Act for Fiscal Year 2022 (NDAA FY 2022), Public Law 117–81, subject to the following:

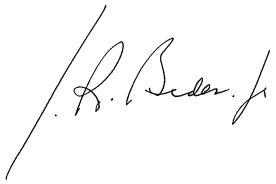
(a) Nothing in Annex 2 shall be construed to make punishable any act committed or omitted prior to the effective date established by section 539C of the NDAA FY 2022.

(b) Nothing in Annex 2 shall be construed to invalidate any nonjudicial punishment proceeding, restraint, preliminary hearing, referral of charges, trial in which arraignment occurred, or other action begun prior to the effective date established by section 539C of the NDAA FY 2022, and any such nonjudicial punishment proceeding, restraint, preliminary hearing, referral of charges, trial in which arraignment occurred, or other action may proceed in the same manner and with the same effect as if the Annex 2 amendments had not been prescribed.

Sec. 3. Appendix 12B, Appendix 12C, and Appendix 12D are added to the Manual for Courts-Martial, United States, and Part II of the Manual is amended as described in Annex 3, which is attached to and made a part of this order. The additions and amendments in Annex 3 shall take effect on December 27, 2023, and shall apply in accordance with section 539E(f) of the NDAA FY 2022 (10 U.S.C. 853 note), subject to the following:

(a) Nothing in Annex 3 shall be construed to make punishable any act committed or omitted prior to the effective date established by section 539E(f) of the NDAA FY 2022.

(b) Nothing in Annex 3 shall be construed to invalidate any nonjudicial punishment proceeding, restraint, preliminary hearing, referral of charges, trial in which arraignment occurred, or other action begun prior to the effective date established by section 539E(f) of the NDAA FY 2022, and any such nonjudicial punishment proceeding, restraint, preliminary hearing, referral of charges, trial in which arraignment occurred, or other action may proceed in the same manner and with the same effect as if the Annex 3 amendments had not been prescribed.



THE WHITE HOUSE,
July 28, 2023.

Billing code 3395–F3–P

ANNEX 1

Section 1. Part II of the Manual for Courts-Martial, United States, is amended as follows:

(a) R.C.M. 104 is amended to read as follows:

"**Rule 104. Command influence**

(a) *General prohibitions.*

(1) *Convening authorities and commanders.*

(A) No court-martial convening authority, nor any other commanding officer, may censure, reprimand, or admonish a court-martial or other military tribunal or any member, military judge, or counsel thereof, with respect to the findings or sentence adjudged by the court-martial or tribunal, or with respect to any other exercise of the functions of the court-martial or tribunal or such persons in the conduct of the proceedings.

(B) No court-martial convening authority, nor any other commanding officer, may deter or attempt to deter a potential witness from participating in the investigatory process or testifying at a court-martial. The denial of a request to travel at government expense or refusal to make a witness available shall not by itself constitute unlawful command influence.

(2) *All persons subject to the UCMJ.* No person subject to the UCMJ may attempt to coerce or, by any unauthorized means, attempt to influence the action of a court-martial or any other military tribunal or any member thereof, in reaching the findings or sentence in any case or the action of any preliminary hearing officer or convening, approving, or reviewing authority with respect to such preliminary hearing officer's or authority's acts concerning the following: any decision to place a Servicemember into pretrial confinement; disposition decisions; rulings on pre-referral matters; findings at a preliminary hearing; convening a court-martial; decisions concerning plea agreements; selecting members; decisions concerning witness requests;

taking action on any clemency or deferment request; or any appellate or post-trial review of a case.

(3) *Scope.*

(A) *Instructions.* Paragraphs (a)(1) and (2) of this rule do not prohibit general instructional or informational courses in military justice if such courses are designed solely for the purpose of instructing personnel of a command in the substantive and procedural aspects of courts-martial.

(B) *Court-martial statements.* Paragraphs (a)(1) and (2) of this rule do not prohibit statements and instructions given in open session by the military judge or counsel.

(C) *Professional supervision.* Paragraphs (a)(1) and (2) of this rule do not prohibit action by the Judge Advocate General concerned under R.C.M. 109.

(D) *Offense.* Paragraphs (a)(1) and (2) of this rule do not prohibit appropriate action against a person for an offense committed while detailed as a military judge, counsel, or member of a court-martial, or while serving as individual counsel.

(E) *General statements regarding criminal activity or offenses.* Paragraphs (a)(1) and (2) of this rule do not prohibit statements regarding criminal activity or a particular criminal offense that do not advocate a particular disposition, do not advocate a particular court-martial finding or sentence, and do not relate to a particular accused.

(b) *Communication between superiors and subordinates.*

(1) A superior convening authority or officer may generally discuss matters to consider regarding the disposition of alleged violations of the UCMJ with a subordinate convening authority or officer, and a subordinate convening authority or officer may seek advice from a superior convening authority or officer regarding the disposition of an alleged offense under the UCMJ.

(2) No superior convening authority or officer may direct a subordinate convening authority or officer to make a particular disposition in a specific case or otherwise substitute the discretion of such authority or such officer for that of the subordinate convening authority or officer.

(c) *Prohibitions concerning evaluations.*

(1) *Evaluation of member or counsel.* In the preparation of an effectiveness, fitness, or efficiency report or any other report or document used in whole or in part for the purpose of determining whether a member of the armed forces is qualified to be advanced in grade, or in determining the assignment or transfer of a member of the armed forces, or in determining whether a member of the armed forces should be retained on active duty, no person subject to the UCMJ may:

(A) Consider or evaluate the performance of duty of any such person as a member of a court-martial; or

(B) Give a less favorable rating or evaluation of any defense counsel or special victims' counsel because of the zeal with which such counsel represented any client. As used in this rule, "special victims' counsel" are judge advocates and civilian counsel, who, in accordance with 10 U.S.C. § 1044e, are designated as Special Victims' Counsel.

(2) *Evaluation of military judge.*

(A) *General courts-martial.* Unless the general court-martial was convened by the President or the Secretary concerned, neither the convening authority nor any member of the convening authority's staff may prepare or review any report concerning the effectiveness, fitness, or efficiency of the military judge detailed to a general court-martial that relates to the performance of duty as a military judge.

(B) *Special courts-martial.* The convening authority may not prepare or review any report concerning the effectiveness, fitness, or efficiency of a military judge detailed to a special court-martial that relates to the performance of duty as a military judge. When the military judge is normally rated or the military judge's report is reviewed by the convening authority, the manner in which such military judge will be rated or evaluated upon the performance of duty as a military judge may be as prescribed in regulations of the Secretary concerned, which shall ensure the absence of any command influence in the rating or evaluation of the military judge's judicial performance.

(d) *Command discretion.*

(1) A superior convening authority or commanding officer may withhold the authority of a subordinate convening authority or officer to dispose of offenses in individual cases, types of cases, or generally.

(2) Except as provided in paragraph (d)(1) of this rule or as otherwise authorized under the UCMJ, a superior convening authority or commanding officer may not limit the discretion of a subordinate convening authority or officer to act with respect to a case for which the subordinate convening authority or officer has the authority to dispose of the offenses."

(b) R.C.M. 201(e) is amended to read as follows:

"(e) *Reciprocal jurisdiction.*

(1) Each armed force has court-martial jurisdiction over all persons subject to the UCMJ.

(2)(A) A commander of a unified or specified combatant command may convene courts-martial over members of any of the armed forces.

(B) So much of the authority vested in the President under Article 22(a)(9), to empower any commanding officer of a joint command or joint task force to convene courts-martial is

delegated to the Secretary of Defense, and such a commanding officer may convene general courts-martial for the trial of members of any of the armed forces assigned or attached to a combatant command or joint command.

(C) A commander who is empowered to convene a court-martial under subparagraphs (e)(2)(A) or (e)(2)(B) of this rule may expressly authorize a commanding officer of a subordinate joint command or subordinate joint task force who is authorized to convene special and summary courts-martial to convene such courts-martial for the trial of members of other armed forces assigned or attached to a joint command or joint task force, under regulations that the superior command may prescribe.

(3)(A) An accused should not ordinarily be tried by a court-martial convened by a member of a different armed force except when the circumstances described in subparagraphs (e)(2)(A) or (B) of this rule exist. However, failure to comply with this non-binding policy does not affect an otherwise valid referral.

(B) The non-binding policy stated by subparagraph (e)(3)(A) of this rule does not apply when one or more of the following circumstances exists:

(i) The court-martial is convened by a commander authorized to convene courts-martial under paragraph (e)(2) of this rule;

(ii) The accused cannot be delivered to the armed force of which the accused is a member without manifest injury to the armed forces;

(iii) The court-martial is convened by a member of the Space Force to try a member of the Air Force; or

(iv) The court-martial is convened by a member of the Air Force to try a member of the Space Force.

(4) Nothing in this rule prohibits detailing to a court-martial a military judge, member, or counsel who is a member of an armed force different from that of the accused, the convening authority, or both.

(5) When a member of one armed force is tried by a court-martial convened by a member of another armed force, the court-martial will use the implementing regulations and procedures prescribed by the Secretary concerned of the military service of the accused. In all cases, departmental review after that by the officer with authority to convene a general court-martial for the command that held the trial, where that review is required by the UCMJ, shall be carried out by the department that includes the armed force of which the accused is a member.

(6) Unless otherwise directed by the President or Secretary of Defense, whenever action under this Manual is required or authorized to be taken by a person superior to—

(A) a commander of a unified or specified combatant command; or

(B) a commander of any other joint command or joint task force that is not part of a unified or specified combatant command,

the matter shall be referred to the Secretary of the armed force of which the accused is a member. The Secretary may convene a court-martial, take other appropriate action, or, subject to R.C.M. 504(c), refer the matter to any person authorized to convene a court-martial of the accused.

(7) When there is a disagreement between the Secretaries of two military departments or between the Secretary of a military department and the commander of a unified or specified combatant command or other joint command or joint task force as to which organization should exercise jurisdiction over a particular case or class of cases, the Secretary of Defense or an official acting under the authority of the Secretary of Defense shall designate which organization will exercise jurisdiction."

(c) R.C.M. 305(j) is amended to read as follows:

"(j) *Review by military judge.* Once the charges for which the accused has been confined are referred to trial, or in a pre-referral proceeding conducted in accordance with R.C.M. 309, the military judge shall review the propriety of pretrial confinement upon motion for appropriate relief.

(1) *Release.* The military judge shall order release from pretrial confinement only if:

(A) The 7-day reviewing officer's decision was an abuse of discretion, and there is not sufficient information presented to the military judge justifying continuation of pretrial confinement under subparagraph (h)(2)(B) of this rule;

(B) Information not presented to the 7-day reviewing officer establishes that the confinee should be released under subparagraph (h)(2)(B) of this rule; or

(C) The provisions of paragraph (i)(1) or (2) of this rule have not been complied with and information presented to the military judge does not establish sufficient grounds for continued confinement under subparagraph (h)(2)(B) of this rule.

(2) *Credit.* Upon sentencing, the military judge shall order administrative credit under subsection (k) of this rule for any pretrial confinement served as a result of an abuse of discretion or failure to comply with the provisions of subsections (f), (h), or (i) of this rule."

(d) R.C.M. 307(b) is amended to read as follows:

"(b) *How charges are preferred; oath.* In preferring charges and specifications —

(1) The person preferring the charges and specifications must sign them under oath before a commissioned officer of the armed forces authorized to administer oaths; and

(2) The writing under paragraph (b)(1) must state that—

(A) the signer has personal knowledge of, or has investigated, the matters set forth in the

charges and specifications; and

(B) the matters set forth in the charges and specifications are true to the best of the knowledge and belief of the signer.

(3) Any procedure, including those by remote means, which appeals to the conscience of the person to whom the oath is administered and which binds that person to properly perform that person's duties under this rule, is sufficient."

(e) R.C.M. 309 is amended to read as follows:

"Rule 309. Proceedings conducted before referral

(a) *In general.*

(1) A military judge detailed under regulations of the Secretary concerned may conduct proceedings under Article 30a, before referral of charges and specifications to court-martial for trial, and may issue such rulings and orders as necessary to further the purpose of the proceedings. A military judge may issue such orders and rulings only when the matters would be subject to consideration by a military judge in a general or special court-martial.

(2) The matters that may be considered and ruled upon by a military judge in proceeding under this rule are limited to those matters specified in subsection (b) of this rule.

(3) If any matter in a proceeding under this rule becomes a subject at issue with respect to charges that have been referred to a general or special court-martial, the matter, to include any motions, related papers, and the record of the hearing, if any, shall be provided to the military judge detailed to the court-martial.

(b) *Pre-referral matters.*

(1) *Pre-referral investigative subpoenas.* A military judge may, upon application by the Government, consider whether to issue a pre-referral investigative subpoena under R.C.M.

703(g)(3)(C). The proceeding may be conducted ex parte and may be conducted in camera.

(2) *Pre-referral warrants or orders for wire or electronic communications.* A military judge may, upon written application by a federal law enforcement officer or authorized counsel for the Government in connection with an ongoing investigation of an offense or offenses under the UCMJ, consider whether to issue a warrant or order for wire or electronic communications and related information as provided under R.C.M. 703A. The proceeding may be conducted ex parte and may be conducted in camera.

(3) *Requests for relief from subpoena or other process.* A person in receipt of a pre-referral investigative subpoena under R.C.M. 703(g)(3)(C), a victim named in a specification whose personal and confidential information has been subpoenaed under R.C.M. 703(g)(3)(C)(ii), or a service provider in receipt of a warrant or court order to disclose information about wire or electronic communications under R.C.M. 703A may request relief on grounds that compliance with the subpoena, warrant, or order is unreasonable, oppressive or prohibited by law. The military judge shall review the request and shall either order the person or service provider to comply with the subpoena, warrant, or order, or modify or quash the subpoena, warrant, or order as appropriate. In a proceeding under this paragraph, the United States shall be represented by an authorized counsel for the Government.

(4) *Pre-referral matters referred by an appellate court.* When a Court of Criminal Appeals or the Court of Appeals for the Armed Forces, in the course of exercising the jurisdiction of such court, remands the case for a pre-referral judicial proceeding, a military judge may conduct such a proceeding under this rule. This includes matters referred by a Court of Criminal Appeals under subsection (e) of Article 6b.

(5) *Pre-referral matters under subsection (c) of Article 6b.* The military judge may

designate a suitable person to assume the rights of a victim who is under 18 years of age (but who is not a member of the armed forces), or who is incompetent, incapacitated, or deceased. Upon appointment by the military judge, the legal guardian of the victim, the representative of the victim's estate, a family member, or any other person designated as suitable by the military judge, may assume the rights of the victim. Under no circumstances may the military judge designate the accused to assume the rights of the victim.

(6) *Pretrial confinement of an accused.* After action by the 7-day reviewing officer under R.C.M. 305(i)(2)(C), a military judge may, upon application of an accused for appropriate relief, review the propriety of pretrial confinement. A military judge may order release from pretrial confinement under the provisions of R.C.M. 305(j)(1).

(7) *The mental capacity or mental responsibility of an accused.*

(A) A military judge may, under the provisions of R.C.M. 706(b)(1), order an inquiry into the mental capacity or mental responsibility of an accused before referral of charges. The proceeding may be conducted ex parte and may be conducted in camera.

(B) A military judge may, under the provisions of R.C.M. 909, conduct a hearing to determine the mental capacity of the accused.

(8) *A request for individual military counsel.* When an accused requests individual military counsel prior to charges being referred to a general or special court-martial, a military judge may review the request subject to the provisions of R.C.M. 506(b).

(9) *Victim's petition for relief.*

(A) A victim of an offense under the UCMJ, as defined in Article 6b(b), may file a motion pre-referral requesting that a military judge require a preliminary hearing officer conducting a preliminary hearing under R.C.M. 405 to comply with:

(i) Articles 6b or 32;

(ii) R.C.M. 405; or

(iii) Mil. R. Evid. 412, 513, 514, or 615.

(B) The military judge may grant or deny such a motion. The ruling is subject to further review pursuant to Article 6b(e).

(c) *Procedure for submissions.* The Secretary concerned shall prescribe the procedures for receiving requests for proceedings under this rule and for detailing military judges to such proceedings.

(d) *Hearings.* Any hearing conducted under this rule shall be conducted in accordance with the procedures generally applicable to sessions conducted under Article 39(a), and R.C.M. 803.

(e) *Record.* A separate record of any proceeding under this rule shall be prepared and forwarded to the convening authority or commander with authority to dispose of the charges or offenses in the case. If charges are referred to trial in the case, such record shall be included in the record of trial.

(f) *Military magistrate.* If authorized under regulations of the Secretary concerned, a military judge detailed to a proceeding under this rule, other than a proceeding under paragraph (b)(2), (b)(7)(B), or (b)(8) of this rule, may designate a military magistrate to preside and exercise the authority of the military judge over the proceeding."

(f) R.C.M. 405(f) is amended to read as follows:

"(f) *Rights of the accused.* At any preliminary hearing under this rule, the accused shall have the right to:

(1) Be advised of the charges under consideration;

(2) Be represented by counsel;

(3) Be informed of the purpose of the preliminary hearing;

(4) Be informed of the right against self-incrimination under Article 31;

(5) In accordance with the terms of R.C.M. 405(j)(4), be present throughout the preliminary hearing;

(6) Cross-examine witnesses on matters relevant to the issues for determination under subsection (a) of this rule;

(7) Present matters relevant to the issues for determination under subsection (a); and

(8) Make a sworn or unsworn statement relevant to the issues for determination under subsection (a).”

(g) R.C.M. 405(h)(3)(B)(iii) is amended to read as follows:

“(iii) If the Government objects to production of the evidence, defense counsel may request that the preliminary hearing officer determine whether the evidence should be produced. If the preliminary hearing officer determines that the evidence is relevant, not cumulative, and necessary to a determination of the issues under subsection (a) of this rule and that the issuance of a pre-referral investigative subpoena would not cause undue delay to the preliminary hearing, the preliminary hearing officer shall direct counsel for the Government to seek a pre-referral investigative subpoena for the defense-requested evidence from a military judge in accordance with R.C.M. 309 or authorization from the general court-martial convening authority to issue an investigative subpoena. If counsel for the Government refuses or is unable to obtain an investigative subpoena, the counsel shall set forth the reasons why the investigative subpoena was not obtained in a written statement that shall be included in the preliminary hearing report under subsection (l) of this rule.”

(h) R.C.M. 405(i)(2)(A) is amended to read as follows:

"(A) *Inadmissibility of certain evidence.* In a case of an alleged sexual offense, as defined under Mil. R. Evid. 412(d), evidence offered to prove that the alleged victim engaged in other sexual behavior or evidence offered to prove any alleged victim's sexual predisposition is not admissible at a preliminary hearing unless—

(i) the evidence would be admissible at trial under Mil. R. Evid. 412(b)(1) or (2); and

(ii) the evidence is not cumulative and is necessary to a determination of the issues under subsection (a) of this rule."

(i) R.C.M. 405(j)(3) is amended to read as follows:

"(3) *Access by spectators.* Preliminary hearings are public proceedings and should remain open to the public whenever possible, whether conducted in person or via remote means. If there is an overriding interest that outweighs the value of an open preliminary hearing, the convening authority or the preliminary hearing officer may restrict or foreclose access by spectators to all or part of the proceedings. Any restriction or closure must be narrowly tailored to protect the overriding interest involved. Before ordering any restriction or closure, a convening authority or preliminary hearing officer must determine whether any reasonable alternatives to such restriction or closure exist, or if some lesser means can be used to protect the overriding interest in the case. The convening authority or preliminary hearing officer shall make specific findings of fact in writing that support the restriction or closure. The written findings of fact shall be included in the preliminary hearing report."

(j) R.C.M. 405(j)(4) is amended to read as follows:

"(4) *Presence of accused.* The accused shall be present for the preliminary hearing.

(A) *Remote presence of the accused.* The convening authority that directed the

preliminary hearing may authorize the use of audio-visual technology between the parties and the preliminary hearing officer. In such circumstances the "presence" requirement of the accused is met only when the accused has a defense counsel physically present at the accused's location or when the accused consents to presence by remote means with the opportunity for confidential consultation with defense counsel during the proceeding. Such technology may include two or more remote sites as long as all parties can see and hear each other.

(B) The accused shall be considered to have waived the right to be present at the preliminary hearing if the accused:

(i) After being notified of the time and place of the proceeding is voluntarily absent; or

(ii) After being warned by the preliminary hearing officer that disruptive conduct will cause removal from the proceeding, persists in conduct that is such as to justify exclusion from the proceeding."

(k) A new R.C.M. 406(c) is inserted immediately after R.C.M. 406(b) to read as follows:

"(c) *Distribution.* A copy of the advice of the staff judge advocate shall be provided to the defense if charges are referred to trial by general court-martial."

(l) R.C.M. 703(d) is amended to read as follows:

"(d) *Employment of expert witnesses and consultants.*

(1) *Experts for the prosecution.* When the employment of a prosecution expert witness or consultant is considered necessary, counsel for the Government shall, in advance of employment of the expert, and with notice to the defense, submit a request for funding of the expert in accordance with regulations prescribed by the Secretary concerned.

(2) *Experts for the defense.* When the employment of a defense expert witness or

consultant is considered necessary, the defense shall submit a request for funding of the expert in accordance with regulations prescribed by the Secretary concerned.

(A) After referral of charges, a denied defense request for an expert witness or consultant may be raised before the military judge. Motions for expert consultants may be raised *ex parte*. The military judge shall determine—

(i) in the case of an expert witness, whether the testimony is relevant and necessary; and

(ii) in the case of an expert consultant, whether the assistance is necessary for an adequate defense.

(B) If the military judge grants a motion for employment of a defense expert witness or consultant, the expert witness or consultant, or an adequate substitute, shall be provided in accordance with regulations prescribed by the Secretary concerned. In the absence of advance approval by an official authorized to grant such approval under the regulations prescribed by the Secretary concerned, expert witnesses and consultants may not be paid fees other than those to which they are entitled under subparagraph (g)(3)(E) of this rule."

(m) R.C.M. 703(g)(3)(G) is amended to read as follows:

"(G) *Relief.* If either a person subpoenaed or a victim named in a specification whose personal and confidential information has been subpoenaed under subparagraph (g)(3)(C)(ii) of this rule requests relief on grounds that compliance is unreasonable, oppressive, or prohibited by law, the military judge or, if before referral, a military judge detailed under Article 30a, shall review the request and shall—

(i) order that the subpoena be modified or quashed, as appropriate; or

(ii) order the person to comply with the subpoena."

(n) R.C.M. 703(g)(3)(H)(iii) is amended to read as follows:

"(iii) *Form*. A warrant of attachment shall be written. All documents in support of the warrant of attachment shall be attached to the warrant, together with any charge sheets and convening orders, if applicable."

(o) R.C.M. 703A is amended to read as follows:

"Rule 703A. Warrant or order for wire or electronic communications

(a) *In general.* A military judge detailed in accordance with Article 26 or Article 30a, may, upon written application by a federal law enforcement officer, trial counsel, or other authorized counsel for the Government in connection with an ongoing investigation of an offense or offenses under the UCMJ, issue one or more of the following:

(1) A warrant for the disclosure by a provider of electronic communication service of the contents of any wire or electronic communication.

(2) A warrant for the disclosure by a provider of remote computing service of the contents of any wire or electronic communication that is held or maintained on that service—

(A) on behalf of, and received by means of electronic transmission from (or created by means of computer processing of communications received by means of electronic transmission from), a subscriber or customer of such remote computing service; and

(B) solely for the purpose of providing storage or computer processing services to such subscriber or customer, if the provider is not authorized to access the contents of any such communications for purposes of providing any services other than storage or computer processing.

(3) A warrant or order for the disclosure by a provider of electronic communication service or remote computing service of a record or other information pertaining to a subscriber to

or customer of such service (not including the contents of communications).

(b) *Warrant procedures.*

(1) *Probable cause required.* A military judge shall issue a warrant authorizing the search for and seizure of information specified in subsection (a) of this rule if—

(A) The federal law enforcement officer, trial counsel, or other authorized counsel for the Government applying for the warrant presents an affidavit or sworn testimony, subject to examination by the military judge, in support of the application; and

(B) Based on the affidavit or sworn testimony, the military judge determines that there is probable cause to believe that the information sought contains evidence of a crime.

(2) *Issuing the warrant.* The military judge shall issue the warrant to the federal law enforcement officer, trial counsel, or other authorized counsel for the Government who applied for the warrant.

(3) *Contents of the warrant.* The warrant shall identify the property to be searched, identify any property or other information to be seized, and designate the military judge to whom the warrant must be returned.

(4) *Executing the warrant.* The presence of the federal law enforcement officer, trial counsel, or other authorized counsel for the Government identified in the warrant shall not be required for service or execution of a search warrant issued in accordance with this rule requiring disclosure by a provider of electronic communications service or remote computing service of the contents of communications or records or other information pertaining to a subscriber to or customer of such service.

(5) *Quashing or modifying the warrant.* A military judge issuing a warrant under subsection (a), on a motion made promptly by the service provider, may quash or modify such

warrant, if the warrant is determined to be unreasonable or oppressive or prohibited by law.

(c) *Order procedures.*

(1) A military judge shall issue an order authorizing the disclosure of information specified in paragraph (a)(3) of this rule if the federal law enforcement officer, trial counsel, or other authorized counsel for the Government applying for the order offers specific and articulable facts showing that there are reasonable grounds to believe that the records or other information sought are relevant and material to an ongoing criminal investigation.

(2) *Quashing or modifying order.* A military judge issuing an order under paragraph (c)(1) of this rule, on a motion made promptly by the service provider, may quash or modify such order if the order is determined to be unreasonable, oppressive, or prohibited by law.

(d) *Non-disclosure orders.*

(1) A federal law enforcement officer, trial counsel, or other authorized counsel for the Government acting under this rule may apply to a military judge for an order commanding a provider of electronic communications service or remote computing service to whom a warrant or order under this rule is directed, for such period as the military judge deems appropriate, not to notify any other person of the existence of the warrant or order. The military judge shall issue the order if the military judge determines that there is reason to believe that notification of the existence of the warrant or order will result in an adverse result described in paragraph (d)(2) of this rule.

(2) An adverse result for the purposes of paragraph (d)(1) of this rule is—

(A) endangering the life or physical safety of an individual;

(B) flight from prosecution;

(C) destruction of or tampering with evidence;

(D) intimidation of potential witnesses; or

(E) otherwise seriously jeopardizing an investigation or unduly delaying a trial.

(e) *No cause of action against a provider disclosing information under this rule.* As provided under 18 U.S.C. § 2703(e), no cause of action shall lie in any court against any provider of wire or electronic communication service, its officers, employees, agents, or other specified persons for providing information, facilities, or assistance in accordance with the terms of a warrant or order under this rule.

(f) *Requirement to preserve evidence.* To the same extent as provided in 18 U.S.C. § 2703(f)—

(1) A provider of wire or electronic communication services or a remote computing service, upon the request of a federal law enforcement officer, trial counsel, or other authorized counsel for the Government, shall take all necessary steps to preserve records and other evidence in its possession pending the issuance of an order or other process; and

(2) Shall retain such records and other evidence for a period of 90 days, which shall be extended for an additional 90-day period upon a renewed request by the governmental entity.

(g) *Definition.* As used in this rule, the term "federal law enforcement officer" includes an employee of the Army Criminal Investigation Command, the Naval Criminal Investigative Service, the Air Force Office of Special Investigations, or the Coast Guard Investigative Service who has authority to request a search warrant."

(p) R.C.M. 705(d)(1) is amended to read as follows:

"(1) *In general.* Subject to such limitations as the Secretary concerned may prescribe pursuant to R.C.M. 705(a), a plea agreement that limits the sentence that can be imposed by the court-martial for one or more charges and specifications may contain:

(A) a limitation on the maximum punishment that can be imposed by the court-

martial;

(B) a limitation on the minimum punishment that can be imposed by the court-martial;

(C) limitations on the maximum and minimum punishments that can be imposed by the court-martial; or,

(D) a specified sentence or portion of a sentence that shall be imposed by the court-martial."

(q) R.C.M. 706(b)(1) is amended to read as follows:

"(1) *Before referral.* Before referral of charges, an inquiry into the mental capacity or mental responsibility of the accused may be ordered by the convening authority before whom the charges are pending for disposition, or by a military judge or magistrate in a proceeding conducted in accordance with R.C.M. 309."

(r) R.C.M. 706(c)(3)(A) is amended to read as follows:

"(A) That upon completion of the board's investigation, a statement consisting only of the board's ultimate conclusions as to all questions specified in the order shall be submitted to the officer ordering the examination, the accused's commanding officer, the preliminary hearing officer, if any, appointed pursuant to Article 32, and to all government and defense counsel in the case, the convening authority, and, after referral, to the military judge."

(s) R.C.M. 707(c)(1) is amended to read as follows:

"(1) *Procedure.* Prior to referral, all requests for pretrial delay, together with supporting reasons, will be submitted to the convening authority for resolution. After referral, such requests for pretrial delay will be submitted to the military judge for resolution."

(t) R.C.M. 707(e) is amended to read as follows:

"(e) *Waiver.* Except as provided in R.C.M. 910(a)(2), a plea of guilty that results in a finding of guilty waives any speedy trial issue under this rule as to that offense."

(u) R.C.M. 804(b) is amended to read as follows:

"(b*) Presence by remote means.*

(1) The military judge may order the use of audiovisual technology, such as video teleconferencing technology, between the parties and the military judge for purposes of Article 39(a) sessions, subject to the limitations in paragraph (2) of this rule. Use of such audiovisual technology will satisfy the "presence" requirement of the accused only when the accused has a defense counsel physically present at the accused's location or when the accused consents to presence by remote means with the opportunity for confidential consultation with defense counsel during the proceeding. Such technology may include two or more remote sites as long as all parties can see and hear each other.

(2) The use of audiovisual technology between the parties and the military judge may be used for a plea inquiry under R.C.M. 910(d), (e), and (f) and for presentencing proceedings before a military judge under R.C.M. 1001, only when there are exceptional circumstances that interfere with the normal administration of military justice, as determined by the military judge, and with the consent of the accused. Defense counsel must be physically present at the accused's location during an inquiry prior to the acceptance of a plea under R.C.M. 910(d), (e), and (f) and during presentencing proceedings before a military judge under R.C.M. 1001."

(v) R.C.M. 813(a) through (d) are amended to read as follows:

"(a) *Opening sessions.* Except as noted in subsection (d), when the court-martial is called to order for the first time in a case, the military judge shall ensure that the following is announced:

(1) The order, including any amendment, by which the court is convened;

(2) The name, rank, and unit or address of the accused;

(3) The name and rank of the military judge presiding;

(4) The names and ranks of the members, if any, who are present;

(5) The names and ranks of members who are absent, if presence of members is required

(6) The names and ranks (if any) of counsel who are present;

(7) The names and ranks (if any) of counsel who are absent; and

(8) The name and rank (if any) of any detailed court reporter.

(b) *Later proceedings.* When the court-martial is called to order after a recess or adjournment or after it has been closed for any reason, the military judge shall ensure that the record reflects whether all parties and members who were present at the time of the adjournment or recess, or at the time the court-martial closed, are present.

(c) *Additions, replacement, and absences of personnel.* Whenever there is a replacement of the military judge, any member, or counsel, either through the appearance of new personnel or personnel previously absent or through the absence of personnel previously present, the military judge shall ensure the record reflects the change and the reason for it.

(d) Under R.C.M. 813(a)(1), the name, grade, and position of the convening authority, with the exception of the Secretary concerned, the Secretary of Defense, or the President, shall be omitted from announcement during the opening session of the court-martial."

(w) R.C.M. 909(c) is amended to read as follows:

"(c) *Determination before referral.*

(1) If an inquiry pursuant to R.C.M. 706 conducted before referral concludes that an accused is suffering from a mental disease or defect that renders the accused mentally incompetent to stand trial, the convening authority before whom the charges are pending for

disposition may disagree with the conclusion and take any action authorized under R.C.M. 401, including referral of the charges to trial. If that convening authority concurs with the conclusion, the convening authority shall forward the charges to the general court-martial convening authority. If, upon receipt of the charges, the general court-martial convening authority similarly concurs, then he or she shall commit the accused to the custody of the Attorney General. If the general court-martial convening authority does not concur, that authority may take any action that the authority deems appropriate in accordance with R.C.M. 407, including referral of the charges to trial.

(2) Upon request of the Government or the accused, a military judge may conduct a hearing to determine the mental capacity of the accused in accordance with R.C.M. 309 and subsection (e) of this rule at any time prior to referral."

(x) A new R.C.M. 910(f)(8) is inserted immediately after R.C.M. 910(f)(7) to read as follows:

"(8) *Basis for rejecting a plea agreement.* The military judge of a general or special court-martial shall reject a plea agreement that—

(A) contains a provision that has not been accepted by both parties;

(B) contains a provision that is not understood by the accused;

(C) except as provided in Article 53a(c), contains a provision for a sentence that is less than the mandatory minimum sentence applicable to an offense referred to in Article 56(b)(2);

(D) is prohibited by law; or

(E) is contrary to, or is inconsistent with, these rules with respect to the terms, conditions, or other aspects of plea agreements."

(y) R.C.M. 910(j) is amended to read as follows:

"(j) *Waiver.* Except as provided in paragraph (a)(2) of this rule, a plea of guilty that results in a finding of guilty waives any objection, whether or not previously raised, as to the factual issue of guilt of the offense(s) to which the plea was made and any non-jurisdictional defect as to the offense(s) to which the plea was made that occurred prior to the plea."

(z) R.C.M. 912A(a)(4)(A) is amended to read as follows:

"(A) If the convening authority authorizes the military judge to impanel a specific number of alternate members, the number of members impaneled shall be the number of members required under paragraphs (1), (2), or (3) of this subsection, as applicable, plus the number of alternate members specified by the convening authority. The military judge shall not impanel the court-martial until the specified number of alternate members has been identified. New members may be detailed in order to impanel the specified number of alternate members."

(aa) A new R.C.M. 912A(d)(3)(C) is inserted immediately after R.C.M. 912A(d)(3)(B) to read as follows:

"(C) In a case in which the accused has elected to be tried by a panel consisting of at least one-third enlisted members under R.C.M. 503(a)(2), the convening authority may instruct the military judge to prioritize impaneling a specific number of alternate enlisted members before impaneling alternate officer members. These members shall be identified in numerical order beginning with the lowest remaining random number assigned pursuant to R.C.M. 912(f)(5), after first identifying members under paragraph (1) of this subsection."

(bb) R.C.M. 914(e) is amended to read as follows:

"(e) *Remedy for failure to produce statement.*

(1) *Party refusal to comply.* If the other party elects not to comply with an order to deliver a statement to the moving party, the military judge shall order that the testimony of the witness

be disregarded by the trier of fact and that the trial proceed, or, if it is the trial counsel who elects not to comply, shall declare a mistrial if required in the interest of justice.

(2) *Exception.* In the event that the other party cannot comply with this rule because the statement is lost, and can prove, by a preponderance of evidence, that the loss of the witness statement was not attributable to bad faith or gross negligence, the military judge may exercise the sanctions set forth in paragraph (e)(1) of this rule only if—

(A) the statement is of such central importance to an issue that it is essential to a fair trial, and

(B) there is no adequate substitute for the statement."

(cc) R.C.M. 916(e)(2) is amended to read as follows:

"(2) *Certain aggravated offer-type assault cases.* It is a defense to aggravated assault that the accused:

(A) Apprehended, on reasonable grounds, that bodily harm was about to be inflicted wrongfully on the accused; and

(B) In order to deter the assailant, offered but did not actually inflict or attempt to inflict substantial or grievous bodily harm."

(dd) A new R.C.M. 920(g) is inserted immediately after R.C.M. 920(f) to read as follows:

"(g) *Waiver.* Instructions on a lesser included offense shall not be given when both parties waive such an instruction. After receiving applicable notification of those lesser included offenses of which an accused may be convicted, the parties may waive the reading of a lesser included offense instruction. A written waiver is not required. The accused must affirmatively acknowledge that the accused understands the rights involved and affirmatively waive the instruction on the record. The accused's waiver must be made freely, knowingly, and

intelligently. In the case of a joint or common trial, instructions on a lesser included offense shall not be given as to an individual accused when that accused and the Government agree to waive such an instruction."

(ee) R.C.M. 1003(b)(2) is amended to read as follows:

"(2) *Forfeiture of pay and allowances.* Unless a total forfeiture is adjudged, a sentence to forfeiture shall state the exact amount in whole dollars to be forfeited each month and the number of months the forfeitures will last. Allowances shall be subject to forfeiture only when the sentence includes forfeiture of all pay and allowances. The maximum authorized amount of a partial forfeiture shall be determined by using the basic pay, retired pay, or retainer pay, as applicable, or, in the case of reserve component personnel on inactive duty, compensation for periods of inactive-duty training, authorized by the cumulative years of service of the accused, and, if no confinement is adjudged, any sea or hardship duty pay. If the sentence also includes reduction in grade, expressly or by operation of law, the maximum forfeiture shall be based on the grade to which the accused is reduced. Forfeitures of greater than two-thirds' pay per month may be imposed only during periods of confinement."

(ff) R.C.M. 1003(c)(2) is amended to read as follows:

"(2) *Based on grade of accused.*

(A) *Commissioned or warrant officers, cadets, and midshipmen.*

(i) A commissioned or warrant officer or a cadet or midshipman may not be reduced in grade by any court-martial. However, in time of war or national emergency, the Secretary concerned, or such Under Secretary or Assistant Secretary as may be designated by the Secretary concerned, may commute a sentence of dismissal to reduction to any enlisted grade.

(ii) A commissioned or warrant officer or a cadet or midshipman may not

be sentenced to hard labor without confinement.

(iii) Only a general court-martial, upon conviction of any offense in violation of the UCMJ, may sentence a commissioned or warrant officer or a cadet or midshipman to be separated from the service with a punitive separation. In the case of commissioned officers, cadets, midshipmen, and commissioned warrant officers, the separation shall be by dismissal. In the case of all other warrant officers, the separation shall be by dishonorable discharge.

(B) *Enlisted persons.* See paragraph (b)(9) of this rule and R.C.M. 1301(d)."

(gg) A new R.C.M. 1101(e) is inserted immediately after R.C.M. 1101(d) to read as follows:

"(e) *Modification.* The Statement of Trial Results may be modified as follows:

(1) The military judge may modify the Statement of Trial Results to correct any errors prior to certification of the record of trial under R.C.M. 1112.

(2) The Court of Criminal Appeals, the Court of Appeals for the Armed Forces, and the Judge Advocate General or the Judge Advocate General's designee may modify the Statement of Trial Results in the performance of their duties and responsibilities.

(3) If a case is remanded to a military judge, the military judge may modify the Statement of Trial Results consistent with the purposes of the remand.

(4) Any modification to the Statement of Trial Results must be included in the record of trial."

(hh) R.C.M. 1102(b)(1) is amended to read as follows:

"(1) *Forfeiture.* Unless deferred under R.C.M. 1103 or suspended under R.C.M. 1107, that part of an adjudged sentence that includes forfeitures is executed and takes effect as follows:

(A) *Generally.* Subject to subparagraph (B), if a sentence includes forfeitures in

pay or allowances, or, if forfeiture is required by Article 58b, that part of the sentence shall take effect on the earlier of—

(i) 14 days after the sentence is announced under R.C.M. 1007; or

(ii) in the case of a summary court-martial, the date on which the sentence is approved by the convening authority.

(B) *Accused Not in Confinement.* If an accused is not confined and is performing military duties, that portion of the sentence that provides for forfeiture of more than two-thirds' pay per month shall not be executed."

(ii) A new R.C.M. 1102(b)(6) is inserted immediately after R.C.M. 1102(b)(5) to read as follows:

"(6) *Reduction in Enlisted Grade.*

(A) *Adjudged Reduction.* Unless deferred under R.C.M. 1103 or suspended under R.C.M. 1107, that part of an adjudged sentence that includes reduction in enlisted grade shall take effect on the earlier of—

(i) 14 days after the sentence is announced under R.C.M. 1007; or

(ii) in the case of a summary court-martial, the date on which the sentence is approved by the convening authority.

(B) *Automatic Reduction.* An enlisted accused in a pay grade above E-1 whose sentence as set forth in the judgment of a court-martial includes a dishonorable or bad-conduct discharge, confinement, or hard labor without confinement may be reduced automatically to pay grade E-1 if permitted by, and under circumstances provided in, regulations prescribed by the Secretary concerned."

(jj) A new R.C.M. 1104(e) is inserted immediately after R.C.M. 1104(d) to read as follows:

"(e) *Notice to Victims.* A victim must be notified of any post-trial motion, filing, or hearing that may address:

(1) the findings or sentence of a court-martial with respect to the accused;

(2) the unsealing of privileged or private information of a victim; or

(3) any action resulting in the release of an accused."

(kk) R.C.M. 1106(a) is amended to read as follows:

"(a) *In general.* After a sentence is announced in a court-martial, the accused may submit matters to the convening authority for consideration in the exercise of the convening authority's powers under R.C.M. 1109, 1110, or 1306."

(ll) R.C.M. 1106A(a) is amended to read as follows:

"(a) *In general.* In a case with a crime victim, after a sentence is announced in a court-martial any crime victim of an offense of which the accused was found guilty may submit matters to the convening authority for consideration in the exercise of the convening authority's powers under R.C.M. 1109, 1110, or 1306."

(mm) R.C.M. 1107(b)(2) is amended to read as follows:

"(2) *Suspension after entry of judgment.* The convening authority who convened the original court-martial, the convening authority's successor in command, or a convening authority otherwise designated by the Secretary concerned may suspend any part of the unexecuted part of any sentence except a sentence of death, dishonorable discharge, bad-conduct discharge, dismissal, or confinement for more than six months."

(nn) R.C.M. 1109(e)(3) is amended to read as follows:

"(3) *Who may act.*

(A) Before entry of judgment, the convening authority who convened the original

court-martial or the convening authority's successor in command may act on the recommendation of trial counsel under paragraph (2).

(B) After entry of judgment, the convening authority who convened the original court-martial or the convening authority's successor in command or a convening authority otherwise designated by the Secretary concerned may act on the recommendation of trial counsel under paragraph (2)."

(oo) R.C.M. 1109(e)(5)(B) is amended to read as follows:

"(B) In the case of a recommendation by trial counsel under paragraph (2) of this subsection made more than one year after entry of judgment, the convening authority who convened the original court-martial or the convening authority's successor in command or a convening authority otherwise designated by the Secretary concerned may reduce a sentence only if the substantial assistance of the accused involved—

(i) Information not known to the accused until one year or more after sentencing;

(ii) Information the usefulness of which could not reasonably have been anticipated by the accused until more than one year after sentencing and which was promptly provided to the Government after its usefulness was reasonably apparent to the accused; or

(iii) Information provided by the accused to the Government within one year of sentencing, but which did not become useful to the Government until more than one year after sentencing."

(pp) R.C.M. 1109(e)(7) is amended to read as follows:

"(7) *Action after entry of judgment.* If the convening authority who convened the original court-martial or the convening authority's successor in command or a convening authority

otherwise designated by the Secretary concerned acts on the sentence of an accused after entry of judgment, the action shall be forwarded to the chief trial judge. The chief trial judge, or a military judge detailed by the chief trial judge, shall modify the judgment of the court-martial to reflect the action. The action and the modified judgment shall be forwarded to the Judge Advocate General and shall be included in the original record of trial. The reduction of a sentence under this rule shall not abridge any right of the accused to appellate review."

(qq) R.C.M. 1109(g)(2) is amended to read as follows:

"(2) *Action on sentence.* If the convening authority decides to act on the sentence under this rule, such action shall be in writing and shall include a written statement explaining the action. If any part of the sentence is disapproved, reduced, commuted, or suspended, the action shall clearly state which parts or parts are disapproved, reduced, commuted, or suspended. The convening authority's staff judge advocate or legal advisor shall forward the action with the written explanation to the military judge to be attached to the record of trial."

(rr) R.C.M. 1111(c) is amended to read as follows:

"(c) *Modification of judgment.* The judgment may be modified as follows—

(1) The military judge who entered a judgment may issue a modified judgment to correct any errors prior to certification of the record of trial under R.C.M. 1112.

(2) The Court of Criminal Appeals, the Court of Appeals for the Armed Forces, and the Judge Advocate General or the Judge Advocate General's designee may modify a judgment in the performance of their duties and responsibilities.

(3) If a case is remanded to a military judge, the military judge may modify the judgment consistent with the purposes of the remand.

(4) Any modification to the judgment of a court-martial must be included in the record of

trial."

(ss) R.C.M. 1112(b)(5) is amended to read as follows:

"(5) The election, if any, for application of sentencing rules as in effect on or after January 1, 2019 under R.C.M. 902A; and the election, if any, for sentencing by members in lieu of sentencing by military judge under R.C.M. 1002(b);"

(tt) R.C.M. 1113(b)(3)(C) is amended to read as follows:

"(C) *Disclosure.* Appellate counsel shall not disclose sealed materials in the absence of:

(i) prior authorization of the Judge Advocate General in the case of review under R.C.M. 1201 or 1210;

(ii) prior authorization of the appellate court before which a case is pending review under R.C.M. 1203 or 1204; or

(iii) prior authorization of the Judge Advocate General for a case eligible for review under R.C.M. 1203 or 1204."

(uu) R.C.M. 1113(b)(3)(D) is amended to read as follows:

"(D) For purposes of this rule, reviewing and appellate authorities are limited to:

(i) Judge advocates reviewing records pursuant to R.C.M. 1307;

(ii) Officers and attorneys in the office of the Judge Advocate General reviewing records pursuant to R.C.M. 1201 and 1210;

(iii) Officers and attorneys designated by the Judge Advocate General;

(iv) Appellate judges of the Courts of Criminal Appeals and their professional staffs;

(v) The judges of the United States Court of Appeals for the Armed Forces

and their professional staffs;

(vi) The Justices of the United States Supreme Court and their professional staffs; and

(vii) Any other court of competent jurisdiction."

(vv) R.C.M. 1115(a) is amended to read as follows:

"(a) *In general.* After any general court-martial, except one in which the judgment entered into the record includes a sentence of death, and after any special court-martial in which the judgment entered into the record includes a finding of guilt, the accused may waive or withdraw the right to appellate review by a Court of Criminal Appeals. The accused may sign a waiver of the right to appeal at any time after entry of judgment and may withdraw an appeal at any time before such review is completed."

(ww) R.C.M. 1116(c) is amended to read as follows:

"(c) *General and special courts-martial not reviewed by a Court of Criminal Appeals.* General and special courts-martial with a finding of guilty not reviewed by a Court of Criminal Appeals under Article 66(b)(1) or (3) shall be reviewed under Article 65(d)(2)."

(xx) R.C.M. 1201(h) is amended to read as follows:

"(h) *Application for relief to the Judge Advocate General after final review.*

(1) *In general.* Notwithstanding R.C.M. 1209, the Judge Advocate General may, upon application of the accused or a person with authority to act for the accused or receipt of the record pursuant to R.C.M. 1307(g):

(A) With respect to a summary court-martial previously reviewed under R.C.M. 1307, modify or set aside, in whole or in part, the findings and sentence; or

(B) With respect to a general or special court-martial previously reviewed under paragraph (a)(1) or (2), order such a court-martial to be reviewed under R.C.M. 1203 by the Court of Criminal Appeals.

(2) Timing. To qualify for consideration under this subsection, an accused must submit an application not later than one year after—

(A) In the case of a summary court-martial, the date of completion of review under R.C.M. 1307; or

(B) In the case of a general or special court-martial, the end of the 90-day period beginning on the date the accused is provided notice of appellate rights under R.C.M. 1116(b)(2).

(3) Extension. The Judge Advocate General may, for good cause shown, extend the period for submission of an application under paragraph (h)(2) for a time period not to exceed three additional years. The Judge Advocate General may not consider an application submitted more than three years after the applicable expiration date specified in paragraph (h)(2)."

(yy) R.C.M. 1202(b)(2)(A) is amended to read as follows:

"(A) In every general and special court-martial that includes a finding of guilty, an appellate defense counsel shall be detailed to review the case, unless the accused has waived the right to appeal under Article 61 or submits a written statement declining representation. Upon request, the detailed appellate defense counsel shall represent the accused in accordance with subparagraph (B)."

(zz) A new R.C.M. 1208(c) is inserted immediately after R.C.M. 1208(b) to read as follows:

"(c) *Effective date of sentences.* Once a sentence has been set aside or disapproved, the effective date of a sentence that relates to that portion which was set aside or disapproved shall be calculated from the date a new sentence relating to that portion is adjudged at a new trial, other

trial, or rehearing and shall be in accordance with R.C.M. 1102."

(aaa) R.C.M. 1304(b)(2)(F) is amended to read as follows:

"(F) *Findings and sentence.*

(i) The summary court-martial shall apply the principles in R.C.M. 918 in determining the findings. The summary court-martial shall announce the findings to the accused in open session.

(ii) The summary court-martial shall follow the procedures in R.C.M. 1001 and 1002 and apply the principles in the remainder of Chapter X in determining a sentence, except as follows:

(I) If an accused is found guilty of more than one offense, a summary court-martial shall determine the appropriate confinement and fine, if any, for all offenses of which the accused was found guilty. The summary court-martial shall not determine or announce separate terms of confinement or fines for each offense; and

(II) The summary court-martial shall announce the sentence to the accused in open session.

(iii) If the sentence includes confinement, the summary court-martial shall advise the accused of the right to apply to the convening authority for deferment of the service of the confinement.

(iv) If the accused is found guilty, the summary court-martial shall advise the accused of the rights under R.C.M. 1306(a) and (h) and R.C.M. 1307(h) after the sentence is announced.

(v) The summary court-martial shall, as soon as practicable, inform the convening authority of the findings, sentence, recommendations, if any, for suspension of the

sentence, and any deferment request.

(vi) If the sentence includes confinement, the summary court-martial shall cause the delivery of the accused to the accused's commanding officer or the commanding officer's designee."

(bbb) R.C.M. 1304(b)(2)(G) is deleted.

Section 2. Part III of the Manual for Courts-Martial, United States, is amended as follows:

(a) Mil. R. Evid. 311(c)(3) is amended to read as follows:

"(3) *Good Faith Exception of a Warrant or Search Authorization:* Evidence that was obtained as a result of an unlawful search or seizure may be used if:

(A) the search or seizure resulted from an authorization to search, seize, or apprehend issued by an individual competent to issue the authorization under Mil. R. Evid. 315(d) or from a search warrant or arrest warrant issued by competent civilian authority, or from such an authorization or warrant issued by an individual whom the officials seeking and executing the authorization or warrant reasonably and with good faith believed was competent to issue the authorization or warrant;

(B) the individual issuing the authorization or warrant had a substantial basis for determining the existence of probable cause or the officials seeking and executing the authorization or warrant reasonably and with good faith believed that the individual issuing the authorization or warrant had a substantial basis for determining the existence of probable cause; and

(C) the officials seeking and executing the authorization or warrant reasonably and with good faith relied on the issuance of the authorization or warrant. Good faith is to be determined using an objective standard."

(b) Mil. R. Evid. 311(d)(4)(B) is amended to read as follows:

"(B) *False Statements.* If the defense makes a substantial preliminary showing that a government agent knowingly and intentionally or with reckless disregard for the truth included a false statement or omitted a material fact in the information presented to the authorizing officer, and if the allegedly false statement or omitted material fact is necessary to the finding of probable cause, the defense, upon request, is entitled to a hearing. At the hearing, the defense has the burden of establishing by a preponderance of the evidence the allegation of knowing and intentional falsity or reckless disregard for the truth. If the defense meets its burden, the prosecution has the burden of proving by a preponderance of the evidence, with the false information set aside, that the remaining information presented to the authorizing officer is sufficient to establish probable cause. If the prosecution does not meet its burden, the objection or motion must be granted unless the search is otherwise lawful under these rules."

(c) Mil. R. Evid. 315(b)(2) is amended to read as follows:

"(2) "Search warrant" means express permission to search and seize issued by competent civilian authority or under R.C.M. 703A."

(d) A new Mil. R. Evid. 315(b)(3) is inserted immediately after Mil. R. Evid. 315(b)(2) to read as follows:

"(3) "Warrant for wire or electronic communications" means a warrant issued by a military judge pursuant to 18 U.S.C. §§ 2703(a), (b)(1)(A), or (c)(1)(A) in accordance with 10 U.S.C. § 846(d)(3) and R.C.M. 309(b)(2) and R.C.M. 703A."

(e) Mil. R. Evid. 315(d) is amended to read as follows:

"(d) *Who May Authorize.* A search authorization under this rule is valid only if issued by an impartial individual in one of the categories set forth in paragraphs (d)(1), (d)(2), and (d)(3) of

this rule. Only a military judge may issue a warrant for wire or electronic communications under this rule. An otherwise impartial authorizing official does not lose impartiality merely because the official is present at the scene of a search or is otherwise readily available to persons who may seek the issuance of a search authorization; nor does such an official lose impartial character merely because the official previously and impartially authorized investigative activities when such previous authorization is similar in intent or function to a pretrial authorization made by the United States district courts.

(1) *Commander.* A commander or other person serving in a position designated by the Secretary concerned as either a position analogous to an officer in charge or a position of command, who has control over the place where the property or person to be searched is situated or found, or, if that place is not under military control, having control over persons subject to military law or the law of war;

(2) *Military Judge or Magistrate.* A military judge or magistrate if authorized under regulations prescribed by the Secretary of Defense or the Secretary concerned; or

(3) *Other competent search authority.* A competent, impartial official as designated under regulations by the Secretary of Defense or the Secretary concerned as an individual authorized to issue search authorizations under this rule."

(f) Mil. R. Evid. 404(b) is amended to read as follows:

"(b) *Other Crimes, Wrongs, or Acts.*

(1) *Prohibited Uses.* Evidence of any other crime, wrong, or act is not admissible to prove a person's character in order to show that on a particular occasion the person acted in accordance with the character.

(2) *Permitted Uses.* This evidence may be admissible for another purpose, such as proving

motive, opportunity, intent, preparation, plan, knowledge, identity, absence of mistake, or lack of accident.

(3) *Notice in a Criminal Case.* In a criminal case, the trial counsel must:

(A) provide reasonable notice of any such evidence that the trial counsel intends to offer at trial, so the accused has a fair opportunity to meet it;

(B) articulate in the notice the permitted purpose for which the trial counsel intends to offer the evidence and the reasoning that supports the purpose; and

(C) do so in writing before trial—or in any form during trial if the court, for good cause, excuses lack of pretrial notice."

(g) **Mil. R. Evid. 503 is amended to read as follows:**

"Rule 503. Communications to clergy

(a) *General Rule.* A person has a privilege to refuse to disclose and to prevent another from disclosing a confidential communication by the person to a clergy member or to a clergy member's assistant, if such communication is made either as a formal act of religion or as a matter of conscience.

(b) *Definitions.* As used in this rule:

(1) "Clergy member" means a minister, priest, rabbi, imam, chaplain, or other similar functionary of a religious organization, or an individual reasonably believed to be so by the person consulting the clergy member.

(2) "Clergy member's assistant" means a person employed or assigned to assist a clergy member in the clergy member's capacity as a spiritual advisor.

(3) A communication is "confidential" if made to a clergy member in the clergy member's capacity as a spiritual advisor or to a clergy member's assistant in the assistant's

official capacity and is not intended to be disclosed to third persons other than those to whom disclosure is in furtherance of the purpose of the communication or to those reasonably necessary for the transmission of the communication.

(c) *Who May Claim the Privilege.* The privilege may be claimed by the person, guardian, or conservator, or by a personal representative if the person is deceased. The clergy member or clergy member's assistant who received the communication may claim the privilege on behalf of the person. The authority of the clergy member or clergy member's assistant to do so is presumed in the absence of evidence to the contrary."

(h) Mil. R. Evid. 611(d)(1) is amended to read as follows:

"(1) In a case involving domestic violence or a case involving the abuse of a child, the military judge must, subject to the requirements of subdivision (d)(3) of this rule, allow a child victim or child witness to testify from an area outside the courtroom as prescribed in R.C.M. 914A."

(i) Mil. R. Evid. 611(d)(2)(E) is amended to read as follows:

"(E) "Domestic violence" means conduct that may constitute an offense under Article 128b."

(j) Mil. R. Evid. 803(16) is amended to read as follows:

"(16) *Statements in Ancient Documents.* A statement in a document that was prepared before January 1, 1998, and whose authenticity is established."

(k) Mil. R. Evid. 803(22) is amended to read as follows:

"(22) *Judgment of a Previous Conviction.* Evidence of a final judgment of conviction if:

(A) the judgment was entered after a trial or guilty plea, but not a nolo contendere plea;

(B) the conviction was for a crime punishable by death, dishonorable discharge, or imprisonment for more than a year;

(C) the evidence is admitted to prove any fact essential to the judgment; and

(D) when offered by the prosecution for a purpose other than impeachment, the judgment was against the accused.

The pendency of an appeal may be shown but does not affect admissibility. In determining whether a crime tried by court-martial was punishable by death, dishonorable discharge, or imprisonment for more than one year, the maximum punishment prescribed by the President under Article 56 of the Uniform Code of Military Justice at the time of the conviction applies without regard to whether the case was tried by general, special, or summary court-martial.

(l) Mil. R. Evid. 807 is amended to read as follows:

"(a) *In General.* Under the following conditions, a hearsay statement is not excluded by the rule against hearsay even if the statement is not admissible under a hearsay exception in Mil. R. Evid. 803 or 804:

(1) the statement is supported by sufficient guarantees of trustworthiness—after considering the totality of circumstances under which it is made and evidence, if any, corroborating the statement; and

(2) the statement is more probative on the point for which it is offered than any other evidence that the proponent can obtain through reasonable efforts.

(b) *Notice.* The statement is admissible only if the proponent gives an adverse party reasonable notice of the intent to offer the statement—including its substance and the declarant's name—so that the party has a fair opportunity to meet it. The notice must be provided in writing before the trial or hearing—or in any form during the trial or hearing if the court, for good cause, excuses a

lack of earlier notice."

(m) A new Mil. R. Evid. 902(12) is inserted immediately after Mil. R. Evid. 902(11) to read as follows:

"(12) Reserved."

(n) A new Mil. R. Evid. 902(13) is inserted immediately after new Mil. R. Evid. 902(12) to read as follows:

"(13) *Certified Records Generated by an Electronic Process or System.* A record generated by an electronic process or system that produces an accurate result, as shown by a certification of a qualified person that complies with the certification requirements of Mil. R. Evid. 902(11). The proponent also must meet the notice requirements of Mil. R. Evid. Rule 902(11)."

(o) A new Mil. R. Evid. 902(14) is inserted immediately after new Mil. R. Evid. 902(13) to read as follows:

"(14) *Certified Data Copied from an Electronic Device, Storage Medium, or File.* Data copied from an electronic device, storage medium, or file, if authenticated by a process of digital identification, as shown by a certification of a qualified person that complies with the certification requirements of Mil. R. Evid. 902(11). The proponent also must meet the notice requirements of Mil. R. Evid. 902(11)."

Section 3. Part IV of the Manual for Courts-Martial, United States, is amended as follows:

(a) Paragraph 3.b.(4) is amended to read as follows:

"(4) *Sua sponte duty.* Subject to R.C.M. 920(g), a military judge must instruct panel members on lesser included offenses reasonably raised by the evidence."

(b) Paragraph 6.d. is amended to read as follows:

"d. *Maximum punishment.*

(1) *Solicitation of espionage.* Such punishment that a court-martial may direct, other than death.

(2) *Solicitation of desertion; mutiny or sedition; misbehavior before the enemy.* If the offense solicited or advised is committed or attempted, then the accused shall be punished with the punishment provided for the commission of the offense solicited or advised. If the offense solicited or advised is not committed or attempted, then the following punishment may be imposed: dishonorable discharge, forfeiture of all pay and allowances, and confinement for 15 years, or the maximum punishment of the underlying offense, whichever is lesser.

(3) *Solicitation of all other offenses.* Any person subject to the UCMJ who is found guilty of soliciting or advising another person to commit an offense not specified in subparagraph d.(1)-(2) of this paragraph that, if committed by one subject to the UCMJ, would be punishable under the UCMJ, shall be subject to the following maximum punishment: dishonorable discharge, forfeiture of all pay and allowances, and confinement for 10 years, or the maximum punishment of the underlying offense, whichever is lesser."

(c) Paragraph 19.c.(2) is amended to read as follows:

"(2) *Nature of act.* The cruelty, oppression, or maltreatment, although not necessarily physical, must be measured by an objective standard. Assault, improper punishment, and sexual harassment may constitute this offense if the conduct meets the elements of this offense. Sexual harassment under this paragraph includes influencing, offering to influence, or threatening the career, pay, or job of another person in exchange for sexual favors, and deliberate or repeated offensive comments or gestures of a sexual nature. The imposition of necessary or proper duties

and the exaction of their performance does not constitute this offense even though the duties are arduous or hazardous or both."

(d) Paragraph 20.b. is amended to read as follows:

"b. *Elements.*

(1) *Abuse of training leadership position.*

(a) That the accused was a commissioned, warrant, noncommissioned, or petty officer;

(b) That the accused was in a training leadership position with respect to a specially protected member of the armed forces; and

(c) That the accused engaged in prohibited sexual activity with a person the accused knew was a specially protected junior member of the armed forces.

(2) *Abuse of position as a military recruiter.*

(a) That the accused was a commissioned, warrant, noncommissioned, or petty officer;

(b) That the accused was performing duties as a military recruiter; and

(c) That the accused engaged in prohibited sexual activity with a person the accused knew was an applicant for military service or a specially protected junior member of the armed forces who is enlisted under a delayed entry program."

(e) Paragraph 20.c. is amended to read as follows:

"c. *Explanation.*

(1) *In general.* The prevention of inappropriate sexual activity by trainers, recruiters, and drill instructors with recruits, trainees, students attending service academies, and other potentially vulnerable persons in the initial training environment is crucial to the maintenance of

good order and military discipline. Military law, regulation, and custom invest officers, non-commissioned officers, drill instructors, recruiters, cadre, and others with the right and obligation to exercise control over those they supervise. In this context, inappropriate sexual activity between those potentially vulnerable persons and those with authority to exercise control over them is inherently destructive to good order and discipline.

(2) *Prohibited activity.* The responsibility for identifying relationships subject to this offense and those outside the scope of this offense is entrusted to the individual Services to determine and specify by appropriate regulations. This offense is intended to cover those situations that involve the improper use of authority by virtue of an individual's position in either a training or recruiting environment. Not all contact or associations are prohibited by this article. Service regulations must consider circumstances where pre-existing relationships (for example, marriage relationships) exist. Additionally, this offense criminalizes only activity occurring when there is a training or recruiting relationship between the accused and the alleged victim of this offense.

(3) *Knowledge.* The accused must have actual or constructive knowledge that a person was a "specially protected junior member of the armed forces" or an "applicant for military service" (as those terms are defined in this offense). Knowledge may be proved by circumstantial evidence.

(4) *Consent.* Consent is not a defense to this offense."

(f) Paragraph 20.e. is amended to read as follows:

"e. *Sample specifications.*

(1) *Prohibited act with specially protected junior member of the armed forces.*

In that ___ (personal jurisdiction data), a (commissioned) (warrant) (noncommissioned) (petty)

officer, while in a training leadership position over ___, did (at/on board—location) (subject-matter jurisdiction data, if required), on or about ___ 20__, engage in a prohibited act, to wit: _____ with _____, whom the accused knew was a specially protected junior Servicemember in initial active duty training.

(2) *Prohibited act with an applicant for military service.*

In that ___ (personal jurisdiction data), a (commissioned) (warrant) (noncommissioned) (petty) officer, while in a training leadership position over ___, did (at/on board—location) (subject-matter jurisdiction data, if required), on or about ___ 20__, engage in a prohibited act, to wit: _____ with _____, whom the accused knew was (an applicant for military service) (a specially protected junior member of the armed forces who is enlisted under a delayed entry program)."

(g) Paragraph 51.e. is amended to read as follows:

"e. *Sample specification.*

In that _____ (personal jurisdiction data), did (at/on board—location) (subject-matter jurisdiction data, if required), on or about _____, 20 __, (in the motor pool area) (near the Officers' Club) (at the intersection of _____ and _____) (while in the Gulf of Mexico) (while in flight over North America) physically control [a vehicle, to wit: (a truck) (a passenger car) (_____)] [an aircraft, to wit: (an AH-64 helicopter) (an F-14A fighter) (a KC-135 tanker) (_____)] [a vessel, to wit: (the aircraft carrier USS _____) (the Coast Guard Cutter _____) (_____)], [while drunk] [while impaired by _____] [while the alcohol concentration in (his) (her) (blood or breath) equaled or exceeded the applicable limit under subsection (b) of the text of the statute in paragraph 51 as shown by chemical analysis] [in a (reckless) (wanton) manner by (attempting to pass another vehicle on a sharp curve) (ordering

that the aircraft be flown below the authorized altitude)] [and did thereby cause said (vehicle) (aircraft) (vessel) to (strike and) (injure _____)]."

(h) Paragraph 55. is amended by deleting the following:

"[NOTE: For Article 117a, UCMJ, Wrongful broadcast, *See* Appendix 2, Article 117a, UCMJ]"

(i) Paragraph 60.e.(3) is amended to read as follows:

"(3) *Aggravated sexual contact.*

(a) *By force.*

In that _____ (personal jurisdiction data), did (at/on board—location) (subject-matter jurisdiction data, if required), on or about _____ 20____, [(touch) (cause ____ to touch)] [(directly) (through the clothing)] the (vulva) (penis) (scrotum) (anus) (groin) (breast) (inner thigh) (buttocks) of _____, with [(_____'s body part) (an object), to wit: _____] with an intent to [(abuse) (humiliate) (harass) (degrade) _____] [(arouse) (gratify) the sexual desire of _____] by using unlawful force.

(b) *By force causing or likely to cause death or grievous bodily harm.*

In that _____ (personal jurisdiction data), did (at/on board—location) (subject-matter jurisdiction data, if required), on or about _____ 20__, [(touch) (cause ____ to touch)] [(directly) (through the clothing)] the (vulva) (penis) (scrotum) (anus) (groin) (breast) (inner thigh) (buttocks) of _____, with [(_____'s body part) (an object), to wit: _____] with an intent to [(abuse) (humiliate) (harass) (degrade) _____] [(arouse) (gratify) the sexual desire of _____], by using force likely to cause death or grievous bodily harm to _____, to wit: _____.

(c) *By threatening or placing that other person in fear that any person would be*

subjected to death, grievous bodily harm, or kidnapping.

In that _____ (personal jurisdiction data), did (at/on board—location) (subject-matter jurisdiction data, if required), on or about _____ 20__, [(touch) (cause ____ to touch)] [(directly) (through the clothing)] the (vulva) (penis) (scrotum) (anus) (groin) (breast) (inner thigh) (buttocks) of _____, with [(_____'s body part) (an object), to wit: _____] with an intent to [(abuse) (humiliate) (harass) (degrade) _____] [(arouse) (gratify) the sexual desire of _____], by (threatening _____) (placing _____ in fear) that _____ would be subjected to (death) (grievous bodily harm) (kidnapping).

(d) *By first rendering that other person unconscious.*

In that _____ (personal jurisdiction data), did (at/on board—location) (subject-matter jurisdiction data, if required), on or about _____ 20____, [(touch) (cause ____ to touch)] [(directly) (through the clothing)] the (vulva) (penis) (scrotum) (anus) (groin) (breast) (inner thigh) (buttocks) of _____, with [(_____'s body part) (an object), to wit: _____] with an intent to [(abuse) (humiliate) (harass) (degrade) _____] [(arouse) (gratify) the sexual desire of _____], by rendering _____ unconscious by_____.

(e) *By administering a drug, intoxicant, or other similar substance.*

In that _____ (personal jurisdiction data), did (at/on board—location) (subject-matter jurisdiction data, if required), on or about _____ 20___, [(touch) (cause ____ to touch)] [(directly) (through the clothing)] the (vulva) (penis) (scrotum) (anus) (groin) (breast) (inner thigh) (buttocks) of _____, with [(_____'s body part) (an object), to wit: _____] with an intent to [(abuse) (humiliate) (harass) (degrade) _____] [(arouse) (gratify) the sexual desire of _____], by administering to _____ (by force) (by threat of force) (without the knowledge or permission of _____) a (drug) (intoxicant) (_____) thereby substantially impairing the

ability of _____ to appraise or control (his) (her) conduct."

(j) Paragraph 60.e.(4) is amended to read as follows:

"(4) *Abusive sexual contact.*

(a) *By threatening or placing that other person in fear*.

In that _____ (personal jurisdiction data), did (at/on board—location) (subject-matter jurisdiction data, if required), on or about _____ 20__, [(touch) (cause ____ to touch)] [(directly) (through the clothing)] the (vulva) (penis) (scrotum) (anus) (groin) (breast) (inner thigh) (buttocks) of _____, with [(_____'s body part) (an object), to wit: _____] with an intent to [(abuse) (humiliate) (harass) (degrade) _____] [(arouse) (gratify) the sexual desire of _____], by (threatening _____) (placing _____ in fear).

(b) *By fraudulent representation.*

In that _____ (personal jurisdiction data), did (at/on board—location) (subject-matter jurisdiction data, if required), on or about _____ 20__, [(touch) (cause ____ to touch)] [(directly) (through the clothing)] the (vulva) (penis) (scrotum) (anus) (groin) (breast) (inner thigh) (buttocks) of _____, with [(_____'s body part) (an object), to wit: _____] with an intent to [(abuse) (humiliate) (harass) (degrade) _____] [(arouse) (gratify) the sexual desire of _____], by making a fraudulent representation that the sexual contact served a professional purpose, to wit: _____.

(c) *By false pretense.*

In that _____ (personal jurisdiction data), did (at/on board—location) (subject-matter jurisdiction data, if required), on or about _____ 20__, [(touch) (cause ____ to touch)] [(directly) (through the clothing)] the (vulva) (penis) (scrotum) (anus) (groin) (breast) (inner thigh) (buttocks) of _____, with [(_____'s body part) (an object), to wit: _____] with an

intent to [(abuse) (humiliate) (harass) (degrade) _____] [(arouse) (gratify) the sexual desire of _____], by inducing a belief by (artifice) (pretense) (concealment) that the said accused was another person.

(d) *Without consent.*

In that _____(personal jurisdiction data), did (at/on board—location) (subject-matter jurisdiction data, if required), on or about _____ 20___, [(touch) (cause ____ to touch)] [(directly) (through the clothing)] the (vulva) (penis) (scrotum) (anus) (groin) (breast) (inner thigh) (buttocks) of _____, with [(_____'s body part) (an object), to wit: _____] with an intent to [(abuse) (humiliate) (harass) (degrade) _____] [(arouse) (gratify) the sexual desire of _____] without the consent of _____.

(e) *Of a person who is asleep, unconscious, or otherwise unaware the act is occurring.*

In that _____ (personal jurisdiction data), did (at/on board—location) (subject-matter jurisdiction data, if required), on or about _____ 20____, [(touch) (cause ____ to touch)] [(directly) (through the clothing)] the (vulva) (penis) (scrotum) (anus) (groin) (breast) (inner thigh) (buttocks) of _____, with [(_____'s body part) (an object), to wit: _____] with an intent to [(abuse) (humiliate) (harass) (degrade) _____] [(arouse) (gratify) the sexual desire of _____], when (he) (she) (knew) (reasonably should have known) that _____ was (asleep) (unconscious) (unaware the sexual contact was occurring due to _____).

(f) *When that person is incapable of consenting.*

In that _____ (personal jurisdiction data), did (at/on board—location) (subject-matter jurisdiction data, if required), on or about _____ 20_____, [(touch) (cause ____ to touch)] [(directly) (through the clothing)] the (vulva) (penis) (scrotum) (anus) (groin) (breast) (inner

thigh) (buttocks) of _____, with [(_____'s body part) (an object), to wit: _____] with an intent to [(abuse) (humiliate) (harass) (degrade) _____] [(arouse) (gratify) the sexual desire of _____], when _____ was incapable of consenting to the sexual contact because (he) (she) [was impaired by (a drug, to wit: _____) (an intoxicant, to wit: _____) (_____)] [had a (mental disease, to wit: _____) (mental defect, to wit: _____) (physical disability, to wit: _____)] and the accused (knew) (reasonably should have known) of that condition."

(k) Paragraph 63.b. is amended to read as follows:

"b. *Elements.*

(1) *Indecent viewing.*

(a) That the accused, without legal justification or lawful authorization, knowingly and wrongfully viewed the private area of another person;

(b) That said viewing was without the other person's consent; and

(c) That said viewing took place under circumstances in which the other person had a reasonable expectation of privacy.

(2) *Indecent recording.*

(a) That the accused, without legal justification or lawful authorization, knowingly recorded (photographed, videotaped, filmed, or recorded by any means) the private area of another person;

(b) That said recording was without the other person's consent; and

(c) That said recording was made under circumstances in which the other person had a reasonable expectation of privacy.

(3) *Broadcasting of an indecent recording.*

(a) That the accused, without legal justification or lawful authorization, knowingly broadcast a certain recording of another person's private area;

(b) That said recording was made without the other person's consent;

(c) That the accused knew or reasonably should have known that the recording was made without the other person's consent;

(d) That said recording was made under circumstances in which the other person had a reasonable expectation of privacy; and

(e) That the accused knew or reasonable should have known that said recording was made under circumstances in which the other person had a reasonable expectation of privacy.

(4) *Distribution of an indecent recording.*

(a) That the accused, without legal justification or lawful authorization, knowingly distributed a certain recording of another person's private area;

(b) That said recording was made without the other person's consent;

(c) That the accused knew or reasonably should have known that said recording was made without the other person's consent;

(d) That said recording was made under circumstances in which the other person had a reasonable expectation of privacy; and

(e) That the accused knew or reasonably should have known that said recording was made under circumstances in which the other person had a reasonable expectation of privacy.

(5) *Forcible pandering.*

That the accused compelled another person to engage in an act of prostitution with any

person.

(6) *Indecent exposure.*

(a) That the accused exposed the accused's genitalia, anus, buttocks, or female areola or nipple;

(b) That the exposure was in an indecent manner; and

(c) That the exposure was intentional."

(l) Paragraph 63.e.(1) is amended to read as follows:

"e. *Sample specifications.*

(1) *Indecent viewing, recording, or broadcasting.*

(a) *Indecent viewing.*

In that _____ (personal jurisdiction data), did (at/on board—location) (subject-matter jurisdiction, if required), on or about _____ 20__, without legal justification or lawful authorization, knowingly and wrongfully view the private area of _____, without (his) (her) consent and under circumstances in which (he) (she) had a reasonable expectation of privacy.

(b) *Indecent recording.*

In that _____ (personal jurisdiction data), did (at/on board—location) (subject-matter jurisdiction, if required), on or about _____ 20__, without legal justification or lawful authorization, knowingly (photograph) (videotape) (film) (make a recording of) the private area of _____, without (his) (her) consent and under circumstances in which (he) (she) had a reasonable expectation of privacy.

(c) *Broadcasting or distributing an indecent recording.*

In that _____ (personal jurisdiction data), did (at/on board—location) (subject-matter

jurisdiction, if required), on or about _____ 20__, without legal justification or lawful authorization, knowingly (broadcast) (distribute) a recording of the private area of _____, when the said accused knew or reasonably should have known that the said recording was made without the consent of _____ and under circumstances in which (he) (she) had a reasonable expectation of privacy."

(m) Paragraph 64.d.(1)(c) is amended to read as follows:

"(c) *Property other than military property of a value of more than $1,000 or any motor vehicle, aircraft, vessel, firearm, or explosive not included in subparagraph d.(1)(b).* Dishonorable discharge, forfeiture of all pay and allowances, and confinement for 5 years."

(n) Paragraph 69.c.(1) is amended to read as follows:

"(1) *Access.* "Access" means to gain entry to, instruct, cause input to, cause output from, cause data processing with, or communicate with, the logical, arithmetical, or memory function resources of a computer, computer system, or computer network."

(o) Paragraph 77.d.(1) is amended to read as follows:

"(1) *Simple assault.*

(a) *Generally.* Confinement for 3 months and forfeiture of two-thirds pay per month for 3 months.

(b) *When committed with an unloaded firearm or other dangerous weapon.* Dishonorable discharge, forfeiture of all pay and allowances, and confinement for 2 years.

(c) *When committed with a loaded firearm.* Dishonorable discharge, forfeiture of all pay and allowances, and confinement for 4 years."

(p) Paragraph 77.d.(5) is amended to read as follows:

"(5) *Assault with intent to commit specified offenses.*

(a) *Assault with intent to commit murder, rape, or rape of a child.* Dishonorable discharge, forfeiture of all pay and allowances, and confinement for 20 years.

(b) *Assault with intent to commit voluntary manslaughter, robbery, arson, burglary, kidnapping, sexual assault, or sexual assault of a child.* Dishonorable discharge, forfeiture of all pay and allowances, and confinement for 10 years."

(q) Paragraph 78. is amended by deleting:

"[NOTE: For Article 128b, UCMJ, Domestic Violence, added as part of the FY19 National Defense Authorization Act, *See* Appendix 2, Article 128b, UCMJ]"

(r) Paragraph 89.c.(2) is amended to read as follows:

"(2) *Personnel action.* For purposes of this offense, "personnel action" means—

(a) any action taken on a Servicemember that affects, or has the potential to affect, that Servicemember's current position or career, including promotion; disciplinary or other corrective action; transfer or reassignment; performance evaluations; decisions concerning pay, benefits, awards, or training; relief and removal; separation; discharge; referral for mental health evaluations; and any other personnel actions as defined by law or regulation, such as 5 U.S.C. § 2302 and DoD Directive 7050.06 (17 April 2015); or,

(b) any action taken on a civilian employee that affects, or has the potential to affect, that person's current position or career, including promotion; disciplinary or other corrective action; transfer or reassignment; performance evaluations; decisions concerning pay, benefits, awards, or training; relief and removal; discharge; and any other personnel actions as defined by law or regulation such as 5 U.S.C. § 2302."

(s) The title of Paragraph 90 is amended to read as follows:

"90. Article 133 (10 U.S.C. 933)—Conduct unbecoming an officer"

(t) Paragraph 90.a. is amended to read as follows:

"a. *Text of statute.*

Any commissioned officer, cadet, or midshipman who is convicted of conduct unbecoming an officer shall be punished as a court-martial may direct."

(u) Paragraph 90.b. is amended to read as follows:

"b. Elements.

(1) That the accused was a commissioned officer, cadet, or midshipman;

(2) That the accused did or omitted to do certain acts; and

(3) That, under the circumstances, these acts or omissions constituted conduct unbecoming an officer."

(v) Paragraph 90.c. is amended to read as follows:

"c. Explanation.

(1) *Officership generally.* As used in the phrase "conduct unbecoming an officer" in this article, "officer" refers to a "commissioned officer, cadet, or midshipman."

(2) *Nature of the offense.* The focus of this article is conduct that is likely to seriously compromise the accused's standing as an officer. A military officer holds a particular position of responsibility in the armed forces, and one critically important responsibility of a military officer is to inspire the trust and respect of the personnel who must obey the officer's orders. Conduct violative of this article is action or behavior in an official capacity that, in dishonoring or disgracing the person as an officer, seriously compromises the officer's character, or action or behavior in an unofficial or private capacity that, in dishonoring or disgracing the officer personally, seriously compromises the person's standing as an officer. This article includes misconduct that approximates, but may not meet every element of, another enumerated offense.

An officer's conduct need not violate other provisions of the UCMJ or be otherwise criminal to violate Article 133. The gravamen of the offense is that the officer's conduct disgraces the officer personally or brings dishonor to the military profession in a manner that affects the officer's fitness to command the obedience of the officer's subordinates so as to effectively complete the military mission. The absence of a "custom of the service," statute, regulation, or order expressly prohibiting certain conduct is not dispositive of whether the officer was on sufficient notice that such conduct was unbecoming.

(3) *Examples of offenses.* Instances of violation of this article include knowingly making a false official statement; dishonorable failure to pay a debt; cheating on an exam; opening and reading a letter of another without authority; using insulting or defamatory language to another officer in that officer's presence or about that officer to other military persons; being drunk and disorderly in a public place; committing or attempting to commit a crime involving moral turpitude; and failing without good cause to support the officer's family.

(4) *Relation to Other Punitive Articles*: This article includes acts made punishable by any other article, provided these acts amount to conduct unbecoming an officer. Thus, a commissioned officer who steals property violates both this article and Article 121. Whenever the offense charged is the same as a specific offense set forth in this Manual, the elements of proof are the same as those set forth in the paragraph that treats that specific offense, with the additional requirement that the act or omission constitutes conduct unbecoming an officer."

(w) Paragraph 91.c.(4)(a)(1)(iii) is as amended to read as follows:

(iii) The Federal Assimilative Crimes Act (18 U.S.C. § 13) is an adoption by Congress of state criminal laws for areas of exclusive or concurrent federal jurisdiction, provided federal criminal law, including the UCMJ, has not defined an applicable

offense for the misconduct committed. The Act applies to state laws validly existing at the time of the offense without regard to when these laws were enacted, whether before or after passage of the Act, and whether before or after the acquisition of the land where the offense was committed. For example, if a person committed an act on a military installation in the United States at a certain location over which the United States had either exclusive or concurrent jurisdiction, and it was not an offense specifically defined by federal law (including the UCMJ), that person could be punished for that act by a court-martial if it was a violation of a noncapital offense under the law of the State where the military installation was located. This is possible because the Act adopts the criminal law of the State wherein the military installation is located and applies it as though it were federal law. As amended, the Act provides that: "Whoever within or upon any of the places now existing or hereafter reserved or acquired as provided in section 7 of this title, or on, above, or below any portion of the territorial sea of the United States not within the jurisdiction of any State, Commonwealth, territory, possession, or district is guilty of any act or omission which, although not made punishable by any enactment of Congress, would be punishable if committed or omitted within the jurisdiction of the State, Territory, Possession, or District in which such place is situated, by the laws thereof in force at the time of such act or omission, shall be guilty of a like offense and subject to a like punishment."

Section 4. Part V of the Manual for Courts-Martial, United States, is amended as follows:

(a) Paragraph 1.f.(4) is amended to read as follows:

"(4) *Statute of limitations.* Except as provided in Article 43(c) and (d), nonjudicial punishment may not be imposed for offenses which were committed more than 2 years before the date of imposition, unless knowingly and voluntarily waived by the member. *See* Article 43(b)(3)."

(b) Paragraph 1.h. is amended to read as follows:

"h. Applicable standards. The burden of proof to be utilized by commanders throughout the nonjudicial punishment process shall be a preponderance of the evidence."

(c) A new paragraph 1.j. is inserted immediately after paragraph 1.i. to read as follows:

"j. *Service regulations and procedures.* Unless otherwise provided, the Service regulations and procedures of the Servicemember shall apply.

(d) Paragraph 4.c.(4) is amended to read as follows:

"(4) Decision. After considering all relevant matters presented by a preponderance of the evidence standard, if the nonjudicial punishment authority—

(A) does not conclude that the Servicemember committed the offenses alleged, the nonjudicial punishment authority shall so inform the member and terminate the proceedings;

(B) concludes that the Servicemember committed one or more of the offenses alleged, the nonjudicial punishment authority shall:

(i) so inform the Servicemember;

(ii) inform the Servicemember of the punishment imposed; and

(iii) inform the Servicemember of the right to appeal (see paragraph 7 of this Part)."

ANNEX 2

Section 1. Part I of the Manual for Courts-Martial, United States, is amended as follows:

(a) Paragraph 3 is amended to read as follows:

"**3. Nature and purpose of military law**

Military law consists of the statutes governing the military establishment and regulations issued thereunder, the constitutional powers of the President and Executive Orders and regulations issued thereunder, and the inherent authority of military commanders. Military law includes jurisdiction exercised by courts-martial and the jurisdiction exercised by commanders with respect to nonjudicial punishment. The purposes of military law are to promote justice, to deter misconduct, to facilitate appropriate accountability, to assist in maintaining good order and discipline in the armed forces, to promote efficiency and effectiveness in the military establishment, and thereby to strengthen the national security of the United States."

(b) Paragraph 4 is redesignated as Paragraph 5 and is amended to read as follows:

"5. Structure and application of the Manual for Courts-Martial

The Manual for Courts-Martial shall consist of this Preamble, the Rules for Courts-Martial, the Military Rules of Evidence, the Punitive Articles, the Nonjudicial Punishment Procedures (Parts I-V), and Appendixes 12A through 12D. This Manual shall be applied in a manner consistent with the purpose of military law.

The Department of Defense (DoD), in conjunction with the Department of Homeland Security, publishes supplementary materials to accompany the Manual for Courts-Martial. These materials consist of a Preface, a Table of Contents, Discussions, Appendices (other than Appendixes 12A through 12D, which were promulgated by the President), and an Index. These supplementary materials do not have the force of law.

The Manual shall be identified by the year in which it was printed; for example, "Manual for Courts-Martial, United States (20xx edition)." Any amendments to the Manual made by Executive Order shall be identified as "20xx" Amendments to the Manual for Courts-Martial, United States, "20xx" being the year the Executive Order was signed.

The DoD-Joint Service Committee on Military Justice (JSC) reviews the Manual for Courts-Martial and proposes amendments to the DoD-for consideration by the President on an annual basis. In conducting its annual review, the JSC is guided by DoD Instruction 5500.17, "Role and Responsibilities of the Joint Service Committee on Military Justice (JSC)." DoD Instruction 5500.17 includes provisions allowing public participation in the annual review process."

(c) A new paragraph 4 is inserted immediately after paragraph 3 to read as follows:

"4. The Evolving Military Justice System

The military operates a modern criminal justice system that recognizes and protects the rights of both the victims of alleged offenses and those accused of offenses. The continuous evolution of the military justice system has progressed through statutes, Executive Orders, regulations, and judicial interpretations. The Uniform Code of Military Justice (UCMJ), enacted in 1950, significantly enhanced the fairness of military justice across the armed forces, including by establishing a civilian appellate court at the system's apex. The Military Justice Act of 1968, which created the position of military judge and enhanced the role of lawyers in the system, resulted in further improvements. The promulgation of the Military Rules of Evidence by a 1980 Executive Order brought court-martial practice into closer alignment with federal civilian criminal practice. In 2014, Congress added a victims' rights article to the UCMJ and also made counsel available to represent certain victims of alleged UCMJ offenses. The Military Justice Act

of 2016 further modernized the military justice system by expanding pretrial judicial authorities, updating trial and post-trial procedures, and enacting new punitive articles. Most recently, the National Defense Authorization Act for Fiscal Year 2022 made historic reforms to the military justice system, including the unprecedented transfer of prosecutorial discretion from commanders to independent, specialized counsel to prosecute certain covered offenses, including sexual assault and domestic violence, as recommended by the Independent Review Commission on Sexual Assault in the Military to strengthen Service members' trust in the military justice system. These and many other improvements have been vital to maintaining a fair, just, and efficient military justice system. The system must continue to evolve to be worthy of those who protect our Nation and its freedoms."

Section 2. Part II of the Manual for Courts-Martial, United States, is amended as follows:

(a) R.C.M. 103 is amended to read as follows:

"Rule 103. Definitions and rules of construction

The following definitions and rules of construction apply throughout this Manual, unless otherwise expressly provided.

(1) "Appellate military judge" means a judge of a Court of Criminal Appeals.

(2) "Article" refers to articles of the Uniform Code of Military Justice unless the context indicates otherwise.

(3) "Capital case" means a general court-martial to which a capital offense has been referred with an instruction that the case be treated as a capital proceeding, and, in the case of a rehearing or new or other trial, for which offense death remains an authorized punishment under R.C.M. 810(d).

(4) "Capital offense" means an offense for which death is an authorized punishment under the UCMJ and Part IV of this Manual or under the law of war.

(5) "Commander" means a commissioned officer in command or an officer in charge except in Part V or unless the context indicates otherwise.

(6) "Convening authority" includes a commissioned officer in command for the time being and successors in command.

(7) "Copy" means an accurate reproduction, however made. Whenever necessary and feasible, a copy may be made by handwriting.

(8) "Court-martial" includes, depending on the context:

(A) The military judge and members of a general or special court-martial;

(B) The military judge when a session of a general or special court-martial is conducted without members under Article 39(a);

(C) The military judge when a request for trial by military judge alone has been approved under R.C.M. 903;

(D) The military judge when the case is referred as a special court-martial consisting of a military judge alone under Article 16(c)(2)(A); or

(E) The summary court-martial officer.

(9) "Days." When a period of time is expressed in a number of days, the period shall be in calendar days, unless otherwise specified. Unless otherwise specified, the date on which the period begins shall not count, but the date on which the period ends shall count as one day.

(10) "Deferral" of an offense means a special trial counsel declines to prefer charges for an offense or declines to refer charges to court-martial. Once a special trial counsel declines to

prefer or refer charges for an offense, a commander shall exercise authority within the scope of these rules.

(11) "Detail" means to order a person to perform a specific temporary duty, unless the context indicates otherwise.

(12) "Exercise authority over" means when a special trial counsel acts on a covered, related, or known offense in furtherance of a special trial counsel's statutory duties or authorities under Article 24a(c).

(13) "Explosive" means gunpowders; powders used for blasting; all forms of high explosives; blasting materials; fuzes (other than electrical circuit breakers), detonators, and other detonating agents; smokeless powders; any explosive bomb, grenade, missile, or similar device; any incendiary bomb or grenade, fire bomb, or similar device; and any other compound, mixture, or device which is an explosive within the meaning of 18 U.S.C. § 232(5) or 844(j).

(14) "Firearm" means any weapon that is designed to or may be readily converted to expel any projectile by the action of an explosive.

(15) "Joint" in connection with military organization connotes activities, operations, organizations, and the like in which elements of more than one military service of the same nation participate.

(16) "Lead Special Trial Counsel" within the Department of Defense means a general or flag officer with significant experience in military justice who is responsible for a dedicated office within each Military Department from which office the Lead Special Trial Counsel will provide for the overall supervision and oversight of the activities of the special trial counsel of a Military Department or Military Service, and who reports directly to the Secretary concerned, without intervening authority.

(17) "Members." The members of a court-martial are the voting members detailed by the convening authority.

(18) "Military judge" means a judge advocate designated under Article 26(c) who is detailed under Article 26(a) or Article 30a to preside over a general or special court-martial or proceeding before referral. In the context of a summary court-martial, "military judge" means the summary court-martial officer. In the context of a pre-referral proceeding or a special court-martial consisting of a military judge alone, "military judge" includes a military magistrate designated under Article 19 or Article 30a.

(19) "Military magistrate" means a commissioned officer of the armed forces certified under Article 26a who is performing duties under Article 19 or 30a.

(20) "Party," in the context of parties to a court-martial or other proceeding under these rules, means:

(A) The accused and any defense or associate or assistant defense counsel and agents of the defense counsel when acting on behalf of the accused with respect to the court-martial or proceeding in question; and

(B) Any trial or assistant trial counsel representing the United States, and agents of the trial counsel or such counsel when acting on behalf of the United States with respect to the court-martial or proceeding in question.

(21) "Preferral" is the act by which a person subject to the UCMJ formally accuses another person subject to the UCMJ of an offense, in accordance with R.C.M. 307(b).

(22) "Referral" is the order of a convening authority or a special trial counsel that one or more charges and specifications against an accused will be tried by a specified court-martial.

(23) "Referral authority" means a convening authority or special trial counsel who may

order that one or more charges and specifications against an accused be tried by a specified court-martial pursuant to R.C.M. 601.

(24) "Special trial counsel" means a judge advocate who is qualified, certified, and assigned as such by the Judge Advocate General of the armed force of which the officer is a member, or, in the case of the Marine Corps, by the Staff Judge Advocate to the Commandant of the Marine Corps, and who is independent of the military chains of command of both the victim and those accused of covered offenses over which a special trial counsel at any time exercises authority in accordance with Article 24a. Special trial counsel shall be well-trained, experienced, highly skilled and competent in handling cases involving covered offenses. Within the Department of Defense, special trial counsel work within dedicated offices under the overall supervision and oversight of a Lead Special Trial Counsel. Within the Coast Guard, special trial counsel work under the overall supervision and oversight of an officer designated under regulations prescribed by the Commandant of the Coast Guard.

(25) "Staff judge advocate" means a judge advocate so designated in the Army, Air Force, or Marine Corps, and means the principal legal advisor of a command in the Navy and Coast Guard who is a judge advocate.

(26) "*Sua sponte*" means that the person involved acts on that person's initiative, without the need for a request, motion, or application.

(27) "Trial counsel," unless otherwise specified in these rules, includes special trial counsel.

(28) "UCMJ" refers to the Uniform Code of Military Justice.

(29) "War, time of." For purposes of R.C.M. 1004(c)(6) and of implementing the applicable paragraphs of Parts IV and V of this Manual only, "time of war" means a period of

war declared by Congress, or the factual determination by the President that the existence of hostilities warrants a finding that a "time of war" exists for purposes of R.C.M. 1004(c)(6) and Parts IV and V of this Manual.

(30) The terms "writings" and "recordings" have the same meaning as in Mil. R. Evid. 1001.

(31) The definitions and rules of construction in 1 U.S.C. §§ 1 through 5 and in 10 U.S.C. §§ 101 and 801."

(b) R.C.M. 104(b)(2) is amended to read as follows:

"(2) *All persons subject to the UCMJ.* No person subject to the UCMJ may attempt to coerce or, by any unauthorized means, attempt to influence the action of:

(A) a court-martial or any other military tribunal or any member thereof, in reaching the findings or sentence in any case or the action of any case; or

(B) any preliminary hearing officer or convening, referral, approving, or reviewing authority with respect to such preliminary hearing officer's or authority's acts concerning the following:

(i) any decision to place a service member into pretrial confinement;

(ii) disposition decisions;

(iii) rulings on pre-referral matters;

(iv) findings at a preliminary hearing;

(v) convening a court-martial;

(vi) decisions concerning plea agreements;

(vii) selecting members;

(viii) decisions concerning witness requests;

(ix) taking action on the findings or sentence;

(x) taking action on any clemency or deferment request; or

(xi) any appellate or post-trial review of a case."

(c) R.C.M. 104(c) is amended to read as follows:

"(c) *Prohibitions concerning evaluations.*

(1) *Evaluation of members, defense counsel, and special victims' counsel.* In the preparation of an effectiveness, fitness, or efficiency report or any other report or document used in whole or in part for the purpose of determining whether a member of the armed forces is qualified to be advanced in grade, or in determining the assignment or transfer of a member of the armed forces, or in determining whether a member of the armed forces should be retained on active duty, no person subject to the UCMJ may:

(A) Consider or evaluate the performance of duty of any such person as a member of a court-martial; or

(B) Give a less favorable rating or evaluation of any defense counsel or special victims' counsel because of the zeal with which such counsel represented any client. As used in this rule, "special victims' counsel" are judge advocates and civilian counsel, who, in accordance with 10 U.S.C. § 1044e, are designated as Special Victims' Counsel."

(d) R.C.M. 105 is amended to read as follows:

"Rule 105. Direct communications: convening authorities and staff judge advocates; among staff judge advocates; with special trial counsel

(a) *Convening authorities and staff judge advocates.* Convening authorities shall at all times communicate directly with their staff judge advocates in matters relating to the administration of military justice, and may communicate directly with special trial counsel, although any input by

the convening authority regarding case dispositions shall be non-binding on the special trial counsel for cases involving covered, known, and related offenses.

(b) *Among staff judge advocates and with the Judge Advocate General.* The staff judge advocate of any command is entitled to communicate directly with the staff judge advocate of a superior or subordinate command, the Judge Advocate General, or, in the case of the Marine Corps, the Staff Judge Advocate to the Commandant of the Marine Corps.

(c) *Communications among special trial counsel, staff judge advocates, and convening authorities.* Special trial counsel, staff judge advocates, and convening authorities may communicate directly while ensuring that all communications regarding case disposition for covered, related, and known offenses are non-binding on the special trial counsel.

(d) *Free from unlawful or unauthorized influence or coercion.* All communications referenced in this rule shall be free from unlawful or unauthorized influence or coercion."

(e) R.C.M. 201(d)(2) is amended to read as follows:

"(2) An act of omission that violates both the UCMJ and local criminal law, foreign or domestic, may be tried by a court-martial, or by a proper civilian tribunal, foreign or domestic, or, subject to R.C.M. 907(b)(2)(C) and regulations of the Secretary concerned, by both."

(f) R.C.M. 201(f)(1)(D) is amended to read as follows:

"(D) *Jurisdiction for Certain Sexual Offenses.* Only a general court-martial has jurisdiction to try offenses under Articles 120(a), 120(b), 120b(a), and 120b(b), and attempts thereof under Article 80."

(g) R.C.M. 201(f)(2)(C) is amended to read as follows:

"(C) *Capital offenses.*

(i) A capital offense for which there is prescribed a mandatory punishment beyond the punitive power of a special court-martial shall not be referred to such a court-martial.

(ii) Other than offenses described in (C)(i):

(I) a general court-martial convening authority over the command that includes the accused may permit any capital offense to be referred to a special court-martial for trial.

(II) a special trial counsel exercising authority over a capital offense may refer such an offense to a special court-martial for trial.

(III) The Secretary concerned may authorize, by regulation, special court-martial convening authorities to refer capital offenses to trial by a special court-martial without first obtaining the consent of the general court-martial convening authority."

(h) R.C.M. 301 is amended to read as follows:

"**Rule 301. Report of offense**

(a) *Who may report.* Any person may report an offense subject to trial by court-martial.

(b) *To whom reports are conveyed.* Ordinarily, any military authority who receives a report of an offense shall forward as soon as practicable the report and any accompanying information to the immediate commander of the suspect. Competent authority superior to that commander may direct otherwise.

(c) *Special trial counsel*. All reports of covered offenses shall be forwarded promptly to a special trial counsel. A special trial counsel shall have the authority to determine whether a reported offense is a covered, known, or related offense in accordance with R.C.M. 303A."

(i) R.C.M. 302(b)(1) is amended to read as follows:

"(1) *Military law enforcement officials.* Persons designated by proper authorities to perform military criminal investigative, guard, or police duties, whether subject to the UCMJ or not, when in each of the foregoing instances, the official making the apprehension is in the execution of law enforcement duties;"

(j) R.C.M. 302(c) is amended to read as follows:

"(c) *Grounds for apprehension.* A person subject to the UCMJ or trial thereunder may be apprehended for an offense triable by court-martial upon probable cause to apprehend. Probable cause to apprehend exists when there is a reasonable belief that an offense has been or is being committed and the person to be apprehended committed or is committing it. Persons authorized to apprehend under R.C.M. 302(b)(2) may also apprehend persons subject to the UCMJ who take part in quarrels, frays, or disorders, wherever they occur."

(k) R.C.M. 303 is amended to read as follows:

"Rule 303. Preliminary inquiry into reported offenses

Except for covered offenses as defined by Article 1(17), upon receipt of information that a member of the command is accused or suspected of committing an offense or offenses triable by court-martial, the immediate commander shall make or cause to be made a preliminary inquiry into the charges or suspected offenses. A commander who receives a report of a covered offense shall promptly forward the report to a special trial counsel in accordance with R.C.M. 301(c) and regulations prescribed by the Secretary concerned."

(l) A new R.C.M. 303A is inserted immediately after R.C.M. 303 to read as follows:

"Rule 303A. Determination by special trial counsel to exercise authority

(a) *Initial determination.* A special trial counsel has the exclusive authority to determine if a reported offense is a covered offense.

(b) *Covered offense.* If a special trial counsel determines that a reported offense is a covered offense or receives a preferred charge alleging a covered offense, a special trial counsel shall exercise authority over that covered offense.

(c) *Related offenses.* If a special trial counsel exercises authority pursuant to R.C.M. 303A(b), the special trial counsel may also exercise authority over any reported offense or charge related to a covered offense, whether alleged to have been committed by the suspect of the covered offense or by anyone else subject to the UCMJ.

(d) *Known offenses.* If a special trial counsel exercises authority pursuant to R.C.M. 303A(b), the special trial counsel may also exercise authority over any offense or charge alleged to have been committed by the suspect of the covered offense.

(e) *Notification to command.* When a special trial counsel exercises authority over any reported offense, the special trial counsel shall notify the officer exercising special court-martial convening authority over the suspect."

(m) R.C.M. 305 is amended to read as follows:

"Rule 305. Pretrial confinement

(a) *In general.* Pretrial confinement is physical restraint, imposed by order of competent authority, depriving a person of freedom pending disposition of charges.

(b) *Who may be confined.* Any person who is subject to trial by court-martial may be confined if the requirements of this rule are met.

(c) *Who may order confinement. See* R.C.M. 304(b).

(d) *When a person may be confined.* No person may be ordered into pretrial confinement except for probable cause. Probable cause to order pretrial confinement exists when there is a reasonable belief that:

(1) An offense triable by court-martial has been committed;

(2) The person confined committed it; and

(3) Confinement is required by the circumstances.

(e) *Advice to the accused upon confinement.* Each person confined shall be promptly informed of: (1) The nature of the offenses for which held;

(2) The right to remain silent and that any statement made by the person may be used against the person;

(3) The right to retain civilian counsel at no expense to the United States, and the right to request assignment of military counsel; and

(4) The procedures by which pretrial confinement will be reviewed.

(f) *Notification to Special Trial Counsel.* If a person who is alleged to have committed a covered offense is ordered into or released from pretrial confinement, the individual ordering confinement or authorizing release shall immediately notify a special trial counsel in accordance with regulations prescribed by the Secretary concerned.

(g) *Military counsel.* If requested by the confinee and such request is made known to military authorities, military counsel shall be provided to the confinee before the initial review under R.C.M. 305(j) or within 72 hours of such a request being first communicated to military authorities, whichever occurs first. Counsel may be assigned for the limited purpose of representing the accused only during the pretrial confinement proceedings before charges are referred. If assignment is made for this limited purpose, the confinee shall be so informed. Unless otherwise provided by regulations of the Secretary concerned, a confinee does not have a right under this rule to have military counsel of the confinee's own selection.

(h) *Who may direct release from confinement.* Any commander of a confinee, an officer appointed under regulations of the Secretary concerned to conduct the review under R.C.M. 305(j) or (k), or, once charges have been referred, a military judge detailed to the court-martial to which the charges against the accused have been referred, may direct release from pretrial confinement. For purposes of this subsection (R.C.M. 305(h)), "any commander" includes the immediate or higher commander of the confinee and the commander of the installation on which the confinement facility is located.

(i) *Notification and action by commander.*

(1) *Report.* Unless the commander of the confinee ordered the pretrial confinement, the commissioned, warrant, noncommissioned, or petty officer into whose charge the confinee was committed shall, within 24 hours after that commitment, cause a report to be made to the commander that shall contain the name of the confinee, the offenses charged against the confinee, and the name of the person who ordered or authorized confinement.

(2) *Action by commander.*

(A) *Decision.* Not later than 72 hours after the commander's ordering of a confinee into pretrial confinement or, after receipt of a report that a member of the commander's unit or organization has been confined, whichever situation is applicable, the commander shall decide whether pretrial confinement will continue. A commander's compliance with this paragraph (R.C.M. 305(i)(2)) may also satisfy the 48-hour probable cause determination of R.C.M. 305(j)(1), provided the commander is a neutral and detached officer and acts within 48 hours of the imposition of confinement under military control. Nothing in R.C.M. 305(d), this subparagraph (R.C.M. 305(i)(2)(A)), or R.C.M. (j)(1) prevents a neutral and detached

commander from completing the 48-hour probable cause determination and the 72-hour commander's decision immediately after an accused is ordered into pretrial confinement.

(B) *Requirements for confinement.* The commander shall direct the confinee's release from pretrial confinement unless the commander believes upon probable cause, that is, upon reasonable grounds, that:

(i) An offense triable by a court-martial has been committed;

(ii) The confinee committed it;

(iii) Confinement is necessary because it is foreseeable that:

(a) The confinee will not appear at trial, pretrial hearing, or preliminary hearing, or

(b) The confinee will engage in serious criminal misconduct; and

(iv) Less severe forms of restraint are inadequate.

Serious criminal misconduct includes intimidation of witnesses or other obstruction of justice, serious injury of others, or other offenses which pose a serious threat to the safety of the community or to the effectiveness, morale, discipline, readiness, or safety of the command, or to the national security of the United States. As used in this rule, "national security" means the national defense and foreign relations of the United States and specifically includes: a military or defense advantage over any foreign nation or group of nations; a favorable foreign relations position; or a defense posture capable of successfully resisting hostile or destructive action from within or without, overt or covert.

(C) *72-hour memorandum.* If continued pretrial confinement is approved, the commander shall prepare a written memorandum that states the reasons for the conclusion that the requirements for confinement in R.C.M. 305(i)(2)(B) have been met. This memorandum may

include hearsay and may incorporate by reference other documents, such as witness statements, investigative reports, or official records. This memorandum shall be forwarded to the 7-day reviewing officer under R.C.M. 305(j)(2). If such a memorandum was prepared by the commander before ordering confinement, a second memorandum need not be prepared; however, additional information may be added to the memorandum at any time.

(j) *Procedures for review of pretrial confinement.*

(1) *48-hour probable cause determination.* Review of the adequacy of probable cause to continue pretrial confinement shall be made by a neutral and detached officer within 48 hours of imposition of confinement under military control. If the confinee is apprehended by civilian authorities and remains in civilian custody at the request of military authorities, reasonable efforts will be made to bring the confinee under military control in a timely fashion.

(2) *7-day review of pretrial confinement.* Within 7 days of the imposition of confinement, a neutral and detached officer appointed in accordance with regulations prescribed by the Secretary concerned shall review the probable cause determination and necessity for continued pretrial confinement. In calculating the number of days of confinement for purposes of this rule, the initial date of confinement under military control shall count as one day and the date of the review shall also count as one day.

(A) *Nature of the 7-day review.*

(i) *Matters considered.* The review under this clause (R.C.M. 305(j)(2)(A)(i)) shall include a review of the memorandum submitted by the confinee's commander under R.C.M. 305(i)(2)(C). Additional written matters may be considered, including any submitted by the confinee. The confinee and the confinee's counsel, if any, shall be allowed to appear before the 7-day reviewing officer and make a statement, if practicable. A

representative of the command may also appear before the reviewing officer to make a statement.

(ii) *Rules of evidence.* Except for Mil. R. Evid., Section V (Privileges) and Mil. R. Evid. 302 and 305, the Military Rules of Evidence shall not apply to the matters considered.

(iii) *Standard of proof.* The requirements for confinement under R.C.M. 305(h)(2)(B) must be proved by a preponderance of the evidence.

(iv) *Victim's right to be reasonably heard.* A victim of an alleged offense committed by the confinee has the right to reasonable, accurate, and timely notice of the 7-day review; the right to confer with the representative of the command and counsel for the Government, if any; and the right to be reasonably heard during the review. However, the hearing may not be unduly delayed for this purpose. The right to be heard under this rule includes the right to be heard through counsel and the right to be reasonably protected from the confinee during the 7-day review. Notice of these rights shall be given to the victim, or victim's counsel, if any, in accordance with regulations of the Secretary concerned

(B) *Extension of time limit.* The 7-day reviewing officer may, for good cause, extend the time limit for completion of the review to 10 days after the imposition of pretrial confinement.

(C) *Action by 7-day reviewing officer.* Upon completion of review, the reviewing officer shall approve continued confinement or order immediate release. If the reviewing officer orders immediate release, a victim of an alleged offense committed by the confinee has the right to reasonable, accurate, and timely notice of the release, unless such notice may endanger the safety of any person.

(D) *Memorandum.* The 7-day reviewing officer's conclusions, including the factual findings on which they are based, shall be set forth in a written memorandum. The memorandum shall also state whether the victim was represented by counsel, whether the victim was notified of the review, was given the opportunity to confer with the representative of the command or counsel for the Government and was given a reasonable opportunity to be heard. A copy of the memorandum and all documents considered by the 7-day reviewing officer shall be maintained in accordance with regulations prescribed by the Secretary concerned and provided to the accused or the Government on request.

(E) *Reconsideration of approval of continued confinement.* The 7-day reviewing officer shall upon request, and after notice to the parties, reconsider the decision to confine the confinee based upon any significant information not previously considered.

(k) *Review by military judge*. Once the charges for which the accused has been confined are referred to trial, or in a pre-referral proceeding conducted in accordance with R.C.M. 309, the military judge shall review the propriety of pretrial confinement upon motion for appropriate relief.

(1) *Release.* The military judge shall order release from pretrial confinement only if:

(A) The 7-day reviewing officer's decision was an abuse of discretion, and there is not sufficient information presented to the military judge justifying continuation of pretrial confinement under R.C.M. 305(i)(2)(B);

(B) Information not presented to the 7-day reviewing officer establishes that the confinee should be released under R.C.M. 305(i)(2)(B); or

(C) The provisions of R.C.M. 305(j)(1) or (2) have not been complied with and information presented to the military judge does not establish sufficient grounds for continued confinement under R.C.M. 305(i)(2)(B).

(2) *Credit.* Upon sentencing, the military judge shall order administrative credit under R.C.M. 305(l) for any pretrial confinement served as a result of an abuse of discretion or failure to comply with the provisions of R.C.M. 305(g), (i), or (j).

(l) *Remedy.* The remedy for noncompliance with R.C.M. 305(g), (i), (j), or (k) shall be an administrative credit against the sentence adjudged for any confinement served as the result of such noncompliance. Such credit shall be computed at the rate of 1 day credit for each day of confinement served as a result of such noncompliance. The military judge may order additional credit for each day of pretrial confinement that involves an abuse of discretion or unusually harsh circumstances. This credit is to be applied in addition to any other credit to which the accused may be entitled as a result of pretrial confinement served. This credit shall be applied first against any confinement adjudged. If no confinement is adjudged, or if the confinement adjudged is insufficient to offset all the credit to which the accused is entitled, the credit shall be applied against hard labor without confinement using the conversion formula under R.C.M. 1003(b)(6), restriction, fine, and forfeiture of pay, in that order. For purposes of R.C.M. 305(l), 1 day of confinement shall be equal to 1 day of total forfeiture or a like amount of fine. The credit shall not be applied against any other form of punishment.

(m) *Confinement after release.* No person whose release from pretrial confinement has been directed by a person authorized in R.C.M. 305(h) may be confined again before completion of trial except upon discovery, after the order of release, of evidence or of misconduct which, either

alone or in conjunction with all other available evidence, meets the criteria for confinement under R.C.M. 305(i)(2)(B)..

(n) *Exceptions.*

(1) *Operational necessity.* The Secretary of Defense may suspend application of R.C.M. 305(e)(3), (e)(4), (g), (i)(2)(A) or (C), or (j) to specific units or in specified areas when operational requirements of such units or in such areas would make application of such provisions impracticable.

(2) *At sea.* R.C.M. 305(e)(3), (e)(4), (g), (i)(2)(C), and (j) shall not apply in the case of a person on board a vessel at sea. In such situations, confinement on board the vessel at sea may continue only until the person can be transferred to a confinement facility ashore. Such transfer shall be accomplished at the earliest opportunity permitted by the operational requirements and mission of the vessel. Upon such transfer, the memorandum required by R.C.M. 305(i)(2)(C) shall be transmitted to the reviewing officer under R.C.M. 305(j) and shall include an explanation of any delay in the transfer.

(o) *Notice to victim of escaped confinee.* Reasonable, accurate, and timely notice of the escape of the prisoner shall be provided to the victim of an alleged offense committed by the confinee for which the confinee has been placed in pretrial confinement or such victim's counsel, if any, unless such notice may endanger the safety of any person."

(n) The title of R.C.M. 306 is amended to read as follows:

"**Rule 306. Initial disposition of offenses over which special trial counsel does not exercise authority**".

(o) R.C.M. 306(a) is amended to read as follows

"(a) *Who may dispose of offenses.*

(1) Except for offenses over which a special trial counsel has exercised authority and has not deferred, each commander has discretion to dispose of offenses by members of that command in accordance with this rule.

(2) Ordinarily the immediate commander of a person accused or suspected of committing offenses over which a special trial counsel has not exercised authority or has deferred initially determines how to dispose of those offenses. A superior commander may withhold the authority to dispose of offenses in individual cases, types of cases, or generally. A superior commander may not limit the discretion of a subordinate commander to act on cases over which authority has not been withheld."

(p) R.C.M. 306(c) is amended to read as follows:

"(c) *Disposition of offenses.* Within the limits of the commander's authority and subject to R.C.M. 306A, a commander may take the actions set forth in this subsection (R.C.M. 306(c)) to initially dispose of a charge or suspected offense.

(1) *No action.* A commander may decide to take no action.

(2) *Administrative action.* A commander may take or initiate administrative action, in addition to or instead of other action taken under this rule, subject to regulations of the Secretary concerned.

(3) *Nonjudicial punishment.* A commander may consider the matter pursuant to Article 15, nonjudicial punishment. *See* Part V.

(4) *Disposition of charges.* Charges may be disposed of in accordance with R.C.M. 401.

(5) *Forwarding for disposition.* A commander may forward a report of suspected offenses or charges to a superior or subordinate authority for disposition."

(q) R.C.M. 306(e)(1) is amended to read as follows:

"(1) For purposes of this subsection (R.C.M. 306(e)), a "sex-related offense" means any allegation of a violation of Article 120, 120b, 120c, or 130, or any attempt thereof under Article 80, occurring on or before December 27, 2023."

(r) A new R.C.M. 306A is inserted immediately after R.C.M. 306 to read as follows:

"**Rule 306A. Initial disposition of offenses over which a special trial counsel exercises authority**

(a) *Disposition of offenses that are not the subject of preferred charges.* Once a special trial counsel has exercised authority over an offense, only a special trial counsel may dispose of that offense, unless a special trial counsel defers the offense. For each offense over which a special trial counsel has exercised authority that is not the subject of a preferred charge, a special trial counsel shall:

(1) Prefer, or cause to be preferred, a charge; or

(2) Defer the offense by electing not to prefer a charge. If a special trial counsel defers the offense, the special trial counsel shall promptly forward the offense to a commander or convening authority for disposition, and the commander or convening authority shall dispose of the offense pursuant to R.C.M. 306.

(b) *Disposition of a preferred specification.* A special trial counsel shall dispose of each preferred specification in accordance with R.C.M. 401A.

(c) *National security matters.* If a commander believes trial would be detrimental to the prosecution of a war or harmful to national security, the matter shall be forwarded to the Secretary concerned for action.

(d) *Sex-related offenses.*

(1) For purposes of this subsection (R.C.M. 306A(d)), "sex-related offense" means any allegation of a violation of Article 120, 120b, 120c, or 130, or any attempt thereof under Article 80.

(2) Under such regulations as the Secretary concerned may prescribe, for alleged sex-related offenses committed in the United States, the victim of the sex-related offense shall be provided an opportunity to express views as to whether the offense should be prosecuted by court-martial or in a civilian court with jurisdiction over the offense. A special trial counsel shall consider the victim's preference for jurisdiction, if available, prior to making an initial disposition decision. For purposes of this rule, "victim" is defined as an individual who has suffered direct physical, emotional, or pecuniary harm as a result of the commission of an alleged sex-related offense as defined in R.C.M. 306A(d)(1).

(3) Under such regulations as the Secretary concerned may prescribe, if the victim of an alleged sex-related offense expresses a preference for prosecution of the offense in a civilian court, a special trial counsel shall ensure that the civilian authority with jurisdiction over the offense is notified of the victim's preference for civilian prosecution. If a special trial counsel learns of any decision by the civilian authority to prosecute or not prosecute the offense in civilian court, the special trial counsel shall ensure the victim, or victim's counsel, if any, is notified."

(s) R.C.M. 307(a) is amended to read as follows:

"(a) *In general.* In accordance with R.C.M. 307(b), preferral is the act by which a person subject to the UCMJ formally accuses another person subject to the UCMJ of an offense. Any person subject to the UCMJ may prefer charges."

(t) R.C.M. 308 is revised to read as follows:

"Rule 308. Notification to accused of charges and required disclosures

(a) *Immediate commander.* The immediate commander of the accused shall cause the accused to be informed of the charges preferred against the accused, and the name of the person who preferred the charges and of any person who ordered the charges to be preferred, if known, as soon as practicable.

(b) *Commanders at higher echelons.* When the accused has not been informed of the charges, commanders at higher echelons to whom the preferred charges are forwarded shall cause the accused to be informed of the matters required under R.C.M. 308(a) as soon as practicable.

(c) *Disclosures generally.* Except as otherwise provided in R.C.M. 308(d) and as soon as practicable after notification to the accused of preferred charges, counsel for the Government shall provide the defense with copies of the charges and any books, papers, documents, data, photographs, or tangible objects that accompanied the charge or charges when preferred. If extraordinary circumstances make it impracticable to provide copies, counsel for the Government shall permit the defense to inspect these items.

(d) *Information not subject to disclosure.*

(1) *Military Rules of Evidence.* Nothing in this rule shall be construed to require the disclosure of information protected from disclosure by the Military Rules of Evidence.

(2) *Work Product.* Nothing in this rule shall require the disclosure or production of notes, memoranda, or similar working papers prepared by counsel or counsel's assistants and representatives.

(3) *Contraband.* If items covered by R.C.M. 308(c) are contraband, the disclosure required under this rule is a reasonable opportunity to inspect said contraband prior to the preliminary hearing.

(4) *Privilege.* If items covered by R.C.M. 308(c) are privileged, classified, or otherwise protected under Section V of Part III, the Military Rules of Evidence, no disclosure of those items is required under this rule. However, counsel for the Government may disclose privileged, classified, or otherwise protected information covered by R.C.M. 308(a) if authorized by the holder of the privilege or, in the case of Mil. R. Evid. 505 or 506, if authorized by a competent authority.

(5) *Protective order if privileged information is disclosed.* If the Government agrees to disclose to the accused information to which the protections afforded by Section V of the Military Rules of Evidence may apply, the convening authority, or other person designated by regulation of the Secretary concerned, may enter an appropriate protective order, in writing, to guard against the compromise of information disclosed to the accused. The terms of any such protective order may include prohibiting the disclosure of the information except as authorized by the authority issuing the protective order, as well as those terms specified by Mil. R. Evid. 505(g)(2)–(6) or 506(g)(2)–(5). (e) *Remedy.* The sole remedy for violation of this rule is a continuance or recess of sufficient length to permit the accused to adequately prepare a defense, and no relief shall be granted upon a failure to comply with this rule unless the accused demonstrates that the accused has been hindered in the preparation of a defense."

(u) R.C.M. 309(a)(2) is amended to read as follows:

"(2) The matters that may be considered and ruled upon by a military judge under this rule are limited to those matters specified in R.C.M. 309(b)."

(v) R.C.M. 309(b)(3) is amended to read as follows:

"(3) *Requests for relief from subpoena or other process.* A person in receipt of a pre-referral investigative subpoena under R.C.M. 703(g)(3)(C), a victim named in a specification

whose personal and confidential information has been subpoenaed under R.C.M. 703(g)(3)(C)(ii), a service provider in receipt of a warrant or court order to disclose information about wire or electronic communications under R.C.M. 703A(a), or a person ordered to sit for a deposition under R.C.M. 702(b)(2) may request relief on grounds that compliance with the subpoena, warrant, or order is unreasonable, oppressive, or prohibited by law. The military judge shall review the request and shall either order the person or service provider to comply with the subpoena, warrant, or order, or modify or quash the subpoena, warrant, or order, as appropriate. In a proceeding under this paragraph, the United States shall be represented by an authorized counsel for the Government."

(w) R.C.M. 309(b)(6) is amended to read as follows:

"(6) *Pretrial confinement of an accused.* After action by the 7-day reviewing officer under R.C.M. 305(j)(2)(C), a military judge may, upon application of an accused for appropriate relief, review the propriety of pretrial confinement. A military judge may order release from pretrial confinement under the provisions of R.C.M. 305(k)(1)."

(x) A new R.C.M. 309(b)(10) is inserted immediately after (b)(9) to read as follows:

"(10) *Pre-referral depositions.* A military judge may, upon application by a party, consider whether to order a pre-referral deposition under R.C.M. 702(c)(2)."

(y) R.C.M. 309(e) is amended to read as follows:

"(e) *Record.* A separate record of any proceeding under this rule shall be prepared and forwarded to the convening authority, special trial counsel, or any combination thereof, with authority to dispose of the charges or offenses in the case. If charges are referred to trial in the case, such record shall be included in the record of trial."

(z) R.C.M. 401(a) is revised to read as follows:

"(a) *Who may dispose of charges.* Only persons authorized to convene courts-martial or to administer nonjudicial punishment under Article 15 may dispose of charges, except for those charges over which a special trial counsel has exercised authority and which must be disposed of in accordance with R.C.M. 401A. A superior competent authority may withhold the authority of a subordinate to dispose of charges in individual cases, types of cases, or generally."

(aa) A new R.C.M. 401A is inserted immediately after R.C.M. 401 to read as follows:

"**Rule 401A. Disposition of charges over which a special trial counsel exercises authority and has not deferred**

(a) *Who may dispose of preferred specifications.* Regardless of who preferred a specification, only a special trial counsel may dispose of a specification alleging a covered offense or another offense over which a special trial counsel has exercised authority and has not deferred. A superior competent authority may withhold the authority of a subordinate special trial counsel to dispose of offenses charged in individual cases, types of cases, or generally.

(b) *Prompt determination.* Special trial counsel shall promptly determine what disposition will be made in the interest of justice and discipline.

(c) *Disposition of preferred specifications.*

(1) *Referral.* For those offenses over which a special trial counsel has exercised authority and not deferred, a special trial counsel may refer a charge and any specification thereunder to a special or general court-martial. If a preliminary hearing in accordance with Article 32 and R.C.M. 405 is required, a special trial counsel shall request a hearing officer and a hearing officer shall be provided by the convening authority.

(2) *Dismissal.* For those offenses over which a special trial counsel has exercised authority and not deferred, a special trial counsel may dismiss any charge or specification

thereunder. A dismissal may be accompanied by a deferral as defined in this rule. Further disposition by a special trial counsel in accordance with this rule or by a convening authority pursuant to RCM 306(c) is not barred.

(3) *Deferral.*

(A) *Pre-referral.* A special trial counsel may defer a charged offense by electing not to refer the charged offense to a special or general court-martial. Upon such a determination, the special trial counsel shall promptly forward the matter to the commander or convening authority for disposition. The commander or convening authority shall dispose of the offense pursuant to R.C.M. 306 or the charged offense pursuant to R.C.M. 401, as applicable. The commander or convening authority may dismiss a charge preferred by a special trial counsel. However, a convening authority may not refer a charge alleging a covered offense to a special or general court-martial.

(B) *Post-referral.* After referral, a charge referred to a general or special court-martial by a special trial counsel must be withdrawn before the offense alleged by that charge may be deferred."

(bb) R.C.M. 402 is amended to read as follows:

"Rule 402. Action by commander not authorized to convene courts-martial

Except for covered offenses and other charges over which a special trial counsel has exercised authority and has not deferred, when in receipt of charges, a commander authorized to administer nonjudicial punishment but not authorized to convene courts-martial may:

(1) Dismiss any charge; or

(2) Forward any charge to a superior commander for disposition."

(cc) R.C.M. 403 is amended to read as follows:

"Rule 403. Action by commander exercising summary court-martial jurisdiction.

(a) *Recording receipt.* Immediately upon receipt of sworn charges, an officer exercising summary court-martial jurisdiction over the command shall cause the hour and date of receipt to be entered on the charge sheet. After recording receipt of charges over which a special trial counsel has exercised authority and has not deferred, the charge sheet shall be returned to the special trial counsel.

(b) *Disposition.* Except for covered offenses and other charges over which a special trial counsel has exercised authority and has not deferred, when in receipt of charges, a commander exercising summary court-martial jurisdiction may:

(1) Dismiss any charge;

(2) Forward any charge (or, after dismissing a charge, the matter) to a subordinate commander for disposition;

(3) Forward any charge to a superior commander for disposition;

(4) Subject to R.C.M. 601(d) and 1301(c), refer any charge to a summary court-martial for trial; or

(5) Unless otherwise prescribed by the Secretary concerned, direct a preliminary hearing under R.C.M. 405, and, if appropriate, forward the report of preliminary hearing with the charges to a superior commander for disposition."

(dd) R.C.M. 404 is amended to read as follows:

"Rule 404. Action by commander exercising special court-martial jurisdiction

Except for covered offenses and other charges over which a special trial counsel has exercised authority and has not deferred, when in receipt of charges, a commander exercising special court-martial jurisdiction may:

(1) Dismiss any charge;

(2) Forward any charge (or, after dismissing a charge, the matter) to a subordinate commander for disposition;

(3) Forward any charge to a superior commander for disposition;

(4) Subject to R.C.M. 201(f)(2)(D) and (E), 601(d), and 1301(c), refer any charge to a summary court-martial or to a special court-martial for trial; or

(5) Unless otherwise prescribed by the Secretary concerned, direct a preliminary hearing under R.C.M. 405, and, if appropriate, forward the report of preliminary hearing with the charges to a superior commander for disposition."

(ee) R.C.M. 404A is deleted.

(ff) R.C.M. 405 is amended to read as follows:

"Rule 405. Preliminary hearing.

(a) *In general.* Except as provided in R.C.M. 405(n), no charge or specification may be referred to a general court-martial for trial until completion of a preliminary hearing in substantial compliance with this rule. The issues for determination at a preliminary hearing are limited to the following: whether each specification alleges an offense; whether there is probable cause to believe that the accused committed the offense or offenses charged; whether the convening authority has court-martial jurisdiction over the accused and over the offense; and to recommend the disposition that should be made of the case. Failure to comply with this rule shall have no effect on the disposition of any charge if the charge is not referred to a general court-martial.

(b) *Earlier preliminary hearing.* If a preliminary hearing on the subject matter of an offense has been conducted before the accused is charged with an offense, and the accused was present at the

preliminary hearing and afforded the rights to counsel, cross-examination, and presentation of evidence required by this rule, no further preliminary hearing is required.

(c) *Who may direct a preliminary hearing.*

(1) Subject to R.C.M. 405(c)(2), unless prohibited by regulations of the Secretary concerned, a preliminary hearing may be directed under this rule by any court-martial convening authority. That authority may also give procedural instructions not inconsistent with these rules.

(2) For charges and specifications over which a special trial counsel has exercised authority, the special trial counsel shall determine whether a preliminary hearing is required. If a special trial counsel determines that a hearing is required, the special trial counsel shall request that a convening authority provide a preliminary hearing officer. Upon such a request, the convening authority shall provide a preliminary hearing officer and direct a preliminary hearing in accordance with this rule. If a special trial counsel determines a previous preliminary hearing is required to be reopened, the convening authority shall direct the preliminary hearing to be reopened.

(d) *Disclosures after direction of a preliminary hearing.*

(1) As soon as practicable but no later than five days after direction of an Article 32 preliminary hearing, counsel for the Government shall provide the defense with copies of, or, if impracticable, permit the defense to inspect:

(A) the order directing the Article 32 preliminary hearing pursuant to this rule (R.C.M. 405);

(B) statements, within the control of military authorities, of witnesses that counsel for the Government intends to call at the preliminary hearing;

(C) evidence counsel for the Government intends to present at the preliminary hearing; and

(D) any matters provided to the convening authority when deciding to direct the preliminary hearing.

(2) *Contraband.* If items covered by R.C.M. 405(d)(1) are contraband, the disclosure required under this rule is a reasonable opportunity to inspect said contraband prior to the preliminary hearing.

(3) *Privilege.* If items covered by R.C.M. 405(d)(1) are privileged, classified, or otherwise protected under Section V of Part III, the Military Rules of Evidence, no disclosure of those items is required under this rule. However, counsel for the Government may disclose privileged, classified, or otherwise protected information covered by R.C.M. 405(d)(1) if authorized by the holder of the privilege, or, in the case of Mil. R. Evid. 505 or 506, if authorized by a competent authority.

(4) *Protective order if privileged information is disclosed.* If the Government agrees to disclose to the accused information to which the protections afforded by Section V of Part III may apply, the convening authority, or other person designated by regulation of the Secretary concerned, may enter an appropriate protective order, in writing, to guard against the compromise of information disclosed to the accused. The terms of any such protective order may include prohibiting the disclosure of the information except as authorized by the authority issuing the protective order, as well as those terms specified by Mil. R. Evid. 505(g)(2)–(6) or 506(g)(2)–(5).

(e) *Personnel.*

(1) Preliminary hearing officer.

(A) The convening authority directing the preliminary hearing shall detail an impartial judge advocate, not the accuser, who is certified under Article 27(b)(2) to conduct the hearing. When it is impracticable to appoint a judge advocate certified under Article 27(b)(2) due to exceptional circumstances:

(i) The convening authority may detail an impartial commissioned officer as the preliminary hearing officer, and

(ii) An impartial judge advocate certified under Article 27(b)(2) shall be available to provide legal advice to the detailed preliminary hearing officer.

(B) Whenever practicable, the preliminary hearing officer shall be equal or senior in grade to the military counsel detailed to represent the accused and the Government at the preliminary hearing.

(C) The Secretary concerned may prescribe additional limitations on the detailing of preliminary hearing officers.

(D) The preliminary hearing officer shall not depart from an impartial role and become an advocate for either side. The preliminary hearing officer is disqualified to act later in the same case in any other capacity.

(2) *Counsel for the Government.*

(A) Subject to R.C.M. 405(e)(2)(B), a judge advocate, not the accuser, shall serve as counsel to represent the Government.

(B) For preliminary hearings requested by a special trial counsel, the special trial counsel shall detail counsel for the Government consistent with regulations prescribed by the Secretary concerned. Any determination by a special trial counsel to prefer or refer charges shall not act to disqualify that special trial counsel as an accuser.

(3) *Defense counsel.*

(A) *Detailed counsel.* Military counsel certified in accordance with Article 27(b) shall be detailed to represent the accused.

(B) *Individual military counsel.* The accused may request to be represented by individual military counsel. Such requests shall be acted on in accordance with R.C.M. 506(b).

(C) *Civilian counsel.* The accused may be represented by civilian counsel at no expense to the Government. Upon request, the accused is entitled to a reasonable time to obtain civilian counsel and to have such counsel present for the preliminary hearing. However, the preliminary hearing shall not be unduly delayed for this purpose. Representation by civilian counsel shall not limit the rights to military counsel under R.C.M. 405(e)(3)(A) or (B).

(4) *Others.* The convening authority who directed the preliminary hearing may also detail or request an appropriate authority to detail a reporter, an interpreter, or both.

(f*) Scope of preliminary hearing.*

(1) The preliminary hearing officer shall limit the inquiry to the examination of evidence, including witnesses, relevant to the issues for determination under R.C.M. 405(a).

(2) If evidence adduced during the preliminary hearing indicates that the accused committed any uncharged offense, the preliminary hearing officer may examine evidence and hear witnesses presented by the parties relating to the subject matter of such offense and make the determination specified in R.C.M. 405(a) regarding such offense without the accused first having been charged with the offense. The rights of the accused under R.C.M. 405(g), and, where it would not cause undue delay to the proceedings, the procedure applicable for production of witnesses and other evidence under R.C.M. 405(i), are the same with regard to both charged and uncharged offenses. When considering uncharged offenses identified during

the preliminary hearing, the preliminary hearing officers shall inform the accused of the general nature of each offense considered and otherwise afford the accused the same opportunity for representation, cross-examination, and presentation afforded during the preliminary hearing of any charged offense.

(3) If evidence adduced during the preliminary hearing indicates that the accused committed any uncharged covered offense and the preliminary hearing was not requested by special trial counsel, the preliminary hearing officer shall provide prompt notice to the convening authority and a special trial counsel and shall submit a copy of the preliminary hearing report to a special trial counsel.

(g) *Rights of the accused.* At any preliminary hearing under this rule the accused shall have the right to:

(1) Be advised of the charges and uncharged misconduct under consideration;

(2) Be represented by counsel;

(3) Be informed of the purpose of the preliminary hearing;

(4) Be informed of the right against self-incrimination under Article 31;

(5) In accordance with the terms of R.C.M. 405(k)(4), be present throughout the taking of evidence;

(6) Cross-examine witnesses on matters relevant to the issues for determination under R.C.M. 405(a);

(7) Present matters relevant to the issues for determination under R.C.M. 405(a); and

(8) Make a sworn or unsworn statement relevant to the issues for determination under R.C.M. 405(a).

(h) *Notice to and presence of victim.*

(1) For the purposes of this rule, a "victim" is an individual who is alleged to have suffered a direct physical, emotional, or pecuniary harm as a result of the commission of an offense under the UCMJ.

(2) A victim of an offense under the UCMJ or the victim's counsel, if any, shall receive reasonable, accurate, and timely notice of a preliminary hearing relating to the alleged offense and a reasonable opportunity to confer with counsel for the Government.

(3) A victim has the right not to be excluded from any public proceeding of the preliminary hearing, except to the extent a similarly situated victim would be excluded at trial.

(i) *Notice, Production of Witnesses, and Production of Other Evidence.*

(1) *Notice.* Prior to any preliminary hearing under this rule, the parties shall, in accordance with timelines set by the preliminary hearing officer, provide to the preliminary hearing officer and the opposing party the following notices:

(A) Notice of the name and contact information for each witness the party intends to call at the preliminary hearing;

(B) Notice of any other evidence that the party intends to offer at the preliminary hearing; and

(C) Notice of any additional information the party intends to submit under R.C.M. 405(l).

(2) *Production of Witnesses.*

(A) *Military Witnesses.*

(i) Prior to the preliminary hearing, defense counsel shall provide to counsel for the Government the names of proposed military witnesses whom the accused requests that the Government produce to testify at the preliminary hearing, and the requested

form of the testimony, in accordance with the timeline established by the preliminary hearing officer. Counsel for the Government shall respond that either (1) the Government agrees that the witness' testimony is relevant, not cumulative, and necessary to a determination of the issues under R.C.M. 405(a) and will seek to secure the witness' testimony for the hearing; or (2) the Government objects to the proposed defense witness on the grounds that the testimony would be irrelevant, cumulative, or unnecessary to a determination of the issues under R.C.M. 405(a).

(ii) If the Government objects to the proposed defense witness, defense counsel may request that the preliminary hearing officer determine whether the witness is relevant, not cumulative, and necessary to a determination of the issues under R.C.M. 405(a).

(iii) If the Government does not object to the proposed defense military witness or the preliminary hearing officer determines that the military witness is relevant, not cumulative, and necessary, counsel for the Government shall request that the commanding officer of the proposed military witness make that person available to provide testimony. The commanding officer shall determine whether the individual is available, and if so, whether the witness will testify in person, by video teleconference, by telephone, or by similar means of remote testimony, based on operational necessity or mission requirements. If the commanding officer determines that the military witness is available, counsel for the Government shall make arrangements for that individual's testimony. The commanding officer's determination of unavailability due to operational necessity or mission requirements is final.

(iv) A victim who is alleged to have suffered a direct physical, emotional, or pecuniary harm as a result of the matters set forth in a charge or specification under consideration and is named in one of the specifications under consideration shall not be required to testify at a preliminary hearing.

(B) *Civilian Witnesses.*

(i) Defense counsel shall provide to counsel for the Government the names of proposed civilian witnesses whom the accused requests that the Government produce to testify at the preliminary hearing, and the requested form of the testimony, in accordance with the timeline established by the preliminary hearing officer. Counsel for the Government shall respond that either (1) the Government agrees that the witness' testimony is relevant, not cumulative, and necessary to a determination of the issues under R.C.M. 405(a) and will seek to secure the witness' testimony for the hearing; or (2) the Government objects to the proposed defense witness on the grounds that the testimony would be irrelevant, cumulative, or unnecessary to a determination of the issues under R.C.M. 405(a).

(ii) If the Government objects to the proposed defense witness, defense counsel may request that the preliminary hearing officer determine whether the witness is relevant, not cumulative, and necessary to a determination of the issues under R.C.M. 405(a).

(iii) If the Government does not object to the proposed civilian witness or the preliminary hearing officer determines that the civilian witness' testimony is relevant, not cumulative, and necessary, counsel for the Government shall invite the civilian witness to provide testimony and, if the individual agrees, shall make arrangements for the witness's testimony. If expense to the Government is to be incurred, the convening authority who directed the preliminary hearing, or the convening authority's delegate, shall determine whether the witness testifies in person, by video teleconference, by telephone, or by similar means of remote testimony.

(3) *Production of other evidence.*

(A) *Evidence under the control of the Government.*

(i) Prior to the preliminary hearing, defense counsel shall provide to counsel for the Government a list of evidence under the control of the Government the accused requests the Government produce to the defense for introduction at the preliminary hearing. The preliminary hearing officer may set a deadline by which defense requests must be received. Counsel for the Government shall respond that either (1) the Government agrees that the evidence is relevant, not cumulative, and necessary to a determination of the issues under R.C.M. 405(a) and shall make reasonable efforts to obtain the evidence; or (2) the Government objects to production of the evidence on the grounds that the evidence would be irrelevant, cumulative, or unnecessary to a determination of the issues under R.C.M. 405(a).

(ii) If the Government objects to the production of the evidence, defense counsel may request that the preliminary hearing officer determine whether the evidence should be produced. The preliminary hearing officer shall determine whether the evidence is relevant, not cumulative, and necessary to a determination of the issues under R.C.M. 405(a). If the preliminary hearing officer determines that the evidence shall be produced, counsel for the Government shall make reasonable efforts to obtain the evidence.

(iii) The preliminary hearing officer may not order the production of any privileged matters; however, when a party offers evidence that an opposing party claims is privileged, the preliminary hearing officer may rule on whether a privilege applies.

(B) *Evidence not under the control of the Government.*

(i) Evidence not under the control of the Government may be obtained through noncompulsory means or by a pre-referral investigative subpoena issued by a military judge under R.C.M. 309 or counsel for the Government in accordance with the process established by R.C.M. 703(g)(3)(C).

(ii) Prior to the preliminary hearing, defense counsel shall provide to counsel for the Government a list of evidence not under the control of the Government that the accused requests the Government obtain. The preliminary hearing officer may set a deadline by which defense requests must be received. Counsel for the Government shall respond that either (1) the Government agrees that the evidence is relevant, not cumulative, and necessary to a determination of the issues under R.C.M. 405(a) and shall issue a pre-referral investigative subpoena for the evidence; or (2) the Government objects to the production of the evidence on the grounds that the evidence would be irrelevant, cumulative, or unnecessary to a determination of the issues under R.C.M. 405(a).

(iii) If the Government objects to production of the evidence, defense counsel may request that the preliminary hearing officer determine whether the evidence should be produced. If the preliminary hearing officer determines that the evidence is relevant, not cumulative, and necessary to a determination of the issues under R.C.M. 405(a) and that the issuance of a pre-referral investigative subpoena would not cause undue delay to the preliminary hearing, the preliminary hearing officer shall direct counsel for the Government to seek a pre-referral investigative subpoena for the defense-requested evidence from a military judge in accordance with R.C.M. 309 or authorization from the general court-martial convening authority to issue an investigative subpoena. If counsel for the Government refuses or is unable to obtain an investigative subpoena, the counsel shall set forth the reasons why the investigative subpoena was not obtained in a written statement that shall be included in the preliminary hearing report under R.C.M. 405(m).

(iv) The preliminary hearing officer may not order the production of any privileged matters; however, when a party offers evidence that an opposing party claims is privileged, the preliminary hearing officer may rule on whether a privilege applies.

(j) *Military Rules of Evidence.*

(1) *In general.*

(A) Only the following Military Rules of Evidence apply to preliminary hearings:

(i) Mil. R. Evid. 301-303 and 305.

(ii) Mil. R. Evid. 412(a), except as provided in R.C.M. 405(j)(2).

(iii) Mil. R. Evid., Section V, Privileges, except that Mil. R. Evid. 505(f)-(h) and (j); 506(f)-(h), (j), (k), and (m); and 514(d)(6) shall not apply.

(B) In applying the rules to a preliminary hearing in accordance with R.C.M. 405(j)(1)(A), the term "military judge," as used in such rules, means the preliminary hearing officer, who shall assume the military judge's authority to exclude evidence from the preliminary hearing, and who shall, in discharging this duty, follow the procedures set forth in such rules. Evidence offered in violation of the procedural requirements of the rules in R.C.M. 405(j)(1)(A) shall be excluded from the preliminary hearing, unless good cause is shown.

(2) *Sex-offense cases.*

(A) *Inadmissibility of certain evidence.* In a case of an alleged sexual offense, as defined under Mil. R. Evid. 412(d), evidence offered to prove that any alleged victim engaged in other sexual behavior or evidence offered to prove any alleged victim's sexual predisposition is not admissible at a preliminary hearing unless—

(i) the evidence would be admissible at trial under Mil. R. Evid. 412(b)(1) or (2); and

(ii) the evidence is relevant, not cumulative, and is necessary to a determination of the issues under R.C.M. 405(a).

(B) *Initial procedure to determine admissibility.* A party intending to offer evidence under R.C.M. 405(j)(2)(A) shall, no later than five days before the preliminary hearing begins, submit a written motion specifically describing the evidence and stating why the evidence is admissible. The preliminary hearing officer may permit a different filing time, but any motion shall be filed prior to the beginning of the preliminary hearing. The moving party shall serve the motion on the opposing party, who shall have the opportunity to respond in writing. Counsel for the Government shall cause the motion and any written responses to be served on the victim, or victim's counsel, if any, or, when appropriate, the victim's guardian or representative. After reviewing the motion and any written responses, the preliminary hearing officer shall either—

(i) deny the motion on the grounds that the evidence does not meet the criteria specified in R.C.M. 405(j)(2)(A)(i) or (ii); or

(ii) conduct a hearing to determine the admissibility of the evidence.

(C) *Admissibility hearing.* If the preliminary hearing officer conducts a hearing to determine the admissibility of the evidence, the admissibility hearing shall be closed and should ordinarily be conducted at the end of the preliminary hearing, after all other evidence offered by the parties has been admitted. At the admissibility hearing, the parties may call witnesses and offer relevant evidence. The victim shall be afforded a reasonable opportunity to attend and be heard, to include being heard through counsel. If the preliminary hearing officer determines that the evidence should be admitted, the victim may directly petition the Court of Criminal Appeals for a writ of mandamus pursuant to Article 6b.

(D) *Sealing.* The motions, related papers, and the record of an admissibility hearing shall be sealed and remain under seal in accordance with R.C.M. 1113.

(k) *Preliminary hearing procedure.*

(1) *Generally*. The preliminary hearing shall begin with the preliminary hearing officer informing the accused of the accused's rights under R.C.M. 405(g). Counsel for the Government will then present evidence. Upon the conclusion of counsel for the Government's presentation of evidence, defense counsel may present matters. Both counsel for the Government and defense counsel shall be afforded an opportunity to cross-examine adverse witnesses. The preliminary hearing officer may also question witnesses called by the parties. If the preliminary hearing officer determines that additional evidence is necessary for a determination of the issues under R.C.M. 405(a), the preliminary hearing officer may provide the parties an opportunity to present additional testimony or evidence. Except as provided in R.C.M. 405(m)(2)(J), the preliminary hearing officer shall not consider evidence not presented at the preliminary hearing in making the determination under R.C.M. 405(a). The preliminary hearing officer shall not call witnesses *sua sponte*.

(2) *Presentation of evidence.*

(A) *Testimony.* Witness testimony may be provided in person, by video teleconference, by telephone, or by similar means of remote testimony. All testimony shall be taken under oath, except that the accused may make an unsworn statement. The preliminary hearing officer shall only consider testimony that is relevant to the issues for determination under R.C.M. 405(a).

(B) *Other evidence.* If relevant to the issues for determination under R.C.M. 405(a) and not cumulative, a preliminary hearing officer may consider other evidence offered by

either counsel for the Government or defense counsel, in addition to or in lieu of witness testimony, including statements, tangible evidence, or reproductions thereof, that the preliminary hearing officer determines is reliable. This other evidence need not be sworn.

(3) *Access by spectators.* Preliminary hearings are public proceedings and should remain open to the public whenever possible, whether conducted in person or via remote means. If there is an overriding interest that outweighs the value of an open preliminary hearing, the convening authority or the preliminary hearing officer may restrict or foreclose access by spectators to all or part of the proceedings. Any restriction or closure must be narrowly tailored to protect the overriding interest involved. Before ordering any restriction or closure, a convening authority or preliminary hearing officer must determine whether any reasonable alternatives to such restriction or closure exist, or if some lesser means can be used to protect the overriding interest in the case. The convening authority or preliminary hearing officer shall make specific findings of fact in writing that support the restriction or closure. The written findings of fact shall be included in the preliminary hearing report.

(4) *Presence of accused.* The accused shall be present for the preliminary hearing.

(A) *Remote presence of the accused.* The convening authority that directed the preliminary hearing may authorize the use of audio-visual technology between the parties and the preliminary hearing officer. In such circumstances, the "presence" requirement of the accused is met only when the accused has a defense counsel physically present at the accused's location or when the accused consents to presence by remote means with the opportunity for confidential consultation with defense counsel during the proceeding. Such technology may include two or more remote sites as long as all parties can see and hear each other.

(B) The accused shall be considered to have waived the right to be present at the preliminary hearing if the accused:

(i) After being notified of the time and place of the proceeding is voluntarily absent; or

(ii) After being warned by the preliminary hearing officer that disruptive conduct will cause removal from the proceeding, persists in conduct which is such as to justify exclusion from the proceeding.

(5) *Recording of the preliminary hearing.* Counsel for the Government shall ensure that the preliminary hearing is recorded by a suitable recording device. A victim named in a specification under consideration may request access to, or a copy of, the recording of the proceedings. Upon request, counsel for the Government shall provide the requested access to, or a copy of, the recording or, at the Government's discretion, a transcript, to the victim or victim's counsel, if any, not later than a reasonable time following dismissal of the charges, unless charges are dismissed for the purpose of rereferral, or court-martial adjournment. This rule does not entitle the victim to classified information or sealed materials consistent with an order issued in accordance with R.C.M. 1113(a).

(6) *Recording and broadcasting prohibited.* Video and audio recording, broadcasting, and the taking of photographs—except as required in R.C.M. 405(k)(5)—are prohibited. The convening authority may, as a matter of discretion, permit contemporaneous closed-caption video or audio transmission to permit viewing or hearing by an accused removed under R.C.M. 405(k)(4) or by spectators when the facilities are inadequate to accommodate a reasonable number of spectators.

(7) *Objections.* Any objection alleging a failure to comply with this rule, other than an objection under R.C.M. 405(m), shall be made to the preliminary hearing officer promptly upon discovery of the alleged error. The preliminary hearing officer is not required to rule on any objection. An objection shall be noted in the preliminary hearing report if the person objecting so requests. The preliminary hearing officer may require a party to file any objection in writing.

(8) *Sealed exhibits and proceedings.* The preliminary hearing officer has the authority to order exhibits, recordings of proceedings, or other matters sealed as described in R.C.M. 1113.

(l) *Supplementary information.*

(1) No later than 24 hours from the closure of the preliminary hearing, counsel for the Government, defense counsel, and any victim named in a specification under consideration (or, if applicable, counsel for such a victim) may submit to the preliminary hearing officer, counsel for the Government, and defense counsel additional information that the submitter deems relevant to the-disposition of the charges and specifications.

(2) Defense counsel may submit additional matters that rebut the submissions of counsel for the Government or any victim provided under R.C.M. 405(l)(1). Such matters must be provided to the preliminary hearing officer and to the counsel for the Government within 5 days of the closure of the preliminary hearing.

(3) The preliminary hearing officer shall examine all supplementary information submitted under R.C.M. 405(l) and shall seal, in accordance with R.C.M. 1113, any matters the preliminary hearing officer deems privileged or otherwise not subject to disclosure.

(A) The preliminary hearing officer shall provide a written summary and an analysis of the supplementary information submitted under R.C.M. 405(l) that is not sealed and

is relevant to disposition for inclusion in the report to the convening authority or special trial counsel, as applicable, under R.C.M. 405(m).

(B) If the preliminary hearing officer seals any supplementary information submitted under R.C.M. 405(l), the preliminary hearing officer shall provide an analysis of those materials. The analysis of the sealed materials shall be sealed. Additionally, the preliminary hearing officer shall generally describe those matters and detail the basis for sealing them in a separate cover sheet. This cover sheet shall accompany the sealed matters and shall not contain privileged information or be sealed.

(4) The supplementary information and any summary and analysis provided by the preliminary hearing officer, and any sealed matters and cover sheets, as applicable, shall be forwarded to the convening authority or special trial counsel, as applicable, for consideration in making a disposition determination.

(5) Submissions under R.C.M. 405(l) shall be maintained as an attachment to the preliminary hearing report provided under R.C.M. 405(m).

(m) *Preliminary hearing report.*

(1) *In general.* The preliminary hearing officer shall make a timely written report of the preliminary hearing to the convening authority or, for hearings requested by a special trial counsel, to the special trial counsel. This report is advisory and does not bind the staff judge advocate, convening authority, or special trial counsel, as applicable.

(2) *Contents.* The preliminary hearing report shall include:

(A) A statement of names and organizations or addresses of counsel for the Government and defense counsel and, if applicable, a statement of why either counsel was not present at any time during the proceedings;

(B) The recording of the preliminary hearing under R.C.M. 405(k)(5);

(C) For each specification, the preliminary hearing officer's reasoning and conclusions with respect to the issues for determination under R.C.M. 405(a), including a summary of relevant witness testimony and documentary evidence presented at the hearing and any observations concerning the testimony of witnesses and the availability and admissibility of evidence at trial;

(D) If applicable, a statement that an essential witness may not be available for trial;

(E) An explanation of any delays in the preliminary hearing;

(F) A notation if counsel for the Government refused to issue a pre-referral investigative subpoena that was directed by the preliminary hearing officer and the counsel's statement of the reasons for such refusal;

(G) Recommendations for any necessary modifications to the form of the charges and specifications;

(H) A statement of whether the preliminary hearing officer examined evidence or heard witnesses relating to any uncharged offenses in accordance with R.C.M. 405(f)(2), and, for each such offense, the preliminary hearing officer's reasoning and conclusions as to whether there is probable cause to believe that the accused committed the offense and whether the convening authority would have court-martial jurisdiction over the offense if it were charged;

(I) A notation of any objections if required under R.C.M. 405(k)(7);

(J) The recommendation of the preliminary hearing officer as to the disposition that should be made of the charges and specifications in the interest of justice and discipline. In

making this disposition recommendation, the preliminary hearing officer may consider any evidence admitted during the preliminary hearing and matters submitted under R.C.M. 405(l);

(K) The written summary and analysis required by R.C.M. 405(l)(3)(A); and

(L) A notation as to whether the parties or the preliminary hearing officer considered any offense to be a covered offense.

(3) *Sealed exhibits and proceedings.* If the preliminary hearing report contains exhibits, proceedings, or other matters ordered sealed by the preliminary hearing officer in accordance with R.C.M. 1113, counsel for the Government shall cause such materials to be sealed so as to prevent unauthorized viewing or disclosure.

(4) *Distribution of preliminary hearing report.* The preliminary hearing officer shall promptly cause the preliminary hearing report to be delivered to the convening authority or, for hearings requested by a special trial counsel, to the special trial counsel. Counsel for the Government shall promptly cause a copy of the report to be delivered to each accused. The convening authority or, for hearings requested by a special trial counsel, the special trial counsel shall promptly determine what disposition will be made in the interest of justice and discipline in accordance with R.C.M. 401 or R.C.M. 401A.

(5) *Objections to the preliminary hearing officer's report.* Upon receipt of the report, the parties shall have five days to submit objections to the preliminary hearing officer. Any objection to the preliminary hearing report shall be made to the convening authority who directed the preliminary hearing, via the preliminary hearing officer. The objection shall be served upon the opposing party, and government counsel must provide notice of the objection to any named victim or named victim's counsel, if any. The preliminary hearing officer will forward the objections to the convening authority as soon as practicable. The convening authority may direct

that the preliminary hearing be reopened or take other action, as appropriate. For cases where a special trial counsel has exercised authority, the special trial counsel may request the convening authority reopen the preliminary hearing. Upon such request, the convening authority shall reopen the preliminary hearing. This paragraph does not prohibit a convening authority or special trial counsel from taking other action prior to the expiration of five days allotted for submitting objections. Failure to make a timely objection under this rule shall constitute waiver of the objection.

(n) *Waiver*. The accused may waive a preliminary hearing. However, the preliminary hearing may still be conducted notwithstanding the waiver. Relief from the waiver may be granted by the convening authority, a superior convening authority, or the military judge, as appropriate, for good cause shown. For offenses over which a special trial counsel has exercised authority, a special trial counsel may grant relief from the waiver. If a special trial counsel declines to grant relief from the waiver and the case is referred, the accused may request relief from the military judge."

(gg) R.C.M. 406 is amended to read as follows:

"Rule 406. Pretrial advice and special trial counsel determinations

(a) *Pretrial Advice by the Staff Judge Advocate.*

(1) *General court-martial.* Except as provided by R.C.M. 406(b), before any charge may be referred for trial by a general court-martial, it shall be submitted to the staff judge advocate of the convening authority for consideration and advice. The advice of the staff judge advocate shall include a written and signed statement which sets forth the staff judge advocate's:

(A) Conclusion with respect to whether each specification alleges an offense under the UCMJ;

(B) Conclusion with respect to whether there is probable cause to believe that the accused committed the offense charged in the specification;

(C) Conclusion with respect to whether a court-martial would have jurisdiction over the accused and the offense; and

(D) Recommendation as to the disposition that should be made of the charges and specifications by the convening authority in the interest of justice and discipline.

(2) *Special-court martial.* Subject to R.C.M. 406(b), before any charge may be referred for trial by a special court-martial, the convening authority shall consult a judge advocate on relevant legal issues. Such issues may include:

(A) Whether each specification alleges an offense under the UCMJ;

(B) Whether there is probable cause to believe the accused committed the offense(s) charged;

(C) Whether a court-martial would have jurisdiction over the accused and the offense;

(D) The form of the charges and specifications and any necessary modifications; and

(E) Any other factors relating to disposition of the charges and specifications in the interest of justice and discipline.

(b) *Special trial counsel determinations.* For all charges alleging covered offenses, and other charges over which special trial counsel has exercised authority and has not deferred, referral to a special or general court-martial may be made only by a special trial counsel and the referral must be accompanied by a special trial counsel's written determination that:

(1) each specification under a charge alleges an offense under the UCMJ;

(2) there is probable cause to believe that the accused committed the offense charged; and

(3) a court-martial would have jurisdiction over the accused and the offense.

(c) *Distribution.*

(1) Subject to R.C.M. 406(c)(2), a copy of the written advice of the staff judge advocate shall be provided to the defense if charges are referred for trial by general court-martial.

(2) For those cases over which special trial counsel exercises exclusive authority, a copy of the written determination by special trial counsel shall be provided to the defense if charges are referred for trial by general or special court-martial."

(hh) R.C.M. 406A is deleted.

(ii) R.C.M. 407(a)(1) is amended to read as follows:

"(a) *Disposition.* Except for covered offenses and any other charges over which a special trial counsel has exercised authority and has not deferred, a commander exercising general court-martial jurisdiction, when in receipt of charges, may:

(1) Dismiss any charge;

(2) Forward any charge (or, after dismissing charges, the matter) to a subordinate commander for disposition;

(3) Forward any charge to a superior commander for disposition;

(4) Subject to R.C.M. 201(f)(2)(D) and (E), 601(d), and 1301(c), refer any charge to a summary court-martial or to a special court-martial for trial;

(5) Unless otherwise prescribed by the Secretary concerned, direct a preliminary hearing under R.C.M. 405, after which additional action under this rule may be taken;

(6) Subject to R.C.M. 601(d), refer any charge to a general court-martial."

(jj) R.C.M. 407(b) is amended to read as follows:

"(b) *National security matters.*

(1) Subject to R.C.M. 407(b)(2), when in receipt of charges the trial of which the commander exercising general court-martial jurisdiction finds would probably be detrimental to the prosecution of a war or harmful to national security, that commander, unless otherwise prescribed by regulations of the Secretary concerned, shall determine whether trial is warranted and, if so, whether the security considerations involved are paramount to trial. As the commander finds appropriate, the commander may dismiss the charges, authorize trial of them, or forward them to a superior authority.

(2) For charges and specifications over which a special trial counsel has exercised authority and has not deferred and a commander believes trial would be detrimental to the prosecution of a war or harmful to national security, the matter shall be forwarded to the Secretary concerned.

(kk) A new R.C.M. 502(d)(1)(C) is inserted immediately after R.C.M. 502(d)(1)(B) to read as follows:

"(C) *Qualifications of special trial counsel.* Only judge advocates qualified, certified, and assigned as special trial counsel may be detailed as special trial counsel in general and special courts-martial. In accordance with regulations prescribed by the Secretary concerned, a special trial counsel shall be a judge advocate who is a member of the bar of a Federal court or a member of the bar of the highest court of a State; and is certified to be qualified, by reason of education, training, experience, and temperament, for duty as a special trial counsel by the Judge Advocate General of the armed force of which the officer is a member or, in the case of the Marine Corps, the Staff Judge Advocate to the Commandant of the Marine Corps. Special trial

counsel shall be well-trained, experienced, highly-skilled and competent in handling cases involving covered offenses."

(ll) R.C.M. 502(d)(3)(A) is amended to read as follows:

"(A) The accuser, except that any determination by a special trial counsel to prefer or refer charges shall not disqualify that special trial counsel;".

(mm) R.C.M. 503(a) is amended to read as follows:

"(a) *Members.*

(1) *In general.* The convening authority shall—

(A) detail qualified persons as members for courts-martial in accordance with the criteria described in Article 25;

(B) state whether the military judge is—

(i) authorized to impanel a specified number of alternate members; or

(ii) authorized to impanel alternate members only if, after the exercise of all challenges, excess members remain; and

(C) provide a list of the detailed members to the military judge to randomize in accordance with R.C.M. 911."

(nn) R.C.M. 503(c)(1) is amended to read as follows:

"(1) *By whom detailed.* Trial and defense counsel, assistant trial and defense counsel, and associate defense counsel shall be detailed in accordance with these rules and the regulations of the Secretary concerned. If authority to detail counsel has been delegated to a person, that person may detail himself or herself as counsel for a court-martial. For each general and special court-martial for which charges and specifications were referred by special trial counsel, a special trial counsel shall be detailed as trial counsel, and, in accordance with regulations prescribed by the

Secretary concerned, a special trial counsel may detail other trial counsel who are judge advocates. In a capital case, counsel learned in the law applicable to such cases under R.C.M. 502(d)(2)(C) shall be assigned in accordance with regulations of the Secretary concerned."

(oo) R.C.M. 504(b)(1) is amended to read as follows:

"(1) *General courts-martial.* Unless otherwise limited by superior competent authority, general courts-martial may be convened by persons occupying positions designated in Article 22(a) and by any commander designated by the Secretary concerned or empowered by the President. A commanding officer shall not be considered an accuser solely due to the role of the commanding officer in convening a special or general court-martial to which charges and specifications were referred by a special trial counsel."

(pp) R.C.M. 504(b)(2)(B)(i) is amended to read as follows:

"(i) In the Army, Air Force, or Space Force, by the officer exercising general court-martial jurisdiction over the command; or".

(qq) R.C.M. 505(c)(1)(A) is amended to read as follows:

"(A) *By convening authority.* Before the court-martial is assembled, the convening authority may change the members detailed to the court-martial without showing cause. New members shall be detailed in accordance with R.C.M. 503(a)."

(rr) R.C.M. 505(c)(2)(B) is amended to read as follows:

"(B) *New members.* In accordance with R.C.M. 503(a), new members may be detailed after assembly only when, as a result of excusals under R.C.M. 505(c)(2)(A), the number of members of the court-martial is reduced below the number of members required under R.C.M. 501(a), or the number of enlisted members, when the accused has made a timely written request for enlisted members, is reduced below one-third of the total membership."

(ss) R.C.M. 601 is amended to read as follows:

"Rule 601. Referral

(a) *In general.* Referral is the order of a convening authority or a special trial counsel that one or more charges and specifications against an accused will be tried by a specified court-martial.

(b) *Who may refer.*

(1) Except as provided in R.C.M. 601(b)(2), any convening authority may refer charges to a court-martial convened by that convening authority or a predecessor, unless the power to do so has been withheld by superior competent authority.

(2) For charges over which a special trial counsel has exercised authority and has not deferred, only a special trial counsel may refer charges to a court-martial.

(c) *Disqualification.*

(1) Except as provided in R.C.M. 601(c)(2), an accuser may not refer charges to a general or special court-martial.

(2) A special trial counsel shall not be disqualified from referring charges to a general or special court-martial as a result of having preferred charges or having caused charges to be preferred.

(d) *When charges may be referred.*

(1) *Basis for referral.*

(A) Except as provided in R.C.M. 601(d)(1)(B), if the convening authority finds or is advised by a judge advocate that there is probable cause to believe that an offense triable by a court-martial has been committed and that the accused committed it, and that the specification alleges an offense, the convening authority may refer it. The finding may be based on hearsay in whole or in part. The convening authority or judge advocate may consider information from any

source and shall not be limited to the information reviewed by any previous authority, but a case may not be referred to a general or special court-martial except in compliance with R.C.M. 601(d)(2) or (d)(3). The convening authority or judge advocate shall not be required before charges are referred to resolve legal issues, including objections to evidence, which may arise at trial.

(B) For offenses over which a special trial counsel has exercised authority and has not deferred, if a special trial counsel makes a written determination that each specification under a charge alleges an offense under the UCMJ, there is probable cause to believe that the accused committed the offense charged, and the court-martial would have jurisdiction over the accused and the offense, a special trial counsel may refer it. The finding may be based on hearsay in whole or in part. A special trial counsel may consider information from any source and shall not be limited to the information reviewed by any previous authority, but a case may not be referred to a general court-martial except in compliance with R.C.M. 601(d)(2) or (d)(3). A special trial counsel shall not be required before charges are referred to resolve legal issues, including objections to evidence, which may arise at trial.

(2) *Consideration.* Referral authorities shall consider whether the admissible evidence will probably be sufficient to obtain and sustain a conviction.

(3) *General courts-martial.* Charges may not be referred to a general court-martial unless there has been substantial compliance with the preliminary hearing requirements of R.C.M. 405 and:

(A) The convening authority has received the advice of the staff judge advocate required under R.C.M. 406(a)(1) and Article 34(a); or

(B) A special trial counsel has made a written determination as required under R.C.M. 406(b) and Article 34(c).

(4) *Special courts-martial.* Charges may not be referred to a special court-martial unless:

(A) The convening authority has consulted with a judge advocate as required under R.C.M. 406(a)(2) and Article 34(b); or

(B) A special trial counsel has made a written determination as required under R.C.M. 406(b) and Article 34(c).

(e) *How charges shall be referred.*

(1) *Order, instructions.* Referral shall be by the personal order of the referral authority.

(A) *Capital cases.* If a case is to be tried as a capital case, the referral authority shall so indicate by including a special instruction on the charge sheet in accordance with R.C.M. 1004(b)(1).

(B) *Special court-martial consisting of a military judge alone.* If a case is to be tried as a special court-martial consisting of a military judge alone under Article 16(c)(2)(A), the referral shall so indicate by including a special instruction on the charge sheet prior to arraignment.

(C) *Other instructions.* The referral authority may include any other additional instructions in the order as may be required.

(2) *Joinder of offenses.* In the discretion of the referral authority, two or more offenses charged against an accused may be referred to the same court-martial for trial, whether serious or minor offenses or both, regardless of whether the offenses are connected. Additional charges may be joined with other charges for a single trial at any time before arraignment if all necessary procedural requirements concerning the additional charges have been complied with. After

arraignment of the accused upon charges, no additional charges may be referred to the same trial without consent of the accused.

(3) *Joinder of accused.* Allegations against two or more accused may be referred for joint trial if the accused are alleged to have participated in the same act or transaction or in the same series of acts or transactions constituting an offense or offenses. Such accused may be charged in one or more specifications together or separately, and every accused need not be charged in each specification. Related allegations against two or more accused which may be proved by substantially the same evidence may be referred to a common trial.

(f) *Superior convening authorities.* Except as otherwise provided in these rules, a superior competent authority may cause charges, whether or not referred, to be transmitted to the authority for further consideration, including, if appropriate, referral.

(g) *Parallel convening authorities.*

(1) Except as provided in R.C.M. 601(g)(2), if it is impracticable for the original convening authority to continue exercising authority over the charges, the convening authority may cause the charges, even if referred, to be transmitted to a parallel convening authority. This transmittal must be in writing and in accordance with such regulations as the Secretary concerned may prescribe. Subsequent actions taken by the parallel convening authority are within the sole discretion of that convening authority.

(2) For offenses over which a special trial counsel has exercised authority and has not deferred, a convening authority seeking to transfer charges to a parallel convening authority may do so in accordance with these rules and such regulations prescribed by the Secretary concerned."

(tt) R.C.M. 603(a) is amended to read as follows:

"(a) *In general.* Any person forwarding, acting upon, or prosecuting charges on behalf of the United States, except a preliminary hearing officer appointed under R.C.M. 405, may make major and minor changes to charges or specifications in accordance with this rule. For charges over which a special trial counsel has exercised authority and has not deferred, only a special trial counsel may make or cause to be made major and minor changes to charges or specifications in accordance with this rule."

(uu) R.C.M. 604(a) is amended to read as follows:

"(a) *Withdrawal.*

(1) Except as provided in R.C.M. 604(a)(2), the convening authority or a superior competent authority may for any reason cause any charge or specification to be withdrawn from a court-martial at any time before findings are announced.

(2) For charges over which a special trial counsel has exercised authority and has not deferred, only a special trial counsel may withdraw or cause to be withdrawn any charge or specification from the court-martial at any time before findings are announced."

(vv) R.C.M. 701(a) is amended to read as follows:

"(a) *Disclosure by trial counsel.* Except as otherwise provided in R.C.M. 701(f) and (g)(2), and unless previously disclosed to the defense, trial counsel shall provide the following to the defense:

(1) *Papers accompanying charges; convening orders; statements.* As soon as practicable after service of charges under R.C.M. 602, the trial counsel shall provide the defense with copies of, or, if extraordinary circumstances make it impracticable to provide copies, permit the defense to inspect:

(A) All papers that accompanied the charges presented to the convening authority;

(B) Any written determination made by a special trial counsel pursuant to Article 34;

(C) Any written recommendation from a commander as to disposition;

(D) Any papers sent with charges upon a rehearing or new trial;

(E) The convening order and any amending orders; and

(F) Any sworn or signed statement relating to an offense charged in the case that is in the possession of trial counsel.

(2) *Documents, tangible objects, reports.*

(A) After service of charges, upon request of the defense, the Government shall permit the defense to inspect any books, papers, documents, data, photographs, tangible objects, buildings, or places, or copies of portions of these items, if the item is within the possession, custody, or control of military authorities and—

(i) the item is relevant to defense preparation;

(ii) the Government intends to use the item in the case-in-chief at trial;

(iii) the Government anticipates using the item in rebuttal; or

(iv) the item was obtained from or belongs to the accused.

(B) After service of charges, upon request of the defense, the Government shall permit the defense to inspect the results or reports of physical or mental examinations, and of any scientific tests or experiments, or copies thereof, which are within the possession, custody, or control of military authorities, the existence of which is known or by the exercise of due diligence may become known to the trial counsel if

(i) the item is relevant to defense preparation;

(ii) the Government intends to use the item in the case-in-chief at trial; or

(iii) the Government anticipates using the item in rebuttal.

(3) *Witnesses.* Before the beginning of trial on the merits, trial counsel shall notify the defense of the names and contact information of the witnesses the trial counsel intends to call:

(A) In the prosecution case-in-chief; and

(B) To rebut a defense of alibi, innocent ingestion, or lack of mental responsibility, when the trial counsel has received timely notice under R.C.M. 701(b)(1) or (2).

(4) *Prior convictions of accused offered on the merits.* Before arraignment, the trial counsel shall notify the defense of any records of prior civilian or court-martial convictions of the accused of which the trial counsel is aware and which the trial counsel may offer on the merits for any purpose, including impeachment, and shall permit the defense to inspect such records when they are in the trial counsel's possession.

(5) *Information to be offered at sentencing.* Upon request of the defense, the trial counsel shall:

(A) Permit the defense to inspect such written material as will be presented by the prosecution at the presentencing proceedings; and

(B) Notify the defense of the names and contact information of the witnesses the trial counsel intends to call at the presentencing proceedings under R.C.M. 1001(b).

(6) *Evidence favorable to the defense.* The trial counsel shall, as soon as practicable, disclose to the defense the existence of evidence known to the trial counsel which reasonably tends to—

(A) Negate the guilt of the accused of an offense charged;

(B) Reduce the degree of guilt of the accused of an offense charged;

(C) Reduce the punishment; or

(D) Adversely affect the credibility of any prosecution witness or evidence."

(ww) R.C.M. 701(b)(4) is amended to read as follows:

"(4) *Reports of examination and tests.* If the defense requests disclosure under R.C.M. 701(a)(2)(B), upon compliance with such request by the Government, the defense, on request of the trial counsel, shall (except as provided in R.C.M. 706, Mil. R. Evid. 302, and Mil. R. Evid. 513) permit the trial counsel to inspect the results or reports, or copies thereof, of any physical or mental examinations and of any scientific tests or experiments made in connection with the particular case if the item is within the possession, custody, or control of the defense; and—

(A) the defense intends to use the item in the defense case-in-chief at trial; or

(B) the item was prepared by a witness whom the defense counsel intends to call at trial and the results or reports relate to that witness' testimony."

(xx) R.C.M. 702(b) is amended to read as follows:

"(b) *Who may order.* Upon request of a party:

(1) Subject to R.C.M. 702(b)(2), before referral, a convening authority, or, after referral, the convening authority or the military judge, may order a deposition.

(2) For offenses over which special trial counsel exercises authority:

(i) Before referral, only a military judge may order a deposition, pursuant to R.C.M. 309(b)(3).

(ii) After referral, only a military judge may order a deposition."

(yy) R.C.M. 703(a) is amended to read as follows:

"(a) *In general.* The prosecution, defense, and court-martial shall have equal opportunity to obtain witnesses and evidence, subject to the limitations set forth in R.C.M. 701, including the benefit of compulsory process."

(zz) R.C.M. 703(d) is amended to read as follows:

"(d) *Employment of expert witnesses and consultants.*

(1) *Funding experts for the prosecution.* When the employment of a prosecution expert witness or consultant is considered necessary, counsel for the Government shall, in advance of employment of the expert, and with notice to the defense, submit a request for funding of the expert in accordance with regulations prescribed by the Secretary concerned.

(2) *Funding experts for the defense.* When the appointment or employment of a defense expert witness or consultant is considered necessary, the defense may submit a request for the appointment or funding of the expert in accordance with regulations prescribed by the Secretary concerned.

(A) After referral of charges, a defense request for an expert witness or consultant may be raised before the military judge. Motions for expert consultants may be raised *ex parte*. The military judge shall determine:

(i) in the case of an expert witness, whether the testimony is relevant and necessary;

(ii) in the case of an expert consultant, whether the assistance is necessary for an adequate defense.

(B) If the military judge grants a motion for the appointment or employment of a defense expert witness or consultant, the expert witness or consultant, or an adequate substitute, shall be provided in accordance with regulations prescribed by the Secretary concerned. In the absence of advance approval by an official authorized to grant such approval under the regulations prescribed by the Secretary concerned, expert witnesses and consultants may not be paid fees other than those to which they are entitled under R.C.M. 207(g)(3)(E).

(3) *Notice of expert witnesses.*

(A) *Expert witnesses.*

(i) *Government.* In addition to the requirements of R.C.M. 701(a)(3), the Government shall provide the defense a written summary of the expected testimony from the expert witness.

(ii) *Defense.* After referral of charges, in addition to the requirements of R.C.M. 701(b)(1), the defense shall provide the Government a written summary of the expected testimony from the expert witness.

(B) *Timing.* The military judge shall set a date upon which notices under R.C.M. 703(d)(3)(A) are due to the opposing party.

(C) *Failure to comply.* If at any time it is brought to the attention of the military judge that a party has failed to comply with this rule, the military judge may take one or more of the following actions:

(i) Order the required notice;

(ii) Order the party to permit discovery;

(iii) Grant a continuance;

(iv) Prohibit the party from introducing evidence, calling a witness, or raising a defense not disclosed; and

(v) Enter such other order as is just under the circumstances."

(aaa) R.C.M. 703(g)(3) is amended to read as follows:

"(3) *Civilian witnesses and evidence not under the control of the Government—subpoenas.*

(A) *In general.* The presence of witnesses not on active duty and evidence not under control of the Government may be obtained by subpoena.

(B) *Contents.* A subpoena shall state the command by which the proceeding or investigation is directed, and the title, if any, of the proceeding. A subpoena shall command each person to whom it is directed to attend and give testimony at the time and place specified therein, or to produce evidence—including books, papers, documents, data, writings, or other objects or electronically stored information designated therein at the proceeding or at an earlier time for inspection by the parties. A subpoena shall not command any person to attend or give testimony at an Article 32 preliminary hearing.

(C) *Investigative subpoenas.*

(i) *In general.* In the case of a subpoena issued before referral for the production of evidence for use in an investigation, the subpoena shall command each person to whom it is directed to produce the evidence requested for inspection by the Government counsel who issued the subpoena or for inspection in accordance with an order issued by the military judge under R.C.M. 309(b).

(ii) *Subpoenas for personal or confidential information about a victim.* After preferral, a subpoena requiring the production of personal or confidential information about a victim named in a specification may be served on an individual or organization by those authorized to issue a subpoena under R.C.M. 703(g)(3)(E) or with the consent of the victim. Before issuing a subpoena under this provision and unless there are exceptional circumstances, the victim must be given notice so that the victim can move for relief under R.C.M 703(g)(3)(I) or otherwise object.

(D) *Ex parte request by defense.* Upon request by the defense after referral, including an *ex parte* request, the military judge shall issue a subpoena to compel the production of witnesses if the witness's testimony is determined to be relevant and necessary.

(E) *Who may issue.* A subpoena may be issued by:

(i) the military judge, after referral;

(ii) the summary court-martial;

(iii) the trial counsel of a general or special court-martial;

(iv) the president of a court of inquiry;

(v) an officer detailed to take a deposition; or

(vi) in the case of a pre-referral investigative subpoena, a military judge or, when issuance of the subpoena is authorized by a general court-martial convening authority, the detailed trial counsel or counsel for the Government.

(F) *Notice.* Notice shall be given to all parties for any subpoena issued for a witness post-referral unless, for good cause, the military judge issues a protective order.

(G) *Service.* A subpoena may be served by the person authorized by this rule to issue it, a United States Marshal, or any other person who is not less than 18 years of age. Service shall be made by delivering a copy of the subpoena to the person named and, in the case of a subpoena of an individual to provide testimony, by providing to the person named travel orders and a means for reimbursement for fees and mileage as may be prescribed by the Secretary concerned, or in the case of hardship resulting in the subpoenaed witness's inability to comply with the subpoena absent initial Government payment, by providing to the person named travel orders, fees, and mileage sufficient to comply with the subpoena in rules prescribed by the Secretary concerned.

(H) *Place of service.*

(i) *In general.* A subpoena may be served at any place within the United States, its Territories, Commonwealths, or possessions.

(ii) *Foreign territory.* In foreign territory, the attendance of civilian witnesses and evidence not under the control of the Government may be obtained in accordance with existing agreements or, in the absence of agreements, with principles of international law.

(iii) *Occupied territory.* In occupied enemy territory, the appropriate commander may compel the attendance of civilian witnesses located within the occupied territory.

(I) *Relief.* If a person subpoenaed requests relief on grounds that compliance is unreasonable, oppressive, or prohibited by law, the military judge or, if before referral, a military judge detailed under Article 30a, shall review the request and shall—

(i) order that the subpoena be modified or quashed, as appropriate; or

(ii) order the person to comply with the subpoena.

(J) *Neglect or refusal to appear or produce evidence.*

(i) *Issuance of warrant of attachment.* If the person subpoenaed neglects or refuses to appear or produce evidence, the military judge or, if before referral, a military judge detailed under Article 30a or a general court-martial convening authority, may issue a warrant of attachment to compel the attendance of a witness or the production of evidence, as appropriate.

(ii) *Requirements.* A warrant of attachment may be issued only upon probable cause to believe that the witness or evidence custodian was duly served with a subpoena, that the subpoena was issued in accordance with these rules, that a means of reimbursement of fees and mileage, if applicable, was provided to the witness or advanced to the

witness in cases of hardship, that the witness or evidence is material, that the witness or evidence custodian refused or willfully neglected to appear or produce the subpoenaed evidence at the time and place specified on the subpoena, and that no valid excuse is reasonably apparent for the witness' failure to appear or produce the subpoenaed evidence.

(iii) *Form.* A warrant of attachment shall be written. All documents in support of the warrant of attachment shall be attached to the warrant, together with the charge sheet and convening orders.

(iv) *Execution.* A warrant of attachment may be executed by a United States Marshal or such other person who is not less than 18 years of age as the authority issuing the warrant may direct. Only such non-deadly force as may be necessary to bring the witness before the court-martial or other proceeding or to compel production of the subpoenaed evidence may be used to execute the warrant. A witness attached under this rule shall be brought before the court-martial or proceeding without delay and shall testify or provide the subpoenaed evidence as soon as practicable and be released.

(v) *Definition.* For purposes of R.C.M. 703(g)(3)(J)(i), "military judge" does not include a summary court-martial."

(bbb) R.C.M. 704(c) is amended to read as follows:

"(c) *Authority to grant immunity.*

(1) Except as provided in R.C.M. 704(c)(2), a general court-martial convening authority, or designee, may grant immunity, and may do so only in accordance with this rule.

(2) For offenses over which a special trial counsel has exercised authority and has not deferred, a special trial counsel designated by the Secretary concerned, or that designated special trial counsel's designee, may grant immunity, and may do so only in accordance with this rule.

(3) *Persons subject to the UCMJ.* A general court-martial convening authority, a special trial counsel designated by the Secretary concerned, or their designees, may grant immunity to a person subject to the UCMJ. However, they may grant immunity to a person subject to the UCMJ extending to a prosecution in a United States District Court only when specifically authorized to do so by the Attorney General of the United States or other authority designated under chapter 601 of title 18 of the U.S. Code.

(4) *Persons not subject to the UCMJ.* A general court-martial convening authority, a special trial counsel designated by the Secretary concerned, or their designees, may grant immunity to persons not subject to the UCMJ only when specifically authorized to do so by the Attorney General of the United States or other authority designated in chapter 601 of title 18 of the U.S. Code.

(5) *Limitations on delegation.*

(A) Subject to Service regulations, the authority to grant immunity under this rule may be delegated in writing at the discretion of the general court-martial convening authority to a subordinate special court-martial convening authority. Further delegation is not permitted. The authority to grant immunity or delegate the authority to grant immunity may be limited by superior authority.

(B) Subject to Service regulations, the authority to grant immunity under this rule may be delegated at the discretion of a special trial counsel designated by the Secretary concerned to a subordinate special trial counsel. The authority to grant immunity or delegate the authority to grant immunity may be limited by superior authority. Any delegation shall be in writing."

(ccc) R.C.M. 704(d) is amended to read as follows:

"(d) *Procedure.*

(1) A grant of immunity shall be written and signed by the individual convening authority, special trial counsel designated by the Secretary concerned, or designee who issues it. The grant shall include a statement of the authority under which it is made and shall identify the matters to which it extends.

(2) Subject to Service regulations, the convening authority shall order a person subject to the UCMJ who has received a grant of immunity, to answer questions by investigators or to testify or answer questions by counsel pursuant to that grant of immunity."

(ddd) R.C.M. 704(e) is amended to read as follows:

"(e) *Decision to grant immunity.* Unless limited by superior competent authority, the decision to grant immunity is a matter within the sole discretion of the general court-martial convening authority, special trial counsel designated by the Secretary concerned, as applicable, or their designees. However, if a defense request to immunize a witness has been denied, the military judge may, upon motion by the defense, grant appropriate relief directing that either an appropriate convening authority or special trial counsel designated by the Secretary concerned, as applicable, grant testimonial immunity to a defense witness or, as to the affected charges and specifications, the proceedings against the accused be abated, upon findings that:

(1) The witness intends to invoke the right against self-incrimination to the extent permitted by law if called to testify;

(2) The Government has engaged in discriminatory use of immunity to obtain a tactical advantage, or the Government through its own overreaching, has forced the witness to invoke the privilege against self-incrimination; and

(3) The witness' testimony is material, clearly exculpatory, not cumulative, not obtainable from any other source, and does more than merely affect the credibility of other witnesses."

(eee) R.C.M. 705(a) is revised to read as follows:

"(a) *In general.* Subject to such limitations as the Secretary concerned may prescribe, an accused and the convening authority or the accused and special trial counsel, as applicable, may enter into a plea agreement in accordance with this rule. In cases over which special trial counsel has exercised authority and has not deferred, an agreement may only be entered into between special trial counsel and the accused; however, any such agreement may bind convening authorities and other commanders subject to such limitations as prescribed by the Secretary concerned."

(fff) R.C.M. 705(b) is amended to read as follows:

"(b) *Nature of agreement.* A plea agreement may include:

(1) A promise by the accused to plead guilty to, or to enter a confessional stipulation as to, one or more charges and specifications, and to fulfill such additional terms or conditions that may be included in the agreement and that are not prohibited under this rule; and

(2) A promise by the convening authority or special trial counsel, as applicable, to do one or more of the following:

(A) Refer the charges to a certain type of court-martial;

(B) Refer a capital offense as noncapital;

(C) Withdraw one or more charges or specifications from the court-martial;

(D) Have trial counsel present no evidence as to one or more specifications or portions thereof; and

(E) Limit the sentence that may be adjudged by the court-martial for one or more charges and specifications in accordance with R.C.M. 705(d); or

(3) A promise by either the convening authority or special trial counsel to take other action within their authority."

(ggg) R.C.M. 705(c)(2) is amended to read as follows:

"(2) *Permissible terms and conditions.* R.C.M. 705(c)(1)(A) and (1)(B) do not prohibit the convening authority, special trial counsel, or the accused from proposing the following additional conditions:

(A) A promise to enter into a stipulation of fact concerning offenses to which a plea of guilty or to which a confessional stipulation will be entered;

(B) A promise to testify as a witness in the trial of another person;

(C) A promise to provide restitution;

(D) A promise to conform the accused's conduct to certain conditions of probation before action by the convening authority in a summary court-martial or before entry of judgment in a general or special court-martial as well as during any period of suspension of the sentence, provided that the requirements of R.C.M. 1108 must be complied with before an alleged violation of such terms may relieve the Government of the obligation to fulfill the agreement;

(E) A promise to waive procedural requirements such as the Article 32 preliminary hearing, the right to trial by a court-martial composed of members, the right to request trial by military judge alone, the right to elect sentencing by members if applicable, or the opportunity to obtain the personal appearance of witnesses at presentencing proceedings;

(F) When applicable, a provision requiring that the sentences to confinement adjudged by the military judge for two or more charges or specifications be served concurrently or consecutively. Such an agreement shall identify the charges or specifications that will be served concurrently or consecutively; and

(G) Any other term or condition that is not contrary to or inconsistent with this rule."

(hhh) R.C.M. 705(e)(3) is amended to read as follows:

"(3) *Acceptance by the convening authority or special trial counsel.*

(A) *In general.* The convening authority or special trial counsel, as applicable, may either accept or reject an offer of the accused to enter into a plea agreement or may propose by counteroffer any terms or conditions not prohibited by law or public policy. The decision whether to accept or reject an offer is within the sole discretion of the convening authority or special trial counsel, as applicable. When the convening authority has accepted a plea agreement, the agreement shall be signed by the convening authority or by a person, such as the staff judge advocate or trial counsel, who has been authorized by the convening authority to sign. When special trial counsel has accepted a plea agreement, the agreement shall be signed by special trial counsel.

(B) *Victim consultation.* Prior to the convening authority or special trial counsel, as applicable, accepting a plea agreement, the convening authority or special trial counsel shall make the convening authority's or special trial counsel's best efforts to provide the victim an opportunity to submit views concerning the plea agreement terms and conditions in accordance with regulations prescribed by the Secretary concerned. The convening authority or special trial counsel, as applicable, shall consider any such views provided prior to accepting a plea

agreement. For purposes of this rule, a "victim" is an individual who is alleged to have suffered direct physical, emotional, or pecuniary harm as a result of the matters set forth in a charge or specification under consideration and is named in one of the specifications under consideration."

(iii) R.C.M. 705(e)(4) is amended to read as follows:

"(4) *Withdrawal.*

(A) *By accused.* The accused may withdraw from a plea agreement at any time prior to the sentence being announced. If the accused elects to withdraw from the plea agreement after the acceptance of the plea agreement but before the sentence is announced, the military judge shall permit the accused to withdraw only for good cause shown. Additionally, the accused may withdraw a plea of guilty or a confessional stipulation entered pursuant to a plea agreement only as provided in R.C.M. 910(h) or 811(d).

(B) *By convening authority or special trial counsel.* The convening authority or special trial counsel, as applicable, may withdraw from a plea agreement at any time:

(i) before substantial performance by the accused of promises contained in the agreement;

(ii) upon the failure by the accused to fulfill any material promise or condition in the agreement;

(iii) when inquiry by the military judge discloses a disagreement as to a material term in the agreement; or

(iv) if findings are set aside because a plea of guilty entered pursuant to the agreement is held improvident on appellate review."

(jjj) R.C.M. 706(b)(1) is amended to read as follows:

"(1) *Before referral.* Before referral of charges, an inquiry into the mental capacity or mental responsibility of the accused may be ordered by any applicable convening authority, or by a military judge or magistrate in a proceeding conducted in accordance with R.C.M. 309."

(kkk) R.C.M. 706(b)(2) is amended to read as follows:

"(2) *After referral.* After referral of charges, an inquiry into the mental capacity or mental responsibility of the accused may be ordered by the military judge. The convening authority may order such an inquiry after referral of charges but before beginning of the first session of the court-martial (including any Article 39(a) session) when the military judge is not reasonably available. The military judge may order a mental examination of the accused regardless of any earlier determination by any authority."

(lll) R.C.M. 707(b)(3)(D) is amended to read as follows:

"(D) *Rehearings.* If a rehearing is ordered or authorized by an appellate court, a new 120-day time period under this rule shall begin on the date that the responsible convening authority or, for charges and specifications referred by a special trial counsel, the special trial counsel receives the record of trial and the opinion authorizing or directing a rehearing. An accused is brought to trial within the meaning of this rule at the time of arraignment under R.C.M. 904 or, if arraignment is not required (such as in the case of a sentence-only rehearing), at the time of the first session under R.C.M. 803."

(mmm) R.C.M. 707(c)(1) is amended to read as follows:

"(1) *Procedure.* Prior to referral, all requests for pretrial delay, together with supporting reasons and with notice to the defense, will be submitted to a convening authority with authority over the accused for resolution. The convening authority may delegate this authority to an

Article 32 preliminary hearing officer. After referral, such requests for pretrial delay will be submitted to the military judge for resolution."

(nnn) R.C.M. 707(d)(1) is amended to read as follows:

"(1) *Dismissal.* Dismissal will be with or without prejudice to the Government's right to reinstitute court-martial proceedings against the accused for the same offense at a later date. The charges must be dismissed with prejudice where the accused has been deprived of his or her constitutional right to a speedy trial. In determining whether to dismiss charges with or without prejudice, the court shall consider, among others, each of the following factors: the seriousness of the offense; the facts and circumstances of the case that lead to dismissal; the impact of a re-prosecution on the administration of justice; and any prejudice to the accused resulting from the denial of a speedy trial."

(ooo) R.C.M. 707(f) is amended as follows:

"(f) *Priority.* When considering the disposition of charges and the ordering of trials, a convening authority or special trial counsel shall give priority to cases in which the accused is held under those forms of pretrial restraint defined by R.C.M. 304(a)(3)-(4). Trial of or other disposition of charges against any accused held in arrest or confinement pending trial shall be given priority."

(ppp) R.C.M. 804 is amended to read as follows:

"Rule 804. Presence at court-martial proceedings

(a) *Accused.*

(1) *Presence required.* The accused shall be present at the arraignment, the time of the plea, every stage of the trial including sessions conducted under Article 39(a), voir dire and challenges of members, the return of the findings, presentencing proceedings, and post-trial sessions, if any, except as otherwise provided by this rule. Attendance at these proceedings shall

constitute the accused's appointed place of duty and, with respect to the accused's travel allowances, none of these proceedings shall constitute disciplinary action. This does not in any way limit authority to implement restriction, up to and including confinement, as necessary in accordance with R.C.M. 304 or R.C.M. 305.

(A) *Appearance.* The accused shall be properly attired in the uniform or dress prescribed by the military judge. An accused service member shall wear the insignia of grade and may wear any decorations, emblems, or ribbons to which the accused is entitled. The accused and defense counsel are responsible for ensuring that the accused is properly attired; however, upon request, the accused's commander shall render such assistance as may be reasonably necessary to ensure that the accused is properly attired.

(B) *Custody.* Responsibility for maintaining custody or control of an accused before and during trial may be assigned, subject to R.C.M. 304 and 305, and R.C.M. 804(c)(3), under such regulations as the Secretary concerned may prescribe.

(C) *Restraint.* Physical restraint shall not be imposed on the accused during open sessions of the court-martial unless prescribed by the military judge.

(2) *Continuation of proceeding without presence.* The further progress of the trial to and including the return of the findings and, if necessary, determination of a sentence shall not be prevented and the accused shall be considered to have waived the right to be present whenever an accused, initially present:

(A) Is voluntarily absent after arraignment (whether or not informed by the military judge of the obligation to remain during the trial); or

(B) After being warned by the military judge that disruptive conduct will cause the accused to be removed from the courtroom, persists in conduct which is such as to justify exclusion from the courtroom.

(3) *Remote presence of the accused.*

(A) Except as provided in R.C.M. 804(a)(3)(B), for Article 39(a) sessions, the military judge may order the accused be present via remote means through the use of audiovisual technology. Use of such audiovisual technology will satisfy the "presence" requirement of the accused only when the accused has a defense counsel physically present at the accused's location or when the accused consents to presence by remote means with the opportunity for confidential consultation with defense counsel during the proceeding. Such technology may include two or more remote sites as long as all parties can see and hear each other.

(B) The accused may be present via remote means through the use of audiovisual technology for a plea inquiry under R.C.M. 910(d), (e) and (f), and presentencing proceedings before a military judge under R.C.M. 1001, only when there are exceptional circumstances that interfere with the normal administration of military justice, as determined by the military judge. The accused must consent to the use of audiovisual technology and defense counsel must be physically present at the accused's location for the hearing.

(4) *Voluntary absence for limited purpose of child testimony.*

(A) *Election by accused.* Following a determination by the military judge that remote live testimony of a child is appropriate pursuant to Mil. R. Evid. 611(d)(3), the accused may elect to be voluntarily absent from the courtroom in order to preclude the use of procedures described in R.C.M. 914A.

(B) *Procedure.* The accused's absence will be conditional upon the accused being able to view the witness' testimony from a remote location. Normally, transmission of the testimony will include a system that will transmit the accused's image and voice into the courtroom from a remote location as well as transmission of the child's testimony from the courtroom to the accused's location. A one-way transmission may be used if deemed necessary by the military judge. The accused will also be provided private, contemporaneous communication with his counsel. The procedures described herein shall be employed unless the accused has made a knowing and affirmative waiver of these procedures.

(C) *Effect on accused's rights generally.* An election by the accused to be absent pursuant to R.C.M. 804(a)(4)(A) shall not otherwise affect the accused's right to be present at the remainder of the trial in accordance with this rule.

(b) *Military judge.*

(1) No court-martial proceeding, except the deliberations of the members, may take place in the absence of the military judge. The military judge may attend Article 39(a) sessions via remote means through the use of audiovisual technology.

(2) When a new military judge is detailed under R.C.M. 505(e)(2) after the presentation of evidence on the merits has begun in a trial before a military judge alone, trial may not proceed unless the accused requests, and the new military judge approves, trial by military judge alone, and a verbatim record of the testimony and evidence or a stipulation thereof is read to or played for the new military judge in the presence of the accused and counsel for both sides, or the trial proceeds as if no evidence had been presented.

(c) *Members.*

(1) Unless the accused is tried or sentenced by military judge alone, no court-martial proceeding may take place in the absence of any detailed member except: Article 39(a) sessions under R.C.M. 803; temporary excusal under R.C.M. 911(b); examination of members under R.C.M. 912(d); when the member has been excused under R.C.M. 505, 912(f), or 912A; as otherwise provided in R.C.M. 1104(d)(1); or as otherwise provided in this Manual.

(2) When after presentation of evidence on the merits has begun, a new member is impaneled under R.C.M. 912A, trial may not proceed unless the testimony and evidence previously admitted on the merits, if recorded verbatim, is read to or played for the new member in the presence of the military judge, the accused, and counsel for both sides, or, if not recorded verbatim, and in the absence of a stipulation as to such testimony and evidence, the trial proceeds as if no evidence has been presented.

(d) *Counsel.* As long as at least one qualified counsel for each party is present, other counsel for each party may be absent from a court-martial session. In the case of a court-martial requiring the detailing of a special trial counsel, the presence of a special trial counsel is required unless a special trial counsel determines otherwise and another trial counsel, who is qualified according to Article 27(b), is also present. An assistant counsel who lacks the qualifications necessary to serve as counsel for a party may not act at a session in the absence of such qualified counsel. For purposes of Article 39(a) sessions and subject to R.C.M. 804(a)(3), the presence of counsel may be satisfied via remote means through the use of audiovisual technology.

(e) *Victim and Victim's Counsel.* Subject to R.C.M. 914B, at the discretion of the military judge and for good cause, the victim and victim's counsel may be present through the use of audiovisual technology."

(qqq) R.C.M. 805 is amended to read as follows:

"Rule 805. [Reserved]".

(rrr) R.C.M. 810(a)(4) is amended to read as follows:

"(4) *Additional charges.* A referral authority may refer additional charges for trial together with charges as to which a rehearing has been directed."

(sss) R.C.M. 810(a)(5) is amended to read as follows:

"(5) *Rehearing impracticable.* If a rehearing was authorized on one or more findings, the convening authority, or in cases referred by a special trial counsel, a special trial counsel, may dismiss the affected charges if the referral authority determines that a rehearing is impracticable. If the referral authority dismisses such charges, a rehearing may proceed on any remaining charges not dismissed by the referral authority."

(ttt) R.C.M. 810(f)(1) is amended to read as follows:

"(1) *In general.* A Court of Criminal Appeals may order a remand for additional fact finding, or for other reasons, in order to address a substantial issue on appeal. A remand under this subsection is generally not appropriate to determine facts or investigate matters which could, through a party's exercise of reasonable diligence, have been investigated or considered at trial. Such orders shall be directed to the Chief Trial Judge. The Judge Advocate General, or the Judge Advocate General's delegate, shall designate a general court-martial convening authority who shall provide support for the hearing. In cases which were referred by a special trial counsel, a special trial counsel designated under regulations prescribed by the Secretary concerned shall be notified of any remand."

(uuu) R.C.M. 810(f)(3) is amended to read as follows:

"(3) *Remand impracticable.* If the general court-martial convening authority designated under R.C.M. 810(f)(1) or, in cases which were referred by a special trial counsel, a special trial

counsel determines that the remand is impracticable due to military exigencies or other reasons, a Government appellate attorney shall notify the Court of Criminal Appeals. Upon receipt of such notification, the Court of Criminal Appeals may take any action authorized by law that does not materially prejudice the substantial rights of the accused."

(vvv) R.C.M. 902(b)(3) is amended to read as follows:

"(3) Where the military judge has been or will be a witness in the same case; is the accuser; has forwarded charges in the case with a personal recommendation as to disposition; has referred charges in the case; or, except in the performance of duties as military judge in a previous trial of the same or a related case, has expressed an opinion concerning the guilt or innocence of the accused."

(www) R.C.M. 905(e)(2) is amended to read as follows:

"(2) Other motions, requests, defenses, or objections, except lack of jurisdiction, must be raised before the court-martial is adjourned for that case. Failure to raise such other motions, requests, defenses, or objections shall constitute forfeiture, absent an affirmative waiver."

(xxx) R.C.M. 906(b)(3) is amended to read as follows:

"(3) *Corrections.* Correction of defects in the Article 32 preliminary hearing, pretrial advice, or a written determination by special trial counsel."

(yyy) R.C.M. 906(b)(5) is amended to read as follows:

"(5) *Severance of specifications.* Severance of a duplicitous specification into two or more specifications."

(zzz) R.C.M. 906(b)(7) is amended to read as follows:

"(7) *Discovery and Production.* Discovery and production of evidence and witnesses."

(aaaa) R.C.M. 906(b)(9) is amended to read as follows:

"(9) *Severance of multiple accused.* Severance of multiple accused, if it appears that an accused or the Government is prejudiced by a joint or common trial. In a common trial, a severance shall be granted whenever any accused, other than the moving accused, faces charges unrelated to those charged against the moving accused."

(bbbb) R.C.M. 906(b)(13) is amended to read as follows:

"(13) *Admissibility.* Preliminary ruling on admissibility of evidence."

(cccc) R.C.M. 906(b)(14) is amended to read as follows:

"(14) *Mental capacity or responsibility.* Motions relating to mental capacity or responsibility of the accused."

(dddd) Rule 908(b)(6) is amended to read as follows:

"(6) *Forwarding.* Upon written notice to the military judge under R.C.M. 908(b)(3), the trial counsel shall promptly and by expeditious means forward the appeal to a representative of the Government designated by the Judge Advocate General. The matter forwarded shall include: a statement of the issues appealed; the record of the proceedings or, if preparation of the record has not been completed, a summary of the evidence; and such other matters as the Secretary concerned may prescribe."

(eeee) Rule 908(b)(7) is amended to read as follows:

"(7) *Appeal filed.*

(A) In cases over which a special trial counsel exercises authority, the decision to appeal shall be made by:

(i) if within the Department of Defense, a Lead Special Trial Counsel; or

(ii) if within the Coast Guard, a special trial counsel designated under regulations by the Secretary concerned.

(B) For all other cases, the person designated by the Judge Advocate General shall promptly decide whether to file the appeal with the Court of Criminal Appeals and notify trial counsel of that decision.

(C) If the United States elects to file an appeal, it shall be filed directly with the Court of Criminal Appeals, in accordance with the rules of that court.

(D) In all cases, a representative of the Government designated by the Judge Advocate General will be responsible for the substance and content of submissions to the Court of Criminal Appeals. For appeals in cases over which a special trial counsel exercises authority, the designated representative of the Government will consult with the special trial counsel who authorized the appeal or that special trial counsel's designee concerning the substance and content of appellate filings."

(ffff) R.C.M. 908(c)(3) is amended to read as follows:

"(3) *Action following decision of Court of Criminal Appeals.* After the Court of Criminal Appeals has decided any appeal under Article 62, the accused may petition for review by the Court of Appeals for the Armed Forces, or the Judge Advocate General may certify a case to the Court of Appeals for the Armed Forces. The parties shall be notified of the decision of the Court of Criminal Appeals promptly. If the decision is adverse to the accused, the accused shall be notified of the decision and of the right to petition the Court of Appeals for the Armed Forces for review within 60 days. Such notification shall be made orally on the record at the court-martial or in accordance with R.C.M. 1203(d). If the accused is notified orally on the record, trial counsel shall forward by expeditious means a certificate that the accused was so notified to the Judge Advocate General, who shall forward a copy to the clerk of the Court of Appeals for the Armed Forces when required by the Court. If the decision by the Court of Criminal Appeals

permits it, the court-martial may proceed as to the affected charges and specifications pending further review by the Court of Appeals for the Armed Forces or the Supreme Court, unless either court orders the proceedings stayed. Unless the case is reviewed by the Court of Appeals for the Armed Forces, it shall be returned to the military judge or the convening authority for appropriate action in accordance with the decision of the Court of Criminal Appeals. If the case is reviewed by the Court of Appeals for the Armed Forces, R.C.M. 1204 and 1205 shall apply.

(gggg) R.C.M. 909(c) is revised to read as follows:

"(c) *Determination before referral.*

(1) For offenses over which special trial counsel has not exercised authority or has deferred, if an inquiry pursuant to R.C.M. 706 conducted before referral concludes that an accused is suffering from a mental disease or defect that renders him or her mentally incompetent to stand trial, the convening authority before whom the charges are pending for disposition may disagree with the conclusion and take any action authorized under R.C.M. 401, including referral of the charges to trial. If that convening authority concurs with the conclusion, the convening authority shall forward the charges to the general court-martial convening authority. If, upon receipt of the charges, the general court-martial convening authority similarly concurs, then the general court-martial convening authority shall commit the accused to the custody of the Attorney General. If the general court-martial convening authority does not concur, that authority may take any action that he or she deems appropriate in accordance with R.C.M. 407, including referral of the charges to trial.

(2) For offenses over which special trial counsel has exercised authority and has not deferred, if an inquiry pursuant to R.C.M. 706 conducted before referral concludes that an accused is suffering from a mental disease or defect that renders him or her mentally

incompetent to stand trial, the general court-martial convening authority may disagree with the conclusion and notify special trial counsel who may take any action authorized under R.C.M. 401A, including referral of charges. If the general court-martial convening authority concurs with the conclusion, that authority shall notify special trial counsel and commit the accused to the custody of the Attorney General.

(3) Upon request of the Government or the accused, a military judge may conduct a hearing to determine the mental capacity of the accused in accordance with R.C.M. 309 and R.C.M. 909(e) at any time prior to referral."

(hhhh) R.C.M. 909(g) is amended to read as follows:

"(g) *Excludable delay.* All periods of commitment shall be excluded as provided by R.C.M. 707(c). The 120-day time period under R.C.M. 707 shall begin anew on the date the general court-martial convening authority takes custody of the accused at the end of any period of commitment. For offenses over which a special trial counsel has exercised authority and not deferred, the general court-martial convening authority shall immediately notify a special trial counsel in accordance with regulations prescribed by the Secretary concerned."

(iiii) R.C.M. 910(a) is amended to read as follows:

"(a) *Types of pleas.*

(1) *In general.* An accused may plead as follows:

(A) guilty;

(B) not guilty of an offense as charged, but guilty of a named lesser included offense;

(C) guilty with exceptions, with or without substitutions, not guilty of the exceptions, but guilty of the substitutions, if any; or

(D) not guilty."

(jjjj) R.C.M. 911 is amended to read as follows:

"Rule 911. Randomization and assembly of the court-martial panel

(a) Prior to assembly of the court-martial, at an open session of the court-martial, the military judge, or a designee thereof, shall randomly assign numbers to the members detailed by the convening authority.

(b) The military judge shall determine, after accounting for any excusals by the convening authority or designee, how many members detailed by the convening authority must be present at the initial session for which members are required. The required number of members shall be present, according to the randomly assigned order determined pursuant to R.C.M. 911(a). The military judge may temporarily excuse any member who has been detailed but is not required to be present.

(c) At the initial session for which members are required, the military judge shall cause the members who are present to be sworn, account on the record for any members who are temporarily excused, and then announce assembly of the court-martial.

(d) The military judge shall ensure any additional member is sworn at the first court session at which the member is present."

(kkkk) R.C.M. 912(f)(5) is deleted.

(llll) R.C.M. 912(g) is amended to read as follows:

"(g) *Peremptory challenges.*

(1) *Procedure.* Each party may challenge one member peremptorily. Any member so challenged shall be excused. No party may be required to exercise a peremptory challenge before the examination of members and determination of any challenges for cause have been completed.

Ordinarily, trial counsel shall enter any peremptory challenge before the defense. No member may be impaneled without being subject to peremptory challenge.

(2) *Additional Members.* If members not previously subject to peremptory challenge are required, the procedures in R.C.M. 912(g)(1) shall be followed with respect to such members.

(3) *Waiver.* Failure to exercise a peremptory challenge when properly called upon to do so shall waive the right to make such a challenge. The military judge may, for good cause shown, grant relief from the waiver, but a peremptory challenge may not be made after the presentation of evidence before the members has begun. However, nothing in this subsection shall bar the exercise of a peremptory challenge against a member newly detailed under R.C.M. 505(c)(2)(B), even if presentation of evidence on the merits has begun."

(mmmm) R.C.M. 912A is amended to read as follows:

"Rule 912A. Impaneling members and alternate members

(a) *In general.* After challenges for cause and peremptory challenges are exercised, the military judge of a general or special court-martial with members shall impanel the members based on the order assigned in R.C.M. 911(a), and, if authorized by the convening authority, alternate members, in accordance with the following numerical requirements:

(1) *Capital cases.* In a general court-martial in which the charges were referred with a special instruction that the case be tried as a capital case, the number of members impaneled, subject to R.C.M. 912A(a)(4), shall be twelve.

(2) *General courts-martial.* In a general court-martial other than as described in R.C.M. 912A(a)(1), the number of members impaneled, subject to R.C.M. 912A(a)(4), shall be eight.

(3) *Special courts-martial.* In a special court-martial, the number of members impaneled, subject to R.C.M. 912A(a)(4), shall be four.

(4) *Alternate members.* A convening authority may authorize the military judge to impanel alternate members. When authorized by the convening authority, the military judge shall designate which of the impaneled members are alternate members in accordance with these rules and consistent with the instructions of the convening authority. Alternate members shall not be notified that they are alternate members until they are excused prior to deliberations on findings.

(A) If the convening authority authorizes the military judge to impanel a specific number of alternate members, the number of members impaneled shall be the number of members required under R.C.M. 912A(a)(1), (2), or (3), as applicable, plus the number of alternate members specified by the convening authority. The military judge shall not impanel the court-martial until the specified number of alternate members has been identified. New members may be detailed in order to impanel the specified number of alternate members.

(B) If the convening authority does not authorize the military judge to impanel a specific number of alternate members, and instead authorizes the military judge to impanel alternate members only if, after the exercise of all challenges, excess members remain, the number of members impaneled shall be the number of members required under R.C.M. 912A(a)(1), (2), or (3) and no more than three alternate members. New members shall not be detailed in order to impanel alternate members.

(b) *Enlisted accused.* In the case of an enlisted accused, the members shall be impaneled under R.C.M. 912A(a) in such numbers and proportion that—

(1) If the accused elected to be tried by a court-martial composed of at least one-third enlisted members, the membership of the panel includes at least one-third enlisted members; and

(2) If the accused elected to be tried by a court-martial composed of all officer members, the membership of the panel includes all officer members.

(c) *Number of members insufficient.*

(1) If, after challenges or excusals, the number of detailed members directed to be present by the military judge in accordance with R.C.M. 911(b) is:

(A) fewer than the number of members required for the court-martial under R.C.M. 912A(a), the military judge shall, according to the randomly assigned order determined pursuant to R.C.M. 911(a), determine how many additional detailed members are required and shall direct their presence for member examination in accordance with R.C.M. 912(d).

(B) fewer than the number of members required for the court-martial under R.C.M. 912A(b), the military judge shall, according to the randomly assigned order determined pursuant to R.C.M. 911(a), determine how many additional detailed enlisted members are required and shall direct their presence for member examination in accordance with R.C.M. 912(d).

(2) If, after challenges or excusals, the number of detailed members remaining is fewer than the number of members required for the court-martial under R.C.M. 912A(a) and (b), the convening authority shall detail new members under R.C.M. 503.

(d) *Impaneling members following the exercise of all challenges.* The military judge shall use the following procedures to identify the members who will be impaneled—

(1) In a case in which the accused has elected to be tried by a panel consisting of at least one-third enlisted members under R.C.M. 503(a)(2), the military judge shall:

(A) first identify the one-third enlisted members required under R.C.M. 912A(a) and (b) in numerical order beginning with the lowest random number assigned pursuant to R.C.M. 911(a); and

(B) then identify the remaining members required for the court-martial under

R.C.M. 912A(a) and (b), in numerical order beginning with the lowest random number assigned pursuant to R.C.M. 911(a).

(2) For all other panels, the military judge shall identify the number of members required under R.C.M. 912A(a) and (b) in numerical order beginning with the lowest random number assigned pursuant to R.C.M. 911(a).

(3) If the convening authority:

(A) Authorizes the military judge to impanel a specific number of alternate members, the specified number of alternate members shall be identified in numerical order beginning with the lowest remaining random number assigned pursuant to R.C.M. 911(a), after first identifying members under R.C.M. 912A(d)(1) or (2).

(B) Does not authorize the military judge to impanel a specific number of alternate members, and instead authorizes the military judge to impanel alternate members only if, after the exercise of all challenges, excess members remain, alternate members shall be identified in numerical order beginning with the lowest remaining random number assigned pursuant to R.C.M. 911(a), after first identifying the members under 912A(d)(1) or (2). The military judge shall identify no more than three alternate members.

(C) In a case in which the accused has elected to be tried by a panel consisting of at least one-third enlisted members under R.C.M. 503(a)(2), the convening authority may instruct the military judge to prioritize impaneling a specific number of alternate enlisted members before impaneling alternate officer members. These members shall be identified in numerical order beginning with the lowest remaining random number assigned pursuant to R.C.M. 911(a), after first identifying members under 912A(d)(1).

(4) The military judge shall excuse any members not identified as members or alternate

members, if any.

(e) *Lowest number.* The lowest number is the number with the lowest numerical value.

(f) *Announcement.* After identifying the members to be impaneled in accordance with this rule, and after excusing any excess members, the military judge shall announce that the members are impaneled."

(nnnn) R.C.M. 912B(a) is amended to read as follows:

"(a) *In general.* Prior to the start of deliberations, a member who has been excused after impanelment shall be replaced in accordance with this rule. Alternate members excused after impanelment shall not be replaced."

(oooo) R.C.M. 912B(b) is amended to read as follows:

"(b) *Alternate members impaneled.* Prior to the start of deliberations, an excused member shall be replaced with an impaneled alternate member. The alternate member with the lowest random number assigned pursuant to R.C.M. 911(a) shall replace the excused member, unless in the case of an enlisted accused, the use of such member would be inconsistent with the specific panel composition established under R.C.M. 903. Alternate members who have not replaced impaneled members prior to deliberations on findings shall be excused at the time the court closes for deliberations."

(pppp) A new R.C.M. 912B(d) is inserted immediately after R.C.M. 912B(c) to read as follows:

"(d) *After the start of deliberations.* Once the military judge has closed the court for deliberations, if the number of members is reduced below the requirements of Article 29, trial may not proceed and the military judge shall declare a mistrial."

(qqqq) R.C.M. 914(e)(1) is amended to read as follows:

"(1) *Party refusal to comply.* If the other party elects not to comply with an order to deliver a statement to the moving party, the military judge shall order that the testimony of the witness be disregarded by the trier of fact and that the trial proceed, or, if it is the Government that elects not to comply, shall declare a mistrial if required in the interest of justice."

(rrrr) R.C.M. 914A(b) is amended to read as follows:

"(b) *Definition.* As used in this rule, "remote live testimony" includes, but is not limited to, testimony by video teleconference, closed circuit television, or similar technology."

(ssss) R.C.M. 914B(b) is amended to read as follows:

"(b) *Definition.* As used in this rule, testimony via "remote means" includes, but is not limited to, testimony by video teleconference, closed circuit television, telephone, or similar technology."

(tttt) R.C.M. 918(a)(1)(B) is amended to read as follows:

"(B) not guilty of an offense as charged, but guilty of a lesser included offense;".

(uuuu) R.C.M. 920(g) is amended to read as follows:

"(g) *Waiver.* Instructions on a lesser included offense shall not be given when both parties waive such an instruction. After receiving applicable notification of those lesser included offenses of which an accused may be convicted, the parties may waive a lesser included offense instruction. A written waiver is not required. The accused must affirmatively acknowledge that the accused understands the rights involved and affirmatively waive the instruction on the record. The accused's waiver must be made freely, knowingly, and intelligently. In the case of a joint or common trial, instructions on a lesser included offense shall not be given as to an individual accused when that accused and the Government agree to waive such an instruction."

(vvvv) R.C.M. 924(c)(2) is amended to read as follows:

"(2) the issue of the finding of guilty of the elements in a finding of not guilty only by reason of lack of mental responsibility at any time before announcement of sentence or, where there was no finding of guilty, entry of judgment."

(wwww) R.C.M. 1113(b)(1) is amended to read as follows:

"(1) *Prior to referral.* Prior to referral of charges, the following individuals may examine and disclose sealed materials only if necessary for proper fulfillment of their responsibilities under the UCMJ, this Manual, governing directives, instructions, regulations, applicable rules for practice and procedure, or rules of professional conduct: the judge advocate advising the convening authority who directed the Article 32 preliminary hearing; the convening authority who directed the Article 32 preliminary hearing; the staff judge advocate to the general court-martial convening authority; a military judge detailed to an Article 30a proceeding; the general court-martial convening authority; and special trial counsel for the purposes of making a determination on referral."

(xxxx) R.C.M. 1202(c) is amended as follows:

"(c) *Counsel in capital cases.* To the greatest extent practicable, in any case in which death is adjudged, at least one appellate defense counsel shall, as determined by the Judge Advocate General, be learned in the law applicable to capital cases. Such counsel may, if necessary, be a civilian, and, if so, may be compensated in accordance with regulations prescribed by the Secretary of Defense or the Secretary of Homeland Security, as applicable."

(yyyy) R.C.M. 1203(e) is amended to read as follows:

"(e) *Action on cases reviewed by a Court of Criminal Appeals.*

(1) *Forwarding by the Judge Advocate General to the Court of Appeals for the Armed Forces.* The Judge Advocate General may forward the decision of the Court of Criminal Appeals

to the Court of Appeals for the Armed Forces for review with respect to any matter of law. In such a case, the Judge Advocate General shall cause a copy of the decision of the Court of Criminal Appeals and the order forwarding the case to be served on the accused and on appellate defense counsel. While a review of a forwarded case is pending, the Secretary concerned may defer further service of a sentence to confinement that has been ordered executed in such a case.

(2) *Action when findings are set aside.* In a case reviewed by the Court of Criminal Appeals under this rule in which it has set aside the findings and which is not forwarded to the Court of Appeals for the Armed Forces under R.C.M. 1203(e)(1), the Judge Advocate General shall instruct an appropriate authority to take action in accordance with the decision of the Court of Criminal Appeals. If the Court of Criminal Appeals has authorized a rehearing on findings, the record shall be sent to an appropriate referral authority.

(A) If the Court has authorized a rehearing, but the convening authority to whom the record is transmitted finds a rehearing impracticable, the convening authority shall dismiss the charges.

(B) If the Court has authorized a rehearing, but the special trial counsel to whom the record is transmitted finds a rehearing impracticable, special trial counsel shall dismiss the charges.

(3) *Action when sentence is set aside.* In a case reviewed by the Court of Criminal Appeals under this rule in which it has set aside the sentence and which is not forwarded to the Court of Appeals for the Armed Forces under R.C.M. 1203(e)(1), the Judge Advocate General shall instruct an appropriate authority to modify the judgment in accordance with the decision of the Court of Criminal Appeals. If the Court of Criminal Appeals has authorized a rehearing on sentence, the record shall be sent to an appropriate referral authority.

(A) If the convening authority finds a rehearing impracticable, the applicable convening authority shall order either that a sentence of no punishment be imposed or that the applicable charges be dismissed.

(B) If special trial counsel finds a rehearing impracticable, special trial counsel may dismiss the applicable charges. If special trial counsel makes a determination not to dismiss the applicable charges, the convening authority shall order that a sentence of no punishment be imposed.

(4) *Action when sentence is affirmed in whole or part.*

(A) *Sentence including death.* If the Court of Criminal Appeals affirms any sentence which includes death, the Judge Advocate General shall transmit the record of trial and the decision of the Court of Criminal Appeals directly to the Court of Appeals for the Armed Forces when any period for reconsideration provided by the rules of the Courts of Criminal Appeals has expired.

(B) *Other cases.* If the Court of Criminal Appeals affirms any sentence other than one which includes death, the Judge Advocate General shall cause a copy of the decision of the Court of Criminal Appeals to be served on the accused in accordance with R.C.M. 1203(f).

(5) *Remission or suspension.* If the Judge Advocate General believes that a sentence as affirmed by the Court of Criminal Appeals, other than one which includes death, should be remitted or suspended in whole or part, the Judge Advocate General may, before taking action under R.C.M. 1203(e)(1) or (4), transmit the record of trial and the decision of the Court of Criminal Appeals to the Secretary concerned with a recommendation for action under Article 74 or may take such action as may be authorized by the Secretary concerned under Article 74(a).

(6) *Action when accused lacks mental capacity.* In a review conducted under R.C.M. 1203(b) or (c), the Court of Criminal Appeals may not affirm the proceedings while the accused lacks mental capacity to understand and to conduct or cooperate intelligently in the appellate proceedings. In the absence of substantial evidence to the contrary, the accused is presumed to have the capacity to understand and to conduct or cooperate intelligently in the appellate proceedings. If a substantial question is raised as to the requisite mental capacity of the accused, the Court of Criminal Appeals may direct an examination of the accused in accordance with R.C.M. 706, but the examination may be limited to determining the accused's present capacity to understand and cooperate in the appellate proceedings. The Court may further order a remand under R.C.M. 810(f) as may be necessary. If the record is thereafter returned to the Court of Criminal Appeals, the Court of Criminal Appeals may affirm part or all of the findings or sentence unless it is established, by a preponderance of the evidence—including matters outside the record of trial—that the accused does not have the requisite mental capacity. If the accused does not have the requisite mental capacity, the Court of Criminal Appeals shall stay the proceedings until the accused regains appropriate capacity or take other appropriate action. Nothing in this subsection shall prohibit the Court of Criminal Appeals from making a determination in favor of the accused which will result in the setting aside of a conviction."

(zzzz) R.C.M. 1203(f)(1) is amended to read as follows:

"(1) *Notification of decision.* The accused shall be notified of the decision of the Court of Criminal Appeals in accordance with regulations prescribed by the Secretary concerned."

(aaaaa) R.C.M. 1204(c)(1) is amended to read as follows:

"(1) *In general.* After it has acted on a case, the Court of Appeals for the Armed Forces may direct the Judge Advocate General to return the record to the Court of Criminal Appeals for

further proceedings in accordance with the decision of the court. Otherwise, unless the decision is subject to review by the Supreme Court, or there is to be further action by the President or the Secretary concerned, the Judge Advocate General shall instruct the appropriate authority to take action in accordance with that decision. If the Court has authorized a rehearing, but the convening authority to whom the record is transmitted finds a rehearing impracticable, the convening authority may dismiss the charges. If a special trial counsel referred the affected charges, the special trial counsel shall determine if a rehearing is impracticable. If a special trial counsel determines a rehearing is impracticable, the special trial counsel shall dismiss the charges."

(bbbbb) R.C.M. 1204(c)(4) amended to read as follows:

"(4) *Decisions subject to review by the Supreme Court.* If the decision of the Court of Appeals for the Armed Forces is subject to review by the Supreme Court, the Judge Advocate General shall take no action under R.C.M. 1204(c)(1), (2), or (3) until:

(A) the time for filing a petition for a writ of certiorari with the Supreme Court has expired; or

(B) the Supreme Court has denied any petitions for writ of certiorari filed in the case."

(ccccc) A new R.C.M. 1204(c)(5) is inserted immediately after R.C.M. 1204(c)(4) to read as follows:

"(5) Upon the occurrence of an event described by R.C.M. 1204(c)(4)(A) or (B), the Judge Advocate General shall take action in accordance with R.C.M. 1204(c)(1), (2), or (3). If the Supreme Court issues a writ of certiorari, the Judge Advocate General shall take action under R.C.M. 1205(b)."

(ddddd) R.C.M. 1210(h)(1) is amended to read as follows:

"(1) *Forwarding to appropriate authority.* When a petition for a new trial is granted, the Judge Advocate General shall select and forward the case to an appropriate authority for disposition."

(eeeee) R.C.M. 1301(a) is amended to read as follows:

"(a) *Composition.* A summary court-martial is composed of one commissioned officer on active duty. Unless otherwise prescribed by the Secretary concerned, a summary court-martial shall be of the same armed force as the accused. Summary courts-martial shall be conducted in accordance with the regulations of the military Service to which the accused belongs. Whenever practicable, a summary court-martial should be an officer whose grade is not below lieutenant of the Navy or Coast Guard or captain of the Army, Marine Corps, Air Force, or Space Force. When only one commissioned officer is present with a command or detachment, that officer shall be the summary court-martial of that command or detachment. When more than one commissioned officer is present with a command or detachment, the convening authority may not be the summary court-martial of that command or detachment."

(fffff) R.C.M. 1301(c)(1) is amended to read as follows:

"(1) Subject to Chapter II and R.C.M. 1301(c)(2), summary courts-martial have the power to try persons subject to the UCMJ, except commissioned officers, warrant officers, cadets, aviation cadets, and midshipmen, for any non-capital offense made punishable by the UCMJ."

(ggggg) R.C.M. 1302(a)(3) is amended to read as follows:

"(3) The commander of a detached squadron or other detachment of the Air Force or a corresponding unit of the Space Force."

(hhhhhh) R.C.M. 1306(b)(3) is amended to read as follows:

"(3) *Action on sentence.* The convening authority shall take action on the sentence. The convening authority may approve the sentence as adjudged or disapprove, commute, or suspend, in whole or in part, any portion of an adjudged sentence. The convening authority shall approve the sentence that is warranted by the circumstances of the offense and appropriate for the accused."

Section 3. Part III of the Manual for Courts-Martial, United States, is amended as follows:

(a) Mil. R. Evid. 505(f)(4) is amended to read as follows:

"(4) *Convening Authority and Special Trial Counsel Notice and Action.* If a claim of privilege has been made under this rule with respect to classified information that apparently contains evidence that is relevant and necessary to an element of the offense or a legally cognizable defense and is otherwise admissible in evidence in the court-martial proceeding, the matter must be reported to the convening authority and special trial counsel, as applicable.

(A) The convening authority may institute action to obtain the classified information for use by the military judge in making a determination under Mil. R. Evid. 505(j).

(B) The convening authority or special trial counsel, as applicable, may:

(i) dismiss the charges;

(ii) dismiss the charges or specifications or both to which the information relates; or

(iii) take such other action as may be required in the interests of justice."

(b) Mil. R. Evid. 506(f)(4) is amended to read as follows:

"(4) *Convening Authority and Special Trial Counsel Notice and Action.* If a claim of privilege has been made under this rule with respect to government information that apparently contains evidence that is relevant and necessary to an element of the offense or a legally cognizable defense and is otherwise admissible in evidence in the court-martial proceeding, the matter must be reported to the convening authority and special trial counsel, as applicable.

(A) The convening authority may institute action to obtain the information for use by the military judge in making a determination under Mil. R. Evid. 505(j);

(B) The convening authority or special trial counsel, as applicable, may:

(i) dismiss the charges;

(ii) dismiss the charges or specifications or both to which the information relates; or

(iii) take such other action as may be required in the interests of justice."

(c) Mil. R. Evid. 507(e)(3) is amended to read as follows:

"(3) *Action by the Convening Authority or* S*pecial Trial Counsel.* If the military judge determines that disclosure of the identity of the informant is required under the standards set forth in this rule, and the prosecution elects not to disclose the identity of the informant, the matter must be reported to the convening authority. The convening authority or the special trial counsel, as applicable, may institute action to secure disclosure of the identity of the informant, terminate the proceedings, or take such other action as may be appropriate under the circumstances."

Section 4. Part IV of the Manual for Courts-Martial, United States, is amended as follows:

(a) Paragraph 77.b.(4)(d)(ii) is amended to read as follows:

"(ii) That the accused did so by strangulation or suffocation; and".

(b) Paragraph 77.d.(1)(b) is amended to read as follows:

"(b) *When committed with a firearm or other dangerous weapon.* Dishonorable discharge, forfeiture of all pay and allowances, and confinement for 2 years."

Section 5. Part V of the Manual for Courts-Martial, United States, is amended as follows:

(a) Paragraph 1.h. is amended to read as follows:

"h. *Burden of proof.* The burden of proof to be utilized by commanders throughout the nonjudicial punishment process shall be a preponderance of the evidence. This means the commanding officer must determine it is "more likely than not" the member committed the offense defined by the UCMJ. Each element of each offense, as defined in the Manual for Courts-Martial, must be supported by a preponderance of the evidence (*i.e.,* "more likely than not"). This standard is more rigorous than a "probable cause" standard of proof used by law enforcement to obtain a warrant but a lower standard of proof than the "beyond a reasonable doubt" standard used at a court-martial."

Section 6. Appendix 12A of the Manual for Courts-Martial, United States, is revised to read as follows:

"**PRESIDENTIALLY-PRESCRIBED LESSER INCLUDED OFFENSES PURSUANT TO ARTICLE 79(b)(2), UNIFORM CODE OF MILITARY JUSTICE"**

This authoritative list provides actual notice of factually similar lesser included offenses designated by the President, pursuant to Article 79(b)(2), that are "reasonably included" in the greater offense. The military justice system has unique, but closely related, military offenses, which are not "necessarily included" lesser offenses under the "elements test." *See United States v. Teters*, 37 M.J. 370 (C.A.A.F. 1993); *see also United States v. Jones*, 68 M.J. 465 (C.A.A.F. 2009). This list is exhaustive as to those lesser included offenses (called "reasonably included

offenses" in the chart below) that the President has designated pursuant to Article 79(b)(2). However, this list is not intended to address, and does not address, those offenses that are necessarily included in a charged offense and are therefore lesser included offenses pursuant to Article 79(b)(1).

Article	Offense (Part IV Citation)	Reasonably Included Offense (RIO) Article	RIO (Part IV Citation)
85 - Desertion	Para. 9.b.(1)-(3)	85 - Desertion	Para. 9.b.(4)
87a - Resistance, flight, breach of arrest, and escape	Par. 12.b.(5)	86 - Absent without leave	Para. 10.b.(3)
87b - Offenses against correctional custody and restriction	Para. 13.b.(1)	86 - Absent without leave	Para. 10.b.(3)
93a - Prohibited activities with military recruit or trainee by person in position of special trust	Para. 20.b.(1); 20.b.(2)	93 - Cruelty and maltreatment	Para. 19.b.
94 - Mutiny or sedition	Para. 21.b.(1)	94 - Mutiny or sedition	Para. 21.b.(6)
100 - Subordinate compelling surrender	Para. 28.b.(1)	100 - Subordinate compelling surrender	Para. 28.b.(2)
103a - Espionage	Para. 32.b.(1)	103a - Espionage	Para. 32.b.(2)
103b - Aiding the enemy	Para. 33.b.(1)	103b - Aiding the enemy	Para. 33.b.(2)
104b - Unlawful enlistment, appointment, or separation	Para. 36.b.	107- False official statements; false swearing	Para. 41.b.(1)
118 - Murder	Para. 56.b.(1); 56.b.(2); 56.b.(3); 56.b.(4)	114 - Endangerment Offenses	Para. 52.b.(1)
119 - Manslaughter	Para. 57.b.(1)	114 - Endangerment Offenses	Para. 52.b.(1)
119a - Death or injury of an unborn child	Para. 58.b.(2); 58.b.(4)	119a - Death or injury of an unborn child	Para. 58.b.(3)
120 - Rape and Sexual Assault	Para. 60.b.(1)	128 - Assault with intent to commit specified offenses (rape)	Para. 77.b.(3)

120 - Rape and Sexual Assault	Para. 60.b.(2)	128 - Assault with intent to commit specified offenses (sexual assault)	Para. 77.b.(3)
120b - Rape of a child	Para. 62.b.(1)	128 - Assault with intent to commit specified offenses (rape of a child)	Para. 77.b.(3)
120b - Rape of a child	Para. 62.b.(2)	128 - Assault with intent to commit specified offenses (sexual assault of a child)	Para. 77.b.(3)
128 - Assault	Para. 77.b.(2); 77.b.(3); 77.b.(4); 77.b.(5)	128 - Assault	Para. 77.b.(1)
134 - Check, worthless making and uttering by dishonorably failing to maintain funds	Para. 94.b.	134 - Debt, dishonorably failing to pay	Para. 96.b.
134 - Child pornography	Para. 95.b.(1); 95.b.(2); 95.b.(3); 95.b.(4)	134 - Indecent conduct	Para. 104.b.
134 - Disloyal statements	Para. 97.b.	88 - Contempt toward officials	Para. 14.b.

”

ANNEX 3

Section 1. Part II of the Manual for Courts-Martial, United States, is amended as follows:

(a) R.C.M. 502(a)(2)(A) is amended to read as follows:

"(A) *Members.* The members of a court-martial shall determine whether the accused is proved guilty and, in a capital case in which the accused is unanimously found guilty of a capital offense, the members shall make a determination in accordance with Article 53(c)(1)(A). Each member has an equal voice and vote with other members in deliberating upon and deciding all matters submitted to them. No member may use rank or position to influence another member. No member of a court-martial may have access to or use in any open or closed session this Manual, reports of decided cases, or any other reference material."

(b) R.C.M. 902A is deleted.

(c) R.C.M. 906(b)(12)(B) is amended to read as follows:

"(B) *As applied to sentence.* Where the military judge finds that the unreasonable multiplication of charges requires a remedy that focuses more appropriately on punishment than on findings, the military judge may find that there is an unreasonable multiplication of charges as applied to sentence. If the military judge makes such a finding, the remedy shall be as set forth in R.C.M. 1002(d)(2). A ruling on this motion ordinarily should be deferred until after findings are entered."

(d) A new R.C.M. 925 is inserted immediately after R.C.M. 924 to read as follows:

"Rule 925. Application of sentencing rules

(a) Only one set of sentencing rules shall apply in a court-martial.

(b) If convicted of any offense for which death may be adjudged, the accused shall be sentenced in accordance with R.C.M. 1004.

(c) Except as provided in R.C.M. 925(b):

(1) If convicted of any offense committed on or before December 27, 2023, the accused shall be sentenced in accordance with the Rules for Courts-Martial in effect prior to December 28, 2023. The military judge shall inquire into the accused's election of sentencing rules after the announcement of findings and before any matter is presented in the presentencing phase.

(2) If convicted of only offenses committed after December 27, 2023, the accused shall be sentenced by a military judge in accordance with R.C.M. 1002(a)(2).

(d) Any elections made by the accused pursuant to R.C.M. 925(c)(1) shall be made orally on the record or be in writing and signed by the accused. The military judge shall ascertain whether the accused has consulted with defense counsel and has been informed of the right to make the election of the applicable sentencing rules."

(e) R.C.M. 1001(a)(1) is amended to read as follows:

"(1) *Procedure.* After findings of guilty have been announced, the Government and defense may present matters pursuant to this rule to aid the court-martial in determining an appropriate sentence. Such matters shall ordinarily be presented in the following sequence:

(A) Presentation by the trial counsel of:

(i) service data relating to the accused taken from the charge sheet;

(ii) personal data relating to the accused and of the character of the accused's prior service as reflected in the personnel records of the accused.

(B) Crime victim's right to be reasonably heard.

(C) Presentation by the defense of evidence in extenuation or mitigation or both.

(D) Rebuttal.

(E) Argument by the trial counsel on sentence.

(F) Argument by the defense counsel on sentence.

(G) Rebuttal argument in the discretion of the military judge."

(f) R.C.M. 1001(b)(2) is amended to read as follows:

"(2) *Personal data and character of prior service of the accused.* Under regulations of the Secretary concerned, the trial counsel may obtain and introduce from the personnel records of the accused evidence of the accused's marital status; number of dependents, if any; and character of prior service. Such evidence includes copies of reports reflecting the past military efficiency, conduct, performance, and history of the accused and evidence of any disciplinary actions, including punishments under Article 15 and summary courts-martial after review has been completed pursuant to Article 64. "Personnel records of the accused" includes any records made or maintained in accordance with departmental regulations that reflect the past military efficiency, conduct, performance, and history of the accused. If the accused objects to a particular document as inaccurate or incomplete in a specified respect, or as containing matter that is not admissible under the Military Rules of Evidence, the matter shall be determined by the military judge. Objections not asserted are forfeited."

(g) R.C.M. 1001(b)(3)(B) is amended to read as follows:

"(B) *Pendency of appeal.* The pendency of an appeal therefrom does not render evidence of a conviction inadmissible. Evidence of the pendency of an appeal is admissible."

(h) R.C.M. 1001(b)(4) is amended to read as follows:

"(4) *Evidence in aggravation.* The trial counsel may present evidence as to any aggravating circumstance directly relating to or resulting from the offenses of which the accused has been found guilty. Evidence in aggravation includes, but is not limited to, evidence of financial, social, psychological, and medical impact on or cost to any person or entity who was

the victim of an offense committed by the accused and evidence of significant adverse impact on the mission, discipline, or efficiency of the command directly and immediately resulting from the accused's offense. In addition, evidence in aggravation may include evidence that the accused intentionally selected any victim or any property as the object of the offense because of the actual or perceived race, color, religion, national origin, ethnicity, sex (including pregnancy), gender (including gender identity), disability, or sexual orientation of any person. Except in capital cases, a written or oral deposition taken in accordance with R.C.M. 702 is admissible in aggravation."

(i) R.C.M. 1001(c) is amended to read as follows:

"(c) *Crime victim's right to be reasonably heard.*

(1) *In general.* After presentation by the trial counsel, a crime victim of an offense of which the accused has been found guilty has the right to be reasonably heard at the presentencing proceeding relating to that offense. A crime victim who makes an unsworn statement under R.C.M. 1001(c)(5) is not considered a witness for the purposes of Article 42(b). If the crime victim exercises the right to be reasonably heard, the crime victim shall be called by the court-martial. The exercise of the right is independent of whether the crime victim testified during findings or is called to testify by the Government or defense under this rule.

(2) *Definitions.*

(A) *Crime victim.* For purposes of R.C.M. 1001(c), a crime victim is an individual who has suffered direct physical, emotional, or pecuniary harm as a result of the commission of an offense of which the accused was found guilty or the individual's lawful representative or designee appointed by the military judge under these rules.

(B) *Victim impact.* For purposes of R.C.M. 1001(c), victim impact includes any financial, social, psychological, or medical impact on the crime victim relating to or arising from the offense of which the accused has been found guilty.

(C) *Mitigation.* For the purposes of R.C.M. 1001(c), mitigation includes any matter that may lessen the punishment to be adjudged by the court-martial or furnish grounds for a recommendation of clemency.

(D) *Right to be reasonably heard.*

(i) *Capital cases.* In capital cases, for purposes of R.C.M. 1001(c), the "right to be reasonably heard" means the right to make a sworn statement. The statement may not recommend a specific sentence.

(ii) *Noncapital cases.* In noncapital cases, for purposes of R.C.M. 1001(c), the "right to be reasonably heard" means the right to make a sworn statement, an unsworn statement, or both. This right includes the right to be heard on any objection to any unsworn statement.

(3) *Contents of statement.* The content of statements made under R.C.M. 1001(c)(4) or (5) may only include victim impact and matters in mitigation, except that, in a noncapital case, the victim may recommend a specific sentence.

(4) *Sworn statement.* The crime victim may make a sworn statement and shall be subject to cross-examination concerning it by the trial counsel and the defense counsel or examination on it by the court-martial.

(5) *Unsworn statement.* The crime victim may make an unsworn statement and may not be cross-examined by the trial counsel or the defense counsel or examined upon it by the court-martial. The Government or defense may, however, rebut any statements of fact therein. The

unsworn statement may be oral, written, or both, and may be made by the crime victim, by counsel representing the crime victim, or both.

(j) R.C.M. 1001(f)(1) is amended to read as follows:

"(1) *In general.* During the presentencing proceedings, there shall be much greater latitude than on the merits to receive information by means other than testimony presented through the personal appearance of witnesses. During presentencing proceedings, a dispute as to the production of a witness at Government expense is a matter within the discretion of the military judge to resolve subject to the limitations in R.C.M. 1001(f)(2)."

(k) R.C.M. 1001(f)(2)(C) is amended to read as follows:

"(C) the other party refuses to enter into a stipulation containing the matters to which the witness is expected to testify, except in an extraordinary case when such a stipulation would be an insufficient substitute for the testimony;".

(l) R.C.M. 1001(h) is amended as follows:

"(h) *Argument.* After introduction of matters relating to the sentence under this rule, counsel for the Government and defense may argue for an appropriate sentence. The trial counsel may not in argument purport to speak for the convening authority or any other higher authority or refer to the views of such authorities or any policy directive relative to punishment or to any punishment or quantum of punishment greater than the court-martial may adjudge. The trial counsel may, however, recommend a specific lawful sentence and may also refer to the sentencing considerations set forth in R.C.M. 1002(f). Failure to object to improper argument before the military judge begins deliberations, or before the military judge instructs the members on sentencing, shall constitute forfeiture of the objection."

(m) R.C.M. 1002 is amended to read as follows:

"Rule 1002. Sentencing determination

(a) *Generally.* Subject to limitations in this Manual, the sentence to be adjudged is a matter within the discretion of the court-martial. A court-martial may adjudge any punishment authorized in this Manual in order to achieve the purposes of sentencing under R.C.M. 1002(c), including the maximum punishment or any lesser punishment, or may adjudge a sentence of no punishment except as outlined below.

(1) *Mandatory minimum.* Unless otherwise authorized, when a mandatory minimum sentence is prescribed by the UCMJ, the sentence for an offense shall include any punishment that is made mandatory by law for that offense. The sentence for an offense may not be greater than the maximum sentence established by law or by the President for that offense.

(2) *Parameters and criteria.*

(A) When an offense is subject to sentencing criteria, the military judge shall consider the applicable sentencing criteria in determining the sentence for that offense.

(B) When an offense is subject to sentencing parameters, the military judge shall sentence the accused for that offense within the applicable parameter, unless the military judge finds specific facts that warrant a sentence outside the applicable parameter. If the military judge imposes a sentence outside a sentencing parameter, the military judge shall include in the record a written statement of the factual basis for the sentence.

(3) If the military judge accepts a plea agreement with a sentence limitation, the court-martial shall sentence the accused in accordance with the limits established by the plea agreement. Subject to Article 53a(c), the military judge shall accept a plea agreement submitted by the parties, except that—

(A) in the case of an offense with a sentencing parameter, the military judge may

reject a plea agreement that proposes a sentence that is outside the sentencing parameter if the military judge determines that the proposed sentence is plainly unreasonable; and

(B) in the case of an offense for which there is no sentencing parameter, the military judge may reject a plea agreement that proposes a sentence if the military judge determines that the proposed sentence is plainly unreasonable.

(b) *Noncapital cases.* The military judge shall determine the sentence of a general or special court-martial in accordance with this subsection in all noncapital cases.

(1) *Segmented sentencing for confinement and fines.* The military judge at a general or special court-martial shall determine an appropriate term of confinement and fine, if applicable, for each specification for which the accused was found guilty. Subject to R.C.M. 1002(a), such a determination may include a term of no confinement or no fine when appropriate for the offense.

(2) *Special court-martial.* The military judge shall, in a special court-martial, to the extent necessary, reduce the total confinement to the maximum confinement authorized under R.C.M. 201(f)(2).

(3) *Unitary sentencing for other forms of punishment.* All punishments other than confinement or a fine available under R.C.M. 1003, if any, shall be determined as a single, unitary component of the sentence, covering all of the guilty findings in their entirety. The military judge shall not segment those punishments among the guilty findings.

(c) *Imposition of sentence.* In sentencing an accused under this rule, the court-martial shall impose punishment that is sufficient, but not greater than necessary, to promote justice and to maintain good order and discipline in the United States Armed Forces, taking into consideration—

(1) the nature and circumstances of the offense and the history and characteristics of the

accused;

(2) the impact of the offense on—

(A) the financial, social, psychological, or medical well-being of any victim of the offense; and

(B) the mission, discipline, or efficiency of the command of the accused and any victim of the offense;

(3) the need for the sentence to—

(A) reflect the seriousness of the offense;

(B) promote respect for the law;

(C) provide just punishment for the offense;

(D) promote adequate deterrence of misconduct;

(E) protect others from further crimes by the accused;

(F) rehabilitate the accused; and

(G) provide, in appropriate cases, the opportunity for retraining and returning to duty to meet the needs of the service; and

(4) the sentences available under these rules.

(d) *Information that may be considered.* The court-martial, in applying the factors listed in R.C.M. 1002(c) to the facts of a particular case, may consider—

(1) Any evidence admitted by the military judge during the presentencing proceeding under R.C.M. 1001; and

(2) Any evidence admitted by the military judge during the findings proceeding."

(n) R.C.M. 1003(b)(5) is amended to read as follows:

"(5) *Restriction to specified limits.* Restriction may be adjudged for no more than 2

months. Confinement and restriction may be adjudged in the same case, but they may not together exceed the maximum authorized period of confinement."

(o) R.C.M. 1003(c)(1)(A)(i) is amended to read as follows:

"(i) *Maximum punishment.* The maximum limits for the authorized punishments of confinement, forfeitures, and punitive discharge (if any) are set forth for each offense listed in Part IV of this Manual. These limitations are for each separate offense, not for each charge, and apply notwithstanding any applicable sentencing parameter. When a dishonorable discharge is authorized, a bad-conduct discharge is also authorized."

(p) R.C.M. 1003(c)(1)(B) is amended to read as follows:

"(B) *Offenses not listed in Part IV.*

(i) *Included or closely related offenses.* For an offense not listed in Part IV of this Manual that is included in or closely related to an offense listed therein, the maximum punishment and the sentencing parameter or criteria shall be that or those of the offense listed; however, if an offense not listed is included in a listed offense, and is closely related to another or is equally closely related to two or more listed offenses, the maximum punishment and the sentencing parameter or criteria shall be the same as that or those of the least severe of the listed offenses.

(ii) *Not included or closely related offenses.* An offense not listed in Part IV and not included in or closely related to an offense listed therein is punishable as authorized by the United States Code or as authorized by the custom of the applicable service. When the United States Code provides for confinement for a specified period or not more than a specified period, the maximum punishment by court-martial shall include confinement for that period. If the period is 1 year or longer, the maximum punishment by court-martial also includes a

dishonorable discharge and forfeiture of all pay and allowances; if the period is 6 months or more but less than 1 year, the maximum punishment by court-martial also includes a bad-conduct discharge and forfeiture of all pay and allowances; if the period is less than 6 months, the maximum punishment by court-martial also includes forfeiture of two-thirds pay per month for the authorized period of confinement."

(q) R.C.M. 1004 is revised to read as follows:

"Rule 1004. Capital cases

(a) *In general.* In addition to the provisions in R.C.M. 1001, the provisions in this rule shall apply in capital cases. Death may be adjudged only when—

(1) Death is expressly authorized under Part IV of this Manual for an offense of which the accused has been found guilty or is authorized under the law of war for an offense of which the accused has been found guilty under the law of war;

(2) The accused was properly notified that the case would be tried as a capital case and was properly notified of the aggravating factors the Government intended to prove;

(3) The accused was convicted of such an offense by either—

(A) the unanimous vote of all twelve members of the court-martial; or

(B) the military judge pursuant to the accused's plea of guilty to such an offense;

(4) The members unanimously find that at least one of the aggravating factors under R.C.M. 1004(c) existed beyond a reasonable doubt for that offense and notice of such factor was provided in accordance with R.C.M. 1004(b);

(5) The members unanimously find that the extenuating and mitigating circumstances are substantially outweighed by any aggravating circumstances, including any relevant aggravating factor(s); and

(6) The members unanimously determine that the sentence for that offense shall be death.

(b) *Notice.*

(1) *Referral.* The referral authority shall indicate that the case is to be tried as a capital case by including a special instruction on the charge sheet. Failure to include this special instruction at the time of the referral shall not bar the referral authority from later adding the required special instruction, provided that—

(A) the referral authority has otherwise complied with the notice requirement of R.C.M. 1004(b)(2); and

(B) if the accused demonstrates specific prejudice from such failure to include the special instruction, the military judge determines that a continuance or a recess is an adequate remedy.

(2) *Arraignment.* Before arraignment, the trial counsel shall give the defense written notice of which specific aggravating factor(s) under R.C.M. 1004(c) the Government intends to prove and to which offense(s) the aggravating factor(s) apply. Failure to provide timely notice under this subsection of any aggravating factors under R.C.M. 1004(c) shall not bar later notice and proof of such additional aggravating factors unless the accused demonstrates specific prejudice from such failure and that a continuance or a recess is not an adequate remedy.

(c) *Aggravating factors.* The trial counsel may present evidence in accordance with R.C.M. 1001(b)(4) tending to establish one or more of the aggravating factors enumerated below. Death may be adjudged only if the members find, beyond a reasonable doubt, one or more of the following aggravating factors:

(1) That the offense was committed before or in the presence of the enemy, except that this factor shall not apply in the case of a violation of Article 118;

(2) That in committing the offense the accused—

(A) Knowingly created a grave risk of substantial damage to the national security of the United States; or

(B) Knowingly created a grave risk of substantial damage to a mission, system, or function of the United States, provided that this subparagraph shall apply only if substantial damage to the national security of the United States would have resulted had the potential damage been effected;

(3) That the offense caused substantial damage to the national security of the United States, regardless of whether the accused intended such damage, except that this factor shall not apply in case of a violation of Article 118;

(4) That the offense was committed in such a way or under such circumstances that the life of one or more persons other than the victim was unlawfully and substantially endangered, except that this factor shall not apply to a violation of Articles 103a or 103b;

(5) That the accused committed the offense with the intent to avoid hazardous duty;

(6) That, only in the case of a violation of Article 118, the offense was committed in time of war and in territory in which the United States or an ally of the United States was then an occupying power or in which the United States Armed Forces were then engaged in active hostilities;

(7) That, only in the case of a violation of Article 118(1)—

(A) The accused was serving a sentence of confinement for 30 years or more or for life at the time of the murder;

(B) The murder was committed while the accused was engaged in the commission or attempted commission of a separate murder, or any robbery, rape, rape of a child, sexual

assault, sexual assault of a child, aggravated sexual contact, sexual abuse of a child, aggravated arson, burglary, kidnapping, mutiny, sedition, or piracy of an aircraft or vessel; or while the accused was engaged in the commission or attempted commission of any offense involving the wrongful distribution, manufacture, or introduction or possession, with intent to distribute, of a controlled substance; or, while the accused was engaged in flight or attempted flight after the commission or attempted commission of any offense listed in this subparagraph (R.C.M. 1004(c)(7)(B)).

(C) The murder was committed for the purpose of receiving money or a thing of value;

(D) The accused procured another by means of compulsion, coercion, or a promise of an advantage, a service, or a thing of value to commit the murder;

(E) The murder was committed with the intent to avoid or to prevent lawful apprehension or effect an escape from custody or confinement;

(F) The victim was the President of the United States; the President-elect; the Vice President, or, if there was no Vice President, the next officer in the order of succession to the office of President of the United States; the Vice President-elect; any individual who is acting as President under the Constitution and laws of the United States; a Member of Congress (including a Delegate to, or Resident Commissioner in, the Congress) or Member of Congress-elect; a justice or judge of the United States; a chief of state or head of government (or the political equivalent) of a foreign nation; or a foreign official (as such term is defined in 18 U.S.C. § 1116(b)(3)(A)), if the official was on official business at the time of the offense and was in the United States or in a place described in Mil. R. Evid. 315(c)(2) or (c)(3);

(G) The accused then knew that the victim was any of the following persons in the execution of office: a commissioned, warrant, noncommissioned, or petty officer of the United States Armed Forces; a member of any law enforcement or security activity or agency, military or civilian, including correctional custody personnel; or any firefighter;

(H) The murder was committed with intent to obstruct justice;

(I) The murder was preceded by the intentional infliction of substantial physical harm or prolonged, substantial mental or physical pain and suffering to the victim. For purposes of this section, "substantial physical harm" means fractured or dislocated bones, deep cuts, torn members of the body, serious damage to internal organs, or other serious bodily injuries. The term "substantial physical harm" does not mean minor injuries, such as a black eye or bloody nose. The term "substantial mental or physical pain and suffering" is accorded its common meaning and includes torture.

(J) The accused has been found guilty in the same case of another violation of Article 118;

(K) The victim of the murder was under 15 years of age;

(8) That, only in the case of a violation of Article 118(4), the accused was the actual perpetrator of the killing or was a principal whose participation in the burglary, rape, rape of a child, sexual assault, sexual assault of a child, aggravated sexual contact, sexual abuse of a child, robbery, or aggravated arson was major and who manifested a reckless indifference for human life.

(9) [Reserved]

(10) That, only in the case of a violation of the law of war, death is authorized under the law of war for the offense;

(11) That, only in the case of a violation of Article 103, 103a, or 103b—

(A) The accused has been convicted of another offense involving espionage, spying, or treason for which either a sentence of death or imprisonment for life was authorized by statute; or

(B) That in committing the offense, the accused knowingly created a grave risk of death to a person other than the individual who was the victim.

For purposes of R.C.M. 1004, "national security" means the national defense and foreign relations of the United States and specifically includes a military or defense advantage over any foreign nation or group of nations; a favorable foreign relations position; or a defense posture capable of successfully resisting hostile or destructive action from within or without.

(d) *Evidence in extenuation and mitigation.* The accused shall be given broad latitude to present evidence in extenuation and mitigation.

(e) *Basis for findings.* The findings specified by R.C.M. 1004(a)(4) and (a)(5) may be based on evidence introduced before or after findings under R.C.M. 921, or both.

(f) *Instructions.* Instructions shall be given after arguments by counsel and before the members close to deliberate on sentence, but the military judge may, upon request of the members, any party, or *sua sponte*, give additional instructions at a later time.

(1) *Requests for instructions.* During presentencing proceedings or at such other time as the military judge may permit, any party may request that the military judge instruct the members on the law as set forth in the request. The military judge may require the requested instruction to be written. Each party shall be given the opportunity to be heard on any proposed instruction before it is given. The military judge shall inform the parties of the proposed action on such requests before their arguments to the members.

(2) *How given.* Instructions shall be given orally on the record in the presence of all parties and the members. Written copies of the instructions or, unless a party objects, portions of them may also be given to the members for their use during deliberations.

(3) *Required instructions.* Instructions shall include—

(A) The charge(s) and specification(s) for which the members shall make a sentencing determination;

(B) The applicable aggravating factor or factors under R.C.M. 1004(c) and to which charge(s) and specification(s) the aggravating factor or factors apply;

(C) A statement of the procedures for deliberation and voting set out in R.C.M. 1004(g);

(D) A statement informing the members that they are solely responsible for selecting an appropriate determination and may not rely on the possibility of any mitigating action by the convening or higher authority;

(E) A statement that the members should consider all matters in aggravation, whether introduced before or after findings, and matters introduced under R.C.M. 1001(b)(1), (2), (3), and (5);

(F) A statement that the members may consider:

(i) Any evidence admitted by the military judge during the presentencing proceeding under R.C.M. 1001; and

(ii) Any evidence admitted by the military judge during the findings proceeding;

(G) A statement that the members shall consider all evidence in extenuation and mitigation before a sentence of death may be determined; and

(H) Such other explanations, descriptions, or directions that the military judge determines to be necessary, whether properly requested by a party or determined by the military judge *sua sponte*.

(4) *Failure to object.* After being afforded an opportunity to object, failure to object to an instruction or to omission of an instruction before the members close to deliberate shall constitute waiver of the objection. The military judge may require the party objecting to specify in what respect the instructions were improper. The parties shall be given the opportunity to be heard on any objection outside the presence of the members.

(g) *Deliberations and voting.*

(1) *In general.* With respect to each charge and specification for which a sentence of death may be determined, the members shall deliberate and vote after the military judge instructs the members. Only the members shall be present during deliberations and voting. Superiority in rank shall not be used in any manner to control the independence of members in the exercise of their judgment.

(2) *Deliberations.* Deliberations require a full and free discussion of the determination to be made in the case. Unless otherwise directed by the military judge, members may take with them in deliberations their notes, if any; any exhibits admitted in evidence; and any written instructions. Members may request that the court-martial be reopened and that portions of the record be read to them or additional evidence introduced. The military judge may, in the exercise of discretion, grant such requests.

(3) *Voting generally.*

(A) *Duty of members.* Each member has the duty to vote on the necessary findings described in R.C.M. 1004(a)(4)-(6) as applicable. No member may abstain from voting.

(B) *Secret ballot.* Voting shall be by secret written ballot.

(4) *Procedure.*

(A) *Initial process.* The members shall employ the following process for each charge and specification for which death may be determined.

(i) The members shall vote separately on each aggravating factor under R.C.M. 1004(c) that applies to the offense and on which the members have been instructed. The members shall not proceed to R.C.M. 1004(g)(4)(A)(ii) unless the members unanimously find that at least one of the aggravating factors existed beyond a reasonable doubt.

(ii) The members shall vote on whether the extenuating and mitigating circumstances are substantially outweighed by any aggravating circumstances, including any relevant aggravating factor(s) under R.C.M. 1004(c). The members shall not proceed to R.C.M. 1004(g)(4)(B) unless the members unanimously find that any extenuating or mitigating circumstances are substantially outweighed by any aggravating circumstances.

(B) *Voting on a sentencing determination if death may be adjudged.*

(i) If the members unanimously find both that at least one aggravating factor exists and that the extenuating and mitigating circumstances are substantially outweighed by the aggravating circumstances, the members shall vote on the following sentencing determinations, which shall be binding on the military judge. Except as permitted under R.C.M. 1004(i), the members must vote on potential sentence determinations in the order listed below. The members must vote on each option separately from the other option, considering only one option at a time. During the voting on a particular option, each member may cast one vote for or against that option. The order of the options to be considered is:

(I) Death; or

(II) Life in prison without eligibility for parole.

(ii) If all 12 members vote for death, the sentencing determination of the members shall be death. If any member does not vote for death, the sentencing determination of the members shall not be death.

(iii) If the members' initial vote does not reach the required unanimous consensus for death, the members shall vote on life in prison without eligibility for parole. If three-fourths or more of the members vote for life in prison without eligibility for parole, the sentencing determination of the members shall be life in prison without eligibility for parole.

(iv) If the members' vote does not reach three-fourths for life in prison without eligibility for parole, the offense shall be returned to the military judge for imposition of a sentence of a lesser punishment in accordance with R.C.M. 1001.

(C) *Voting on a sentencing determination if death may not be adjudged.*

(i) If the members do not unanimously find that at least one aggravating factor exists or the members do not unanimously find that the aggravating circumstances substantially outweigh the extenuating and mitigating circumstances, the members shall vote on life in prison without eligibility for parole.

(ii) If the members' vote does not reach three-fourths for life in prison without eligibility for parole, the offense shall be returned to the military judge for imposition of a sentence of a lesser punishment in accordance with R.C.M. 1001.

(D) *Counting votes.* The junior member shall collect the ballots and count the votes. The president shall check the count and inform the other members of the result.

(h) *Action after a sentence is reached.* After the members have agreed upon a determination by the required number of votes in accordance with this rule, the court-martial shall be opened, and

the president shall inform the military judge that the members have reached a determination. The military judge may, in the presence of the parties, examine any writing used by the president to state the determination and may assist the members in putting the determination in proper form. If the members voted unanimously for a determination of death, the writing shall indicate which aggravating factor or factors under R.C.M. 1004(c) the members unanimously found to exist beyond a reasonable doubt. Neither that writing nor any oral or written clarification or discussion concerning it shall constitute announcement of the determination.

(i) *Reconsideration.* Subject to this rule, a sentence may be reconsidered at any time before it is announced in open session of the court.

(1) *Clarification of determination.* A sentence determination may be clarified at any time before entry of judgment. When a determination by the members in a capital case is ambiguous, the military judge shall bring the matter to the attention of the members if the matter is discovered before the court-martial is adjourned. If the matter is discovered after adjournment, the military judge may call a session for clarification by the members as soon as practicable after the ambiguity is discovered, or the military judge may resolve the ambiguity.

(2) *Action by the convening authority.*

(A) Prior to entry of judgment, if a convening authority becomes aware that the sentence of the court-martial is ambiguous, the convening authority shall return the matter to the court-martial for clarification. When the sentence of the court-martial appears to be illegal, the convening authority shall return the matter to the court-martial for correction.

(B) Prior to entry of judgment in a case in which a special trial counsel has exercised authority—

(i) if the special trial counsel becomes aware that the sentence of a court-martial is ambiguous, the special trial counsel shall make a binding determination that the convening authority return the matter to the court-martial for clarification; or

(ii) if the sentence of the court-martial appears to be illegal, the special trial counsel shall make a binding determination that the convening authority shall return the matter to the court-martial for correction.

(3) *Reconsideration procedure.* Any member of the court-martial may propose that a determination of the members in a capital case be reconsidered.

(A) *Instructions.* When reconsideration has been requested, the military judge shall instruct the members on the procedure for reconsideration.

(B) *Voting.* The members shall vote by secret written ballot in closed session whether to reconsider a determination.

(C) *Number of votes required for aggravating factors in capital cases.* Members may reconsider a unanimous vote under R.C.M. 1004(g)(4)(A) (i) that an aggravating factor was proven beyond a reasonable doubt if at least one member votes to reconsider. Members may reconsider a unanimous vote under R.C.M. 1004(g)(4)(A)(ii) that any extenuating and mitigating circumstances are substantially outweighed by any aggravating circumstances admissible under R.C.M. 1001(b)(4), including the factors under R.C.M. 1004(c), if at least one member votes to reconsider. In all other circumstances, a vote under R.C.M. 1004(g)(4)(A)(i) or (ii) may be reconsidered only if at least a majority of the members vote for reconsideration.

(D) *Number of votes required for determinations.*

(i) *With a view toward increasing.* Members may reconsider a determination with a view toward increasing the severity of the determination only if at least a

majority votes for reconsideration. However, members may not reconsider a non-unanimous vote for a determination of death.

(ii) *With a view toward decreasing.* Members may reconsider a determination with a view toward decreasing the severity of the determination only if—

(I) In the case of a death determination, at least one member votes to reconsider; or

(II) In the case of a determination of life in prison without eligibility for parole, more than one-fourth of the members vote to reconsider.

(E) *Successful vote*. If a vote to reconsider succeeds, the members will revote in accordance with R.C.M. 1001(g)(3) and (4).

(j) *Sentencing by military judge.*

(1) The military judge shall sentence the accused in accordance with the binding determination of the members under R.C.M. 1004(g). The military judge may include in any sentence to death or life in prison without eligibility for parole any other authorized lesser punishment. When the military judge's sentence includes confinement or fines, the military judge shall determine an appropriate term of confinement and fine for each specification for which the accused was found guilty.

(2) Where there is a finding of guilty for a specification for which death may be adjudged and a finding of guilty for a specification for which death may not be adjudged—

(A) The members shall make a determination for each specification for which death may be adjudged in accordance with subsection (g);

(B) The military judge shall determine the sentence for any specification returned by the members for sentencing of a lesser punishment than death or life in prison without eligibility for parole; and

(C) The military judge shall determine the sentence for all charges and specifications for which death may not be adjudged. If the sentence includes more than one term of confinement, the military judge shall determine whether the terms of confinement will run concurrently or consecutively.

(k) *Other penalties.* When death is an authorized punishment for an offense, all other punishments authorized under R.C.M. 1003 are also authorized for that offense, including confinement for life, with or without eligibility for parole, and may be adjudged in lieu of death, subject to limitations specifically prescribed in this Manual. A sentence of death includes a dishonorable discharge or dismissal as appropriate. Confinement is a necessary incident of a sentence of death, but not a part of it.

(l) *Impeachment of determination.* A determination that is proper on its face may be impeached only when extraneous prejudicial information was improperly brought to the attention of any member, outside influence was improperly brought to bear upon any member, or unlawful command influence was brought to bear upon any member."

(r) R.C.M. 1005 is amended to read as follows:

"Rule 1005. Reconsideration of sentence in noncapital cases

(a) *Reconsideration.* Subject to this rule, a sentence may be reconsidered at any time before such sentence is announced in open session of the court.

(b) *Exceptions.*

(1) If the sentence announced in open session was less than the mandatory minimum prescribed for an offense of which the accused has been found guilty, the court that announced the sentence may reconsider such sentence.

(2) If the sentence announced in open session exceeds the maximum permissible punishment for the offense or the jurisdictional limitation of the court-martial, the court that announced the sentence may reconsider such sentence.

(3) If the sentence announced in open session is not in accordance with a sentence limitation in the plea agreement, if any, the court that announced the sentence may reconsider such sentence.

(c) *Clarification of sentence.* A sentence may be clarified at any time before entry of judgment. When a sentence determined by the military judge is ambiguous, the military judge shall call a session for clarification as soon as practicable after the ambiguity is discovered.

(d) *Action by the convening authority or special trial counsel.*

(1) Prior to entry of judgment, if a convening authority becomes aware that the sentence of the court-martial is ambiguous, the convening authority shall return the matter to the court-martial for clarification. When the sentence of the court-martial appears to be illegal, the convening authority shall return the matter to the court-martial for correction.

(2) Prior to entry of judgment in a case in which a special trial counsel has exercised authority—

(A) if the special trial counsel becomes aware that the sentence of a court-martial is ambiguous, the special trial counsel shall make a binding determination that the convening authority return the matter to the court-martial for clarification.

(B) if the sentence of the court-martial appears to be illegal, the special trial counsel shall make a binding determination that the convening authority shall return the matter to the court-martial for correction.

(e) *Limitation.* A military judge may reconsider a sentence once announced only under the circumstances described in R.C.M. 1005(b).”

(s) R.C.M. 1006 is amended to read as follows.

“Rule 1006. [Reserved]”.

(t) R.C.M. 1007(b)(1) is amended to read as follows:

“(1) In a capital case, the determination of the members shall be announced by the military judge. If the members voted unanimously for death, the military judge shall announce which aggravating factor or factors under R.C.M. 1004(c) the members unanimously found to exist beyond a reasonable doubt.”

(u) R.C.M. 1008 is amended to read as follows:

“Rule 1008. Impeachment of sentence in noncapital cases

A sentence that is proper on its face may be impeached only when extraneous prejudicial information was improperly brought to the attention of the military judge, outside influence was improperly brought to bear upon the military judge, or unlawful command influence was brought to bear upon the military judge.”

(v) R.C.M. 1009 is amended to read as follows:

“Rule 1009. [Reserved]”.

(w) R.C.M. 1112(b) is amended to read as follows:

(b) *Contents of the record of trial.* The record of trial contains the court-martial proceedings and includes any evidence or exhibits considered by the court-martial in determining the findings or sentence. The record of trial in every general and special court-martial shall include:

(1) A substantially verbatim recording of the court-martial proceedings except sessions closed for deliberations and voting;

(2) The original charge sheet or a duplicate;

(3) A copy of the convening order and any amending order;

(4) The request, if any, for trial by military judge alone; the accused's election, if any, of members under R.C.M. 903; and, when applicable, any statement by the convening authority required under R.C.M. 503(a)(2);

(5) Exhibits, or, if permitted by the military judge, copies, photographs, or descriptions of any exhibits that were received in evidence and any appellate exhibits;

(6) The Statement of Trial Results;

(7) Any action by the convening authority under R.C.M. 1109 or 1110; and

(8) The judgment entered into the record by the military judge."

(x) R.C.M. 1117 is amended to read as follows:

"Rule 1117. Appeal of sentence by the United States

(a) *In general.* With the approval of the Judge Advocate General concerned, the Government may appeal a sentence announced under R.C.M. 1007 to the Court of Criminal Appeals on the grounds that—

(1) The sentence violates the law;

(2) The sentence is a result of an incorrect application of sentencing parameters or criteria established under Article 56(c); or

(3) The sentence is plainly unreasonable.

(b) *Timing.*

(1) An appeal under this rule must be filed within 60 days after the date on which the judgment of the court-martial is entered into the record under R.C.M. 1111.

(2) Any request for approval must be submitted in sufficient time to obtain and consider submissions under R.C.M. 1117(c)(5).

(c) *Approval process.*

(1) A request from the Government to the Judge Advocate General for approval of an appeal under this rule shall include a statement of reasons in support of an appeal under R.C.M. 1117(a)(1), (a)(2), or (a)(3), as applicable, based upon the information contained in the record before the sentencing authority at the time the sentence was announced under R.C.M. 1007.

(2) A statement of reasons in support of an appeal under R.C.M. 1117(a)(1) shall identify the specific provisions of law at issue and the facts in the record demonstrating a violation of the law in the announced sentence under R.C.M. 1007.

(3) A statement of reasons in support of an appeal under R.C.M. 1117(a)(2) shall identify parameters or criteria at issue and the facts supporting how parameters or criteria were applied incorrectly.

(4) A statement of reasons in support of an appeal under R.C.M. 1117(a)(3) shall identify the facts in the record that demonstrate by clear and convincing evidence that the sentence announced under R.C.M. 1007 was plainly unreasonable.

(5) Prior to acting on a request from the Government, the Judge Advocate General shall transmit the request to the military judge who presided over the presentencing proceeding for purposes of providing the military judge, the parties, and any person who, at the time of

sentencing, was a crime victim as defined by R.C.M. 1001(c)(2)(A), with an opportunity to make a submission addressing the statement of reasons in the Government's request.

(A) The military judge shall establish the time for the parties and crime victims to provide such a submission to the military judge and for the military judge to forward all submissions to the Judge Advocate General. The military judge shall ensure that the parties have not less than 7 days to prepare, review, and transmit such submissions.

(B) Submissions under this paragraph (R.C.M. 1117(c)(5)) shall not include facts beyond the record established at the time the sentence was announced under R.C.M. 1007.

(6) The decision of the Judge Advocate General as to whether to approve a request shall be based on the information developed under this rule.

(7) If an appeal is approved by the Judge Advocate General and submitted to the Court of Criminal Appeals under this rule, the following shall be included with the appeal: the statement of approval, the Government's request and statement of reasons under R.C.M. 1117(c), and any submissions under R.C.M. 1117(c)(5).

(d) *Contents of the record of trial*. Unless the record has been forwarded to the Court of Criminal Appeals for review under R.C.M. 1116(b), the record of trial for an appeal under this rule shall consist of—

(1) Any portion of the record in the case that is designated as pertinent by either of the parties;

(2) The information submitted during the presentencing proceeding; and

(3) Any information required by rule or order of the Court of Criminal Appeals."

Section 2. A new Appendix 12B is inserted immediately after Appendix 12A to read as follows:

"Appendix 12B

Offense Category	Months
1	0–12
2	1–36
3	30–120
4	120–240
5	240–480
6	Confinement for life with eligibility for parole

Sentencing Parameter Table – Confinement Range Categories

Note: For all above categories, if the confinement portion of the maximum authorized punishment for the offense is less than the Offense Category's confinement maximum, the lesser confinement portion of the maximum authorized punishment shall control as the recommended maximum confinement time for that offense. At a special court-martial, for an offense that is a category 3 offense or greater, the jurisdictional maximum period of confinement (12 months) constitutes the parameter; however, the military judge may impose a period of confinement less than the jurisdictional maximum period of confinement upon finding specific facts that warrant such a sentence."

Section 3. A new Appendix 12C is inserted immediately after the new Appendix 12B to read as follows:

"Appendix 12C – Offense Category Chart

Article	*Offense*	*Offense Category*
77	Principals	Dependent on underlying offense
78	Accessory after the fact	Dependent on underlying offense
79	Conviction of offense charged, lesser included offenses, and attempts	Dependent on underlying offense
80	Attempts	Dependent on underlying offense
81	Conspiracy	Dependent on underlying offense
82	Soliciting commission of offenses	
	Solicitation of espionage	Category 4
	Solicitation of desertion, mutiny or sedition, misbehavior before the enemy if committed or attempted	Dependent on underlying offense
	Solicitation of desertion in time of war if not committed or attempted	Criteria
	Solicitation of desertion if not committed or attempted	Category 1
	Solicitation of mutiny or sedition if not committed or attempted	Category 3
	Solicitation of misbehavior before enemy if not committed or attempted	Category 3
	Solicitation of other offense regardless of whether committed or attempted	Dependent on underlying offense
83	Malingering	
	Feigning illness, physical disablement, mental lapse, or mental derangement	
	In time of war or in a hostile fire pay zone	Criteria
	Other	Category 1
	Intentional self-inflicted injury	
	In time of war or in a hostile fire pay zone	Criteria
	Other	Category 2
84	Breach of medical quarantine	
	Breach of medical quarantine involving a quarantinable communicable disease defined by 42 CFR 70.1	Category 1
	Breach of medical quarantine	Category 1
85	Desertion	
	In time of war	Criteria
	Intent to avoid hazardous duty or to shirk important services	Category 2
	Other cases	
	Terminated by apprehension	Category 2
	Terminated otherwise	Category 1
86	Absence without leave	
	Failing to go, going from appointed place of duty	Category 1
	Absence from unit, organization, etc.	
	Not more than 3 days	Category 1
	More than 3, not more than 30 days	Category 1
	More than 30 days	Category 1
	More than 30 days and terminated by apprehension	Category 1
	Absence from guard or watch	Category 1
	Absence from guard or watch with intent to abandon	Category 1
	Absence with intent to avoid maneuvers or field exercises	Category 1
87	Missing movement; jumping from vessel	
	Missing movement	
	Design	Category 2
	Neglect	Category 1
	Jumping from vessel into the water	Category 1
87a	Resistance, flight, breach of arrest, and escape	
	Resisting apprehension	Category 1
	Flight from apprehension	Category 1
	Breaking arrest	Category 1
	Escape from custody, pretrial confinement, or confinement pursuant to Article 15	Category 1
	Escape from post-trial confinement	Category 2
87b	Offenses against correctional custody and restriction	
	Escape from correctional custody	Category 1
	Breach of correctional custody	Category 1
	Breach of restriction	Category 1

Article	*Offense*	*Offense Category*
88	Contempt toward officials	Category 1
89	Disrespect toward superior commissioned officer; assault of superior commissioned officer	
	Disrespect toward superior commissioned officer	
	In command	Category 1
	In rank	Category 1
	Striking, drawing, or lifting up a weapon or offering any violence to superior commissioned officer in execution of office	
	In time or war	Criteria
	Other	Category 2
90	Willfully disobeying superior commissioned officer	
	In time of war	Criteria
	Other	Category 2
91	Insubordinate conduct toward warrant officer, noncommissioned officer, or petty officer	
	Striking or assaulting	
	Warrant officer	Category 2
	Superior noncommissioned or petty officer	Category 2
	Other noncommissioned or petty officer	Category 1
	Willfully disobeying	
	Warrant officer	Category 1
	Noncommissioned or petty officer	Category 1
	Contempt or disrespect	
	Warrant officer	Category 1
	Superior noncommissioned or petty officer	Category 1
	Other noncommissioned or petty officer	Category 1
92	Failure to obey order or regulation	
	Violation of or failure to obey general order or regulation	Category 1
	Violation of or failure to obey other lawful order	Category 1
	Dereliction in performance of duties	
	Through neglect or culpable inefficiency	Category 1
	Through neglect or culpable inefficiency resulting in death or grievous bodily harm	Category 2
	Willful	Category 1
	Willful dereliction of duty resulting in death or grievous bodily harm	Category 2
93	Cruelty and maltreatment	Category 1
93a	Prohibited activities with military recruit or trainee by person in position of special trust	Category 2
94	Mutiny or sedition	Criteria
95	Offenses by sentinel or lookout	
	Drunk or sleeping on post, or leaving post before being relieved	
	In time of war	Criteria
	While receiving special pay under 37 USC 310	Criteria
	In all other places	Category 1
	Loitering or wrongfully sitting on post by a sentinel or lookout	
	In time of war or while receiving special pay under 37 USC 310	Criteria
	Other cases	Category 1
95a	Disrespect toward sentinel or lookout	Category 1
96	Release of prisoner without authority; drinking with prisoner	
	Releasing a prisoner without authority	Category 2
	Allowing a prisoner to escape through neglect	Category 1
	Allowing a prisoner to escape through design	Category 2
	Drinking with prisoner	Category 1
97	Unlawful Detention	Category 2
98	Misconduct as prisoner	Criteria
99	Misbehavior before the enemy	Criteria
100	Subordinate compelling surrender	Criteria
101	Improper use of countersign	Criteria
102	Forcing a safeguard	Criteria
103	Spies	Category 5
103a	Espionage	
	Espionage as a capital offense	Category 5
	Espionage or attempted espionage	Category 5

Article	*Offense*	*Offense Category*
103b	Aiding the enemy	Criteria
104	Public records offenses	Category 2
104a	Fraudulent enlistment, appointment, or separation	
	Fraudulent enlistment or appointment	Category 2
	Fraudulent separation	Category 2
104b	Unlawful enlistment, appointment, or separation	Category 2
105	Forgery	Category 2
105a	False or unauthorized pass offenses	
	Possessing or using with intent to defend or deceive, or making, altering, counterfeiting, tampering with, or selling	Category 2
	All other cases	Category 1
106	Impersonation of officer, noncommissioned or petty officer, or agent or official	
	With intent to defraud	Category 2
	All other cases	Category 1
106a	Wearing unauthorized insignia, decoration, badge, ribbon, device, or lapel button	
	Wrongful wearing of the Medal of Honor; Distinguished Service Cross; Navy Cross; Air Force Cross; Silver Star; Purple Heart: or a valor device on any personal award	Category 1
	All other cases	Category 1
107	False official statements; false swearing	
	False official statement	Category 2
	False swearing	Category 1
107a	Parole violation	Category 1
108	Military property of United States—Loss, damage, destruction, or wrongful disposition	
	Selling or otherwise disposing	
	Of a value of $1,000 or less	Category 1
	Of a value of more than $1,000 or any firearm or explosive	Category 2
	Damaging, destroying, losing or suffering to be lost, damaged, destroyed, sold, or wrongfully disposed	
	Through neglect, of a value or damage of	
	Of a value of $1,000 or less	Category 1
	Of a value of more than $1,000	Category 1
	Willfully, of a value or damage of	
	$1,000 or less	Category 1
	More than $1,000 or of any firearm or explosive	Category 2
108a	Captured or abandoned property	
	Captured, abandoned property; failure to secure, etc.	
	Of a value of $1,000 or less	Category 1
	Of a value of more than $1,000 or any firearm or explosive	Category 2
	Looting or pillaging	Criteria
109	Property other than military property of United States—— Waste, spoilage, or destruction	
	Wasting, spoiling, destroying, or damaging non-military property	
	Of a value of $1,000 or less	Category 1
	Of a value of more than $1,000	Category 2
109a	Mail matter: wrongful taking, opening, etc.	Category 2
110	Improper hazarding of vessel or aircraft	
	Willfully and wrongfully	Criteria
	Negligently	Category 2
111	Leaving scene of vehicle accident	Category 1
112	Drunkenness and other incapacitation offenses	
	Drunk on duty	Category 1
	Incapacitation for duty from drunkenness or drug use	Category 1
	Drunk prisoner	Category 1

Article	*Offense*	*Offense Category*
112a	Wrongful use, possession, etc., of controlled substances	
	Wrongful use, possession, manufacture, or introduction of controlled substance	
	Wrongful use or possession of amphetamine, cocaine, heroin, lysergic acid diethylamide, marijuana, methamphetamine, opium, phencyclidine, secobarbital, and Schedule I, II, and III controlled substances	Category 1
	Wrongful manufacture or introduction of amphetamine, cocaine, heroin, lysergic acid diethylamide, marijuana, methamphetamine, opium, phencyclidine, secobarbital, and Schedule I, II, and III controlled substances	Category 2
	Wrongful use, possession, manufacture, or introduction of phenobarbital and Schedule IV and V controlled substances	Category 1
	Wrongful distribution, possession, manufacture, or introduction of controlled substance with intent to distribute, or wrongful importation or exportation of a controlled substance	
	Amphetamine, cocaine, heroin, lysergic acid diethylamide, marijuana, methamphetamine, opium, phencyclidine, secobarbital, and Schedule I, II, and III controlled substances	Category 2
	Phenobarbital and schedule IV and V controlled substances	Category 2
113	Drunken or reckless operation of a vehicle, aircraft, or vessel	
	Resulting in personal injury	Category 2
	No personal injury involved	Category 1
114	Endangerment offenses	
	Carrying concealed weapon	Category 1
	Discharging firearm, willfully, under such circumstances as to endanger human life	Category 1
	Reckless endangerment	Category 1
	Dueling	Category 1
115	Communicating threats	
	Threats and false threats generally	Category 2
	Threats and false threats concerning use of explosives, etc.	Category 3
116	Riot or breach of peace	
	Riot	Category 3
	Breach of the peace	Category 1
117	Provoking speeches or gestures	Category 1
117a	Wrongful broadcast or distribution of intimate visual images	Category 2
118	Murder	
	Article 118(1) or (4)	Category 6
	Article 118(2) or (3)	Category 5
119	Manslaughter	
	Voluntary manslaughter	Category 4
	Involuntary manslaughter	Category 3
	Voluntary manslaughter of a child under 16 years of age	Category 4
	Involuntary manslaughter of a child under 16 years of age	Category 3
119a	Death or injury of an unborn child	
	Injuring or killing an unborn child	Dependent on underlying offense
	Attempting to kill an unborn child	Dependent on underlying offense
	Intentionally killing an unborn child	Dependent on underlying offense
119b	Child endangerment	
	Endangerment by design resulting in grievous bodily harm	Category 3
	Endangerment by design resulting in harm	Category 2
	Other cases by design	Category 2
	Endangerment by culpable negligence resulting in grievous bodily harm	Category 2
	Endangerment by culpable negligence resulting in harm	Category 2
	Other cases by culpable negligence	Category 1

Article	*Offense*	*Offense Category*
120	Rape and sexual assault generally	
	Rape	Category 4
	Sexual assault	Category 3
	Aggravated sexual contact	Category 3
	Abusive sexual contact	Category 2
120a	Mails: deposit of obscene matter	Category 2
120b	Rape and sexual assault of a child	
	Rape of a child	Category 5
	Sexual assault of a child	Category 4
	Sexual abuse of a child	
	Cases involving sexual contact	Category 3
	Other cases	Category 3
120c	Other sexual misconduct	
	Indecent viewing	Category 1
	Indecent recording	Category 2
	Broadcasting or distributing of an indecent recording	Category 2
	Forcible pandering	Category 3
	Indecent exposure	Category 1
121	Larceny and wrongful appropriation	
	Larceny	
	Property of a value of $1,000 or less	Category 1
	Military property of a value of more than $1,000 or of any military motor vehicle, aircraft, vessel, firearm, or explosive	Category 2
	Property other than military property of a value of more than $1,000 or any motor vehicle, aircraft, vessel, firearm, or explosive	Category 2
	Wrongful appropriation	
	Of a value of $1,000 or less	Category 1
	Of a value of more than $1,000	Category 1
	Of any motor vehicle, aircraft, vessel, firearm, explosive, or military property of a value of more than $1,000	Category 1
121a	Fraudulent use of credit cards, debit cards, and other access devices	
	Fraudulent use of a credit card, debit card, or other access device to obtain property of a value of $1,000 or less	Category 1
	Fraudulent use during any 1-year period of a credit card, debit card, or other access device to obtain property the aggregate value of which is more than $1,000	Category 2
121b	False pretenses to obtain services	
	Of a value of $1,000 or less	Category 1
	Of a value of more than $1,000	Category 2
122	Robbery	
	When committed with a dangerous weapon	Category 3
	All other cases	Category 3
122a	Receiving stolen property	
	Receiving, buying, or concealing stolen property of a value of $1,000 or less	Category 1
	Receiving, buying, or concealing stolen property of a value of more than $1,000	Category 2
123	Offenses concerning Government computers	
	Unauthorized distribution of classified information obtained from a Government computer	Category 3
	Unauthorized access of a Government computer and obtaining classified or other protected information	Category 2
	Causing damage to a Government computer	Category 3
123a	Making, drawing, or uttering check, draft, or order without sufficient funds	
	For the procurement of any article or thing of value, with intent to defraud, in the face amount of:	
	$1,000 or less	Category 1
	More than $1,000	Category 2
	For the payment of any past due obligation, or for any other purpose, with intent to deceive	Category 1

Article	*Offense*	*Offense Category*
124	Frauds against the United States	
	Article 124(1) and (2)	Category 2
	Article 124(3) and (4)	
	When amount is $1,000 or less	Category 1
	When amount is more than $1,000	Category 2
124a	Bribery	Category 2
124b	Graft	Category 2
125	Kidnapping	Category 3
126	Arson; burning property with intent to defraud	
	Aggravated arson	Category 3
	Simple arson, where property value is:	
	$1,000 or less	Category 1
	More than $1,000	Category 2
	Burning with intent to defraud	Category 2
127	Extortion	Category 2
128	Assault	
	Simple assault	
	Generally	Category 1
	When committed with an unloaded firearm	Category 2
	Battery	
	Assault consummated by a battery	Category 1
	Assault upon a commissioned officer of the armed forces of the United States or of a friendly foreign power, not in the execution of office	Category 2
	Assault upon a warrant officer, not in the execution of office	Category 2
	Assault upon a noncommissioned or petty officer, not in the execution of office	Category 1
	Assault upon a sentinel or lookout in the execution of duty, or upon any person who, in the execution of office, is performing security police, military police, shore patrol, master at arms, or other military or civilian law enforcement duties	Category 2
	Assault consummated by a battery upon a child under 16 years	Category 2
	Assault with intent to commit murder or rape	Category 3
	Assault with intent to commit voluntary manslaughter, robbery, arson, burglary, or kidnapping	Category 3
	Aggravated assault	
	Aggravated assault with a dangerous weapon	
	When committed with a loaded firearm	Category 3
	When committed upon a child under the age of 16 years	Category 3
	Other cases	Category 2
	Aggravated assault in which substantial bodily harm in inflicted	
	When the injury is inflicted with a loaded firearm	Category 3
	When the injury is inflicted upon a child under the age of 16 years	Category 3
	Other cases	Category 2
	Aggravated assault in which grievous bodily harm is inflicted	
	When the injury is inflicted with a loaded firearm	Category 3
	When the injury is inflicted upon a child under the age of 16 years	Category 3
	Other cases	Category 2
	Aggravated assault by strangulation or suffocation	
	When committed upon a child under the age of 16 years	Category 3
	Other cases	Category 2
128a	Maiming	Category 3
128b	Domestic Violence	
	Commission of violent offense against spouse, intimate partner, or immediate family member of that person	Dependent on underlying offense
	Commission of UCMJ violation against any person with intent to threaten or intimidate spouse, intimate partner, or immediate family member of that person	Dependent on underlying offense

Article	*Offense*	*Offense Category*
	Commission of UCMJ violation against any property, including animal, with intent to threaten or intimidate spouse, intimate partner, or immediate family member of that person	Dependent on underlying offense
	Violation of protection order with intent to threaten or intimidate spouse, intimate partner, or immediate family member of that person	Category 2
	Violation of protection order with intent to commit a violent offense against spouse, intimate partner, or immediate family member of that person	Category 2
	Assaulting spouse, intimate partner, or immediate family member of that person by strangulation or suffocation	
	Aggravated assault by strangulation or suffocation when committed upon a child under 16 years	Category 3
	Other cases	Category 2
129	Burglary; unlawful entry	
	Burglary (with intent to commit an offense punishable under Article 118–120, 120b–121, 122, 125–128a, or 130)	Category 3
	Burglary (with intent to commit any other offense punishable under the UCMJ)	Category 2
	Unlawful entry	Category 1
130	Stalking	Category 2
131	Perjury	Category 2
131a	Subornation of perjury	Category 2
131b	Obstructing justice	Category 2
131c	Misprision of serious offense	Category 2
131d	Wrongful refusal to testify	Category 2
131e	Prevention of authorized seizure of property	Category 1
131f	Noncompliance with procedural rules	
	Unnecessary delay in disposing of case	Category 1
	Knowingly and intentionally failing to enforce or comply with provisions of the UCMJ	Category 2
131g	Wrongful interference with adverse administrative proceeding	Category 2
132	Retaliation	Category 2
133	Conduct unbecoming an officer.	Criteria
134	General article	Criteria
	Animal abuse	
	Abuse, neglect, or abandonment of an animal	Category 1
	Abuse, neglect, or abandonment of a public animal	Category 1
	Sexual act with an animal or cases where the accused caused the serious injury or death of the animal	Category 2
	Bigamy	Category 1
	Check, worthless making and uttering – by dishonorably failing to maintain funds	Category 1
	Child pornography	
	Possessing, receiving, or viewing child pornography	Category 2
	Possessing child pornography with intent to distribute	Category 3
	Distributing child pornography	Category 3
	Producing child pornography	Category 4
	Debt, dishonorably failing to pay	Category 1
	Disloyal statements	Category 1
	Disorderly conduct, drunkenness	
	Disorderly conduct	
	Under such circumstances as to bring discredit upon the military Service	Category 1
	Other cases	Category 1
	Drunkenness	
	Aboard ship or under such circumstances as to bring discredit upon the military Service	Category 1
	Other cases	Category 1

Article	*Offense*	*Offense Category*
134	Drunk and disorderly	
	Aboard ship	Category 1
	Under such circumstances as to bring discredit upon the military Service	Category 1
	Other cases	Category 1
	Extramarital sexual conduct	Category 1
	Firearm, discharging – through negligence	Category 1
	Fraternization	Category 1
	Gambling with subordinate	Category 1
	Homicide, negligent	Category 2
	Indecent conduct	Category 2
	Indecent language	
	Communicated to any child under the age of 16 years	Category 2
	Other cases	Category 1
	Pandering and prostitution	
	Prostitution and patronizing a prostitute	Category 1
	Pandering	Category 2
	Self-injury without intent to avoid service	
	In time of war or in a hostile fire pay zone	Criteria
	Intentional self-inflicted injury	Category 1
	Sexual harassment	Category 2
	Straggling	Category 1”

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Section 4. A new Appendix 12D is inserted immediately after Appendix 12C to read as follows:

"Appendix 12D - List of Sentencing Criteria Offenses

UCMJ Article	Title
82	Solicitation to desert (in time of war)
83	Malingering (in time of war or in hostile fire pay zone)
85	Desertion (in time of war)
89	Striking, drawing, or lifting up a weapon or offering any violence to superior commissioned officer in execution of office (in time of war)
90	Willfully disobeying a lawful order of superior commissioned officer (in time of war)
94	Mutiny or sedition
95	Offenses by sentinel or lookout (in time of war or while receiving special pay under 37 U.S.C. 310)
98	Misconduct as prisoner
99	Misbehavior before the enemy
100	Subordinate compelling surrender
101	Improper use of countersign
102	Forcing a safeguard
103b	Aiding the enemy
108a	Captured or abandoned property (looting or pillaging)
110	Improper hazarding of vessel or aircraft (willfully and wrongfully)
133	Conduct unbecoming an officer
134	General article
134	Self-injury without intent to avoid service (in time of war or in a hostile fire pay zone)

SENTENCING CRITERIA

The military judge shall consider the sentencing criteria established for the following offenses:

Article 82. Solicitation to desert (*in time of war*).

The age and experience of the accused;

Any mental impairment or deficiency of the accused;

Whether the offense disrupted or, in any way, impacted the operations of any organization;

Whether the offense caused damage to the national security of the United States, regardless of whether the accused intended such damage;

Whether the offense was committed in a way or under circumstances that unlawfully and substantially endangered the life of one or more persons; and

Whether the offense was committed in territory in which the United States or an ally of the United States was then an occupying power or in which the United States Armed Forces were then engaged in a contingency operation or active hostilities.

Article 83. Malingering (*in time of war or in hostile fire pay zone*).

The age and experience of the accused;

Any mental impairment or deficiency of the accused;

Whether the offense was committed before or in the presence of the enemy;

Whether the offense disrupted or, in any way, impacted the operations of any organization;

Whether the offense caused damage to the national security of the United States, regardless of whether the accused intended such damage;

Whether the offense was committed in a way or under circumstances that unlawfully and substantially endangered the life of one or more persons;

Whether the offense was committed to avoid the movement of a vessel or hazardous duty or shirk important service; and

Whether the offense was committed in territory in which the United States or an ally of the United States was then an occupying power or in which the United States Armed Forces were then engaged in a contingency operation or active hostilities.

Article 85. Desertion (*in time of war*).

The age and experience of the accused;

Any mental impairment or deficiency of the accused;

Whether the offense was committed before or in the presence of the enemy;

Whether the offense was committed while the accused was under charges, investigation, or adverse action;

Whether the offense caused damage to the national security of the United States, regardless of whether the accused intended such damage;

Whether the offense disrupted or, in any way, impacted the operations of any organization;

Whether the offense was committed to avoid the movement of a vessel or hazardous duty or shirk important service;

Whether the offense was committed in a way or under circumstances that unlawfully and substantially endangered the life of one or more persons; and

Whether the offense was committed in a way or under circumstances such that the location from which the accused absented himself or remained absent was a territory in which

the United States or an ally of the United States was then an occupying power or in which the United States Armed Forces were then engaged in a contingency operation or active hostilities.

Article 89. Striking, drawing, or lifting up a weapon or offering any violence to superior commissioned officer in execution of office (*in time of war*).

The age and experience of the accused;

Any mental impairment or deficiency of the accused;

Whether the offense disrupted or, in any way, impacted the operations of any organization;

Whether the offense was committed to avoid the movement of a vessel or hazardous duty or shirk important service;

Whether the offense was committed before or in the presence of the enemy;

Whether the offense was committed before or in the presence of other members of the accused's or the superior commissioned officer's unit;

Whether the offense caused damage to the national security of the United States, regardless of whether the accused intended such damage;

The status of the superior commissioned officer and command relationship to the accused;

Whether the accused abused a position of trust or authority, or used specialized skill or training, in a manner that significantly facilitated the offense;

The amount of force or violence used or threatened by the accused and other participants in the offense;

The nature or extent of any injuries suffered by the victim;

Whether the offense was committed in a way that created, or under circumstances creating, a substantial risk of bodily harm or death to any person;

Whether the offense involved the conscious or reckless disregard of a risk of death or serious bodily harm to any person;

Whether the offense involved possession of a dangerous weapon; and

Whether the offense was committed in territory in which the United States or an ally of the United States was then an occupying power or in which the United States Armed Forces were then engaged in a contingency operation or active hostilities.

Article 90. Willfully disobeying a lawful order of superior commissioned officer (*in time of war*).

The age and experience of the accused;

Any mental impairment or deficiency of the accused;

Whether the offense disrupted or, in any way, impacted the operations of any organization;

Whether the offense was committed to avoid the movement of a vessel or hazardous duty or shirk important service;

Whether the offense was committed before or in the presence of the enemy;

Whether the offense was committed before or in the presence of other members of the accused's or the superior commissioned officer's unit;

Whether the offense caused damage to the national security of the United States, regardless of whether the accused intended such damage;

The status of the superior commissioned officer and command relationship to the accused;

Whether the accused abused a position of trust or authority, or used specialized skill or training, in a manner that significantly facilitated the offense;

Whether the offense was committed in a way that created, or under circumstances creating, a substantial risk of bodily harm or death to any person;

Whether the offense involved the conscious or reckless disregard of a risk of death or serious bodily harm to any person;

Whether the offense involved possession of a dangerous weapon; and

Whether the offense was committed in territory in which the United States or an ally of the United States was then an occupying power or in which the United States Armed Forces were then engaged in a contingency operation or active hostilities.

Article 94. Mutiny or sedition.

The age and experience of the accused;

Any mental impairment or deficiency of the accused;

The accused's relationship to the military or civil authority against which the accused committed the mutiny or sedition;

Whether the offense disrupted or, in any way, impacted the operations of any organization;

Whether the offense was committed to avoid the movement of a vessel or hazardous duty or shirk important service;

Whether the offense was committed before or in the presence of the enemy;

Whether the offense caused damage to the national security of the United States, regardless of whether the accused intended such damage;

Whether the accused was the actual perpetrator of the offense or was a principal whose participation in the offense was major;

Whether the accused was an organizer, leader, manager, or supervisor in the offense and the number of other participants in the offense;

Whether the accused was a minimal or minor participant in the offense;

Whether the accused abused a position of trust or authority, or used specialized skill or training, in a manner that significantly facilitated the offense;

The amount of force or violence used or threatened by the accused and other participants in the offense;

The nature or extent of any injuries suffered by any victims of the offense;

The nature or extent of any public or private property damage related to the offense;

Whether the offense was committed in a way or under circumstances that unlawfully and substantially endangered the life of one or more persons;

Whether the offense involved the conscious or reckless disregard of a risk of death or serious bodily harm to any person;

Whether the offense involved possession of a dangerous weapon;

Whether the offense involved the conscious or reckless disregard of a risk of serious damage to public or private property; and

Whether the offense was committed in territory in which the United States or an ally of the United States was then an occupying power or in which the United States Armed Forces were then engaged in a contingency operation or active hostilities.

Article 95. Offenses by sentinel or lookout *(in time of war or while the accused was receiving special pay under 37 U.S.C. 310*).

The age and experience of the accused;

Any mental impairment or deficiency of the accused;

Whether the offense disrupted or, in any way, impacted the operations of any organization;

Whether the offense was committed to avoid the movement of a vessel or hazardous duty or shirk important service;

Whether the offense was committed before or in the presence of the enemy;

Whether the offense caused damage to the national security of the United States, regardless of whether the accused intended such damage;

Whether the offense was committed in a way or under circumstances that unlawfully and substantially endangered the life of one or more persons; and

Whether the offense was committed in territory in which the United States or an ally of the United States was then an occupying power or in which the United States Armed Forces were then engaged in a contingency operation or active hostilities.

Article 98. Misconduct as prisoner.

The age and experience of the accused;

Any mental impairment or deficiency of the accused;

Whether the offense caused damage to the national security of the United States, regardless of whether the accused intended such damage;

Whether the accused was the actual perpetrator of the offense or was a principal whose participation in the offense was major;

Whether the accused was an organizer, leader, manager, or supervisor in the offense and the number of other participants in the offense;

Whether the accused was a minimal or minor participant in the offense;

Whether the accused abused a position of trust or authority, or used specialized skill or training, in a manner that significantly facilitated the offense;

The nature of any maltreatment inflicted on other prisoners;

The amount of force or violence used or threatened by the accused and other participants in the offense;

The nature or extent of any injuries suffered by any victims of the offense;

Whether the offense was committed in a way or under circumstances that unlawfully and substantially endangered the life of one or more persons;

Whether the offense involved the conscious or reckless disregard of a risk of death or serious bodily harm to any person;

Whether the offense involved possession of a dangerous weapon;

The nature of any benefits or improvements enjoyed by the accused as a result of his or her conduct; and

Whether the offense was committed in territory in which the United States or an ally of the United States was then an occupying power or in which the United States Armed Forces were then engaged in a contingency operation or active hostilities.

Article 99. Misbehavior before the enemy.

The age and experience of the accused;

Any mental impairment or deficiency of the accused;

Whether the offense disrupted or, in any way, impacted the operations of any organization;

Whether the offense caused damage to the national security of the United States, regardless of whether the accused intended such damage;

Whether the accused abused a position of trust or authority, or used specialized skill or training, in a manner that significantly facilitated the offense;

Whether the accused was the actual perpetrator of the offense or was a principal whose participation in the offense was major;

Whether the accused was an organizer, leader, manager, or supervisor in the offense and the number of other participants in the offense;

Whether the accused was a minimal or minor participant in the offense;

Whether the offense was committed in a way or under circumstances that unlawfully and substantially endangered the life of one or more persons;

Whether the offense involved the conscious or reckless disregard of a risk of death or serious bodily harm to any person;

Whether the offense involved possession of a dangerous weapon;

Whether the offense was committed in a way that created, or under circumstances creating, a substantial risk of bodily harm or death to any person; and

Whether the offense was committed in territory in which the United States or an ally of the United States was then an occupying power or in which the United States Armed Forces were then engaged in a contingency operation or active hostilities.

Article 100. Subordinate compelling surrender.

The age and experience of the accused;

Any mental impairment or deficiency of the accused;

The nature of the conflict or hostilities in which the accused's unit was engaged;

Whether the offense was committed in the immediate presence of the enemy;

Whether the offense caused damage to the national security of the United States, regardless of whether the accused intended such damage;

Whether the offense impacted the operations of any organization in addition to the unit of the accused;

Whether the offense was committed in a way or under circumstances that unlawfully and substantially endangered the life of one or more persons;

Whether the offense was committed in territory in which the United States or an ally of the United States was then an occupying power or in which the United States Armed Forces were then engaged in a contingency operation or active hostilities;

Whether the accused abused a position of trust or authority, or used specialized skill or training, in a manner that significantly facilitated the offense;

Whether the offense was committed for the purpose of receiving money or a thing of value;

Whether the accused was the actual perpetrator of the offense or was a principal whose participation in the offense was major;

Whether the accused was an organizer, leader, manager, or supervisor in the offense and the number of other participants in the offense; and

Whether the accused was a minimal or minor participant in the offense.

Article 101. Improper use of countersign.

The age and experience of the accused;

Any mental impairment or deficiency of the accused;

Whether the offense was committed before or in the presence of the enemy;

Whether the offense caused damage to the national security of the United States, regardless of whether the accused intended such damage;

Whether the offense was committed in a way or under circumstances that unlawfully and substantially endangered the life of one or more persons;

Whether the offense was committed in territory in which the United States or an ally of the United States was then an occupying power or in which the United States Armed Forces were then engaged in a contingency operation or active hostilities;

Whether the accused abused a position of trust or authority, or used specialized skill or training, in a manner that significantly facilitated the offense; and

Whether the offense was committed for the purpose of receiving money or a thing of value.

Article 102. Forcing a safeguard.

The age and experience of the accused;

Any mental impairment or deficiency of the accused;

That nature of the person or persons, place, or property intended to be protected by the safeguard;

Whether the offense was committed before or in the presence of the enemy;

Whether the offense caused damage to the national security of the United States, regardless of whether the accused intended such damage;

Whether the offense was committed in a way or under circumstances that unlawfully and substantially endangered the life of one or more persons;

Whether the offense was committed in territory in which the United States or an ally of the United States was then an occupying power or in which the United States Armed Forces were then engaged in a contingency operation or active hostilities;

Whether the accused abused a position of trust or authority, or used specialized skill or training, in a manner that significantly facilitated the offense;

Whether the offense was committed for the purpose of receiving money or a thing of value;

Whether any person or persons, place, or property intended to be protected by the safeguard was injured or damaged;

Whether the accused was the actual perpetrator of the offense or was a principal whose participation in the offense was major;

Whether the accused actually knew of the safeguard;

Whether the accused was an organizer, leader, manager, or supervisor in the offense and the number of other participants in the offense; and

Whether the accused was a minimal or minor participant in the offense.

Article 103b. Aiding the enemy

The age and experience of the accused;

Any mental impairment or deficiency of the accused;

Whether the accused abused a position of trust or authority, or used specialized skill or training, in a manner that significantly facilitated the offense;

Whether the offense disrupted or, in any way, impacted the operations of any organization;

Whether the accused intended to cause damage to national security;

Whether the offense caused damage to the national security of the United States, regardless of whether the accused intended such damage;

Whether the offense involved the conscious or reckless disregard of a risk of death or serious bodily harm to any person;

Whether the offense involved possession of a dangerous weapon;

Whether the offense was committed in a way or under circumstances that unlawfully and substantially endangered the life of one or more persons; and

Whether the offense was committed in territory in which the United States or an ally of the United States was then an occupying power or in which the United States Armed Forces were then engaged in a contingency operation or active hostilities.

Article 108a. Captured or abandoned property (*looting or pillaging*)

The age and experience of the accused;

Any mental impairment or deficiency of the accused;

Whether the offense was committed before or in the presence of the enemy;

Whether the offense caused damage to the national security of the United States, regardless of whether the accused intended such damage;

Whether the offense was committed in territory in which the United States or an ally of the United States was then an occupying power or in which the United States Armed Forces were then engaged in a contingency operation or active hostilities;

Whether the accused was the actual perpetrator of the offense or was a principal whose participation in the offense was major;

Whether the accused was an organizer, leader, manager, or supervisor in the offense and the number of other participants in the offense;

Whether the accused was a minimal or minor participant in the offense;

Whether the accused abused a position of trust or authority, or used specialized skill or training, in a manner that significantly facilitated the offense;

Whether the offense involved the conscious or reckless disregard of a risk of death or serious bodily harm to any person;

Whether the offense involved possession of a dangerous weapon;

Whether the offense was committed in a way or under circumstances that unlawfully and substantially endangered the life of one or more persons;

Whether the offense involved the conscious or reckless disregard of a risk of serious damage to public or private property;

The amount of force or violence used or threatened by the accused and other participants in the offense;

The value and nature of the captured or abandoned property; and

The amount of restitution, if any, paid by the accused.

Article 110. Improper hazarding of vessel or aircraft (*willfully and wrongfully*).

The age and experience of the accused;

Any mental impairment or deficiency of the accused;

The position, responsibility, and authority of the accused at the time of the offense;

Whether the offense caused damage to the vessel or aircraft and the amount and type of damage;

Whether the accused committed the offense with the intent to prevent the vessel's or aircraft's deployment, movement, or departure;

Whether the offense occurred in a time of active hostilities;

Whether the offense disrupted or, in any way, impacted the operations of any organization;

Whether the offense caused damage to the national security of the United States, regardless of whether the accused intended such damage;

Whether the offense involved the conscious or reckless disregard of a risk of death or serious bodily harm to any person;

Whether the accused abused a position of trust or authority, or used specialized skill or training, in a manner that significantly facilitated the offense;

Whether the accused was an organizer, leader, manager, or supervisor in the offense and the number of other participants in the offense; and

Whether the accused was the actual perpetrator of the offense or was a principal whose participation in the offense was major.

Article 133. Conduct unbecoming an officer.

The age and experience of the accused;

Any mental impairment or deficiency of the accused;

The sentencing parameter for the most analogous enumerated offense;

The grade of the accused;

Whether the offense occurred in a time of active hostilities;

Whether the offense disrupted or, in any way, impacted the operations of any organization;

Whether the offense caused damage to the national security of the United States, regardless of whether the accused intended such damage;

Whether the offense involved a severe lack of integrity and judgment.

Whether the offense involved the conscious or reckless disregard of a risk of death or serious bodily harm to any person; and

Whether the accused abused a position of trust or authority, or used specialized skill or training, in a manner that significantly facilitated the offense.

Article 134. General article.

(A) For offenses under Article 134's "disorders and neglects to the prejudice of good order and discipline" or "conduct of a nature to bring discredit upon the armed forces" clause that are not listed in Part IV of the Manual for Courts-Martial:

(1) For offenses for which the maximum punishment is calculated pursuant to Rule for Courts-Martial 1003(c)(1)(B)(i), the sentencing parameter for the offense that provided the maximum punishment.

(2) For offenses for which the maximum punishment is calculated by reference to a provision of the United States Code pursuant to Rule for Courts-Martial 1003(c)(1)(B)(ii), the Federal Sentencing Guideline range for the offense that provided the maximum punishment.

(3) For offenses for which the maximum punishment is calculated by reference to a custom of the applicable service pursuant to Rule for Courts-Martial 1003(c)(1)(B)(ii), the sentencing parameter for the most analogous enumerated offense.

(B) For offenses under Article 134's "crimes and offenses not capital" clause, the Federal Sentencing Guideline range for the underlying offense.

Article 134. Self-injury without intent to avoid service in a time of war or in a hostile fire pay zone.

The age and experience of the accused;

Any mental impairment or deficiency of the accused;

Whether the offense was committed before or in the presence of the enemy;

Whether the offense disrupted or, in any way, impacted the operations of any organization;

Whether the offense caused damage to the national security of the United States, regardless of whether the accused intended such damage;

Whether the offense was committed in a way or under circumstances that unlawfully and substantially endangered the life of one or more persons; and

Whether the offense was committed in territory in which the United States or an ally of the United States was then an occupying power or in which the United States Armed Forces were then engaged in a contingency operation or active hostilities."

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Rules and Regulations

Federal Register
Vol. 88, No. 147
Wednesday, August 2, 2023

This section of the FEDERAL REGISTER contains regulatory documents having general applicability and legal effect, most of which are keyed to and codified in the Code of Federal Regulations, which is published under 50 titles pursuant to 44 U.S.C. 1510.

The Code of Federal Regulations is sold by the Superintendent of Documents.

DEPARTMENT OF HOMELAND SECURITY

8 CFR Part 217

Hungary Electronic System for Travel Authorization Validity Period

AGENCY: Office of Strategy, Policy, and Plans; DHS.

ACTION: Announcement of ESTA validity period.

SUMMARY: This document announces that the U.S. Department of Homeland Security (DHS) is reducing Hungary's Electronic System for Travel Authorization (ESTA) travel authorization validity period for travel by citizens or nationals of Hungary under the Visa Waiver Program (VWP) to the United States from two years from the date of issuance to one year and also limiting the validity of an ESTA for citizens or nationals of Hungary to a single use for ESTA applications received after the date of publication of this document. DHS is making these changes based on the Government of Hungary's inability to satisfy a number of VWP requirements.

DATES: This announcement is effective on August 1, 2023.

FOR FURTHER INFORMATION CONTACT: Anjum Agarwala, Visa Waiver Program Office, Office of Strategy, Policy, and Plans, Department of Homeland Security, 2707 Martin Luther King Jr Ave. SE, Washington, DC 20528.

SUPPLEMENTARY INFORMATION:

I. Background

A. The Visa Waiver Program

Pursuant to section 217 of the Immigration and Nationality Act (INA), 8 U.S.C. 1187, the Secretary of Homeland Security (the Secretary),[1] in consultation with the Secretary of State, may designate certain countries for participation in the Visa Waiver Program (VWP) if certain requirements are met. Those requirements include, among others:

(1) a rate of nonimmigrant visitor visa refusals for citizens or nationals of the country below the statutorily established threshold;

(2) certification by the government seeking designation for VWP participation that it issues machine-readable passports that comply with internationally accepted standards;

(3) a determination by the Secretary, in consultation with the Secretary of State, that the country's designation would not negatively affect U.S. law enforcement and security interests;

(4) an agreement to report, or make available through INTERPOL or other designated means authorized by the Secretary, information about the theft or loss of passports to the U.S. government within the designated timeframe;

(5) the country's government's acceptance for repatriation of any citizen, former citizen, or national not later than three weeks after the issuance of a final order of removal; and

(6) an agreement with the United States to share information regarding whether citizens and nationals of the country traveling to the United States represent a threat to the security or welfare of the United States or its citizens.

See INA section 217(c)(2)(A)–(F), 8 U.S.C. 1187(c)(2)(A)–(F).

The INA also sets forth requirements for countries' continued VWP eligibility and, where appropriate, probation, suspension, or termination of program countries. *See* INA section 217(c)–(f), 8 U.S.C. 1187(c)–(f).

Citizens and nationals of VWP countries may apply for admission to the United States at U.S. ports of entry as nonimmigrant visitors for business or pleasure for a period of ninety days or less without first obtaining a nonimmigrant visa, provided they are otherwise eligible for admission under applicable statutory and regulatory requirements. To travel to the United States under the VWP, a noncitizen must, without limitation:

(1) be seeking entry as a visitor for business or pleasure for ninety days or less;

(2) be a citizen or national of a VWP country;

(3) present a valid unexpired electronic and machine-readable passport that meets program requirements and is issued by a designated VWP country to the air or vessel carrier before departure;

(4) execute the required immigration forms;

(5) if arriving at a port of entry into the U.S. by air or sea, arrive on an authorized carrier;

(6) not represent a threat to the welfare, health, safety or security of the United States;

(7) not have failed to comply with the conditions of any previous admission as a nonimmigrant visitor;

(8) possess a round-trip transportation ticket;

(9) obtain an approved travel authorization via Electronic System for Travel Authorization (ESTA);

(10) waive the right to review or appeal a decision regarding admissibility at the port of entry or to contest, other than on the basis of an application for asylum, any action for removal; and

(11) meet other program requirements.

See INA section 217(a)–(b); 8 U.S.C. 1187(a)–(b). *See also* 8 CFR part 217.

Hungary was designated for participation in the VWP on November 17, 2008. *See* 73 FR 67711.

B. ESTA Validity Period

Typically, pursuant to DHS regulations, a travel authorization issued under ESTA is valid for a period of two years from the date of issuance. *See* 8 CFR 217.5(d)(1). However, the Secretary, in consultation with the Secretary of State, may decrease the ESTA travel authorization validity period for a designated VWP country. *See* 8 CFR 217.5(d)(3).[2] DHS publishes notice of any changes to ESTA travel authorization validity periods in the **Federal Register**. *See* 8 CFR 217.5(d)(3).

II. Reduction of Hungary's ESTA Validity Period

DHS conducts the statutorily required review of each VWP country at least once every two years to evaluate the effects that continuing the country's designation in the program will have on U.S. national security, law enforcement, and immigration enforcement interests. *See* INA section 217(c)(5)(A), 8 U.S.C. 1187(c)(5)(A).

In April 2017, DHS learned that individuals had fraudulently procured legitimate Hungarian passports by falsely assuming the identities of citizens who naturalized through a ''simplified process.'' This simplified naturalization process, created in 2011, extends citizenship to ethnic Hungarians living outside Hungary and waives the standard naturalization

[1] The Secretary of Homeland Security has delegated this authority to the Under Secretary for Strategy, Policy, and Plans pursuant to DHS Delegation 23000, Delegation to the Under Secretary for Strategy, Policy, and Plans, Sec. II.L.4.

[2] As noted above, this authority is delegated to the Under Secretary for Strategy, Policy, and Plans.

requirement for an applicant to be a Hungarian resident for five years. This simplified process also eliminated identity management protocols that are conditions of the Government of Hungary's standard naturalization procedure, including the collection of fingerprints and a facial image of the applicant. Without complete biometric data, including an image of the recently-naturalized citizen from the simplified naturalization process, the Government of Hungary's passport application process became susceptible to imposter fraud. Additionally, the Government of Hungary identified corrupt officials who sold Hungarian passports.

In October 2017, the Secretary notified the Government of Hungary by letter that it had been placed on provisional VWP status (pursuant to which Hungary is subject to an annual assessment, rather than an assessment every two years) due to its noncooperation with earlier U.S. Government requests for information and collaboration in the investigation of passport fraud. The letter outlined steps necessary for Hungary to return to normalized status as a participating country in the VWP.

Despite engagement by U.S. ambassadors and DHS up to the Secretary level since 2017, the Government of Hungary has made only limited progress in addressing vulnerabilities created by its ''simplified'' naturalization process. Its failure to address the large volume of identities that continue to be at risk of being exploited for *mala fide* purposes and its lack of investigative cooperation with U.S. law enforcement presents an elevated level of risk to the national security, law enforcement, and immigration enforcement interests of the United States.

DHS is publishing this document announcing that effective August 1, 2023, DHS is decreasing Hungary's ESTA validity period for travel to the United States from two years from the date of issuance to one year and limiting the validity of an ESTA for citizens or nationals of Hungary to a single use for ESTA applications received after the effective date of this document. This will have the dual effect of (1) sending a public signal regarding Hungary's non-compliance with VWP requirements, and (2) in the case of those with regular travel to the United States, creating an opportunity to obtain updated application and travel history information of Hungarian VWP travelers for vetting purposes. This is necessary due to Hungary's inability to fully satisfy its obligations under the VWP. Should Hungary's non-compliance with VWP requirements continue, DHS, in consultation with State, may make further adjustments to Hungary's VWP designation at any time, including suspension or termination from the program.

Robert Silvers,

Under Secretary for Strategy, Policy, and Plans Department of Homeland Security.

[FR Doc. 2023–16412 Filed 8–1–23; 8:45 am]

BILLING CODE P

FEDERAL RESERVE SYSTEM

12 CFR Part 201

[Docket No. R–1811; RIN 7100 AG62]

Regulation A: Extensions of Credit by Federal Reserve Banks

AGENCY: Board of Governors of the Federal Reserve System.

ACTION: Final rule.

SUMMARY: The Board of Governors of the Federal Reserve System (''Board'') has adopted final amendments to its Regulation A to reflect the Board's approval of an increase in the rate for primary credit at each Federal Reserve Bank. The secondary credit rate at each Reserve Bank automatically increased by formula as a result of the Board's primary credit rate action.

DATES: *Effective date:* This rule is effective August 2, 2023.

Applicability date: The rate changes for primary and secondary credit were applicable on July 27, 2023.

FOR FURTHER INFORMATION CONTACT: M. Benjamin Snodgrass, Senior Counsel (202–263–4877), Legal Division, or Kristen Payne, Lead Financial Institution & Policy Analyst (202–452–2872), Division of Monetary Affairs; for users of telephone systems via text telephone (TTY) or any TTY-based Telecommunications Relay Services, please call 711 from any telephone, anywhere in the United States; Board of Governors of the Federal Reserve System, 20th and C Streets NW, Washington, DC 20551.

SUPPLEMENTARY INFORMATION: The Federal Reserve Banks make primary and secondary credit available to depository institutions as a backup source of funding on a short-term basis, usually overnight. The primary and secondary credit rates are the interest rates that the twelve Federal Reserve Banks charge for extensions of credit under these programs. In accordance with the Federal Reserve Act, the primary and secondary credit rates are established by the boards of directors of the Federal Reserve Banks, subject to review and determination of the Board.

On July 26, 2023, the Board voted to approve a 0.25 percentage point increase in the primary credit rate, thereby increasing the primary credit rate from 5.25 percent to 5.5 percent. In addition, the Board had previously approved the renewal of the secondary credit rate formula, the primary credit rate plus 50 basis points. Under the formula, the secondary credit rate increased by 0.25 percentage points as a result of the Board's primary credit rate action, thereby increasing the secondary credit rate from 5.75 percent to 6.0 percent. The amendments to Regulation A reflect these rate changes.

The 0.25 percentage point increase in the primary credit rate was associated with 0.25 percentage point increase in the target range for the Federal funds rate (from a target range of 5 percent to 5¼ percent to a target range of 5¼ percent to 5½ percent) announced by the Federal Open Market Committee on July 26, 2023, as described in the Board's amendment of its Regulation D published elsewhere in this issue of the **Federal Register**.

Administrative Procedure Act

In general, the Administrative Procedure Act (''APA'') [1] imposes three principal requirements when an agency promulgates legislative rules (rules made pursuant to Congressionally-delegated authority): (1) publication with adequate notice of a proposed rule; (2) followed by a meaningful opportunity for the public to comment on the rule's content; and (3) publication of the final rule not less than 30 days before its effective date. The APA provides that notice and comment procedures do not apply if the agency for good cause finds them to be ''unnecessary, impracticable, or contrary to the public interest.'' [2] Section 553(d) of the APA also provides that publication at least 30 days prior to a rule's effective date is not required for (1) a substantive rule which grants or recognizes an exemption or relieves a restriction; (2) interpretive rules and statements of policy; or (3) a rule for which the agency finds good cause for shortened notice and publishes its reasoning with the rule.[3] The APA further provides that the notice, public comment, and delayed effective date requirements of 5 U.S.C. 553 do not apply ''to the extent that there is involved . . . a matter relating to agency management or personnel or to public

[1] 5 U.S.C. 551 *et seq.*

[2] 5 U.S.C. 553(b)(3)(A).

[3] 5 U.S.C. 553(d).

property, loans, grants, benefits, or contracts.'' [4]

Regulation A establishes the interest rates that the twelve Reserve Banks charge for extensions of primary credit and secondary credit. The Board has determined that the notice, public comment, and delayed effective date requirements of the APA do not apply to these final amendments to Regulation A. The amendments involve a matter relating to loans and are therefore exempt under the terms of the APA. Furthermore, because delay would undermine the Board's action in responding to economic data and conditions, the Board has determined that ''good cause'' exists within the meaning of the APA to dispense with the notice, public comment, and delayed effective date procedures of the APA with respect to the final amendments to Regulation A.

Regulatory Flexibility Analysis

The Regulatory Flexibility Act (''RFA'') does not apply to a rulemaking where a general notice of proposed rulemaking is not required.[5] As noted previously, a general notice of proposed rulemaking is not required if the final rule involves a matter relating to loans. Furthermore, the Board has determined that it is unnecessary and contrary to the public interest to publish a general notice of proposed rulemaking for this final rule. Accordingly, the RFA's requirements relating to an initial and final regulatory flexibility analysis do not apply.

Paperwork Reduction Act

In accordance with the Paperwork Reduction Act (''PRA'') of 1995,[6] the Board reviewed the final rule under the authority delegated to the Board by the Office of Management and Budget. The final rule contains no requirements subject to the PRA.

List of Subjects in 12 CFR Part 201

Banks, banking, Federal Reserve System, Reporting and recordkeeping.

Authority and Issuance

For the reasons set forth in the preamble, the Board is amending 12 CFR chapter II as follows:

PART 201 EXTENSIONS OF CREDIT BY FEDERAL RESERVE BANKS (REGULATION A)

■ 1. The authority citation for part 201 continues to read as follows:

Authority: 12 U.S.C. 248(i)–(j), 343 *et seq.,* 347a, 347b, 347c, 348 *et seq.,* 357, 374, 374a, and 461.

■ 2. Section 201.51 is amended by revising paragraphs (a) and (b) to read as follows:

§ 201.51 Interest rates applicable to credit extended by a Federal Reserve Bank.[3]

(a) *Primary credit.* The interest rate at each Federal Reserve Bank for primary credit provided to depository institutions under § 201.4(a) is 5.5 percent.

(b) *Secondary credit.* The interest rate at each Federal Reserve Bank for secondary credit provided to depository institutions under § 201.4(b) is 6.0 percent.

* * * * *

[3] The primary, secondary, and seasonal credit rates described in this section apply to both advances and discounts made under the primary, secondary, and seasonal credit programs, respectively.

By order of the Board of Governors of the Federal Reserve System.

Ann E. Misback,

Secretary of the Board.

[FR Doc. 2023–16381 Filed 8–1–23; 8:45 am]

BILLING CODE 6210–01–P

FEDERAL RESERVE SYSTEM

12 CFR Part 204

[Docket No. R–1812; RIN 7100–AG63]

Regulation D: Reserve Requirements of Depository Institutions

AGENCY: Board of Governors of the Federal Reserve System.

ACTION: Final rule.

SUMMARY: The Board of Governors of the Federal Reserve System (''Board'') has adopted final amendments to its Regulation D to revise the rate of interest paid on balances (''IORB'') maintained at Federal Reserve Banks by or on behalf of eligible institutions. The final amendments specify that IORB is 5.4 percent, a 0.25 percentage point increase from its prior level. The amendment is intended to enhance the role of IORB in maintaining the Federal funds rate in the target range established by the Federal Open Market Committee (''FOMC'' or ''Committee'').

DATES: *Effective date:* This rule is effective August 2, 2023.

Applicability date: The IORB rate change was applicable on July 27, 2023.

FOR FURTHER INFORMATION CONTACT: M. Benjamin Snodgrass, Senior Counsel (202–263–4877), Legal Division, or Kristen Payne, Lead Financial Institution & Policy Analyst (202–452–2872); for users of telephone systems via text telephone (TTY) or any TTY-based Telecommunications Relay Services, please call 711 from any telephone, anywhere in the United States; Board of Governors of the Federal Reserve System, 20th and C Streets NW, Washington, DC 20551.

SUPPLEMENTARY INFORMATION:

I. Statutory and Regulatory Background

For monetary policy purposes, section 19 of the Federal Reserve Act (''Act'') imposes reserve requirements on certain types of deposits and other liabilities of depository institutions.[1] Regulation D, which implements section 19 of the Act, requires that a depository institution meet reserve requirements by holding cash in its vault, or if vault cash is insufficient, by maintaining a balance in an account at a Federal Reserve Bank (''Reserve Bank'').[2] Section 19 also provides that balances maintained by or on behalf of certain institutions in an account at a Reserve Bank may receive earnings to be paid by the Reserve Bank at least once each quarter, at a rate or rates not to exceed the general level of short-term interest rates.[3] Institutions that are eligible to receive earnings on their balances held at Reserve Banks (''eligible institutions'') include depository institutions and certain other institutions.[4] Section 19 also provides that the Board may prescribe regulations concerning the payment of earnings on balances at a Reserve Bank.[5] Prior to these amendments, Regulation D established IORB at 5.15 percent.[6]

II. Amendment to IORB

The Board is amending § 204.10(b)(1) of Regulation D to establish IORB at 5.4 percent. The amendment represents a 0.25 percentage point increase in IORB. This decision was announced on July 26, 2023, with an effective date of July 27, 2023, in the Federal Reserve Implementation Note that accompanied the FOMC's statement on July 26, 2023. The FOMC statement stated that the Committee decided to raise the target range for the Federal funds rate to 5¼ to 5½ percent.

The Federal Reserve Implementation Note stated:

[4] 5 U.S.C. 553(a)(2).

[5] 5 U.S.C. 603, 604.

[6] 44 U.S.C. 3506; *see* 5 CFR part 1320, appendix A.1.

[1] 12 U.S.C. 461(b). In March 2020, the Board set all reserve requirement ratios to zero percent. *See* Interim Final Rule, 85 FR 16525 (Mar. 24, 2020); Final Rule, 86 FR 8853 (Feb. 10, 2021).

[2] 12 CFR 204.5(a)(1).

[3] 12 U.S.C. 461(b)(1)(A) and (b)(12)(A).

[4] *See* 12 U.S.C. 461(b)(1)(A) & (b)(12)(C); *see* also 12 CFR 204.2(y).

[5] *See* 12 U.S.C. 461(b)(12)(B).

[6] *See* 12 CFR 204.10(b)(1).

The Board of Governors of the Federal Reserve System voted unanimously to raise the interest rate paid on reserve balances to 5.4 percent, effective July 27, 2023.

As a result, the Board is amending § 204.10(b)(1) of Regulation D to establish IORB at 5.4 percent.

III. Administrative Procedure Act

In general, the Administrative Procedure Act (''APA'')[7] imposes three principal requirements when an agency promulgates legislative rules (rules made pursuant to Congressionally-delegated authority): (1) publication with adequate notice of a proposed rule; (2) followed by a meaningful opportunity for the public to comment on the rule's content; and (3) publication of the final rule not less than 30 days before its effective date. The APA provides that notice and comment procedures do not apply if the agency for good cause finds them to be ''unnecessary, impracticable, or contrary to the public interest.''[8] Section 553(d) of the APA also provides that publication at least 30 days prior to a rule's effective date is not required for (1) a substantive rule which grants or recognizes an exemption or relieves a restriction; (2) interpretive rules and statements of policy; or (3) a rule for which the agency finds good cause for shortened notice and publishes its reasoning with the rule.[9]

The Board has determined that good cause exists for finding that the notice, public comment, and delayed effective date provisions of the APA are unnecessary, impracticable, or contrary to the public interest with respect to these final amendments to Regulation D. The rate change for IORB that is reflected in the final amendment to Regulation D was made with a view towards accommodating commerce and business and with regard to their bearing upon the general credit situation of the country. Notice and public comment would prevent the Board's action from being effective as promptly as necessary in the public interest and would not otherwise serve any useful purpose. Notice, public comment, and a delayed effective date would create uncertainty about the finality and effectiveness of the Board's action and undermine the effectiveness of that action. Accordingly, the Board has determined that good cause exists to dispense with the notice, public comment, and delayed effective date procedures of the APA with respect to this final amendment to Regulation D.

IV. Regulatory Flexibility Analysis

The Regulatory Flexibility Act (''RFA'') does not apply to a rulemaking where a general notice of proposed rulemaking is not required.[10] As noted previously, the Board has determined that it is unnecessary and contrary to the public interest to publish a general notice of proposed rulemaking for this final rule. Accordingly, the RFA's requirements relating to an initial and final regulatory flexibility analysis do not apply.

V. Paperwork Reduction Act

In accordance with the Paperwork Reduction Act (''PRA'') of 1995,[11] the Board reviewed the final rule under the authority delegated to the Board by the Office of Management and Budget. The final rule contains no requirements subject to the PRA.

List of Subjects in 12 CFR Part 204

Banks, Banking, Reporting and recordkeeping requirements.

Authority and Issuance

For the reasons set forth in the preamble, the Board amends 12 CFR part 204 as follows:

PART 204—RESERVE REQUIREMENTS OF DEPOSITORY INSTITUTIONS (REGULATION D)

■ 1. The authority citation for part 204 continues to read as follows:

Authority: 12 U.S.C. 248(a), 248(c), 461, 601, 611, and 3105.

■ 2. Section 204.10 is amended by revising paragraph (b)(1) to read as follows:

§ 204.10 Payment of interest on balances.

* * * * *

(b) * * *

(1) For balances maintained in an eligible institution's master account, interest is the amount equal to the interest on reserve balances rate (''IORB rate'') on a day multiplied by the total balances maintained on that day. The IORB rate is 5.4 percent.

* * * * *

By order of the Board of Governors of the Federal Reserve System.

Ann E. Misback,

Secretary of the Board.

[FR Doc. 2023–16386 Filed 8–1–23; 8:45 am]

BILLING CODE 6210–01–P

[7] 5 U.S.C. 551 *et seq.*

[8] 5 U.S.C. 553(b)(3)(A).

[9] 5 U.S.C. 553(d).

[10] 5 U.S.C. 603, 604.

[11] 44 U.S.C. 3506; see 5 CFR part 1320 Appendix A.1.

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. FAA–2023–0934; Project Identifier AD–2022–01443–T; Amendment 39–22503; AD 2023–14–03]

RIN 2120–AA64

Airworthiness Directives; The Boeing Company Airplanes

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule.

SUMMARY: The FAA is adopting a new airworthiness directive (AD) for all The Boeing Company Model 747–8F and 747–8 series airplanes. This AD was prompted by a report of cracks in stringers, common to the end fittings, on the aft side of the bulkhead at station (STA) 2598. This AD requires detailed inspections of the stringers, common to the end fittings, forward and aft of the bulkhead at a certain station for cracking and applicable on-condition actions. The FAA is issuing this AD to address the unsafe condition on these products.

DATES: This AD is effective September 6, 2023.

The Director of the Federal Register approved the incorporation by reference of a certain publication listed in this AD as of September 6, 2023.

ADDRESSES:

AD Docket: You may examine the AD docket at *regulations.gov* under Docket No. FAA–2023–0934; or in person at Docket Operations between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The AD docket contains this final rule, any comments received, and other information. The address for Docket Operations is U.S. Department of Transportation, Docket Operations, M–30, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE, Washington, DC 20590.

Material Incorporated by Reference:

- For service information identified in this final rule, contact Boeing Commercial Airplanes, Attention: Contractual & Data Services (C&DS), 2600 Westminster Blvd., MC 110–SK57, Seal Beach, CA 90740–5600; telephone 562–797–1717; website *myboeingfleet.com.*
- You may view this service information at the FAA, Airworthiness Products Section, Operational Safety Branch, 2200 South 216th St., Des Moines, WA. For information on the availability of this material at the FAA,

call 206–231–3195. It is also available at *regulations.gov* under Docket No. FAA–2023–0934.

FOR FURTHER INFORMATION CONTACT: Stefanie Roesli, Aviation Safety Engineer, FAA, 2200 South 216th St., Des Moines, WA 98198; phone: 206–231–3964; email: *stefanie.n.roesli@faa.gov.*

SUPPLEMENTARY INFORMATION:

Background

The FAA issued a notice of proposed rulemaking (NPRM) to amend 14 CFR part 39 by adding an AD that would apply to all The Boeing Company (Boeing) Model 747–8F and 747–8 series airplanes. The NPRM published in the **Federal Register** on May 8, 2023 (88 FR 29555). The NPRM was prompted by a report indicating the presence of cracks in stringers, common to the end fittings, at stringer location S–42L/R and S–46L/R on the aft side of the bulkhead at station 2598. The airplane had accumulated 5,517 total flight cycles and 32,468 total flight hours at time the cracks were found. In addition, during foreign object debris (FOD) inspections Boeing found five cracks in stringers, common to the end fittings, at stringer locations S–2L, S–6L, S–8L, and S–2R on the forward side and S–5L on the aft side of the bulkhead at STA 2598 on two airplanes. The FAA has also received reports of similar cracks found on additional airplanes. In all cases, the cracks were found in the side walls of the stringers and had grown in longitudinal and transverse directions, but there was no other damage or deformation in the surrounding area. An investigation by Boeing found that during airplane assembly, un-shimmed or incorrectly shimmed gaps that were larger than engineering requirements caused excessive and sustained internal tensile stresses and resulted in stress corrosion cracking in the stringers. In the NPRM, the FAA proposed to require detailed inspections of the stringers, common to the end fittings, forward and aft of the bulkhead at a certain station for cracking and applicable on-condition actions. The FAA is issuing this AD to address stress corrosion cracking in the stringers. This condition, if not addressed, could lead to a failure of the skin adjacent to the bulkhead at STA 2598, which could adversely affect the structural integrity of the airplane.

Discussion of Final Airworthiness Directive

Comments

The FAA received a comment from Boeing, who supported the NPRM without change.

Conclusion

The FAA reviewed the relevant data, considered the comment received, and determined that air safety requires adopting this AD as proposed. Accordingly, the FAA is issuing this AD to address the unsafe condition on these products. Except for minor editorial changes, this AD is adopted as proposed in the NPRM. None of the changes will increase the economic burden on any operator.

Related Service Information Under 1 CFR Part 51

The FAA reviewed Boeing Alert Requirements Bulletin 747–53A2911 RB, dated November 3, 2022. This service information specifies procedures for repetitive detailed inspections of the stringers, common to the end fittings, forward and aft of the bulkhead at STA 2598, for any crack, and applicable on-condition actions. On-condition actions include repair. This service information is reasonably available because the interested parties have access to it through their normal course of business or by the means identified in **ADDRESSES**.

Costs of Compliance

The FAA estimates that this AD affects 42 airplanes of U.S. registry. The FAA estimates the following costs to comply with this AD:

ESTIMATED COSTS

Action	Labor cost	Parts cost	Cost per product	Cost on U.S. operators
Detailed inspection	91 work-hours × $85 per hour = $7,735 per inspection cycle.	$0	$7,735 per inspection cycle	$324,870 per inspection cycle.

The FAA estimates the following costs to do any necessary repairs that would be required based on the results of the inspection. The agency has no way of determining the number of aircraft that might need these repairs:

ON-CONDITION COSTS

Action	Labor cost	Parts cost	Cost per product
Repair	13 work-hours × $85 per hour = $1,105	$600	$1,705 (per stringer).

The FAA has included all known costs in its cost estimate. According to the manufacturer, however, some or all of the costs of this AD may be covered under warranty, thereby reducing the cost impact on affected operators.

Authority for This Rulemaking

Title 49 of the United States Code specifies the FAA's authority to issue rules on aviation safety. Subtitle I, section 106, describes the authority of the FAA Administrator. Subtitle VII: Aviation Programs, describes in more detail the scope of the Agency's authority.

The FAA is issuing this rulemaking under the authority described in Subtitle VII, Part A, Subpart III, Section 44701: General requirements. Under that section, Congress charges the FAA with promoting safe flight of civil aircraft in air commerce by prescribing regulations for practices, methods, and procedures the Administrator finds necessary for safety in air commerce. This regulation is within the scope of that authority because it addresses an unsafe condition that is likely to exist or develop on products identified in this rulemaking action.

Regulatory Findings

This AD will not have federalism implications under Executive Order 13132. This AD will not have a substantial direct effect on the States, on the relationship between the national government and the States, or on the

distribution of power and responsibilities among the various levels of government.

For the reasons discussed above, I certify that this AD:

(1) Is not a ''significant regulatory action'' under Executive Order 12866,

(2) Will not affect intrastate aviation in Alaska, and

(3) Will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Incorporation by reference, Safety.

The Amendment

Accordingly, under the authority delegated to me by the Administrator, the FAA amends 14 CFR part 39 as follows:

PART 39—AIRWORTHINESS DIRECTIVES

■ 1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40113, 44701.

§ 39.13 [Amended]

■ 2. The FAA amends § 39.13 by adding the following new airworthiness directive:

2023–14–03 The Boeing Company: Amendment 39–22503; Docket No. FAA–2023–0934; Project Identifier AD–2022–01443–T.

(a) Effective Date

This airworthiness directive (AD) is effective September 6, 2023.

(b) Affected ADs

None.

(c) Applicability

This AD applies to all The Boeing Company Model 747–8F and 747–8 series airplanes, certificated in any category.

(d) Subject

Air Transport Association (ATA) of America Code 53, Fuselage.

(e) Unsafe Condition

This AD was prompted by a report of cracks in stringers, common to the end fittings, on the aft side of the bulkhead at station (STA) 2598. The FAA is issuing this AD to address stress corrosion cracking in the stringers. This condition, if not addressed, could lead to a failure of the skin adjacent to the bulkhead at STA 2598, which could adversely affect the structural integrity of the airplane.

(f) Compliance

Comply with this AD within the compliance times specified, unless already done.

(g) Required Actions

Except as specified by paragraph (h) of this AD: At the applicable times specified in the ''Compliance'' paragraph of Boeing Alert Requirements Bulletin 747–53A2911 RB, dated November 3, 2022, do all applicable actions identified in, and in accordance with, the Accomplishment Instructions of Boeing Alert Requirements Bulletin 747–53A2911 RB, dated November 3, 2022.

Note 1 to paragraph (g): Guidance for accomplishing the actions required by this AD can be found in Boeing Alert Service Bulletin 747–53A2911, dated November 3, 2022, which is referred to in Boeing Alert Requirements Bulletin 747–53A2911 RB, dated November 3, 2022.

(h) Exceptions to Service Information Specifications

(1) Where the Compliance Time column of the table in the ''Compliance'' paragraph of Boeing Alert Requirements Bulletin 747–53A2911 RB, dated November 3, 2022, uses the phrase ''the original issue date of Requirements Bulletin 747–53A2911 RB,'' this AD requires using ''the effective date of this AD.''

(2) Where Boeing Alert Requirements Bulletin 747–53A2911 RB, dated November 3, 2022, specifies contacting Boeing for repair instructions: This AD requires doing the repair using a method approved in accordance with the procedures specified in paragraph (i) of this AD.

(i) Alternative Methods of Compliance (AMOCs)

(1) The Manager AIR–520 Continued Operational Safety Branch, FAA, has the authority to approve AMOCs for this AD, if requested using the procedures found in 14 CFR 39.19. In accordance with 14 CFR 39.19, send your request to your principal inspector or responsible Flight Standards Office, as appropriate. If sending information directly to the manager of the certification office, send it to the attention of the person identified in paragraph (j) of this AD. Information may be emailed to: *9-ANM-Seattle-ACO-AMOC-Requests@faa.gov.*

(2) Before using any approved AMOC, notify your appropriate principal inspector, or lacking a principal inspector, the manager of the responsible Flight Standards Office.

(3) An AMOC that provides an acceptable level of safety may be used for any repair, modification, or alteration required by this AD if it is approved by The Boeing Company Organization Designation Authorization (ODA) that has been authorized by the Manager, AIR–520 Continued Operational Safety Branch, FAA, to make those findings. To be approved, the repair method, modification deviation, or alteration deviation must meet the certification basis of the airplane, and the approval must specifically refer to this AD.

(j) Related Information

For more information about this AD, contact Stefanie Roesli, Aviation Safety Engineer, FAA, 2200 South 216th St., Des Moines, WA 98198; phone: 206–231–3964; email: *stefanie.n.roesli@faa.gov.*

(k) Material Incorporated by Reference

(1) The Director of the Federal Register approved the incorporation by reference (IBR) of the service information listed in this paragraph under 5 U.S.C. 552(a) and 1 CFR part 51.

(2) You must use this service information as applicable to do the actions required by this AD, unless the AD specifies otherwise.

(i) Boeing Alert Requirements Bulletin 747–53A2911 RB, dated November 3, 2022.

(ii) [Reserved]

(3) For service information identified in this AD, contact Boeing Commercial Airplanes, Attention: Contractual & Data Services (C&DS), 2600 Westminster Blvd., MC 110–SK57, Seal Beach, CA 90740–5600; telephone 562–797–1717; website *myboeingfleet.com.*

(4) You may view this service information at the FAA, Airworthiness Products Section, Operational Safety Branch, 2200 South 216th St., Des Moines, WA. For information on the availability of this material at the FAA, call 206–231–3195.

(5) You may view this service information that is incorporated by reference at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, *fr.inspection@nara.gov,* or go to: *www.archives.gov/federal-register/cfr/ibr-locations.html.*

Issued on July 8, 2023.

Michael Linegang,

Acting Director, Compliance & Airworthiness Division, Aircraft Certification Service.

[FR Doc. 2023–16366 Filed 8–1–23; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 71

[Docket No. FAA–2022–0216; Airspace Docket No. 19–AAL–63]

RIN 2120–AA66

Amendment of United States Area Navigation (RNAV) Route T–230; St. Paul Island, AK

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule, delay of effective date.

SUMMARY: This action changes the effective date of a final rule published in the **Federal Register** on July 17, 2023, that amends the United States Area Navigation (RNAV) route T–230 in the vicinity of St. Paul Island, AK, in support of a large and comprehensive T-route modernization project for the state of Alaska. The effective date in the final

rule was incorrectly stated as August 10, 2023. The correct effective date for Airspace Docket No. 19–AAL–63 is October 5, 2023.

DATES: The effective date of the final rule published on July 17, 2023 (88 FR 45329) is delayed until October 5, 2023. The Director of the Federal Register approved this incorporation by reference action under Title 1 Code of Federal Regulations part 51, subject to the annual revision of FAA Order JO 7400.11 and publication of conforming amendments.

FOR FURTHER INFORMATION CONTACT: Steven Roff, Rules and Regulations Group, Office of Policy, Federal Aviation Administration, 800 Independence Avenue SW, Washington, DC 20591; telephone: (202) 267–8783.

SUPPLEMENTARY INFORMATION:

Background

The FAA published a final rule for Docket No. FAA–2022–0216 in the **Federal Register** (88 FR 45329; July 17, 2023), that amended RNAV route T–230 in the vicinity of St. Paul Island, AK. The effective date in the final rule was incorrectly stated as August 10, 2023. The correct effective date for Airspace Docket No. 19–AAL–63 is October 5, 2023.

Delay of Effective Date

Accordingly, pursuant to the authority delegated to me, the effective date of the final rule, Airspace Docket 19–AAL–63, as published in the **Federal Register** on July 17, 2023 (88 FR 45329), FR Doc. 2023–15011, is hereby delayed until October 5, 2023.

Authority: 49 U.S.C. 106(f), 106(g); 40103, 40113, 40120; E.O. 10854, 24 FR 9565, 3 CFR, 1959–1963 Comp., P. 389.

Issued in Washington, DC, on July 27, 2023.

Karen L. Chiodini,

Acting Manager, Rules and Regulations Group.

[FR Doc. 2023–16317 Filed 8–1–23; 8:45 am]

BILLING CODE 4910–13–P

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION

14 CFR Part 1204

[NASA Document No: NASA–23–054; NASA Docket No: NASA–2023–0003]

RIN 2700–AE70

Delegations and Designations

AGENCY: National Aeronautics and Space Administration.

ACTION: Direct final rule, withdrawal.

SUMMARY: NASA published a document in the **Federal Register** on July 5, 2023, concerning Delegations and Designations. The Agency is withdrawing the document for allow for additional internal coordination.

DATES: Effective on September 5, 2023, the direct final rule published at 88 FR 42870, July 5, 2023 is withdrawn.

FOR FURTHER INFORMATION CONTACT: Daniela Cruzado, 202–295–7589.

SUPPLEMENTARY INFORMATION:

NASA published a document in the **Federal Register** on July 5, 2023 [88 FR 42870], in FR Doc. 2023–14042, concerning Delegations and Designations. The Agency is withdrawing the document to allow for additional internal coordination.

Nanette Smith,

Team Lead, NASA Directives and Regulations.

[FR Doc. 2023–16123 Filed 8–1–23; 8:45 am]

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DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 165

[Docket Number USCG–2023–0613]

RIN 1625–AA00

Safety Zone; Kanawha River, Mile Markers 41.5 to 42.5, Nitro, WV

AGENCY: Coast Guard, DHS.

ACTION: Temporary final rule.

SUMMARY: The Coast Guard is establishing a temporary safety zone for navigable waters within a half mile radius of the Donald Legg Memorial Bridge. The safety zone is needed to protect personnel, vessels, and the marine environment from potential hazards created by adding a center section of the bridge. Entry of vessels or persons into this zone is prohibited unless specifically authorized by the Captain of the Port Sector Ohio Valley (COTP) or a designated representative.

DATES: This rule is effective from 5:30 a.m. on August 24, 2023, through 7 p.m. on August 25, 2023.

ADDRESSES: To view documents mentioned in this preamble as being available in the docket, go to *https://www.regulations.gov,* type USCG–2023–0613 in the search box and click ''Search.'' Next, in the Document Type column, select ''Supporting & Related Material.''

FOR FURTHER INFORMATION CONTACT: If you have questions on this rule, call or email Petty Officer Chelsea Zimmerman, Marine Safety Unit Huntington, U.S. Coast Guard, telephone 304–733–0198, email *Chelsea.M.Zimmerman@uscg.mil.*

SUPPLEMENTARY INFORMATION:

I. Table of Abbreviations

CFR Code of Federal Regulations
COTP Captain of the Port
DHS Department of Homeland Security
FR Federal Register
NPRM Notice of proposed rulemaking
§ Section
U.S.C. United States Code

II. Background Information and Regulatory History

The Coast Guard is issuing this temporary rule without prior notice and opportunity to comment pursuant to authority under section 4(a) of the Administrative Procedure Act (APA) (5 U.S.C. 553(b)). This provision authorizes an agency to issue a rule without prior notice and opportunity to comment when the agency for good cause finds that those procedures are ''impracticable, unnecessary, or contrary to the public interest.'' Under 5 U.S.C. 553(b)(B), the Coast Guard finds that good cause exists for not publishing a notice of proposed rulemaking (NPRM) with respect to this rule because publishing an NPRM would be impracticable. A safety zone is needed to alleviate safety concerns associated with construction operations for the purpose of adding the center section of the Donald Legg Memorial Bridge. It is impracticable to publish an NPRM because we must establish this safety zone by August 24th, 2023, and lack sufficient time to provide a reasonable comment period and then consider those comments before issuing the rule.

Under 5 U.S.C. 553(d)(3), the Coast Guard finds that good cause exists for making this rule effective less than 30 days after publication in the **Federal Register**. Delaying the effective date of this rule would be impracticable and contrary to the public interest because we must establish the safety zone by August 24, 2023 in order to protect personnel, vessels, and the marine environment from the potential safety hazards associated with the bridge construction beginning on that date.

III. Legal Authority and Need for Rule

The Coast Guard is issuing this rule under authority in 46 U.S.C. 70034. The Captain of the Port Sector Ohio Valley (COTP) has determined that safety needs associated with construction operations on the Donald Legg Memorial Bridge on August 23, 2023, and August 24, 2023, present a safety concern. The purpose of this rulemaking

is to ensure the safety of the public surrounding regulated area before, during, and after the construction event.

IV. Discussion of the Rule

This rule establishes a safety zone that will be enforced from 5:30 a.m. until 8 p.m. on August 24, 2023, and from 7 a.m. until 7 p.m. on August 25, 2023. The safety zone will cover all navigable waters between mile markers 41.5 to 42.5 on the Kanawha River. The duration of the zone is intended to protect personnel, vessels, and the marine environment in these navigable waters while the bridge span is being added. No vessel or person will be permitted to enter the safety zone without obtaining permission from the COTP or a designated representative. A designated representative means a Coast Guard Patrol Commander, including a Coast Guard coxswain, petty officer, or other officer operating a Coast Guard vessel and a Federal, State, and local officer designated by or assisting the Captain of the Port Sector Ohio Valley (COTP) in the enforcement of the safety zone.

Persons or vessels seeking to enter the safety zone must request permission from the COTP on VHF–FM channel 16 or by telephone at 1–502–779–5424. If permission is granted, all persons and vessels shall comply with the instructions of the COTP or designated representative.

The COTP or a designated representative will inform the public of the enforcement times and date for this safety zone through Broadcast Notices to Mariners, Local Notices to Mariners, and/or Safety Marine Information Broadcasts as appropriate.

V. Regulatory Analyses

We developed this rule after considering numerous statutes and Executive orders related to rulemaking. Below we summarize our analyses based on a number of these statutes and Executive orders, and we discuss First Amendment rights of protestors.

A. Regulatory Planning and Review

Executive Orders 12866 and 13563 direct agencies to assess the costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits. This rule has not been designated a ''significant regulatory action,'' under section 3(f) of Executive Order 12866, as amended by Executive Order 14094 (Modernizing Regulatory Review). Accordingly, this rule has not been reviewed by the Office of Management and Budget (OMB).

This regulatory action determination is based on the size, location, duration, and time-of-day of the regulated area. This rule is limited to the Kanawha River from mile 41.5 to 42.5 on August 23, 2023, and August 24, 2023, and will be enforced only during the times specified. Moreover, the Coast Guard will issue Broadcast Notice to Mariners via VHF–FM marine channel 16 about the regulated area and the rule allows vessels to seek permission to enter the area.

B. Impact on Small Entities

The Regulatory Flexibility Act of 1980, 5 U.S.C. 601–612, as amended, requires Federal agencies to consider the potential impact of regulations on small entities during rulemaking. The term ''small entities'' comprises small businesses, not-for-profit organizations that are independently owned and operated and are not dominant in their fields, and governmental jurisdictions with populations of less than 50,000. The Coast Guard certifies under 5 U.S.C. 605(b) that this rule will not have a significant economic impact on a substantial number of small entities.

While some owners or operators of vessels intending to transit the safety zone may be small entities, for the reasons stated in section V.A above, this rule will not have a significant economic impact on any vessel owner or operator.

Under section 213(a) of the Small Business Regulatory Enforcement Fairness Act of 1996 (Pub. L. 104–121), we want to assist small entities in understanding this rule. If the rule would affect your small business, organization, or governmental jurisdiction and you have questions concerning its provisions or options for compliance, please call or email the person listed in the **FOR FURTHER INFORMATION CONTACT** section.

Small businesses may send comments on the actions of Federal employees who enforce, or otherwise determine compliance with, Federal regulations to the Small Business and Agriculture Regulatory Enforcement Ombudsman and the Regional Small Business Regulatory Fairness Boards. The Ombudsman evaluates these actions annually and rates each agency's responsiveness to small business. If you wish to comment on actions by employees of the Coast Guard, call 1–888–REG–FAIR (1–888–734–3247). The Coast Guard will not retaliate against small entities that question or complain about this rule or any policy or action of the Coast Guard.

C. Collection of Information

This rule will not call for a new collection of information under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3520).

D. Federalism and Indian Tribal Governments

A rule has implications for federalism under Executive Order 13132, Federalism, if it has a substantial direct effect on the States, on the relationship between the National Government and the States, or on the distribution of power and responsibilities among the various levels of government. We have analyzed this rule under that order and have determined that it is consistent with the fundamental federalism principles and preemption requirements described in Executive Order 13132.

Also, this rule does not have tribal implications under Executive Order 13175, Consultation and Coordination with Indian Tribal Governments, because it does not have a substantial direct effect on one or more Indian tribes, on the relationship between the Federal Government and Indian tribes, or on the distribution of power and responsibilities between the Federal Government and Indian tribes.

E. Unfunded Mandates Reform Act

The Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1531–1538) requires Federal agencies to assess the effects of their discretionary regulatory actions. In particular, the Act addresses actions that may result in the expenditure by a State, local, or tribal government, in the aggregate, or by the private sector of $100,000,000 (adjusted for inflation) or more in any one year. Though this rule will not result in such an expenditure, we do discuss the effects of this rule elsewhere in this preamble.

F. Environment

We have analyzed this rule under Department of Homeland Security Directive 023–01, Rev. 1, associated implementing instructions, and Environmental Planning COMDTINST 5090.1 (series), which guide the Coast Guard in complying with the National Environmental Policy Act of 1969 (42 U.S.C. 4321–4370f), and have determined that this action is one of a category of actions that do not individually or cumulatively have a significant effect on the human environment. This rule involves establishing a temporary safety zone on the Kanawha River at mile 41.5 to 42.5 on August 23, 2023, and August 24, 2023. It is categorically excluded from further review under paragraph L60(a) of Appendix A, Table 1 of DHS

Instruction Manual 023–01–001–01, Rev. 1. A Record of Environmental Consideration supporting this determination is available in the docket. For instructions on locating the docket, see the **ADDRESSES** section of this preamble.

G. Protest Activities

The Coast Guard respects the First Amendment rights of protesters. Protesters are asked to call or email the person listed in the **FOR FURTHER INFORMATION CONTACT** section to coordinate protest activities so that your message can be received without jeopardizing the safety or security of people, places, or vessels.

List of Subjects in 33 CFR Part 165

Harbors, Marine safety, Navigation (water), Reporting and recordkeeping requirements, Security measures, Waterways.

For the reasons discussed in the preamble, the Coast Guard amends 33 CFR part 165 as follows:

PART 165—REGULATED NAVIGATION AREAS AND LIMITED ACCESS AREAS

■ 1. The authority citation for part 165 continues to read as follows:

Authority: 46 U.S.C 70034, 70051, 70124; 33 CFR 1.05–1, 6.04–6, and 160.5; Department of Homeland Security Delegation No. 00170.1, Revision No. 01.3.

■ 2. Add § 165.T08–0613 to read as follows:

§ 165.T08–0613 Safety Zone; Kanawha River, Mile Markers 41.5 to 42.5 Nitro, WV.

(a) *Location.* The following area is a safety zone: all navigable waters of the Kanawha River from mile marker 41.5 to mile marker 42.5, extending the entire width of the river.

(b) *Definitions. Designated representative* means a Coast Guard Patrol Commander (PATCOM), including a Coast Guard coxswain, petty officer, or other officer operating a Coast Guard vessel and a Federal, State, and local officer designated by or assisting the Captain of the Port Ohio Valley (COTP) in the enforcement of the regulations in this section.

(c) *Regulations.* (1) Under the general safety zone regulations in subpart C of this part, you may not enter the safety zone described in paragraph (a) of this section unless authorized by the COTP or the COTP's designated representative. The Coast Guard may patrol the event area under the direction of a designated Coast Guard Patrol Commander.

(2) To seek permission to enter, the COTP or the COTP's representative may be contacted on Channel 16 VHF–FM (156.8 MHz) by the call sign ''PATCOM'', or phone at 1–502–779–5424. Those in the safety zone must comply with all lawful orders or directions given to them by the COTP or the COTP's designated representative.

(3) The Patrol Commander may forbid and control the movement of all vessels in the regulated area. When hailed or signaled by an official patrol vessel, a vessel shall come to an immediate stop and comply with the directions given. Failure to do so may result in expulsion from the area, citation for failure to comply, or both.

(4) The Patrol Commander may terminate the event or the operation of any vessel at any time it is deemed necessary for the protection of life or property.

(5) The COTP will provide notice of the regulated area through advanced notice via local notice to mariners and broadcast notice to mariners and by on-scene designated representatives.

(d) *Enforcement periods.* This section will be enforced from 5:30 a.m. to 8 p.m. on August 23, 2023, and 6:30 a.m. to 7 p.m. on August 24, 2023.

Dated: July 25, 2023.

H.R. Mattern,

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

[FR Doc. 2023–16428 Filed 8–1–23; 8:45 am]

BILLING CODE 9110–04–P

DEPARTMENT OF COMMERCE

Patent and Trademark Office

37 CFR Part 6

[Docket No. PTO–T–2023–0032]

RIN 0651–AD70

International Trademark Classification Changes

AGENCY: United States Patent and Trademark Office, Department of Commerce.

ACTION: Final rule.

SUMMARY: The United States Patent and Trademark Office (USPTO) issues this final rule to incorporate classification changes adopted by the Nice Agreement Concerning the International Classification of Goods and Services for the Purposes of the Registration of Marks (Nice Agreement). These changes are listed in the International Classification of Goods and Services for the Purposes of the Registration of Marks (Nice Classification), which is published by the World Intellectual Property Organization (WIPO), and will become effective on January 1, 2024.

DATES: This rule is effective on January 1, 2024.

FOR FURTHER INFORMATION CONTACT: Catherine Cain, Office of the Deputy Commissioner for Trademark Examination Policy, at 571–272–8946 or *TMPolicy@uspto.gov.*

SUPPLEMENTARY INFORMATION:

Purpose: As noted above, this final rule incorporates classification changes adopted by the Nice Agreement that will become effective on January 1, 2024. Specifically, this rule modifies the class heading for Class 3 to align the English class heading with the French class heading.

Summary of Major Provisions: The USPTO is revising § 6.1 of 37 CFR part 6 to incorporate classification changes and modifications, as listed in the Nice Classification (12th ed., ver. 2024), published by WIPO, that will become effective on January 1, 2024.

The Nice Agreement is a multilateral treaty, administered by WIPO, that establishes the international classification of goods and services for the purposes of registering trademarks and service marks. As of September 1, 1973, this international classification system is the controlling system used by the United States, and it applies, for all statutory purposes, to all applications filed on or after September 1, 1973, and their resulting registrations. *See* 37 CFR 2.85(a). Every signatory to the Nice Agreement must use the international classification system.

Each state party to the Nice Agreement is represented in the Committee of Experts of the Nice Union (Committee of Experts), which meets annually to vote on proposed changes to the Nice Classification. Any state that is a party to the Nice Agreement may submit proposals for consideration by the other members of the Committee of Experts, in accordance with agreed-upon rules of procedure. Proposals are currently submitted annually to an electronic forum on the WIPO website, where they are commented on, modified, and compiled for further discussion and voting at the annual Committee of Experts meeting.

In 2013, the Committee of Experts began annual revisions to the Nice Classification. The annual revisions, which are published electronically and enter into force on January 1 each year, are referred to as versions and identified by an edition number and the year of the effective date (*e.g.,* ''Nice Classification, 10th ed., ver. 2013'' or ''NCL 10–2013''). Each annual version includes all changes adopted by the Committee of Experts since the adoption of the previous version. The changes

consist of: (1) the addition of new goods and services to, and the deletion of goods and services from, the Alphabetical List; and (2) any modifications to the wording in the Alphabetical List, the class headings, or the explanatory notes that do not involve the transfer of goods or services from one class to another.

As of January 1, 2023, new editions of the Nice Classification are published electronically every three years. They include all changes adopted since the previous annual version, as well as goods or services transferred from one class to another and new classes that have been created since the previous edition.

The 33rd session of the Committee of Experts, which took place from May 1–5, 2023, was held in a hybrid format, with WIPO participating at the WIPO headquarters in Geneva and member states participating via an online platform or in person. The annual revisions contained in this final rule consist of a modification to a class heading that was incorporated into the Nice Agreement through e-voting during the session.

Under the Nice Classification, there are 34 classes of goods and 11 classes of services, each with a class heading. Class headings generally indicate the fields to which goods and services belong. Specifically, this rule modifies the class heading for Class 3 by deleting the term ''scouring'' from the phrase ''cleaning, polishing, scouring and abrasive preparations'' and modifying the punctuation, as set forth in the discussion of regulatory changes below. This change was made to align the English class heading with the French class heading. The term ''scouring'' does not appear in the French version. Moreover, the remaining wording, ''abrasive preparations,'' encompasses ''scouring preparations.'' As a signatory to the Nice Agreement, the United States adopts these revisions pursuant to article 1.

Discussion of Regulatory Changes

The USPTO is revising § 6.1 as follows:

In Class 3, the wording and punctuation ''cleaning, polishing, scouring and abrasive preparations'' is replaced with ''cleaning, polishing and abrasive preparations.''

Rulemaking Requirements

A. Administrative Procedure Act: The changes in this rulemaking involve rules of agency practice and procedure or interpretive rules. *See Perez* v. *Mortg. Bankers Ass'n,* 575 U.S. 92, 97 (2015) (interpretive rules ''advise the public of the agency's construction of the statutes and rules which it administers'') (citation and internal quotation marks omitted); *Nat'l Org. of Veterans' Advocates* v. *Sec'y of Veterans Affairs,* 260 F.3d 1365, 1375 (Fed. Cir. 2001) (rule that clarifies interpretation of a statute is interpretive); *Bachow Commc'ns Inc.* v. *FCC,* 237 F.3d 683, 690 (D.C. Cir. 2001) (rules governing an application process are procedural under the Administrative Procedure Act); *Inova Alexandria Hosp.* v. *Shalala,* 244 F.3d 342, 350 (4th Cir. 2001) (rules for handling appeals were procedural where they did not change the substantive standard for reviewing claims).

Accordingly, prior notice and opportunity for public comment for the changes in this rulemaking are not required pursuant to 5 U.S.C. 553(b) or (c), or any other law. *See Perez,* 575 U.S. at 101 (notice-and-comment procedures are required neither when an agency ''issue[s] an initial interpretive rule'' nor ''when it amends or repeals that interpretive rule''); *Cooper Techs. Co.* v. *Dudas,* 536 F.3d 1330, 1336–37 (Fed. Cir. 2008) (stating that 5 U.S.C. 553, and thus 35 U.S.C. 2(b)(2)(B), do not require notice-and-comment rulemaking for ''interpretative rules, general statements of policy, or rules of agency organization, procedure, or practice'') (quoting 5 U.S.C. 553(b)(A)).

B. Regulatory Flexibility Act: As prior notice and an opportunity for public comment are not required pursuant to 5 U.S.C. 553 or any other law, neither a Regulatory Flexibility Act analysis nor a certification under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*) is required. *See* 5 U.S.C. 603.

C. Executive Order 12866 (Regulatory Planning and Review): This rulemaking has been determined to be not significant for purposes of Executive Order 12866 (Sept. 30, 1993).

D. Executive Order 13563 (Improving Regulation and Regulatory Review): The USPTO has complied with Executive Order 13563 (Jan. 18, 2011). Specifically, the USPTO has, to the extent feasible and applicable: (1) made a reasoned determination that the benefits justify the costs of the rule; (2) tailored the rule to impose the least burden on society consistent with obtaining the regulatory objectives; (3) selected a regulatory approach that maximizes net benefits; (4) specified performance objectives; (5) identified and assessed available alternatives; (6) involved the public in an open exchange of information and perspectives among experts in relevant disciplines, affected stakeholders in the private sector, and the public as a whole, and provided online access to the rulemaking docket; (7) attempted to promote coordination, simplification, and harmonization across Government agencies and identified goals designed to promote innovation; (8) considered approaches that reduce burdens and maintain flexibility and freedom of choice for the public; and (9) ensured the objectivity of scientific and technological information and processes.

E. Executive Order 13132 (Federalism): This rulemaking does not contain policies with federalism implications sufficient to warrant preparation of a Federalism Assessment under Executive Order 13132 (Aug. 4, 1999).

F. Executive Order 13175 (Tribal Consultation): This rulemaking will not: (1) have substantial direct effects on one or more Indian tribes, (2) impose substantial direct compliance costs on Indian tribal governments, or (3) preempt tribal law. Therefore, a tribal summary impact statement is not required under Executive Order 13175 (Nov. 6, 2000).

G. Executive Order 13211 (Energy Effects): This rulemaking is not a significant energy action under Executive Order 13211 because this rulemaking is not likely to have a significant adverse effect on the supply, distribution, or use of energy. Therefore, a Statement of Energy Effects is not required under Executive Order 13211 (May 18, 2001).

H. Executive Order 12988 (Civil Justice Reform): This rulemaking meets applicable standards to minimize litigation, eliminate ambiguity, and reduce burden as set forth in sections 3(a) and 3(b)(2) of Executive Order 12988 (Feb. 5, 1996).

I. Executive Order 13045 (Protection of Children): This rulemaking does not concern an environmental risk to health or safety that may disproportionately affect children under Executive Order 13045 (Apr. 21, 1997).

J. Executive Order 12630 (Taking of Private Property): This rulemaking will not affect a taking of private property or otherwise have taking implications under Executive Order 12630 (Mar. 15, 1988).

K. Congressional Review Act: Under the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 *et seq.*), the USPTO will submit a report containing the final rule and other required information to the United States Senate, the United States House of Representatives, and the Comptroller General of the Government Accountability Office. The changes in

this rulemaking are not expected to result in an annual effect on the economy of $100 million or more; a major increase in costs or prices; or significant adverse effects on competition, employment, investment, productivity, innovation, or the ability of United States-based enterprises to compete with foreign-based enterprises in domestic and export markets. Therefore, this rulemaking is not expected to result in a ''major rule'' as defined in 5 U.S.C. 804(2).

L. Unfunded Mandates Reform Act of 1995: The changes set forth in this rulemaking do not involve a Federal intergovernmental mandate that will result in the expenditure by state, local, and tribal governments, in the aggregate, of $100 million (as adjusted) or more in any one year, or a Federal private sector mandate that will result in the expenditure by the private sector of $100 million (as adjusted) or more in any one year, and will not significantly or uniquely affect small governments. Therefore, no actions are necessary under the provisions of the Unfunded Mandates Reform Act of 1995. *See* 2 U.S.C. 1501 *et seq.*

M. National Environmental Policy Act of 1969: This rulemaking will not have any effect on the quality of the environment and is thus categorically excluded from review under the National Environmental Policy Act of 1969. *See* 42 U.S.C. 4321 *et seq.*

N. National Technology Transfer and Advancement Act of 1995: The requirements of section 12(d) of the National Technology Transfer and Advancement Act of 1995 (15 U.S.C. 272 note) are not applicable because this rulemaking does not contain provisions that involve the use of technical standards.

O. Paperwork Reduction Act of 1995: This final rule does not involve information collection requirements that are subject to review by the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

Notwithstanding any other provision of law, no person is required to respond to, nor shall any person be subject to a penalty for failure to comply with, a collection of information subject to the requirements of the Paperwork Reduction Act unless that collection of information has a currently valid OMB control number.

P. E-Government Act Compliance: The USPTO is committed to compliance with the E-Government Act to promote the use of the internet and other information technologies, to provide increased opportunities for citizen access to Government information and services, and for other purposes.

List of Subjects in 37 CFR Part 6

Administrative practice and procedure, Courts, Lawyers, Trademarks.

For the reasons given in the preamble and under the authority contained in 15 U.S.C. 1112 and 1123 and 35 U.S.C. 2, as amended, the USPTO is amending 37 CFR part 6 as follows:

PART 6—CLASSIFICATION OF GOODS AND SERVICES UNDER THE TRADEMARK ACT

■ 1. The authority citation for part 6 continues to read as follows:

Authority: Secs. 30, 41, 60 Stat. 436, 440; 15 U.S.C. 1112, 1123; 35 U.S.C. 2, unless otherwise noted.

■ 2. Revise § 6.1 to read as follows:

§ 6.1 International schedule of classes of goods and services.

GOODS

1. Chemicals for use in industry, science and photography, as well as in agriculture, horticulture and forestry; unprocessed artificial resins, unprocessed plastics; fire extinguishing and fire prevention compositions; tempering and soldering preparations; substances for tanning animal skins and hides; adhesives for use in industry; putties and other paste fillers; compost, manures, fertilizers; biological preparations for use in industry and science.

2. Paints, varnishes, lacquers; preservatives against rust and against deterioration of wood; colorants, dyes; inks for printing, marking and engraving; raw natural resins; metals in foil and powder form for use in painting, decorating, printing and art.

3. Non-medicated cosmetics and toiletry preparations; non-medicated dentifrices; perfumery, essential oils; bleaching preparations and other substances for laundry use; cleaning, polishing and abrasive preparations.

4. Industrial oils and greases, wax; lubricants; dust absorbing, wetting and binding compositions; fuels and illuminants; candles and wicks for lighting.

5. Pharmaceuticals, medical and veterinary preparations; sanitary preparations for medical purposes; dietetic food and substances adapted for medical or veterinary use, food for babies; dietary supplements for human beings and animals; plasters, materials for dressings; material for stopping teeth, dental wax; disinfectants; preparations for destroying vermin; fungicides, herbicides.

6. Common metals and their alloys, ores; metal materials for building and construction; transportable buildings of metal; non-electric cables and wires of common metal; small items of metal hardware; metal containers for storage or transport; safes.

7. Machines, machine tools, power-operated tools; motors and engines, except for land vehicles; machine coupling and transmission components, except for land vehicles; agricultural implements, other than hand-operated hand tools; incubators for eggs; automatic vending machines.

8. Hand tools and implements, hand-operated; cutlery; side arms, except firearms; razors.

9. Scientific, research, navigation, surveying, photographic, cinematographic, audiovisual, optical, weighing, measuring, signalling, detecting, testing, inspecting, life-saving and teaching apparatus and instruments; apparatus and instruments for conducting, switching, transforming, accumulating, regulating or controlling the distribution or use of electricity; apparatus and instruments for recording, transmitting, reproducing or processing sound, images or data; recorded and downloadable media, computer software, blank digital or analogue recording and storage media; mechanisms for coin-operated apparatus; cash registers, calculating devices; computers and computer peripheral devices; diving suits, divers' masks, ear plugs for divers, nose clips for divers and swimmers, gloves for divers, breathing apparatus for underwater swimming; fire-extinguishing apparatus.

10. Surgical, medical, dental and veterinary apparatus and instruments; artificial limbs, eyes and teeth; orthopaedic articles; suture materials; therapeutic and assistive devices adapted for persons with disabilities; massage apparatus; apparatus, devices and articles for nursing infants; sexual activity apparatus, devices and articles.

11. Apparatus and installations for lighting, heating, cooling, steam generating, cooking, drying, ventilating, water supply and sanitary purposes.

12. Vehicles; apparatus for locomotion by land, air or water.

13. Firearms; ammunition and projectiles; explosives; fireworks.

14. Precious metals and their alloys; jewellery, precious and semi-precious stones; horological and chronometric instruments.

15. Musical instruments; music stands and stands for musical instruments; conductors' batons.

16. Paper and cardboard; printed matter; bookbinding material;

photographs; stationery and office requisites, except furniture; adhesives for stationery or household purposes; drawing materials and materials for artists; paintbrushes; instructional and teaching materials; plastic sheets, films and bags for wrapping and packaging; printers' type, printing blocks.

17. Unprocessed and semi-processed rubber, gutta-percha, gum, asbestos, mica and substitutes for all these materials; plastics and resins in extruded form for use in manufacture; packing, stopping and insulating materials; flexible pipes, tubes and hoses, not of metal.

18. Leather and imitations of leather; animal skins and hides; luggage and carrying bags; umbrellas and parasols; walking sticks; whips, harness and saddlery; collars, leashes and clothing for animals.

19. Materials, not of metal, for building and construction; rigid pipes, not of metal, for building; asphalt, pitch, tar and bitumen; transportable buildings, not of metal; monuments, not of metal.

20. Furniture, mirrors, picture frames; containers, not of metal, for storage or transport; unworked or semi-worked bone, horn, whalebone or mother-of-pearl; shells; meerschaum; yellow amber.

21. Household or kitchen utensils and containers; cookware and tableware, except forks, knives and spoons; combs and sponges; brushes, except paintbrushes; brush-making materials; articles for cleaning purposes; unworked or semi-worked glass, except building glass; glassware, porcelain and earthenware.

22. Ropes and string; nets; tents and tarpaulins; awnings of textile or synthetic materials; sails; sacks for the transport and storage of materials in bulk; padding, cushioning and stuffing materials, except of paper, cardboard, rubber or plastics; raw fibrous textile materials and substitutes therefor.

23. Yarns and threads for textile use.

24. Textiles and substitutes for textiles; household linen; curtains of textile or plastic.

25. Clothing, footwear, headwear.

26. Lace, braid and embroidery, and haberdashery ribbons and bows; buttons, hooks and eyes, pins and needles; artificial flowers; hair decorations; false hair.

27. Carpets, rugs, mats and matting, linoleum and other materials for covering existing floors; wall hangings, not of textile.

28. Games, toys and playthings; video game apparatus; gymnastic and sporting articles; decorations for Christmas trees.

29. Meat, fish, poultry and game; meat extracts; preserved, frozen, dried and cooked fruits and vegetables; jellies, jams, compotes; eggs; milk, cheese, butter, yogurt and other milk products; oils and fats for food.

30. Coffee, tea, cocoa and substitutes therefor; rice, pasta and noodles; tapioca and sago; flour and preparations made from cereals; bread, pastries and confectionery; chocolate; ice cream, sorbets and other edible ices; sugar, honey, treacle; yeast, baking-powder; salt, seasonings, spices, preserved herbs; vinegar, sauces and other condiments; ice (frozen water).

31. Raw and unprocessed agricultural, aquacultural, horticultural and forestry products; raw and unprocessed grains and seeds; fresh fruits and vegetables, fresh herbs; natural plants and flowers; bulbs, seedlings and seeds for planting; live animals; foodstuffs and beverages for animals; malt.

32. Beers; non-alcoholic beverages; mineral and aerated waters; fruit beverages and fruit juices; syrups and other preparations for making non-alcoholic beverages.

33. Alcoholic beverages, except beers; alcoholic preparations for making beverages.

34. Tobacco and tobacco substitutes; cigarettes and cigars; electronic cigarettes and oral vaporizers for smokers; smokers' articles; matches.

SERVICES

35. Advertising; business management, organization and administration; office functions.

36. Financial, monetary and banking services; insurance services; real estate services.

37. Construction services; installation and repair services; mining extraction, oil and gas drilling.

38. Telecommunications services.

39. Transport; packaging and storage of goods; travel arrangement.

40. Treatment of materials; recycling of waste and trash; air purification and treatment of water; printing services; food and drink preservation.

41. Education; providing of training; entertainment; sporting and cultural activities.

42. Scientific and technological services and research and design relating thereto; industrial analysis, industrial research and industrial design services; quality control and authentication services; design and development of computer hardware and software.

43. Services for providing food and drink; temporary accommodation.

44. Medical services; veterinary services; hygienic and beauty care for human beings or animals; agriculture, aquaculture, horticulture and forestry services.

45. Legal services; security services for the physical protection of tangible property and individuals; dating services, online social networking services; funerary services; babysitting.

Katherine K. Vidal,

Under Secretary of Commerce for Intellectual Property and Director of the United States Patent and Trademark Office.

[FR Doc. 2023–16396 Filed 8–1–23; 8:45 am]

BILLING CODE 3510–16–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[EPA–R04–OAR–2022–0457; FRL–11008–02–R4]

Air Plan Approval; Georgia;

Miscellaneous Rule Revisions to Gasoline Dispensing Facility—Stage I

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final rule.

SUMMARY: The Environmental Protection Agency (EPA) is approving changes to the Georgia State Implementation Plan (SIP), submitted by the State of Georgia through the Georgia Environmental Protection Division (GA EPD) via a letter dated November 4, 2021. The SIP revision revises Georgia's Stage I vapor recovery rules primarily by removing outdated references and making several clarifying edits. The revision also updates several definitions and makes two substantive changes. EPA is approving these changes pursuant to the Clean Air Act (CAA or Act).

DATES: This rule is effective September 1, 2023.

ADDRESSES: EPA has established a docket for this action under Docket Identification No. EPA–R04–OAR–2022–0457. All documents in the docket are listed on the *www.regulations.gov* website. Although listed in the index, some information may not be publicly available, *i.e.,* Confidential Business Information or other information whose disclosure is restricted by statute. Certain other material, such as copyrighted material, is not placed on the internet and will be publicly available only in hard copy form. Publicly available docket materials are available either electronically through *www.regulations.gov* or in hard copy at the Air Regulatory Management Section, Air Planning and Implementation Branch, Air and Radiation Division,

U.S. Environmental Protection Agency, Region 4, 61 Forsyth Street, SW, Atlanta, Georgia 30303–8960. EPA requests that, if at all possible, you contact the person listed in the **FOR FURTHER INFORMATION CONTACT** section to schedule your inspection. The Regional Office's official hours of business are Monday through Friday 8:30 a.m. to 4:30 p.m., excluding Federal holidays.

FOR FURTHER INFORMATION CONTACT: Kelly Sheckler, Air Regulatory Management Section, Air Planning and Implementation Branch, Air and Radiation Division, U.S. Environmental Protection Agency, Region 4, 61 Forsyth Street SW, Atlanta, Georgia 30303–8960. The telephone number is (404) 562–9222. Ms. Sheckler can also be reached via electronic mail at *sheckler.kelly@epa.gov*.

SUPPLEMENTARY INFORMATION:

I. Background

CAA section 182(b)(2) requires states to revise their SIPs to include provisions implementing Reasonably Available Control Technology (RACT) for each category of volatile organic compound (VOC) sources covered by a Control Techniques Guidelines (CTG) [1] document in ozone nonattainment areas that are classified as moderate or above. CAA Section 182(b)(2)(B) specifically requires states to include VOC RACT measures in their SIPs if the area is covered by a CTG issued prior to November 15, 1990. In 1975, EPA established a CTG addressing the control of VOC emissions from gasoline dispensing facilities (GDFs).[2] For certain GDFs, owners or operators are required to install systems for the recovery of gasoline vapor emissions. These requirements are also known as Stage I and Stage II vapor recovery.

Stage I vapor recovery requires the control of hydrocarbon gasoline vapors, such as VOCs, when dispensing gasoline from tanker trucks into gasoline storage tanks. Specifically, Stage I vapor recovery systems capture vapors displaced from storage tanks at GDFs during gasoline cargo truck deliveries. When gasoline is delivered into an above ground or underground storage tank, vapors that were taking up space in the storage tank are displaced by the gasoline entering the storage tank. The Stage I vapor recovery systems route these displaced vapors into the tank of the delivery truck. Some vapors are vented when the storage tank exceeds a specified pressure threshold, however, the Stage I vapor recovery systems greatly reduce the possibility of these displaced vapors being released into the atmosphere.

Georgia's Gasoline Dispensing Facilities Rule, found at 391–3–1–.02(2)(rr), applies to GDFs located in Barrow, Bartow, Carroll, Catoosa, Cherokee, Clayton, Cobb, Coweta, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Hall, Henry, Newton, Paulding, Richmond, Rockdale, Spalding, Walker, and Walton Counties. Georgia's November 4, 2021, submittal includes changes to Rule 391–3–1–.02(2)(rr), ''Gasoline Dispensing Facility—Stage I.'' [3] The revision primarily contains non-substantive changes such as language edits, removing outdated references, and clarifying edits. The revision also updates several definitions and makes two substantive changes.

Specifically, the State makes several changes to clarify the physical nature of gasoline vapor recovery control systems and clarifies a provision that outlines one method to control vapors displaced from gasoline stationary storage tanks during filling. In addition to changes addressing the physical nature of the control technology, the State has made other edits to clarify various certification and recertification testing requirements, and also the rule's recordkeeping requirements. Further, Georgia has made changes to specify the required vapor efficiency to qualify as a ''Stage 1 Gasoline Vapor Recovery System'' or an ''Enhanced Stage I Gasoline Vapor Recovery System'', including updated definitions and a clarification that functional testing is not conducted by Georgia EPD.

EPA is approving this SIP revision because the rule changes are not expected to result in any change to air pollutant emissions and therefore would not interfere with any applicable requirement concerning attainment and reasonable further progress or any other applicable CAA requirement. In addition, these changes are consistent with all applicable federal requirements for Stage I gasoline dispensing facilities.

In a notice of proposed rulemaking (NPRM), published on June 13, 2023 (88 FR 38430), EPA proposed to approve the November 4, 2021, changes to Georgia Rule 391–3–1–.02(2)(rr). The details of Georgia's submission, as well as EPA's rationale for approving the changes, are described in more detail in the June 13, 2023, NPRM. Comments on the June 13, 2023, NPRM were due on or before July 13, 2023. No comments were received on the June 13, 2023, NPRM, adverse or otherwise.

II. Incorporation by Reference

In this document, EPA is finalizing regulatory text that includes incorporation by reference. In accordance with requirements of 1 CFR 51.5, and as discussed in Section I of this preamble, EPA is finalizing the incorporation by reference of Georgia Rule 391–3–1–.02(2)(rr), ''Gasoline Dispensing Facility—Stage I,'' state effective on October 25, 2021, with the exception of the changes to subparagraph 391–3–1–.02(2)(rr)16.(x).[4] EPA has made, and will continue to make, these materials generally available at the EPA Region 4 Office (please contact the person identified in the ''For Further Information Contact'' section of this preamble for more information). Therefore, these materials have been approved by EPA for inclusion in the SIP, have been incorporated by reference by EPA into that plan, are fully federally enforceable under sections 110 and 113 of the CAA as of the effective date of the final rulemaking of EPA's approval, and will be incorporated by reference in the next update to the SIP compilation.[5]

III. Final Action

In accordance with section 110 of the CAA, EPA is finalizing the approval of the aforementioned changes to the Georgia SIP. Specifically, EPA is approving changes to Rule 391–3–1–.02(2)(rr), ''Gasoline Dispensing Facility—Stage I,'' with the exception of changes to subparagraph 391–3–1–.02(2)(rr)16.(x). EPA is finalizing the approval of these changes because they are consistent with the CAA.

IV. Statutory and Executive Order Reviews

Under the CAA, the Administrator is required to approve a SIP submission that complies with the provisions of the Act and applicable Federal regulations. *See* 42 U.S.C. 7410(k); 40 CFR 52.02(a).

[1] CTG documents are documents issued by EPA to provide States with EPA's presumptive VOC RACT recommendations on how to control VOC emissions from specific products or source categories in ozone nonattainment areas.

[2] *See* ''*Design Criteria for Stage I Vapor Control Systems Gasoline Service Stations*'' U.S. Environmental Protection Agency, Office of Air Quality Planning and Standards Emission Standards and Engineering Division Research Triangle Park, EPA–450 (November 1975). Available at: *https://nepis.epa.gov/Exe/ZyPDF.cgi?Dockey=20013S56.txt*.

[3] In the November 4, 2021, cover letter, GA EPD requested that EPA not incorporate the changes to paragraphs 391–3–1–.01(nnnn), 391–3–1–.02(2)(rr)16.(x), 391–3–1–.02(8), and 391–3–1–.02(9) into the SIP. For this reason, EPA is not approving the changes to these paragraphs in this action.

[4] The version of subparagraph 391–3–1–.02(2)(rr)16.(x) remaining in the SIP has a state-effective date of June 8, 2008, and was approved by EPA on September 28, 2012. *See* 77 FR 59554.

[5] *See* 62 FR 27968 (May 22, 1997).

Thus, in reviewing SIP submissions, EPA's role is to approve state choices, provided that they meet the criteria of the CAA. This action merely approves state law as meeting Federal requirements and do not impose additional requirements beyond those imposed by state law. For that reason, this action:

- Is not a significant regulatory action subject to review by the Office of Management and Budget under Executive Orders 12866 (58 FR 51735, October 4, 1993) and 14094 (88 FR 21879, April 11, 2023);
- Does not impose an information collection burden under the provisions of the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*);
- Is certified as not having a significant economic impact on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*);
- Does not contain any unfunded mandates or significantly or uniquely affect small governments, as described in the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4);
- Does not have Federalism implications as specified in Executive Order 13132 (64 FR 43255, August 10, 1999);
- Is not subject to Executive Order 13045 (62 FR 19885, April 23, 1997) because it approves a state program;
- Is not a significant regulatory action subject to Executive Order 13211 (66 FR 28355, May 22, 2001); and
- Is not subject to requirements of Section 12(d) of the National Technology Transfer and Advancement Act of 1995 (15 U.S.C. 272 note) because application of those requirements would be inconsistent with the CAA.

In addition, the SIP is not approved to apply on any Indian reservation land or in any other area where EPA or an Indian tribe has demonstrated that a Tribe has jurisdiction. In those areas of Indian country, the rule does not have Tribal implications and will not impose substantial direct costs on Tribal governments or preempt Tribal law as specified by Executive Order 13175 (65 FR 67249, November 9, 2000).

Executive Order 12898 (Federal Actions To Address Environmental Justice in Minority Populations and Low-Income Populations, 59 FR 7629, February 16, 1994) directs Federal agencies to identify and address ''disproportionately high and adverse human health or environmental effects'' of their actions on minority populations and low-income populations to the greatest extent practicable and permitted by law. EPA defines environmental justice (EJ) as ''the fair treatment and meaningful involvement of all people regardless of race, color, national origin, or income with respect to the development, implementation, and enforcement of environmental laws, regulations, and policies.'' EPA further defines the term fair treatment to mean that ''no group of people should bear a disproportionate burden of environmental harms and risks, including those resulting from the negative environmental consequences of industrial, governmental, and commercial operations or programs and policies.''

GA EPD did not evaluate EJ considerations as part of its SIP submittal; the CAA and applicable implementing regulations neither prohibit nor require such an evaluation. EPA did not perform an EJ analysis and did not consider EJ in this action. Due to the nature of the action being taken here, this action is expected to have a neutral to positive impact on the air quality of the affected area. Consideration of EJ is not required as part of this action, and there is no information in the record inconsistent with the stated goal of E.O. 12898 of achieving EJ for people of color, low-income populations, and Indigenous peoples.

This action is subject to the Congressional Review Act, and EPA will submit a rule report to each House of the Congress and to the Comptroller General of the United States. This action is not a ''major rule'' as defined by 5 U.S.C. 804(2).

Under section 307(b)(1) of the CAA, petitions for judicial review of this action must be filed in the United States Court of Appeals for the appropriate circuit by October 2, 2023. Filing a petition for reconsideration by the Administrator of this final rule does not affect the finality of this action for the purposes of judicial review nor does it extend the time within which a petition for judicial review may be filed and shall not postpone the effectiveness of such rule or action. This action may not be challenged later in proceedings to enforce its requirements. *See* section 307(b)(2).

List of Subjects in 40 CFR Part 52

Environmental Protection, Air Pollution Control, Incorporation by Reference, Intergovernmental Relations, Nitrogen Oxides, Ozone, Reporting and Recordkeeping Requirements, Volatile Organic Compounds.

Jeaneanne Gettle,

Acting Regional Administrator, Region 4.

For the reasons stated in the preamble, EPA amends 40 CFR part 52 as follows:

PART 52—APPROVAL AND PROMULGATION OF IMPLEMENTATION PLANS

■ 1. The authority citation for part 52 continues to read as follows:

Authority: 42 U.S.C. 7401 *et seq.*

Subpart L—Georgia

■ 2. In § 52.570, in paragraph (c), amend table 1 by revising the entry for ''391–3–1–.02(2)(rr)'' to read as follows:

§ 52.570 Identification of plan.

* * * * *

(c) * * *

TABLE 1 TO PARAGRAPH (c)—EPA-APPROVED GEORGIA REGULATIONS

State citation	Title/subject	State effective date	EPA approval date	Explanation
*	*	*	*	*
391–3–1–.02(2)(rr)	Gasoline Dispensing Facility—Stage I.	10/25/2021	8/2/2023, [Insert citation of publication].	Except for subparagraph 391–3–1–.02(2)(rr)16.(x), which was approved on 9/28/2012 with a state-effective date of 6/8/2008.
*	*	*	*	*

* * * * *

[FR Doc. 2023–16274 Filed 8–1–23; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[EPA–R04–OAR–2022–0512; FRL–10177–01–R4]

Air Plan Approval; North Carolina; Update to Materials Incorporated by Reference

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final rule; notification of administrative change.

SUMMARY: The Environmental Protection Agency (EPA) is updating the materials that are incorporated by reference (IBR) into the North Carolina State Implementation Plan (SIP). The regulations affected by this update have been previously submitted by North Carolina and approved by EPA. In this final rule, EPA is also notifying the public of corrections and clarifying changes in the Code of Federal Regulations (CFR) tables that identify material incorporated by reference into the North Carolina SIP. This update affects the materials that are available for public inspection at the National Archives and Records Administration (NARA) and the EPA Regional Office.

DATES: This action is effective August 2, 2023.

ADDRESSES: The SIP materials whose incorporation by reference into 40 CFR part 52 is finalized through this action are available for inspection at the following locations: Environmental Protection Agency, Region 4, 61 Forsyth Street SW, Atlanta, GA 30303; and *www.regulations.gov.* To view the materials at the Region 4 Office, EPA requests that you email the contact listed in the **FOR FURTHER INFORMATION CONTACT** section to schedule your inspection. The Regional Office's official hours of business are Monday through Friday 8:30 a.m. to 4:30 p.m., excluding Federal holidays.

FOR FURTHER INFORMATION CONTACT: Sarah LaRocca, Air Planning and Implementation Branch, Air and Radiation Division, Region 4, U.S. Environmental Protection Agency, 61 Forsyth Street SW, Atlanta, Georgia 30303–8960. Ms. LaRocca can be reached via telephone at (404) 562–8994 and via electronic mail at *larocca.sarah@epa.gov.*

SUPPLEMENTARY INFORMATION:

I. Background

Each state has a SIP containing the control measures and strategies used to attain and maintain the national ambient air quality standards (NAAQS). The SIP is extensive, containing such elements as air pollution control regulations, emission inventories, monitoring networks, attainment demonstrations, and enforcement mechanisms.

Each state must formally adopt the control measures and strategies in the SIP after the public has had an opportunity to comment on them and then submit the proposed SIP revisions to EPA. Once these control measures and strategies are approved by EPA, and after notice and comment, they are incorporated into the federally-approved SIP and are identified in part 52—''Approval and Promulgation of Implementation Plans,'' Title 40 of the Code of Federal Regulations (40 CFR part 52). The full text of the state regulation approved by EPA is not reproduced in its entirety in 40 CFR part 52 but is ''incorporated by reference.'' This means that EPA has approved a given state regulation or specified changes to the given regulation with a specific effective date. The public is referred to the location of the full text version should they want to know which measures are contained in a given SIP. The information provided allows EPA and the public to monitor the extent to which a state implements a SIP to attain and maintain the NAAQS and to take enforcement action for violations of the SIP.

The SIP is a living document which the state can revise as necessary to address the unique air pollution problems in the state. Therefore, EPA from time to time must take action on proposed revisions containing new or revised state regulations. A submission from a state can revise one or more rules in their entirety or portions of rules. The state indicates the changes in the submission (such as by using redline/strikethrough text) and EPA then takes action on the requested changes. EPA establishes a docket for its actions using a unique Docket Identification Number, which is listed in each action. These dockets and the complete submission are available for viewing on *www.regulations.gov.*

On May 22, 1997 (62 FR 27968), EPA revised the procedures for incorporating by reference, into the Code of Federal Regulations, materials approved by EPA into each SIP. These changes revised the format for the identification of the SIP in 40 CFR part 52, streamlined the mechanisms for announcing EPA approval of revisions to a SIP, and streamlined the mechanisms for EPA's updating of the IBR information contained for each SIP in 40 CFR part 52. The revised procedures also called for EPA to maintain ''SIP Compilations'' that contain the federally approved regulations and source-specific permits submitted by each state agency.

EPA generally updates these SIP Compilations on an annual basis. Under the revised procedures, EPA must periodically publish an informational document in the rules section of the **Federal Register** notifying the public that updates have been made to a SIP Compilation for a particular state. EPA began applying the 1997 revised procedures to North Carolina on May 20, 1999 (64 FR 27465), Forsyth County on August 9, 2002 (67 FR 51763), Mecklenburg County on October 22, 2002 (67 FR 64999), Western North Carolina on October 26, 2018 (83 FR 54032), and EPA-Approved North Carolina Source-Specific Requirements on November 24, 2020 (85 FR 74884), and is providing this notification in accordance with such procedures.

II. EPA Action

In this action, EPA is providing notification of an update to the materials incorporated by reference into the North Carolina SIP as of April 29, 2023, and identified in 40 CFR 52.1770(c) and (d). This update includes SIP materials submitted by North Carolina and approved by EPA since the last IBR update. *See* 83 FR 54032 (October 26, 2018). In addition, EPA is providing notification of the following corrections and clarifying changes to 40 CFR 52.1770(c) and (e):

Changes Applicable to Paragraph (c), Table (1), EPA Approved North Carolina Regulations

A. Correcting Table (c)'s title, from ''*(c) EPA approved regulations*'' to ''*EPA-Approved Regulations*''

B. Correcting the header of Paragraph (c), Table (1) from ''EPA Approved North Carolina Regulations'' to ''EPA-Approved North Carolina Regulations''

C. Under the ''State citation'' column, changing ''Section'' to ''Rule'' before all rules in the table

D. Under ''EPA approval date,'' correcting a **Federal Register** citation to reflect the beginning page of the preamble as opposed to that of the regulatory text

E. Changing the title ''Subchapter 2D Air Pollution Control Requirements'' to ''Subchapter 02D Air Pollution Control Requirements''

F. In ''Subchapter 02D Air Pollution Control Requirements,'' under ''Section .0500 Emission Control Standards'' adding the explanation ''Except for the annual average opacity limits and except as the rule applies to Carolina Power & Light's Asheville, Lee, Sutton, and Weatherspoon facilities.'' to Rule .0536

G. In ''Subchapter 02D Air Pollution Control Requirements,'' changing the title of Rule .0923, ''Surface Coating of Large Appliances'' to ''Surface Coating of Large Appliance Parts''

H. In ''Subchapter 02D Air Pollution Control Requirements,'' changing the title of Rule .0925, ''Petroleum Liquid Storage'' to ''Petroleum Liquid Storage in Fixed Roof Tanks''

I. In ''Subchapter 02D Air Pollution Control Requirements,'' changing the title of Section .1000 from ''Motor Vehicle Emission Control Standard'' to ''Motor Vehicle Emission Control Standards''

J. In ''Subchapter 02D Air Pollution Control Requirements,'' under ''Section .2600 Source Testing,'' correcting the state effective date for Rules .2601–.2608, .2612–.2615, and .2621, from ''3/13/2008'' to ''6/1/2008''

K. Changing the title ''Subchapter 2Q Air Quality Permits'' to ''Subchapter 02Q Air Quality Permits''

L. In ''Subchapter 02Q Air Quality Permits,'' under ''Section .0800 Exclusionary Rules,'' correcting the state effective date for Rule .0807 from ''4/1/2002'' to ''4/1/2001''

M. In ''Subchapter 02Q Air Quality Permits,'' under ''Section .0800 Exclusionary Rules,'' adding ''Rule .0810 Air Curtain Burners,'' which was approved into the SIP on 7/18/2017 (82 FR 32767)

N. In ''Subchapter 02Q Air Quality Permits,'' under ''Section .0800 Exclusionary Rules,'' and ''Section .0900 Permit Exemptions'' correcting the approval dates and citations for Rules .0809, .0901, and .0902 from ''9/27/2017, 82 FR 45473'' to ''9/29/2017, 82 FR 45473''

Changes Applicable to Paragraph (c), Table (2), EPA Approved Forsyth County Regulations

A. Correcting the header of paragraph (c), Table (2) from ''EPA Approved Forsyth County Regulations'' to ''EPA-Approved Forsyth County Regulations''

B. Changing the ''State citation'' and ''State effective date'' column titles to ''Citation'' and ''Effective date'', respectively

C. Under the ''Citation'' column, changing ''Section'' to ''Rule'' before all rules in the table

D. Correcting the header of Subchapter 3A from ''Subchapter 3A Air Pollution Control Requirements'' to ''Subchapter 3A Air Pollution Control''

E. For all applicable rules in ''Subchapter 3A Air Pollution Control,'' ''Subchapter 3B Relationship to State Code,'' ''Subchapter 3D Air Pollution Control Requirements,'' and ''Subchapter 3Q Air Quality Permits,'' correcting the effective date and citation from ''6/14/1990'' to ''12/19/1994'' and correcting the citation from ''5/2/1991, 56 FR 20140'' to ''2/1/1996, 61 FR 3586''

F. In ''Subchapter 3A Air Pollution Control,'' under ''Section .0100 In General,'' correcting the effective date for Rule .0106 from ''1/17/1997'' to ''9/14/1998''

G. In ''Subchapter 3D Air Pollution Control Requirements,'' under ''Section .0100 Definitions and References,'' correcting the effective date of Rule .0101 from 11/6/1998'' to ''9/14/1998''

H. In ''Subchapter 3D Air Pollution Control Requirements,'' under Section .0400 Ambient Air Quality Standards,'' changing the title of Rule .0409 from ''PM_{10} Particulate Matter'' to ''Particulate Matter'', and correcting the effective date and EPA approval date from ''6/14/1990; 5/2/1991, 56 FR 20140'' to ''12/19/1994; 2/1/1996, 61 FR 3586''

I. In ''Subchapter 3D Air Pollution Control Requirements,'' under ''Section .0500 Emission Control Standards,'' changing the title of the following Rules:

1. Rule .0509 ''Particulates from MICA or FELDSPAR Processing Plants'' to ''Particulates from Mica or Feldspar Processing Plants''
2. Rule .0513 ''Particulates From Portland Cement Plants'' to ''Control of Particulates From Portland Cement Plants''
3. Rule .0514 ''Particulates From Ferrous Jobbing Foundries'' to ''Control of Particulates From Ferrous Jobbing Foundries''

J. In ''Subchapter 3D Air Pollution Control Requirements,'' under ''Section .0500 Emission Control Standards,'' adding the following rules:

1. Rule .0520 Control and Prohibition of Open Burning; effective 12/19/1994; EPA approval date 2/1/1996, 61 FR 3586
2. Rule .0523 Control of Conical Incinerators; effective 12/19/1994; EPA approval date 2/1/1996, 61 FR 3586

K. In ''Subchapter 3D Air Pollution Control Requirements,'' under ''Section .0500 Emission Control Standards,'' removing the following rules:

1. Rule .0522 Control and Prohibition of Odorous Emissions
2. Rule .0528 Total Reduced Sulfur from Kraft Pulp Mills
3. Rule .0529 Fluoride Emissions from Primary Aluminum Reduction Plants
4. Rule .0534 Fluoride Emissions from Phosphate Fertilizer Industry
5. Rule .0539 Odor Control of Feed Ingredient Manufacturing Plants
6. Rule .0540 Particulates from Fugitive Non-process Dust Emission Sources
7. Rule .0541 Control of Emissions from Abrasive Blasting
8. Rule .0542 Control of Particulate Emissions from Cotton Ginning Operations

L. In Subchapter 3D Air Pollution Control Requirements,'' under ''Section .0500 Emission Control Standards,'' adding the explanation ''Except for item (2)'' for Rule .0527

M. In Subchapter 3D Air Pollution Control Requirements,'' under ''Section .0500 Emission Control Standards,'' removing Rules .0524, .0537, and .0538

N. In Subchapter 3D Air Pollution Control Requirements,'' under ''Section .0500 Emission Control Standards,'' correcting the effective date and EPA approval date for Rule .0530 from ''10/10/1997'' to ''8/14/1995'' and ''12/31/1998, 63 FR 72190'' to ''5/23/1996, 61 FR 25789'', respectively, and adding an explanation to read ''Except for paragraphs (a), (l), (o), and (s) approved on 12/31/1998 with an effective date of 7/28/1997''

O. In Subchapter 3D Air Pollution Control Requirements,'' under ''Section .0500 Emission Control Standards,'' correcting the title of Rule .0533 from ''Stack Heights'' to ''Stack Height''

P. In ''Subchapter 3D Air Pollution Control Requirements,'' under ''Section .0500 Emission Control Standards,'' and ''Section .0900 Volatile Organic Compounds'' correcting the effective date for Rules .0506, .0507, .0508, .0509, .0510, .0511, .0515, .0521, .0535, .0914, and .0953 from ''11/6/1998'' to ''9/14/1998''

Q. In ''Subchapter 3D Air Pollution Control Requirements,'' under ''Section .0500 Emission Control Standards,'' and ''Section .0900 Volatile Organic Compounds'' correcting the effective date of Rules

.0531 and .0909 from ''11/6/1998'' to 11/13/1995''

R. In ''Subchapter 3D Air Pollution Control Requirements,'' under ''Section .0600 Monitoring: Recordkeeping: Reporting'' adding the following rules:

1. Rule .0608 Program Schedule; effective 12/19/1994; EPA approval date 2/1/1996, 61 FR 3586
2. Rule .0610 Delegation; effective 12/19/1994; EPA approval date 2/1/1996, 61 FR 3586

S. In ''Subchapter 3D Air Pollution Control Requirements,'' under ''Section .0600 Air Monitoring: Recordkeeping: Reporting'' correcting the effective date and EPA approval date of Rule .0615 from ''6/14/1990'' and ''5/2/1991, 56 FR 20140'' to ''5/24/1999'' and ''10/22/2002, 67 FR 64994''

T. In ''Subchapter 3D Air Pollution Control Requirements,'' under ''Section .0900 Volatile Organic Compounds'' correcting the effective date of Rule .0902 from ''10/10/1997'' to ''7/28/1997'' and adding the explanation ''Paragraph (a) through (i) only''

U. In ''Subchapter 3D Air Pollution Control Requirements,'' under ''Section .0900 Volatile Organic Compounds'' adding the explanation ''Except Paragraphs (a) through (c), (g), and (h) approved on 12/31/1998 with an effective date of 7/28/1997'' to Rule .0909

V. In ''Subchapter 3D Air Pollution Control Requirements,'' under ''Section .0900 Volatile Organic Compounds'' adding Rule .0929 Petroleum Refinery Sources; effective 12/19/1994; with an EPA approval date of 2/1/1996, 61 FR 3586

W. In ''Subchapter 3D Air Pollution Control Requirements,'' under ''Section .0900 Volatile Organic Compounds,'' correcting the effective date and EPA approval date of Rule .0952 from ''11/29/1995'' to ''11/13/1995'' and from ''5/23/1996, 61 FR 25789'' to ''2/17/2000, 65 FR 8053'', respectively

X. In ''Subchapter 3D Air Pollution Control Requirements,'' under ''Section .0900 Volatile Organic Compounds,'' correcting the effective date and EPA approval date of Rule .0954 from ''10/10/1997'' to ''11/13/1995'' and ''5/23/1996, 61 FR 25789'' to ''2/17/2000, 65 FR 8053'', respectively, and adding the explanation ''Except Paragraphs (a) and (f) approved on 12/31/1998 with an effective date of 7/28/1997''

Y. In ''Subchapter 3D Air Pollution Control Requirements,'' under ''Section .0900 Volatile Organic Compounds,'' correcting the effective date of Rules .0955, .0956, and .0957 from ''11/29/1995'' to ''8/14/1995''

Z. In ''Subchapter 3D Air Pollution Control Requirements,'' under ''Section .0900 Volatile Organic Compounds'' removing Rule .0958

AA. In ''Subchapter 3D Air Pollution Control Requirements'' removing ''Section .1200 Control of Emissions from Incinerators 111(a)'' and Rules .1201 and .1202

BB. In ''Subchapter 3D Air Pollution Control Requirements,'' under ''Section .1900 Open Burning'' removing Rules .1901, .1902, and .1905

CC. In ''Subchapter 3D Air Pollution Control Requirements,'' under ''Section .1900 Open Burning,'' correcting the EPA approval date of Rule .1903 from ''9/8/2002, 67 FR 5176'' to ''8/9/2002, 67 FR 51763''

DD. In ''Subchapter 3D Air Pollution Control Requirements,'' under ''Section .1900 Open Burning'' correcting the effective date and EPA approval date of Rule .1904 from ''6/14/1990'' to ''10/25/1996'' and ''5/2/1991, 56 FR 20140'' to ''8/9/2002, 67 FR 51763'', respectively

EE. In ''Subchapter 3D Air Pollution Control Requirements,'' adding ''Section .2000 Transportation Conformity'' and adding ''Rule .2003 Transportation Conformity Determination'' with a 10/25/1999 effective date and EPA approval of 8/9/2002, 67 FR 51763

FF. In ''Subchapter 3Q Air Quality Permits,'' under ''Section .0100 General Provisions,'' adding the following Rules with an effective date of ''12/19/1994'' and EPA approval date of ''2/1/1996, 61 FR 3586'':

1. Rule .0105 Copies of Referenced Documents
2. Rule .0106 Incorporation by Reference
2. Rule .0108 Delegation of Authority
3. Rule .0109 Compliance Schedule for Previously Exempted Activities
4. Rule .0110 Retention of Permit at Permit Facility
5. Rule .0111 Applicability Determinations

GG. In ''Subchapter 3Q Air Quality Permits,'' under ''Section .0100 General Provisions,'' correcting the effective date and EPA approval date of Rule .0103 from ''5/24/1999; 67 FR 64994'' to ''10/25/1999; 67 FR 51763''

HH. In ''Subchapter 3Q Air Quality Permits,'' under ''Section .0100 General Provisions,'' correcting the effective and EPA approval date of Rule .0104 from ''10/10/1997'' to ''12/19/1994'' and ''12/31/1998, 63 FR 72190'' to ''2/1/1996, 61 FR 3586'', respectively, and adding the explanation ''Except paragraph (b) approved on 12/31/1998 with a state effective date of 7/28/1997''

II. In ''Subchapter 3Q Air Quality Permits,'' under ''Section .0100 General Provisions,'' ''Section .0200 Permit Fees,'' ''Section .0300 Construction and Operation Permit,'' and ''Section .0800 Exclusionary Rules,'' correcting the effective date of Rules .0101, .0207, .0301, .0302, .0312, .0805, .0806, and .0807 from ''11/6/1998'' to ''9/14/1998''; and also correcting the EPA approval date for .0805, .0806, and .0807 from ''2/17/2000, 65 FR 8093 to ''2/17/2000, 65 FR 8053''

JJ. In ''Subchapter 3Q Air Quality Permits,'' under ''Section .0300 Construction and Operation Permit,'' and Section .0800 Exclusionary Rules,'' correcting the effective date of Rules .0304, .0306, .0309, .0315 and .0808 from ''7/1/1999'' to ''5/24/1999''

KK. In ''Subchapter 3Q Air Quality Permits,'' under ''Section .0300 Construction and Operation Permit,'' correcting the effective date and EPA approval date of Rule .0307 from ''10/10/1997'' to ''12/19/1994'' and ''12/31/1998, 63 FR 72190'' to ''2/1/1996, 61 FR 3586'' and adding the explanation ''Except paragraph (i) approved on 12/31/1998 with a 7/28/1999 effective date''

LL. In ''Subchapter 3Q Air Quality Permits,'' adding ''Section .0600 Transportation Facility Procedures,'' in sequential order and adding the following Rules with an effective date of ''12/14/1994'' and EPA approval date of ''2/1/1996, 61 FR 3586'':

1. Rule .0601, Purpose of Section and Requirement for a Permit
2. Rule .0602, Definitions
3. Rule .0603, Applications, and also adding the explanation ''Except paragraph (e) approved on 12/31/1998 with an effective date of 7/28/97''
4. Rule .0604, Public Participation
5. Rule .0605, Final Action on Permit Application
6. Rule .0606, Termination, Modification and Revocation of Permits
7. Rule .0607, Application Processing Schedule

MM. In ''Subchapter 3Q Air Quality Permits,'' under ''Section .0800 Exclusionary Rules,'' correcting the effective date of Rule .0803 from ''7/30/1999'' to ''5/24/1999''

NN. In ''Subchapter 3Q Air Quality Permits,'' under ''Section .0300 Construction and Operation Permit,'' correcting the effective date of Rule .0308 from ''3/14/1995'' to ''12/19/1994''

OO. In ''Subchapter 3Q Air Quality Permits,'' under ''Section .0800 Exclusionary Rules,'' correcting the effective date and EPA approval date of Rules .0802 and .0804 from ''6/14/1990; 5/2/1991, 56 FR 20140'' to 11/13/1995; 2/17/2000, 65 FR 8053,'' respectively

Changes Applicable to Paragraph (c), Table (3), EPA Approved Mecklenburg County Regulations

A. Correcting the header of paragraph (c), Table (3) from ''EPA Approved Mecklenburg County Regulations'' to ''EPA-Approved Mecklenburg County Regulations''
B. Changing the ''State citation'' and ''State effective date'' column titles to ''Citation'' and ''Effective date'', respectively
C. Under the ''County citation'' column, changing ''Section'' to ''Rule'' before all rules in the table
D. For all applicable rules in ''Article 1.0000 Permitting Provisions for Air Pollution Sources, Rules and Operating Regulations for Acid Rain Sources, Title V and Toxic Air Pollutants,'' and ''Article 2.0000 Air Pollution Control Regulations and Procedures,'' correcting the effective date from ''6/14/1990'' to ''4/3/1989''
E. In ''Article 1.0000 Permitting Provisions for Air Pollution Sources, Rules and Operating Regulations for Acid Rain Sources, Title V and Toxic Air Pollutants,'' under ''Section 1.5200 Air Quality Permits'' changing the title of Rule 1.5235 from ''Expedited Application Processing Schedule'' to ''Delegation of Authority''
F. In ''Article 2.0000 Air Pollution Control Regulations and Procedures,'' under ''Section 2.0100 Definitions and References'' changing the title of Rule 2.0104 from ''Incorporation by Reference'' to ''Adoption by Reference Updates''
G. In ''Article 2.0000 Air Pollution Control Regulations and Procedures,'' under ''Section 2.0400 Ambient Air Quality Standards'' changing the title of Rule 2.0409 from ''PM_{10} Particulate Matter'' to ''Particulate Matter''
H. In ''Article 2.0000 Air Pollution Control Regulations and Procedures,'' under ''Section 2.0500 Emission Control Standards,'' adding the explanation ''Except for item (2)'' to Rule 2.0517
I. In ''Article 2.0000 Air Pollution Control Regulations and Procedures,'' under ''Section 2.0500 Emission Control Standards,'' removing Rules 2.0527, 2.0538, and 2.0539
J. In ''Article 2.0000 Air Pollution Control Regulations and Procedures,'' under ''Section 2.0500 Emission Control Standards,'' changing the titles of the following Rules:
1. Rule 2.0506 from ''Particulates from Hot Mix Asphalt Plants'' to ''Control of Particulates from Hot Mix Asphalt Plants''
2. Rule 2.0508 from ''Particulates from Pulp and Paper Mills'' to ''Control of Particulates from Pulp and Paper Mills''
3. Rule 2.0509 from ''Particulates from MICA or FELDSPAR Processing Plants'' to ''Particulates from Mica or Feldspar Processing Plants''
4. Rule 2.0510 from ''Particulates from Sand, Gravel, or Crushed Stone Operations'' to ''Particulates: Sand: Gravel: Crushed Stone Operations''
5. Rule 2.0511 from ''Particulates from Lightweight Aggregate Processes'' to ''Particulates: SO(2) From Lightweight Aggregate Processes''
6. Rule 2.0513 from ''Particulates from Portland Cement Plants'' to ''Control of Particulates From Portland Cement Plants''
7. Rule 2.0514 from ''Particulates from Ferrous Jobbing Foundries'' to ''Control of Particulates From Ferrous Jobbing Foundries''
8. Rule 2.0516 from ''Sulfur Dioxide Emissions from Combustion Sources'' to '' Sulfur Dioxide Emissions from Fuel Burning Installations''
9. Rule 2.0519 from ''Control of Nitrogen Dioxide and Nitrogen Oxides Emissions'' to ''Control of Nitrogen Dioxide Emissions''
10. Rule 2.0535 from ''Excess Emissions Reporting and Malfunction'' to ''Malfunctions, Start-Up and Shut-Down''

K. In ''Article 2.0000 Air Pollution Control Regulations and Procedures'' under ''Section .0600 Monitoring: Recordkeeping: Reporting'' removing Rules 2.0612, 2.0614, and 2.0615
L. In ''Article 2.0000 Air Pollution Control Regulations and Procedures'' under ''Section .0600 Monitoring: Recordkeeping: Reporting'' changing the title of Rule 2.0608 from ''Other Large Coal or Residual Oil Burners'' to ''Program Schedule''
M. In ''Article 2.0000 Air Pollution Control Regulations and Procedures'' under ''Section 2.0900 Volatile Organic Compounds'' changing the title of the following Rules:
1. Rule 2.0907 from ''''Equipment Installation Compliance Schedule'' to ''Equipment Installation Compliance Schedules''
2. Rule 2.0909 from ''Compliance Schedules for Sources In New Nonattainment Areas'' to ''Low Solvent Content Coating Compliance Schedules''

N. In ''Article 2.000 Air Pollution Control Regulations and Procedures,'' under ''Section 2.900 Volatile Organic Compounds,'' adding the following Rules with effective dates of 4/3/1989 and approved into the SIP on 5/2/1991 (56 FR 20140):
1. Rule 2.0911 Expectation for Compliance Schedule
2. Rule 2.0914 Determination of VOC Emission Control Efficiency

Changes Applicable to Paragraph (c), Table (4), EPA Approved Western North Carolina Regulations

A. Replacing Table (4) in its entirety due to errors in the entries when the table was created in 83 FR 54032 (October 26, 2018)

Changes Applicable to Paragraph (e) EPA-Approved North Carolina Non-Regulatory Provisions

A. Correcting the header of paragraph (e) from ''EPA Approved North Carolina Non-regulatory Provisions'' to ''EPA-Approved North Carolina Non-Regulatory Provisions'' to match the table heading
B. Under ''**Federal Register** Citation,'' correcting a **Federal Register** citation to reflect the beginning page of the preamble as opposed to that of the regulatory text
C. Under the ''State effective date'' and ''EPA approval date'' removing the leading zero from the month and day, changing the 2-digit year to reflect a 4-digit year (for consistency), and changing all dates to a numeric m/d/yyyy format
D. Removing the period after all **Federal Register** citations (for consistency) under ''**Federal Register** citation''
E. Under the ''Explanation,'' capitalizing the first word of each phrase or sentence (for consistency)
F. Under ''North Carolina portion of bi-state Charlotte Area; 2008 8-Hour Ozone Base Year Emissions Inventory,'' correcting the EPA approval date from ''4/21/15 2015'' to ''4/21/2015''
G. Under ''2008 8-hour ozone Maintenance Plan for the North Carolina portion of the bi-state Charlotte Area,'' correcting the **Federal Register** citation from ''80 FR 44869'' to ''80 FR 44873''
H. Under ''110(a)(1) and (2) Infrastructure Requirements for the 2008 Lead NAAQS'' and ''110(a)(1) and (2) Infrastructure Requirements for the 2008 8-hour Ozone NAAQS,'' adding the EPA approval date of ''11/3/2015'' and the **Federal Register** citation ''80 FR 67646''

III. Good Cause Exemption

EPA has determined that this action falls under the ''good cause'' exemption in section 553(b)(3)(B) of the Administrative Procedure Act (APA) which, upon finding ''good cause,'' authorizes agencies to dispense with public participation and section 553(d)(3) which allows an agency to make an action effective immediately (thereby avoiding the 30-day delayed effective date otherwise provided for in the APA). This administrative action simply codifies provisions which are already in effect as a matter of law in Federal and approved state programs, makes corrections and clarifying changes to the tables in the CFR, and makes ministerial changes to the prefatory heading to the tables in the CFR. Under section 553 of the APA, an agency may find good cause where procedures are ''impracticable, unnecessary, or contrary to the public interest.'' Public comment for this administrative action is ''unnecessary'' and ''contrary to the public interest'' since the codification (and corrections) only reflect existing law. Immediate notice of this action in the **Federal Register** benefits the public by providing the public notification of the updated North Carolina SIP Compilation and notification of corrections to the North Carolina ''Identification of Plan'' portion of the CFR. Further, pursuant to section 553(d)(3), making this action immediately effective benefits the public by immediately updating both the SIP Compilation and the CFR ''Identification of plan'' section (which includes table entry corrections).

IV. Incorporation by Reference

In this rule, EPA is finalizing regulatory text that includes incorporation by reference. In accordance with requirements of 1 CFR 51.5, EPA is finalizing the incorporation by reference of regulations promulgated by North Carolina, previously approved by EPA and federally effective before April 29, 2023, contained in ''North Carolina, Volume 1, 40 CFR 52.1770(c)(1), EPA-Approved North Carolina Regulations'', ''North Carolina, Volume 2, 40 CFR 52.1770(c)(2), EPA-Approved Forsyth County Regulations'', ''North Carolina, Volume 3, 40 CFR 52.1770(c)(3), EPA-Approved Mecklenburg County Regulations'', ''North Carolina, Volume 4, 40 CFR 52.1770(c)(4), EPA-Approved Western North Carolina Regulations,'' and ''North Carolina, Volume 5, 40 CFR 52.1770(d), EPA-Approved Source-Specific Regulations''. EPA has made, and will continue to make, these materials generally available through *www.regulations.gov* and at the EPA Region 4 Office (please contact the person identified in the **FOR FURTHER INFORMATION CONTACT** section of this preamble for more information).

V. Statutory and Executive Order Reviews

Under the CAA, the Administrator is required to approve a SIP submission that complies with the provisions of the Act and applicable Federal regulations. *See* 42 U.S.C. 7410(k); 40 CFR 52.02(a). Thus, in reviewing SIP submissions, EPA's role is to approve state choices, provided that they meet the criteria of the CAA. Accordingly, this final rule and notification of administrative change does not impose additional requirements beyond those imposed by state law. For that reason, this action:

- Is not a significant regulatory action subject to review by the Office of Management and Budget under Executive Orders 12866 (58 FR 51735, October 4, 1993) and 13563 (76 FR 3821, January 21, 2011);
- Does not impose an information collection burden under the provisions of the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*);
- Is certified as not having a significant economic impact on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*);
- Does not contain any unfunded mandate or significantly or uniquely affect small governments, as described in the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4);
- Does not have Federalism implications as specified in Executive Order 13132 (64 FR 43255, August 10, 1999);
- Is not an economically significant regulatory action based on health or safety risks subject to Executive Order 13045 (62 FR 19885, April 23, 1997);
- Is not a significant regulatory action subject to Executive Order 13211 (66 FR 28355, May 22, 2001); and
- Is not subject to requirements of Section 12(d) of the National Technology Transfer and Advancement Act of 1995 (15 U.S.C. 272 note) because application of those requirements would be inconsistent with the CAA.

The SIP is not approved to apply on any Indian reservation land or in any other area where EPA or an Indian tribe has demonstrated that a tribe has jurisdiction. In those areas of Indian country, the rule does not have tribal implications as specified by Executive Order 13175 (65 FR 67249, November 9, 2000), nor will it impose substantial direct costs on tribal governments or preempt tribal law.

Executive Order 12898 (Federal Actions To Address Environmental Justice in Minority Populations and Low-Income Populations, 59 FR 7629, Feb. 16, 1994) directs Federal agencies to identify and address ''disproportionately high and adverse human health or environmental effects'' of their actions on minority populations and low-income populations to the greatest extent practicable and permitted by law. EPA defines environmental justice (EJ) as ''the fair treatment and meaningful involvement of all people regardless of race, color, national origin, or income with respect to the development, implementation, and enforcement of environmental laws, regulations, and policies.'' EPA further defines the term fair treatment to mean that ''no group of people should bear a disproportionate burden of environmental harms and risks, including those resulting from the negative environmental consequences of industrial, governmental, and commercial operations or programs and policies.'' EPA did not perform an EJ analysis and did not consider EJ in this action. Consideration of EJ is not required as part of this action, and there is no information in the record inconsistent with the stated goal of E.O. 12898 of achieving EJ for people of color, low-income populations, and Indigenous peoples.

The Congressional Review Act, 5 U.S.C. 801 *et seq.,* as added by the Small Business Regulatory Enforcement Fairness Act of 1996, generally provides that before a rule may take effect, the agency promulgating the rule must submit a rule report, which includes a copy of the rule, to each House of the Congress and to the Comptroller General of the United States. EPA will submit a report containing this action and other required information to the U.S. Senate, the U.S. House of Representatives, and the Comptroller General of the United States prior to publication of the rule in the **Federal Register**. A major rule cannot take effect until 60 days after it is published in the **Federal Register**. This action is not a ''major rule'' as defined by 5 U.S.C. 804(2).

EPA also believes that the provisions of section 307(b)(1) of the CAA pertaining to petitions for judicial review are not applicable to this action. This is because prior EPA rulemaking actions for each individual component of the North Carolina SIP Compilation previously afforded interested parties the opportunity to file a petition for judicial review in the United States Court of Appeals for the appropriate

circuit within 60 days of such rulemaking action. Thus, EPA believes judicial review of this action under section 307(b)(1) is not available.

List of Subjects in 40 CFR Part 52

Environmental protection, Air pollution control, Carbon monoxide, Incorporation by reference, Intergovernmental relations, Lead, Nitrogen dioxide, Ozone, Particulate matter, Reporting and recordkeeping requirements, Sulfur oxides, Volatile organic compounds.

Dated: July 24, 2023.

Jeaneanne Gettle,

Acting Regional Administrator, Region 4.

For the reasons set out in the preamble, EPA amends 40 CFR part 52 as follows:

PART 52—APPROVAL AND PROMULGATION OF IMPLEMENTATION PLANS

■ 1. The authority for citation for part 52 continues to read as follows:

Authority: 42 U.S.C. 7401 *et seq.*

Subpart II—North Carolina

■ 2. Section 52.1770 paragraphs (b), (c), and (e) are revised to read as follows:

§ 52.1770 Identification of plan.

* * * * *

(b) *Incorporation by reference.*

(1) Material listed in paragraphs (c) and (d) of this section with an EPA approval date prior to April 29, 2023, was approved for incorporation by reference by the Director of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. Material is incorporated as it exists on the date of the approval and notification of any change in the material will be published in the **Federal Register**. Entries in paragraphs (c) and (d) of this section with EPA approval dates after April 29, 2023, will be incorporated by reference in the next update to the SIP compilation.

(2) EPA Region 4 certifies that the rules/regulations provided by EPA in the SIP compilation at the addresses in paragraph (b)(3) of this section are an exact duplicate of the officially promulgated State rules/regulations which have been approved as part of the State Implementation Plan as of the dates referenced in paragraph (b)(1).

(3) Copies of the materials incorporated by reference may be inspected at the Region 4 EPA Office at 61 Forsyth Street SW, Atlanta, GA 30303. To obtain the material, please call (404) 562–9022. You may inspect the material with an EPA approval date prior to April 29, 2023, for North Carolina at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA email *fedreg.legal@nara.gov* or go to *http://www.archives.gov/federal-register/cfr/ibr-locations.html.*

(c) *EPA-Approved Regulations.*

(1) EPA-Approved North Carolina Regulations

State citation	Title/subject	State effective date	EPA approval date	Explanation
Subchapter 02D Air Pollution Control Requirements				
Section .0100 Definitions and References				
Rule .0101	Definitions	1/1/2018	7/17/2020, 85 FR 43461	
Rule .0103	Copies of Referenced Federal Regulations.	1/1/2018	4/10/2019, 84 FR 14308	
Rule .0104	Incorporation by Reference	1/1/2018	4/10/2019, 84 FR 14308	
Rule .0105	Mailing List	1/1/2018	4/10/2019, 84 FR 14308	
Section .0200 Air Pollution Sources				
Rule .0201	Classification of Air Pollution Sources.	1/1/2018	4/10/2019, 84 FR 14308	
Rule .0202	Registration of Air Pollution Sources.	1/1/2018	4/10/2019, 84 FR 14308	
Section .0300 Air Pollution Emergencies				
Rule .0301	Purpose	2/1/1976	6/3/1986, 51 FR 19834	
Rule .0302	Episode Criteria	1/1/2018	4/10/2019, 84 FR 14308	
Rule .0303	Emission Reduction Plans	1/1/2018	4/10/2019, 84 FR 14308	
Rule .0304	Preplanned Abatement Program	1/1/2018	4/10/2019, 84 FR 14308	
Rule .0305	Emission Reduction Plan: Alert Level.	1/1/2018	4/10/2019, 84 FR 14308	
Rule .0306	Emission Reduction Plan: Warning Level.	1/1/2018	4/10/2019, 84 FR 14308	
Rule .0307	Emission Reduction Plan: Emergency Level.	1/1/2018	4/10/2019, 84 FR 14308	
Section .0400 Ambient Air Quality Standards				
Rule .0401	Purpose	1/1/2018	4/10/2019, 84 FR 14308	
Rule .0402	Sulfur Oxides	1/1/2018	4/10/2019, 84 FR 14308	
Rule .0403	Total Suspended Particulates	7/1/1988	1/16/1990, 55 FR 1419	
Rule .0404	Carbon Monoxide	1/1/2018	4/10/2019, 84 FR 14308	
Rule .0405	Ozone	1/1/2018	2/14/2019, 84 FR 3991	
Rule .0407	Nitrogen Dioxide	1/1/2018	4/10/2019, 84 FR 14308	
Rule .0408	Lead	1/1/2018	4/10/2019, 84 FR 14308	
Rule .0409	PM_{10} Particulate Matter	1/1/2018	4/10/2019, 84 FR 14308	

(1) EPA-APPROVED NORTH CAROLINA REGULATIONS—Continued

State citation	Title/subject	State effective date	EPA approval date	Explanation
Rule .0410	$PM_{2.5}$ Particulate Matter	1/1/2018	4/10/2019, 84 FR 14308	
Section .0500 Emission Control Standards				
Rule .0501	Compliance with Emission Control Standards.	6/1/2008	4/9/2019, 84 FR 14019	
Rule .0502	Purpose	3/1/1981	7/26/1982, 47 FR 32118	
Rule .0503	Particulates from Fuel Burning Indirect Heat Exchangers.	5/1/1999	10/22/2002, 67 FR 64989	
Rule .0504	Particulates from Wood Burning Indirect Heat Exchangers.	7/1/2002	12/27/2002, 67 FR 78980	
Rule .0505	Control of Particulates from Incinerators.	7/1/1987	2/29/1988, 53 FR 5974	
Rule .0506	Particulates from Hot Mix Asphalt Plants.	3/20/1998	11/10/1999, 64 FR 61213	
Rule .0507	Particulates from Chemical Fertilizer Manufacturing Plants.	4/1/2003	9/17/2003, 68 FR 54362	
Rule .0508	Particulates from Pulp and Paper Mills.	3/20/1998	11/10/1999, 64 FR 61213	
Rule .0509	Particulates from Mica or Feldspar Processing Plants.	4/1/2003	9/17/2003, 68 FR 54362	
Rule .0510	Particulates from Sand, Gravel, or Crushed Stone Operations.	3/20/1998	11/10/1999, 64 FR 61213	
Rule .0511	Particulates from Lightweight Aggregate.	3/20/1998	11/10/1999, 64 FR 61213	
Rule .0512	Particulates from Wood Products Finishing Plants.	11/1/1984	12/19/1986, 51 FR 45468	
Rule .0513	Particulates from Portland Cement Plants.	3/20/1998	11/10/1999, 64 FR 61213	
Rule .0514	Particulates from Ferrous Jobbing Foundries.	3/20/1998	11/10/1999, 64 FR 61213	
Rule .0515	Particulates from Miscellaneous Industrial Processes.	4/1/2003	9/17/2003, 68 FR 54362	
Rule .0516	Sulfur Dioxide Emissions from Combustion Sources.	11/1/2020	10/25/2022, 87 FR 64382	
Rule .0517	Emissions from Plants Producing Sulfuric Acid.	11/1/2020	10/25/2022, 87 FR 64382	
Rule .0519	Control of Nitrogen Dioxide and Nitrogen Oxides Emissions.	11/1/2020	10/25/2022, 87 FR 64382	
Rule .0521	Control of Visible Emissions	1/1/2005	10/25/2005, 70 FR 61556	Approving changes to Paragraphs (c) and (d) that reference new Paragraph (g). Also, approving Paragraph (g) excluding the following language: ''excluding startups, shutdowns, maintenance periods when fuel is not being combusted, and malfunctions approved as such according to procedures approved under Rule .0535 of this Section.''
Rule .0522	Control and Prohibition of Odorous Emissions.	2/1/1976	6/3/1986, 51 FR 19834	
Rule .0523	Control of Conical Incinerators	1/1/1985	9/9/1987, 52 FR 33933	
Rule .0527	Emissions from Spodumene Ore Roasting.	11/1/1984	12/19/1986, 51 FR 45468	

(1) EPA-APPROVED NORTH CAROLINA REGULATIONS—Continued

State citation	Title/subject	State effective date	EPA approval date	Explanation
Rule .0530	Prevention of Significant Deterioration.	10/1/2020	1/5/2023, 88 FR 773	Except for the incorporation by reference of 40 CFR 51.166(b)(2)(iii)(*a*), which is instead the incorporation of the March 15, 1996, version of that section as approved into the SIP on October 15, 1999. Except for the incorporation by reference of 40 CFR 51.166(i)(2), which is instead the incorporation of the July 1, 2014, version of that section as approved into the SIP on September 11, 2018. Except for the incorporation by reference of 40 CFR 51.166(b)(2)(v), 51.166(b)(3)(iii)(*d*), 51.166(b)(53)–(56), 51.166(i)(11), and 51.166(y).
Rule .0531	Sources in Nonattainment Areas	9/1/2013	9/14/2016, 81 FR 63107	The version of Section .0531 in the SIP does not incorporate by reference the provisions amended in the Ethanol Rule (published in the FEDERAL REGISTER on May 1, 2007) that excludes facilities that produce ethanol through a natural fermentation process from the definition of ''chemical process plants'' at § 52.21(b)(1)(i)(a) and (b)(1)(iii)(t).
Rule .0532	Sources Contributing to an Ambient Violation.	7/1/1994	2/1/1996, 61 FR 3584	
Rule .0533	Stack Height	11/1/2020	10/25/2022, 87 FR 64382	
Rule .0535	Excess Emissions Reporting and Malfunctions.	7/1/1996	8/1/1997, 62 FR 41277	
Rule .0536	Particulate Emissions from Electric Utility Boilers.	6/1/2008	4/9/2019, 84 FR 14019	Except for the annual average opacity limits and except as the rule applies to Carolina Power & Light's Asheville, Lee, Sutton, and Weatherspoon facilities.
Rule .0540	Particulates from Fugitive Dust Emission Sources.	8/1/2007	7/16/2019, 84 FR 33850	
Rule .0542	Control of Particulate Emissions from Cotton Ginning Operations.	11/1/2020	1/11/2022, 87 FR 1358	
Rule .0543	Best Available Retrofit Technology	11/1/2020	6/21/2022, 87 FR 36769	
Rule .0544	Prevention of Significant Deterioration Requirements for Greenhouse Gases.	11/1/2020	1/5/2023, 88 FR 773	Except for the Biomass Deferral Rule language contained in the second sentence of 40 CFR 51.166(b)(48)(ii)(*a*).
Section .0600 Monitoring: Recordkeeping: Reporting				
Rule .0601	Purpose and Scope	11/1/2019	8/25/2021, 86 FR 47393	
Rule .0602	Definitions	11/1/2019	8/25/2021, 86 FR 47393	
Rule .0604	Exceptions to Monitoring and Reporting Requirements.	11/1/2019	8/25/2021, 86 FR 47393	
Rule .0605	General Recordkeeping and Reporting Requirements.	11/1/2019	8/25/2021, 86 FR 47393	
Rule .0606	Sources Covered by Appendix P of 40 CFR Part 51.	11/1/2019	8/25/2021, 86 FR 47393	
Rule .0607	Large Wood and Wood-Fossil Fuel Combination Units.	11/1/2019	10/7/2022, 87 FR 60895	
Rule .0608	Other Large Coal or Residual Oil Burners.	11/1/2019	10/7/2022, 87 FR 60895	
Rule .0609	Monitoring Condition in Permit	4/12/1984	10/4/1985, 50 FR 41501	
Rule .0610	Federal Monitoring Requirements	11/1/2019	10/7/2022, 87 FR 60895	
Rule .0611	Monitoring Emissions from Other Sources.	4/1/1999	8/8/2002, 67 FR 51461	
Rule .0612	Alternative Monitoring and Reporting Procedures.	11/1/2019	10/7/2022, 87 FR 60895	
Rule .0613	Quality Assurance Program	11/1/2019	10/7/2022, 87 FR 60895	

(1) EPA-APPROVED NORTH CAROLINA REGULATIONS—Continued

State citation	Title/subject	State effective date	EPA approval date	Explanation
Rule .0614	Compliance Assurance Monitoring	4/1/1999	8/8/2002, 67 FR 51461	
Section .0900 Volatile Organic Compounds				
Rule .0901	Definitions	1/1/2009	5/9/2013, 78 FR 27065	
Rule .0902	Applicability	5/1/2013	9/23/2013, 78 FR 58184	This approval does not include the start-up shutdown language as described in Section II.A.a. of EPA's 3/13/2013 proposed rule (78 FR 15895).
Rule .0903	Recordkeeping: Reporting: Monitoring.	5/1/2013	7/25/2013, 78 FR 44892	
Rule .0905	Petition for Alternative Controls	11/8/1984	12/19/1986, 51 FR 45468	
Rule .0906	Circumvention	11/8/1984	12/19/1986, 51 FR 45468	
Rule .0908	Equipment Modification Compliance Schedules.	11/8/1984	12/19/1986, 51 FR 45468	
Rule .0909	Compliance Schedules for Sources in Ozone Nonattainment and Maintenance Areas.	5/1/2013	9/23/2013, 78 FR 58186	
Rule .0912	General Provisions on Test Methods and Procedures.	3/13/2008	5/9/2013, 78 FR 27065	
Rule .0918	Can Coating	7/1/1996	8/1/1997, 62 FR 41277	
Rule .0919	Coil Coating	7/1/1996	8/1/1997, 62 FR 41277	
Rule .0922	Metal Furniture Coating	9/1/2010	5/9/2013, 78 FR 27065	
Rule .0923	Surface Coating of Large Appliance Parts.	9/1/2010	5/9/2013, 78 FR 27065	
Rule .0924	Magnet Wire Coating	7/1/1996	8/1/1997, 62 FR 41277	
Rule .0925	Petroleum Liquid Storage in Fixed Roof Tanks.	12/1/1989	6/23/1994, 59 FR 32362	
Rule .0926	Bulk Gasoline Plants	7/1/1996	8/1/1997, 62 FR 41277	
Rule .0927	Bulk Gasoline Terminals	6/1/2008	5/9/2013, 78 FR 27065	
Rule .0928	Gasoline Service Stations Stage I	7/1/1996	8/1/1997, 62 FR 41277	
Rule .0930	Solvent Metal Cleaning	6/1/2008	5/9/2013, 78 FR 27065	
Rule .0931	Cutback Asphalt	12/1/1989	6/23/1994, 59 FR 32362	
Rule .0932	Gasoline Truck Tanks and Vapor Collection Systems.	11/7/2007	5/9/2013, 78 FR 27065	
Rule .0933	Petroleum Liquid Storage in External Floating Roof Tanks.	8/1/2004	5/9/2013, 78 FR 27065	
Rule .0935	Factory Surface Coating of Flat Wood Paneling.	9/1/2010	5/9/2013, 78 FR 27065	
Rule .0937	Manufacture of Pneumatic Rubber Tires.	7/1/1996	8/1/1997, 62 FR 41277	
Rule .0943	Synthetic Organic Chemical and Polymer Manufacturing.	11/7/2007	5/9/2013, 78 FR 27065	
Rule .0944	Manufacture of Polyethylene, Polypropylene, and Polystyrene.	3/14/1985	11/19/1986, 51 FR 41786	
Rule .0945	Petroleum Dry Cleaning	11/7/2007	5/9/2013, 78 FR 27065	
Rule .0947	Manufacture of Synthesized Pharmaceutical Products.	7/1/1994	5/5/1995, 60 FR 22284	
Rule .0948	VOC Emissions from Transfer Operations.	7/1/2000	8/27/2001, 66 FR 34117	
Rule .0949	Storage of Miscellaneous Volatile Organic Compounds.	7/1/2000	8/27/2001, 66 FR 34117	
Rule .0951	RACT for Sources of Volatile Organic Compounds.	5/1/2013	7/25/2013, 78 FR 44890	
Rule .0952	Petitions for Alternative Controls for RACT.	9/18/2009	9/23/2013, 78 FR 58184	
Rule .0955	Thread Bonding Manufacturing	4/1/1995	2/1/1996, 61 FR 3588	
Rule .0956	Glass Christmas Ornament Manufacturing.	4/1/1995	2/1/1996, 61 FR 3588	
Rule .0957	Commercial Bakeries	4/1/1995	2/1/1996, 62 FR 3588	
Rule .0958	Work Practices for Sources of Volatile Organic Compounds.	7/1/2000	8/27/2001, 66 FR 34117	
Rule .0961	Offset Lithographic Printing and Letterpress Printing.	5/1/2013	7/25/2013, 78 FR 44890	
Rule .0962	Industrial Cleaning Solvents	5/1/2013	7/25/2013, 78 FR 44890	
Rule .0963	Fiberglass Boat Manufacturing Materials.	9/1/2010	5/9/2013, 78 FR 27065	
Rule .0964	Miscellaneous Industrial Adhesives	9/1/2010	5/9/2013, 78 FR 27065	
Rule .0965	Flexible Package Printing	9/1/2010	5/9/2013, 78 FR 27065	

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State citation	Title/subject	State effective date	EPA approval date	Explanation
Rule .0966	Paper, Film and Foil Coatings	9/1/2010	5/9/2013, 78 FR 27065	
Rule .0967	Miscellaneous Metal and Plastic Parts Coatings.	9/1/2010	5/9/2013, 78 FR 27065	
Rule .0968	Automobile and Light Duty Truck Assembly Coatings.	9/1/2010	5/9/2013, 78 FR 27065	
Section .1000 Motor Vehicle Emission Control Standards				
Rule .1001	Purpose	7/1/2018	9/11/2019, 84 FR 47889	
Rule .1002	Applicability	7/1/2018	9/11/2019, 84 FR 47889	
Rule .1003	Definitions	7/1/2018	9/11/2019, 84 FR 47889	
Rule .1005	On-Board Diagnostic Standards	7/1/2018	9/11/2019, 84 FR 47889	
Section .1400 Nitrogen Oxides				
Rule .1401	Definitions	10/1/2020	1/13/2023, 88 FR 2243	
Rule .1402	Applicability	10/1/2020	1/13/2023, 88 FR 2243	
Rule .1403	Compliance Schedules	10/1/2020	1/13/2023, 88 FR 2243	
Rule .1404	Recordkeeping: Reporting: Monitoring.	10/1/2020	1/13/2023, 88 FR 2243	
Rule .1407	Boilers and Indirect Process Heaters.	10/1/2020	1/13/2023, 88 FR 2243	
Rule .1408	Stationary Combustion Turbines	10/1/2020	1/13/2023, 88 FR 2243	
Rule .1409	Stationary Internal Combustion Engines.	10/1/2020	1/13/2023, 88 FR 2243	
Rule .1410	Emissions Averaging	10/1/2020	1/13/2023, 88 FR 2243	
Rule .1411	Seasonal Fuel Switching	10/1/2020	1/13/2023, 88 FR 2243	
Rule .1412	Petition for Alternative Limitations	10/1/2020	1/13/2023, 88 FR 2243	
Rule .1413	Sources Not Otherwise Listed in This Section.	10/1/2020	1/13/2023, 88 FR 2243	
Rule .1414	Tune-Up Requirements	10/1/2020	1/13/2023, 88 FR 2243	
Rule .1415	Test Methods and Procedures	10/1/2020	1/13/2023, 88 FR 2243	
Rule .1418	New Electric Generating Units, Large Boilers, and Large I/C Engines.	10/1/2020	1/13/2023, 88 FR 2243	
Rule .1423	Large Internal Combustion Engines	7/15/2002	4/28/2020, 85 FR 23700	
Section .1900 Open Burning				
Rule .1901	Open Burning: Purpose: Scope	7/1/2007	7/18/2017, 82 FR 32767	
Rule .1902	Definitions	7/1/2007	7/18/2017, 82 FR 32767	
Rule .1903	Open Burning Without an Air Quality Permit.	7/1/2007	7/18/2017, 82 FR 32767	
Rule .1904	Air Curtain Burners	7/1/1996	8/1/1997, 62 FR 41277	
Rule .1907	Multiple Violations Arising from a Single Episode.	7/1/2007	7/16/2019, 84 FR 33850	
Section .2000 Transportation Conformity				
Rule .2001	Purpose, Scope and Applicability	1/1/2018	9/30/2019, 84 FR 51416	
Rule .2002	Definitions	1/1/2018	9/30/2019, 84 FR 51416	
Rule .2003	Transportation Conformity Determination.	1/1/2018	9/30/2019, 84 FR 51416	
Rule .2004	Determining Transportation Related Emissions.	4/1/1999	12/27/2002, 67 FR 78983	
Rule .2005	Memorandum of Agreement	1/1/2018	9/30/2019, 84 FR 51416	
Section .2400 Clean Air Interstate Rules				
Rule .2401	Purpose and Applicability	5/1/2008	11/30/2009, 74 FR 62496	
Rule .2402	Definitions	5/1/2008	11/30/2009, 74 FR 62496	
Rule .2403	Nitrogen Oxide Emissions	5/1/2008	11/30/2009, 74 FR 62496	
Rule .2404	Sulfur Dioxide	5/1/2008	11/30/2009, 74 FR 62496	
Rule .2405	Nitrogen Oxide Emissions During Ozone Season.	5/1/2008	11/30/2009, 74 FR 62496	
Rule .2406	Permitting	7/1/2006	11/30/2009, 74 FR 62496	
Rule .2407	Monitoring, Reporting, and Recordkeeping.	5/1/2008	11/30/2009, 74 FR 62496	
Rule .2408	Trading Program and Banking	7/1/2006	11/30/2009, 74 FR 62496	
Rule .2409	Designated Representative	5/1/2008	11/30/2009, 74 FR 62496	
Rule .2410	Computation of Time	7/1/2006	11/30/2009, 74 FR 62496	

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Rule .2411	Opt-In Provisions	7/1/2006	11/30/2009, 74 FR 62496	
Rule .2412	New Unit Growth	5/1/2008	11/30/2009, 74 FR 62496	
Rule .2413	Periodic Review and Reallocations	7/1/2006	11/30/2009, 74 FR 62496	
Section .2600 Source Testing				
Rule .2601	Purpose and Scope	6/1/2008	5/9/2013, 78 FR 27065	
Rule .2602	General Provisions on Test Methods and Procedures.	6/1/2008	5/9/2013, 78 FR 27065	
Rule .2603	Testing Protocol	11/1/2019	10/7/2022, 87 FR 60895	
Rule .2604	Number of Test Points	11/1/2019	10/7/2022, 87 FR 60895	
Rule .2605	Velocity and Volume Flow Rate	11/1/2019	10/7/2022, 87 FR 60895	
Rule .2606	Molecular Weight	11/1/2019	10/7/2022, 87 FR 60895	
Rule .2607	Determination of Moisture Content	11/1/2019	10/7/2022, 87 FR 60895	
Rule .2608	Number of Runs and Compliance Determination.	11/1/2019	10/7/2022, 87 FR 60895	
Rule .2609	Particulate Testing Methods	6/1/2008	4/9/2019, 84 FR 14019	
Rule .2610	Opacity	11/1/2019	10/7/2022, 87 FR 60895	
Rule .2611	Sulfur Dioxide Testing Methods	6/1/2008	4/9/2019, 84 FR 14019	
Rule .2612	Nitrogen Oxide Testing Methods	11/1/2019	10/7/2022, 87 FR 60895	
Rule .2613	Volatile Organic Compound Testing Methods.	11/1/2019	10/7/2022, 87 FR 60895	
Rule .2614	Determination of VOC Emission Control System Efficiency.	11/1/2019	10/7/2022, 87 FR 60895	
Rule .2615	Determination of Leak Tightness and Vapor Leaks.	6/1/2008	5/9/2013, 78 FR 27065	
Rule .2617	Total Reduced Sulfur	6/1/2008	4/9/2019, 84 FR 14019	
Rule .2621	Determination of Fuel Heat Content Using F-Factor.	6/1/2008	5/9/2013, 78 FR 27065	
Subchapter 02Q Air Quality Permits				
Section .0100 General Provisions				
Rule .0101	Required Air Quality Permits	4/1/2018	7/17/2020, 85 FR 43461	
Rule .0102	Activities Exempted from Permit Requirements.	1/1/2005	8/22/2008, 73 FR 49613	
Rule .0103	Definitions	4/1/2018	7/17/2020, 85 FR 43461	
Rule .0104	Where to Obtain and File Permit Applications.	4/1/2018	7/17/2020, 85 FR 43461	
Rule .0105	Copies of Referenced Documents	4/1/2018	7/17/2020, 85 FR 43461	
Rule .0106	Incorporation by Reference	4/1/2018	7/17/2020, 85 FR 43461	
Rule .0107	Confidential Information	4/1/2018	7/17/2020, 85 FR 43461	
Rule .0108	Delegation of Authority	4/1/2018	7/17/2020, 85 FR 43461	
Rule .0109	Compliance Schedule for Previously Exempted Activities.	4/1/2018	7/17/2020, 85 FR 43461	
Rule .0110	Retention of Permit at Permitted Facility.	4/1/2018	7/17/2020, 85 FR 43461	
Rule .0111	Applicability Determinations	4/1/2018	7/17/2020, 85 FR 43461	
Section .0200 Permit Fees				
Rule .0207	Annual Emissions Reporting	4/1/2018	3/1/2021, 86 FR 11867	
Section .0300 Construction and Operating Permits				
Rule .0301	Applicability	4/1/2018	3/1/2021, 86 FR 11875	
Rule .0303	Definitions	4/1/2018	3/1/2021, 86 FR 11875	
Rule .0304	Applications	4/1/2018	3/1/2021, 86 FR 11875	
Rule .0305	Application Submittal Content	4/1/2018	3/1/2021, 86 FR 11875	
Rule .0306	Permits Requiring Public Participation.	4/1/2018	3/1/2021, 86 FR 11875	
Rule .0307	Public Participation Procedures	4/1/2018	3/1/2021, 86 FR 11875	
Rule .0308	Final Action on Permit Applications	4/1/2018	3/1/2021, 86 FR 11875	
Rule .0309	Termination, Modification and Revocation of Permits.	4/1/2018	3/1/2021, 86 FR 11875	
Rule .0310	Permitting of Numerous Similar Facilities.	4/1/2018	3/1/2021, 86 FR 11875	
Rule .0311	Permitting of Facilities at Multiple Temporary Sites.	4/1/2018	3/1/2021, 86 FR 11875	
Rule .0312	Application Processing Schedule	4/1/2018	3/1/2021, 86 FR 11875	

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State citation	Title/subject	State effective date	EPA approval date	Explanation
Rule .0313	Expedited Application Processing Schedule.	4/1/2018	3/1/2021, 86 FR 11875	
Rule .0314	General Permitting for All Requirements.	4/1/2018	3/1/2021, 86 FR 11875	
Rule .0315	Synthetic Minor Facilities	4/1/2018	3/1/2021, 86 FR 11875	
Rule .0316	Administrative Permit Amendments	4/1/2018	3/1/2021, 86 FR 11875	
Rule .0317	Avoidance Conditions	4/1/2018	3/1/2021, 86 FR 11875	
Section .0800 Exclusionary Rules				
Rule .0801	Purpose and Scope	4/1/2018	10/18/2022, 87 FR 62990	
Rule .0802	Gasoline Service Stations and Dispensing Facilities.	4/1/2018	10/18/2022, 87 FR 62990	
Rule .0803	Coating, Solvent Cleaning, Graphic Arts Operations.	4/1/2018	10/18/2022, 87 FR 62990	
Rule .0804	Dry Cleaning Facilities	4/1/2018	10/18/2022, 87 FR 62990	
Rule .0805	Grain Elevators	4/1/2018	10/18/2022, 87 FR 62990	
Rule .0806	Cotton Gins	4/1/2018	10/18/2022, 87 FR 62990	
Rule .0807	Emergency Generators	4/1/2018	10/18/2022, 87 FR 62990	
Rule .0808	Peak Shaving Generators	11/10/2005	6/18/2017, 82 FR 32767	
Section .0900 Permit Exemptions				
Rule .0901	Purpose and Scope	1/1/2005	9/29/2017, 82 FR 45473	
Rule .0902	Portable Crushers	1/1/2005	9/29/2017, 82 FR 45473	

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Citation	Title/subject	County effective date	EPA approval date	Explanation
Subchapter 3A Air Pollution Control				
Section .0100 In General				
Rule .0101	Department Established	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0102	Enforcement of Chapter	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0103	General Powers and Duties of Director.	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0104	Authority of Director to Establish Administrative Procedures.	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0105	Fees for Inspections, Permits, and Certificates Required by Chapter.	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0106	Penalties for Violation of Chapter	9/14/1998	2/17/2000, 65 FR 8053	
Rule .0107	Civil Relief for Violations of Chapter	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0108	Chapter Does Not Prohibit Private Actions For Relief.	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0109	Judicial Review of Administrative Decisions Rendered Under Chapter.	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0111	Copies of Referenced Federal Regulations.	12/19/1994	2/1/1996, 61 FR 3586	
Section .0200 Advisory Board				
Rule .0201	Established; Composition; Terms of Members.	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0202	Secretary	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0203	Meetings	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0204	To Serve in Advisory Capacity; General Functions.	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0205	Appeals to and Other Appearances Before Board.	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0206	Opinions Not Binding	12/19/1994	2/1/1996, 61 FR 3586	
Section .0300 Remedies for Enforcement of Standards—Special Orders				
Rule .0301	Applicability	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0302	Issuance	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0303	Definitions	12/19/1994	2/1/1996, 61 FR 3586	

(2) EPA-APPROVED FORSYTH COUNTY REGULATIONS—Continued

Citation	Title/subject	County effective date	EPA approval date	Explanation
Rule 0304	Categories of Sources	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0305	Enforcement Procedures	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0306	Required Procedures for Issuance of Special Orders by Consent and Special Orders.	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0307	Documentation for Special Orders	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0308	Public Hearing	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0309	Compliance Bonds	12/19/1994	2/1/1996, 61 FR 3586	
Section .0400 Forsyth County Air Quality Technical Code				
Rule .0401	Adopted	12/19/1994	2/1/1996, 61 FR 3586	
Subchapter 3B Relationship to State Code				
Rule .0101	In General	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0102	Air Pollution Control Requirements (Subchapter 3D).	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0103	Air Quality Permits (Subchapter 3Q).	12/19/1994	2/1/1996, 61 FR 3586	
Subchapter 3D Air Pollution Control Requirements				
Section .0100 Definitions and References				
Rule .0101	Definitions	9/14/1998	2/17/2000, 65 FR 8053	
Rule .0103	Copies of Referenced Federal Regulations.	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0104	Incorporation by Reference	5/24/1999	10/22/2002, 67 FR 64994	
Section .0200 Air Pollution Sources				
Rule .0201	Classification of Air Pollution Sources.	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0202	Registration of Air Pollution Sources.	12/19/1994	2/1/1996, 61 FR 3586	
Section .0300 Air Pollution Emergencies				
Rule .0301	Purpose	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0302	Episode Criteria	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0303	Emission Reduction Plans	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0304	Preplanned Abatement Program	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0305	Emission Reduction Plan: Alert Level.	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0306	Emission Reduction Plan: Warning Level.	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0307	Emission Reduction Plan: Emergency Level.	12/19/1994	2/1/1996, 61 FR 3586	
Section .0400 Ambient Air Quality Standards				
Rule .0401	Purpose	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0402	Sulfur Oxides	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0403	Total Suspended Particulates	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0404	Carbon Monoxide	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0405	Ozone	5/24/1999	10/22/2002, 67 FR 64994	
Rule .0407	Nitrogen Dioxide	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0408	Lead	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0409	Particulate Matter	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0410	$PM_{2.5}$ Particulate Matter	5/24/1999	10/22/2002, 67 FR 64994	
Section .0500 Emission Control Standards				
Rule .0501	Compliance With Emission Control Standards.	5/24/1999	10/22/2002, 67 FR 64994	
Rule .0502	Purpose	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0503	Particulates From Fuel Burning Indirect Heat Exchangers.	5/24/1999	10/22/2002, 67 FR 64994	
Rule .0504	Particulates from Wood Burning Indirect Heat Exchangers.	7/22/2002	9/16/2003, 68 FR 54166	

(2) EPA-APPROVED FORSYTH COUNTY REGULATIONS—Continued

Citation	Title/subject	County effective date	EPA approval date	Explanation
Rule .0506	Particulates from Hot Mix Asphalt Plants.	9/14/1998	2/17/2000, 65 FR 8053	
Rule .0507	Particulates from Chemical Fertilizer Manufacturing Plants.	9/14/1998	2/17/2000, 65 FR 8053	
Rule .0508	Particulates from Pulp and Paper Mills.	9/14/1998	2/17/2000, 65 FR 8053	
Rule .0509	Particulates from Mica or Feldspar Processing Plants.	9/14/1998	2/17/2000, 65 FR 8053	
Rule .0510	Particulates from Sand, Gravel, or Crushed Stone Operations.	9/14/1998	2/17/2000, 65 FR 8053	
Rule .0511	Particulates from Lightweight Aggregate Processes.	9/14/1998	2/17/2000, 65 FR 8053	
Rule .0512	Particulates from Wood Products Finishing Plants.	7/28/1997	12/31/1998, 63 FR 72190	
Rule .0513	Control of Particulates From Portland Cement Plants.	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0514	Control of Particulates From Ferrous Jobbing Foundries.	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0515	Particulates from Miscellaneous Industrial Processes.	9/14/1998	2/17/2000, 65 FR 8053	
Rule .0516	Sulfur Dioxide Emissions from Combustion Sources.	11/29/1995	5/26/1996, 61 FR 25789	
Rule .0517	Emissions from Plants Producing Sulfuric Acid.	12/19/1994	2/1/1996, 61 FR 3586	Except for item 2.
Rule .0519	Control of Nitrogen Dioxide and Nitrogen Oxides Emissions.	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0520	Control and Prohibition of Open Burning.	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0521	Control of Visible Emissions	9/14/1998	2/17/2000, 65 FR 8053	
Rule .0523	Control of Conical Incinerators	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0527	Emissions from Spodumene Ore Roasting.	12/19/1994	2/1/1996, 61 FR 3586	Except for item (2).
Rule .0530	Prevention of Significant Deterioration.	8/14/1995	5/23/1996, 61 FR 25789	Except for Paragraphs (a), (l), (o), and (s) approved on 12/31/1998 with a state effective date of 7/28/1997.
Rule .0531	Sources in Nonattainment Areas	11/13/1995	2/17/2000, 65 FR 8053	
Rule .0532	Sources Contributing to an Ambient Violation.	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0533	Stack Height	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0535	Excess Emissions Reporting and Malfunctions.	9/14/1998	2/17/2000, 65 FR 8053	
Rule .0536	Particulate Emissions From Electric Utility Boilers.	12/19/1994	2/1/1996, 61 FR 3586	
Section .0600 Monitoring: Recordkeeping: Reporting				
Rule .0601	Purpose and Scope	5/24/1999	10/22/2002, 67 FR 64994	
Rule .0602	Definitions	5/24/1999	10/22/2002, 67 FR 64994	
Rule .0604	Exceptions to Monitoring and Reporting Requirements.	5/24/1999	10/22/2002, 67 FR 64994	
Rule .0605	General Recordkeeping and Reporting Requirements.	5/24/1999	10/22/2002, 67 FR 64994	
Rule .0606	Sources Covered By Appendix P of 40 CFR Part 51.	5/24/1999	10/22/2002, 67 FR 64994	
Rule .0607	Large Wood and Wood-fossil Fuel Combination Units.	5/24/1999	10/22/2002, 67 FR 64994	
Rule .0608	Program Schedule	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0610	Delegation	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0611	Monitoring Emissions from Other Sources.	5/24/1999	10/22/2002, 67 FR 64994	
Rule .0612	Alternative Monitoring and Reporting Procedures.	5/24/1999	10/22/2002, 67 FR 64994	
Rule .0613	Quality Assurance Program	5/24/1999	10/22/2002, 67 FR 64994	
Rule .0614	Compliance Assurance Monitoring	5/24/1999	10/22/2002, 67 FR 64994	
Rule .0615	Delegation	5/24/1999	10/22/2002, 67 FR 64994	
Section .0800 Transportation Facilities				
Rule .0801	Purpose and Scope	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0802	Definitions	12/19/1994	2/1/1996, 61 FR 3586	

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Citation	Title/subject	County effective date	EPA approval date	Explanation
Rule .0803	Highway Projects	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0804	Airport Facilities	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0805	Parking Facilities	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0806	Ambient Monitoring and Modeling Analysis.	12/19/1994	2/1/1996, 61 FR 3586	
Section .0900 Volatile Organic Compounds				
Rule .0901	Definitions	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0902	Applicability	7/28/1997	12/31/1998, 63 FR 72190	Paragraphs (a) through (i) only.
Rule .0903	Recordkeeping: Reporting: Monitoring.	5/24/1999	10/22/2002, 67 FR 64994	
Rule .0906	Circumvention	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0909	Compliance Schedules for Sources in New Nonattainment Areas.	11/13/1995	2/17/2000, 65 FR 8053	Except Paragraphs (a) through (c), (g), and (h) approved on 12/31/1998 with a state effective date of 7/28/1997.
Rule .0912	General Provisions on Test Methods and Procedures.	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0913	Determination of Volatile Content of Surface Coatings.	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0914	Determination of VOC Emission Control System Efficiency.	9/14/1998	2/17/2000, 65 FR 8053	
Rule .0915	Determination of Solvent Metal Cleaning VOC Emissions.	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0916	Determination: VOC Emissions from Bulk Gasoline Terminals.	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0917	Automobile and Light-Duty Truck Manufacturing.	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0918	Can Coating	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0919	Coil Coating	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0920	Paper Coating	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0921	Fabric and Vinyl Coating	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0922	Metal Furniture Coating	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0923	Surface Coating of Large Appliances.	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0924	Magnet Wire Coating	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0925	Petroleum Liquid Storage in Fixed Roof Tanks.	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0926	Bulk Gasoline Plants	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0927	Bulk Gasoline Terminals	7/22/2002	9/16/2003, 68 FR 54166	
Rule .0928	Gasoline Service Stations Stage I	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0929	Petroleum Refinery Sources	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0930	Solvent Metal Cleaning	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0931	Cutback Asphalt	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0932	Gasoline Truck Tanks and Vapor Collection Systems.	7/22/2002	9/16/2003, 68 FR 54166	
Rule .0933	Petroleum Liquid Storage in External Floating Roof Tanks.	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0934	Coating of Miscellaneous Metal Parts and Products.	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0935	Factory Surface Coating of Flat Wood Paneling.	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0936	Graphic Arts	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0937	Manufacture of Pneumatic Rubber Tires.	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0939	Determination of Volatile Organic Compound Emissions.	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0940	Determination of Leak Tightness and Vapor Leaks.	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0941	Alternative Method for Leak Tightness.	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0942	Determination of Solvent in Filter Waste.	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0943	Synthetic Organic Chemical and Polymer Manufacturing.	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0944	Manufacture of Polyethylene, Polypropylene and Polystyrene.	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0945	Petroleum Dry Cleaning	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0947	Manufacture of Synthesized Pharmaceutical Products.	12/19/1994	2/1/1996, 61 FR 3586	

(2) EPA-APPROVED FORSYTH COUNTY REGULATIONS—Continued

Citation	Title/subject	County effective date	EPA approval date	Explanation
Rule .0948	VOC Emissions from Transfer Operations.	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0949	Storage of Miscellaneous Volatile Organic Compounds.	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0950	Interim Standards for Certain Source Categories.	11/13/1995	2/17/2000, 65 FR 8053	
Rule .0951	Miscellaneous Volatile Organic Compound Emissions.	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0952	Petition for Alternative Controls	11/13/1995	2/17/2000, 65 FR 8053	
Rule .0953	Vapor Return Piping for Stage II Vapor Recovery.	9/14/1998	2/17/2000, 65 FR 8053	
Rule .0954	Stage II Vapor Recovery	11/13/1995	2/17/2000, 65 FR 8053	Except Paragraphs (a) and (f) approved on 12/31/1998 with a state effective date of 7/28/1997.
Rule .0955	Thread Bonding Manufacturing	8/14/1995	5/23/1996, 61 FR 25789	
Rule .0956	Glass Christmas Ornament Manufacturing.	8/14/1995	5/23/1996, 61 FR 25789	
Rule .0957	Commercial Bakeries	8/14/1995	5/23/1996, 61 FR 25789	
Section .1900 Open Burning				
Rule .1903	Permissible Open Burning	10/25/1999	8/9/2002, 67 FR 51763	
Rule .1904	Air Curtain Burners	10/25/1999	8/9/2002, 67 FR 51763	
Section .2000 Transportation Conformity				
Rule .2003	Transportation Conformity Determination.	10/25/1999	8/9/2002, 67 FR 51763	
Subchapter 3Q Air Quality Permits				
Section .0100 General Provisions				
Rule .0101	Required Air Quality Permits	9/14/1998	2/17/2000, 65 FR 8053	
Rule .0102	Activities Exempted From Permit Requirements.	7/22/2002	9/16/2003, 68 FR 54163	
Rule .0103	Definitions	10/25/1999	8/9/2002, 67 FR 51763	
Rule .0104	Where to Obtain and File Permit Applications.	12/19/1994	2/1/1996, 61 FR 3586	Except paragraph (b) approved on 12/31/1998 with a state effective date of 7/28/1997.
Rule .0105	Copies of Referenced Documents	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0106	Incorporation by Reference	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0107	Confidential Information	5/24/1999	10/22/2002, 67 FR 64994	
Rule .0108	Delegation of Authority	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0109	Compliance Schedule for Previously Exempted Activities.	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0110	Retention of Permit at Permitted Facility.	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0111	Applicability Determinations	12/19/1994	2/1/1996, 61 FR 3586	
Section .0200 Permit Fees				
Rule .0207	Annual Emissions Reporting	9/14/1998	2/17/2000, 65 FR 8053	
Section .0300 Construction and Operation Permit				
Rule .0301	Applicability	9/14/1998	2/17/2000, 65 FR 8053	
Rule .0302	Facilities Not Likely to Contravene Demonstration.	9/14/1998	2/17/2000, 65 FR 8053	
Rule .0303	Definitions	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0304	Applications	5/24/1999	10/22/2002, 67 FR 64994	
Rule .0305	Application Submittal Content	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0306	Permits Requiring Public Participation.	5/24/1999	10/22/2002, 67 FR 64994	
Rule .0307	Public Participation Procedures	12/19/1994	2/1/1996, 61 FR 3586	Except paragraph (i) approved on 12/31/1998 with a 7/28/1999 effective date.
Rule .0308	Final Action on Permit Applications	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0309	Termination, Modification and Revocation of Permits.	5/24/1999	10/22/2002, 67 FR 64994	
Rule .0310	Permitting of Numerous Similar Facilities.	12/19/1994	2/1/1996, 61 FR 3586	

(2) EPA-APPROVED FORSYTH COUNTY REGULATIONS—Continued

Citation	Title/subject	County effective date	EPA approval date	Explanation
Rule .0311	Permitting of Facilities at Multiple Temporary Sites.	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0312	Application Processing Schedule	9/14/1998	2/17/2000, 65 FR 8053	
Rule .0314	General Permit Requirements	5/24/1999	10/22/2002, 67 FR 64994	
Rule .0315	Synthetic Minor Facilities	5/24/1999	10/22/2002, 67 FR 64994	
Section .0600 Transportation Facility Procedures				
Rule .0601	Purpose of Section and Requirement for a Permit.	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0602	Definitions	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0603	Applications	12/19/1994	2/1/1996, 61 FR 3586	Except paragraph (e) approved on 12/31/1998 with a state effective date of 7/28/97.
Rule .0604	Public Participation	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0605	Final Action on Permit Application	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0606	Termination, Modification and Revocation of Permits.	12/19/1994	2/1/1996, 61 FR 3586	
Rule .0607	Application Processing Schedule	9/14/1998	2/17/2000, 65 FR 8053	
Section .0800 Exclusionary Rules				
Rule .0801	Purpose and Scope	5/24/1999	10/22/2002, 67 FR 64994	
Rule .0802	Gasoline Service Stations and Dispensing Facilities.	11/13/1995	2/17/2000, 65 FR 8053	
Rule .0803	Coating, Solvent Cleaning, Graphic Arts Operations.	5/24/1999	10/22/2002, 75 FR 64994	
Rule .0804	Dry Cleaning Facilities	11/13/1995	2/17/2000, 65 FR 8053	
Rule .0805	Grain Elevators	9/14/1998	2/17/2000, 65 FR 8053	
Rule .0806	Cotton Gins	9/14/1998	2/17/2000, 65 FR 8053	
Rule .0807	Emergency Generators	9/14/1998	2/17/2000, 65 FR 8053	
Rule .0808	Peak Shaving Generators	5/24/1999	10/22/2002, 67 FR 64990	

(3) EPA-APPROVED MECKLENBURG COUNTY REGULATIONS

Citation	Title/subject	County effective date	EPA approval date	Explanation
Article 1.000 Permitting Provisions for Air Pollution Sources, Rules and Operating Regulations for Acid Rain Sources, Title V and Toxic Air Pollutants				
Section 1.5100 General Provisions and Administrations				
Rule 1.5101	Declaration of Policy	4/3/1989	5/2/1991, 56 FR 20140	
Rule 1.5102	Definition of Terms	12/18/2018	1/11/2022, 87 FR 1356	
Rule 1.5103	Enforcement Agency	4/3/1989	5/2/1991, 56 FR 20140	
Rule 1.5104	General Duties and Powers of the Director, With the Approval of the Board.	12/15/2015	1/11/2022, 87 FR 1356	
Rule 1.5111	General Recordkeeping, Reporting and Monitoring Requirements.	12/18/2018	1/11/2022, 87 FR 1356	
Section 1.5200 Air Quality Permits				
Rule 1.5210	Purpose and Scope	4/3/1989	5/2/1991, 56 FR 20140	
Rule 1.5211	Applicability	11/21/2000	10/22/2002, 67 FR 64999	
Rule 1.5212	Applications	12/18/2018	12/2/2021, 86 FR 68411	
Rule 1.5213	Action on Application; Issuance of Permit.	12/18/2018	12/2/2021, 86 FR 68411	
Rule 1.5214	Commencement of Operation	12/15/2015	12/2/2021, 86 FR 68411	
Rule 1.5215	Application Processing Schedule	12/18/2018	12/2/2021, 86 FR 68411	
Rule 1.5216	Incorporated By Reference	6/6/1994	7/28/1995, 60 FR 38715	
Rule 1.5217	Confidential Information	12/18/2018	12/2/2021, 86 FR 68411	
Rule 1.5218	Compliance Schedule for Previously Exempted Activities.	12/18/2018	12/2/2021, 86 FR 68411	
Rule 1.5219	Retention of Permit at Permitted Facility.	12/18/2018	12/2/2021, 86 FR 68411	
Rule 1.5220	Applicability Determination	12/18/2018	12/2/2021, 86 FR 68411	
Rule 1.5221	Permitting of Numerous Similar Facilities.	12/18/2018	12/2/2021, 86 FR 68411	

(3) EPA-APPROVED MECKLENBURG COUNTY REGULATIONS—Continued

Citation	Title/subject	County effective date	EPA approval date	Explanation
Rule 1.5222	Permitting of Facilities at Multiple Temporary Sites.	12/18/2018	12/2/2021, 86 FR 68411	
Rule 1.5230	Permitting Rules and Procedures.	4/3/1989	5/2/1991, 56 FR 20140	
Rule 1.5231	Air Quality Fees	7/1/1996	6/30/2003, 68 FR 38632	
Rule 1.5232	Issuance, Revocation, and Enforcement of Permits.	12/18/2018	12/2/2021, 86 FR 68411	
Rule 1.5234	Hearings	6/6/1994	7/28/1995, 60 FR 38715	
Rule 1.5235	Delegation of Authority	4/3/1989	5/2/1991, 56 FR 20140	
Section 1.5300 Enforcement; Variances; Judicial Review				
Rule 1.5301	Special Enforcement Procedures	12/15/2015	9/28/2021, 86 FR 53552	
Rule 1.5302	Criminal Penalties	12/15/2015	9/28/2021, 86 FR 53552	
Rule 1.5303	Civil Injunction	12/15/2015	9/28/2021, 86 FR 53552	
Rule 1.5304	Civil Penalties	12/15/2015	9/28/2021, 86 FR 53552	
Rule 1.5305	Variances	7/1/1996	6/30/2003, 68 FR 38632	
Rule 1.5306	Hearings	12/15/2015	9/28/2021, 86 FR 53552	
Rule 1.5307	Judicial Review	12/15/2015	9/28/2021, 86 FR 53552	
Section 1.5600 Transportation Facility Procedures				
Rule 1.5604	Public Participation	7/1/1996	6/30/2003, 68 FR 38632	
Rule 1.5607	Application Processing Schedule	7/1/1996	6/30/2003, 68 FR 38632	
Article 2.0000 Air Pollution Control Regulations and Procedures				
Section 2.0100 Definitions and References				
Rule 2.0101	Definitions	12/18/2015	9/28/2021, 86 FR 53552	
Rule 2.0104	Adoption by Reference Updates	4/3/1989	5/2/1991, 56 FR 20140	
Section 2.0200 Air Pollution Sources				
Rule 2.0201	Classification of Air Pollution Sources.	12/18/2015	9/28/2021, 86 FR 53552	
Rule 2.0202	Registration of Air Pollution Sources.	12/18/2015	9/28/2021, 86 FR 53552	
Section 2.0300 Air Pollution Emergencies				
Rule 2.0301	Purpose	12/15/2015	9/28/2021, 86 FR 53552	
Rule 2.0302	Episode Criteria	12/18/2015	9/28/2021, 86 FR 53552	
Rule 2.0303	Emission Reduction Plans	12/18/2015	9/28/2021, 86 FR 53552	
Rule 2.0304	Preplanned Abatement Program	12/18/2015	9/28/2021, 86 FR 53552	
Rule 2.0305	Emission Reduction Plan: Alert Level.	12/15/2015	9/28/2021, 86 FR 53552	
Rule 2.0306	Emission Reduction Plan: Warning Level.	4/3/1989	5/2/1991, 56 FR 20140	
Rule 2.0307	Emission Reduction Plan: Emergency Level.	4/3/1989	5/2/1991, 56 FR 20140	
Section 2.0400 Ambient Air Quality Standards				
Rule 2.0401	Purpose	12/18/2018	11/17/2021, 86 FR 64073	
Rule 2.0402	Sulfur Oxides	12/18/2018	11/17/2021, 86 FR 64073	
Rule 2.0403	Total Suspended Particulates	12/15/2015	11/17/2021, 86 FR 64073	
Rule 2.0404	Carbon Monoxide	12/18/2018	11/17/2021, 86 FR 64073	
Rule 2.0405	Ozone	12/18/2018	11/17/2021, 86 FR 64073	
Rule 2.0407	Nitrogen Dioxide	12/18/2018	11/17/2021, 86 FR 64073	
Rule 2.0408	Lead	12/18/2018	11/17/2021, 86 FR 64073	
Rule 2.0409	Particulate Matter	4/3/1989	5/2/1991, 56 FR 20140	
Rule 2.0410	$PM_{2.5}$ Particulate Matter	12/18/2018	11/17/2021, 86 FR 64073	

(3) EPA-APPROVED MECKLENBURG COUNTY REGULATIONS—Continued

Citation	Title/subject	County effective date	EPA approval date	Explanation
Section 2.0500 Emission Control Standards				
Rule 2.0501	Compliance With Emission Control Standards.	6/1/2008	1/25/2022, 87 FR 3663	Except for the addition of paragraph 2.0501(e); and except for changes to remove and recodify the prefatory text at 2.0501(c) and for subparagraphs (c)(3), (c)(4), (c)(5), (c)(6), (c)10, (c)(15), (c)(16), and (c)(18), which will remain unchanged with a state effective date of June 14, 1990. Because EPA is acting on other portions of Rule 2.0501, which includes moving former paragraph (e) to paragraph (c) with an effective date of June 1, 2008, there are two paragraphs 2.0501(c), with different state effective dates.
Rule 2.0502	Purpose	4/3/1989	5/2/1991, 56 FR 20140	
Rule 2.0503	Particulates from Fuel Burning Indirect Heat Exchangers.	4/3/1989	5/2/1991, 56 FR 20140	
Rule 2.0504	Particulates from Wood Burning Indirect Heat Exchangers.	4/3/1989	5/2/1991, 56 FR 20140	
Rule 2.0506	Control of Particulates from Hot Mix Asphalt Plants.	4/3/1989	5/2/1991, 56 FR 20140	
Rule 2.0507	Particulates from Chemical Fertilizer Manufacturing Plants.	4/3/1989	5/2/1991, 56 FR 20140	
Rule 2.0508	Control of Particulates from Pulp and Paper Mills.	4/3/1989	5/2/1991, 56 FR 20140	
Rule 2.0509	Particulates from Mica or Feldspar Processing Plants.	4/3/1989	5/2/1991, 56 FR 20140	
Rule 2.0510	Particulates: Sand: Gravel: Crushed Stone Operations.	4/3/1989	5/2/1991, 56 FR 20140	
Rule 2.0511	Particulates: SO(2) From Lightweight Aggregate Processes.	4/3/1989	5/2/1991, 56 FR 20140	
Rule 2.0512	Particulates from Wood Products Finishing Plants.	4/3/1989	5/2/1991, 56 FR 20140	
Rule 2.0513	Control of Particulates from Portland Cement Plants.	4/3/1989	5/2/1991, 56 FR 20140	
Rule 2.0514	Control of Particulates from Ferrous Jobbing Foundries.	4/3/1989	5/2/1991, 56 FR 20140	
Rule 2.0515	Particulates from Miscellaneous Industrial Processes.	4/3/1989	5/2/1991, 56 FR 20140	
Rule 2.0516	Sulfur Dioxide Emissions from Fuel Burning Installations.	4/3/1989	5/2/1991, 56 FR 20140	
Rule 2.0517	Emissions From Plants Producing Sulfuric Acid.	4/3/1989	5/2/1991, 56 FR 20140	Except for item (2).
Rule 2.0518	Miscellaneous Volatile Organic Compound Emissions.	11/21/2000	10/22/2002, 67 FR 64999	
Rule 2.0519	Control of Nitrogen Dioxide Emissions.	4/3/1989	5/2/1991, 56 FR 20140	
Rule 2.0523	Control of Conical Incinerators	11/21/2000	10/22/2002, 67 FR 64999	
Rule 2.0530	Prevention of Significant Deterioration.	10/17/2017	10/6/2022, 87 FR 60551	Except for the incorporation by reference of 40 CFR 51.166(b)(2)(iii)(*a*), which is instead incorporated by reference as of July 1, 1988. Except for the incorporation by reference of 40 CFR 51.166(b)(2)(v), (b)(3)(iii)(*d*), (b)(53) through (56), and (y).
Rule 2.0531	Sources in Nonattainment Areas	4/3/1989	5/2/1991, 56 FR 20140	
Rule 2.0532	Sources Contributing to an Ambient Violation.	4/3/1989	5/2/1991, 56 FR 20140	
Rule 2.0533	Stack Height	4/3/1989	5/2/1991, 56 FR 20140	
Rule 2.0535	Malfunctions, Start-Up and Shut-Down.	4/3/1989	5/2/1991, 56 FR 20140	

(3) EPA-APPROVED MECKLENBURG COUNTY REGULATIONS—Continued

Citation	Title/subject	County effective date	EPA approval date	Explanation
Rule 2.0544	Prevention of Significant Deterioration Requirements for Greenhouse Gases.	12/15/2015	10/6/2022, 87 FR 60551	Except for the Biomass Deferral Rule language contained in the second sentence of 40 CFR 51.166(b)(48)(ii)(*a*).
Section 2.0600 Monitoring: Recordkeeping: Reporting				
Rule 2.0601	Purpose and Scope	12/15/2015	1/25/2022, 87 FR 3675	
Rule 2.0602	Definitions	12/15/2015	1/25/2022, 87 FR 3675	
Rule 2.0604	Exceptions to Monitoring and Reporting Requirements.	12/15/2015	1/25/2022, 87 FR 3675	
Rule 2.0605	General Recordkeeping and Reporting Requirements.	12/15/2015	1/25/2022, 87 FR 3675	
Rule 2.0606	Sources Covered by Appendix P of 40 CFR Part 51.	6/14/1991	5/2/1991, 56 FR 20140	
Rule 2.0607	Large Wood and Wood-Fossil Fuel Combination Units.	12/15/2015	1/25/2022, 87 FR 3675	
Rule 2.0608	Program Schedule	4/3/1989	5/2/1991, 56 FR 20140	
Rule 2.0610	Delegation Federal Monitoring Requirements.	12/15/2015	1/25/2022, 87 FR 3675	
Rule 2.0611	Monitoring Emissions From Other Sources.	12/15/2015	1/25/2022, 87 FR 3675	
Rule 2.0613	Quality Assurance Program	12/15/2015	1/25/2022, 87 FR 3675	
Section 2.0900 Volatile Organic Compounds				
Rule 2.0901	Definitions	1/1/2009	1/25/2022, 87 FR 3663	
Rule 2.0902	Applicability	10/16/2004	9/12/2007, 72 FR 52012	
Rule 2.0903	Recordkeeping: Reporting: Monitoring.	7/1/1991	6/23/1994, 59 FR 32362	
Rule 2.0906	Circumvention	12/15/2015	2/28/2022, 87 FR 10975	
Rule 2.0907	Equipment Installation Compliance Schedules.	4/3/1989	5/2/1991, 56 FR 20140	
Rule 2.0909	Low Solvent Content Coating Compliance Schedules.	4/3/1989	5/2/1991, 56 FR 20140	
Rule 2.0911	Expectation for Compliance Schedule.	4/3/1989	5/2/1991, 56 FR 20140	
Rule 2.0912	General Provisions on Test Methods and Procedures.	6/1/2008	1/25/2022, 87 FR 3663	
Rule 2.0914	Determination of VOC Emission Control System Efficiency.	4/3/1989	5/2/1991, 56 FR 20140	
Rule 2.0917	Automobile and Light-Duty Truck Manufacturing.	4/3/1989	5/2/1991, 56 FR 20140	
Rule 2.0918	Can Coating	12/15/2015	2/28/2022, 87 FR 10975	
Rule 2.0919	Coil Coating	12/15/2015	2/28/2022, 87 FR 10975	
Rule 2.0920	Paper Coating	4/3/1989	5/2/1991, 56 FR 20140	
Rule 2.0921	Fabric and Vinyl Coating	4/3/1989	5/2/1991, 56 FR 20140	
Rule 2.0922	Metal Furniture Coating	4/3/1989	5/2/1991, 56 FR 20140	
Rule 2.0923	Surface Coating of Large Appliances.	4/3/1989	5/2/1991, 56 FR 20140	
Rule 2.0924	Magnet Wire Coating	12/15/2015	2/28/2022, 87 FR 10975	
Rule 2.0925	Petroleum Liquid Storage in Fixed Roof Tanks.	12/15/2015	2/28/2022, 87 FR 10975	
Rule 2.0926	Bulk Gasoline Plants	12/15/2015	2/28/2022, 87 FR 10975	
Rule 2.0927	Bulk Gasoline Terminals	12/15/2015	2/28/2022, 87 FR 10975	
Rule 2.0928	Gasoline Service Stations Stage 1.	12/15/2015	2/28/2022, 87 FR 10975	
Rule 2.0930	Solvent Metal Cleaning	12/15/2015	2/28/2022, 87 FR 10975	
Rule 2.0931	Cutback Asphalt	12/15/2015	2/28/2022, 87 FR 10975	
Rule 2.0932	Gasoline Truck Tanks and Vapor Collection Systems.	4/3/1989	5/2/1991, 56 FR 20140	
Rule 2.0933	Petroleum Liquid Storage in External Floating Roof Tanks.	12/15/2015	2/28/2022, 87 FR 10975	
Rule 2.0934	Coating of Miscellaneous Metal Parts and Products.	3/1/1991	6/23/1994, 59 FR 32362	
Rule 2.0935	Factory Surface Coating of Flat Wood Paneling.	4/3/1989	5/2/1991, 56 FR 20140	
Rule 2.0936	Graphic Arts	4/3/1989	5/2/1991, 56 FR 20140	
Rule 2.0937	Manufacture of Pneumatic Rubber Tires.	12/15/2015	2/28/2022, 87 FR 10975	

(3) EPA-APPROVED MECKLENBURG COUNTY REGULATIONS—Continued

Citation	Title/subject	County effective date	EPA approval date	Explanation
Rule 2.0943	Synthetic Organic Chemical and Polymer Manufacturing.	6/1/2008	1/25/2022, 87 FR 3663	
Rule 2.0944	Manufacture of Polyethylene, Polypropylene and Polystyrene.	12/15/2015	2/28/2022, 87 FR 10975	
Rule 2.0945	Petroleum Dry Cleaning	6/1/2008	1/25/2022, 87 FR 3663	
Rule 2.0947	Manufacture of Synthesized Pharmaceutical Products.	12/15/2015	2/28/2022, 87 FR 10975	
Rule 2.0948	VOC Emissions from Transfer Operations.	12/15/2015	2/28/2022, 87 FR 10975	
Rule 2.0949	Storage of Miscellaneous Volatile Organic Compounds.	12/15/2015	2/28/2022, 87 FR 10975	
Rule 2.0951	Miscellaneous Volatile Organic Compound Emissions.	7/1/2000	10/22/2002, 67 FR 64999	
Rule 2.0958	Work Practices for Sources of Volatile Organic Compounds.	12/15/2015	2/28/2022, 87 FR 10975	
Section 2.2600 Source Testing				
Rule 2.2602	General Provisions on Test Methods and Procedures.	6/1/2008	1/25/2022, 87 FR 3663	Except for paragraph 2.2602(i).
Rule 2.2603	Testing Protocol	6/1/2008	1/25/2022, 87 FR 3663	
Rule 2.2604	Number of Test Points	6/1/2008	1/25/2022, 87 FR 3663	
Rule 2.2605	Velocity and Volume Flow Rate	6/1/2008	1/25/2022, 87 FR 3663	
Rule 2.2606	Molecular Weight	6/1/2008	1/25/2022, 87 FR 3663	
Rule 2.2607	Determination of Moisture Content.	6/1/2008	1/25/2022, 87 FR 3663	
Rule 2.2608	Number of Runs and Compliance Determination.	6/1/2008	1/25/2022, 87 FR 3663	
Rule 2.2610	Opacity	6/1/2008	1/25/2022, 87 FR 3663	
Rule 2.2612	Nitrogen Oxide Testing Methods	6/1/2008	1/25/2022, 87 FR 3663	
Rule 2.2613	Volatile Organic Compound Testing Methods.	6/1/2008	1/25/2022, 87 FR 3663	
Rule 2.2614	Determination of VOC Emission Control System Efficiency.	6/1/2008	1/25/2022, 87 FR 3663	
Rule 2.2615	Determination of Leak Tightness and Vapor Leaks.	6/1/2008	1/25/2022, 87 FR 3663	

(4) EPA-APPROVED WESTERN NORTH CAROLINA REGULATIONS

Citation	Title/subject	State effective date	EPA approval date	Explanation
Article I. Resolutions, Organization, Administration				
Sec. 1–1	Resolution	7/1/1970	5/2/1991, 56 FR 20140	
Sec. 1–2	Ordinance	7/1/1970	5/2/1991, 56 FR 20140	
Sec. 1–3	Authority	7/1/1970	5/2/1991, 56 FR 20140	
Sec. 1–4	Organization	7/1/1970	5/2/1991, 56 FR 20140	
Sec. 1–5	Administrative Procedures	7/1/1970	5/2/1991, 56 FR 20140	
Sec. 1–6	Appeals to and other Appearances before Board.	7/1/1970	5/2/1991, 56 FR 20140	
Sec. 1–7	Opinions not Binding	7/1/1970	5/2/1991, 56 FR 20140	
Article II. Definitions				
Sec. 1–25	Definitions	11/9/1988	5/2/1991, 56 FR 20140	
Sec. 1–26	Enforcement of Chapter	11/9/1988	5/2/1991, 56 FR 20140	
Sec. 1–27	General Powers and Duties of Director.	11/9/1988	5/2/1991, 56 FR 20140	
Sec. 1–28	Authority of Director to Establish Administrative Procedures.	11/9/1988	5/2/1991, 56 FR 20140	
Sec. 1–29	Confidentiality of Records and Information Furnished to the Department.	11/9/1988	5/2/1991, 56 FR 20140	
Sec. 1–30	Fees for Inspection Permits and Certificates Required by Chapter.	11/9/1988	5/2/1991, 56 FR 20140	
Sec. 1–32	Variances	11/9/1988	5/2/1991, 56 FR 20140	
Sec. 1–33	Penalties for Violation of Chapter	11/9/1988	5/2/1991, 56 FR 20140	
Sec. 1–34	Civil Relief for Violation of Chapter	11/9/1988	5/2/1991, 56 FR 20140	

(4) EPA-APPROVED WESTERN NORTH CAROLINA REGULATIONS—Continued

Citation	Title/subject	State effective date	EPA approval date	Explanation
Sec. 1–35	Chapter Does Not Prohibit Private Actions for Relief.	11/9/1988	5/2/1991, 56 FR 20140	
Sec. 1–36	Judicial Review of Administrative Decisions Rendered Under Chapter.	11/9/1988	5/2/1991, 56 FR 20140	
Article III. Open Burning				
Sec. 1–42	Purpose of Article	3/13/1985	5/2/1991, 56 FR 20140	
Sec. 1–43	Application of Article	3/13/1985	5/2/1991, 56 FR 20140	
Sec. 1–44	General Prohibition	3/13/1985	5/2/1991, 56 FR 20140	
Sec. 1–45	Permissible Burning—Generally	3/13/1985	5/2/1991, 56 FR 20140	
Article IV. Visible Emissions				
Sec. 1–59	Purpose of Article	3/13/1985	5/2/1991, 56 FR 20140	
Article V. Odorous Emissions				
Sec. 1–75	Control and Prohibition of Odorous Emissions.	3/13/1985	5/2/1991, 56 FR 20140	
Sec. 1–76	Control of Conical Incinerators	3/13/1985	5/2/1991, 56 FR 20140	
Article VI. Ambient Air Quality Standards				
Sec. 1–89	Purpose	3/13/1985	5/2/1991, 56 FR 20140	
Sec. 1–90	Sampling Locations for Enforcement of Article.	11/9/1988	5/2/1991, 56 FR 20140	
Sec. 1–91	Sulfur Oxides	6/5/1985	5/2/1991, 56 FR 20140	
Sec. 1–92	Suspended Particulates	6/5/1985	5/2/1991, 56 FR 20140	
Sec. 1–93	Carbon Monoxide	6/5/1985	5/2/1991, 56 FR 20140	
Sec. 1–94	Ozone	6/5/1985	5/2/1991, 56 FR 20140	
Sec. 1–95	Nitrogen Dioxide	6/5/1985	5/2/1991, 56 FR 20140	
Sec. 1–96	Lead	6/5/1985	5/2/1991, 56 FR 20140	
Sec. 1–97	Particulate Matter	11/9/1988	5/2/1991, 56 FR 20140	
Article VII. Classification of Air Contaminant Sources				
Sec. 1–108	Purpose of Article	8/19/1970	5/2/1991, 56 FR 20140	
Sec. 1–109	Application of Article	8/19/1970	5/2/1991, 56 FR 20140	
Sec. 1–110	System Established	8/19/1970	5/2/1991, 56 FR 20140	
Article VIII. Registration of Air Contaminant Sources				
Sec. 1–121	Purpose of Article	1/20/1982	5/2/1991, 56 FR 20140	
Sec. 1–122	Application of Article	1/20/1982	5/2/1991, 56 FR 20140	
Sec. 1–123	Operator and Premises Registration.	1/20/1982	5/2/1991, 56 FR 20140	
Sec. 1–124	Process Registration—Generally	1/20/1982	5/2/1991, 56 FR 20140	
Sec. 1–125	Director to Establish Dates	1/20/1982	5/2/1991, 56 FR 20140	
Sec. 1–126	Responsibility of Obtaining Forms	1/20/1982	5/2/1991, 56 FR 20140	
Article IX. Air Contaminant Emission Control Standards				
Sec. 1–135	Emission Control Standards	6/5/1985	5/2/1991, 56 FR 20140	
Sec. 1–136	Purpose of Article; All Sources to Be Provided with Maximum Feasible Control.	11/9/1988	5/2/1991, 56 FR 20140	
Sec. 1–137	Malfunction Regulations	11/9/1988	5/2/1991, 56 FR 20140	Except for paragraph (g).
Sec. 1–138	Control of Particulate from Fuel Burning Sources.	11/9/1988	5/2/1991, 56 FR 20140	
Sec. 1–140	Particulates from Wood Burning Indirect Heat Exchangers.	11/9/1988	5/2/1991, 56 FR 20140	
Sec. 1–141	Control of Particulates from Incinerators.	11/9/1988	5/2/1991, 56 FR 20140	
Sec. 1–142	Control of Particulates from Hot Mix Asphalt Plants.	11/9/1988	5/2/1991, 56 FR 20140	
Sec. 1–143	Particulates from Chemical Fertilizer Manufacturing Plants.	11/9/1988	5/2/1991, 56 FR 20140	
Sec. 1–144	Particulate Matter and Reduced Sulfur Emissions from Pulp and Paper Mills.	11/9/1988	2/7/1992, 57 FR 4737	Except paragraphs (f) and (g).

(4) EPA-APPROVED WESTERN NORTH CAROLINA REGULATIONS—Continued

Citation	Title/subject	State effective date	EPA approval date	Explanation
Sec. 1–145	Particulate Matter Emissions from Processing Mica or Feldspar.	11/18/1971	5/2/1991, 56 FR 20140	
Sec. 1–146	Particulate Matter Emissions from Sand, Gravel and Crushed Stone Operations.	11/18/1971	5/2/1991, 56 FR 20140	
Sec. 1–147	Particulate Matter and Sulfur Dioxide Emissions from Lightweight Aggregate Process.	11/18/1971	5/2/1991, 56 FR 20140	
Sec. 1–148	Control and Prohibition of Particulate Matter Emissions from Plants Engaged in the Finishing of Wood Products.	11/18/1971	5/2/1991, 56 FR 20140	
Sec. 1–149	Control and Prohibition of Particulate Matter Emissions from Portland Cement Plants.	11/18/1971	5/2/1991, 56 FR 20140	
Sec. 1–150	Particulates from Miscellaneous Industrial Processes.	11/18/1971	5/2/1991, 56 FR 20140	
Sec. 1–151	Sulfur Dioxide Emissions from Fuel-Burning Installations.	11/9/1988	5/2/1991, 56 FR 20140	
Sec. 1–152	Emissions from plants Producing Sulfuric Acid.	11/18/1971	5/2/1991, 56 FR 20140	Except for item (2).
Sec. 1–153	Vapor of Gas Emissions from Stationary Tanks Containing Carbon and Hydrogen.	11/9/1988	5/2/1991, 56 FR 20140	
Sec. 1–154	Restriction on Loading of Volatile Organic Compounds.	11/9/1988	5/2/1991, 56 FR 20140	
Sec. 1–155	Emissions from Operations Involving Photochemically Reactive Materials.	7/1/1972	5/2/1991, 56 FR 20140	
Sec. 1–156	Nitrogen Dioxide Emissions	7/1/1972	5/2/1991, 56 FR 20140	
Sec. 1–157	Control of Particulates from Ferrous Jobbing Foundries.	11/9/1988	5/2/1991, 56 FR 20140	
Sec. 1–160	Prevention of Significant Deterioration.	3/13/1985	5/2/1991, 56 FR 20140	
Sec. 1–162	Control of Mercury Emissions	3/13/1985	5/2/1991, 56 FR 20140	
Sec. 1–165	Sources Contributing to an Ambient Violation.	6/5/1985	5/2/1991, 56 FR 20140	
Article XII. Air Pollutants: Monitoring, Reporting				
Sec. 1–202	Purpose and Scope	3/13/1985	5/2/1991, 56 FR 20140	
Sec. 1–203	Definitions	6/5/1985	5/2/1991, 56 FR 20140	
Sec. 1–204	Sources Covered by Implementation Plan Requirements.	6/5/1985	5/2/1991, 56 FR 20140	
Sec. 1–205	Wood and Wood-Fossil Fuel Combination Units.	11/9/1988	5/2/1991, 56 FR 20140	
Sec. 1–206	Other Coal or Residual Oil Burners	3/13/1985	5/2/1991, 56 FR 20140	
Sec. 1–207	Exemptions to Monitoring and Reporting Requirements.	3/13/1985	5/2/1991, 56 FR 20140	
Sec. 1–208	Program Schedule	3/13/1985	5/2/1991, 56 FR 20140	
Article XIII. Air Pollution Alerts, Warnings and Emergencies				
Sec. 1–222	Purpose of Article	11/9/1988	5/2/1991, 56 FR 20140	
Sec. 1–223	General Procedure	11/9/1988	5/2/1991, 56 FR 20140	
Sec. 1–224	Episode Criteria	11/9/1988	5/2/1991, 56 FR 20140	
Sec. 1–225	Emission Reduction Plans	3/13/1985	5/2/1991, 56 FR 20140	
Sec. 1–226	Preplanned Abatement Program	3/13/1985	5/2/1991, 56 FR 20140	
Sec. 1–227	Emission Reduction Plan: Alert Level.	11/9/1988	5/2/1991, 56 FR 20140	
Sec. 1–228	Emission Reduction Plan: Warning Level.	3/13/1985	5/2/1991, 56 FR 20140	
Sec. 1–229	Emergency Reduction Plan: Emergency Level.	3/13/1985	5/2/1991, 56 FR 20140	
Article XIV. Complex Sources				
Sec. 1–230	Purpose of Article	6/5/1985	5/2/1991, 56 FR 20140	
Sec. 1–231	Definition of "Complex Sources"	6/5/1985	5/2/1991, 56 FR 20140	
Sec. 1–232	Application of Article	6/5/1985	5/2/1991, 56 FR 20140	

(4) EPA-APPROVED WESTERN NORTH CAROLINA REGULATIONS—Continued

Citation	Title/subject	State effective date	EPA approval date	Explanation
Sec. 1–233	Submission of Permits for Review and Approval.	6/5/1985	5/2/1991, 56 FR 20140	
Sec. 1–234	Highway Projects	6/5/1985	5/2/1991, 56 FR 20140	
Sec. 1–235	Airport Facility	6/5/1985	5/2/1991, 56 FR 20140	
Sec. 1–236	Facility Under Construction	6/5/1985	5/2/1991, 56 FR 20140	
Sec. 1–237	Applications	6/5/1985	5/2/1991, 56 FR 20140	
Sec. 1–238	No Deviation from Standards	6/5/1985	5/2/1991, 56 FR 20140	
Sec. 1–239	Control of Airborne Particulate Matter in the Ambient Air.	11/9/1988	5/2/1991, 56 FR 20140	
Chapter 17 Air Quality Permit Procedures				
Section .0100 General Provisions				
Rule .0101	Required Air Quality Permits	9/12/1994	7/28/1998, 60 FR 38707	
Rule .0102	Activities Exempted from Permit Requirements.	9/12/1994	7/28/1998, 60 FR 38707	
Rule .0103	Definitions	9/12/1994	7/28/1998, 60 FR 38707	
Rule .0104	Where to Obtain and File Permit Applications.	9/12/1994	7/28/1998, 60 FR 38707	
Rule .0105	Copies of Referenced Documents	9/12/1994	7/28/1998, 60 FR 38707	
Rule .0106	Incorporation by Reference	9/12/1994	7/28/1998, 60 FR 38707	
Rule .0107	Confidential Information	9/12/1994	7/28/1998, 60 FR 38707	
Rule .0109	Compliance Schedule for Previously Exempted Activities.	9/12/1994	7/28/1998, 60 FR 38707	
Rule .0110	Retention of Permit at Permitted Facility.	9/12/1994	7/28/1998, 60 FR 38707	
Rule .0111	Applicability Determinations	9/12/1994	7/28/1998, 60 FR 38707	
Section .0200 Permit Fees				
Rule .0201	Applicability	9/12/1994	7/28/1998, 60 FR 38707	
Rule .0202	Definitions	9/12/1994	7/28/1998, 60 FR 38707	
Rule .0203	Permit and Application Fees	9/12/1994	7/28/1998, 60 FR 38707	
Rule .0204	Inflation Adjustment	9/12/1994	7/28/1998, 60 FR 38707	
Rule .0205	Other Adjustments	9/12/1994	7/28/1998, 60 FR 38707	
Rule .0206	Payment of Fees	9/12/1994	7/28/1998, 60 FR 38707	
Rule .0207	Annual Emissions Reporting	9/12/1994	7/28/1998, 60 FR 38707	
Section .0300 Construction and Operation Permit				
Rule .0301	Applicability	9/12/1994	7/28/1998, 60 FR 38707	
Rule .0302	Facilities Not Likely to Contravene Demonstration.	9/12/1994	7/28/1998, 60 FR 38707	
Rule .0303	Definitions	9/12/1994	7/28/1998, 60 FR 38707	
Rule .0304	Applications	9/12/1994	7/28/1998, 60 FR 38707	
Rule .0305	Application Submittal Content	9/12/1994	7/28/1998, 60 FR 38707	
Rule .0306	Permits Requiring Public Participation.	9/12/1994	7/28/1998, 60 FR 38707	
Rule .0307	Public Participation Procedures	9/12/1994	7/28/1998, 60 FR 38707	
Rule .0308	Final Action On Permit Applications	9/12/1994	7/28/1998, 60 FR 38707	
Rule .0309	Termination, Modification and Revocation of Permits.	9/12/1994	7/28/1998, 60 FR 38707	
Rule .0310	Permitting of Numerous Similar Facilities.	9/12/1994	7/28/1998, 60 FR 38707	
Rule .0311	Permitting of Facilities at Multiple Temporary Sites.	9/12/1994	7/28/1998, 60 FR 38707	
Section .0400 Acid Rain Procedures				
Rule .0401	Applicability	9/12/1994	7/28/1998, 60 FR 38707	
Rule .0402	Definitions	9/12/1994	7/28/1998, 60 FR 38707	
Rule .0403	New Units Exemption	9/12/1994	7/28/1998, 60 FR 38707	
Rule .0404	Retired Units Exemption	9/12/1994	7/28/1998, 60 FR 38707	
Rule .0405	Requirement to Apply	9/12/1994	7/28/1998, 60 FR 38707	
Rule .0406	Requirement for Permit Applications.	9/12/1994	7/28/1998, 60 FR 38707	
Rule .0407	Permit Application Shield and Binding Effect of Permit Application.	9/12/1994	7/28/1998, 60 FR 38707	
Rule .0408	Compliance Plans	9/12/1994	7/28/1998, 60 FR 38707	
Rule .0409	Phase II Repowering Extensions	9/12/1994	7/28/1998, 60 FR 38707	
Rule .0410	Permit Contents	9/12/1994	7/28/1998, 60 FR 38707	

(4) EPA-APPROVED WESTERN NORTH CAROLINA REGULATIONS—Continued

Citation	Title/subject	State effective date	EPA approval date	Explanation
Rule .0411	Standard Requirements	9/12/1994	7/28/1998, 60 FR 38707	
Rule .0412	Permit Shield	9/12/1994	7/28/1998, 60 FR 38707	
Rule .0413	Permit Revisions Generally	9/12/1994	7/28/1998, 60 FR 38707	
Rule .0414	Permit Modifications	9/12/1994	7/28/1998, 60 FR 38707	
Rule .0415	Fast-Track Modifications	9/12/1994	7/28/1998, 60 FR 38707	
Rule .0416	Administrative Permit Amendment	9/12/1994	7/28/1998, 60 FR 38707	
Rule .0417	Automatic Permit Amendment	9/12/1994	7/28/1998, 60 FR 38707	
Rule .0418	Permit Reopenings	9/12/1994	7/28/1998, 60 FR 38707	

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(e) *EPA-Approved North Carolina Non-Regulatory Provisions.*

EPA-APPROVED NORTH CAROLINA NON-REGULATORY PROVISIONS

Provision	State effective date	EPA approval date	**Federal Register** citation	Explanation
Capital Area, North Carolina Interagency Transportation Conformity Memorandum of Agreement.	1/1/2002	12/27/2002	67 FR 78986	
Durham-Chapel Hill Interagency Transportation Conformity Memorandum of Agreement.	1/1/2002	12/27/2002	67 FR 78986	
Winston-Salem Interagency Transportation Conformity Memorandum of Agreement.	1/1/2002	12/27/2002	67 FR 78986	
High Point Interagency Transportation Conformity Memorandum of Agreement.	1/1/2002	12/27/2002	67 FR 78986	
Greensboro Interagency Transportation Conformity Memorandum of Agreement.	1/1/2002	12/27/2002	67 FR 78986	
Gaston, North Carolina Interagency Transportation Conformity Memorandum of Agreement.	1/1/2002	12/27/2002	67 FR 78986	
Mecklenburg-Union Interagency Transportation Conformity Memorandum of Agreement.	8/7/2003	9/15/2003	68 FR 53887	
10 Year Maintenance Plan Update for the Raleigh/Durham Area.	6/4/2004	9/20/2004	69 FR 56163	
10 Year Maintenance Plan Update for the Greensboro/Winston-Salem/High Point Area.	6/4/2004	9/20/2004	69 FR 56163	
Attainment Demonstration of the Mountain, Unifour, Triad and Fayetteville Early Action Compact Areas.	12/21/2004	9/21/2005	70 FR 48874	

EPA-APPROVED NORTH CAROLINA NON-REGULATORY PROVISIONS—Continued

Provision	State effective date	EPA approval date	**Federal Register** citation	Explanation
Charlotte, Raleigh-Durham, and Winston-Salem Carbon Monoxide Second 10-Year Maintenance Plan.	3/18/2005	3/24/2006	71 FR 14817	
8-Hour Ozone Maintenance plan for the Rocky Mount, North Carolina area (Edgecombe and Nash Counties).	6/19/2006	11/6/2006	71 FR 64891	
8-Hour Ozone Maintenance plan for the Raleigh-Durham-Chapel Hill, North Carolina area (Durham, Franklin, Granville, Johnston, Orange, Person and Wake Counties in their entireties, and Baldwin, Center, New Hope and Williams Townships in Chatham County).	6/7/2007	12/26/2007	72 FR 72948	
1-Hour Ozone Maintenance plan revision for the Greensboro/Winston-Salem/High Point area (Davidson, Forsyth, and Guilford counties and a portion of Davie County).	2/4/2008	4/8/2008	73 FR 18963	
8-Hour Ozone Maintenance Plan for the Great Smoky Mountains National Park Area.	7/24/2009	12/7/2009	74 FR 63995	
1997 Annual $PM_{2.5}$ Maintenance Plan for the Hickory, North Carolina Area—(Catawba County).	12/18/2009	11/18/2011	76 FR 71452	
1997 Annual $PM_{2.5}$ Maintenance Plan for the Hickory, North Carolina Area—MOVES Update.	12/22/2010	11/18/2011	76 FR 71452	
1997 Annual $PM_{2.5}$ Maintenance Plan for the Greensboro, North Carolina Area (Davidson and Guilford Counties).	12/18/2009	11/18/2011	76 FR 71455	
1997 Annual $PM_{2.5}$ Maintenance Plan for the Greensboro, North Carolina Area—MOVES Update.	12/22/2010	11/18/2011	76 FR 71455	

EPA-APPROVED NORTH CAROLINA NON-REGULATORY PROVISIONS—Continued

Provision	State effective date	EPA approval date	Federal Register citation	Explanation
North Carolina 110(a)(1) and (2) Infrastructure Requirements for the 1997 8-Hour Ozone National Ambient Air Quality Standards.	12/12/2007	2/6/2012	77 FR 5703	
1997 8-Hour Ozone 110(a)(1) Maintenance Plan for the Triad Area.	4/13/2011	3/26/2012	76 FR 3611	
Supplement to 110(a)(1) Maintenance Plan for the Triad Area.	5/18/2011	3/26/2012	76 FR 3611	
North Carolina portion of bi-state Charlotte; 1997 8-Hour Ozone 2002 Base Year Emissions Inventory.	11/12/2009	5/4/2012	77 FR 26441	
Regional Haze Plan	11/17/2007	6/27/2012	77 FR 38185	
110(a)(1) and (2) Infrastructure Requirements for 1997 Fine Particulate Matter National Ambient Air Quality Standards.	4/1/2008	10/16/2012	77 FR 63238	With the exception of section 110(a)(2)(D)(i). With respect to sections 110(a)(2)(C) related to PSD requirements, 110(a)(2)(E)(ii) and 110(a)(2)(J) related to PSD requirements, EPA conditionally approved these requirements.
110(a)(1) and (2) Infrastructure Requirements for 2006 Fine Particulate Matter National Ambient Air Quality Standards.	9/21/2009	10/16/2012	77 FR 63238	With the exception of section 110(a)(2)(D)(i). With respect to sections 110(a)(2)(C) related to PSD requirements, 110(a)(2)(E)(ii) and 110(a)(2)(J) related to PSD requirements, EPA conditionally approved these requirements.
MVEB Update for the Redesignation and Maintenance Plan for the Rocky Mount, NC Area for the 1997 8-hour Ozone Standard.	2/7/2011	11/26/2012	77 FR 59335	
1997 8-hour ozone reasonable further progress plan for North Carolina portion of the bi-state Charlotte Area.	11/30/2009	10/12/2012	77 FR 62166	
8-Hour Carbon Monoxide Limited Maintenance Plan for Charlotte, Raleigh/Durham and Winston-Salem Maintenance Area.	8/2/2012	6/20/2013	78 FR 37122	
1997 8-hour ozone Maintenance Plan for the North Carolina portion of the bi-state Charlotte Area.	11/2/2011, and supplemented on 3/28/2013.	12/2/2013	78 FR 72039	
North Carolina Transportation Conformity Air Quality Implementation Plan.	7/12/2013	12/26/2013	78 FR 78272	

EPA-APPROVED NORTH CAROLINA NON-REGULATORY PROVISIONS—Continued

Provision	State effective date	EPA approval date	**Federal Register** citation	Explanation
Supplement Maintenance Plan for the Raleigh-Durham-Chapel Hill, NC 1997 8-hour Ozone Maintenance Area and RVP Standard.	3/27/2013	1/2/2014	79 FR 50	
Supplement Maintenance Plan for the Greensboro/Winston-Salem/High Point Area, NC 1997 8-hour Ozone Maintenance Area and RVP Standard.	4/2/2013	1/24/2014	79 FR 4085	
110(a)(1) and (2) Infrastructure Requirements for 1997 Fine Particulate Matter National Ambient Air Quality Standards.	4/1/2008	5/7/2014	79 FR 26149	Addressing prong 4 of section 110(a)(2)(D)(i) only.
110(a)(1) and (2) Infrastructure Requirements for 2006 Fine Particulate Matter National Ambient Air Quality Standards.	9/21/2009	5/7/2014	79 FR 26149	Addressing prong 4 of section 110(a)(2)(D)(i) only.
Non-Interference Demonstration for the North Carolina Inspection and Maintenance Program.	10/11/2013	2/5/2015	80 FR 6457	
110(a)(1) and (2) Infrastructure Requirements for the 2008 Lead National Ambient Air Quality Standards.	6/15/2012	3/9/2015	80 FR 12344	With the exception of PSD permitting requirements for major sources of sections 110(a)(2)(C), prong 3 of D(i), and (J) and the state board requirements of 110(E)(ii).
North Carolina portion of bi-state Charlotte Area; 2008 8-Hour Ozone Base Year Emissions Inventory.	7/7/2014	4/21/2015	80 FR 22211	
North Carolina portion of bi-state Charlotte Area; 2008 8-Hour Ozone Annual Emissions Reporting (Emissions Statements).	7/7/2014	4/21/2015	80 FR 22211	
Supplement Maintenance Plan for the Charlotte Area, NC 2008 8-hour Ozone Maintenance Area and RVP Standard.	4/16/2015	7/28/2015	80 FR 44868	Provides the non-interference demonstration for revising the Federal Low-Reid Vapor Pressure requirement for the Charlotte Area, NC.
2008 8-hour ozone Maintenance Plan for the North Carolina portion of the bi-state Charlotte Area.	4/16/2015	7/28/2015	80 FR 44873	
110(a)(1) and (2) Infrastructure Requirements for the 1997 8-hour Ozone NAAQS.	7/27/2015	11/3/2015	80 FR 67646	Approving 110(a)(2)(E)(ii) as it relates to the Secretary of the DENR and his/her delegatee that approve permit or enforcement orders and appeal matters decided by ALJs.

EPA-APPROVED NORTH CAROLINA NON-REGULATORY PROVISIONS—Continued

Provision	State effective date	EPA approval date	Federal Register citation	Explanation
110(a)(1) and (2) Infrastructure Requirements for the 1997 Annual $PM_{2.5}$ NAAQS.	7/27/2015	11/3/2015	80 FR 67646	Approving 110(a)(2)(E)(ii) as it relates to the Secretary of the DENR and his/her delegatee that approve permit or enforcement orders and appeal matters decided by ALJs.
110(a)(1) and (2) Infrastructure Requirements for the 2006 24-hour $PM_{2.5}$ NAAQS.	7/27/2015	11/3/2015	80 FR 67646	Approving 110(a)(2)(E)(ii) as it relates to the Secretary of the DENR and his/her delegatee that approve permit or enforcement orders and appealed matters decided by ALJs.
110(a)(1) and (2) Infrastructure Requirements for the 2008 Lead NAAQS.	7/27/2015	11/3/2015	80 FR 67646	Approving 110(a)(2)(E)(ii) as it relates to the Secretary of the DENR and his/her delegatee that approve permit or enforcement orders and appeal matters decided by ALJs.
110(a)(1) and (2) Infrastructure Requirements for the 2008 8-hour Ozone NAAQS.	7/27/2015	11/3/2015	80 FR 67646	Approving 110(a)(2)(E)(ii) as it relates to the Secretary of the DENR and his/her delegatee that approve permit or enforcement orders and appeal matters decided by ALJs.
110(a)(1) and (2) Infrastructure Requirements for the 2010 NO_2 NAAQS.	7/27/2015	11/3/2015	80 FR 67646	Approving 110(a)(2)(E)(ii) as it relates to the Secretary of the DENR and his/her delegatee that approve permit or enforcement orders and appeal matters decided by ALJs.
110(a)(1) and (2) Infrastructure Requirements for the 2010 SO_2 NAAQS.	7/27/2015	11/3/2015	80 FR 67646	Approving 110(a)(2)(E)(ii) as it relates to the Secretary of the DENR and his/her delegatee that approve permit or enforcement orders and appeal matters decided by ALJs.
Chapter 7A section 754 of the North Carolina General Statues.	7/27/2015	11/3/2015	80 FR 67646	Specifically, the following paragraph of 7A–754 stating ''The Chief Administrative Law Judge and the administrative law judges shall comply with the Model Code of Judicial Conduct for State Administrative Law Judges, as adopted by the National Conference of Administrative Law Judges, Judicial Division, American Bar Association, (revised August 1998), as amended from time to time, except that the provisions of this section shall control as to the private practice of law in lieu of Canon 4G, and G.S. 126–13 shall control as to political activity in lieu of Canon 5.'' is approved into the SIP.
110(a)(1) and (2) Infrastructure Requirements for the 2008 8-Hour Ozone National Ambient Air Quality Standards.	11/2/2012	11/5/2015	80 FR 68457	With the exception of sections: 110(a)(2)(C) and (J) concerning PSD permitting requirements; 110(a)(2)(D)(i)(I) and (II) (prongs 1 through 4) concerning interstate transport requirements; 110(a)(2)(E)(ii) concerning state board requirements.

EPA-APPROVED NORTH CAROLINA NON-REGULATORY PROVISIONS—Continued

Provision	State effective date	EPA approval date	**Federal Register** citation	Explanation
110(a)(1) and (2) Infrastructure Requirements for the 2010 1-hour SO_2 NAAQS.	3/18/2014	4/26/2016	81 FR 24497	With the exception of the PSD permitting requirements for major sources of sections 110(a)(2)(C) and (J), the interstate transport requirements of section 110(a)(2)(D)(i)(I) and (II) (prongs 1, 2, 3, and 4), and the state board requirements of section 110(E)(ii).
BART Alternative Plan	10/31/2014	5/24/2016	81 FR 32654	This plan modifies the Regional Haze Plan approved with a state effective date of 11/17/2007 (see above) and converts the June 27, 2012, limited approval to a full approval.
110(a)(1) and (2) Infrastructure Requirements for the 2008 8-Hour Ozone NAAQS.	11/2/2012	6/3/2016	81 FR 35636	Addressing prong 4 of section 110(a)(2)(D)(i) only.
110(a)(1) and (2) Infrastructure Requirements for the 2010 1-hour NO2 NAAQS.	8/23/2013	6/3/2016	81 FR 35636	Addressing prong 4 of section 110(a)(2)(D)(i) only.
110(a)(1) and (2) Infrastructure Requirements for the 2010 1-hour SO_2 NAAQS.	3/18/2014	6/3/2016	81 FR 35636	Addressing prong 4 of section 110(a)(2)(D)(i) only.
110(a)(1) and (2) Infrastructure Requirements for the 2012 Annual $PM_{2.5}$ NAAQS.	12/4/2015	6/3/2016	81 FR 35636	Addressing prong 4 of section 110(a)(2)(D)(i) only.
May 2013 Regional Haze Progress Report.	5/31/2013	8/25/2016	81 FR 58401	Includes updated reasonable progress goals for North Carolina's Class I areas.
110(a)(1) and (2) Infrastructure Requirements for 1997 Fine Particulate Matter NAAQS.	4/1/2008	9/14/2016	81 FR 63111	Partially approve the PSD elements of sections 110(a)(2)(C), 110(a)(2)(D)(i)(II) (prong 3) and 110(a)(2)(J) and disapprove with respect to the $PM_{2.5}$ increment requirements of 2010 PSD $PM_{2.5}$ Rule.
110(a)(1) and (2) Infrastructure Requirements for 2006 Fine Particulate Matter NAAQS.	9/21/2009	9/14/2016	81 FR 63111	Partially approve the PSD elements of sections 110(a)(2)(C), 110(a)(2)(D)(i)(II) (prong 3) and 110(a)(2)(J) and disapprove with respect to the $PM_{2.5}$ increment requirements of 2010 PSD $PM_{2.5}$ Rule.
110(a)(1) and (2) Infrastructure Requirements for the 2008 Lead NAAQS.	6/15/2012	9/14/2016	81 FR 63111	Partially approve the PSD elements of sections 110(a)(2)(C), 110(a)(2)(D)(i)(II) (prong 3) and 110(a)(2)(J) and disapprove with respect to the $PM_{2.5}$ increment requirements of 2010 PSD $PM_{2.5}$ Rule.
110(a)(1) and (2) Infrastructure Requirements for the 2008 8-Hour Ozone NAAQS.	11/2/2012	9/14/2016	81 FR 63111	Partially approve the PSD elements of sections 110(a)(2)(C), 110(a)(2)(D)(i)(II) (prong 3) and 110(a)(2)(J) and disapprove with respect to the $PM_{2.5}$ increment requirements of 2010 PSD $PM_{2.5}$ Rule.

EPA-APPROVED NORTH CAROLINA NON-REGULATORY PROVISIONS—Continued

Provision	State effective date	EPA approval date	Federal Register citation	Explanation
110(a)(1) and (2) Infrastructure Requirements for the 2010 1-hour NO_2 NAAQS.	8/23/2013	9/14/2016	81 FR 63111	Partially approve the PSD elements of sections 110(a)(2)(C), 110(a)(2)(D)(i)(II) (prong 3) and 110(a)(2)(J) and disapprove with respect to the $PM_{2.5}$ increment requirements of 2010 PSD $PM_{2.5}$ Rule.
110(a)(1) and (2) Infrastructure Requirements for the 2010 1-hour SO_2 NAAQS.	3/18/2014	9/14/2016	81 FR 63111	Partially approve the PSD elements of sections 110(a)(2)(C), 110(a)(2)(D)(i)(II) (prong 3) and 110(a)(2)(J) and disapprove with respect to the $PM_{2.5}$ increment requirements of 2010 PSD $PM_{2.5}$ Rule.
110(a)(1) and (2) Infrastructure Requirements for the 2012 Annual $PM_{2.5}$ NAAQS.	12/4/2015	9/14/2016	81 FR 63111	Partially approve the PSD elements of sections 110(a)(2)(C), 110(a)(2)(D)(i)(II) (prong 3) and 110(a)(2)(J) and disapprove with respect to the $PM_{2.5}$ increment requirements of 2010 PSD $PM_{2.5}$ Rule.
Good Neighbor Provisions (Section 110(a)(2)(D)(i)(I)) for the 2010 1-hour NO_2 NAAQS.	3/24/2016	9/22/2016	81 FR 65288	
110(a)(1) and (2) Infrastructure Requirements for the 2010 1-hour NO_2 NAAQS.	8/23/2013	10/14/2016	81 FR 70969	With the exception of sections: 110(a)(2)(E)(ii) concerning state boards; 110(a)(2)(C) and (J) concerning PSD permitting requirements; and 110(a)(2)(D)(i)(I) and (II) (prongs 1 through 4) concerning interstate transport requirements.
110(a)(1) and (2) Infrastructure Requirements for the 2012 Annual $PM_{2.5}$ NAAQS.	12/4/2015	4/7/2017	82 FR 16924	With the exception of section 110(a)(2)(D)(i)(I) and (II) (prongs 1 through 4) and the PSD requirements of section 110(a)(2)(C) and (J).
110(a)(1) and (2) Infrastructure Requirements for the 2008 8-Hour Ozone NAAQS.	12/9/2015	10/4/2017	82 FR 46134	Addressing prongs 1 and 2 of section 110(a)(2)(D)(i) only.
North Carolina Removal of 26 Counties from Inspection and Maintenance Program and 110(l) Non-Interference Demonstration.	11/17/2017	9/25/2018	83 FR 48383	
110(a)(1) and (2) Infrastructure Requirements for 1997 Fine Particulate Matter NAAQS.	4/1/2008	9/11/2018	83 FR 45827	Approved the PSD elements of sections 110(a)(2)(C), 110(a)(2)(D)(i)(II) (prong 3) and 110(a)(2)(J).
110(a)(1) and (2) Infrastructure Requirements for 2006 Fine Particulate Matter NAAQS.	9/21/2009	9/11/2018	83 FR 45827	Approved the PSD elements of sections 110(a)(2)(C), 110(a)(2)(D)(i)(II) (prong 3) and 110(a)(2)(J).
110(a)(1) and (2) Infrastructure Requirements for the 2008 Lead NAAQS.	6/15/2012	9/11/2018	83 FR 45827	Approved the PSD elements of sections 110(a)(2)(C), 110(a)(2)(D)(i)(II) (prong 3) and 110(a)(2)(J).
110(a)(1) and (2) Infrastructure Requirements for the 2008 8-Hour Ozone NAAQS.	11/2/2012	9/11/2018	83 FR 45827	Approved the PSD elements of sections 110(a)(2)(C), 110(a)(2)(D)(i)(II) (prong 3) and 110(a)(2)(J).

EPA-APPROVED NORTH CAROLINA NON-REGULATORY PROVISIONS—Continued

Provision	State effective date	EPA approval date	**Federal Register** citation	Explanation
110(a)(1) and (2) Infrastructure Requirements for the 2010 1-hour NO_2 NAAQS.	8/23/2013	9/11/2018	83 FR 45827	Approved the PSD elements of sections 110(a)(2)(C), 110(a)(2)(D)(i)(II) (prong 3) and 110(a)(2)(J).
110(a)(1) and (2) Infrastructure Requirements for the 2010 1-hour SO_2 NAAQS.	3/18/2014	9/11/2018	83 FR 45827	Approved the PSD elements of sections 110(a)(2)(C), 110(a)(2)(D)(i)(II) (prong 3) and 110(a)(2)(J).
110(a)(1) and (2) Infrastructure Requirements for the 2012 Annual $PM_{2.5}$ NAAQS.	12/4/2015	9/11/2018	83 FR 45827	Approved the PSD elements of sections 110(a)(2)(C), 110(a)(2)(D)(i)(II) (prong 3) and 110(a)(2)(J).
110(a)(1) and (2) Infrastructure Requirements for the 2012 Annual $PM_{2.5}$ NAAQS.	12/4/2015	9/25/2018	83 FR 48387	Addressing Prongs 1 and 2 of section 110(a)(2)(D)(i)(I) only.
2008 8-hour ozone Maintenance Plan for the North Carolina portion of the bi-state Charlotte Area.	7/25/2018	9/11/2019	84 FR 47889	
110(a)(1) and (2) Infrastructure Requirements for the 2015 8-Hour Ozone NAAQS.	9/27/2018	3/11/2020	85 FR 14147	With the exception of 110(a)(2)(D)(i)(I) (prongs 1 and 2) and PSD provisions related to major sources under sections 110(a)(2)(C), 110(a)(2)(D)(i)(II) (prong 3), and 110(a)(2)(J).
MVEB Revision to the 2008 8-hour ozone Maintenance Plan for the North Carolina portion of the bi-state Charlotte Area.	7/16/2020	8/25/2021	86 FR 47387	
110(a)(1) and (2) Infrastructure Requirements for the 2015 8-Hour Ozone NAAQS.	9/27/2018	12/2/2021	86 FR 68413	Addressing Prongs 1 and 2 of section 110(a)(2)(D)(i)(I) only.
1997 8-hour Ozone NAAQS 2nd Maintenance Plans (Limited Maintenance Plans) for the Great Smoky Mountains National Park, Raleigh-Durham-Chapel Hill, and Rocky Mount, North Carolina Areas.	9/22/2020	5/9/2022	87 FR 27521	
Removal of Lee, Onslow, and Rockingham Counties from North Carolina's Inspection and Maintenance Program and 110(l) Non-Interference Demonstration.	12/14/2020	8/11/2022	87 FR 49524	
110(a)(1) and (2) Infrastructure Requirements for the 2015 8-Hour Ozone NAAQS.	4/13/2021	1/5/2023	88 FR 773	Addressing the PSD provisions of sections 110(a)(2)(C), (D)(i)(II) (Prong 3), and (J) only.

EPA-APPROVED NORTH CAROLINA NON-REGULATORY PROVISIONS—Continued

Provision	State effective date	EPA approval date	Federal Register citation	Explanation
1997 8-hour Ozone 2nd Maintenance Plan (Limited Maintenance Plan) for the North Carolina portion of the bi-state Charlotte Area.	12/9/2021	1/13/2023	88 FR 2245	
Burlington-Graham Interagency Transportation Conformity Memorandum of Agreement.	1/30/2023	3/29/2023	88 FR 18423	
Cabarrus-Rowan Interagency Transportation Conformity Memorandum of Agreement.	1/20/2023	3/29/2023	88 FR 18423	
Charlotte Regional Interagency Transportation Conformity Memorandum of Agreement.	1/30/2023	3/29/2023	88 FR 18423	
Durham-Chapel Hill-Carrboro Interagency Transportation Conformity Memorandum of Agreement.	1/30/2023	3/29/2023	88 FR 18423	
Gaston-Cleveland-Lincoln Interagency Transportation Conformity Memorandum of Agreement.	1/30/2023	3/29/2023	88 FR 18423	
Greater Hickory Interagency Transportation Conformity Memorandum of Agreement.	1/30/2023	3/29/2023	88 FR 18423	
Greensboro Urban Area Interagency Transportation Conformity Memorandum of Agreement.	1/27/2023	3/29/2023	88 FR 18423	
High Point Urban Area Interagency Transportation Conformity Memorandum of Agreement.	1/27/2023	3/29/2023	88 FR 18423	
North Carolina Capital Area Interagency Transportation Conformity Memorandum of Agreement.	1/27/2023	3/29/2023	88 FR 18423	
Rocky Mount Urban Area Interagency Transportation Conformity Memorandum of Agreement.	1/27/2023	3/29/2023	88 FR 18423	
Winston-Salem-Forsyth Urban Area Interagency Transportation Conformity Memorandum of Agreement.	1/27/2023	3/29/2023	88 FR 18423	

EPA-APPROVED NORTH CAROLINA NON-REGULATORY PROVISIONS—Continued

Provision	State effective date	EPA approval date	**Federal Register** citation	Explanation
Rural (counties not covered by MPO, administered by North Carolina DOT) Interagency Transportation Conformity Memorandum of Agreement.	1/27/2023	3/29/2023	88 FR 18423	
Great Smoky Mountains National Park (administered by NPS) Interagency Transportation Conformity Memorandum of Agreement.	1/30/2023	3/29/2023	88 FR 18423	

[FR Doc. 2023–15965 Filed 8–1–23; 8:45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 622

[Docket No. 140501394–5279–02;RTID 0648–XD176]

Fisheries of the Caribbean, Gulf of Mexico, and South Atlantic; 2023 Commercial Closure for Blueline Tilefish in the South Atlantic

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

ACTION: Temporary rule; closure.

SUMMARY: NMFS implements an accountability measure for blueline tilefish in the exclusive economic zone (EEZ) of the South Atlantic. NMFS estimates that commercial landings of blueline tilefish have reached the commercial annual catch limit (ACL) for the 2023 fishing year. Accordingly, NMFS closes the commercial sector for the harvest of blueline tilefish in the South Atlantic EEZ to protect the blueline tilefish resource from overfishing.

DATES: This temporary rule is effective from 12:01 a.m. eastern time on August 2, 2023, through December 31, 2023.

FOR FURTHER INFORMATION CONTACT: Mary Vara, NMFS Southeast Regional Office, telephone: 727–824–5305, email: *mary.vara@noaa.gov.*

SUPPLEMENTARY INFORMATION: The snapper-grouper fishery of the South Atlantic includes blueline tilefish and is managed under the Fishery Management Plan for the Snapper-Grouper Fishery of the South Atlantic Region (FMP). The South Atlantic Fishery Management Council and NMFS prepared the FMP, and the FMP is implemented by NMFS under the authority of the Magnuson-Stevens Fishery Conservation and Management Act (Magnuson-Stevens Act) by regulations at 50 CFR part 622. All weights in this temporary rule are given in round weight.

Regulations at 50 CFR 622.193(z)(1)(i) specify the commercial ACL for blueline tilefish of 117,148 lb (53,137 kg), and the commercial accountability measure for blueline tilefish. NMFS is required to close the commercial sector when its ACL is reached, or is projected to be reached, by filing a notification to that effect with the Office of the Federal Register. NMFS estimates that for the 2023 fishing year, commercial landings of blueline tilefish will reach the commercial ACL by August 2, 2023. Accordingly, the commercial sector for South Atlantic blueline tilefish is closed effective at 12:01 a.m. eastern time on August 2, 2023, through December 31, 2023.

During the commercial closure, all sale or purchase of blueline tilefish is prohibited. While the recreational harvest of blueline tilefish is open, harvest of blueline tilefish in or from the South Atlantic EEZ is limited to the recreational bag and possession limits specified in 50 CFR 622.187. The bag and possession limits for blueline tilefish apply in state or Federal waters of the South Atlantic on a vessel for which NMFS has issued a valid commercial or charter vessel/headboat permit for South Atlantic snapper-grouper.

Classification

NMFS issues this action pursuant to section 305(d) of the Magnuson-Stevens Act. This action is required by 50 CFR 622.193(z)(1)(i), which was issued pursuant to section 304(b) of the Magnuson-Stevens Act, and is exempt from review under Executive Order 12866.

Pursuant to 5 U.S.C. 553(b)(B), there is good cause to waive prior notice and an opportunity for public comment on this action, as notice and comment are unnecessary and contrary to the public interest. Such procedures are unnecessary because the regulations associated with the closure of the blueline tilefish commercial sector at 50 CFR 622.193(z)(1)(i) have already been subject to notice and public comment, and all that remains is to notify the public of the closure. Prior notice and opportunity for public comment are contrary to the public interest because there is a need to immediately implement this action to protect blueline tilefish, because the capacity of the fishing fleet allows for rapid harvest of the commercial ACL. Prior notice and opportunity for public comment would require time and would potentially result in a harvest well in excess of the established commercial ACL.

For the reasons stated earlier, the Assistant Administrator also finds good cause to waive the 30-day delay in the effectiveness of this action under 5 U.S.C. 553(d)(3).

Authority: 16 U.S.C. 1801 *et seq.*

Dated: July 27, 2023.

Jennifer M. Wallace,

Acting Director, Office of Sustainable Fisheries, National Marine Fisheries Service.

[FR Doc. 2023–16442 Filed 7–28–23; 4:15 pm]

BILLING CODE 3510–22–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 635

[Docket No. 220919–0193; RTID 0648–XD160]

Atlantic Highly Migratory Species; Atlantic Bluefin Tuna Fisheries; Closure of the Harpoon Category Fishery for 2023

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

ACTION: Temporary rule; closure.

SUMMARY: NMFS closes the Harpoon category fishery for large medium and giant (*i.e.,* measuring 73 inches (185 cm) curved fork length (CFL) or greater) Atlantic bluefin tuna (BFT) for the remainder of the 2023 fishing year. This closure applies to Atlantic Tunas Harpoon category permitted vessels.

DATES: Effective 11:30 p.m., local time, July 30, 2023, through December 31, 2023.

FOR FURTHER INFORMATION CONTACT: Larry Redd, Jr., *larry.redd@noaa.gov,* 301–427–8503, or Ann Williamson, *ann.williamson@noaa.gov,* 301–427–8503.

SUPPLEMENTARY INFORMATION: Atlantic highly migratory species (HMS) fisheries, including BFT fisheries, are managed under the authority of the Atlantic Tunas Convention Act (ATCA; 16 U.S.C. 971 *et seq.*) and the Magnuson-Stevens Fishery Conservation and Management Act (Magnuson-Stevens Act; 16 U.S.C. 1801 *et seq.*). The 2006 Consolidated Atlantic HMS Fishery Management Plan (FMP) and its amendments are implemented by regulations at 50 CFR part 635. Section 635.27 divides the U.S. BFT quota recommended by the International Commission for the Conservation of Atlantic Tunas (ICCAT) and as implemented by the United States among the various domestic fishing categories, per the allocations established in the 2006 Consolidated HMS FMP and its amendments. NMFS is required under the Magnuson-Stevens Act to provide U.S. fishing vessels with a reasonable opportunity to harvest quotas under relevant international fishery agreements, such as the ICCAT Convention, which is implemented domestically pursuant to ATCA.

Under § 635.28(a)(1), NMFS files a closure action with the Office of the Federal Register for publication when a BFT quota (or subquota) is reached or is projected to be reached. Retaining, possessing, or landing BFT under a quota category is prohibited on or after the effective date and time of a closure notice for that category, for the remainder of the fishing year, until the opening of the relevant subsequent quota period, or until such date as specified.

As described in § 635.27(a), the current baseline U.S. BFT quota is 1,316.14 metric tons (mt) (not including the 25 mt ICCAT allocated to the United States to account for bycatch of BFT in pelagic longline fisheries in the Northeast Distant Gear Restricted Area). The Harpoon category baseline quota is 59.2 mt. Effective July 21, 2023, NMFS transferred 10.8 mt from the Reserve category to the Harpoon category, resulting in an adjusted quota of 70.0 mt for the Harpoon category and 27.4 mt for the Reserve category (88 FR 48136, July 26, 2023). As described under § 635.27(a)(4), the Harpoon category quota is only available between June 1 and November 15 of each year.

Harpoon Category Closure

To date, reported landings for the Harpoon category total approximately 68.5 mt. Based on these landings data, as well as average catch rates and anticipated fishing conditions, NMFS projects that the Harpoon category adjusted subquota of 70.0 mt will be reached shortly. Therefore, retaining, possessing, or landing large medium or giant (*i.e.,* measuring 73 inches (185 cm) CFL or greater) BFT by persons aboard vessels permitted in the Atlantic tunas Harpoon category must cease at 11:30 p.m. local time on July 30, 2023. The Harpoon category BFT fishery will be closed for the remainder of the Harpoon category season, which ends November 15, 2023, and thus for the year. The Harpoon category will reopen automatically on June 1, 2024, for the 2024 fishing season. This action applies to Atlantic Tunas Harpoon category (commercial) permitted vessels, and is taken consistent with the regulations at § 635.28(a)(1).

Monitoring and Reporting

NMFS will continue to monitor the BFT fisheries closely. Dealers are required to submit landing reports within 24 hours of a dealer receiving BFT. Late reporting by dealers compromises NMFS' ability to implement actions in a timely manner such as quota and retention limit adjustment, as well as closures, and may result in enforcement actions. Additionally, and separate from the dealer-reporting requirement, Harpoon category vessel owners are required to report the catch of all BFT retained or discarded dead within 24 hours of the landing(s) or end of each trip, by accessing *https://www.hmspermits.noaa.gov,* using the HMS Catch Reporting app, or calling 888–872–8862 (Monday through Friday from 8 a.m. until 4:30 p.m.).

Depending on the level of fishing effort and catch rates of BFT, NMFS may determine that additional adjustments are necessary to ensure available subquotas are not exceeded or to enhance scientific data collection from, and fishing opportunities in, all geographic areas. If needed, subsequent adjustments will be published in the **Federal Register**. In addition, fishermen may access *https://www.hmspermits.noaa.gov,* for updates on quota monitoring and inseason adjustments.

Classification

NMFS issues this action pursuant to section 305(d) of the Magnuson-Stevens Act and regulations at 50 CFR part 635 and is exempt from review under Executive Order 12866.

The Assistant Administrator for NMFS (AA) finds that pursuant to 5 U.S.C. 553(b)(B), there is good cause to waive prior notice and opportunity to provide comment on this action, as notice and comment would be impracticable and contrary to the public interest for the following reasons. Specifically, the regulations implementing the 2006 Consolidated HMS FMP and amendments provide for inseason retention limit adjustments and fishery closures to respond to the unpredictable nature of BFT availability on the fishing grounds, the migratory nature of this species, and the regional variations in the BFT fishery. Providing for prior notice and an opportunity to comment is impracticable and contrary to the public interest as this fishery is currently underway and the available quota for the category is projected to be reached shortly. Delaying this action could result in BFT landings exceeding the Harpoon category quota. Taking this action does not raise conservation and management concerns. NMFS notes that the public had an opportunity to comment on the underlying rulemakings that established the U.S. BFT quota and the inseason adjustment criteria.

For all of the above reasons, the AA finds that pursuant to 5 U.S.C. 553(d), there is also good cause to waive the 30-day delay in effective date.

Authority: 16 U.S.C. 971 *et seq.* and 1801 *et seq.*

Dated: July 28, 2023.

Jennifer M. Wallace,

Acting Director, Office of Sustainable Fisheries, National Marine Fisheries Service.

[FR Doc. 2023–16445 Filed 7–28–23; 4:15 pm]

BILLING CODE 3510–22–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 648

[Docket No. 230724–0172; RTID 0648–XD211]

Fisheries of the Northeastern United States; Mackerel, Squid, and Butterfish Fishery; Longfin Squid 2023 Trimester II Quota Harvested

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

ACTION: Temporary rule; reduction of possession limit.

SUMMARY: NMFS is closing the directed longfin squid fishery through the remainder of 2023 Trimester II (May 1–August 31, 2023). This closure is required by regulation because NMFS projects that 90 percent of the longfin squid Trimester II quota will be caught by the effective date. This action is necessary to comply with the regulations implementing the Mackerel, Squid, and Butterfish Fishery Management Plan and is intended to prevent overharvest of longfin squid.

DATES: Effective 00:01 hours (hr) local time, August 2, 2023, through 24 hr local time on August 31, 2023.

FOR FURTHER INFORMATION CONTACT: Maria Fenton, Fishery Management Specialist, (978) 281–9196.

SUPPLEMENTARY INFORMATION: The regulations at 50 CFR part 648 require specifications for maximum sustainable yield, initial optimum yield, allowable biological catch (ABC), domestic annual harvest (DAH), domestic annual processing, joint venture processing, and total allowable levels of foreign fishing for the species managed under the Mackerel, Squid, and Butterfish Fishery Management Plan (FMP). The procedures for setting the annual initial specifications are described in § 648.22.

In 2023, the longfin squid Trimester II quota was increased by 50 percent to account for an underage in Trimester I catch. The remainder of the 2023 quota for longfin squid will become available on September 1, 2023.

When the Regional Administrator projects that 90 percent of the longfin squid Trimester II quota will be harvested before August 15, the regulations at § 648.24(a)(1) require NMFS to close the directed fishery in Federal waters for longfin squid for the remainder of the trimester. Regulations at § 648.26(b)(2)(iii) state that while such a closure is in effect, vessels are prohibited from fishing for, possessing, or landing more than 250 pounds (lb) (113.4 kilograms (kg)) of longfin squid at any time per trip, and from landing longfin squid more than once per calendar day, unless the vessel meets all the conditions described at § 648.26(b)(2)(iv). The Regional Administrator monitors longfin squid fishery catch based on dealer reports, and other available information. Regulations at § 648.24(d) require that upon determining that a closure is necessary, NMFS must: Notify the Executive Directors of the Mid-Atlantic, New England, and South Atlantic Fishery Management Councils; notify permit holders at least 72 hr before the effective date of the closure; notify recreational participants in the fishery; and publish notification of the closure in the **Federal Register**.

Based on dealer reports and other available information, the Regional Administrator has determined that 90 percent of the longfin squid Trimester II quota will be harvested by August 2, 2023. Therefore, except as described below, effective 00:01 hr local time on August 2, 2023, vessels may not fish for, possess, or land more than 250 lb (113.4 kg) of longfin squid at any time per trip, and may only land longfin squid once per calendar day, through 24 hr local time on August 31, 2023. Vessels that enter port before 00:01 hr local time on August 2, 2023, may land and sell more than 250 lb (113.4 kg) of longfin squid from that trip.

During Trimester 2, the regulations at § 648.26(b)(2)(iv) provide an exception to the incidental limit specified above, such that vessels issued a Tier 1 or Tier 2 longfin squid moratorium permit may possess more than 250 lb (113.4 kg) of longfin squid per trip, provided that the vessel: Declares into the directed *Illex* fishery via its vessel monitoring system; fishes in the *Illex* Squid Exemption Area (as defined in Table 1 and at § 648.23(a)(5)); possesses more than 10,000 lb (4,535.9 kg) of *Illex* squid on board; and possesses less than 15,000 lb (6,803.9 kg) (Tier 1 longfin squid moratorium permit) or 5,000 lb (2,268.0 kg) (Tier 2 longfin squid moratorium permit) of longfin squid on board. All fishing gear must be stowed and rendered not available for immediate use as defined in § 648.2 once such a vessel is landward of the coordinates defining the *Illex* Squid Exemption Area specified at § 648.23(a)(5).

TABLE 1—*Illex* SQUID EXEMPTION AREA COORDINATES

North latitude	West longitude
43°58.0′	67°22.0′
43°50.0′	68°35.0′
43°30.0′	69°40.0′
43°20.0′	70°00.0′
42°45.0′	70°10.0′
42°13.0′	69°55.0′
41°00.0′	69°00.0′
41°45.0′	68°15.0′
42°10.0′	67°10.0′
41°18.6′	66°24.8′
40°55.5′	66°38.0′
40°45.5′	68°00.0′
40°37.0′	68°00.0′
40°30.0′	69°00.0′
40°22.7′	69°00.0′
40°18.7′	69°40.0′
40°21.0′	71°03.0′
39°41.0′	72°32.0′
38°47.0′	73°11.0′
38°04.0′	74°06.0′
37°08.0′	74°46.0′
36°00.0′	74°52.0′
35°45.0′	74°53.0′
35°28.0′	74°52.0′

Also effective 00:01 hr local time on August 2, 2023, through 24 hr local time on August 31, 2023, federally permitted dealers may not purchase more than 250 lb (113.4 kg) of longfin squid from a federally permitted longfin squid vessel unless it is from a trip landed by a vessel that entered port before 00:01 hr local time on August 2, 2023; except that they may purchase up to 15,000 lb (6,803 kg) of longfin squid from vessels issued a Tier 1 longfin squid moratorium permit or 5,000 lb (2,268 kg) from vessels issued a Tier 2 longfin squid moratorium permit if such vessels that were on a declared *Illex* squid trip in the *Illex* Squid Exemption Area and such vessels possess more than 10,000 lb (4,536 kg) of *Illex* squid on board.

Classification

This action is required by 50 CFR part 648 and is exempt from review under Executive Order 12866.

NMFS finds good cause pursuant to 5 U.S.C. 553(b)(B) to waive prior notice and the opportunity for public comment because it would be contrary to the public interest and impracticable. The longfin squid Trimester II fishery opened for the 2023 fishing year on May 1, 2023. Data and other information indicating the longfin squid fleet will have landed at least 90 percent of the 2023 Trimester II quota have only recently become available. Landings data is updated on a weekly basis, and NMFS monitors catch data on a daily

basis as catch increases toward the limit. Further, high-volume catch and landings in this fishery increases total catch relative to the quota quickly. The regulations at § 648.24(a)(1) require such action to ensure that longfin squid vessels do not exceed the 2023 Trimester II quota. If implementation of this action is delayed to solicit prior public comment, the quota for this Trimester II may be exceeded, thereby undermining the conservation objectives of the FMP. Additionally, if the Trimester II quota is exceeded, the excess must be deducted from a future Trimester and would reduce future fishing opportunities. Furthermore, the public had prior notice and full opportunity to comment on this process when these provisions were put in place. Based on these considerations, NMFS further finds, pursuant to 5 U.S.C 553(d)(3), good cause to waive the 30-day delayed effectiveness period for the reasons stated above.

Authority: 16 U.S.C. 1801 *et seq.*

Dated: July 28, 2023.

Jennifer M. Wallace,

Acting Director, Office of Sustainable Fisheries, National Marine Fisheries Service.

[FR Doc. 2023–16480 Filed 7–28–23; 4:15 pm]

BILLING CODE 3510–22–P

Proposed Rules

Federal Register
Vol. 88, No. 147
Wednesday, August 2, 2023

This section of the FEDERAL REGISTER contains notices to the public of the proposed issuance of rules and regulations. The purpose of these notices is to give interested persons an opportunity to participate in the rule making prior to the adoption of the final rules.

DEPARTMENT OF ENERGY

10 CFR Part 430

[EERE–2014–BT–STD–0005]

RIN 1904–AD15

Energy Conservation Program: Energy Conservation Standards for Consumer Conventional Cooking Products

AGENCY: Office of Energy Efficiency and Renewable Energy, Department of Energy.

ACTION: Notification of data availability and request for comment.

SUMMARY: On February 1, 2023, the U.S. Department of Energy (''DOE'') published a supplemental notice of proposed rulemaking (''SNOPR''), in which DOE proposed new and amended energy conservation standards for consumer conventional cooking products. In this notification of data availability (''NODA''), DOE is updating its analysis for consumer conventional cooking products based on stakeholder data and information it received in response to that SNOPR. DOE requests comments, data, and information regarding the updated analysis.

DATES: DOE will accept comments, data, and information regarding this NODA on or before September 1, 2023.

ADDRESSES: Interested persons are encouraged to submit comments using the Federal eRulemaking Portal at *www.regulations.gov,* under docket number EERE–2014–BT–STD–0005. Follow the instructions for submitting comments. Alternatively, interested persons may submit comments, identified by docket number EERE–2014–BT–STD–0005, by any of the following methods:

Email: ConventionalCookingProducts2014STD0005@ee.doe.gov. Include the docket number EERE–2014–BT–STD–0005 in the subject line of the message.

Postal Mail: Appliance and Equipment Standards Program, U.S. Department of Energy, Building Technologies Office, Mailstop EE–5B, 1000 Independence Avenue SW, Washington, DC, 20585–0121. Telephone: (202) 287–1445. If possible, please submit all items on a compact disc (''CD''), in which case it is not necessary to include printed copies.

Hand Delivery/Courier: Appliance and Equipment Standards Program, U.S. Department of Energy, Building Technologies Office, Mailstop EE–5B, 1000 Independence Avenue SW, Washington, DC, 20585–0121. Telephone: (202) 287–1445. If possible, please submit all items on a CD, in which case it is not necessary to include printed copies.

No telefacsimiles (''faxes'') will be accepted. For detailed instructions on submitting comments and additional information on this process, see section III of this document.

Docket: The docket for this activity, which includes **Federal Register** notices, comments, and other supporting documents/materials, is available for review at *www.regulations.gov.* All documents in the docket are listed in the *www.regulations.gov* index. However, not all documents listed in the index may be publicly available, such as information that is exempt from public disclosure.

The docket web page can be found at *www.regulations.gov/docket/EERE–2014–BT–STD–0005.* The docket web page contains instructions on how to access all documents, including public comments, in the docket. See section III of this document for information on how to submit comments through *www.regulations.gov.*

FOR FURTHER INFORMATION CONTACT: Dr. Carl Shapiro, U.S. Department of Energy, Office of Energy Efficiency and Renewable Energy, Building Technologies Office, EE–5B, 1000 Independence Avenue SW, Washington, DC, 20585–0121. Telephone: (202) 287–5649. Email: *ApplianceStandardsQuestions@ee.doe.gov.*

Mr. Pete Cochran, U.S. Department of Energy, Office of the General Counsel, GC–33, 1000 Independence Avenue SW, Washington, DC, 20585–0121. Telephone: (202) 586–9496. Email: *Peter.Cochran@hq.doe.gov.*

For further information on how to submit a comment or review other public comments and the docket, contact the Appliance and Equipment Standards Program staff at (202) 287–1445 or by email: *ApplianceStandardsQuestions@ee.doe.gov.*

SUPPLEMENTARY INFORMATION:

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I. Background

The Energy Policy and Conservation Act, as amended (''EPCA''),[1] authorizes DOE to regulate the energy efficiency of a number of consumer products and certain industrial equipment. (42 U.S.C. 6291–6317) Title III, Part B [2] of EPCA established the Energy Conservation Program for Consumer Products Other Than Automobiles. These products include consumer conventional cooking products, the subject of this rulemaking. (42 U.S.C. 6292(a)(10))

The currently applicable energy conservation standards for consumer conventional cooking products consist of a prescriptive prohibition on constant burning pilots for all gas cooking products (*i.e.,* gas cooking products both with or without an electrical supply cord) manufactured on and after April 9, 2012. These standards are set forth at title 10 of the Code of Federal Regulations (''CFR'') § 430.32(j)(1) and (2).

Consumer conventional cooking products comprise conventional cooking tops and conventional ovens, as defined as 10 CFR 430.2. Representations of energy use or energy efficiency of conventional cooking tops made on or after February 20, 2023, must be based on results generated

[1] All references to EPCA in this document refer to the statute as amended through the Energy Act of 2020. Public Law 116–260 (Dec. 27, 2020), which reflect the last statutory amendments that impact Parts A and A–1 of EPCA.

[2] For editorial reasons, upon codification in the U.S. Code, Part B was redesignated Part A.

using the test procedure for conventional cooking products at 10 CFR part 430, subpart B, appendix I1 (''appendix I1''). There are currently no DOE test procedures for conventional ovens.

On February 1, 2023, DOE published a supplemental notice of proposed rulemaking (''February 2023 SNOPR'') proposing to establish new and amended standards for consumer conventional cooking products, consisting of maximum integrated annual energy consumption (''IAEC'') levels, in kilowatt-hours per year (''kWh/year'') for electric cooking tops and thousand British thermal units per year (''kBtu/year'') for gas cooking tops. 88 FR 6818. Compliance with the new and amended standards would be required 3 years after the publication date of final rule, should DOE finalize the proposed standards. *Id.* The technical support document (''TSD'') that presented the methodology and results of the February 2023 SNOPR analysis is available at: *www.regulations.gov/document/EERE-2014-BT-STD-0005-0090.*

On February 28, 2023, DOE published a notification of data availability (''February 2023 NODA'') providing additional information to clarify the February 2023 SNOPR analysis for gas cooking tops. 88 FR 12603. DOE provided further data on the gas cooking top test sample used for the February 2023 SNOPR analysis and estimated that currently available gas cooking tops representing nearly half of the market would already meet the standards that were proposed in the February 2023 SNOPR, and therefore would not be impacted by the proposed standard, if finalized. 88 FR 12603, 12605.

In response to the February 2023 SNOPR, DOE received additional data and information regarding consumer conventional cooking products. Specifically, DOE received additional gas and electric cooking top test data from the Association of Home Appliance Manufacturers (''AHAM'') and Pacific Gas and Electric (''PG&E'').[3] Stakeholders also provided substantive information regarding gas cooking top features that are desired by consumers. In addition, AHAM provided shipment estimates of gas and electric cooking tops by product type and/or configuration. (AHAM, No. 2285 at pp. 6, 27)

Upon consideration of further information received from interested parties in response to the February 2023 SNOPR, this NODA presents updated efficiency levels, manufacturer production costs, no-new-standards-case market shares, life-cycle costs (''LCC''), payback periods (''PBP''), and national impact analysis (''NIA'') results for all consumer conventional cooking products. DOE is requesting comments, data, and information regarding the updated analysis.

DOE notes that it is continuing to consider all of the stakeholder comments received in response to the February 2023 SNOPR and the February 2023 NODA in further development of the rulemaking.

II. Discussion

In the following sections, DOE details its updated analysis for consumer conventional cooking products. As discussed in the February 2023 SNOPR, DOE has not identified any higher efficiency levels for electric open (coil) element cooking tops and as such, is not including them in this NODA.

A. Efficiency Levels

1. Electric Cooking Tops

In the February 2023 SNOPR, DOE established efficiency levels for electric smooth element cooking tops based on combining an active-mode annual energy consumption (''AEC'') value and a combined low-power mode annual energy consumption (''E_{TLP}'') value associated with specific design options, noting that different combinations of AEC and E_{TLP} could be used to meet the IAEC of a given efficiency level. 88 FR 6818, 6845–6846. DOE received additional electric smooth element cooking top test data from AHAM and PG&E in response to the February 2023 SNOPR. These additional data are consistent with DOE's tentative determination in the February 2023 SNOPR regarding efficiency levels for these products. Therefore, in this NODA, DOE maintains the efficiency levels for electric smooth element cooking tops that were proposed in the February 2023 SNOPR. Table II.1 shows the efficiency levels for electric smooth element cooking tops.

TABLE II.1—ELECTRIC SMOOTH ELEMENT COOKING TOP EFFICIENCY LEVELS

Level	IAEC (*kWh/year*)
Baseline	250
1	207
2	189
3	179

DOE is publishing the full expanded test sample for electric smooth cooking tops (including the stakeholder-provided data and one additional DOE unit) in an attachment to this NODA, available in the docket for this rulemaking.[4]

DOE requests comment on the efficiency levels for electric smooth element cooking tops.

2. Gas Cooking Tops

In the February 2023 SNOPR, DOE proposed new and amended energy conservation standards for consumer conventional cooking products. Per its authority in 42 U.S.C. 6295(h)(2), DOE proposed to remove the existing prescriptive standard for gas cooking tops prohibiting a constant burning pilot light. 88 FR 6818, 6819. Instead, for gas cooking tops, DOE proposed a performance standard of a maximum allowable IAEC of 1,204 kBtu/year. 88 FR 6818, 6819–6820. These proposed standards for conventional cooking tops, if adopted, would apply to all gas cooking tops manufactured in, or imported into, the United States starting on the date 3 years after the publication of any final rule for this rulemaking. 88 FR 6818, 6819.

For the February 2023 SNOPR, DOE considered efficiency levels (''ELs'') associated with an optimized burner and grate design, but only insofar as the efficiency level was achievable with continuous cast-iron grates and at least one high input rate (''HIR'') burner (which DOE defined in the February 2023 SNOPR as burners with input rates greater than or equal to 14,000 British thermal units per hour (''Btu/h'')). 88 FR 6818, 6845. DOE's testing showed that energy use was correlated to burner design and cooking top configuration (*e.g.,* grate weight, flame angle, distance from burner ports to the cooking surface) and could be reduced by optimizing the design of the burner and grate system. *Id.* DOE reviewed the test data for the gas cooking tops in its test sample and identified two efficiency levels associated with improving the burner and grate design that corresponded to different design criteria. *Id.*

In the February 2023 SNOPR, DOE established efficiency levels for gas cooking tops based on combining an AEC value and an E_{TLP} value associated with specific design options, noting that different combinations of AEC and E_{TLP} could be used to meet the IAEC of a given efficiency level. 88 FR 6818, 6845–6846.

[3] The AHAM comment containing its data set is available at *www.regulations.gov/comment/EERE-2014-BT-STD-0005-2285.* The PG&E data was provided confidentially to DOE's contractor.

[4] *www.regulations.gov/docket/EERE-2014-BT-STD-0005/document.*

In the February 2023 SNOPR, DOE set the baseline gas cooking top IAEC equal to the sum of the maximum AEC and the maximum E_{TLP} observed in its test sample for gas cooking tops. 88 FR 6818, 6844.

In the February 2023 SNOPR, DOE defined EL 1 based on an AEC achievable by a gas cooking top with four or more HIR burners and continuous cast-iron grates and the same E_{TLP} as used for the baseline efficiency level. 88 FR 6818, 6845–6846. The AEC selected for EL 1 was the highest measured among the units in its test sample with four or more HIR burners and continuous cast-iron grates, as shown in Table 5.5.2 in chapter 5 of the TSD for the February 2023 SNOPR.[5]

In the February 2023 SNOPR, DOE defined EL 2 based on the highest measured AEC measured among the units in its test sample with at least one HIR burner and continuous cast-iron grates and the same E_{TLP} as used for the baseline efficiency level. 88 FR 6818, 6845–6846. In the February 2023 SNOPR, DOE stated that HIR burners provide unique consumer utility and allow consumers to perform high heat cooking activities such as searing and stir-frying. *Id.* at 88 FR 6845. DOE also stated that it is aware that some consumers derive utility from continuous cast-iron grates, such as the ability to use heavy pans, or to shift cookware between burners without needing to lift them. *Id.* DOE notes that EL 2 was defined based on the highest measured efficiency unit that met the screening analysis criteria (*i.e.,* gas cooking tops that include at least one HIR burner and continuous cast-iron grates), rather than the highest measured efficiency unit of all tested units, so that all ELs would be achievable with continuous cast-iron grates and at least one HIR burner.

Table II.2 shows the efficiency levels for gas cooking tops evaluated in the February 2023 SNOPR. *Id.* at 88 FR 6846.

TABLE II.2—FEBRUARY 2023 SNOPR GAS COOKING TOP EFFICIENCY LEVELS

Level	IAEC (*kBtu/year*)
Baseline	1,775
1	1,440
2	1,204

As discussed in section I of this document, DOE received additional gas cooking top test data from AHAM and PG&E that has prompted DOE to review the engineering analysis for gas cooking tops as presented in the February 2023 SNOPR. The additional gas cooking top test data provided to DOE includes a unit with a more energy consumptive AEC value and a different unit with a more energy consumptive maximum E_{TLP} value than the most energy consumptive values in DOE's gas cooking top test sample. As discussed, in the February 2023 SNOPR, DOE established efficiency levels for gas cooking tops based on combining the AEC value associated with specific cooking top characteristics and the maximum E_{TLP} value in DOE's test sample, to avoid any potential loss of utility from setting a standard based on a unit without clock functionality.

DOE is publishing the full expanded test sample for gas cooking tops (including the stakeholder-provided data) in an attachment to this NODA, available in the docket for this rulemaking.[6]

As discussed, in the February 2023 SNOPR, DOE used the maximum E_{TLP} value in its test sample to define the ELs for gas cooking tops. In this NODA, DOE is updating the E_{TLP} estimate at each EL for gas cooking tops to be equal to the average of the non-zero E_{TLP} values measured in the expanded test sample. E_{TLP} ranged from 6–57 kBtu/year, with one additional outlier at 101 kBtu/year. Upon closer examination of the data, DOE has tentatively determined that the E_{TLP} value used in the SNOPR was unrepresentative for use in defining the ELs. Instead, DOE has tentatively determined that a more representative E_{TLP} value to use in determining each efficiency level would be the average of the non-zero E_{TLP} values in the test sample. Through a close examination of the control functionality associated with various standby levels, DOE has tentatively determined that using the non-zero average E_{TLP} value would not preclude gas standalone cooking tops or gas ranges with electronic controls and/or displays from achieving any potential standard level.

In response to the February 2023 SNOPR and February 2023 NODA, stakeholders provided substantive information regarding gas cooking top features that are desired by consumers. A review of these stakeholder comments has led DOE to better understand what features some consumers value, including: the presence of multiple HIR burners; continuous cast-iron grates; the ability to choose between nominal unit widths; burner type (open versus sealed burners); at least one low input rate burner (*i.e.,* rated below 5,000 Btu/h); the ability to have multiple dual-stacked and/or multi-ring HIR burners; and at least one extra-high input rate burner (*i.e.,* rated above 18,000 Btu/h).

In this NODA, therefore, DOE is updating its definition of the max-tech efficiency level to be based on the most efficient AEC value in its expanded test sample achievable with continuous cast-iron grates and multiple HIR burners, rather than the single HIR burner utility defined in the February 2023 SNOPR. DOE's data show that among the gas cooking tops in the expanded test sample, units with two to six HIR burners can also achieve this EL and that the updated EL 2 can be achieved by a gas cooking top with all HIR burners.

As discussed, in the February 2023 SNOPR, DOE defined EL 1 based on the optimized burner/grate design option yielding the most energy efficient AEC achievable with at least four HIR burners and continuous cast-iron grates. In this NODA, DOE is updating its definition of EL 1 to represent the most energy efficient AEC among units with multiple (up to six) HIR burners and continuous cast-iron grates that would not preclude any combination of the other features mentioned by manufacturers (including different nominal unit widths, at least one low input rate burner, all HIR burners, multiple dual-stacked and/or multi-ring HIR burners, and at least one extra-high input rate burner), as demonstrated by products from multiple manufacturers in DOE's expanded test sample.

As discussed, in the February 2023 SNOPR, DOE tentatively determined the baseline cooking top AEC as the maximum value observed in its test sample. In this NODA, DOE is updating the baseline efficiency level for gas cooking tops by applying the same methodology as was used in the engineering analysis for the February 2023 SNOPR to the expanded test sample. Using the expanded test sample, DOE is setting a higher baseline IAEC value, corresponding to a lower efficiency.

Table II.3 shows the efficiency levels for gas cooking tops that DOE evaluated for this NODA.

TABLE II.3—UPDATED GAS COOKING TOP EFFICIENCY LEVELS

Level	IAEC (*kBtu/year*)
Baseline	1,900
1	1,633
2	1,343

[5] Available at *www.regulations.gov/document/EERE-2014-BT-STD-0005-0090.*

[6] *www.regulations.gov/docket/EERE-2014-BT-STD-0005/document.*

DOE requests comment on the efficiency levels for gas cooking tops.

3. Conventional Ovens

As discussed in the February 2023 SNOPR, there are no current test procedures for conventional ovens. 88 FR 6818, 6846. Therefore, DOE considered only efficiency levels corresponding to prescriptive design requirements as defined by the design options developed as part of the screening analysis: forced convection, the use of a switch-mode power supply (''SMPS''), and an oven separator. *Id.* DOE ordered the design options by incremental manufacturer production cost (''MPC''). *Id.* In this NODA, DOE maintains the efficiency levels for conventional ovens that were proposed in the February 2023 SNOPR. Table II.4 and Table II.5 define the efficiency levels for conventional electric and gas ovens, respectively.

TABLE II.4—CONVENTIONAL ELECTRIC OVEN EFFICIENCY LEVELS

Level	Design option
Baseline	Baseline
1	Baseline + SMPS
2	1 + Forced Convection
3	2 + Oven Separator

TABLE II.5—CONVENTIONAL GAS OVEN EFFICIENCY LEVELS

Level	Design Option
Baseline	Baseline
1	Baseline + SMPS
2	1 + Forced Convection

DOE requests comment on the efficiency levels for conventional ovens.

B. Manufacturer Production Costs

1. Electric Cooking Tops

For the February 2023 SNOPR, DOE developed cost-efficiency results for electric smooth element cooking tops based on manufacturing cost modeling of units in its sample featuring the design options. 88 FR 6818, 6850. In this NODA, DOE maintains the incremental MPCs for electric smooth element cooking tops that were proposed in the February 2023 SNOPR, as shown in Table II.6.

TABLE II.6—ELECTRIC SMOOTH ELEMENT COOKING TOPS INCREMENTAL MANUFACTURER PRODUCTION COSTS

Level	IAEC (*kWh/year*)	Incremental MPC *(2021$)*
1	207	$2.17
2	189	11.05
3	179	263.19

DOE is requesting comment, data, and information on the incremental manufacturer production costs for electric smooth element cooking tops.

2. Gas Cooking Tops

For the February 2023 SNOPR, DOE developed the incremental MPCs associated with each efficiency levels shown in Table II.7. 88 FR 6818, 6850–6851. DOE developed incremental MPCs based on manufacturing cost modeling of units in its sample featuring the design options. *Id.*

As discussed, in the February 2023 SNOPR, DOE evaluated two versions of the optimized burner and grate design option, representative of a minimum of either four or one HIR burners. *Id.* DOE's testing showed that decreased energy use could be correlated to burner design and cooking top configuration (*e.g.,* grate weight, flame angle, distance from burner ports to the cooking surface). *Id.* Because this design option effectively corresponds to a whole burner and grate system redesign, regardless of the efficiency level achieved by the redesign, DOE stated that the incremental costs for EL 1 and for EL 2 for gas cooking tops include the cost for redesigning the combination of each burner and grate configuration. *Id.* Therefore, DOE stated that it was not able to determine different incremental costs for EL 1 and EL 2 for gas cooking tops. *Id.*

TABLE II.7—FEBRUARY 2023 SNOPR GAS COOKING TOPS INCREMENTAL MANUFACTURER PRODUCTION COSTS

Level	IAEC (*kBtu/year*)	Incremental MPC *(2021$)*
1	1,440	$12.41
2	1,204	12.41

In this NODA, DOE is updating the MPCs for gas cooking tops based on its understanding of the different types of burner and grate redesign likely to be needed to achieve each of the revised ELs, using the same underlying data as was used in the February 2023 SNOPR.

DOE's analysis shows that the incremental MPC developed in the February 2023 SNOPR, $12.41, representing the optimized burner and grate design option (*e.g.,* grate weight, flame angle, distance from burner ports to the cooking surface), accurately represents the cost to redesign a unit at EL 1 to meet EL 2.

To develop the incremental MPC between the updated baseline and EL 1, DOE analyzed the test data in its expanded test sample which shows that cooking tops at the baseline efficiency level typically include one or two burners with ''non-optimized'' turndown capability (*i.e.,* the lowest available simmer setting is more energy consumptive than necessary to hold the test load in a constant simmer close to 90 degrees Celsius, resulting in significantly higher energy consumption than for a burner with a simmer setting that holds the test load close to that temperature). In this NODA, DOE estimates that the cost of implementing a burner with optimized turndown capability in place of a burner with non-optimized turndown capability to meet typical efficiencies available in the market is smaller than the cost of an entirely redesigned burner and grate system (associated with the incremental MPC between EL 1 and EL 2). DOE estimates that the percentage of burners with non-optimized turndown capability (defined empirically from the expanded test sample as burners with a specific energy use of more than 1.45 Btu per gram of water in the test load, as measured by appendix I1) in the baseline units in its expanded test sample ranged from 16 percent (one out of six burners) to 40 percent (two out of five burners). In order to conservatively assess the incremental MPC between baseline and EL 1, DOE defined it as 40 percent of the $12.41 incremental MPC between EL 1 and EL 2, or $4.96.

In sum, for this NODA, DOE developed the incremental MPCs relative to the baseline associated with the updated efficiency levels shown in Table II.8.

TABLE II.8—UPDATED GAS COOKING TOPS INCREMENTAL MANUFACTURER PRODUCTION COSTS

Level	IAEC (*kBtu/year*)	Incremental MPC *(2021$)*
1	1,633	$4.96
2	1,343	17.37

DOE is requesting comment, data, and information on the incremental

manufacturer production costs for gas cooking tops.

3. Conventional Ovens

For the February 2023 SNOPR, DOE developed cost-efficiency results for each conventional oven product class based on manufacturing cost modeling of units in its sample featuring the design options. 88 FR 6818, 6851. In this NODA, DOE maintains the incremental MPCs for conventional ovens that were presented in the February 2023 SNOPR, as shown in Table II.9 and Table II.10 for electric and gas ovens respectively.

TABLE II.9—ELECTRIC OVEN INCREMENTAL MANUFACTURER PRODUCTION COSTS

Level	Design option	Incremental MPC *(2021$)*
1	Baseline + SMPS	$2.03
2	1 + Forced Convection.	34.11
3	2 + Oven Separator ...	67.77

TABLE II.10—GAS OVEN INCREMENTAL MANUFACTURER PRODUCTION COSTS

Level	Design option	Incremental MPC *(2021$)*
1	Baseline + SMPS	$2.17
2	1 + Forced Convection.	24.96

DOE is requesting comment, data, and information on the incremental manufacturer production costs for conventional ovens.

C. Market Distribution

1. Electric Cooking Tops

In the February 2023 SNOPR, DOE estimated the efficiency distribution for each cooking top product class from the sample of cooking tops used to develop the engineering analysis. 88 FR 6818, 6856. Given the lack of data on historic efficiency trends, DOE assumed that the estimated current distributions would apply in 2027. *Id.* The estimated market shares for the no-new-standards case for electric smooth element cooking tops in 2027 used in the February 2023 SNOPR are shown in Table II.11. 88 FR 6818, 6857.

TABLE II.11—FEBRUARY 2023 SNOPR NO-NEW-STANDARDS CASE MARKET SHARE FOR ELECTRIC SMOOTH ELEMENT COOKING TOPS BY EFFICIENCY LEVEL IN 2027

EL	IAEC *(kWh/year)*	Market share (%)
0	250	20
1	207	50
2	189	25
3	179	5

In its comment on the February 2023 SNOPR, AHAM provided shipment estimates of electric cooking tops by product type (*i.e.,* open (coil) element versus electric smooth resistance versus induction).[7] The AHAM shipment data specified that of electric smooth element cooking top shipments, 93.8 percent use resistance heating elements, and 6.2 percent use induction heating elements. AHAM also provided shipment estimates of electric cooking tops by configuration (*i.e.,* standalone cooking top versus conventional range). The AHAM shipment data specified that 93.4 percent of electric cooking tops are sold as components of conventional ranges.

Combining these percentages, DOE estimates the current market distributions for electric smooth element cooking tops by product categories as shown in Table II.12.

TABLE II.12—ELECTRIC SMOOTH ELEMENT COOKING TOP DISTRIBUTIONS BY PRODUCT CATEGORY

	Radiant (93.8%)	Induction (6.2%)
Standalone cooking top (6.6%) ...	6.2	0.4
Component of a conventional range (93.4%) ...	87.6	5.8

To calculate the no-new-standards case market shares, DOE first determined the efficiency level and category of each unit in its expanded test sample, then applied the appropriate weighting factors to adjust the efficiency level distribution of the test sample to a market share distribution representing the full market.

Table II.13 shows the results for the NODA estimate of the no-new-standards case efficiency distribution in 2027 for electric smooth element cooking tops.

TABLE II.13—UPDATED NO-NEW-STANDARDS CASE MARKET SHARE FOR ELECTRIC SMOOTH ELEMENT COOKING TOPS BY EFFICIENCY LEVEL IN 2027

EL	IAEC *(kWh/year)*	Market share (%)
0	250	23
1	207	62
2	189	15
3	179	0.02

DOE requests comment on the no-new-standards case market share for electric smooth element cooking tops.

2. Gas Cooking Tops

In the February 2023 SNOPR analysis, DOE's estimate of the current market share of gas cooking tops that meet each efficiency level under consideration reflected the exclusion of higher-efficiency products that DOE had screened out (*i.e.,* excluded products that do not have at least one HIR burner and continuous cast-iron grates). (See Table 8.2.43 in chapter 8 of the TSD for the February 2023 SNOPR). In the February 2023 NODA, DOE clarified that it has tentatively determined that gas cooking tops with steel grates, non-continuous grates, and/or burners with input rates less than 14,000 Btu/h would also be able to meet the efficiency levels described in the February 2023 SNOPR and therefore would not be impacted by the proposed standard, if finalized. 88 FR 12603, 12604. Based on its testing results and model counts of the burner/grate configurations of gas cooking top models currently available on the websites of major U.S. retailers, DOE estimated in the February 2023 NODA that the products that were screened out of the engineering analysis for the February 2023 SNOPR represent over 40 percent of the market. 88 FR 12603, 12605. Together with the models included in the engineering analysis, DOE estimated that nearly half of the total gas cooking top market currently achieves the proposed EL 2 and therefore would not be impacted by the proposed standard, if finalized. *Id.* DOE estimated that the remaining portion of the total market was distributed equally between the baseline and EL 1. *Id.*

In its comment on the February 2023 SNOPR, AHAM provided shipment estimates of gas cooking tops by configuration (*i.e.,* standalone cooking top versus conventional range).[8] According to AHAM's shipment data,

[7] Available at *www.regulations.gov/document/EERE-2014-BT-STD-0005-2285.*

[8] Available at *www.regulations.gov/document/EERE-2014-BT-STD-0005-2285.*

86.7 percent of gas cooking tops are sold as components of conventional ranges.

For this NODA, DOE confirmed the estimate of the products that were screened out of the February 2023 SNOPR engineering analysis based on a thorough, model-by-model evaluation of these specific features on online retailer websites. DOE notes that these models represent ''entry-level'' products that feature steel grates, non-continuous grates, and/or burners with input rates less than 14,000 Btu/h. DOE notes that these are typically the lowest-cost products available in the market, and are typically purchased by price-sensitive consumers.

Combining these percentages, DOE estimates the current market distributions for gas cooking tops by product categories as shown in Table II.14.

TABLE II.14—GAS COOKING TOP MARKET DISTRIBUTIONS BY PRODUCT CATEGORY

	Entry-level (40%)	Non-entry-level (60%)
Standalone cooking top (13.3%)	5.3	8.0
Component of a conventional range (86.7%)	34.7	52.0

To calculate the no-new-standards case market shares, DOE first determined the efficiency level and category of each unit in its expanded test sample, then applied the appropriate weighting factors to adjust the efficiency level distribution of the test sample to a market share distribution representing the full market.

Table II.15 shows the results for the NODA estimate of the no-new-standards case efficiency distribution in 2027 for gas cooking tops shipments.

TABLE II.15—UPDATED NO-NEW-STANDARDS CASE MARKET SHARE FOR GAS COOKING TOP SHIPMENTS BY EFFICIENCY LEVEL IN 2027

EL	IAEC *(kBtu/year)*	Market share (%)
0	1,900	10
1	1,633	49
2	1,343	41

DOE requests comment on the no-new-standards case market share for gas cooking tops.

3. Conventional Ovens

In the February 2023 SNOPR, DOE relied on model counts of the current market distribution for ovens. 88 FR 6818, 6856. Given the lack of data on historic efficiency trends, DOE assumed that the estimated current distributions would apply in 2027. *Id.* The estimated market shares for the no-new-standards case for gas and electric ovens in 2027 are shown in Table II.16 and Table II.17, respectively. 88 FR 6818, 6857. DOE maintains the February 2023 SNOPR market share estimates for this NODA.

TABLE II.16—NO-NEW-STANDARDS CASE MARKET SHARE FOR GAS OVENS BY EFFICIENCY LEVEL IN 2027

EL	Gas standard ovens, freestanding (%)	Gas standard ovens, built-in/slide-in (%)	Gas self-clean ovens, freestanding (%)	Gas self-clean ovens, built-in/slide-in (%)
0	4	4	4	4
1	34	58	3	19
2	62	38	93	77

TABLE II.17—NO-NEW-STANDARDS CASE MARKET SHARE FOR ELECTRIC OVENS BY EFFICIENCY LEVEL IN 2027

EL	Electric standard ovens, freestanding (%)	Electric standard ovens, built-in/slide-in (%)	Electric self-clean ovens, freestanding (%)	Electric self-clean ovens, built-in/slide-in (%)
0	5	5	5	5
1	57	65	18	7
2	38	30	77	86
3	0	0	0	2

DOE requests comment on the no-new-standards case market share for conventional ovens.

D. Life-Cycle Cost and Payback Period Analysis

DOE conducted LCC and PBP analyses to evaluate the economic impacts on individual consumers of potential energy conservation standards for the gas cooking top efficiency levels presented in this NODA. For this NODA analysis, DOE used the same inputs and assumptions as in the February 2023 SNOPR LCC analysis, including using the 2015 Residential Energy Consumption Survey (''2015 RECS'') [9] as the basis for the consumer sample and Energy Information Administration's (''EIA's'') Annual Energy Outlook 2022 (''AEO 2022'') [10] for energy price projections. Details of the analysis inputs and methodology are available in chapter 8 of the TSD for the February 2023 SNOPR analysis.[11] Subsequent rulemaking analyses will be updated with the most recent data releases (*e.g.,* 2020 RECS, AEO 2023).

The results of this NODA analysis are presented in Table II.18 through Table II.37. In the first of each pair of tables, the simple payback is measured relative to the baseline product. In the second table, impacts are measured relative to the efficiency distribution in the no-new-standards case in the compliance

[9] Available at *www.eia.gov/consumption/residential/data/2015/.*

[10] Available at *www.eia.gov/outlooks/aeo/index.php.*

[11] Available at *www.regulations.gov/document/EERE-2014-BT-STD-0005-0090.*

year (see section II.C of this document). Because some consumers purchase products with higher efficiency in the no-new-standards case, the average savings are less than the difference between the average LCC of the baseline product and the average LCC at each EL. The savings refer only to consumers who are affected by a standard at a given EL.[12] Those who already purchase a product with efficiency at or above a given EL are not affected. Consumers for whom the LCC increases at a given EL experience a net cost.

TABLE II.18—AVERAGE LCC AND PBP RESULTS FOR ELECTRIC SMOOTH ELEMENT COOKING TOPS

Efficiency level	Average costs 2021$				Simple payback years	Average lifetime years
	Installed cost	First year's operating cost	Lifetime operating cost	LCC		
Baseline	$552	$20	$405	$957	.....	16.8
1	555	14	332	887	0.6	16.8
2	568	13	319	887	2.5	16.8
3	1,204	12	311	1,515	87.7	16.8

Note: The results for each efficiency level are calculated assuming that all consumers use products at that efficiency level. The PBP is measured relative to the baseline product.

TABLE II.19—AVERAGE LCC SAVINGS RELATIVE TO THE NO-NEW STANDARDS CASE FOR ELECTRIC SMOOTH ELEMENT COOKING TOPS

Efficiency level	Life-cycle cost savings	
	Average LCC savings * ** 2021$	Percent of consumers thatexperience net cost
1	$68.87	0
2	19.07	40
3	(611.59)	100

* The savings represent the average LCC for affected consumers.
** Negative values denoted in parenthesis.

TABLE II.20—AVERAGE LCC AND PBP RESULTS FOR GAS COOKING TOPS

Efficiency level	Average costs 2021$				Simple payback years	Average lifetime years
	Installed cost	First year's operating cost	Lifetime operating cost	LCC		
Baseline	$376	$16	$342	$719	.....	14.5
1	384	14	322	705	4.3	14.5
2	402	12	299	701	7.2	14.5

Note: The results for each efficiency level are calculated assuming that all consumers use products at that efficiency level. The PBP is measured relative to the baseline product.

TABLE II.21—AVERAGE LCC SAVINGS RELATIVE TO THE NO-NEW STANDARDS CASE FOR GAS COOKING TOPS

Efficiency level	Life-cycle cost savings	
	Average LCC savings * 2021$	Percent of consumers that experience net cost
1	14.78	4
2	6.86	35

* The savings represent the average LCC for affected consumers.

[12] LCC savings presented in the February 2023 SNOPR were mislabeled as only including impacted consumers; however, they also included unimpacted consumers. The values in this NODA have been updated to reflect only impacted consumers to be consistent with current DOE rulemakings.

TABLE II.22—AVERAGE LCC AND PBP RESULTS FOR ELECTRIC STANDARD OVENS, FREESTANDING

Efficiency level	Average costs 2021$				Simple payback years	Average lifetime years
	Installed cost	First year's operating cost	Lifetime operating cost	LCC		
Baseline	$652	$23	$480	$1,133	.....	16.8
1	655	21	457	1,113	1.7	16.8
2	704	20	447	1,151	19.8	16.8
3	755	17	403	1,159	17.2	16.8

Note: The results for each efficiency level are calculated assuming that all consumers use products at that efficiency level. The PBP is measured relative to the baseline product.

TABLE II.23—AVERAGE LCC SAVINGS RELATIVE TO THE NO-NEW STANDARDS CASE FOR ELECTRIC STANDARD OVENS, FREESTANDING

Efficiency level	Life-cycle cost savings	
	Average LCC savings* ** 2021$	Percent of consumers that experience net cost
1	$19.82	0
2	(36.62)	60
3	(30.65)	80

* The savings represent the average LCC for affected consumers.
** Negative values denoted in parenthesis.

TABLE II.24—AVERAGE LCC AND PBP RESULTS FOR ELECTRIC STANDARD OVENS, BUILT-IN/SLIDE-IN

Efficiency level	Average costs 2021$				Simple payback years	Average lifetime years
	Installed cost	First year's operating cost	Lifetime operating cost	LCC		
Baseline	$682	$23	$492	$1,175	.....	16.8
1	685	22	470	1,155	1.8	16.8
2	734	21	459	1,194	20.2	16.8
3	785	18	416	1,202	17.3	16.8

Note: The results for each efficiency level are calculated assuming that all consumers use products at that efficiency level. The PBP is measured relative to the baseline product.

TABLE II.25—AVERAGE LCC SAVINGS RELATIVE TO THE NO-NEW STANDARDS CASE FOR ELECTRIC STANDARD OVENS, BUILT-IN/SLIDE-IN

Efficiency level	Life-cycle cost savings	
	Average LCC savings* ** 2021$	Percent of consumers that experience net cost
1	$19.86	0
2	(36.66)	67
3	(33.53)	81

* The savings represent the average LCC for affected consumers.
** Negative values denoted in parenthesis.

TABLE II.26—AVERAGE LCC AND PBP RESULTS FOR ELECTRIC SELF-CLEAN OVENS, FREESTANDING

Efficiency level	Average costs 2021$				Simple payback years	Average lifetime years
	Installed cost	First year's operating cost	Lifetime operating cost	LCC		
Baseline	$699	$28	$550	$1,250	.....	16.8
1	702	26	527	1,229	1.7	16.8
2	751	25	517	1,268	19.8	16.8
3	802	22	473	1,276	17.2	16.8

Note: The results for each efficiency level are calculated assuming that all consumers use products at that efficiency level. The PBP is measured relative to the baseline product.

TABLE II.27—AVERAGE LCC SAVINGS RELATIVE TO THE NO-NEW STANDARDS CASE FOR ELECTRIC SELF-CLEAN OVENS, FREESTANDING

Efficiency level	Life-cycle cost savings	
	Average LCC savings* ** 2021$	Percent of consumers that experience net cost
1	$20.55	0
2	(33.71)	22
3	(15.70)	75

* The savings represent the average LCC for affected consumers.
** Negative values denoted in parenthesis.

TABLE II.28—AVERAGE LCC AND PBP RESULTS FOR ELECTRIC SELF-CLEAN OVENS, BUILT-IN/SLIDE-IN

Efficiency level	Average costs 2021$				Simple payback years	Average lifetime years
	Installed cost	First year's operating cost	Lifetime operating cost	LCC		
Baseline	$729	$29	$561	$1,291	.....	16.8
1	732	27	539	1,271	1.8	16.8
2	781	26	528	1,310	20.2	16.8
3	832	23	485	1,318	17.3	16.8

Note: The results for each efficiency level are calculated assuming that all consumers use products at that efficiency level. The PBP is measured relative to the baseline product.

TABLE II.29—AVERAGE LCC SAVINGS RELATIVE TO THE NO-NEW STANDARDS CASE FOR ELECTRIC SELF-CLEAN OVENS, BUILT-IN/SLIDE-IN

Efficiency level	Life-cycle cost savings	
	Average LCC savings* ** 2021$	Percent of consumers that experience net cost
1	$20.23	0
2	(30.20)	11
3	(11.88)	72

* The savings represent the average LCC for affected consumers.
** Negative values denoted in parenthesis.

TABLE II.30—AVERAGE LCC AND PBP RESULTS FOR GAS STANDARD OVENS, FREESTANDING

Efficiency level	Average costs 2021$				Simple payback years	Average lifetime years
	Installed cost	First year's operating cost	Lifetime operating cost	LCC		
Baseline	$677	$42	$682	$1,359	.....	14.5
1	681	41	662	1,343	1.9	14.5
2	715	40	651	1,366	14.3	14.5

Note: The results for each efficiency level are calculated assuming that all consumers use products at that efficiency level. The PBP is measured relative to the baseline product.

TABLE II.31—AVERAGE LCC SAVINGS RELATIVE TO THE NO-NEW STANDARDS CASE FOR GAS STANDARD OVENS, FREESTANDING

Efficiency level	Life-cycle cost savings	
	Average LCC savings* ** 2021$	Percent of consumers that experience net cost
1	$15.05	1
2	(20.68)	34

* The savings represent the average LCC for affected consumers.
** Negative values denoted in parenthesis.

TABLE II.32—AVERAGE LCC AND PBP RESULTS FOR GAS STANDARD OVENS, BUILT-IN/SLIDE-IN

Efficiency level	Average costs 2021$				Simple payback years	Average lifetime years
	Installed cost	First year's operating cost	Lifetime operating cost	LCC		
Baseline	$707	$43	$690	$1,397	.....	14.5
1	710	41	671	1,381	2.0	14.5
2	744	40	660	1,404	14.5	14.5

Note: The results for each efficiency level are calculated assuming that all consumers use products at that efficiency level. The PBP is measured relative to the baseline product.

TABLE II.33—AVERAGE LCC SAVINGS RELATIVE TO THE NO-NEW STANDARDS CASE FOR GAS STANDARD OVENS, BUILT-IN/SLIDE-IN

Efficiency level	Life-cycle cost savings	
	Average LCC savings* ** 2021$	Percent of consumers that experience net cost
1	$15.73	1
2	(21.74)	56

* The savings represent the average LCC for affected consumers.
** Negative values denoted in parenthesis.

TABLE II.34—AVERAGE LCC AND PBP RESULTS FOR GAS SELF-CLEAN OVENS, FREESTANDING

Efficiency level	Average costs 2021$				Simple payback years	Average lifetime years
	Installed cost	First year's operating cost	Lifetime operating cost	LCC		
Baseline	$847	$44	$702	$1,548	.....	14.5
1	850	42	682	1,532	1.9	14.5
2	884	41	671	1,555	14.3	14.5

Note: The results for each efficiency level are calculated assuming that all consumers use products at that efficiency level. The PBP is measured relative to the baseline product.

TABLE II.35—AVERAGE LCC SAVINGS RELATIVE TO THE NO-NEW STANDARDS CASE FOR GAS SELF-CLEAN OVENS, FREESTANDING

Efficiency level	Life-cycle cost savings	
	Average LCC savings* ** 2021$	Percent of consumers that experience net cost
1	$15.22	1
2	(14.43)	6

* The savings represent the average LCC for affected consumers.
** Negative values denoted in parenthesis.

TABLE II.36—AVERAGE LCC AND PBP RESULTS FOR GAS SELF-CLEAN OVENS, BUILT-IN/SLIDE-IN

Efficiency level	Average costs 2021$				Simple payback years	Average lifetime years
	Installed cost	First year's operating cost	Lifetime operating cost	LCC		
Baseline	$876	$45	$710	$1,586	.....	14.5
1	879	43	691	1,571	2.0	14.5
2	913	42	680	1,593	14.5	14.5

Note: The results for each efficiency level are calculated assuming that all consumers use products at that efficiency level. The PBP is measured relative to the baseline product.

TABLE II.37—AVERAGE LCC SAVINGS RELATIVE TO THE NO-NEW STANDARDS CASE FOR GAS SELF-CLEAN OVENS, BUILT-IN/SLIDE-IN

Efficiency level	Life-cycle cost savings	
	Average LCC savings * ** 2021$	Percent of consumers that experience net cost
1	$15.53	1
2	(19.69)	20

* The savings represent the average LCC for affected consumers.
** Negative values denoted in parenthesis.

The LCC spreadsheet used to calculate the results of this NODA are available on the DOE website for this rulemaking.[13]

DOE requests comment on the LCC results for conventional cooking products.

E. National Impact Analysis

The NIA assesses the national energy savings (''NES'') and the net present value (''NPV'') from a national perspective of total consumer costs and savings that would be expected to result from new or amended standards at specific efficiency levels. In this section, DOE presents the NIA results analyzing the impacts of the updated analysis discussed in this NODA. As in the LCC analysis, DOE maintained the same methodologies and assumptions presented in the February 2023 SNOPR analysis, including using estimates from 2015 RECS and AEO 2022 projections. Details of the NIA analysis are available in chapter 10 of the TSD for the February 2023 SNOPR. Subsequent rulemaking analyses will be updated with most recent data releases (*e.g.,* 2020 RECS, AEO 2023).

Table II.38 shows full-fuel cycle NES results of a potential standard at each efficiency level. Full-fuel cycle national energy savings are presented in quadrillion British thermal units, or quads. Table II.39 and Table II.40 show NPV results at each considered efficiency level, discounted at 3 and 7 percent, respectively.

TABLE II.38—CUMULATIVE FULL-FUEL CYCLE NATIONAL ENERGY SAVINGS; 30 YEARS OF SHIPMENTS

[2027–2056]

Efficiency level	Electric smooth cooking tops	Gas cooking tops	Electric ovens	Gas ovens
	quads			
1	0.14	0.02	0.02	0.01
2	0.23	0.16	0.08	0.03
3	0.25	.....	0.90	

TABLE II.39—CUMULATIVE NET PRESENT VALUE OF CONSUMER BENEFITS AT A 3 PERCENT DISCOUNT RATE; 30 YEARS OF SHIPMENTS

[2027–2056]

Efficiency level	Electric smooth cooking tops	Gas cooking tops	Electric ovens	Gas ovens
	billion 2021$			
1	0.89	0.05	0.13	0.04
2*	1.01	(0.02)	(1.05)	(0.25)
3*	(28.61)	.....	(1.06)	

* Negative values denoted in parenthesis.

TABLE II.40—CUMULATIVE NET PRESENT VALUE OF CONSUMER BENEFITS AT A 7 PERCENT DISCOUNT RATE; 30 YEARS OF SHIPMENTS

[2027–2056]

Efficiency level	Electric smooth cooking tops	Gas cooking tops	Electric ovens	Gas ovens
	billion 2021$			
1	0.36	0.01	0.05	0.02

[13] *www.regulations.gov/docket/EERE-2014-BT-STD-0005/document.*

TABLE II.40—CUMULATIVE NET PRESENT VALUE OF CONSUMER BENEFITS AT A 7 PERCENT DISCOUNT RATE; 30 YEARS OF SHIPMENTS—Continued

[2027–2056]

Efficiency level	Electric smooth cooking tops	Gas cooking tops	Electric ovens	Gas ovens
2*	0.35	(0.09)	(0.63)	(0.15)
3*	(15.17)	.....	(1.34)	

* Negative values denoted in parenthesis.

The NIA spreadsheet used to calculate the results of this NODA are available on the DOE website for this rulemaking.[14]

DOE requests comment on the NIA results for conventional cooking products.

III. Public Participation

DOE requests comment on the updated efficiency levels, incremental MPCs, no-new-standards case market shares, LCC, PBP, and NIA results for consumer conventional cooking products presented in this NODA. As noted in the February 2023 SNOPR, DOE may adopt energy efficiency levels that are either higher or lower than the proposed standards, or some combination of level(s) that incorporate the proposed standards in part.

DOE will accept comments, data, and information regarding this document, but no later than the date provided in the **DATES** section at the beginning of this document. Interested parties may submit comments, data, and other information using any of the methods described in the **ADDRESSES** section at the beginning of this document.

Submitting comments via www.regulations.gov. The *www.regulations.gov* web page will require you to provide your name and contact information. Your contact information will be viewable to DOE Building Technologies staff only. Your contact information will not be publicly viewable except for your first and last names, organization name (if any), and submitter representative name (if any). If your comment is not processed properly because of technical difficulties, DOE will use this information to contact you. If DOE cannot read your comment due to technical difficulties and cannot contact you for clarification, DOE may not be able to consider your comment.

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Include contact information each time you submit comments, data, documents, and other information to DOE. No telefacsimiles (''faxes'') will be accepted.

Comments, data, and other information submitted to DOE electronically should be provided in PDF (preferred), Microsoft Word or Excel, WordPerfect, or text (ASCII) file format. Provide documents that are not secured, that are written in English, and that are free of any defects or viruses. Documents should not contain special characters or any form of encryption and, if possible, they should carry the electronic signature of the author.

Campaign form letters. Please submit campaign form letters by the originating organization in batches of between 50 to 500 form letters per PDF or as one form letter with a list of supporters' names compiled into one or more PDFs. This reduces comment processing and posting time.

Confidential Business Information. Pursuant to 10 CFR 1004.11, any person submitting information that he or she believes to be confidential and exempt by law from public disclosure should submit via email two well-marked copies: one copy of the document marked ''confidential'' including all the information believed to be confidential, and one copy of the document marked ''non-confidential'' with the information believed to be confidential deleted. DOE will make its own determination about the confidential status of the information and treat it according to its determination.

It is DOE's policy that all comments may be included in the public docket, without change and as received, including any personal information provided in the comments (except information deemed to be exempt from public disclosure).

Signing Authority

This document of the Department of Energy was signed on July 27, 2023, by Francisco Alejandro Moreno, Acting Assistant Secretary for Energy Efficiency and Renewable Energy, pursuant to delegated authority from the Secretary of Energy. That document with the original signature and date is maintained by DOE. For administrative purposes only, and in compliance with requirements of the Office of the Federal

[14] *www.regulations.gov/docket/EERE-2014-BT-STD-0005/document.*

Register, the undersigned DOE Federal Register Liaison Officer has been authorized to sign and submit the document in electronic format for publication, as an official document of the Department of Energy. This administrative process in no way alters the legal effect of this document upon publication in the **Federal Register**.

Signed in Washington, DC, on July 28, 2023.

Treena V. Garrett,

Federal Register Liaison Officer, U.S. Department of Energy.

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DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 635

[Docket No. 230724–0173]

RIN 0648–BM33

Atlantic Highly Migratory Species; 2024 Atlantic Shark Commercial Fishing Year

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

ACTION: Proposed rule; request for comments.

SUMMARY: This proposed rule would adjust quotas and retention limits and establish the opening date for the 2024 fishing year for the Atlantic shark commercial fisheries. Within this proposed rule, NMFS also considers options for the 2024 and future fishing years to automatically open the commercial fishing year on January 1 of each year under the base quotas and default retention limits, and to increase the default commercial retention limit for the large coastal shark (LCS) fisheries. Quotas would be adjusted as required or allowable based on any underharvests from the previous fishing years. The proposed measures could affect fishing opportunities for commercial shark fishermen in the northwestern Atlantic Ocean, Gulf of Mexico, and Caribbean Sea.

DATES: Written comments must be received by September 1, 2023.

ADDRESSES: You may submit comments on this document, identified by NOAA–NMFS–2023–0081, by electronic submission. Submit all electronic public comments via the Federal e-Rulemaking Portal. Go to *https://www.regulations.gov* and enter NOAA–NMFS–2023–0081 in the search box. Click on the ''Comment'' icon, complete the required fields, and enter or attach your comments.

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

Copies of this proposed rule and supporting documents are available from the Atlantic Highly Migratory Species (HMS) Management Division website at *https://www.fisheries.noaa.gov/topic/atlantic-highly-migratory-species* or by contacting Ann Williamson (*ann.williamson@noaa.gov*) by phone at 301–427–8503.

FOR FURTHER INFORMATION CONTACT: Ann Williamson (*ann.williamson@noaa.gov*), Guy DuBeck (*guy.dubeck@noaa.gov*), or Karyl Brewster-Geisz (*karyl.brewster-geisz@noaa.gov*) at 301–427–8503.

SUPPLEMENTARY INFORMATION:

Background

Atlantic shark fisheries are managed under the authority of the Magnuson-Stevens Fishery Conservation and Management Act (Magnuson-Stevens Act; 16 U.S.C. 1801 *et seq.*) and the Atlantic Tunas Convention Act (16 U.S.C. 971 *et seq.*). The 2006 Consolidated Atlantic HMS Fishery Management Plan (2006 Consolidated HMS FMP) and its amendments are implemented by regulations at 50 CFR part 635. The shark commercial retention limits, quotas, and closure requirements can be found in §§ 635.24(a), 635.27(b), and 635.28(b), respectively.

For the Atlantic shark commercial fisheries, the 2006 Consolidated HMS FMP and its amendments established default commercial shark retention limits, commercial quotas for species and management groups, and adjustment procedures for underharvests and overharvests. Regulations also include provisions allowing flexible opening dates for the fishing year (§ 635.27(b)(3)) and inseason adjustments to shark trip limits (§ 635.24(a)(8)), which provide management flexibility in furtherance of equitable fishing opportunities, to the extent practicable, for commercial shark fishermen in all regions and areas. In addition, § 635.28(b)(4) lists species and management groups with quotas that are linked. If quotas are linked, meaning when the specified quota threshold for one management group or species is reached and that management group or species is closed, the linked management group or species closes at the same time (§ 635.28(b)(3)). Lastly, pursuant to § 635.27(b)(2), any annual or inseason adjustments to the base annual commercial overall, regional, or sub-regional quotas will be published in the **Federal Register**.

Proposed Opening Date and Retention Limit Measures

NMFS is proposing to open the 2024 fishing year on January 1, permitting the maximum allowable retention limit for LCS fisheries, and is proposing options, described below, to change the opening date and default retention limit measures for LCS fisheries for future fishing years. These options are based on catch rates and landings information for 2021, 2022, and to date in 2023. In 2022 and 2023, NMFS opened the fishing years on January 1, with the maximum retention limit of 55 LCS other than sandbar sharks per vessel per trip for Shark Directed permit holders. The 2021 fishing year opened on January 1, with the default retention limit of 45 LCS other than sandbar sharks per vessel per trip; however, the retention limit was increased in all regions to 55 LCS other than sandbar sharks per vessel per trip by the end of March (86 FR 16075, March 26, 2021; 86 FR 47395, August 25, 2021). Despite having the maximum retention limits allowed under the regulations, the quotas for the various LCS management groups were not fully harvested in 2021 or 2022. Under current catch rates, it is unlikely the current quotas will be fully harvested in 2023. Given the current number of active and inactive permit holders, NMFS does not expect catch rates to increase in the near future. As such, NMFS is proposing opening the Atlantic shark commercial fishing year on January 1 under the highest possible allowable retention limit for LCS fisheries for 2024 and considering establishing those as the default opening date and retention limit for future fishing years.

Option 1, status quo, maintains the current management measures that require NMFS to adjust quotas and retention limits and establish the opening date for the upcoming fishing

year for the Atlantic shark commercial fisheries. Adjustments to quota levels for the various shark stock and management groups, commercial shark fishing opening dates, and default retention limits for directed shark permits must be proposed and finalized prior to the start of the upcoming fishing year based on data available from the previous fishing year. As a result, quota adjustments are based on incomplete data from the previous fishing year. Additionally, because the opening of the commercial shark fishing season is dependent upon implementation of an annual rulemaking, delays caused by the regulatory process could result in the fishery not opening on time. The uncertainty of this process can also mean that fishermen and dealers are unable to plan for the fishery starting January 1. This uncertainty may be one reason why the number of active permit holders and, accordingly, catch rates, has been declining over the years. Additionally, annually establishing the quotas, default retention limits, and opening date for the upcoming fishing year can be administratively burdensome for NMFS.

Option 2, the preferred option, would revise both the start date for all Atlantic shark fisheries and the default retention limit for Shark Directed permit holders in the LCS fisheries. Specifically regarding the start date, the preferred option would revise the regulations at § 635.27(b) to have the fishery automatically open on January 1 each year under base quotas and default retention limits. However, under this option NMFS would maintain the flexibility to prevent a regional or sub-regional shark management group from automatically opening on January 1 if the respective quota was overharvested or there were indications that opening on January 1 would result in the quota being overharvested. A change in opening date for a regional or sub-regional shark management group could occur during the respective fishing year or prior to January 1 for the following fishing year. Before changing the opening date from January 1, NMFS would consider the seven ''Opening Commercial Fishing Season Criteria'' listed at § 635.27(b)(3). Under Option 2, each year, during the fishing year, NMFS would follow the quota adjustment process specified in § 635.27(b)(2) and publish in the **Federal Register** an adjustment for any quota over- or underharvests based on landings reported from the previous fishing year.

The proposed January 1 start date for 2024 and future fishing years is based on recent catch rates and fishing effort. NMFS has opened the Atlantic shark fishery on January 1 for the past 8 years. NMFS considered the underharvests of the different management groups in 2023 and the past few years to determine the likely effects of the commercial quotas on shark stocks and fishermen across regional and sub-regional fishing areas. NMFS also examined the potential season length and previous catch rates to ensure, to the extent practicable, that equitable fishing opportunities will be provided to fishermen in all areas. Lastly, NMFS assessed the seasonal variation of the different species and management groups, as well as seasonal variation in fishing opportunities. Based on these analyses, NMFS believes that automatically opening the Atlantic shark fishery on January 1 would not cause the commercial quotas to be exceeded, and, considering trends in current catch rates, should continue to provide equitable fishing opportunities across all areas. However, if the situation changes and a significant portion of the quota begins to be harvested in one area, NMFS may adjust retention limit, as appropriate, to provide equitable fishing opportunities in all areas during the fishing year. Furthermore, having a stable start date may provide fishermen and dealers with more certainty for business planning purposes.

The proposed default retention limit adjustment to 55 LCS other than sandbar sharks per vessel per trip for Shark Directed permit holders for 2024 and future fishing years is based on catch rates and landings information in 2023 and the past few years. The current default commercial retention limit is 45 LCS other than sandbar sharks per vessel per trip, unless NMFS determines otherwise and publishes a notice of inseason adjustment in the **Federal Register** (§ 635.24(a)(2)). NMFS reviewed landings on a weekly basis for all species and/or management groups and determined that fishermen have been able to participate in the fishery, and landings from both Gulf of Mexico sub-regions and the Atlantic region are not projected to exceed the 2023 overall aggregated LCS quota. This review indicates that in recent years the seasonal distribution of the shark species has not had an effect on the commercial shark landings within a region or sub-region. This result could be because in recent years shark fishermen have been able to operate throughout the year and target more profitable species in other fisheries depending on the season and availability of fish, including sharks.

Under Option 2, NMFS would not change the existing regulations that allow for changes to the retention limit during the fishing year. Specifically, NMFS could continue to adjust the retention limit from 0 to 55 LCS other than sandbar sharks per vessel per trip if the respective LCS management group is open under §§ 635.27 and 635.28, and after considering the seven ''Inseason Trip Limit Adjustment'' criteria at § 635.24(a)(8).

The proposed automatic opening date and default retention limit combination would provide, to the extent practicable, equitable opportunities across the fisheries management sub-regions. Automatically opening the fishing year on January 1 each year under base quotas and retention limits reduces the likelihood of delays caused by the regulatory process and provides more certainty to stakeholders. Additionally, any quota adjustments, based on over- and/or underharvest, could be accounted for at one time, based upon complete data from the prior fishing year. NMFS could also continue to adjust retention limits as needed throughout the fishing year to ensure quotas are harvested and not exceeded.

Consistent with existing regulations, all of the regional or sub-regional commercial fisheries for shark management groups would remain open until December 31 each year, or until NMFS determines that the landings for any shark management group are projected to reach 80 percent of the quota given the realized catch rates and are projected to reach 100 percent of the quota before the end of the fishing season, or until a quota-linked species or management group is closed. If NMFS determines that a non-quota-linked shark species or management group fishery must be closed, then, consistent with § 635.28(b)(2) for non-linked quotas (*e.g.,* eastern Gulf of Mexico blacktip sharks, western Gulf of Mexico blacktip sharks, Gulf of Mexico non-blacknose small coastal sharks (SCS), pelagic sharks, or the Atlantic or Gulf of Mexico smoothhound sharks), NMFS will publish in the **Federal Register** a notice of closure for that shark species, shark management group, region, and/or sub-region. The closure will be effective no fewer than 4 days from the date of filing for public inspection with the Office of the Federal Register. The linked and non-linked quotas are shown in Table 1.

For the regional or sub-regional Gulf of Mexico blacktip shark management group(s), regulations at § 635.28(b)(5)(i) through (v) authorize NMFS to close the management group(s) before landings have reached, or are projected to reach,

80 percent of the quota after considering the following criteria and other relevant factors: season length based on available sub-regional quota and average sub-regional catch rates; variability in regional and/or sub-regional seasonal distribution, abundance, and migratory patterns of blacktip sharks, hammerhead sharks, and aggregated LCS; effects on accomplishing the objectives of the 2006 Consolidated HMS FMP and its amendments; amount of remaining shark quotas in the relevant sub-region; and regional and/or sub-regional catch rates of the relevant shark species or management groups. The fisheries for the shark species or management group would be closed from the effective date and time of the closure until the start of the following fishing year or until NMFS publishes in the **Federal Register** a notice that additional quota is available and the season is reopened.

If NMFS determines that a quota-linked species and/or management group must be closed, then, consistent with § 635.28(b)(3) for linked quotas, NMFS will publish in the **Federal Register** a notice of closure for all of the species and/or management groups in a linked group. The closure will be effective no fewer than 4 days from the date of filing for public inspection with the Office of the Federal Register. In that event, from the effective date and time of the closure until the start of the following fishing year or until NMFS announces that the season is reopened and additional quota is available (via publication of another notice in the **Federal Register**), the fisheries for all quota-linked species and/or management groups will be closed. The quota-linked species and/or management groups are: Atlantic hammerhead sharks and Atlantic aggregated LCS; eastern Gulf of Mexico hammerhead sharks and eastern Gulf of Mexico aggregated LCS; western Gulf of Mexico hammerhead sharks and western Gulf of Mexico aggregated LCS; and Atlantic blacknose sharks and Atlantic non-blacknose SCS south of 34° N latitude.

TABLE 1—QUOTA LINKAGES AND COMMERCIAL RETENTION LIMIT BY REGIONAL OR SUB-REGIONAL SHARK MANAGEMENT GROUP

Region or sub-region	Management group	Quota linkages [1]	Commercial retention limits for directed shark limited access permit holders [2]
Western Gulf of Mexico	Blacktip Sharks	Not Linked	55 LCS other than sandbar sharks per vessel per trip.
	Aggregated LCS Hammerhead Sharks	Linked	
Eastern Gulf of Mexico	Blacktip Sharks	Not Linked	55 LCS other than sandbar sharks per vessel per trip.
	Aggregated LCS Hammerhead Sharks	Linked	
Gulf of Mexico	Non-Blacknose SCS	Not Linked	N/A.
	Smoothhound Sharks	Not Linked	N/A.
Atlantic	Aggregated LCS Hammerhead Sharks	Linked	55 LCS other than sandbar sharks per vessel per trip.
	Non-Blacknose SCS	Linked (South of 34° N lat. only)	N/A.
	Blacknose Sharks (South of 34° N lat. Only)		8 blacknose sharks per vessel per trip.[3]
	Smoothhound Sharks	Not Linked	N/A.
No Regional Quotas	Non-Sandbar LCS Research	Linked [4]	N/A.
	Sandbar Shark Research		
	Blue Sharks	Not Linked	N/A.
	Porbeagle Sharks		
	Pelagic Sharks Other Than Porbeagle or Blue		

[1] Section 635.28(b)(4) lists species and management groups with quotas that are linked. If quotas are linked, when the specified quota threshold for one management group or species is reached and that management group or species is closed, the linked management group or species closes at the same time (§ 635.28(b)(3)).

[2] Inseason adjustments are possible.

[3] Applies to Shark Directed and Shark Incidental permit holders.

[4] Shark research permits "terms and conditions" state that when the individual sandbar or research LCS quotas authorized by the permit are landed, all fishing trips under the permit must stop.

Proposed 2024 Commercial Shark Quotas

NMFS proposes to adjust the quota levels for the various shark stocks and management groups for the 2024 Atlantic shark commercial fishing year (*i.e.,* January 1 through December 31, 2024) based on underharvests that occurred during the 2023 fishing year, consistent with existing regulations at § 635.27(b). Overharvests and underharvests are accounted for in the same region, sub-region, or fishery in which they occurred the following year, except that large overharvests may be spread over a number of subsequent fishing years up to a maximum of 5 years. If a sub-regional quota is overharvested, but the overall regional quota is not, no subsequent adjustment is required. Unharvested quota may be added to the quota for the next fishing year, but only for shark management groups that have shark stocks that are declared not overfished and not experiencing overfishing. No more than 50 percent of a base annual quota may be carried over from a previous fishing year.

Based on 2023 harvests to date, and after considering catch rates and landings from previous years, NMFS proposes to adjust the 2024 quotas for certain management groups as shown in Table 2. All of the 2024 proposed quotas for the respective stocks and management groups will be subject to further adjustment in the final rule after NMFS considers landings submitted in the dealer reports through mid-October. NMFS anticipates that dealer reports received after that time will be used to adjust 2025 quotas, as appropriate, noting that, in some circumstances, NMFS re-adjusts quotas during the subject year.

Because the Gulf of Mexico blacktip shark management group and smoothhound shark management groups in the Gulf of Mexico and Atlantic

regions are not overfished, and overfishing is not occurring, available underharvest (up to 50 percent of the base annual quota) from the 2023 fishing year for these management groups may be added to their respective 2024 base quotas. NMFS proposes to account for any underharvest of Gulf of Mexico blacktip sharks by dividing underharvest between the eastern and western Gulf of Mexico sub-regional quotas based on the sub-regional quota split percentage (§ 635.27(b)(1)(ii)(C)).

For the sandbar shark, aggregated LCS, hammerhead shark, non-blacknose small coastal shark (SCS), blacknose shark, blue shark, porbeagle shark, and pelagic shark (other than porbeagle or blue sharks) management groups, the 2023 underharvests cannot be carried over to the 2024 fishing year because those stocks or management groups are overfished, are experiencing overfishing, or have an unknown status. There are no overharvests to account for in these management groups to date. Thus, NMFS proposes that quotas for these management groups be equal to the annual base quota without adjustment, although the ultimate decision will be based on current data at the time of the final rule.

The proposed 2024 quotas by species and management group are summarized in Table 2 and the description of the calculations for each stock and management group can be found below. All quotas and landings are in dressed weight (dw) metric tons (mt). Table 2 includes landings data as of May 12, 2023. Final quotas are subject to change based on landings as of mid-October 2023.

TABLE 2—2024 PROPOSED QUOTAS FOR THE ATLANTIC SHARK MANAGEMENT GROUPS

Region or sub-region	Management group	2023 Annual quota (A)	Preliminary 2023 landings [1] (B)	Adjustments [2] (C)	2024 Base annual quota (D)	2024 Proposed annual quota (D+C)
Western Gulf of Mexico.	Blacktip Sharks	347.2 mt (765,392 lb)	225.3 mt (496,649 lb)	115.7 mt (225,131 lb)	231.5 mt (510,261 lb)	347.2 mt (765,392 lb).
	Aggregate Large Coastal Sharks [3].	72.0 mt (158,724 lb)	75.9 mt (167,296 lb)		72.0 mt (158,724 lb)	72.0 mt (158,724 lb).
	Hammerhead Sharks [4].	11.9 mt (26,301 lb)	<3.0 mt (<6,612 lb)		11.9 mt (26,301 lb)	11.9 mt (26,301 lb).
Eastern Gulf of Mexico.	Blacktip Sharks	37.7 mt (83,158 lb)	0.6 mt (1,394 lb)	12.6 mt (27,719 lb)	25.1 mt (55,439 lb)	37.7 mt (83,158 lb).
	Aggregate Large Coastal Sharks [3].	85.5 mt (188,593 lb)	<1.0 mt (327 lb)		85.5 mt (188,593 lb)	85.5 mt (188,593 lb).
	Hammerhead Sharks.	13.4 mt (29,421 lb)	<1.0 mt (2,204 lb)		13.4 mt (29,421 lb)	13.4 mt (29,421 lb).
Gulf of Mexico	Non-Blacknose Small Coastal Sharks.	112.6 mt (428,215 lb)	<1.0 mt (351 lb)		112.6 mt (428,215 lb)	112.6 mt (428,215 lb).
	Smoothhound Sharks.	504.6 mt (1,112,441 lb)	0.0 mt (0 lb)	168.2 mt (370,814 lb)	336.4 mt (741,627 lb)	504.6 mt (1,112,441 lb).
Atlantic	Aggregate Large Coastal Sharks.	168.9 mt (372,552 lb)	41.8 mt (92,088 lb)		168.9 mt (372,552 lb)	168.9 mt (372,552 lb).
	Hammerhead Sharks.	27.1 mt (59,736 lb)	12.9 mt (28,547 lb)		27.1 mt (59,736 lb)	27.1 mt (59,736 lb).
	Non-Blacknose Small Coastal Sharks.	264.1 mt (582,333 lb)	18.8 mt (41,502 lb)		264.1 mt (582,333 lb)	264.1 mt (582,333 lb).
	Blacknose Sharks (South of 34° N lat. Only).	17.2 mt (3,921 lb)	<3.0 mt (<6,612 lb)		17.2 mt (3,921 lb)	17.2 mt (3,921 lb).
	Smoothhound Sharks.	1,802.6 mt (3,973,902 lb)	47.0 mt (103,672 lb)	600.9 mt (1,324,634 lb)	1,201.7 mt (2,649,268 lb)	1,802.6 mt (3,973,902 lb).
No Regional Quotas.	Non-Sandbar LCS Research.	50.0 mt (110,230 lb)	<2.0 mt (<4,408 lb)		50.0 mt (110,230 lb)	50.0 mt (110,230 lb).
	Sandbar Shark Research.	90.7 mt (199,943 lb)	<22.0 mt (<48,500 lb)		90.7 mt (199,943 lb)	90.7 mt (199,943 lb).
	Blue Sharks	273.0 mt (601,856 lb)	<2.0 mt (<4,408 lb)		273.0 mt (601,856 lb)	273.0 mt (601,856 lb).
	Porbeagle Sharks	1.7 mt (3,748 lb)	<1.0 mt (<2,204 lb)		1.7 mt (3,748 lb)	1.7 mt (3,748 lb).
	Pelagic Sharks Other Than Porbeagle or Blue.	488.0 mt (1,075,856 lb)	9.9 mt (21,910 lb)		488.0 mt (1,075,856 lb)	488.0 mt (1,075,856 lb).

[1] Landings are from January 1, 2023 through May 12, 2023 and are subject to change.

[2] Underharvest adjustments can only be applied to stocks or management groups that are declared not overfished and have no overfishing occurring. The underharvest adjustments cannot exceed 50 percent of the base quota.

[3] NMFS transferred 40.0 mt dw of the aggregate LCS quota from the Gulf of Mexico eastern sub-region to the western sub-region as of March 21, 2023 (88 FR 17742, March 24, 2023).

Shark Management Groups Where Underharvests Can Be Carried Over

The Gulf of Mexico blacktip shark management group (which is divided between eastern and western sub-regions) and smoothhound shark management groups in the Gulf of Mexico and Atlantic regions are not overfished and overfishing is not occurring. Pursuant to § 635.27(b)(2)(ii), available underharvest (up to 50 percent of the base annual quota) from the 2023 fishing year for these management groups may be added to their respective 2024 base quotas. Reported landings for blacktip sharks and smoothhound sharks have not exceeded their 2023 quotas to date.

Blacktip Sharks: The 2024 proposed commercial quota for blacktip sharks in the western Gulf of Mexico sub-region is 347.2 mt dw (765,392 lb dw) and in the eastern Gulf of Mexico sub-region is 37.7 mt dw (83,158 lb dw). As of May 12, 2023, preliminary reported landings for blacktip sharks in the Gulf of Mexico western sub-region were 65 percent (225.3 mt dw) of their 2023 quota (347.2 mt dw), and in the eastern sub-region were at 2 percent (0.6 mt dw) of their 2023 quota (37.7 mt dw). Consistent with § 635.27(b)(1)(ii)(C), any

underharvest would be divided between the two Gulf of Mexico sub-regions based on the percentages that are allocated to each sub-region (*i.e.,* 90.2 percent to the western sub-region and 9.8 percent to the eastern sub-region). As of May 12, 2023, the overall Gulf of Mexico blacktip shark management group is underharvested by 159.0 mt dw (350,307 lb dw). The proposed 2024 adjusted base annual quota for blacktip sharks in the western Gulf of Mexico sub-region is 347.2 mt dw (231.5 mt dw annual base quota + 115.7 mt dw 2023 underharvest = 347.2 mt dw 2024 adjusted annual quota) and in the eastern Gulf of Mexico sub-region is 37.7 mt dw (25.1 mt dw annual base quota + 12.6 mt dw 2023 underharvest = 37.7 adjusted annual quota).

Smoothhound Sharks: The 2024 proposed commercial quota for smoothhound sharks in the Gulf of Mexico region is 504.6 mt dw (1,112,441 lb dw) and in the Atlantic region is 1,802.6 mt dw (3,973,902 lb dw). As of May 12, 2023, there have been no smoothhound shark landings in the Gulf of Mexico region, and 3 percent (47.0 mt dw) of their 2023 quota (1,802.6 mt dw) has been landed in the Atlantic region. NMFS proposes to adjust the 2024 Gulf of Mexico and Atlantic smoothhound shark quotas for anticipated underharvests in 2023 to the full extent allowed. The proposed 2024 adjusted base annual quota for Gulf of Mexico smoothhound sharks is 504.6 mt dw (336.4 mt dw annual base quota + 168.2 mt dw 2023 underharvest = 504.6 mt dw 2024 adjusted annual quota) and for Atlantic smoothhound sharks is 1,802.6 mt dw (1,201.7 mt dw annual base quota + 600.9 mt dw 2023 underharvest = 1,802.6 mt dw 2024 adjusted annual quota).

Shark Management Groups Where Underharvests Cannot Be Carried Over

Consistent with the current regulations at § 635.27(b)(2)(ii), 2023 underharvests cannot be carried over to the 2024 fishing year for the following stocks or management groups because they are overfished, are experiencing overfishing, or have an unknown status: sandbar shark, aggregated LCS, hammerhead shark, non-blacknose SCS, blacknose shark, blue shark, porbeagle shark, and pelagic shark (other than porbeagle or blue sharks) management groups. For these stocks, the 2024 proposed commercial quotas reflect the codified annual base quotas, without adjustment for underharvest. At this time, no overharvests have occurred, which would require adjustment downward.

Aggregated LCS: The 2024 proposed commercial quota for aggregated LCS in the western Gulf of Mexico sub-region is 72.0 mt dw (158,724 lb dw) and in the eastern Gulf of Mexico sub-region is 85.5 mt dw (188,593 lb dw). The 2024 proposed commercial quota for aggregated LCS in the Atlantic region is 168.9 mt dw (372,552 lb dw). In a recent action, NMFS transferred 40.0 mt dw of aggregate LCS quota from the eastern Gulf of Mexico sub-region to the western Gulf of Mexico sub-region (88 FR 17742, March 24, 2023). That inseason quota transfer would not impact the proposed actions in this rulemaking. As of May 12, 2023, preliminary reported landings for aggregated LCS in the western Gulf of Mexico sub-region were at 68 percent (75.9 mt dw) of their 2023 quota (112.0 mt dw), in the eastern Gulf of Mexico sub-region were less than 1 percent (<1.0 mt dw) of their 2023 quota (45.5 mt dw), and in the Atlantic region were 25 percent (41.8 mt dw) of their 2023 quota (168.9 mt dw). Reported landings from both Gulf of Mexico sub-regions and the Atlantic region have not exceeded the 2023 overall aggregated LCS quota to date. Given the unknown status of some species in the aggregated LCS complex, the aggregated LCS quota cannot be adjusted for any underharvests. Based on preliminary estimates and catch rates from previous years, NMFS proposes that the 2024 quotas for aggregated LCS in the western and eastern Gulf of Mexico sub-regions and the Atlantic region be equal to their annual base quotas without adjustment.

Hammerhead Sharks: The 2024 proposed commercial quotas for hammerhead sharks in the western Gulf of Mexico sub-region is 11.9 mt dw (26,301 lb dw) and eastern Gulf of Mexico sub-region is 13.4 mt dw (29,421 lb dw). The 2024 proposed commercial quota for hammerhead sharks in the Atlantic region is 27.1 mt dw (59,736 lb dw). As of May 12, 2023, preliminary reported landings of hammerhead sharks in the western Gulf of Mexico sub-region were less than 25 percent (<3.0 mt dw) of their 2023 quota (11.9 mt dw), in the eastern Gulf of Mexico sub-region were less than 7 percent (<1.0 mt dw) of their 2023 quota (13.4 mt dw), and in the Atlantic region were at 48 percent (12.9 mt dw) of their 2023 quota (27.1 mt dw). Reported landings from the Gulf of Mexico sub-regions and the Atlantic region have not exceeded the 2023 overall hammerhead quota to date. Given the overfished status of the scalloped hammerhead shark, the hammerhead shark quota cannot be adjusted for any underharvests. Based on preliminary estimates and catch rates from previous years, NMFS proposes that the 2024 quotas for hammerhead sharks in the western and eastern Gulf of Mexico sub-regions and Atlantic region be equal to their annual base quotas without adjustment.

Blacknose Sharks: The 2024 proposed commercial quota for blacknose sharks in the Atlantic region is 17.2 mt dw (37,921 lb dw). This quota is available in the Atlantic region only for those vessels operating south of 34° N. latitude. North of 34° N. latitude, retention, landing, or sale of blacknose sharks is prohibited. As of May 12, 2023, preliminary reported landings of blacknose sharks in the Atlantic region were less than 17 percent (<3.0 mt dw) of their 2023 quota (17.2 mt dw). Given the overfished status of the blacknose shark, the blacknose shark quota cannot be adjusted for any underharvests. Based on preliminary estimates and catch rates from previous years, NMFS proposes that the 2024 quota for blacknose sharks in the Atlantic region be equal to their annual base quota without adjustment.

Non-Blacknose SCS: The 2024 proposed commercial quota for non-blacknose SCS in the Gulf of Mexico region is 112.6 mt dw (428,215 lb dw) and in the Atlantic region is 264.1 mt dw (582,333 lb dw). As of May 12, 2023, preliminary reported landings of non-blacknose SCS in the Gulf of Mexico were less than 1 percent (<1.0 mt dw) of their 2023 quota (112.6 mt dw) and in the Atlantic region were at 7 percent (18.8 mt dw) of their 2023 quota (264.1 mt). Given the unknown status of bonnethead sharks within Atlantic and Gulf of Mexico non-blacknose SCS management groups, underharvests cannot be carried forward. Based on preliminary estimates and catch rates from previous years, NMFS proposes that the 2024 quotas for non-blacknose SCS in the Gulf of Mexico and Atlantic regions be equal to their annual base quotas without adjustment.

Blue Sharks, Porbeagle Sharks, and Pelagic Sharks (Other Than Porbeagle and Blue Sharks): The 2024 proposed commercial quotas for blue sharks, porbeagle sharks, and pelagic sharks (other than porbeagle or blue sharks) are 273.0 mt dw (601,856 lb dw), 1.7 mt dw (3,748 lb dw), and 488.0 mt dw (1,075,856 lb dw), respectively. Given the current shortfin mako shark retention limit of zero in commercial and recreational HMS fisheries, the pelagic sharks (other than porbeagle or blue sharks) management group comprises only common thresher shark landings. As of May 12, 2023, landings of porbeagle sharks were less than 59

percent (<1.0 mt dw) of their 2023 quota (1.7 mt dw), and landings of blue sharks were less than 1 percent (<2.0 mt) of their 2023 quota (273.0 mt), and landings of pelagic sharks (other than porbeagle and blue sharks) were at 2 percent (9.9 mt dw) of their 2023 quota (488.0 mt dw). Given that all of these pelagic species are overfished, have overfishing occurring, or have an unknown status, underharvests cannot be carried forward. Based on preliminary estimates of catch rates from previous years, NMFS proposes that the 2024 quotas for blue sharks, porbeagle sharks, and pelagic sharks (other than porbeagle and blue sharks) be equal to their annual base quotas without adjustment.

Shark Research Fishery: The 2024 proposed commercial quotas within the shark research fishery are 50.0 mt dw (110,230 lb dw) for research LCS and 90.7 mt dw (199,943 lb dw) for sandbar sharks. Within the shark research fishery, as of May 12, 2023, preliminary reported landings of research LCS were less than 4 percent (<2.0 mt dw) of their 2023 quota (50.0 mt dw) and sandbar shark reported landings were less than 24 percent (<22.0 mt dw) of their 2023 quota (90.7 mt dw). Because sandbar sharks and scalloped hammerhead sharks within the research LCS management group are either overfished or overfishing is occurring, underharvests for these management groups cannot be carried forward. Based on preliminary estimates, NMFS proposes that the 2024 quotas in the shark research fishery be equal to their annual base quotas without adjustment.

Request for Comments

Comments on this proposed rule and on NMFS' determination that this proposed rule, if adopted, would not have a significant economic impact on a substantial number of small entities (as discussed below in the Classification section), may be submitted via *www.regulations.gov.* NMFS solicits comments on this proposed rule by September 1, 2023 (see **DATES** and **ADDRESSES**).

Classification

The NMFS Assistant Administrator has determined that this proposed rule is consistent with the 2006 Consolidated HMS FMP and its amendments, the Magnuson-Stevens Act, and other applicable law, subject to further consideration after public comment.

This proposed rule has been determined to be not significant for purposes of Executive Order 12866.

The Chief Counsel for Regulation of the Department of Commerce certified to the Chief Counsel for Advocacy of the Small Business Administration (SBA) that this proposed rule, if adopted, would not have a significant economic impact on a substantial number of small entities. The factual basis for this determination is as follows.

This proposed rule would adjust quotas and default retention limits and establish the opening date for the 2024 Atlantic shark commercial fisheries. This proposed rule would also consider options for 2024 and future years to automatically open the commercial fishing year on January 1 each year under the base quotas and retention limits and increase the default commercial retention limit for the LCS fisheries. NMFS would adjust quotas as required or allowable based on any overharvests and/or underharvests from the 2023 fishing year. NMFS has limited flexibility to otherwise modify the quotas in this proposed rule. NMFS notes that the impacts of the quotas (and any potential modifications based on overharvests or underharvests from the previous fishing year) were analyzed in previous regulatory flexibility analyses, including the initial regulatory flexibility analysis (IRFA) and the final regulatory flexibility analysis (FRFA) that accompanied the 2011 Atlantic shark commercial fishing year rule (75 FR 76302, December 8, 2010). That final rule established the opening dates and quotas for the 2011 fishing season and implemented new adaptive management measures, including flexible opening dates and inseason adjustments to shark trip limits. Consistent with the adaptive management measures implemented in 2011 and based on the most recent data, in this action NMFS proposes adjusted quotas, retention limits, and opening date to provide, to the extent practicable, fishing opportunities for commercial shark fishermen in all regions and areas.

This proposed rule's measures could affect fishing opportunities for commercial shark fishermen in the northwestern Atlantic Ocean, Gulf of Mexico, and Caribbean Sea. Section 603(b)(3) of the Regulatory Flexibility Act (RFA) requires Agencies to provide an estimate of the number of small entities to which the rule would apply. The SBA authorizes an agency to develop its own industry-specific size standards after consultation with the SBA Office of Advocacy and an opportunity for public comment (see 13 CFR 121.903(c)). Pursuant to this process, NMFS issued a final rule that established a small business size standard of $11 million in annual gross receipts for all businesses in the commercial fishing industry (NAICS 11411) for RFA compliance purposes (80 FR 81194, December 29, 2015; effective on July 1, 2016). The 2011 IRFA/FRFA analyzed the overall number of limited access permits, which covers all of our active participants today. NMFS still considers all HMS permit holders to be small entities because in total they have average annual receipts of less than $11 million for commercial fishing.

As of March 2023, this proposed rule would apply to the approximately 196 directed commercial shark permit holders, 240 incidental commercial shark permit holders, 153 smoothhound shark permit holders, and 55 commercial shark dealers. Not all permit holders are active in the fishery in any given year. Active directed commercial shark permit holders are defined as those with valid permits that landed one shark based on HMS electronic dealer reports. Of the 436 directed and incidental commercial shark permit holders, to date this year, 9 permit holders landed sharks in the Gulf of Mexico region, and 28 landed sharks in the Atlantic region. Of the 153 smoothhound shark permit holders, to date this year, 25 permit holders landed smoothhound sharks in the Atlantic region, and none have landed smoothhound sharks in the Gulf of Mexico region. As described below, NMFS has determined that all of these entities are small entities for purposes of the RFA.

Based on the 2022 ex-vessel prices (Table 3), fully harvesting the unadjusted 2024 Atlantic shark commercial base quotas could result in estimated total fleet revenues of $10,233,205. For adjusted management groups, the following are changes in potential revenues resulting from the adjustments proposed in this rule. For the Gulf of Mexico blacktip shark management group, NMFS is proposing to adjust the base sub-regional quotas upward due to underharvests in 2023. The increase for the western Gulf of Mexico blacktip shark management group could result in a potential $232,169 gain in total revenues for fishermen in that sub-region, while the increase for the eastern Gulf of Mexico blacktip shark management group could result in a potential $34,926 gain in total revenues for fishermen in that sub-region. For the Gulf of Mexico and Atlantic smoothhound shark management groups, NMFS is proposing to increase the base quotas due to underharvest in 2023. This would cause a potential gain in revenue of $381,938 for the fleet in the Gulf of Mexico region, and a potential gain in revenue of $1,483,590 for the fleet in the Atlantic

region. Since a small business is defined as having annual receipts not in excess of $11 million, and each individual shark fishing vessel would be its own entity, the total Atlantic shark fishery is within the small entity definition since the total revenue is less than $13 million (*i.e.,* the estimated total fleet revenues plus the potential gain in revenues due to underharvest). NMFS has also determined that the proposed rule would not likely affect any small governmental jurisdictions.

TABLE 3—AVERAGE EX-VESSEL PRICES PER lb dw FOR EACH SHARK MANAGEMENT GROUP, 2022

Region	Management group	Average ex-vessel meat price
Western Gulf of Mexico	Blacktip Sharks	$0.91
	Aggregated LCS	0.83
	Hammerhead Sharks	0.80
Eastern Gulf of Mexico	Blacktip Sharks	1.26
	Aggregated LCS	1.09
	Hammerhead Sharks	0.93
Gulf of Mexico	Non-Blacknose SCS	1.31
	Smoothhound Sharks	1.03
Atlantic	Aggregated LCS	1.27
	Hammerhead Sharks	0.72
	Non-Blacknose SCS	1.31
	Blacknose Sharks	1.38
	Smoothhound Sharks	1.12
No Region	Shark Research Fishery (Aggregated LCS)	1.22
	Shark Research Fishery (Sandbar only)	0.98
	Blue sharks	0.80
	Porbeagle sharks	.....
	Pelagic Sharks Other Than Porbeagle or Blue	1.51
All	Shark Fins	.....
Atlantic	Shark Fins	.....
Gulf of Mexico	Shark Fins	.....

All of these changes in gross revenues are similar to the gross revenues analyzed in the 2006 Consolidated HMS FMP and its Amendments 2, 3, 5a, 6, and 9. The final regulatory flexibility analyses for those amendments concluded that the economic impacts on these small entities from adjustments such as those contemplated in this action are expected to be minimal. In accordance with the 2006 Consolidated HMS FMP, as amended, NMFS now conducts annual rulemakings in which NMFS considers the potential economic impacts of adjusting the quotas for underharvests and overharvests. For the adjustments included in this proposed rule, NMFS concludes that the effects this proposed rule would have on small entities would be minimal.

In conclusion, although this proposed rule would adjust quotas based on over- and underharvest, automatically open the commercial fishing year on January 1 each year under base quotas and retention limits, and revise the default commercial retention limit for the LCS fisheries, this proposed rule does not practically change the regulations and management measures currently in place that govern commercial shark fishing in Federal waters of the northwestern Atlantic Ocean, Gulf of Mexico, and Caribbean Sea, nor does it effectively change how those shark fisheries have been managed over the past eight years. Furthermore, as described above, this action is not expected to significantly affect the amount of sharks caught and sold or result in any significant change in the ex-vessel revenues those fishermen could expect, because, for the most part, the proposed quotas, retention limits, and opening dates are the same as those for the prior year. In addition, as described above, for the areas in which this action proposes adjustments, the increases in revenues for the participating small entities are minimal. Therefore, NMFS has determined that this proposed rule, if adopted, would not have a significant economic impact on a substantial number of small entities. As a result, an IRFA is not required and none has been prepared. NMFS invites comments from the public on the information in this determination that this proposed rule, if adopted, would not have a significant economic impact on a substantial number of small entities.

This proposed rule contains no information collection requirements under the Paperwork Reduction Act of 1995.

List of Subjects in 50 CFR Part 635

Fisheries, Fishing, Fishing vessels, Foreign relations, Imports, Penalties, Reporting and recordkeeping requirements, Statistics, reaties.

Samuel D. Rauch, III,

Deputy Assistant Administrator for Regulatory Programs, National Marine Fisheries Service.

For the reasons set out in the preamble, NMFS proposes to amend 50 CFR part 635 as follows:

PART 635—ATLANTIC HIGHLY MIGRATORY SPECIES

■ 1. The authority citation for part 635 continues to read as follows:

Authority: 16 U.S.C. 971 *et seq.;* 16 U.S.C. 1801 *et seq.*

■ 2. In § 635.24, revise paragraph (a)(2) to read as follows:

§ 635.24 Commercial retention limits for sharks, swordfish, and BAYS tunas.

* * * * *

(a) * * *

(2) The commercial retention limit for LCS other than sandbar sharks for a person who owns or operates a vessel that has been issued a directed LAP for sharks and does not have a valid shark research permit, or a person who owns or operates a vessel that has been issued a directed LAP for sharks and that has been issued a shark research permit but does not have a NMFS-approved observer on board, may range between

0 and 55 LCS other than sandbar sharks per vessel per trip if the respective LCS management group(s) is open per §§ 635.27 and 635.28. Such persons may not retain, possess, or land sandbar sharks. At the start of each fishing year, the default commercial retention limit is 55 LCS other than sandbar sharks per vessel per trip unless NMFS determines otherwise and files with the Office of the Federal Register for publication notification of an inseason adjustment. During the fishing year, NMFS may adjust the retention limit per the inseason trip limit adjustment criteria listed in paragraph (a)(8) of this section.

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■ 3. In § 635.27, revise paragraphs (b)(2) introductory text and (b)(3) introductory text to read as follows:

§ 635.27 Quotas.

* * * * *

(b) * * *

(2) *Annual and inseason adjustments of commercial quotas.* NMFS will publish in the **Federal Register** any annual or inseason adjustments to the base annual commercial overall, regional, or sub-regional quotas. Unless the opening date of a commercial shark fishery is adjusted under paragraph (b)(3) of this section, on January 1 of each year, base quotas, as established in paragraph (b)(1) of this section, will be available, and any adjustments will be published in the **Federal Register**. Within a fishing year or at the start of a fishing year, NMFS may transfer quotas between regions and sub-regions of the same species or management group, as appropriate, based on the criteria in paragraph (b)(2)(iii) of this section.

* * * * *

(3) *Opening commercial fishing season.* Unless adjusted under this paragraph (b)(3), the commercial shark fisheries will open on January 1 of each year under the base quotas, as established in paragraph (b)(1) of this section. If NMFS determines a commercial shark fishery or a part of a commercial shark fishery should open on a date other than January 1, NMFS will file with the Office of the Federal Register for publication notification of the opening date(s) of the relevant overall, regional, or sub-regional shark fishery(ies) for the relevant species or management group(s). Before making any decisions, NMFS would consider the following criteria and other relevant factors in establishing the opening date(s):

* * * * *

■ 4. In § 635.28, revise paragraphs (b)(2) and (3) to read as follows:

§ 635.28 Fishery closures.

* * * * *

(b) * * *

(2) *Non-linked quotas.* If the overall, regional, and/or sub-regional quota of a species or management group is not linked to another species or management group and that overall, regional, and/or sub-regional quota is available, then that overall, regional, and/or sub-regional commercial fishery for the shark species or management group will open as specified in § 635.27(b). When NMFS calculates that the overall, regional, and/or sub-regional landings for a shark species and/or management group, as specified in § 635.27(b)(1), has reached or is projected to reach 80 percent of the applicable available overall, regional, and/or sub-regional quota as specified in § 635.27(b)(1) and is projected to reach 100 percent of the relevant quota by the end of the fishing season, NMFS will file for publication with the Office of the Federal Register a closure action, as applicable, for that shark species and/or shark management group that will be effective no fewer than 4 days from date of filing. From the effective date and time of the closure until the start of the following fishing year or until NMFS announces, via the publication of a notice in the **Federal Register**, that additional overall, regional, and/or sub-regional quota is available and the season is reopened, the overall, regional, and/or sub-regional fisheries for that shark species or management group are closed.

(3) *Linked quotas.* As specified in paragraph (b)(4) of this section, the overall, regional, and/or sub-regional quotas of some shark species and/or management groups are linked to the overall, regional, and/or sub-regional quotas of other shark species and/or management groups. For each pair of linked species and/or management groups, if the overall, regional, and/or sub-regional quota specified in § 635.27(b)(1) is available for each pair of linked species and/or management groups, then the overall, regional, and/or sub-regional commercial fishery for both of the linked species and/or management groups will open as specified in § 635.27(b)(1). When NMFS calculates that the overall, regional, and/or sub-regional landings for any species and/or management group of a linked group have reached or are projected to reach 80 percent of the applicable available overall, regional, and/or sub-regional quota as specified in § 635.27(b)(1) and are projected to reach 100 percent of the relevant quota before the end of the fishing season, NMFS will file for publication with the Office of the Federal Register a closure action for all of the species and/or management groups in that linked group that will be effective no fewer than 4 days from date of filing. From the effective date and time of the closure until the start of the following fishing year or until NMFS announces, via the publication of a notice in the **Federal Register**, that additional overall, regional, and/or sub-regional quota is available and the season is reopened, the overall, regional, and/or sub-regional fishery for all species and/or management groups in that linked group is closed.

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[FR Doc. 2023–15967 Filed 8–1–23; 8:45 am]

BILLING CODE 3510–22–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 635

[RTID 0648–XD183]

Atlantic Highly Migratory Species; Amendments 15 and 16 to the 2006 Consolidated Atlantic Highly Migratory Species Fishery Management Plan

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

ACTION: Notice of additional public hearing locations.

SUMMARY: On May 5, 2023, NMFS published a proposed rule for Amendment 15 to the 2006 Consolidated Highly Migratory Species (HMS) Fishery Management Plan (FMP) on spatial fisheries management and electronic monitoring cost allocation. On May 8, 2023, NMFS published a notice of intent for scoping of Amendment 16 to the 2006 Consolidated HMS FMP on shark management. In both actions, NMFS announced several public hearings and webinars to provide the opportunity for public comment. This notice announces that NMFS is adding a public hearing for both Amendment 15 and Amendment 16 based on public interest.

DATES: NMFS will hold one additional public hearing on Draft Amendment 15 and its proposed rule and another public hearing on the scoping document for Amendment 16. See **SUPPLEMENTARY INFORMATION** for all meeting dates and times. See **SUPPLEMENTARY INFORMATION**

in the Amendment 15 proposed rule (May 5, 2023, 88 FR 29050) and Amendment 16 notice of intent (May 8, 2023, 88 FR 29617) for the other public hearings and conference calls dates, times, and locations.

ADDRESSES: NMFS will hold a public hearing on the proposed rule for Amendment 15 and its proposed rule in Panama City, FL, and a public hearing on the scoping document for Amendment 16 in San Juan, PR. For specific location, date and time see the **SUPPLEMENTARY INFORMATION** section of this document.

Electronic copies of the draft document for Amendment 15 to the 2006 Consolidated HMS FMP (*https://www.fisheries.noaa.gov/action/amendment-15-2006-consolidated-hms-fishery-management-plan-spatial-fisheries-management-and*) and the scoping document for Amendment 16 to the 2006 Consolidated HMS FMP (*https://www.fisheries.noaa.gov/action/scoping-amendment-16-2006-consolidated-atlantic-highly-migratory-species-fishery-management*) may be obtained on the internet.

FOR FURTHER INFORMATION CONTACT: Guy DuBeck (*Guy.DuBeck@noaa.gov*), Steve Durkee (*Steve.Durkee@noaa.gov*), Larry Redd (*Larry.Redd@noaa.gov*), and Karyl Brewster-Geisz (*Karyl.Brewster-Geisz@noaa.gov*), by email, or by phone at (301) 427–8503.

SUPPLEMENTARY INFORMATION:

Background

Atlantic HMS fisheries are managed under the authority of the Magnuson-Stevens Fishery Conservation and Management Act (Magnuson-Stevens Act; 16 U.S.C. 1801 *et seq.*) and the Atlantic Tunas Convention Act (16 U.S.C. 971 *et seq.*). The 2006 Consolidated HMS FMP and its amendments are implemented by regulations at 50 CFR part 635.

On May 5, 2023, NMFS published a proposed rule (88 FR 29050) for Draft Amendment 15 to the 2006 Consolidated HMS FMP on spatial fisheries management and electronic monitoring cost allocation. On May 8, 2023, NMFS published a notice of intent (88 FR 29617) for scoping of Amendment 16 to the 2006 Consolidated HMS FMP on shark management. In both actions, NMFS announced public hearings and webinars to provide the opportunity for public comment. Due to requests for additional public hearings, NMFS has decided conduct an additional public hearing for Draft Amendment 15 and its proposed rule in Panama City, FL, and an additional public hearing for scoping for Amendment 16 in San Juan, PR (Table 1). None of the other public hearing timing or locations have changed.

TABLE 1—DATES, TIMES, AND LOCATIONS OF UPCOMING PUBLIC HEARINGS AND CONFERENCE CALLS

Rulemaking	Venue	Date/time	Street address/webinar information
Amendment 16	Public Hearing	August 16, 2023, 5:30 p.m.–8:30 p.m.	Embassy Suites, 8000 Jose M. Tartak Avenue, San Juan, PR 00979.
Amendment 15	Public Hearing	August 29, 2023, 5 p.m.–8 p.m.	National Marine Fisheries Service, Southeast Fisheries Science Center, 3500 Delwood Beach Road, Panama City, FL 32408.

The public is reminded that NMFS expects participants to conduct themselves appropriately. At the beginning of each meeting, a representative of NMFS will explain the ground rules (*e.g.,* all comments are to be directed to the Agency; attendees will be called to give their comments in the order in which they registered to speak; each attendee will have an equal amount of time to speak; and attendees should not interrupt one another). The in-person meeting locations will be physically accessible to people with disabilities. Requests for sign language interpretation or other auxiliary aids should be directed to Guy DuBeck or Steve Durkee at 301–427–8503, at least 7 days prior to the meeting. A NMFS representative will attempt to structure the meeting so that all attending members of the public will be able to comment if they so choose, regardless of the controversial nature of the subject matter. If attendees do not respect the ground rules they will be asked to leave the meeting.

Dated: July 28, 2023.

Jennifer M. Wallace,

Acting Director, Office of Sustainable Fisheries, National Marine Fisheries Service.

[FR Doc. 2023–16440 Filed 8–1–23; 8:45 am]

BILLING CODE 3510–22–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 660

RIN 0648–BM28

Magnuson-Stevens Act Provisions; Fisheries Off West Coast States; Pacific Coast Groundfish Fishery; Pacific Coast Groundfish Fishery Management Plan; Amendment 32; Modifications to Non-Trawl Area Management Measures

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

ACTION: Announcement of availability of proposed fishery management plan amendment; request for comments.

SUMMARY: NMFS announces that the Pacific Fishery Management Council submitted Amendment 32 to the Pacific Coast Groundfish Fishery Management Plan to the Secretary of Commerce for review. If approved, Amendment 32 would: create a new type of Essential Fish Habitat Conservation Area that prohibits fishing with non-trawl bottom contact gear for all groundfish fisheries and the non-tribal directed commercial halibut fishery; remove the Cowcod Conservation Area seaward of California for commercial and recreational groundfish non-trawl fisheries; create and authorize the use of Groundfish Exclusion Areas as a new type of Groundfish Conservation Area; authorize the use of Block Area Closures for groundfish non-trawl fisheries, and make necessary administrative changes to relevant sections of the Pacific Coast Groundfish Fishery Management Plan. Altogether, these changes are anticipated to provide additional fishing opportunity to groundfish non-trawl fishery sectors while continuing to protect rebuilding yelloweye rockfish and mitigating fishing impacts to sensitive areas.

DATES: Comments on Amendment 32 must be received on or before Sunday, October 1, 2023.

ADDRESSES: You may submit comments on this document, identified by NOAA–NMFS–2023–0051, by the following method:

• *Electronic Submission:* Submit all electronic public comments via the Federal e-Rulemaking Portal. Go to *https://www.regulations.gov* and enter NOAA–NMFS–2023–0051, in the Search box. Click on the ''Comment'' icon, complete the required fields, and enter or attach your comments.

Instructions: Comments must be submitted by the above method to ensure that the comments are received, documented, and considered by NMFS. Comments sent by any other method, to any other address or individual, or received after the end of the comment period, may not be considered. All comments received are a part of the public record and NMFS will post for public viewing on *www.regulations.gov* without change. All personal identifying information (*e.g.,* name, address, *etc.*), confidential business information, or otherwise sensitive information submitted voluntarily by the sender is publicly accessible. NMFS will accept anonymous comments (enter ''N/A'' in the required fields if you wish to remain anonymous).

Electronic Access

This notification of availability is accessible via the internet at the Office of the Federal Register website at *https://www.federalregister.gov/*. Information relevant to Amendment 32, which includes a draft Environmental Assessment, a regulatory impact review, a Regulatory Flexibility Act certification, and a Magnuson Stevens Fishery Conservation and Management Act (Magnuson-Stevens Act) analysis, are accessible via the internet at the NMFS West Coast Region website at: *https://www.fisheries.noaa.gov/west-coast/laws-and-policies/west-coast-region-national-environmental-policy-act-documents.*

FOR FURTHER INFORMATION CONTACT: Lynn Massey, phone, or email: 562–900–2060, *Lynn.Massey@noaa.gov.*

SUPPLEMENTARY INFORMATION: NMFS manages the groundfish fisheries in the exclusive economic zone (EEZ) seaward of Washington, Oregon, and California under the Pacific Coast Groundfish fishery management plan (FMP). The Pacific Fishery Management Council (Council) prepared and NMFS implemented the Pacific Coast Groundfish FMP under the authority of the Magnuson-Stevens Act, 16 U.S.C. 1801 *et seq.* and by regulations at 50 CFR parts 600 and 660. The Magnuson-Stevens Act requires that each regional fishery management council submit any FMP or plan amendment it prepares to NMFS for review and approval, disapproval, or partial approval by the Secretary of Commerce. The Magnuson-Stevens Act also requires that NMFS, upon receiving an FMP or amendment, immediately publish a notice that the FMP or amendment is available for public review and comment. This notification announces that the proposed Amendment 32 to the FMP is available for public review and comment. NMFS will consider the public comments received during the comment period described above in determining whether to approve, partially approve, or disapprove Amendment 32 to the FMP.

Background

In the early 2000s, several types of groundfish conservation areas (GCAs, defined at § 660.11) were enacted to protect overfished groundfish species off the U.S. West Coast, including the coastwide Non-Trawl Rockfish Conservation Area (Non-Trawl RCA, (68 FR 907, January 7, 2003)) and the Cowcod Conservation Areas (CCAs, (66 FR 2338, January 11, 2001)) in the Southern California Bight. With the rebuilt status of almost all of these groundfish species (the exception being yelloweye rockfish, which is projected to rebuild by 2029), the Council has been prioritizing increased fishing access to these areas for groundfish non-trawl fisheries (*i.e.,* the directed open access sector, the California recreational sector, the limited entry fixed gear sector, and vessels that use non-trawl gear under the Trawl Individual Fishing Quota Program). In November 2019, the Council directed the Groundfish Advisory Subpanel (GAP) to develop the scope of action and draft a purpose and need statement for non-trawl area management modifications during the GAP's March and April 2020 meetings. The GAP then submitted an informational report (see Informational Report 4 in the June 2020 briefing book at *pcouncil.org*) for Council consideration and scheduling of further scoping of the issues. In April 2021, the Council initiated a scoping process to address modifying Non-Trawl RCA catch restrictions and boundaries (see Agenda Item F.3, Attachment 2 in the April 2021 briefing book at *pcouncil.org*). In November 2021 and April 2022, the Council further refined the range of alternatives, which included expanding the action to include changes to the CCA (East and West) seaward of California, consideration of new closed areas (*i.e.,* Groundfish Exclusion Areas (GEAs) and Yelloweye Rockfish Conservation Areas (YRCAs)), and changes to Essential Fish Habitat Conservation Areas (EFHCAs) that exposed to fishing activity under the alternatives. The Council selected a preliminary preferred range of alternatives at their September 2022 meeting and a final range of alternatives at their March 2023 meeting. The resulting final action constitutes Amendment 32 to the Pacific Coast Groundfish FMP. Amendment 32 and its implementing regulations would provide additional fishing opportunity in these closures through a suite of modifications to GCA boundaries, gear specifications, and catch restrictions, while continuing to protect rebuilding yelloweye rockfish and mitigating fishing impacts to sensitive areas. These regulatory changes will be presented in a forthcoming proposed rule.

In terms of specific changes to the Pacific Coast Groundfish FMP, Amendment 32 would: (1) create a new type of EFHCA that prohibits fishing with non-trawl bottom contact gear for all groundfish fisheries and the non-tribal directed commercial halibut fishery; (2) remove the CCA for commercial and recreational groundfish non-trawl fisheries; (3) create and authorize the use of GEAs as a new type of GCA; (4) authorize the use of Block Area Closures (BACs) for groundfish non-trawl fisheries, and (5) make necessary administrative changes to relevant sections of the Pacific Coast Groundfish FMP. Each of these changes is further described below.

New Type of Essential Fish Habitat Conservation Area

The Magnuson-Stevens Act requires that FMPs describe and identify essential fish habitat (EFH) and minimize to the extent practicable adverse effects on EFH caused by fishing. The Pacific Coast Groundfish FMP authorizes the use of EFHCAs (Amendment 19, 71 FR 27408, May 11, 2006; Amendment 28, 84 FR 63966, November 19, 2019) to protect groundfish EFH from specific types of fishing activity. Federal regulations at 50 CFR 660.75 through 660.79 provide the coordinates for all current EFHCAs off the U.S. West Coast. At present, there are two types of EFHCAs based on gear type: bottom trawl and bottom contact. Both bottom trawl and bottom contact EFHCAs apply to all fisheries utilizing that gear type and are not limited in application to groundfish fisheries. Amendment 32 would create a new type of EFHCA that prohibits using

non-trawl bottom contact gear (*e.g.,* pot/longline) in the non-tribal groundfish fisheries and the non-tribal directed commercial halibut fishery. In the forthcoming proposed rule, NMFS is proposing moving the seaward boundary of the Non-Trawl RCA from 100 fathoms (fm, 183 meters (m)) to 75 fm (137 m) off the coast of Oregon. The purpose of this new type of EFHCA is to protect groundfish EFH that would be newly exposed to non-trawl bottom contact gear as a result of this change. Specifically, five new EFHCAs would be established: (1) Nehalem Bank East; (2) Bandon High Spot East; (3) Arago Reef West; (4) Garibaldi Reef North; and (5) Garibaldi Reef South. All of these new EFHCAs overlap partially or entirely with existing bottom trawl EFHCAs, which is why the specified gear prohibition only includes non-trawl bottom contact gear (*i.e.,* bottom trawl gear is already prohibited in these areas).

Removing the Cowcod Conservation Area for Groundfish Non-Trawl Fisheries

The CCA was enacted in 2001 to protect overfished cowcod (Amendment 16–3, 66 FR 2338, January 11, 2001), which was declared rebuilt in 2019. The CCA is comprised of the Western and Eastern CCAs and applies to all commercial and recreational groundfish fisheries, including those that use both trawl and non-trawl gear. Amendment 32 would remove the CCA for all groundfish non-trawl fisheries; the CCA would remain in place for groundfish trawl fisheries. The purpose of this change is to provide fishing opportunity in this area given that cowcod has been declared rebuilt.

Groundfish Exclusion Areas

Amendment 32 would create a new type of GCA called GEAs, which are intended to mitigate the impacts to sensitive environments from certain groundfish fishing activity. Specifically, eight GEAs would be established: (1) Hidden Reef; (2) West of Santa Barbara Island; (3) Potato Bank; (4) 107/118 Bank; (5) Cherry Bank; (6) Seamount 109; (7) Northeast Bank; and (8) The 43-Fathom Spot. All of these GEAs would be located in the Southern California Bight within the area that non-trawl CCA restrictions would be removed. The purpose of this change is to create a GCA that can be used to protect sensitive environments that are separate and distinct from groundfish EFH.

Block Area Closures for Groundfish Non-Trawl Fisheries

The Pacific Coast Groundfish FMP currently authorizes the use of BACs to control bycatch of groundfish in trawl fisheries. Amendment 28 to the FMP (84 FR 63966, November 19, 2019) first established BACs as a management tool. The salmon bycatch minimization measures action (86 FR 10857, February 23, 2021) expanded BACs as a tool to minimize salmon bycatch. Amendment 32 would expand the use of BACs to be enacted for groundfish non-trawl fisheries. The purpose of this change is to create a mechanism to control bycatch of groundfish, as well as protected or prohibited species from non-trawl fisheries given the new flexibilities that would result from the approval of Amendment 32 and its proposed regulations.

Administrative Changes

The Council and NMFS are proposing additional changes to the relevant sections of the Pacific Coast Groundfish FMP being modified by Amendment 32. These changes include revising the terms ''Bottom Contact Closed Areas'' and ''Bottom Trawl Closed Areas'' to ''Bottom Trawl Essential Fish Habitat Conservation Areas'' and ''Bottom Contact Essential Fish Habitat Conservation Areas.'' Revising this terminology throughout the FMP will make these terms consistent with how they appear in Federal Regulations, maps, and Council records. These changes would also include adding a placeholder in Section 1.1 for a description of Amendment 31 to the Pacific Coast Groundfish FMP, as it is likely that Amendment 32 would be approved before Amendment 31.

NMFS welcomes comments on the proposed FMP amendment through the end of the comment period. A proposed rule to implement Amendment 32 has been submitted for Secretarial review and approval. NMFS expects to publish and request public review and comment on proposed regulations to implement Amendment 32 in the near future. For public comments on the proposed rule to be considered in the approval or disapproval decision on Amendment 32, those comments must be received by the end of the comment period on the amendment. All comments received by the end of the comment period for the amendment, whether specifically directed to the amendment or the proposed rule, will be considered in the approval/disapproval decision.

(Authority: 16 U.S.C. 1801 *et seq.*)

Dated: July 24, 2023.

Jennifer M. Wallace,

Acting Director, Office of Sustainable Fisheries, National Marine Fisheries Service.

[FR Doc. 2023–15966 Filed 8–1–23; 8:45 am]

BILLING CODE 3510–22–P

Notices

Federal Register
Vol. 88, No. 147
Wednesday, August 2, 2023

This section of the FEDERAL REGISTER contains documents other than rules or proposed rules that are applicable to the public. Notices of hearings and investigations, committee meetings, agency decisions and rulings, delegations of authority, filing of petitions and applications and agency statements of organization and functions are examples of documents appearing in this section.

DEPARTMENT OF COMMERCE

Foreign-Trade Zones Board

[B–47–2023]

Foreign-Trade Zone (FTZ) 183, Notification of Proposed Production Activity; Flextronics America, LLC; (Automatic Data Processing Machines); Austin, Texas

Flextronics America, LLC submitted a notification of proposed production activity to the FTZ Board (the Board) for its facility in Austin, Texas within Subzone 183C. The notification conforming to the requirements of the Board's regulations (15 CFR 400.22) was received on July 28, 2023.

Pursuant to 15 CFR 400.14(b), FTZ production activity would be limited to the specific foreign-status material(s)/component(s) and specific finished product(s) described in the submitted notification (summarized below) and subsequently authorized by the Board. The benefits that may stem from conducting production activity under FTZ procedures are explained in the background section of the Board's website—accessible via *www.trade.gov/ftz.* The proposed finished product(s) and material(s)/component(s) would be added to the production authority that the Board previously approved for the operation, as reflected on the Board's website.

The proposed finished products include: mass data storage units; various boards (logic; midplane; backplane); riser cards; structural frames and structural enclosures for mass data storage units; internal component support units; network switches; network adapters; network switch chassis; firewalls; IoT network security appliances; and, centralized network and firewall management appliances (duty rates are duty-free).

The proposed foreign-status materials and components include: clay desiccants; plastic components (labels; packaging; dust covers; insulators; bags for packaging); die cut polyurethane foams; pallet strap protectors; electrostatic discharge antistatic bags; cord organizers; kraft tape; pack boxes (cardboard; corrugated cardboard); paper components (labels; non-corrugated boxes; printed labels); printed instruction sheets; stainless steel metal components (screws; bolts; socket screws; hex screws; nuts; standoffs; washers; brackets; structural frames and structural enclosures for mass data storage units; contacts); steel components (springs; buttons); cooling fans for multiple disk drive storage units; various drives (hard disk; serial advanced technology attachment (SATA) solid state; flash storage); dual controller base arrays; dual in-line memory modules; various boards (logic (finished; unfinished); midplane; backplane; bare); riser cards; internal component support units; transformers; power supply units; power inductors; ferrite beads and bead filters; switches (network; push button); optical transceivers; adapters (fabric; ethernet); network interface cards; network switch chassis; loudspeakers for automatic data processing machines; software; capacitors (tantalum; aluminum electrolytic; multilayer ceramic chip; polymer); supercapacitors; flat chip resistors; fuses; resettable fuses; switches; connectors (printed circuit board; jumper wire); ethernet jacks; pin guides; Zener diodes; diodes; transistors; transistor chips; light-emitting diodes; mounted piezoelectric crystal oscillators; integrated circuits (microprocessor; dynamic random access memory (DRAM); static random access memory (SRAM); electrically erasable programmable read-only memory (EEPROM); flash memory; power management; programable logic; clock; switch; multiplexer; microprocessor); firewall or network security appliance components (printed circuit boards; chassis assemblies); and, cables (coaxial; ethernet; passive SFP+; power) (duty rate ranges from duty-free to 8.5%). The request indicates that certain materials/components are subject to duties under section 301 of the Trade Act of 1974 (section 301), depending on the country of origin. The applicable section 301 decisions require subject merchandise to be admitted to FTZs in privileged foreign status (19 CFR 146.41).

Public comment is invited from interested parties. Submissions shall be addressed to the Board's Executive Secretary and sent to: *ftz@trade.gov.* The closing period for their receipt is September 11, 2023.

A copy of the notification will be available for public inspection in the ''Online FTZ Information System'' section of the Board's website.

For further information, contact Juanita Chen at *juanita.chen@trade.gov.*

Dated: July 28, 2023.

Elizabeth Whiteman,

Executive Secretary.

[FR Doc. 2023–16458 Filed 8–1–23; 8:45 am]

BILLING CODE 3510–DS–P

DEPARTMENT OF COMMERCE

Bureau of Industry and Security

Agency Information Collection Activities; Submission to the Office of Management and Budget (OMB) for Review and Approval; Comment Request; Five-Year Records Retention Requirement for Export Transactions and Boycott Actions

The Department of Commerce will submit the following information collection request to the Office of Management and Budget (OMB) for review and clearance in accordance with the Paperwork Reduction Act of 1995, on or after the date of publication of this notice. We invite the general public and other Federal agencies to comment on proposed, and continuing information collections, which helps us assess the impact of our information collection requirements and minimize the public's reporting burden. Public comments were previously requested via the **Federal Register** on April 5, 2023, during a 60-day comment period. This notice allows for an additional 30 days for public comments.

Agency: Bureau of Industry and Security, Commerce Department.

Title: Five-Year Records Retention Requirement for Export Transactions and Boycott Actions.

OMB Control Number: 0694–0096.

Form Number(s): None.

Type of Request: Extension of a current information collection.

Number of Respondents: 100,000.

Average Hours per Response: 1 to 60 seconds.

Burden Hours: 258.

Needs and Uses: This collection is necessary under Sections 760 and 762.6(a) of the Export Administration Regulations (EAR). The five-year retention requirement corresponds with the statute of limitations for violations and is necessary to preserve potential evidence for investigations. All parties involved in the export, reexport, transshipment or diversion of items subject to the EAR and the U.S. party involved in the export transaction involving a reportable boycott request are required to maintain records of these activities for a period of five years. The frequency depends upon how often each entity is involved in an export transaction or one involving a reportable boycott request.

Affected Public: Business or other for-profit organizations.

Frequency: On Occasion.

Respondent's Obligation: Voluntary.

Legal Authority: 760 and 762.6(a) of the Export Administration Regulations (EAR).

This information collection request may be viewed at *www.reginfo.gov.* Follow the instructions to view the Department of Commerce collections currently under review by OMB.

Written comments and recommendations for the proposed information collection should be submitted within 30 days of the publication of this notice on the following website *www.reginfo.gov/public/do/PRAMain.* Find this particular information collection by selecting ''Currently under 30-day Review—Open for Public Comments'' or by using the search function and entering either the title of the collection or the OMB Control Number 0694–0096.

Sheleen Dumas,

Department PRA Clearance Officer, Office of the Under Secretary for Economic Affairs, Commerce Department.

[FR Doc. 2023–16374 Filed 8–1–23; 8:45 am]

BILLING CODE 3510–33–P

DEPARTMENT OF COMMERCE

International Trade Administration

[C–533–825]

Polyethylene Terephthalate Film, Sheet, and Strip From India: Preliminary Results of Countervailing Duty Administrative Review and Partial Rescission of Administrative Review; 2021

AGENCY: Enforcement and Compliance, International Trade Administration, Department of Commerce.

SUMMARY: The U.S. Department of Commerce (Commerce) preliminarily determines that countervailable subsidies are being provided to certain producers and exporters of polyethylene terephthalate film, sheet, and strip (PET film) from India during the period of review (POR) January 1, 2021, through December 31, 2021. We are rescinding this review with respect to seven companies. Interested parties are invited to comment on these preliminary results.

DATES: Applicable August 2, 2023.

FOR FURTHER INFORMATION CONTACT: John McGowan, AD/CVD Operations, Office I, Enforcement and Compliance, International Trade Administration, U.S. Department of Commerce, 1401 Constitution Avenue NW, Washington, DC 20230; telephone: (202) 482–0461.

Background

On July 1, 2002, Commerce published in the **Federal Register** the countervailing duty (CVD) order on PET film from India.[1] On September 6, 2022, Commerce published in the **Federal Register** the notice of initiation of an administrative review of the *Order* with respect to eight companies.[2] On October 27, 2022, Commerce selected SRF Ltd. (SRF) as the sole mandatory respondent.[3] Between December 2 and 5, 2022, DuPont Teijin Films, Mitsubishi Chemical America, Inc.—Polyester Film Division, and SK Microworks America, Inc. (collectively, the petitioners), Polyplex Corporation Ltd., and SRF withdrew their requests for review regarding all companies, except Jindal Poly Films Limited (Jindal).[4] Therefore, on December 9, 2022, we selected Jindal as the sole mandatory respondent.[5] On December 12, 2022, we reissued the initial questionnaire to the Government of India.[6] Subsequently, Jindal failed to provide a timely response to the affiliated companies portion of section III of the initial questionnaire by the December 26, 2022 deadline.[7] Pursuant to section 751(a)(3)(A) of the Tariff Act of 1930, as amended (the Act), Commerce extended the deadline for the preliminary results of this administrative review to July 28, 2023.[8]

For a complete description of the events that followed the initiation of this review, *see* the Preliminary Decision Memorandum.[9] A list of topics discussed in the Preliminary Decision Memorandum is included as Appendix I to this notice. The Preliminary Decision Memorandum is a public document and is on file electronically via Enforcement and Compliance's Antidumping and Countervailing Duty Centralized Electronic Service System (ACCESS). ACCESS is available to registered users at *https://access.trade.gov.* In addition, a complete version of the Preliminary Decision Memorandum can be accessed directly at *https://access.trade.gov/public/FRNoticesListLayout.aspx.*

Scope of the Order

The products covered by this *Order* are PET film from India. For a complete description of the scope, *see* the Preliminary Decision Memorandum.[10]

Methodology

Commerce is conducting this review in accordance with section 751(a)(l)(A) of the Act. For each of the subsidy programs found to be countervailable, we preliminarily determine that there is a subsidy, *i.e.,* a government-provided financial contribution that gives rise to a benefit to the recipient, and that the subsidy is specific.[11] For a full description of the methodology underlying our conclusions, including our reliance on adverse facts available pursuant to sections 776(a) and (b) of the Act, *see* the Preliminary Decision Memorandum.

[1] *See Countervailing Duty Order; Polyethylene Terephthalate Film Sheet, and Strip (PET Film) from India,* 67 FR 44179 (July 1, 2002) (*Order*).

[2] *See Initiation of Antidumping and Countervailing Duty Administrative Reviews,* 87 FR 54463 (September 6, 2022).

[3] *See* Memorandum, ''Respondent Selection,'' dated October 27, 2022.

[4] *See* Polyplex's Letter, ''Withdrawal of Request for Review for Polyplex USA LLC,'' dated December 2, 2022 (Polyplex Withdrawal Request); SRF's Letter, ''Withdrawal of Request for Countervailing Duty Admin Review of SRF,'' dated December 5, 2022 (SRF Withdrawal Request); and Petitioners' Letter, ''Withdrawal of Request for Countervailing Duty Administrative Review,'' dated December 5, 2022 (Petitioners Withdrawal Request).

[5] *See* Memorandum, ''Intent to Rescind Review, in Part, and Company Subject to Individual Examination,'' dated December 9, 2022.

[6] *See* Commerce's Letter, ''Countervailing Duty Questionnaire,'' dated December 12, 2022 (Initial Questionnaire).

[7] *Id.*

[8] *See* Memoranda, ''Extension of Deadline for Preliminary Results,'' dated March 28, 2023; and ''Second Extension of Deadline for Preliminary Results,'' dated May 17, 2023.

[9] *See* Memorandum, ''Decision Memorandum for the Preliminary Results of Countervailing Duty Administrative Review: Polyethylene Terephthalate Film, Sheet, and Strip (PET film) from India,'' dated concurrently with, and hereby adopted by, this notice (Preliminary Decision Memorandum).

[10] *Id.* at 3.

[11] *See* sections 771(5)(B) and (D) of the Act regarding financial contribution; section 771(5)(E) of the Act regarding benefit; and section 771(5A) of the Act regarding specificity.

Partial Rescission of Administrative Review

Pursuant to 19 CFR 351.213(d)(1), Commerce will rescind an administrative review, in whole or in part, if the parties that requested a review withdraw the request within 90 days of the date of publication of the notice of initiation. Commerce received timely-filed withdrawal requests with respect to the following seven companies: (1) Ester Industries Ltd.; (2) Garware Polyester Ltd.; (3) Vacmet India Ltd.; (4) MTZ Polyesters Ltd.; (5) Uflex Ltd.; (6) SRF; and (7) Polyplex.[12] Because the withdrawal requests were timely filed, and no other parties requested a review of these companies, in accordance with 19 CFR 351.213(d)(1), Commerce is rescinding this review of the *Order* with respect to the seven companies noted above.

Preliminary Results of Review

As a result of this review, we preliminarily determine that the following estimated countervailable subsidy rates exist for the period January 1, 2021, through December 31, 2021:

Company	Subsidy rate 2021 (percent ad valorem)
Jindal Poly Films Limited	116.96

Cash Deposit Requirements

Pursuant to section 751(a)(2)(C) of the Act, Commerce intends, upon publication of the final results, to instruct U.S. Customs and Border Protection (CBP) to collect cash deposits of estimated countervailing duties in the amounts shown for each of the respondents listed above on shipments of subject merchandise entered, or withdrawn from warehouse, for consumption on or after the date of publication of the final results of this administrative review. If the rate calculated in the final results is zero or *de minimis,* no cash deposit will be required on shipments of the subject merchandise entered or withdrawn from warehouse, for consumption on or after the date of publication of the final results of this review.

Assessment Rates

In accordance with 19 CFR 351.221(b)(4)(i), we preliminarily assigned subsidy rates in the amounts shown above for the producers/exporters shown above. Consistent with section 751(a)(1) of the Act and 19 CFR 351.212(b)(2), upon issuance of the final results, Commerce shall determine, and CBP shall assess, countervailing duties on all appropriate entries covered by this review. We intend to issue assessment instructions to CBP no earlier than 35 days after the date of publication of the final results of this review in the **Federal Register**. If a timely summons is filed at the U.S. Court of International Trade, the assessment instructions will direct CBP not to liquidate relevant entries until the time for parties to file a request for a statutory injunction has expired (*i.e.,* within 90 days of publication).

For the companies for which this review is rescinded with these preliminary results, we will instruct CBP to assess countervailing duties on all appropriate entries at a rate equal to the cash deposit of estimated countervailing duties required at the time of entry, or withdrawal from warehouse, for consumption, during the period January 1, 2021, through December 31, 2021, in accordance with 19 CFR 351.212(c)(l)(i).

Disclosure

Normally, Commerce discloses its calculations and analysis performed in connection with the preliminary results to interested parties within five days of its public announcement, or if there is no public announcement, within five days of the date of publication of this notice, in accordance with 19 CFR 351.224(b). However, because Commerce preliminarily applied total adverse facts available (AFA) in the calculation of the benefit for Jindal, and the applied AFA rates are based on rates calculated in prior segments of the proceeding, there are no calculations to disclose.

Public Comment

Case briefs or other written comments may be submitted to the Assistant Secretary for Enforcement and Compliance no later than 30 days after the publication of these preliminary results of review in the **Federal Register**.[13] Rebuttal comments, limited to issues raised in case briefs, may be submitted no later than seven days after the deadline for filing case briefs.[14] Parties who submit case or rebuttal briefs in this administrative review are encouraged to submit with each argument: (1) a statement of the issue; (2) a brief summary of the argument; and (3) a table of authorities.[15] Case and rebuttal briefs must be filed using ACCESS.[16] An electronically filed document must be received successfully in its entirety by ACCESS by 5:00 p.m. Eastern Time on the established deadline. Note that Commerce has temporarily modified certain of its requirements for serving documents containing business proprietary information, until further notice.[17]

Pursuant to 19 CFR 351.310(c), interested parties who wish to request a hearing, limited to issues raised in the case and rebuttal briefs, must submit a written request to the Assistant Secretary for Enforcement and Compliance, U.S. Department of Commerce, filed electronically using ACCESS. An electronically-filed request must be received successfully, and in its entirety, by ACCESS by 5:00 p.m. Eastern Time, within 30 days after the date of publication of this notice. Hearing requests should contain: (1) the party's name, address, and telephone number; (2) the number of participants; and (3) a list of the issues to be discussed. If a request for a hearing is made, parties will be notified of the date and time for the hearing to be determined.

Final Results

Unless extended, we intend to issue the final results of this administrative review, which will include the results of our analysis of the issues raised in the case briefs, within 120 days of publication of these preliminary results in the **Federal Register**, pursuant to section 751(a)(3)(A) of the Act.

Notification to Interested Parties

These preliminary results of review are issued and published in accordance with sections 751(a)(1) and 777(i)(1) of the Act, and 19 CFR 351.213 and 351.221(b)(4).

Dated: July 27, 2023.

Abdelali Elouaradia,

Deputy Assistant Secretary for Enforcement and Compliance.

Appendix I

List of Topics Discussed in the Preliminary Decision Memorandum

I. Summary
II. Background
III. Scope of the *Order*
IV. Partial Rescission of Administrative Review

[12] *See* Polyplex Withdrawal Request; SRF Withdrawal Request; and Petitioners Withdrawal Request.

[13] *See* 19 CFR 351.309(c)(1)(ii).

[14] *See* 19 CFR 351.309(d).

[15] *See* 19 CFR 351.309(c)(2) and 351.309(d)(2).

[16] *See* 19 CFR 351.303.

[17] *See* 19 CFR 351.309; 19 CFR 351.303 (for general filing requirements); and *Temporary Rule Modifying AD/CVD Service Requirements Due to COVID–19; Extension of Effective Period,* 85 FR 41363 (July 10, 2020).

V. Use of Facts Otherwise Available and Adverse Inferences
VI. Analysis of Programs
VIII. Recommendation

Appendix II

List of Companies Commerce Is Rescinding on in This Administrative Review

1. Ester Industries Ltd.
2. Garware Polyester Ltd.
3. Vacmet India Ltd.
4. MTZ Polyesters Ltd.
5. Uflex Ltd.
6. SRF Ltd.
7. Polyplex Corporation Ltd.

[FR Doc. 2023–16464 Filed 8–1–23; 8:45 am]

BILLING CODE 3510–DS–P

DEPARTMENT OF COMMERCE

International Trade Administration

[A–583–856]

Certain Corrosion-Resistant Steel Products From Taiwan: Preliminary Results of Antidumping Duty Administrative Review and Preliminary Determination of No Shipments; 2021–2022

AGENCY: Enforcement and Compliance, International Trade Administration, Department of Commerce.

SUMMARY: The U.S. Department of Commerce (Commerce) is conducting an administrative review of the antidumping duty order on certain corrosion-resistant steel products (CORE) from Taiwan. We preliminarily determine that producers/exporters subject to this review did not make sales of subject merchandise at less than normal value during the period of review (POR) July 1, 2021, through June 30, 2022. We further preliminarily determine that Xxentria Technology Materials Company Ltd. (Xxentria) had no shipments during the POR. We invite interested parties to comment on these preliminary results.

DATES: Applicable August 2, 2023.

FOR FURTHER INFORMATION CONTACT: Matthew Palmer or Deborah Cohen, AD/CVD Operations, Office III, Enforcement and Compliance, International Trade Administration, U.S. Department of Commerce, 1401 Constitution Avenue NW, Washington, DC 20230; telephone: (202) 482–1678 and (202) 482–4521, respectively.

SUPPLEMENTARY INFORMATION:

Background

On July 25, 2016, Commerce published the antidumping duty order on CORE from Taiwan in the **Federal Register**.[1] On September 6, 2022, pursuant to section 751(a)(1) of the Tariff Act of 1930, as amended (the Act), Commerce initiated an administrative review of the *Order* covering the following respondents: (1) Yieh Phui Enterprise Co., Ltd. (YP); (2) Prosperity Tieh Enterprise Co., Ltd. (Prosperity); (3) Sheng Yu Steel Co., Ltd. (SYSCO); (4) Synn Industrial Co., Ltd. (Synn); (5) China Steel Corporation (CSC); (6) Chung Hung Steel Corporation (CHSC); (7) Great Fortune Steel Co., Ltd. (Great Fortune); (8) Great Grandeul Steel Co., Ltd. (Great Grandeul); (9) Great Grandeul Steel Company Limited (Somoa) (also known as, Great Grandeul Steel Company Limited Somoa) (Great Grandeul Somoa); (10) Great Grandeul Steel Corporation (Great Grandeul Steel); and (11) Xxentria.[2] However, pursuant to the recently-issued final judgement of the U.S. Court of International Trade (the Court) in *Prosperity V,*[3] concerning the litigation of the underlying less-than-fair-value (LTFV) investigation of the *Order,* Commerce intends to issue an amended final antidumping duty determination of sales at LTFV which reflects a below *de minimis* margin for the collapsed YP/Synn entity that results in the exclusion of YP and Synn from the *Order* and all subsequent segments of the proceeding, including the instant administrative review. Accordingly, we hereby provide notification of the discontinuation of the instant administrative review with respect to the respondent selected for individual examination, YP, and the non-selected respondent, Synn.[4] As a result, Prosperity remains the sole respondent selected for individual examination in this review.

On March 7, 2023, we extended the preliminary results of this review to no later than July 28, 2023.[5] For a complete description of the events that followed the initiation of this review, *see* the Preliminary Decision Memorandum. A list of topics discussed in the Preliminary Decision Memorandum is included as an appendix to this notice. The Preliminary Decision Memorandum is a public document and is on file electronically via Enforcement and Compliance's Antidumping and Countervailing Duty Centralized Electronic Service System (ACCESS). ACCESS is available to registered users at *https://access.trade.gov.* In addition, the complete Preliminary Decision Memorandum can be accessed directly at *https://access.trade.gov/public/FRNoticesListLayout.aspx.*

Scope of the Order

The products covered by the *Order* are flat-rolled steel products, either clad, plated, or coated with corrosion-resistant metals such as zinc, aluminum, or zinc-, aluminum-, nickel- or iron-based alloys, whether or not corrugated or painted, varnished, laminated, or coated with plastics or other non-metallic substances in addition to the metallic coating. The subject merchandise is currently classifiable under the Harmonized Tariff Schedule of the United States (HTSUS) subheadings: 7210.30.0030, 7210.30.0060, 7210.41.0000, 7210.49.0030, 7210.49.0040, 7210.49.0045, 7210.49.0091, 7210.49.0095, 7210.61.0000, 7210.69.0000, 7210.70.6030, 7210.70.6060, 7210.70.6090, 7210.90.6000, 7210.90.9000, 7212.20.0000, 7212.30.1030, 7212.30.1090, 7212.30.3000, 7212.30.5000, 7212.40.1000, 7212.40.5000, 7212.50.0000, and 7212.60.0000. The products subject to the orders may also enter under the following HTSUS item numbers: 7210.90.1000, 7215.90.1000, 7215.90.3000, 7215.90.5000, 7217.20.1500, 7217.30.1530, 7217.30.1560, 7217.90.1000, 7217.90.5030, 7217.90.5060, 7217.90.5090, 7225.91.0000, 7225.92.0000, 7225.99.0090, 7226.99.0110, 7226.99.0130, 7226.99.0180, 7228.60.6000, 7228.60.8000, and 7229.90.1000. The HTSUS subheadings above are provided for convenience and customs purposes only. The written description of the scope of the *Order* is dispositive. For the full text of the scope of the *Order, see* the Preliminary Decision Memorandum

Preliminary Determination of No Shipments

On October 4, 2022, Synn submitted a letter certifying that it had no exports or sales of subject merchandise into the

[1] *See Certain Corrosion-Resistant Steel Products from India, Italy, the People's Republic of China, the Republic of Korea and Taiwan: Amended Final Affirmative Antidumping Determination for India and Taiwan, and Antidumping Duty Orders,* 81 FR 48390 (July 25, 2016) (*Order*).

[2] *See Initiation of Antidumping and Countervailing Duty Administrative Reviews,* 87 FR 54463 (September 6, 2022).

[3] *See Prosperity Tieh Enterprise Co., Ltd. and Yieh Phui Enterprise Co., Ltd.* v. *United States,* Consolidated Court No. 16–00138, Slip Op. 23–95 (CIT 2023) (*Prosperity V*).

[4] *See* Memorandum, ''Decision Memorandum for the Preliminary Results of the 2021–2022 Antidumping Duty Administrative Review: Certain Corrosion-Resistant Steel Products from Taiwan,'' dated concurrently with, and hereby adopted by, this notice (Preliminary Decision Memorandum).

[5] *See* Memorandum, ''Extension of Deadline for Preliminary Results,'' dated March 7, 2023.

United States during the POR.[6] On October 5, 2022, Xxentria submitted a letter certifying that it had no exports or sales of subject merchandise into the United States during the POR.[7] As discussed above, Synn is excluded from the *Order,* and this review is discontinued with respect to Synn pursuant to the final judgement of the Court in *Prosperity V.* Thus, no preliminary finding with respect to Synn's no-shipments certification is necessary. Currently, the record contains no information which contradicts Xxentria's claims, and therefore, we preliminarily determine that Xxentria did not have any reviewable transactions during the POR, though Commerce may revisit this finding following these preliminary results if we receive additional information from U.S. Customs and Border Protection (CBP) to contradict this finding. Our final decision will also be based on an assessment of any comments received by interested parties. Consistent with Commerce's practice, we will not rescind the review with respect to Xxentria, but rather will complete the review and issue instructions to CBP based on the final results.[8]

Methodology

Commerce is conducting this review in accordance with sections 751(a)(1) and (2) of the Act. Export price is calculated in accordance with section 772 of the Act. Normal value is calculated in accordance with section 773 of the Act. For a full description of the methodology underlying our conclusions, *see* the Preliminary Decision Memorandum.

Rate for Non-Selected Companies

For the rate for companies not selected for individual examination in an administrative review, generally, Commerce looks to section 735(c)(5) of the Act, which provides instructions for calculating the all-others rate in a LTFV investigation. Under section 735(c)(5)(A) of the Act, the all-others rate is normally ''an amount equal to the weighted average of the estimated weighted-average dumping margins established for exporters and producers individually investigated, excluding any zero or *de minimis* margins, and any margins determined entirely {on the basis of facts available}.'' However, section 735(c)(5)(B) of the Act provides that, where the dumping margins established for all companies selected for individual examination are zero, *de minimis,* or based entirely on facts available, Commerce may use any reasonable method to establish the estimated all-others rate for the non-selected companies.

In this administrative review, we calculated a weighted-average dumping margin of zero percent for Prosperity, the sole respondent selected for individual examination for which the administrative review continues. As such, the record does not contain a calculated weighted-average dumping margin that is not zero, *de minimis,* or based on adverse facts available. Therefore, we are preliminarily assigning Prosperity's zero percent margin to the non-selected respondents CSC, CHSC, Great Fortune, Great Grandeul, Great Grandeul Somoa, Great Grandeul Steel, and SYSCO. For further discussion, *see* the Preliminary Decision Memorandum.

Preliminary Results of Review

Commerce preliminarily determines the following weighted-average dumping margins exist for the period July 1, 2021, through June 30, 2022:

Exporter/producer	Weighted-average dumping margin (percent)
Prosperity Tieh Enterprise Co., Ltd	0.00
CSC	0.00
CHSC	0.00
Great Fortune	0.00
Great Grandeul	0.00
Great Grandeul Somoa	0.00
Great Grandeul Steel	0.00
SYSCO	0.00

Disclosure and Public Comment

Commerce intends to disclose to interested parties the calculations performed for these preliminary results within five days of the date of publication of this notice.[9]

Interested parties may submit case briefs to the Assistant Secretary for Enforcement and Compliance no later than 30 days after the date of publication of this notice.[10] Rebuttal briefs, limited to issues raised in the case briefs, may be filed no later than seven days after the date for filing case briefs.[11] Parties who submit case briefs or rebuttal briefs in this proceeding are requested to submit with the argument: (1) a statement of the issue, (2) a summary of the argument, and (3) a table of authorities.[12] All briefs must be filed electronically using ACCESS. An electronically filed document must be received successfully in its entirety by Commerce's electronic records system, ACCESS.[13] Note that Commerce has temporarily modified certain of its requirements for serving documents containing business proprietary information, until further notice.[14]

Interested parties who wish to request a hearing, limited to issues raised in the case and rebuttal briefs, must submit a written request to the Assistant Secretary for Enforcement and Compliance, U.S. Department of Commerce, using Enforcement and Compliance's ACCESS system within 30 days of publication of this notice.[15] Requests should contain: (1) the party's name, address, and telephone number; (2) the number of participants; (3) whether any participant is a foreign national; and (4) a list of issues to be discussed. If a request for a hearing is made, we will inform parties of the scheduled date for the hearing at a time and location to be determined.[16] Parties should confirm by telephone the date, time, and location of the hearing.

Unless the deadline is extended pursuant to section 751(a)(3)(A) of the Act and 19 CFR 351.213(h)(2), Commerce will issue the final results of this administrative review, including the results of our analysis of the issues raised by the parties in their case briefs, not later than 120 days after the date of publication of this notice.

Assessment Rates

Upon issuance of the final results, Commerce shall determine, and CBP shall assess, antidumping duties on all appropriate entries covered by this review. For any individually examined respondents whose weighted-average dumping margin is above *de minimis* (*i.e.,* 0.50 percent), we will calculate importer-specific *ad valorem*

[6] *See* Synn's Letter, ''No Shipment Certification,'' dated October 4, 2022.

[7] *See* Xxentria's Letter, ''Notice of No Sales,'' dated October 5, 2022.

[8] *See, e.g., Certain Frozen Warmwater Shrimp from Thailand; Preliminary Results of Antidumping Duty Administrative Review, Partial Rescission of Review, Preliminary Determination of No Shipments; 2012–2013,* 79 FR 15951, 15952 (March 24, 2014), unchanged in *Certain Frozen Warmwater Shrimp from Thailand: Final Results of Antidumping Duty Administrative Review, Final Determination of No Shipments, and Partial Rescission of Review; 2012–2013,* 79 FR 51306, 51307 (August 28, 2014).

[9] *See* 19 CFR 351.224(b).

[10] *See* 19 CFR 351.309(c)(1)(ii).

[11] *See* 19 CFR 351.309(d); *see also Temporary Rule Modifying AD/CVD Service Requirements Due to COVID–19,* 85 FR 17006 (March 26, 2020); and *Temporary Rule Modifying AD/CVD Service Requirements Due to COVID–19; Extension of Effective Period,* 85 FR 41363 (July 10, 2020) (collectively, *Temporary Rule*).

[12] *See* 19 CFR 351.309(c)(2) and (d)(2).

[13] *See* 19 CFR 351.303.

[14] *See Temporary Rule.*

[15] *See* 19 CFR 351.310(c).

[16] *See* 19 CFR 351.310.

antidumping duty assessment rates based on the ratio of the total amount of dumping calculated for the importer's examined sales to the total entered value of those same sales in accordance with 19 CFR 351.212(b)(1).[17] We will instruct CBP to assess antidumping duties on all appropriate entries covered by this review when the importer-specific assessment rate calculated in the final results of this review is above *de minimis* (*i.e.,* 0.50 percent). Where either the respondent's weighted-average dumping margin is zero or *de minimis,* or an importer-specific assessment rate is zero or *de minimis,* we will instruct CBP to liquidate the appropriate entries without regard to antidumping duties. The final results of this review shall be the basis for the assessment of antidumping duties on entries of merchandise covered by the final results of this review where applicable.

For the companies which were not selected for individual review (*i.e.,* CSC, CHSC, Great Fortune, Great Grandeul, Great Grandeul Somoa, Great Grandeul Steel, and SYSCO), we will assign an assessment rate based on the cash deposit rate calculated for the company selected for mandatory review (*i.e.,* Prosperity). The final results of this review shall be the basis for the assessment of antidumping duties on entries of merchandise covered by the final results of this review and for future deposits of estimated duties, where applicable.[18] Further, if we continue to find in the final results that Xxentria had no shipments of subject merchandise during the POR, we will instruct CBP to liquidate any suspended entries that entered under that company's antidumping duty case number at the all-others rate.

In accordance with Commerce's ''automatic assessment'' practice, for entries of subject merchandise during the POR produced by Prosperity for which it did not know that its merchandise was destined for the United States, we will instruct CBP to liquidate entries not reviewed at the all-others rate of 3.66 percent established in the LTFV investigation [19] if there is no rate for the intermediate company(ies) involved in the transaction.[20]

We intend to issue assessment instructions to CBP no earlier than 35 days after date of publication of the final results of this review in the **Federal Register**. If a timely summons is filed at the Court, the assessment instructions will direct CBP not to liquidate relevant entries until the time for parties to file a request for a statutory injunction has expired (*i.e.,* within 90 days of publication).

Cash Deposit Requirements

The following deposit requirements will be effective upon publication of the notice of final results of administrative review for all shipments of CORE from Taiwan entered, or withdrawn from warehouse, for consumption on or after the date of publication provided by section 751(a)(2) of the Act: (1) the cash deposit rate for each company listed above will be equal to the dumping margins established in the final results of this review except if the ultimate rates are *de minimis* within the meaning of 19 CFR 351.106(c)(1), in which case the cash deposit rates will be zero; (2) for merchandise exported by producers or exporters not covered in this administrative review but covered in a prior segment of the proceeding, the cash deposit rate will continue to be the company-specific rate published for the most recently completed segment of this proceeding in which the producer or exporter participated; (3) if the exporter is not a firm covered in this review, a prior review, or the original LTFV investigation but the producer is, the cash deposit rate will be the rate established for the most recently completed segment of the proceeding for the producer of the merchandise; and (4) the cash deposit rate for all other producers or exporters will continue to be 3.66 percent, the all-others rate established in *Amended Final Determination*.[21] These cash deposit requirements, when imposed, shall remain in effect until further notice.

Notification to Importers

This notice also serves as a preliminary reminder to importers of their responsibility under 19 CFR 351.402(f)(2) to file a certificate regarding the reimbursement of antidumping duties prior to liquidation of the relevant entries during this review period. Failure to comply with this requirement could result in Commerce's presumption that reimbursement of antidumping duties occurred and the subsequent assessment of double antidumping duties.

Notification to Interested Parties

These preliminary results of review are issued and published in accordance with sections 751(a)(1) and 777(i)(1) of the Act and 19 CFR 351.221(b)(4).

Dated: July 27, 2023.

Abdelali Elouaradia,

Deputy Assistant Secretary for Enforcement and Compliance.

Appendix

List of Topics Discussed in the Preliminary Decision Memorandum

I. Summary
II. Background
III. Scope of the Order
IV. Discontinuation of the Review With Respect to YP and Synn
V. Preliminary Determination of No Shipments
VI. Rate for Respondents Not Selected for Individual Examination
VII. Discussion of the Methodology
VIII. Currency Conversion
IX. Recommendation

[FR Doc. 2023–16462 Filed 8–1–23; 8:45 am]

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[17] In these preliminary results, Commerce applied the assessment rate calculation method adopted in *Antidumping Proceedings: Calculation of the Weighted-Average Dumping Margin and Assessment Rate in Certain Antidumping Proceedings; Final Modification,* 77 FR 8101 (February 14, 2012).

[18] *See* section 751(a)(2)(C) of the Act.

[19] *See Corrosion-Resistant Steel Products from Taiwan: Notice of Court Decision Not in Harmony with Final Determination of Antidumping Duty Investigation and Notice of Amended Final Determination of Investigation,* 84 FR 6129 (February 26, 2019) (*Amended Final Determination*).

[20] For a full discussion of this practice, *see Antidumping and Countervailing Duty Proceedings: Assessment of Antidumping Duties,* 68 FR 23954 (May 6, 2003).

[21] *See Amended Final Determination.*

DEPARTMENT OF COMMERCE

International Trade Administration

The Association of Universities for Research in Astronomy; Notice of Decision on Application for Duty-Free Entry of Scientific Instruments

This is a decision pursuant to section 6(c) of the Educational, Scientific, and Cultural Materials Importation Act of 1966 (Pub. L. 89–651, as amended by Pub. L. 106–36; 80 Stat. 897; 15 CFR part 301). On January 24, 2023, the Department of Commerce published a notice in the **Federal Register** requesting public comment on whether instruments of equivalent scientific value, for the purposes for which the instruments identified in the docket(s) below are intended to be used, are being manufactured in the United States. *See Application(s) for Duty-Free Entry of Scientific Instruments, 88 FR 4155, January 24, 2023 (Notice).* We received no public comments.

Docket Number: 23–004. Applicant: The Association of Universities for Research in Astronomy (AURA), 950 N Cherry Avenue, Tucson, AZ 85719. Instrument: (4) Laser Launch Telescopes. Manufacturer: Officina Stellare, S.p.A., Italy. Intended Use: The

instrument is intended to be used to study the creation of four artificial stars for the purpose of conducting Adaptive Optics scientific observations. Existing and upcoming next generation optical telescopes require highly reliable 589 nm high power lasers—to generate so-called Guide Star Lasers—for the implementation of adaptive optics facilities. The four Laser Launch Telescopes will be used to project these laser beacons to create a constellation of artificial laser guide stars on top of the telescope. The experiments to be conducted: The four Laser Launch Telescopes used as an accessory to the Adaptive Optics system GMAO (currently in development) will propagate a constellation of artificial guide stars to measure the incoming wavefront. The objectives pursued during the investigations will be used on selected nights for selected astronomical targets in hopes of attaining better scientific data.

Dated: July 27, 2023.

Gregory W. Campbell,

Director, Subsidies Enforcement and Economic Analysis, Enforcement and Compliance.

[FR Doc. 2023–16363 Filed 8–1–23; 8:45 am]

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DEPARTMENT OF COMMERCE

International Trade Administration

[C–533–839]

Carbazole Violet Pigment 23 From India: Initiation of Countervailing Duty New Shipper Review

AGENCY: Enforcement and Compliance, International Trade Administration, Department of Commerce.

SUMMARY: The U.S. Department of Commerce (Commerce) has determined that a request for a new shipper review (NSR) of the countervailing duty (CVD) order on carbazole violet pigment 23 (CVP–23) from India meets the statutory and regulatory requirements for initiation. The period of review (POR) for this NSR is January 1, 2022, through December 31, 2022.

DATES: Applicable August 2, 2023.

FOR FURTHER INFORMATION CONTACT: Gene H. Calvert, AD/CVD Operations, Office VII, Enforcement and Compliance, International Trade Administration, U.S. Department of Commerce, 1401 Constitution Avenue NW, Washington, DC 20230; telephone: (202) 482–3586.

SUPPLEMENTARY INFORMATION:

Background

Commerce published the CVD order on CVP–23 from India on December 29, 2004.[1] On January 20, 2023, pursuant to section 751(a)(2)(B)(i) of the Tariff Act of 1930, as amended (the Act), and 19 CFR 351.214(c), Commerce received a timely NSR request from Sudarshan Chemical Industries Limited (Sudarshan Chemical).[2]

In its submission, Sudarshan Chemical certified that it is the producer and exporter of the subject merchandise subject to this NSR request.[3] Pursuant to section 751(a)(2)(B)(I) of the Act and 19 CFR 351.214(b)(2)(i), Sudarshan Chemical certified that it did not export CVP–23 to the United States during the period of investigation (POI).[4] Additionally, pursuant to section 751(a)(2)(B)(i)(II) of the Act and 19 CFR 351.214(b)(2)(iii)(A), Sudarshan Chemical certified that, since the initiation of the CVD investigation, it has not been affiliated with any producer or exporter that exported CVP–23 to the United States during the POI, including those not individually examined during the CVD investigation.[5]

In its submission, pursuant to 19 CFR 351.214(b)(2)(iv), Sudarshan Chemical certified that it would provide necessary information related to the unaffiliated customer in the United States during this NSR.[6] Sudarshan Chemical also provided a certification by its unaffiliated customer of its willingness to participate in this NSR.[7]

In addition to the certifications described above, pursuant to 19 CFR 351.214(b)(2)(v), Sudarshan Chemical submitted documentation establishing the following: (1) the date on which the subject merchandise was first entered, or withdrawn from warehouse, for consumption; (2) the volume of its first shipment and any subsequent shipments, including whether such shipments were made in commercial quantities; and (3) the date of its first sale and any subsequent sales to an unaffiliated customer in the United States.[8] Finally, pursuant to 19 CFR 351.214(b)(2)(vi), Sudarshan Chemical submitted a certification that it informed the Government of India (GOI) that the GOI will be required to provide a full response to Commerce's questionnaire.

Commerce queried the database of U.S. Customs and Border Protection (CBP) to confirm whether the shipment reported by Sudarshan Chemical had entered the United States for consumption and that liquidation had been suspended as subject to the *Order*.[9] The CBP Entry Data for which Commerce examined were consistent with the information submitted by Sudarshan Chemical in its NSR request. In particular, the CBP Entry Data confirmed the price and quantity reported by Sudarshan Chemical for the sale that forms the basis for its NSR request. Finally, Commerce's examination of the CBP Entry Data also leads it to conclude that this sale is a suspended/Type-3 entry.

Period of Review

In accordance with 19 CFR 351.214(g)(2), in a countervailing duty proceeding, the POR for an NSR will be the same period as that specified in 19 CFR 351.213(e)(2) for a CVD administrative review. Section 351.213(e)(2)(i) of Commerce's regulations provides that a CVD administrative review normally will cover entries or exports of subject merchandise during the most recently completed calendar year. Because Sudarshan Chemical's NSR Request was submitted on January 20, 2023, the POR for this NSR will be January 1, 2022, through December 31, 2022 (*i.e.,* the most recently completed calendar year prior to the date of Sudarshan Chemical's NSR Request).

Initiation of New Shipper Review

Pursuant to section 751(a)(2)(B) of the Act and 19 CFR 351.214(b), and based on the information on the record, Commerce finds that Sudarshan Chemical's NSR Request meets the threshold requirements for initiating an NSR of its shipments of CVP–23 from India to the United States.[10] However, if the information submitted by Sudarshan Chemical is later found to be incorrect or insufficient during the course of this NSR, Commerce may rescind the review or apply adverse facts available, pursuant to section 776 of the Act, as

[1] *See Notice of Countervailing Duty Order: Carbazole Violet Pigment 23 from India,* 69 FR 77995 (December 29, 2004) (*Order*).

[2] *See* Sudarshan Chemical's Letter, ''Request for Initiation of a New Shipper Review of the Countervailing Duty Order (C–533–839),'' dated January 20, 2023 (Sudarshan Chemical's NSR Request).

[3] *Id.* at Exhibit 1.

[4] *Id.*

[5] *Id.*

[6] *Id.*

[7] *Id.* at Exhibit 2.

[8] *Id.* at Exhibits C and D.

[9] *See* Memorandum, ''Release of U.S. Customs and Border Protection Data Query Results,'' dated May 30, 2023, at Attached Excel Data File (CBP Entry Data).

[10] *See,* generally, Sudarshan Chemical's NSR Request; *see also* New Shipper Initiation Checklist: Sudarshan Chemical Industries Limited, dated concurrently with this notice.

appropriate. Pursuant to 19 CFR 351.221(c)(1)(i), Commerce will publish the notice of initiation of an NSR no later than the last day of the month following the anniversary or semiannual anniversary month of the order. Commerce intends to issue the preliminary results of this NSR no later than 180 days from the date of initiation, and the final results of this review no later than 90 days after the date the preliminary results are issued.[11]

We intend to conduct this NSR in accordance with section 751(a)(2)(B) of the Act.[12] Because Sudarshan Chemical certified that it exported subject merchandise, the sale of which is the basis for its NSR request, Commerce will instruct CBP to suspend, or continue to suspend, liquidation of all entries of subject merchandise produced/or exported by Sudarshan.

Interested parties requiring access to proprietary information in this NSR should submit applications for disclosure under administrative protective order in accordance with 19 CFR 351.305 and 351.306.

This initiation notice is published in accordance with section 751(a)(2)(B) of the Act and 19 CFR 351.214 and 351.221(c)(1)(i).

Dated: July 26, 2023.

James Maeder,

Deputy Assistant Secretary for Antidumping and Countervailing Duty Operations.

[FR Doc. 2023–16466 Filed 8–1–23; 8:45 am]

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DEPARTMENT OF COMMERCE

International Trade Administration

Antidumping or Countervailing Duty Order, Finding, or Suspended Investigation; Opportunity To Request Administrative Review and Join Annual Inquiry Service List

AGENCY: Enforcement and Compliance, International Trade Administration, Department of Commerce.

FOR FURTHER INFORMATION CONTACT: Brenda E. Brown, Office of AD/CVD Operations, Customs Liaison Unit, Enforcement and Compliance, International Trade Administration, U.S. Department of Commerce, 1401 Constitution Avenue NW, Washington, DC 20230, telephone: (202) 482–4735.

Background

Each year during the anniversary month of the publication of an antidumping or countervailing duty order, finding, or suspended investigation, an interested party, as defined in section 771(9) of the Tariff Act of 1930, as amended (the Act), may request, in accordance with 19 CFR 351.213, that the Department of Commerce (Commerce) conduct an administrative review of that antidumping or countervailing duty order, finding, or suspended investigation.

All deadlines for the submission of comments or actions by Commerce discussed below refer to the number of calendar days from the applicable starting date.

Respondent Selection

In the event Commerce limits the number of respondents for individual examination for administrative reviews initiated pursuant to requests made for the orders identified below, Commerce intends to select respondents based on U.S. Customs and Border Protection (CBP) data for U.S. imports during the period of review. We intend to release the CBP data under Administrative Protective Order (APO) to all parties having an APO within five days of publication of the initiation notice and to make our decision regarding respondent selection within 35 days of publication of the initiation **Federal Register** notice. Therefore, we encourage all parties interested in commenting on respondent selection to submit their APO applications on the date of publication of the initiation notice, or as soon thereafter as possible. Commerce invites comments regarding the CBP data and respondent selection within five days of placement of the CBP data on the record of the review.

In the event Commerce decides it is necessary to limit individual examination of respondents and conduct respondent selection under section 777A(c)(2) of the Act:

In general, Commerce finds that determinations concerning whether particular companies should be ''collapsed'' (*i.e.,* treated as a single entity for purposes of calculating antidumping duty rates) require a substantial amount of detailed information and analysis, which often require follow-up questions and analysis. Accordingly, Commerce will not conduct collapsing analyses at the respondent selection phase of a review and will not collapse companies at the respondent selection phase unless there has been a determination to collapse certain companies in a previous segment of this antidumping proceeding (*i.e.,* investigation, administrative review, new shipper review or changed circumstances review). For any company subject to a review, if Commerce determined, or continued to treat, that company as collapsed with others, Commerce will assume that such companies continue to operate in the same manner and will collapse them for respondent selection purposes. Otherwise, Commerce will not collapse companies for purposes of respondent selection. Parties are requested to: (a) identify which companies subject to review previously were collapsed; and (b) provide a citation to the proceeding in which they were collapsed. Further, if companies are requested to complete a Quantity and Value Questionnaire for purposes of respondent selection, in general each company must report volume and value data separately for itself. Parties should not include data for any other party, even if they believe they should be treated as a single entity with that other party. If a company was collapsed with another company or companies in the most recently completed segment of a proceeding where Commerce considered collapsing that entity, complete quantity and value data for that collapsed entity must be submitted.

Deadline for Withdrawal of Request for Administrative Review

Pursuant to 19 CFR 351.213(d)(1), a party that requests a review may withdraw that request within 90 days of the date of publication of the notice of initiation of the requested review. The regulation provides that Commerce may extend this time if it is reasonable to do so. Determinations by Commerce to extend the 90-day deadline will be made on a case-by-case basis.

Deadline for Particular Market Situation Allegation

Section 504 of the Trade Preferences Extension Act of 2015 amended the Act by adding the concept of particular market situation (PMS) for purposes of constructed value under section 773(e) of the Act.[1] Section 773(e) of the Act states that ''if a particular market situation exists such that the cost of materials and fabrication or other processing of any kind does not accurately reflect the cost of production in the ordinary course of trade, the administering authority may use

[11] *See* section 751(a)(2)(B)(iii) of the Act.

[12] The Act was amended by the Trade Facilitation Trade Enforcement Act of 2015, which removed from section 751(a)(2)(B) of the Act the provision directing Commerce to instruct CBP to allow an importer the option of posting a bond or security in lieu of a cash deposit during the pendency of an NSR. This was also codified in Commerce's regulations at 19 CFR 351.214(e).

[1] *See* Trade Preferences Extension Act of 2015, Public Law 114–27, 129 Stat. 362 (2015).

another calculation methodology under this subtitle or any other calculation methodology.'' When an interested party submits a PMS allegation pursuant to section 773(e) of the Act, Commerce will respond to such a submission consistent with 19 CFR 351.301(c)(2)(v). If Commerce finds that a PMS exists under section 773(e) of the Act, then it will modify its dumping calculations appropriately.

Neither section 773(e) of the Act nor 19 CFR 351.301(c)(2)(v) set a deadline for the submission of PMS allegations and supporting factual information. However, in order to administer section 773(e) of the Act, Commerce must receive PMS allegations and supporting factual information with enough time to consider the submission. Thus, should an interested party wish to submit a PMS allegation and supporting new factual information pursuant to section 773(e) of the Act, it must do so no later than 20 days after submission of initial Section D responses.

Opportunity To Request a Review: Not later than the last day of August 2023,[2] interested parties may request administrative review of the following orders, findings, or suspended investigations, with anniversary dates in August for the following periods:

	Period of review
Antidumping Duty Proceedings	
CANADA: Utility Scale Wind Towers A–122–867	8/1/22–7/31/23
GERMANY: Seamless Line and Pressure Pipe A–428–820	8/1/22–7/31/23
GERMANY: Sodium Nitrite A–428–841	8/1/22–7/31/23
INDIA: Finished Carbon Steel Flanges A–533–871	8/1/22–7/31/23
INDONESIA: Utility Scale Wind Towers A–560–833	8/1/22–7/31/23
ITALY: Finished Carbon Steel Flanges A–475–835	8/1/22–7/31/23
JAPAN: Brass Sheet & Strip A–588–704	8/1/22–7/31/23
JAPAN: Tin Mill Products A–588–854	8/1/22–7/31/23
MALAYSIA: Polyethylene Retail Carrier Bags A–557–813	8/1/22–7/31/23
MALAYSIA: Silicon Metal A–557–820	8/1/22–7/31/23
MEXICO: Light-Walled Rectangular Pipe and Tube A–201–836	8/1/22–7/31/23
MEXICO: Standard Steel Welded Wire Mesh A–201–853	8/1/22–7/31/23
REPUBLIC OF KOREA: Dioctyl Terephthalate A–580–889	8/1/22–7/31/23
REPUBLIC OF KOREA: Large Power Transformers A–580–867	8/1/22–7/31/23
REPUBLIC OF KOREA: Light-Walled Rectangular Pipe and Tube A–580–859	8/1/22–7/31/23
REPUBLIC OF KOREA: Low Melt Polyester Staple Fiber A–580–895	8/1/22–7/31/23
REPUBLIC OF KOREA: Seamless Carbon and Alloy Steel Standard, Line, and Pressure Pipe A–580–909	8/1/22–7/31/23
REPUBLIC OF KOREA: Utility Scale Wind Towers A–580–902	8/1/22–7/31/23
ROMANIA: Carbon and Alloy Seamless Standard, Line, and Pressure Pipe A–485–805 (Under 4½ Inches)	8/1/22–7/31/23
RUSSIA: Seamless Carbon and Alloy Steel Standard, Line, and Pressure PipeA–821–826	8/1/22–7/31/23
SPAIN: Ripe Olives A–469–817	8/1/22–7/31/23
SPAIN: Utility Scale Wind Towers A–469–823	8/1/22–7/31/23
SOCIALIST REPUBLIC OF VIETNAM: Frozen Fish Fillets A–552–801	8/1/22–7/31/23
SOCIALIST REPUBLIC OF VIETNAM: Seamless Refined Copper Pipe and Tube A–552–831	8/1/22–7/31/23
SOCIALIST REPUBLIC OF VIETNAM: Utility Scale Wind Towers A–552–825	8/1/22–7/31/23
SOCIALIST REPUBLIC OF VIETNAM: Raw Honey[3] A–552–833	8/25/21–5/31/23
TAIWAN: Low Melt Polyester Staple Fiber A–583–861	8/1/22–7/31/23
THAILAND: Polyethylene Retail Carrier Bags A–549–821	8/1/22–7/31/23
THAILAND: Steel Propane Cylinders A–549–839	8/1/22–7/31/23
THE PEOPLE'S REPUBLIC OF CHINA: Cast Iron Soil Pipe Fittings A–570–062	8/1/22–7/31/23
THE PEOPLE'S REPUBLIC OF CHINA: Certain Metal Lockers and Parts Thereof A–570–133	8/1/22–7/31/23
THE PEOPLE'S REPUBLIC OF CHINA: Floor-Standing, Metal-Top Ironing Tables and A–570–888 Parts Thereof	8/1/22–7/31/23
THE PEOPLE'S REPUBLIC OF CHINA: Hydrofluorocarbon Blends and Components Thereof A–570–028	8/1/22–7/31/23
THE PEOPLE'S REPUBLIC OF CHINA: Laminated Woven Sacks A–570–916	8/1/22–7/31/23
THE PEOPLE'S REPUBLIC OF CHINA: Light-Walled Rectangular Pipe and TubeA–570–914	8/1/22–7/31/23
THE PEOPLE'S REPUBLIC OF CHINA: Passenger Vehicle and Light Truck Tires A–570–016	8/1/22–7/31/23
THE PEOPLE'S REPUBLIC OF CHINA: Petroleum Wax Candles A–570–504	8/1/22–7/31/23
THE PEOPLE'S REPUBLIC OF CHINA: Polyethylene Retail Carrier Bags A–570–886	8/1/22–7/31/23
THE PEOPLE'S REPUBLIC OF CHINA: Sodium Nitrite A–570–925	8/1/22–7/31/23
THE PEOPLE'S REPUBLIC OF CHINA: Stainless Steel Flanges A–570–064	8/1/22–7/31/23
THE PEOPLE'S REPUBLIC OF CHINA: Steel Nails A–570–909	8/1/22–7/31/23
THE PEOPLE'S REPUBLIC OF CHINA: Steel Propane Cylinders A–570–086	8/1/22–7/31/23
THE PEOPLE'S REPUBLIC OF CHINA: Tetrahydrofurfuryl Alcohol A–570–887	8/1/22–7/31/23
THE PEOPLE'S REPUBLIC OF CHINA: Tow-Behind Lawn Groomers and Parts Thereof A–570–939	8/1/22–7/31/23
UKRAINE: Seamless Carbon and Alloy Steel Standard, Line, and Pressure Pipe A–823–819	8/1/22–7/31/23
UKRAINE: Silicomanganese A–823–805	8/1/22–7/31/23
Countervailing Duty Proceedings	
CANADA: Utility Scale Wind Towers C–122–868	1/1/22–12/31/22
INDIA: Finished Carbon Steel Flanges C–533–872	1/1/22–12/31/22
MALAYSIA: Utility Scale Wind Towers C–557–822	1/1/22–12/31/22
REPUBLIC OF KOREA: Seamless Carbon and Alloy Steel Standard, Line, and Pressure Pipe C–580–910	1/1/22–12/31/22

[2] Or the next business day, if the deadline falls on a weekend, federal holiday or any other day when Commerce is closed.

[3] In the notice of opportunity to request administrative review for June anniversary orders, published in the **Federal Register** on June 1, 2023 (88 FR 35835), Commerce inadvertently listed an incorrect period of review. Commerce hereby corrects that error. Commerce also is granting interested parties to the underlying raw honey from Vietnam proceeding 30 days from the publication of this opportunity notice to request an administrative review of raw honey from Vietnam for the period noted above.

	Period of review
REPUBLIC OF KOREA: Stainless Steel Sheet and Strip in Coils C–580–835	1/1/22–12/31/22
RUSSIA: Seamless Carbon and Alloy Steel Standard, Line, and Pressure Pipe C–821–827	1/1/22–12/31/22
RUSSIA: Sodium Nitrite C–821–837	4/15/22–12/31/22
SPAIN: Ripe Olives C–469–818	1/1/22–12/31/22
SOCIALIST REPUBLIC OF VIETNAM: Utility Scale Wind Towers C–552–826	1/1/22–12/31/22
THE PEOPLE'S REPUBLIC OF CHINA: Cast Iron Soil Pipe Fittings C–570–063	1/1/22–12/31/22
THE PEOPLE'S REPUBLIC OF CHINA: Certain Metal Lockers and Parts Thereof C–570–134	1/1/22–12/31/22
THE PEOPLE'S REPUBLIC OF CHINA: Laminated Woven Sacks C–570–917	1/1/22–12/31/22
THE PEOPLE'S REPUBLIC OF CHINA: Light-Walled Rectangular Pipe and Tube C–570–915	1/1/22–12/31/22
THE PEOPLE'S REPUBLIC OF CHINA: Passenger Vehicle and Light Truck Tires C–570–017	1/1/22–12/31/22
THE PEOPLE'S REPUBLIC OF CHINA: Sodium Nitrite C–570–926	1/1/22–12/31/22
THE PEOPLE'S REPUBLIC OF CHINA: Steel Propane Cylinders C–570–087	1/1/22–12/31/22
Suspension Agreements	
None.	

In accordance with 19 CFR 351.213(b), an interested party as defined by section 771(9) of the Act may request in writing that the Secretary conduct an administrative review. For both antidumping and countervailing duty reviews, the interested party must specify the individual producers or exporters covered by an antidumping finding or an antidumping or countervailing duty order or suspension agreement for which it is requesting a review. In addition, a domestic interested party or an interested party described in section 771(9)(B) of the Act must state why it desires the Secretary to review those particular producers or exporters. If the interested party intends for the Secretary to review sales of merchandise by an exporter (or a producer if that producer also exports merchandise from other suppliers) which was produced in more than one country of origin and each country of origin is subject to a separate order, then the interested party must state specifically, on an order-by-order basis, which exporter(s) the request is intended to cover.

Note that, for any party Commerce was unable to locate in prior segments, Commerce will not accept a request for an administrative review of that party absent new information as to the party's location. Moreover, if the interested party who files a request for review is unable to locate the producer or exporter for which it requested the review, the interested party must provide an explanation of the attempts it made to locate the producer or exporter at the same time it files its request for review, in order for the Secretary to determine if the interested party's attempts were reasonable, pursuant to 19 CFR 351.303(f)(3)(ii).

As explained in *Antidumping and Countervailing Duty Proceedings: Assessment of Antidumping Duties,* 68 FR 23954 (May 6, 2003), and *Non-Market Economy Antidumping Proceedings: Assessment of Antidumping Duties,* 76 FR 65694 (October 24, 2011), Commerce clarified its practice with respect to the collection of final antidumping duties on imports of merchandise where intermediate firms are involved. The public should be aware of this clarification in determining whether to request an administrative review of merchandise subject to antidumping findings and orders.[4]

Commerce no longer considers the non-market economy (NME) entity as an exporter conditionally subject to an antidumping duty administrative reviews.[5] Accordingly, the NME entity will not be under review unless Commerce specifically receives a request for, or self-initiates, a review of the NME entity.[6] In administrative reviews of antidumping duty orders on merchandise from NME countries where a review of the NME entity has not been initiated, but where an individual exporter for which a review was initiated does not qualify for a separate rate, Commerce will issue a final decision indicating that the company in question is part of the NME entity. However, in that situation, because no review of the NME entity was conducted, the NME entity's entries were not subject to the review and the rate for the NME entity is not subject to change as a result of that review (although the rate for the individual exporter may change as a function of the finding that the exporter is part of the NME entity). Following initiation of an antidumping administrative review when there is no review requested of the NME entity, Commerce will instruct CBP to liquidate entries for all exporters not named in the initiation notice, including those that were suspended at the NME entity rate.

All requests must be filed electronically in Enforcement and Compliance's Antidumping and Countervailing Duty Centralized Electronic Service System (ACCESS) on Enforcement and Compliance's ACCESS website at *https://access.trade.gov.*[7] Further, in accordance with 19 CFR 351.303(f)(l)(i), a copy of each request must be served on the petitioner and each exporter or producer specified in the request. Note that Commerce has temporarily modified certain of its requirements for serving documents containing business proprietary information, until further notice.[8]

Commerce will publish in the **Federal Register** a notice of ''Initiation of Administrative Review of Antidumping or Countervailing Duty Order, Finding, or Suspended Investigation'' for requests received by the last day of August 2023. If Commerce does not receive, by the last day of August 2023, a request for review of entries covered by an order, finding, or suspended investigation listed in this notice and for the period identified above, Commerce will instruct CBP to assess antidumping or countervailing duties on those entries at a rate equal to the cash deposit of estimated antidumping or

[4] *See* the Enforcement and Compliance website at *https://www.trade.gov/us-antidumping-and-countervailing-duties.*

[5] *See Antidumping Proceedings: Announcement of Change in Department Practice for Respondent Selection in Antidumping Duty Proceedings and Conditional Review of the Nonmarket Economy Entity in NME Antidumping Duty Proceedings*, 78 FR 65963 (November 4, 2013).

[6] In accordance with 19 CFR 351.213(b)(1), parties should specify that they are requesting a review of entries from exporters comprising the entity, and to the extent possible, include the names of such exporters in their request.

[7] *See Antidumping and Countervailing Duty Proceedings: Electronic Filing Procedures; Administrative Protective Order Procedures,* 76 FR 39263 (July 6, 2011).

[8] *See Temporary Rule Modifying AD/CVD Service Requirements Due to COVID–19; Extension of Effective Period,* 85 FR 41363 (July 10, 2020).

countervailing duties required on those entries at the time of entry, or withdrawal from warehouse, for consumption and to continue to collect the cash deposit previously ordered.

For the first administrative review of any order, there will be no assessment of antidumping or countervailing duties on entries of subject merchandise entered, or withdrawn from warehouse, for consumption during the relevant provisional-measures ''gap'' period of the order, if such a gap period is applicable to the period of review.

Establishment of and Updates to the Annual Inquiry Service List

On September 20, 2021, Commerce published the final rule titled ''*Regulations to Improve Administration and Enforcement of Antidumping and Countervailing Duty Laws*'' in the **Federal Register**.[9] On September 27, 2021, Commerce also published the notice entitled ''*Scope Ruling Application; Annual Inquiry Service List; and Informational Sessions*'' in the **Federal Register**.[10] The *Final Rule* and *Procedural Guidance* provide that Commerce will maintain an annual inquiry service list for each order or suspended investigation, and any interested party submitting a scope ruling application or request for circumvention inquiry shall serve a copy of the application or request on the persons on the annual inquiry service list for that order, as well as any companion order covering the same merchandise from the same country of origin.[11]

In accordance with the *Procedural Guidance,* for orders published in the **Federal Register** before November 4, 2021, Commerce created an annual inquiry service list segment for each order and suspended investigation. Interested parties who wished to be added to the annual inquiry service list for an order submitted an entry of appearance to the annual inquiry service list segment for the order in ACCESS, and on November 4, 2021, Commerce finalized the initial annual inquiry service lists for each order and suspended investigation. Each annual inquiry service list has been saved as a public service list in ACCESS, under each case number, and under a specific segment type called ''AISL-Annual Inquiry Service List.'' [12]

As mentioned in the *Procedural Guidance,* beginning in January 2022, Commerce will update these annual inquiry service lists on an annual basis when the *Opportunity Notice* for the anniversary month of the order or suspended investigation is published in the **Federal Register**.[13] Accordingly, Commerce will update the annual inquiry service lists for the above-listed antidumping and countervailing duty proceedings. All interested parties wishing to appear on the updated annual inquiry service list must take one of the two following actions: (1) new interested parties who did not previously submit an entry of appearance must submit a new entry of appearance at this time; (2) interested parties who were included in the preceding annual inquiry service list must submit an amended entry of appearance to be included in the next year's annual inquiry service list. For these interested parties, Commerce will change the entry of appearance status from ''Active'' to ''Needs Amendment'' for the annual inquiry service lists corresponding to the above-listed proceedings. This will allow those interested parties to make any necessary amendments and resubmit their entries of appearance. If no amendments need to be made, the interested party should indicate in the area on the ACCESS form requesting an explanation for the amendment that it is resubmitting its entry of appearance for inclusion in the annual inquiry service list for the following year. As mentioned in the *Final Rule,*[14] once the petitioners and foreign governments have submitted an entry of appearance for the first time, they will automatically be added to the updated annual inquiry service list each year.

Interested parties have 30 days after the date of this notice to submit new or amended entries of appearance. Commerce will then finalize the annual inquiry service lists five business days thereafter. For ease of administration, please note that Commerce requests that law firms with more than one attorney representing interested parties in a proceeding designate a lead attorney to be included on the annual inquiry service list.

Commerce may update an annual inquiry service list at any time as needed based on interested parties' amendments to their entries of appearance to remove or otherwise modify their list of members and representatives, or to update contact information. Any changes or announcements pertaining to these procedures will be posted to the ACCESS website at *https://access.trade.gov.*

Special Instructions for Petitioners and Foreign Governments

In the *Final Rule,* Commerce stated that, ''after an initial request and placement on the annual inquiry service list, both petitioners and foreign governments will automatically be placed on the annual inquiry service list in the years that follow.'' [15] Accordingly, as stated above and pursuant to 19 CFR 351.225(n)(3), the petitioners and foreign governments will not need to resubmit their entries of appearance each year to continue to be included on the annual inquiry service list. However, the petitioners and foreign governments are responsible for making amendments to their entries of appearance during the annual update to the annual inquiry service list in accordance with the procedures described above.

This notice is not required by statute but is published as a service to the international trading community.

Dated: July 21, 2023.

James Maeder,

Deputy Assistant Secretary for Antidumping and Countervailing Duty Operations.

[FR Doc. 2023–16465 Filed 8–1–23; 8:45 am]

BILLING CODE 3510–DS–P

[9] *See Regulations to Improve Administration and Enforcement of Antidumping and Countervailing Duty Laws,* 86 FR 52300 (September 20, 2021) (*Final Rule*).

[10] *See Scope Ruling Application; Annual Inquiry Service List; and Informational Sessions,* 86 FR 53205 (September 27, 2021) (*Procedural Guidance*).

[11] *Id.*

[12] This segment has been combined with the ACCESS Segment Specific Information (SSI) field which will display the month in which the notice of the order or suspended investigation was published in the **Federal Register**, also known as the anniversary month. For example, for an order under case number A–000–000 that was published in the **Federal Register** in January, the relevant segment and SSI combination will appear in ACCESS as ''AISL-January Anniversary.'' Note that there will be only one annual inquiry service list segment per case number, and the anniversary month will be pre-populated in ACCESS.

[13] *See Procedural Guidance,* 86 FR at 53206.

[14] *See Final Rule,* 86 FR at 52335.

[15] *Id.*

DEPARTMENT OF COMMERCE

International Trade Administration

[C–570–074]

Common Alloy Aluminum Sheet From the People's Republic of China: Final Results of Countervailing Duty Administrative Review; 2021

AGENCY: Enforcement and Compliance, International Trade Administration, Department of Commerce.

SUMMARY: The U.S. Department of Commerce (Commerce) determines that

countervailable subsidies were provided to producers and exporters of common alloy aluminum sheet (CAAS) from the People's Republic of China (China) during the period of review (POR), January 1, 2021, through December 31, 2021.

DATES: Applicable August 2, 2023.

FOR FURTHER INFORMATION CONTACT: James R. Hepburn or Scarlet K. Jaldin, AD/CVD Operations, Office VI, Enforcement and Compliance, International Trade Administration, U.S. Department of Commerce, 1401 Constitution Avenue NW, Washington, DC 20230; telephone: (202) 482–1882 or (202) 482–4275, respectively.

SUPPLEMENTARY INFORMATION:

Background

Commerce published the *Preliminary Results* of this administrative review in the **Federal Register** on March 7, 2023, and invited interested parties to comment.[1] On April 17, 2023, we received a case brief[2] from the domestic industry.[3] On April 24, 2023, we received a joint rebuttal brief from Alcha[4] and Yinbang Clad Materials Co., Ltd. (Yinbang).[5] For a detailed description of the events that occurred subsequent to the *Preliminary Results, see* the Issues and Decision Memorandum.[6] On June 21, 2023,[7] in accordance with section 751(a)(3)(A) of the Tariff Act of 1930, as amended (the Act), Commerce extended the deadline for issuing the final results until July 28, 2023.

Scope of the Order

The product covered by the order is CAAS from China.[8] For a complete description of the scope of this *Order, see* the Issues and Decision Memorandum.

Analysis of Comments Received

All issues raised by interested parties are addressed in the Issues and Decision Memorandum. A list of the issues addressed in the Issues and Decision Memorandum is provided in the appendix to this notice. The Issues and Decision Memorandum is a public document and is on file electronically via Enforcement and Compliance's Antidumping and Countervailing Duty Centralized Electronic System (ACCESS). ACCESS is available to registered users at *https://access.trade.gov.* In addition, a complete version of the Issues and Decision Memorandum can be accessed directly at *https://access.trade/gov/public/FRNoticesListLayout.aspx.*

Changes Since the Preliminary Results

Based on our analysis of comments from interested parties and the evidence on the record, we revised the calculation of the net countervailable subsidy rates for Alcha and Yinbang. For a discussion of the issues and changes, *see* Issues and Decision Memorandum.

Methodology

Commerce is conducting this administrative review in accordance with section 751(a)(1)(A) of the Act. For each of the subsidy programs found countervailable, we find that there is a subsidy, *i.e.,* a financial contribution from an authority that gives rise to a benefit to the recipient and that the subsidy is specific.[9] The Issues and Decision Memorandum contains a full description of the methodology underlying Commerce's conclusions, including any determination that relied upon the use of adverse facts available pursuant to sections 776(a) and (b) of the Act.

Final Results of Administrative Review

In accordance with 19 CFR 351.221(b)(5), Commerce calculated a countervailable subsidy rate for the mandatory respondents that are identified below. Because there are no other producers or exporters subject to this review and not selected for individual examination (*i.e.,* non-selected companies), Commerce does not need to establish a rate for such companies in this review.

Commerce determines the net countervailable subsidy rates for the period January 1, 2021, through December 31, 2021, are as follows:

Company	Subsidy rate (percent ad valorem)
Alcha International Holdings Limited; Jiangsu Alcha Aluminium Group Co., Ltd., and Jiangsu Alcha Aluminum Group Co., Ltd. (both formally known as Jiangsu Alcha Aluminium Co., Ltd. or Jiangsu Alcha Aluminum Co., Ltd.);[10] Baotou Alcha Aluminium Co., Ltd., Baotou Alcha Aluminum Co., Ltd., Baotou Alcha North Aluminum Co., Ltd., and Baotou Changlv Northern Aluminium Industry Co., Ltd.;[11] and Jiangsu Alcha New Energy Materials Co., Ltd[12]	11.25

[1] *See Common Alloy Aluminum Sheet from the People's Republic of China: Preliminary Results of Countervailing Duty Administrative Review; 2021,* 88 FR 14127 (March 7, 2023) (*Preliminary Results*), and accompanying Preliminary Decision Memorandum.

[2] *See* Domestic Industry's Letter, ''Case Brief,'' dated April 17, 2023.

[3] The domestic industry is represented by the Aluminum Association Common Alloy Aluminum Sheet Trade Enforcement Working Group and its individual members are: Arconic Corporation; Commonwealth Rolled Products, Inc.; Constellium Rolled Products Ravenswood, LLC; Jupiter Aluminum Corporation; JW Aluminum Company; and Novelis Corporation.

[4] The ''Alcha'' companies include the following: Alcha International Holdings Limited (Alcha International); Jiangsu Alcha Aluminium Group Co., Ltd. (Jiangsu Alcha); Baotou Alcha Aluminium Co., Ltd. (Baotou Alcha); and Jiangsu Alcha New Energy Materials Co., Ltd. (Alcha Materials). We refer to Alcha International, Jiangsu Alcha, Baotou Alcha, and Jiangsu Alcha Materials, hereafter, collectively, ''Alcha.''

[5] *See* Alcha's and Yinbang's Letter, ''Rebuttal Brief,'' dated April 24, 2023.

[6] *See* Memorandum, ''Issues and Decision Memorandum for the Final Results of the Countervailing Duty Administrative Review of Common Alloy Aluminum Sheet from the People's Republic of China; 2021,'' dated concurrently with, and hereby adopted by, this notice (Issues and Decision Memorandum).

[7] *See* Memorandum, ''Extension of Deadline for Final Results of Countervailing Duty Administrative Review,'' dated June 21, 2023.

[8] *See Common Alloy Aluminum Sheet from the People's Republic of China: Countervailing Duty Order,* 84 FR 2157 (February 6, 2019) (*Order*).

[9] *See* sections 771(5)(B) and (D) of the Act regarding financial contribution; section 771(5)(E) of the Act regarding benefit; and section 771(5A) of the Act regarding specificity.

[10] We initiated this review on Jiangsu Alcha Aluminium Co., Ltd. However, it was reported that ''Jiangsu Alcha Aluminium Co., Ltd.,'' also known as ''Jiangsu Alcha Aluminum Co., Ltd.,'' legally changed its name to ''Jiangsu Alcha Aluminium Group Co., Ltd.'' on May 21, 2019. It was also reported that both ''Jiangsu Alcha Aluminium Group Co., Ltd.'' and ''Jiangsu Alcha Aluminum Group Co., Ltd.'' refer to the same entity. Accordingly, we intend to treat ''Jiangsu Alcha Aluminium Group Co., Ltd.'' and ''Jiangsu Alcha Aluminum Group Co., Ltd.'' (formerly known as ''Jiangsu Alcha Aluminium Co., Ltd.'' or ''Jiangsu Alcha Aluminum Co., Ltd.'') as one entity (Jiangsu Alcha). For further discussion, *see* the Preliminary Decision Memorandum at section ''II. Background.''

[11] It was reported that although the legal name for one of Jiangsu Alcha's subsidiaries is ''Baotou Alcha Aluminium Co., Ltd.,'' other names (*i.e.,* ''Baotou Alcha Aluminum Co., Ltd.,'' ''Baotou Alcha North Aluminum Co., Ltd.,'' and ''Baotou Changlv Northern Aluminium Industry Co., Ltd.'') also refer to the same entity due to different English translations of its Chinese-language name. Accordingly, we intend to treat ''Baotou Alcha Aluminium Co., Ltd.,'' ''Baotou Alcha Aluminum Co., Ltd.,'' ''Baotou Alcha North Aluminum Co., Ltd.,'' and ''Baotou Changlv Northern Aluminium Industry Co., Ltd.'' as one entity (Baotou Alcha). For further discussion, *see* the Preliminary Decision Memorandum at section ''II. Background.''

[12] We find that Baotou Alcha and Alcha Materials are crossed-owned with Jiangsu Alcha. In addition, Alcha International is wholly owned by Jiangsu Alcha. For further discussion, *see* Preliminary Decision Memorandum.

Company	Subsidy rate (percent ad valorem)
Yinbang Clad Material Co., Ltd	12.21

Assessment Rates

Pursuant to section 751(a)(2)(C) of the Act and 19 CFR 351.221(b)(2), Commerce will determine, and U.S. Customs and Border Protection (CBP) shall assess, countervailing duties on all appropriate entries of subject merchandise in accordance with the final results of this review, for the companies listed above at the applicable *ad valorem* assessment rates listed. We intend to issue assessment instructions to CBP no earlier than 35 days after the date of publication of these final results of this review in the **Federal Register**. If a timely summons is filed at the U.S. Court of International Trade, the assessment instructions will direct CBP not to liquidate relevant entries until the time for parties to file a request for a statutory injunction has expired (*i.e.,* within 90 days of publication).

Cash Deposit Instructions

In accordance with section 751(a)(1) of the Act, Commerce intends to instruct CBP to collect cash deposits of estimated countervailing duties in the amounts shown for each of the respective companies listed above on shipments of subject merchandise entered, or withdrawn from warehouse, for consumption on or after the date of publication of the final results of this administrative review. With regard to Jiangsu Alcha, we intend to instruct CBP to collect cash deposits of estimated countervailing duties under its new names (*i.e.,* ''Jiangsu Alcha Aluminium Group Co., Ltd.,'' ''Jiangsu Alcha Aluminum Group Co., Ltd.''). Concerning Baotou Alcha, we intend to instruct CBP to collect cash deposits of estimated countervailing duties under all of its names as identified in this notice. These cash deposit requirements, effective upon publication of the final results of review, shall remain in effect until further notice.

Administrative Protective Order

This notice also serves as a reminder to parties subject to an APO of their responsibility concerning the return or destruction of proprietary information disclosed under APO in accordance with 19 CFR 351.305(a)(3), which continues to govern business proprietary information in this segment of the proceeding. Timely written notification of the return or destruction of APO materials, or conversion to judicial protective order, is hereby requested. Failure to comply with the regulations and terms of an APO is a violation which is subject to sanction.

Notification to Interested Parties

We are issuing and publishing these final results of administrative review and notice in accordance with sections 751(a)(l) and 777(i)(l) of the Act, and 19 CFR 351.221(b)(5).

Dated: July 27, 2023.

Abdelali Elouaradia,

Deputy Assistant Secretary for Enforcement and Compliance.

Appendix

List of Topics Discussed in the Issues and Decision Memorandum

I. Summary
II. Background
III. Scope of the Order
IV. Diversification of China's Economy
V. Use of Facts Otherwise Available and Application of Adverse Inferences
VI. Subsidies Valuation Information
VII. Analysis of Programs
VIII. Changes Since the Preliminary Results
IX. Discussion of the Issues
Comment 1: Whether Commerce Should Find That Falcon Technology Co., Ltd. Met the Criteria for Attribution of Subsidies with Yinbang and Apply an AFA Subsidy Rate for Each Initiated Program to Falcon
Comment 2: Whether Commerce Should Find Alcha and Yinbang Used the Export Buyer's Credit Program as Adverse Facts Available
Comment 3: Whether Commerce Should Subtract Certain Adjustment Amounts From Yinbang's POR Sales Value
Comment 4: Whether Commerce Should Revise its Calculation of the Benchmark for Primary Aluminum for Less Than Adequate Remuneration
Comment 5: Whether Commerce Should Apply Partial AFA to Jiangsu Alcha and Include Financing From Non-Reporting Affiliates as Policy Loans to the Common Alloy Sheet Industry (Policy Loans to the CAAS Industry) Program
Comment 6: Whether Commerce Should Make Certain Adjustments to the Calculation of Benefit From Certain Financial Leases of Yinbang Under Policy Loans to the CAAS Industry
Comment 7: Whether Commerce Should Make Certain Revisions to Its Calculation of Baotou Alcha's Benefits From Policy Loans to the CAAS Industry
Comment 8: Whether Commerce Should Make Certain Revisions to Its Calculation for Provision of Electricity for LTAR
X. Recommendation

[FR Doc. 2023–16463 Filed 8–1–23; 8:45 am]

BILLING CODE 3510–DS–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

[RTID 0648–XD198]

New England Fishery Management Council; Public Meeting

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

ACTION: Notice of public meeting.

SUMMARY: The New England Fishery Management Council (Council) is scheduling a public meeting of its Groundfish Committee to consider actions affecting New England fisheries in the exclusive economic zone (EEZ). Recommendations from this group will be brought to the full Council for formal consideration and action, if appropriate.

DATES: This hybrid meeting will be held on Thursday, August 17, 2023, at 9:30 a.m.

ADDRESSES: This meeting will be held at the Four Points by Sheraton, One Audubon Road, Wakefield, MA 01880; telephone: (781) 245–9300.

Webinar registration URL information: *https://attendee.gotowebinar.com/register/3030861409128586587*.

Council address: New England Fishery Management Council, 50 Water Street, Mill 2, Newburyport, MA 01950.

FOR FURTHER INFORMATION CONTACT: Thomas A. Nies, Executive Director, New England Fishery Management Council; telephone: (978) 465–0492.

SUPPLEMENTARY INFORMATION:

Agenda

The Groundfish Committee will meet to discuss Framework Adjustment on Acceptable Biological Catches (ABC) Control Rules including a facilitated session with members of the Groundfish Committee, Scientific and Statistical Committee, Groundfish Plan Development Team, Groundfish and Recreational Advisory Panels, the Risk Policy Working Group, and the public to discuss developing draft goals and

objectives for this action that are consistent with National Standard 1, National Standard 1 guidelines and the Council's Risk Policy, followed by a Groundfish Committee session to make recommendations to the Council on possible goals and objectives for the action.

They will possibly discuss other 2023 Council priorities for groundfish. Other business will be discussed as necessary.

Although non-emergency issues not contained on the agenda may come before this Council for discussion, those issues may not be the subject of formal action during this meeting. Council action will be restricted to those issues specifically listed in this notice and any issues arising after publication of this notice that require emergency action under section 305(c) of the Magnuson-Stevens Act, provided the public has been notified of the Council's intent to take final action to address the emergency. The public also should be aware that the meeting will be recorded. Consistent with 16 U.S.C. 1852, a copy of the recording is available upon request.

Special Accommodations

This meeting is physically accessible to people with disabilities. Requests for sign language interpretation or other auxiliary aids should be directed to Thomas A. Nies, Executive Director, at (978) 465–0492, at least 5 days prior to the meeting date.

Authority: 16 U.S.C. 1801 *et seq.*

Dated: July 28, 2023.

Rey Israel Marquez,

Acting Deputy Director, Office of Sustainable Fisheries, National Marine Fisheries Service.

[FR Doc. 2023–16470 Filed 8–1–23; 8:45 am]

BILLING CODE 3510–22–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

Agency Information Collection Activities; Submission to the Office of Management and Budget (OMB) for Review and Approval; Comment Request; Western Alaska Community Development Quota Program

The Department of Commerce will submit the following information collection request to the Office of Management and Budget (OMB) for review and clearance in accordance with the Paperwork Reduction Act of 1995, on or after the date of publication of this notice. We invite the general public and other Federal agencies to comment on proposed, and continuing information collections, which helps us assess the impact of our information collection requirements and minimize the public's reporting burden. Public comments were previously requested via the **Federal Register** on May 16, 2023 (88 FR 31245), during a 60-day comment period. This notice allows for an additional 30 days for public comments.

Agency: National Oceanic & Atmospheric Administration (NOAA), Commerce.

Title: Western Alaska Community Development Quota (CDQ) Program

OMB Control Number: 0648–0269.

Form Number(s): None.

Type of Request: Regular submission (extension of a current information collection).

Number of Respondents: 6.

Average Hours per Response: CDQ Vessel Registration System, 10 minutes; Groundfish/Halibut CDQ and PSQ Transfer Request, 30 minutes; Application for Approval of Use of Non-CDQ Harvest Regulations, 5 hours; Appeals, 4 hours.

Total Annual Burden Hours: 36 hours.

Needs and Uses: The National Marine Fisheries Service (NMFS), Alaska Regional Office, is requesting extension of a currently approved information collection that contains four components necessary for NMFS to manage the Western Alaska Community Development Quota Program (CDQ Program). No changes were made to this collection other than updates to reflect the most current data available and minor editorial changes to the forms to increase clarity.

NMFS and the North Pacific Fishery Management Council manage the groundfish fisheries in the exclusive economic zone off Alaska under the authority of the Magnuson-Stevens Fishery Conservation and Management Act (16 U.S.C. 1801 *et seq.*) (Magnuson-Stevens Act). The groundfish fisheries in the Bering Sea and Aleutian Islands are managed under the Fishery Management Plan for Groundfish of the Bering Sea and Aleutian Islands Management Area.

The CDQ Program is an economic development program authorized under the Magnuson Stevens Act to provide eligible western Alaska villages with the opportunity to participate and invest in fisheries in the Bering Sea and Aleutian Islands Management Area, to support economic development in western Alaska, to alleviate poverty and provide economic and social benefits for residents of western Alaska, and to achieve sustainable and diversified local economies in western Alaska.

This information collection is used by NMFS to manage the small vessel CDQ fisheries, transfer quota among the CDQ groups, and authorize the use of alternative harvest regulations under certain circumstances.

This information collection contains the following four components:

- The CDQ Vessel Registration System is an online system used by the CDQ groups to add small hook-and-line catcher vessels to the CDQ vessel registration list. Registered vessels are exempt from the requirements to obtain and carry a License Limitation Program license under regulations at 50 part 679. This system is also used to remove vessels from the CDQ vessel registration list.
- The Groundfish/Halibut CDQ and Prohibited Species Quota (PSQ) Transfer Request form is used to transfer annual amounts of groundfish and halibut CDQ and PSQ, except Bering Sea Chinook salmon, between two CDQ groups. This form is completed by the transferring and receiving CDQ groups.
- The Application for Approval of Use of Non-CDQ Harvest Regulations is used by a CDQ group, an association representing CDQ groups, or a voluntary fishing cooperative to request approval to use non CDQ harvest regulations when the CDQ regulations are more restrictive than the regulations otherwise required for participants in non-CDQ groundfish fisheries.
- An appeals process is provided for an applicant who receives an adverse initial administrative determination related to its Application for Approval of Use of Non-CDQ Harvest Regulations.

Affected Public: Not-for-profit institutions; Business or other for-profit organizations.

Frequency: On occasion.

Respondent's Obligation: Required to Obtain or Retain Benefits.

Legal Authority: Magnuson-Stevens Fishery Conservation and Management Act.

This information collection request may be viewed at *www.reginfo.gov*. Follow the instructions to view the Department of Commerce collections currently under review by OMB.

Written comments and recommendations for the proposed information collection should be submitted within 30 days of the publication of this notice on the following website *www.reginfo.gov/public/do/PRAMain*. Find this particular information collection by selecting ''Currently under 30-day Review—Open for Public Comments'' or by using the search function and

entering either the title of the collection or the OMB Control Number 0648–0269.

Sheleen Dumas,

Department PRA Clearance Officer, Office of the Under Secretary for Economic Affairs, Commerce Department.

[FR Doc. 2023–16417 Filed 8–1–23; 8:45 am]

BILLING CODE 3510–22–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

[RTID 0648–XD149]

Caribbean Fishery Management Council; Public Meeting

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

ACTION: Notice of public virtual meeting.

SUMMARY: The Caribbean Fishery Management Council's (Council) District Advisory Panels (DAPs) will hold a public virtual meeting to discuss the items contained in the tentative agenda included in the **SUPPLEMENTARY INFORMATION**.

DATES: The DAPs public virtual meeting will be held on August 30, 2023, from 10 a.m. to 12 p.m., Atlantic Standard Time (AST).

ADDRESSES: You may join the DAPs public virtual meeting (via Zoom) from a computer, tablet or smartphone by entering the following addresses:

Join Zoom Meeting: DAPs *https://us02web.zoom.us/j/88004907357?pwd=ZnRPL0g4ekMzWHRJUzA1K1FoRnVOdz09*

Meeting ID: 880 0490 7357

Passcode: 849982

One tap mobile

+17879451488,,88004907357#,,,,*849982# Puerto Rico

+17879667727,,88004907357#,,,,*849982# Puerto Rico

Dial by your location:

- +1 787 945 1488 Puerto Rico
- +1 787 966 7727 Puerto Rico
- +1 939 945 0244 Puerto Rico
- +1 669 444 9171 US

Meeting ID: 880 0490 7357

Passcode: 849982

Find your local number: https://us02web.zoom.us/u/kbtRmz6s7w

FOR FURTHER INFORMATION CONTACT: Miguel Rolón, Executive Director, Caribbean Fishery Management Council, 270 Muñoz Rivera Avenue, Suite 401, San Juan, Puerto Rico 00918–1903, telephone: (787) 398–3717.

SUPPLEMENTARY INFORMATION: The items included in the tentative agenda are:

August 30, 2023

10 a.m.–10:30 a.m.

—Melded Conceptual Models in the US Caribbean—Tarsila Seara

10:30 a.m.–11:30 a.m.

—Process for Establishing Accountable Measures—Sarah Stephenson and María López

11:30 a.m.–12 p.m.

—The SERO's EEJ Strategy Implementation Plan for Underserved Communities: An Examination of Barriers and Development of Actionable Solutions—Heather Blough

Other than the starting date and time the order of business may be adjusted as necessary to accommodate the completion of agenda items, at the discretion of the Chair. The meeting will begin on August 30, 2023 at 10 a.m. AST, and will end on August 30, 2023, at 12 p.m. AST. In this specific case, the Chair may extend the meeting until 1 p.m., to allow further discussion, if warranted.

Special Accommodations

For any additional information on this public hybrid meeting, you may contact Diana Martino, Caribbean Fishery Management Council, 270 Muñoz Rivera Avenue, Suite 401, San Juan, Puerto Rico, 00918–1903, telephone: (787) 226–8849.

Authority: 16 U.S.C. 1801 *et seq.*

Dated: July 28, 2023.

Rey Israel Marquez,

Acting Deputy Director, Office of Sustainable Fisheries, National Marine Fisheries Service.

[FR Doc. 2023–16468 Filed 8–1–23; 8:45 am]

BILLING CODE 3510–22–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

Evaluation of Grand Bay National Estuarine Research Reserve; Notice of Public Meeting; Request for Comments

AGENCY: Office for Coastal Management, National Ocean Service, National Oceanic and Atmospheric Administration, Department of Commerce.

ACTION: Notice of public meeting and opportunity to comment.

SUMMARY: The National Oceanic and Atmospheric Administration (NOAA), Office for Coastal Management, will hold a public meeting to solicit input on the performance evaluation of the Grand Bay National Estuarine Research Reserve. NOAA also invites the public to submit written comments.

DATES: NOAA will consider all written comments received by Friday, September 29, 2023. A hybrid (virtual and in-person) public meeting will be held on Wednesday, September 20, 2023, from noon to 1 p.m. Central Daylight Time (CDT). NOAA may close the meeting 10 minutes after the conclusion of public testimony and after responding to any clarifying questions from participants.

ADDRESSES: Comments may be submitted by one of the following methods:

Public Meeting: Provide oral comments during the virtual and in-person public meeting on Wednesday, September 20, 2023, from noon to 1 p.m. CDT. Both in-person and virtual participants should register if they wish to provide public comment. Virtual participants must register in order to receive an emailed link to the public meeting. The lineup of speakers will be based on the date and time of registration. As time allows, public comment will then be opened to all participants.

- *For virtual participation,* register as an attendee or speaker at *https://forms.gle/tCXQoVBVGVCZrWpB7* by Tuesday, September 19, 2023, at 7 p.m. CDT. Upon registration, a confirmation email will be sent. The lineup of speakers will be based on the date and time of registration. Two hours prior to the start of the meeting on Wednesday, September 20, 2023, registrants will be emailed a link to join the public meeting and information about participating. Members of the public may also register to attend the meeting virtually as a non-speaker. If, after registering online, virtual registrants opt to participate in person, they can do so by following the in-person participation direction.
- *For in-person participation,* you may attend the public meeting onsite on Wednesday, September 20, 2023, noon to 1 p.m. CDT at the Grand Bay Reserve, 6005 Bayou Heron Road, Moss Point, MS 39562. Advance registration to attend onsite is not required. Sign-in registration for providing public comment in-person will be available at the meeting venue.

Email: Carrie Hall, Evaluator, NOAA Office for Coastal Management, at *czma.evaluations@noaa.gov.* Include ''Comments on Performance Evaluation of the Grand Bay Research Reserve'' in the subject line of the message.

NOAA will accept anonymous comments; however, the written comments NOAA receives are

considered part of the public record, and the entirety of the comment, including the name of the commenter, email address, attachments, and other supporting materials, will be publicly accessible. Sensitive personally identifiable information, such as account numbers and social security numbers, should not be included with the comment. Comments that are not related to the performance evaluation of the Grand Bay Research Reserve, or that contain profanity, vulgarity, threats, or other inappropriate language will not be considered.

FOR FURTHER INFORMATION CONTACT: Carrie Hall, Evaluator, NOAA Office for Coastal Management, by email at *Carrie.Hall@noaa.gov* or by phone at (240) 410–3422. Copies of the previous evaluation findings, reserve management plan, and reserve site profile may be viewed and downloaded at *https://coast.noaa.gov/czm/evaluations/.* A copy of the evaluation notification letter and most recent progress report may be obtained upon request by contacting Carrie Hall.

SUPPLEMENTARY INFORMATION: Section and 315(f) of the Coastal Zone Management Act (CZMA) requires NOAA to conduct periodic evaluations of federally approved national estuarine research reserves. The evaluation process includes holding one or more public meetings, considering public comments, and consulting with interested Federal, State, and local agencies and members of the public. During the evaluation, NOAA will consider the extent to which the State of Mississippi has met the national objectives, adhered to the reserve's management plan approved by the Secretary of Commerce, and adhered to the terms of financial assistance under the CZMA. When the evaluation is complete, NOAA's Office for Coastal Management will place a notice in the **Federal Register** announcing the availability of the final evaluation findings.

Authority: 16 U.S.C. 1461.

Keelin Kuipers,

Deputy Director, Office for Coastal Management, National Ocean Service, National Oceanic and Atmospheric Administration.

[FR Doc. 2023–16410 Filed 8–1–23; 8:45 am]

BILLING CODE 3510–JE–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

Evaluation of Puerto Rico Coastal Management Program; Notice of Public Meeting; Request for Comments

AGENCY: Office for Coastal Management, National Ocean Service, National Oceanic and Atmospheric Administration, Department of Commerce.

ACTION: Notice of public meeting and opportunity to comment.

SUMMARY: The National Oceanic and Atmospheric Administration (NOAA), Office for Coastal Management, will hold an in-person public meeting to solicit input on the performance evaluation of the Puerto Rico Coastal Management Program. NOAA also invites the public to submit written comments.

DATES: NOAA will hold an in-person public meeting on Wednesday, September 20, 2023, at 5 p.m. Atlantic Standard Time (AST). NOAA may close the meeting 15 minutes after the conclusion of public testimony and after responding to any clarifying questions from hearing participants. NOAA will consider all relevant written comments received by Friday, September 29, 2023.

ADDRESSES: Comments may be submitted by one of the following methods:

- *In-Person Public Meeting:* Provide oral comments during the in-person public meeting on Wednesday, September 20, 2023, at 5 p.m. AST at Environmental Agencies Building, Auditorium, 4th Floor, Road 8838, Km. 6.3, Sector El Cinco, Rio Piedras, Puerto Rico.
- *Email:* Send written comments to Ralph Cantral, Evaluator, NOAA Office for Coastal Management, at *Ralph.Cantral@noaa.gov.* Include ''Comments on Performance Evaluation of the Puerto Rico Coastal Management Program'' in the subject line of the message.

NOAA will accept anonymous comments; however, the written comments NOAA receives are considered part of the public record, and the entirety of the comment, including the name of the commenter, email address, attachments, and other supporting materials, will be publicly accessible. Sensitive personally identifiable information, such as account numbers and Social Security numbers, should not be included with the comment. Comments that are not related to the performance evaluation of the Puerto Rico Coastal Management Program or that contain profanity, vulgarity, threats, or other inappropriate language will not be considered.

FOR FURTHER INFORMATION CONTACT: Ralph Cantral, Evaluator, NOAA Office for Coastal Management, by email at *Ralph.Cantral@noaa.gov* or by phone at (843) 474–1357. Copies of the previous evaluation findings and Assessment and Strategies may be viewed and downloaded at *http://coast.noaa.gov/czm/evaluations/.* A copy of the evaluation notification letter and most recent progress report may be obtained upon request by contacting Ralph Cantral.

SUPPLEMENTARY INFORMATION: Section 312 of the Coastal Zone Management Act (CZMA) requires NOAA to conduct periodic evaluations of federally approved coastal management programs. The evaluation process includes holding one or more public meetings, considering public comments, and consulting with interested Federal, State, and local agencies and members of the public. During the evaluation, NOAA will consider the extent to which the Commonwealth of Puerto Rico has met the national objectives, adhered to the management program approved by the Secretary of Commerce, and adhered to the terms of financial assistance under the CZMA. When the evaluation is complete, NOAA's Office for Coastal Management will place a notice in the **Federal Register** announcing the availability of the final evaluation findings.

Authority: 6 U.S.C. 1458.

Keelin Kuipers,

Deputy Director, Office for Coastal Management, National Ocean Service, National Oceanic and Atmospheric Administration.

[FR Doc. 2023–16411 Filed 8–1–23; 8:45 am]

BILLING CODE 3510–JE–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

[RTID 0648–XD153]

Fisheries of the South Atlantic; Southeast Data, Assessment, and Review (SEDAR); Public Meeting

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

ACTION: Notice of SEDAR 77 Highly Migratory Species (HMS) Hammerhead Sharks Review Workshop.

SUMMARY: The SEDAR 77 assessment of the Atlantic stock of hammerhead sharks will consist of a stock identification (ID) process, data webinars/workshop, a series of assessment webinars, and a review workshop. A SEDAR 77 Review Workshop has been scheduled in person for August 28 through September 1, 2023. See **SUPPLEMENTARY INFORMATION**.

DATES: The SEDAR 77 HMS Hammerhead Sharks Review Workshop is scheduled for August 28–August 31, 2023, from 9 a.m. until 5 p.m., Eastern each day, and September 1, 2023, from 9 a.m. until 1 p.m., Eastern. The established times may be adjusted as necessary to accommodate the timely completion of discussion relevant to the assessment process. Such adjustments may result in the meeting being extended from or completed prior to the time established by this notice.

ADDRESSES:

Meeting address: The meeting will be held at the Boardwalk Beach Hotel & Convention Center, 9600 S Thomas Dr, Panama City Beach, FL 32408; phone: (850) 234–3484. The meeting is also available for broadcast, via the following link: *https://register.gotowebinar.com/register/5173918420842903386.* The workshop is open to members of the public. Registration for the main plenary webinar is available by contacting the SEDAR coordinator via email at *Kathleen.Howington@safmc.net.*

SEDAR address: South Atlantic Fishery Management Council, 4055 Faber Place Drive, Suite 201, N. Charleston, SC 29405; *www.sedarweb.org.*

FOR FURTHER INFORMATION CONTACT: Kathleen Howington, SEDAR Coordinator, 4055 Faber Place Drive, Suite 201, North Charleston, SC 29405; phone: (843) 571–4371; email: *Kathleen.Howington@safmc.net.*

SUPPLEMENTARY INFORMATION: The Gulf of Mexico, South Atlantic, and Caribbean Fishery Management Councils, in conjunction with NOAA Fisheries and the Atlantic and Gulf States Marine Fisheries Commissions, have implemented the Southeast Data, Assessment and Review (SEDAR) process, a multi-step method for determining the status of fish stocks in the Southeast Region. SEDAR is a three-step process including: (1) Data Workshop; (2) Assessment Process utilizing webinars; and (3) Review Workshop. The product of the Data Workshop is a data report which compiles and evaluates potential datasets and recommends which datasets are appropriate for assessment analyses. The product of the Assessment Process is a stock assessment report which describes the fisheries, evaluates the status of the stock, estimates biological benchmarks, projects future population conditions, and recommends research and monitoring needs. The assessment is independently peer reviewed at the Review Workshop. The product of the Review Workshop is a Summary documenting panel opinions regarding the strengths and weaknesses of the stock assessment and input data. Participants for SEDAR Workshops are appointed by the Gulf of Mexico, South Atlantic, and Caribbean Fishery Management Councils and NOAA Fisheries Southeast Regional Office, Highly Migratory Species Management Division, and Southeast Fisheries Science Center. Participants include: data collectors and database managers; stock assessment scientists, biologists, and researchers; constituency representatives including fishermen, environmentalists, and non-governmental organizations (NGOs); international experts; and staff of Councils, Commissions, and State and Federal agencies.

The items of discussion at the SEDAR 77 HMS Hammerhead Shark Review Workshop are as follows: Participants will evaluate the stock identification, data, and assessment reports, as specified in the Terms of Reference for the workshop, and determine if they are scientifically sound.

Although non-emergency issues not contained in this agenda may come before this group for discussion, those issues may not be the subject of formal action during this meeting. Action will be restricted to those issues specifically identified in this notice and any issues arising after publication of this notice that require emergency action under section 305(c) of the Magnuson-Stevens Fishery Conservation and Management Act, provided the public has been notified of the intent to take final action to address the emergency.

Special Accommodations

This meeting is accessible to people with disabilities. Requests for auxiliary aids should be directed to the South Atlantic Fishery Management Council office (see **ADDRESSES**) at least 5 business days prior to the meeting.

Note: The times and sequence specified in this agenda are subject to change.

Authority: 16 U.S.C. 1801 *et seq.*

Dated: July 28, 2023.

Rey Israel Marquez,

Acting Deputy Director, Office of Sustainable Fisheries, National Marine Fisheries Service.

[FR Doc. 2023–16469 Filed 8–1–23; 8:45 am]

BILLING CODE 3510–22–P

COMMODITY FUTURES TRADING COMMISSION

Sunshine Act Meetings

FEDERAL REGISTER CITATION OF PREVIOUS ANNOUNCEMENT: 88 FR 47130, July 21, 2023.

PREVIOUSLY ANNOUNCED TIME AND DATE OF THE MEETING: 9:00 a.m. EDT, Friday, July 28, 2023.

CHANGES IN THE MEETING: The meeting has been canceled.

CONTACT PERSON FOR MORE INFORMATION: Christopher Kirkpatrick, Secretary of the Commission, 202–418–5964.

Authority: 5 U.S.C. 552b.

Dated: July 28, 2023.

Christopher Kirkpatrick,

Secretary of the Commission.

[FR Doc. 2023–16496 Filed 7–31–23; 11:15 am]

BILLING CODE 6351–01–P

CONSUMER PRODUCT SAFETY COMMISSION

Sunshine Act Meetings

TIME AND DATE: Wednesday, August 2, 2023; 10:00 a.m.

PLACE: The meeting will be held virtually and in person at Bethesda, MD.

STATUS: Commission Meeting—Closed to the Public.

MATTERS TO BE CONSIDERED: *Briefing Matter.*

CONTACT PERSON FOR MORE INFORMATION: Alberta E. Mills, Office of the Secretary, U.S. Consumer Product Safety Commission, 4330 East West Highway, Bethesda, MD 20814, 301–504–7479 (Office) or 240–863–8938 (Cell).

Dated: July 28, 2023.

Alberta E. Mills,

Commission Secretary.

[FR Doc. 2023–16527 Filed 7–31–23; 11:15 am]

BILLING CODE 6355–01–P

DEPARTMENT OF DEFENSE

Department of the Air Force

Record of Decision for the Airspace Optimization for Readiness at Mountain Home Air Force Base, Idaho Environmental Impact Statement

ACTION: Notice of availability of record of decision.

SUMMARY: On July 14, 2023, the Department of the Air Force (DAF) signed the Record of Decision (ROD) for the Airspace Optimization for Readiness at Mountain Home Air Force Base, Idaho, Environmental Impact Statement.

ADDRESSES: Mr. Austin Naranjo, 366th Fighter Wing Headquarters, Office of Public Affairs, 366 Gunfighter Ave., Building 512, Suite 2014, Mountain Home AFB ID, 83648, (208) 828–6800; *austin.naranjo.1@us.af.mil.*

SUPPLEMENTARY INFORMATION: The DAF has selected Alternative 1, 100-Foot Above Ground Level (AGL) floor for subsonic flight across all Military Operations Areas (MOA) and Alternative B, 10,000-Foot AGL Supersonic Floor across all MOAs. Based on this decision, the DAF will request the Federal Aviation Administration modify the subsonic low-altitude floors and supersonic altitude floors to be consistent across all the MOAs in the Mountain Home Special Use Airspace.

The DAF decision documented in the ROD was based on matters discussed in the Final Environmental Impact Statement, inputs from the public and regulatory agencies, and other relevant factors. The Final Environmental Impact Statement was made available to the public on March 3, 2023, through a Notice of Availability in the **Federal Register** (Volume 88, Number 42, Page 13443) with a waiting period that ended on April 3, 2023.

Authority: This Notice of Availability is published pursuant to the regulations (40 CFR part 1506.6) implementing the provisions of the National Environmental Policy Act (42 U.S.C. 4321, *et seq.*) and the Air Force's Environmental Impact Analysis Process (32 CFR parts 989.21(b) and 989.24(b)(7)).

Tommy W. Lee,

Acting Air Force Federal Register Liaison Officer.

[FR Doc. 2023–16362 Filed 8–1–23; 8:45 am]

BILLING CODE 5001–10–P

DEPARTMENT OF DEFENSE

Office of the Secretary

Modifications to the Overseas Implementation of the TRICARE Childbirth and Breastfeeding Support Demonstration

AGENCY: Department of Defense (DoD).

ACTION: Notice of demonstration modifications.

SUMMARY: The Assistant Secretary of Defense for Health Affairs (ASD(HA)) is notifying the public that the TRICARE Childbirth and Breastfeeding Support Demonstration (CBSD) will be modified for implementation to the TRICARE Overseas Program (TOP). Additionally, the ASD(HA) is notifying the public that due to current financial constraints, all or part of the evaluation of the CBSD may be conducted by internal DoD analytics staff.

DATES: The CBSD will expand overseas with the modifications discussed in this notice on January 1, 2025.

FOR FURTHER INFORMATION CONTACT: Erica Ferron, 303–676–3626, *erica.c.ferron.civ@health.mil.*

SUPPLEMENTARY INFORMATION:

A. Background

Section 746 of the William M. (Mac) Thornberry National Defense Authorization Act for Fiscal Year 2021 directed the Secretary of Defense to establish a five-year demonstration project under TRICARE to evaluate the cost, quality of care, and impact on maternal and fetal outcomes of covering the services of doulas and lactation consultants or counselors not otherwise TRICARE-authorized, and to determine whether it would be appropriate to implement permanent coverage. On October 29, 2021, the ASD(HA) published a **Federal Register** Notice (FRN) announcing the CBSD (86 **Federal Register** (FR) 60006), which began nationwide in the United States (U.S.) on January 1, 2022, and will expand to include overseas beneficiaries and locations on January 1, 2025.

The FRN announced that the CBSD was designed to evaluate the following hypotheses:

(1) Access to doulas will have a positive and measurable impact on maternal and fetal outcomes.

(2) Access to lactation consultants and lactation counselors will have the same or better impact on maternal and fetal outcomes when compared to the same services provided by other TRICARE-authorized providers.

(3) The cost of providing access to such providers is justified by the impact of the providers on maternal and fetal outcomes.

(4) It is feasible to administer the new provider classes and the services they provide.

The FRN specified that coverage would be provided under private sector care and excluded care provided in direct care within Military Medical Treatment Facilities (MTFs). To participate, beneficiaries were required to be enrolled in Prime or Select with one of the managed care support contractors (MCSCs). TRICARE for Life, the Uniformed Services Family Health Plan, the Continued Health Care Benefit Program beneficiaries were excluded from participation. Beginning January 1, 2025, beneficiaries in Prime (including Prime Remote) and Select enrolled to the TOP contractor will be eligible to participate. The demonstration created a new benefit category (childbirth support services) and added three new extra-medical maternity care provider classes (Certified Labor Doulas (CLDs), Certified Lactation Consultants, and Certified Lactation Counselors). It also created qualification criteria for the new provider classes, established benefit limitations, added group breastfeeding counseling sessions to the existing individual breastfeeding counseling benefit, and established reimbursement methodologies.

B. Maternity Care Under the TOP

Each year, approximately 60,000 beneficiaries give birth under the MCSCs in private sector care facilities in the United States. The number of beneficiaries who give birth overseas under the TOP program is comparatively very small. Based on claims data for calendar year (CY) 2022, TRICARE beneficiaries enrolled with the TOP contractor gave birth 1,093 times in private sector care facilities in 41 countries. Over half of those deliveries occurred in Germany, with the next most frequent locations for deliveries being Italy, South Korea, the U.S. (TOP beneficiaries electing to deliver in one of the 50 states or District of Columbia), Puerto Rico, and Japan. These six locations accounted for 87 percent of deliveries under TOP. Of the 34 remaining countries, 13 had only one delivery, and another nine only had two deliveries in 2022. In 2021, the top six locations were the same, but there were 14 countries that had a delivery in 2021 that did not have one in 2022 while there were births in 15 countries in 2022 for which a birth was not recorded in 2021. In other words, there is a small group of countries within which the DoD can reliably expect most TOP deliveries to occur and a larger number of countries in which a small number of deliveries may occur. Expansion of the demonstration overseas accounts for this variability as well as the overall smaller number of deliveries overseas.

C. CBSD Modifications for Implementation Overseas

This FRN notifies the public that the DoD intends to modify the CBSD for overseas implementation by way of guidance to be published to the TRICARE manuals (found at *manuals.health.mil*). These changes are expected to impact some or all of the requirements published in the initial CBSD FRN and are intended to facilitate the DoD's ability to measure the CBSD hypotheses. The DoD's focus for overseas implementation will be testing

the fourth hypothesis, that is, *is it feasible to administer the new provider classes and the services they provide in overseas locations?* The other three hypotheses will be measured primarily using the larger beneficiary population already receiving services under the CBSD in the U.S.

As a worldwide benefit, the TRICARE Basic (*i.e.,* medical) benefit recognizes that cultural differences unique to health care practices and services in overseas locations necessitate allowances for variations in care delivery from how the program is administered in the U.S. in order to ensure a robust benefit (see the TRICARE Policy Manual (TPM), Chapter 12, Section 1.1). Such uniquities and cultural differences are expected to impact care provided under the CBSD, such that deviating from the CBSD requirements will be required. The requirements for the three classes of providers under the CBSD are likely to need adjustment in some or all locations to ensure applicability in the many countries in which TRICARE beneficiaries may give birth each year. These modifications will be enacted prior to the start of the CBSD overseas, but additional modifications may occur during the two-year overseas period. While the DoD selected certification bodies that had an international component, these bodies may be less available outside of the U.S. and Western Europe, such that additional bodies are required. The overseas CBSD modifications will extend to the extra-medical maternity provider classes approved under the CBSD in the U.S., but will not include new classes of extra-medical maternity providers. Additionally, we anticipate modifying reimbursement rates for CBSD services overseas, commensurate with how reimbursement is typically modified for overseas delivery of the TRICARE Basic (*i.e.,* medical) benefit (see the TRICARE Reimbursement Manual, Chapter 1, Section 34 and 35 for examples of such variances).

Finally, the DoD also anticipates that it may be necessary to add an enrollment requirement. The lack of an enrollment process in the U.S. was facilitated by known, uniform provider requirements such that both beneficiaries and providers could be assured that requirements were met prior to the receipt of services. Given that the DoD may need to approve changes to provider requirements consistent with care delivery in other countries, beneficiaries may not have the same ability to independently verify the qualifications of a provider without interacting with the TOP contractor. As such, an enrollment requirement would ensure beneficiaries understand the requirements for the CBSD in their location.

These and other modifications necessary to ensure DoD's ability to evaluate the CBSD hypotheses overseas will be published to the TRICARE Operations Manual, which is publicly available at *http://manuals.health.mil.* Additionally, the DoD will continue to publish information about the CBSD on its website (see *tricare.mil/cbsd*) and social media accounts.

D. Modification to the Demonstration Evaluation

Separately, the ASD(HA) is notifying the public of a change to the evaluation of the CBSD. The DoD stated in the October 29, 2021, FRN that we intended to use an independent contractor to evaluate the CBSD, at an estimated cost of $4.3M. Due to a constrained financial environment, the DoD may use internal DoD staff and resources to perform some or all of this evaluation. More information on the evaluation will be reported in the annual reports to Congress.

Dated: July 28, 2023.

Aaron T. Siegel,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 2023–16477 Filed 8–1–23; 8:45 am]

BILLING CODE 5001–06–P

DEPARTMENT OF EDUCATION

Applications for New Awards; Fund for the Improvement of Postsecondary Education—Historically Black Colleges or Universities (HBCUs), Tribally Controlled Colleges or Universities (TCCUs), and Minority-Serving Institutions (MSIs) Research and Development Infrastructure Grant Program (RDI)

AGENCY: Office of Postsecondary Education, Department of Education.

ACTION: Notice.

SUMMARY: The Department of Education (Department) is issuing a notice inviting applications for new awards for fiscal year (FY) 2023 for the HBCU, TCCU, and MSI RDI grant program, Assistance Listing Number 84.116H. This notice relates to the approved information collection under OMB control number 1894–0006.

DATES:

Applications Available: August 2, 2023.

Deadline for Transmittal of Applications: October 2, 2023.

Deadline for Intergovernmental Review: November 30, 2023.

ADDRESSES: For the addresses for obtaining and submitting an application, please refer to our Common Instructions for Applicants to Department of Education Discretionary Grant Programs, published in the **Federal Register** on December 7, 2022 (87 FR 75045) and available at *www.federalregister.gov/d/2021-27979.* Please note that these Common Instructions supersede the version published on December 27, 2021.

FOR FURTHER INFORMATION CONTACT: Jason Cottrell, Ph.D., U.S. Department of Education, 400 Maryland Avenue SW, Room 5C122, Washington, DC 20202–4260. Telephone: (202) 453–7530. Email: *Jason.Cottrell@ed.gov.*

If you are deaf, hard of hearing, or have a speech disability and wish to access telecommunications relay services, please dial 7–1–1.

SUPPLEMENTARY INFORMATION:

Full Text of Announcement

I. Funding Opportunity Description

Purpose of Program: The RDI grant program is designed to provide four-year HBCUs, TCCUs, and MSIs including Asian American and Native American Pacific Islander Serving Institutions (AANAPISIs), Alaska Native and Native Hawaiian Serving Institutions (ANNH), Hispanic Serving Institutions (HSIs), Native American Serving Non-Tribal Institutions (NASNTIs), and/or Predominantly Black Institutions (PBIs), or consortia led by an eligible institution of higher education (institution), with funds to implement transformational investments in research infrastructure, including research productivity, faculty expertise, graduate programs, physical infrastructure, human capital development, and partnerships leading to increases in external funding.

For HBCUs and MSIs, the RDI grant program will support institutions in increasing their level of research activity in alignment with the Carnegie Classification designations. Grant funds can be utilized by HBCU and MSI institutions with a Doctoral and Professional Universities (D/PU) classification to move toward the Doctoral Universities with High Research Activity (R2) classification, and by Doctoral Universities with High Research Activity (R2) to move toward a classification of Doctoral Universities with Very High Research Activity (R1). For TCCUs, which have their own Carnegie Classification designation and cannot be classified as R1, R2, or D/PU, this program seeks to support an

increase in research activities, undergraduate research opportunities, faculty development, research development, and infrastructure, including physical infrastructure and human capital development.

Background: According to the American Council on Education's Carnegie Classification dashboard,[1] of the 146 R1 universities, there are no HBCUs and only 33 MSIs. Of the 133 R2 universities, only 11 are HBCUs and 28 are MSIs. As noted above, TCCUs have their own Carnegie Classification and are not included in the R1 and R2 classifications.

The R1 and R2 Carnegie Classifications for Doctoral Universities describe institutions that award at least 20 research/scholarship doctoral degrees or awarded at least 30 professional practice doctorates across at least 2 programs during the Carnegie Classification's update year, and expend at least $5 million in research, with an indexed cutoff between the two categories.[2] The Doctoral/Professional University classification describe institutions that award at least 20 research/scholarship doctoral degrees during the Carnegie Classification's update year or awarded at least 30 professional practice doctoral degrees in at least 2 programs, and expend less than $5 million in research.

The Nation's HBCUs, TCCUs, and MSIs provide access to an education for many of the Nation's students of color. HSIs represent 17 percent of the Nation's institutions and educate 68 percent of the Nation's Hispanic undergraduate students.[3] The most recent research available provides that, in 2012, of the 34 TCCUs, 12 conferred 252 Bachelor's Degrees to American Indian and Alaska Native students, representing 82 percent of those TCCU's Bachelor's Degree recipients.[4] A report from the United Negro College Fund shows that the Nation's HBCUs enroll 10 percent of all African American students and produce almost 20 percent of all African American graduates.[5] Because of their central role in educating students of color, it is important for HBCUs, TCCUs, and MSIs to excel in research activity. Teaching and research go hand-in-hand in ensuring student[6] and institutional success.[7] Research activity can impact funding, faculty and student recruitment, student research opportunities, and promote diversity in graduate students and faculty at an institution.

The Nation's HBCUs, TCCUs, and many MSIs often lack the resources to plan, implement, and promote transformational investments in research infrastructure. According to a recent report from the Center for American Progress,[8] Black researchers and inventors are less likely to receive Federal funds due to the barriers that exist in the research profession. At the institutional level, these barriers are compounded. Per the Congressional Research Service,[9] HBCUs receive fewer research and development dollars than predominantly white institutions, although seven of the top eight institutions that graduate the highest number of Black undergraduates in science and engineering are HBCUs. According to the National Science Foundation,[10] HBCUs enroll only 9 percent of Black undergraduates in the United States, but they account for a much higher percentage of Black students who graduate with degrees in engineering, mathematics, and biological sciences.

At TCCUs, the opportunity to integrate culturally relevant research into educational curricula[11] can assist with improving student success.[12] However, efforts to sustain and implement extensive research activities at TCCUs face obstacles. Administrations often have difficulty maintaining research activities due to the young nature of the institutions and their lack of research support offices.[13] One study found that TCCUs' biggest obstacles in developing research activities are scheduling, infrastructure needs (lack of space, equipment, and literature), partnership problems (lack of Tribal community knowledge), faculty capacity, and mistrust,[14] while recent events like COVID have renewed questions about technology infrastructure and funding constraints (long-term funding),[15] and isolation (remote areas).[16] However, the authors found that the benefits of research activities for faculty and student development—such as conferences, collaborations, and presentations—far outweigh these obstacles.

This notice includes three absolute priorities to ensure support for each type of institution (HBCUs, TCCUs, and MSIs), consistent with Congress' explanatory statement in Division H of the Consolidated Appropriations Act, 2023 (Pub. L. 117–328) for this program. In general, the Department plans to allocate funding across the absolute priorities under this program proportionally based on the relative share of funding appropriated to each category of eligible institutions in the American Rescue Plan Act (Pub. L. 117–2). However, the ultimate allocation of funding across the absolute priorities will depend, in part, on the quality of applications. In addition, within the MSI absolute priority, there is a competitive preference priority for applicants enrolling high proportions of undergraduate students in need of financial assistance. Specifically, competitive preference priority points will be awarded to institutions where at least half of the enrolled students receive Pell Grants.

Priorities: This notice contains three absolute priorities and one competitive preference priority. Applicants may only apply for one of the three absolute priorities based on the institution's eligibility as described in this notice. We are establishing these priorities for the fiscal year (FY) 2023 grant competition and any subsequent year in which we make awards from the list of unfunded applications from this competition, in accordance with section 437(d)(1) of the General Education Provisions Act (GEPA), 20 U.S.C. 1232(d)(1).

Absolute Priorities: For FY 2023 and any subsequent year in which we make awards from the list of unfunded applications from this competition, these priorities are absolute priorities. Under 34 CFR 75.105(c)(3), we consider only applications that meet one of these

[1] *https://carnegieclassifications.acenet.edu/.*

[2] *https://carnegieclassifications.acenet.edu/carnegie-classification/classification-methodology/basic-classification/.*

[3] *https://www.edexcelencia.org/.*

[4] *https://cmsi.gse.rutgers.edu/sites/default/files/MSI_TBLCLLGreport_Final.pdf.*

[5] *https://uncf.org/the-latest/the-numbers-dont-lie-hbcus-are-changing-the-college-landscape.*

[6] *https://nsse.indiana.edu/research/annual-results/2022/story2.html.*

[7] *https://www.forbes.com/sites/davidrosowsky/2022/03/02/the-role-of-research-at-universities-why-it-matters/?sh=35c9dce96bd5.*

[8] *https://www.americanprogress.org/article/redesigning-federal-funding-research-development/.*

[9] *https://www.everycrsreport.com/files/20111110_RL34435_acbcccd5c0d382bec3cd87763ad8061e6945941c.pdf.*

[10] *https://new.nsf.gov/science-matters/science-behind-hbcu-success.*

[11] *https://repository.upenn.edu/cgi/viewcontent.cgi?article=1386&context=gse_pubs.*

[12] Brayboy, B.M.J., Fann, A.J., Castagno, A.E., & Solyom, J.A. (2012). Postsecondary education for American Indian and Alaska Natives: Higher education for nation building and self-determination. ASHE Higher Education Report, 37(5), 1–154. San Francisco: Jossey-Bass.

[13] *https://tribalcollegejournal.org/the-evolution-of-research-at-tribal-colleges-and-universities/.*

[14] *https://tribalcollegejournal.org/survey-tribal-colleges-reveals-researchs-benefits-obstacles/.*

[15] *https://www.insidehighered.com/news/2021/03/16/tribal-colleges-report-pandemic-related-challenges-around-mental-health-persistence.*

[16] *https://repository.upenn.edu/cgi/viewcontent.cgi?article=1386&context=gse_pubs.*

priorities and the requirements included in this notice. A lead applicant can only apply under one absolute priority.

These priorities are:

Absolute Priority 1—Funding for Historically Black Colleges and Universities' Research and Development Infrastructure.

Applications will be accepted for this absolute priority from HBCUs, as defined in this notice, that propose to support high-quality implementation of transformative research capacity initiatives and that seek to attain higher research activity status, as measured by the Carnegie Classifications of Institutions of Higher Education, to either move from R2 to R1 status or from D/PU to R2 status. HBCUs that currently have an R1 Carnegie Classification are ineligible to apply as the lead applicant in this competition but are eligible to participate as part of a consortium.

Absolute Priority 2—Funding for Tribally Controlled Colleges and Universities' Research and Development Infrastructure.

Applications will be accepted for this absolute priority from TCCUs, as defined in this notice, that propose to improve their research and development activities, including infrastructure, faculty development, and academic programs.

Absolute Priority 3—Funding for Minority-Serving Institutions' Research and Development Infrastructure.

Applications will be accepted for this absolute priority from MSIs, as defined in this notice, that propose to support high-quality implementation of transformative research capacity initiatives at institutions designated as at least one type of MSI (AANAPISI, ANNH, HSI, NASNTI, and/or PBI) and that seek to attain higher research activity status according to the Carnegie Classifications, to either move from R2 to R1 status or from D/PU to R2 status. Institutions that currently have an R1 Carnegie Classification are ineligible to apply as the lead applicant but are eligible to participate as part of a consortium.

Competitive Preference Priority: Within this absolute priority, we give competitive preference to applications that address the following priority. Under 34 CFR 75.105(c)(2)(i), we award an additional two points to an application that meets this priority.

The priority is:

MSI Pell Grant Percentage (0 or 2 points).

Lead applicants whose Pell Grant recipients account for 50 percent or higher of their undergraduate student enrollment, as measured by the Department using the most recent data available in the Integrated Postsecondary Education Data System (IPEDS), will be awarded 2 additional points.

Use of Funds: For FY 2023 and any subsequent year in which we make awards from the list of unfunded applications from this competition, we are establishing the following allowable uses of funds in accordance with section 437(d)(1) of GEPA. Applicants must propose projects that would do one or more of the activities listed in this notice. Additionally, consistent with the FIPSE program statute in 20 U.S.C. 1138 and the explanatory statement accompanying Division H of the Consolidated Appropriations Act, 2023 (Pub. L. 117–328), the Department uses its authority under section 437(d)(1) of GEPA to authorize the use of grant funds for construction and the acquisition of real property to the extent set forth in the allowable uses below.

(1) Providing for the improvement of infrastructure existing on the date of the grant award, including deferred maintenance, or the establishment of new physical infrastructure, including instructional program spaces, laboratories, or research facilities relating to the fields of science, technology, engineering, the arts, mathematics, health, agriculture, education, medicine, law, and other disciplines.

(2) Hiring and retaining faculty, students, research-related staff, or other personnel, including research personnel skilled in operating, using, or applying technology, equipment, or devices used to conduct or support research.

(3) Supporting research internships and fellowships for students, including undergraduate (Absolute Priority 2 for TCCUs only), graduate, and post-doctoral positions, which may include providing direct student financial assistance to such students.

Note: Per 20 U.S.C. 1138(d)(1), no funds made available under FIPSE can be used to provide direct financial assistance in the form of grants or scholarships to students who do not meet eligibility criteria under Title IV of the HEA.

(4) Creating new, or expanding existing, academic positions, including internships, fellowships, and post-doctoral positions, in fields of research for which research and development infrastructure funds have been awarded under this program.

(5) Creating and supporting inter- and intra-institutional research centers (including formal and informal communities of practice) in fields of research for which research and development infrastructure funds have been awarded under this program, including hiring staff, purchasing supplies and equipment, and funding travel to relevant conferences and seminars to support the work of such centers.

(6) Building new institutional support structures and departments that help faculty learn about, and increase faculty and student access to, Federal research and development grant funds and non-Federal academic research grants.

(7) Building data and collaboration infrastructure so that early findings and research can be securely shared to facilitate peer review and other appropriate collaboration.

(8) Providing programs of study and courses in fields of research for which research and development infrastructure funds have been awarded under this program.

(9) Paying operating and administrative expenses for, and coordinating project partnerships with members of, a consortium as described in this notice on behalf of which the eligible institution has received a grant under this program. A grantee under this competition may not pay for expenses to R1 institutions that are members of the consortia.

(10) Installing or extending the life and usability of basic systems and components of campus facilities related to research, including high-speed broadband internet infrastructure sufficient to support digital and technology-based learning.

(11) Expanding, remodeling, renovating, or altering biomedical and behavioral research facilities existing on the date of the grant award that received support under section 404I of the Public Health Service Act (42 U.S.C. 283k).

(12) Acquiring and installing furniture, fixtures, and instructional research-related equipment and technology for academic instruction in campus facilities in fields of research for which research and development infrastructure funds have been awarded under this program.

(13) Providing increased funding to programs that support research and development at the eligible institution that are funded by National Institutes of Health, including the Path to Excellence and Innovation program with the National Institutes of Health.

(14) Faculty professional development.

(15) Planning purposes, for TCCUs applying under Absolute Priority 2 only.

Definitions: In accordance with section 437(d)(1) of GEPA, we are establishing definitions for ''Doctoral/Professional University,'' ''Minority-Serving Institution,'' ''four-year

institution of higher education,'' ''Historically Black College or University,'' ''R1,'' ''R2,'' ''Tribally Controlled College or University,'' and ''underrepresented students.'' The definitions of ''demonstrates a rationale,'' ''logic model,'' ''project component,'' and ''relevant outcomes'' are from 34 CFR 77.1.

Demonstrates a rationale means a key project component included in the project's logic model is informed by research or evaluation findings that suggest the project component is likely to improve relevant outcomes.

Doctoral/Professional University means an institution that awarded at least 20 research/scholarship doctoral degrees during the Carnegie Classification's update year, as well as institutions that awarded fewer than 20 research/scholarship doctoral degrees during that year but that awarded at least 30 professional practice doctoral degrees in at least 2 programs, and that expended less than $5 million in research.[17]

Four-year institution of higher education means a postsecondary institution that offers programs of at least four years duration or one that offers programs at or above the baccalaureate level. This includes schools that offer postbaccalaureate certificates only or those that offer graduate programs only. It also includes free-standing medical, law, or other first-professional schools.

Historically Black College or University means an institution that meets the eligibility requirements under section 322(2) of the Higher Education Act of 1965, as amended (HEA).

Logic model (also referred to as a theory of action) means a framework that identifies key project components of the proposed project (*i.e.,* the active ''ingredients'' that are hypothesized to be critical to achieving the relevant outcomes) and describes the theoretical and operational relationships among the key project components and relevant outcomes.

Note: In developing logic models, applicants may want to use resources such as the Regional Educational Laboratory Program's (REL Pacific) Education Logic Model Application, available at *https://ies.ed.gov/ncee/rel/regions/pacific/pdf/ELMUserGuideJune2014.pdf.* Other sources include: *https://ies.ed.gov/ncee/edlabs/regions/pacific/pdf/REL_2014025.pdf, https://ies.ed.gov/ncee/edlabs/regions/pacific/pdf/REL_2014007.pdf,* and *https://ies.ed.gov/ncee/edlabs/regions/northeast/pdf/REL_2015057.pdf.*

Minority-Serving Institution means an institution that is eligible to receive assistance under sections 317 through 320 of part A of title III, or under title V of the HEA.

Note: The list of institutions currently designated as eligible under titles III and V of the HEA is available at *www2.ed.gov/about/offices/list/ope/idues/eligibility.html#el-inst.*

Project component means an activity, strategy, intervention, process, product, practice, or policy included in a project. Evidence may pertain to an individual project component or to a combination of project components (*e.g.,* training teachers on instructional practices for English learners and follow-on coaching for these teachers).

R1 is based on the Carnegie Classification category of the same name and means an institution that awarded at least 20 research/scholarship doctoral degrees during the Carnegie Classification's update year, as well as institutions that awarded fewer than 20 research/scholarship doctoral degrees but that awarded at least 30 professional practice doctoral degrees in at least 2 programs, and had at least $5 million in total research expenditures as reported through the National Science Foundation Higher Education Research Development Survey (HERD). Additionally, the Carnegie Classifications developed two indices of research activity using (1) the aggregate level of research activity and (2) the per-capita research activity using the expenditure and staffing measures divided by the number of full-time faculty within the assistant, associate, and full professor ranks. These two indices were charted for each institution and assigned to one of two categories based on a common reference point (the minima of each scale). Institutions that are above the minima during the Carnegie Classification's update year are considered R1.

R2 is based on the Carnegie Classification category of the same name and means an institution that awarded at least 20 research/scholarship doctoral degrees during the Carnegie Classification's update year, as well as institutions that awarded fewer than 20 research/scholarship doctoral degrees but that awarded at least 30 professional practice doctoral degrees in at least 2 programs, and had at least $5 million in total research expenditures as reported through the National Science Foundation HERD. Additionally, the Carnegie Classifications developed two indices of research activity using (1) the aggregate level of research activity and (2) the per-capita research activity using the expenditure and staffing measures divided by the number of full-time faculty within the assistant, associate, and full professor ranks. These two indices were charted for each institution and assigned to one of two categories based on a common reference point (the minima of each scale). Institutions that are below the minima during the Carnegie Classification's update year are considered R2.

Relevant outcome means the student outcome(s) or other outcome(s) the key project component is designed to improve, consistent with the specific goals of the program.

Tribally Controlled College or University means an institution that meets the eligibility requirements of Section 316 of the HEA, namely one that qualifies for funding under the Tribally Controlled College or University Assistance Act of 1978 or the Navajo Community College Assistance Act of 1978; or is cited in section 532 of the Equity in Educational Land Grant Status Act of 1994.

Underrepresented students means students enrolled in postsecondary, career, or technical education who are in one or more of the following subgroups:

(i) A student who is living in poverty.

(ii) A student who is American Indian, Alaska Native, Asian American, Black, Hispanic or Latino, Native Hawaiian, and/or Pacific Islander.

Waiver of Proposed Rulemaking: Under the Administrative Procedure Act (5 U.S.C. 553), the Department generally offers interested parties the opportunity to comment on proposed priorities, selection criteria, definitions, and other requirements. Section 437(d)(1) of GEPA, however, allows the Secretary to exempt from rulemaking requirements regulations governing the first grant competition under a new or substantially revised program authority. This is the first grant competition for this program, and therefore qualifies for this exemption. In order to ensure timely grant awards, the Secretary has decided to forgo public comment on the priorities, requirements, and definitions under section 437(d)(1) of GEPA. These priorities, requirements, and definitions will apply to the FY 2023 grant competition and any subsequent year in which we make awards from the list of unfunded applications from this competition.

Program Authority: 20 U.S.C. 1138–1138d; the Explanatory Statement accompanying Division H of the Consolidated Appropriation Act, 2023 (Pub. L. 117–328).

[17] *https://carnegieclassifications.acenet.edu/carnegie-classification/classification-methodology/basic-classification/.*

Note: Projects will be awarded and must be operated in a manner consistent with the nondiscrimination requirements contained in Federal civil rights laws.

Applicable Regulations: (a) The Education Department General Administrative Regulations in 34 CFR parts 75, 77, 79, 82, 84, 86, 97, 98, and 99. (b) The Office of Management and Budget Guidelines to Agencies on Governmentwide Debarment and Suspension (Nonprocurement) in 2 CFR part 180, as adopted and amended as regulations of the Department in 2 CFR part 3485. (c) The Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards in 2 CFR part 200, as adopted and amended as regulations of the Department in 2 CFR part 3474.

II. Award Information

Type of Award: Discretionary grants.

Estimated Available Funds: $49,500,000.

Contingent upon the availability of funds and the quality of applications, we may make additional awards in subsequent years from the list of unfunded applications from this competition.

Estimated Range of Awards: Contingent upon the number and quality of applications received under each absolute priority.

Estimated Average Size of Awards: Contingent upon the number and quality of applications received under each absolute priority.

Maximum Award Amount:

Applicants under Absolute Priority 1 or Absolute Priority 3: $5,000,000 for a 48-month project period.

Applicants under Absolute Priority 2: $2,000,000 for a 48-month project period.

Project Period: Up to 48 months.

III. Eligibility Information

1. *Eligible Applicants:* Eligible applicants are four-year institutions of higher education (as defined in this notice) that are HBCUs (as defined in this notice), TCCUs (as defined in this notice), and MSIs (as defined in this notice). Eligible applicants may apply individually or as lead applicants of a consortium with other eligible applicants and/or other partners such as an institution of higher education with an R1 Carnegie Classification, community colleges, or non-profit, industry and philanthropic partners. The lead applicant must be an eligible applicant under the absolute priority under which it is applying.

2. a. *Cost Sharing or Matching:* This program requires cost sharing or matching for all applicants. Grantees will need to provide a 1:1 match, which can include in-kind donations. The goal of the match is to promote sustainability and alignment to the institution's strategic plan. Full or partial waivers may be granted using the criteria below.

The Secretary may waive the matching requirement on a case-by-case basis upon showing any of the following exceptional circumstances, which we establish in accordance with section 437(d)(1) of GEPA:

(i) The difficulty of raising matching funds for a program to serve a high poverty area in the lead applicant's geographic location, defined as a Census tract, a set of contiguous Census tracts, an American Indian Reservation, Oklahoma Tribal Statistical Area (as defined by the U.S. Census Bureau), Alaska Native Village Statistical Area or Alaska Native Regional Corporation Area, Native Hawaiian Homeland Area, or other Tribal land or county that has a poverty rate of at least 25 percent as determined every 5 years using American Community Survey 5-Year data;

(ii) Serving a significant population of low-income students at the lead applicant location, defined as at least 50 percent (or the eligibility threshold for the appropriate institutional sector available at *https://www2.ed.gov/about/offices/list/ope/idues/eligibility.html#app*) of degree-seeking enrolled students receiving need-based grant aid under Title IV of the HEA;

(iii) Significant economic hardship as demonstrated by low average educational and general expenditures per full-time equivalent undergraduate student at the lead applicant institution, in comparison with the average educational and general expenditures per full-time equivalent undergraduate student of institutions that offer similar instruction; or

(iv) Information that otherwise demonstrates a commitment to the long-term sustainability of the applicant's projects, such as evidence of a consortium relationship with an R1 institution, a State bond, State matching, planning documents such as a campus plan, multi-year faculty hiring plan, support of industry, Federal grants received, or a demonstration of institutional commitment that may include commitment from the institution's board.

Note: Institutions seeking to waive the matching requirement must provide the waiver request information outlined above within their application.

b. *Indirect Cost Rate Information:* This program limits a grantee's indirect cost reimbursement to 8 percent of a modified total direct cost base. We are establishing this indirect cost limit for the FY 2023 grant competition and any subsequent year in which we make awards from the list of unfunded applications from this competition in accordance with section 437(d)(1) of GEPA. For more information regarding indirect costs, or to obtain a negotiated indirect cost rate, please see *www2.ed.gov/about/offices/list/ocfo/intro.html.*

c. *Administrative Cost Limitation:* This program does not include any program-specific limitation on administrative expenses. All administrative expenses must be reasonable and necessary and conform to Cost Principles described in 2 CFR part 200 subpart E of the Uniform Guidance.

3. *Subgrantees:* A grantee under this competition may not award subgrants to entities to directly carry out project activities described in its application.

4. *Build America Buy America Act:* This program is subject to the Build America, Buy America Act (Pub. L. 117–58) domestic sourcing requirements. Accordingly, under this program, grantees and contractors may not use their grant funds for infrastructure projects or activities (*e.g.,* construction, remodeling, and broadband infrastructure) unless—

(a) All iron and steel used in the infrastructure project or activity are produced in the United States;

(b) All manufactured products used in the infrastructure project or activity are produced in the United States; and

(c) All construction materials are manufactured in the United States.

Grantees may request waivers to these requirements by submitting a Build America, Buy America Act Waiver Request Form. For more information, including a link to the Waiver Request Form, see the Department's Build America Buy America Waiver website at: *https://www2.ed.gov/policy/fund/guid/buy-america/index.html.*

IV. Application and Submission Information

1. *Application Submission Instructions:* Applicants are required to follow the Common Instructions for Applicants to Department of Education Discretionary Grant Programs, published in the **Federal Register** on December 7, 2022 (87 FR 75045), and available at *www.federalregister.gov/d/2022-26554,* which contain requirements and information on how to submit an application. Please note that these Common Instructions supersede the version published on December 27, 2021.

2. *Submission of Proprietary Information:* Given the types of projects that may be proposed in applications for the RDI grant program, your application may include business information that you consider proprietary. In 34 CFR 5.11 we define ''business information'' and describe the process we use in determining whether any of that information is proprietary and, thus, protected from disclosure under Exemption 4 of the Freedom of Information Act (5 U.S.C. 552, as amended).

Because we plan to make successful applications available to the public, you may wish to request confidentiality of business information.

Consistent with Executive Order 12600, please designate in your application any information that you believe is exempt from disclosure under Exemption 4. In the appropriate Appendix section of your application, under ''Other Attachments Form,'' please list the page number or numbers on which we can find this information. For additional information please see 34 CFR 5.11(c).

3. *Intergovernmental Review:* This competition is subject to Executive Order 12372 and the regulations in 34 CFR part 79. Information about Intergovernmental Review of Federal Programs under Executive Order 12372 is in the application package for this program.

4. *Funding Restrictions:* We reference regulations outlining funding restrictions in the *Applicable Regulations* section of this notice. Additionally, no funds received by an institution of higher education under this section shall be used to fund any activities or services provided by institutions that are not eligible as lead applicants in this competition.

5. *Recommended Page Limit:* The application narrative is where you, the applicant, address the selection criteria that reviewers use to evaluate your application. We recommend that you (1) limit the application narrative to no more than 50 pages and (2) use the following standards:

- A ''page'' is 8.5″ x 11″, on one side only, with 1'' margins at the top, bottom, and both sides.
- Double-space (no more than three lines per vertical inch) all text in the application narrative, including titles, headings, footnotes, quotations, references, and captions, as well as all text in charts, tables, figures, and graphs.
- Use a font that is either 12 point or larger, and no smaller than 10-pitch (characters per inch).
- Use one of the following fonts: Times New Roman, Courier, Courier New, or Arial.

The recommended page limit does not apply to the cover sheet; the budget section, including the narrative budget justification; the assurances and certifications; or the one-page abstract, the resumes, the bibliography, or the letters of support; or the waiver request for the matching requirement. However, the recommended 50-page limit does apply to all of the application narrative.

V. Application Review Information

1. *Selection Criteria:* The selection criteria for this competition are from 34 CFR 75.210. The points assigned to each criterion are indicated in the parentheses next to the criterion. An application may earn up to a total of 110 points based on the selection criteria. Applications submitted under Absolute Priority 3 may receive 2 additional points under the competitive preference priority, for a total score of up to 112 points. All applications will be evaluated based on the selection criteria as follows:

(a) *Significance.* (Maximum 25 points)

(1) The Secretary considers the significance of the proposed project.

(2) In determining the significance of the proposed project, the Secretary considers the following factors:

(i) The likelihood that the proposed project will result in system change or improvement. (Up to 10 points)

(ii) The extent to which the proposed project involves the development or demonstration of promising new strategies that build on, or are alternatives to, existing strategies. (Up to 5 points)

(iii) The importance or magnitude of the results or outcomes likely to be attained by the proposed project. (Up to 10 points)

(b) *Quality of the Project Design.* (Maximum 30 points)

(1) The Secretary considers the quality of the project design.

(2) In determining the quality of the project design, the Secretary considers the following factors:

(i) The extent to which the goals, objectives, and outcomes to be achieved by the proposed project are clearly specified and measurable. (Up to 5 points)

(ii) The extent to which the proposed activities constitute a coherent, sustained program of training in the field. (Up to 5 points)

(iii) The extent to which the proposed project is designed to build capacity and yield results that will extend beyond the period of Federal financial assistance. (Up to 5 points)

(iv) The extent to which the proposed project represents an exceptional approach to the priority or priorities established in the competition. (Up to 5 points)

(v) The extent to which the proposed project will integrate with or build on similar or related efforts in order to improve relevant outcomes (as defined this notice), using nonpublic funds or resources. (Up to 5 points)

(vi) The extent to which the proposed project will integrate with, or build on similar or related efforts, to improve relevant outcomes (as defined in this notice), using existing funding streams from other programs or policies supported by community, State, and Federal resources. (Up to 5 points)

(c) *Quality of Project Services.* (Maximum 15 points)

(1) The Secretary considers the quality of the services to be provided by the proposed project.

(2) In determining the quality of the services to be provided by the proposed project, the Secretary considers the quality and sufficiency of strategies for ensuring equal access and treatment for eligible project participants who are members of groups that have traditionally been underrepresented based on race, color, national origin, gender, age, or disability. (Up to 5 points)

(3) In addition, the Secretary considers the following factors:

(i) The likely impact of the services to be provided by the proposed project on the intended recipients of those services. (Up to 5 points)

(ii) The extent to which the technical assistance services to be provided by the proposed project involve the use of efficient strategies, including the use of technology, as appropriate, and the leveraging of non-project resources. (Up to 5 points)

Note: For the purpose of this competition, technical assistance services could include, for example, technical assistance provided to faculty, staff, and students (at all levels) designed to increase research activities, including to expand institutional capacity to secure new funding, support student research experiences, or facilitate faculty professional development.

(d) *Adequacy of Resources.* (Maximum 15 points)

(1) The Secretary considers the adequacy of resources for the proposed project.

(2) In determining the adequacy of resources for the proposed project, the Secretary considers the following factors:

(i) The adequacy of support, including facilities, equipment, supplies, and other resources, from the applicant organization or the lead applicant organization. (Up to 5 points)

(ii) The potential for the incorporation of project purposes, activities, or benefits into the ongoing program of the agency or organization at the end of Federal funding. (Up to 5 points)

(iii) The potential for continued support of the project after Federal funding ends, including, as appropriate, the demonstrated commitment of appropriate entities to such support. (Up to 5 points)

(e) *Quality of the Management Plan.* (Maximum 10 points)

(1) The Secretary considers the quality of the management plan for the proposed project.

(2) In determining the quality of the management plan for the proposed project, the Secretary considers the following factors:

(i) The adequacy of the management plan to achieve the objectives of the proposed project on time and within budget, including clearly defined responsibilities, timelines, and milestones for accomplishing project tasks. (Up to 5 points)

(ii) The adequacy of procedures for ensuring feedback and continuous improvement in the operation of the proposed project. (Up to 5 points)

(f) *Quality of the Project Evaluation.* (Maximum 15 points)

(1) The Secretary considers the quality of the evaluation to be conducted of the proposed project.

(2) In determining the quality of the evaluation, the Secretary considers the following factors:

(i) The extent to which the methods of evaluation will provide timely guidance for quality assurance. (Up to 5 points)

(ii) The extent to which the methods of evaluation will provide performance feedback and permit periodic assessment of progress toward achieving intended outcomes. (Up to 5 points)

(iii) The extent to which the methods of evaluation include the use of objective performance measures that are clearly related to the intended outcomes of the project and will produce quantitative and qualitative data to the extent possible. (Up to 5 points)

2. *Review and Selection Process:* We remind potential applicants that in reviewing applications in any discretionary grant competition, the Secretary may consider, under 34 CFR 75.217(d)(3), the past performance of the applicant in carrying out a previous award, such as the applicant's use of funds, achievement of project objectives, and compliance with grant conditions. The Secretary may also consider whether the applicant failed to submit a timely performance report or submitted a report of unacceptable quality.

In addition, in making a competitive grant award, the Secretary requires various assurances, including those applicable to Federal civil rights laws that prohibit discrimination in programs or activities receiving Federal financial assistance from the Department (34 CFR 100.4, 104.5, 106.4, 108.8, and 110.23).

For this competition, a panel of external reviewers will read, prepare a written evaluation of, and score all eligible applications using the selection criteria and the competitive preference priority, if applicable, provided in this notice. The individual scores of the reviewers will be added and the sum divided by the number of reviewers to determine the peer review score. The Department may use more than one tier of reviews in evaluating applications. The Department will prepare a rank order of applications for each absolute priority based solely on the evaluation of their quality according to the selection criteria and competitive preference priority points. The rank order of applications for each absolute priority will be used to create three slates.

Within each slate, in the event there are two or more applications with the same final score in the rank order listing, and there are insufficient funds to fully support each of these applications, the Department will apply the following procedure to determine which application or applications will receive an award:

First Tiebreaker: The first tiebreaker will be the highest average score for the selection criterion titled ''Adequacy of Resources.'' If a tie remains, the second tiebreaker will be utilized.

Second Tiebreaker: The second tiebreaker will be the highest average score for the selection criterion titled ''Significance.'' If a tie remains, the third tiebreaker will be utilized.

Third Tiebreaker: The third tiebreaker will be the applicant with the highest percentage of Pell Grant students enrolled at the lead applicant institution based on the most recent IPEDS data available.

3. *Risk Assessment and Specific Conditions:* Consistent with 2 CFR 200.206, before awarding grants under this competition, the Department conducts a review of the risks posed by applicants. Under 2 CFR 200.208, the Secretary may impose specific conditions and, under 2 CFR 3474.10, in appropriate circumstances, high-risk conditions on a grant if the applicant or grantee is not financially stable; has a history of unsatisfactory performance; has a financial or other management system that does not meet the standards in 2 CFR part 200, subpart D; has not fulfilled the conditions of a prior grant; or is otherwise not responsible.

4. *Integrity and Performance System:* If you are selected under this competition to receive an award that over the course of the project period may exceed the simplified acquisition threshold (currently $250,000), under 2 CFR 200.206(a)(2) we must make a judgement about your integrity, business ethics, and record of performance under Federal awards—that is, the risk posed by you as an applicant—before we make an award. In doing so, we must consider any information about you that is in the integrity and performance system (currently referred to as the Federal Awardee Performance and Integrity Information System (FAPIIS)), accessible through the System for Award Management. You may review and comment on any information about yourself that a Federal agency previously entered and that is currently in FAPIIS.

Please note that, if the total value of your currently active grants, cooperative agreements, and procurement contracts from the Federal Government exceeds $10,000,000, the reporting requirements in 2 CFR part 200, Appendix XII, require you to report certain integrity information to FAPIIS semiannually. Please review the requirements in 2 CFR part 200, Appendix XII, if this grant plus all the other Federal funds you receive exceed $10,000,000.

5. *In General:* In accordance with the Office of Management and Budget's guidance located at 2 CFR part 200, all applicable Federal laws, and relevant Executive guidance, the Department will review and consider applications for funding pursuant to this notice inviting applications in accordance with:

(a) Selecting recipients most likely to be successful in delivering results based on the program objectives through an objective process of evaluating Federal award applications (2 CFR 200.205);

(b) Prohibiting the purchase of certain telecommunication and video surveillance services or equipment in alignment with section 889 of the National Defense Authorization Act of 2019 (Pub. L. 115–232) (2 CFR 200.216);

(c) Providing a preference, to the extent permitted by law, to maximize use of goods, products, and materials produced in the United States (2 CFR 200.322); and

(d) Terminating agreements in whole or in part to the greatest extent authorized by law if an award no longer effectuates the program goals or agency priorities (2 CFR 200.340).

VI. Award Administration Information

1. *Award Notices:* If your application is successful, we notify your U.S. Representative and U.S. Senators and send you a Grant Award Notification (GAN); or we may send you an email containing a link to access an electronic version of your GAN. We also may notify you informally.

If your application is not evaluated or not selected for funding, we notify you.

2. *Administrative and National Policy Requirements:* We identify administrative and national policy requirements in the application package and reference these and other requirements in the *Applicable Regulations* section of this notice.

We reference the regulations outlining the terms and conditions of an award in the *Applicable Regulations* section of this notice and include these and other specific conditions in the GAN. The GAN also incorporates your approved application as part of your binding commitments under the grant.

3. *Open Licensing Requirements:* Unless an exception applies, if you are awarded a grant under this competition, you will be required to openly license to the public grant deliverables created in whole, or in part, with Department grant funds. When the deliverable consists of modifications to pre-existing works, the license extends only to those modifications that can be separately identified and only to the extent that open licensing is permitted under the terms of any licenses or other legal restrictions on the use of pre-existing works. Additionally, a grantee or subgrantee that is awarded competitive grant funds must have a plan to disseminate these public grant deliverables. This dissemination plan can be developed and submitted after your application has been reviewed and selected for funding. For additional information on the open licensing requirements please refer to 2 CFR 3474.20.

4. *Reporting:* (a) If you apply for a grant under this competition, you must ensure that you have in place the necessary processes and systems to comply with the reporting requirements in 2 CFR part 170 should you receive funding under the competition. This does not apply if you have an exception under 2 CFR 170.110(b).

(b) At the end of your project period, you must submit a final performance report, including financial information, as directed by the Secretary. If you receive a multiyear award, you must submit an annual performance report that provides the most current performance and financial expenditure information as directed by the Secretary under 34 CFR 75.118. The Secretary may also require more frequent performance reports under 34 CFR 75.720(c). For specific requirements on reporting, please go to *www.ed.gov/fund/grant/apply/appforms/appforms.html.*

5. *Performance Measures:* For purposes of Department reporting under 34 CFR 75.110, the Department will use the following performance measures to evaluate the success of the RDI grant program:

(a) For Absolute Priorities 1 and 3, the following program-level performance measures:

(1) The annual number of doctoral students enrolled at the lead applicant university.

(2) The annual number of doctoral conferrals.

(3) The annual number of doctoral conferrals to underrepresented students.

(4) Annual faculty development expenditures.

(5) The annual research and development expenditures in:

(i) Science and engineering.

(ii) Non-science and engineering.

(b) For Absolute Priority 2, the following program-level performance measures:

(1) The annual research and development expenditures in:

(i) Science and engineering.

(ii) Non-science and engineering.

(2) Annual faculty development expenditures.

VII. Other Information

Accessible Format: On request to the program contact person listed under **FOR FURTHER INFORMATION CONTACT**, individuals with disabilities can obtain this document and a copy of the application package in an accessible format. The Department will provide the requestor with an accessible format that may include Rich Text Format (RTF) or text format (txt), a thumb drive, an MP3 file, braille, large print, audiotape, or compact disc, or other accessible format.

Electronic Access to This Document: The official version of this document is the document published in the **Federal Register**. You may access the official edition of the **Federal Register** and the Code of Federal Regulations at *www.govinfo.gov.* At this site you can view this document, as well as all other documents of this Department published in the **Federal Register**, in text or Portable Document Format (PDF). To use PDF you must have Adobe Acrobat Reader, which is available free at the site.

You may also access documents of the Department published in the **Federal Register** by using the article search feature at *www.federalregister.gov.* Specifically, through the advanced search feature at this site, you can limit your search to documents published by the Department.

Nasser H. Paydar,

Assistant Secretary for Postsecondary Education.

[FR Doc. 2023–16402 Filed 8–1–23; 8:45 am]

BILLING CODE 4000–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. RD23–2–000]

North American Electric Reliability Corporation; Supplemental Notice of Joint Technical Conference

As announced in the Notice of Joint Technical Conference issued in this proceeding on May 30, 2023, the Federal Energy Regulatory Commission (Commission) and North American Electric Reliability Corporation (NERC) staff will convene a technical conference on August 10, 2023, from 9:00 a.m. to 4:30 p.m. Eastern Time.

The purpose of this conference is to discuss physical security of the Bulk-Power System, including the adequacy of existing physical security controls, challenges, and solutions. The conference will include two parts and four panel discussions. Part 1 will address the effectiveness of Reliability Standard CIP–014–3 (Physical Security) and include two panels on the applicability of CIP–014–3 and minimum levels of physical protection. Part 2 will address solutions beyond Reliability Standard CIP–014–3 and include two panels on physical security best practices and operational preparedness and planning a more resilient grid.

Attached to this Supplemental Notice is an agenda for the technical conference, which includes more detail for each panel. Only invited panelists and staff from the Commission and NERC will participate in the panel discussions. Interested parties may listen and observe, and written comments may be submitted after the conference in Docket No. RD23–2–000.

The conference will be held in-person at NERC's headquarters at 3353 Peachtree Road NE, Suite 600, North

Tower, Atlanta, GA 30326. Information on travelling to NERC's Atlanta office is available here. The conference will be open for the public to attend, and there is no fee for attendance. It will be transcribed and webcast. Those observing via webcast may register here. Those who would like to attend in-person must register here. Space is limited for in-person attendance and therefore registration is required. In-person attendees are encouraged to ensure they have a confirmed in-person registration prior to finalizing any travel plans. Information on this conference will also be posted on the Calendar of Events on the Commission's website, *www.ferc.gov,* prior to the event.

Commission conferences are accessible under section 508 of the Rehabilitation Act of 1973. For accessibility accommodations, please send an email to *accessibility@ferc.gov,* call toll-free (866) 208–3372 (voice) or (202) 208–8659 (TTY), or send a fax to (202) 208–2106 with the required accommodations. The conference will also be transcribed. Transcripts will be available for a fee from Ace Reporting, (202) 347–3700.

For more information about this technical conference, please contact Terrance Clingan at *Terrance.Clingan@ferc.gov* or (202) 502–8823. For information related to logistics, please contact Lonnie Ratliff at *Lonnie.Ratliff@nerc.net* or Sarah McKinley at *Sarah.McKinley@ferc.gov* or (202) 502–8004.

Dated: July 27, 2023.

Kimberly D. Bose,

Secretary.

Joint Physical Security Technical Conference

Agenda

Docket No. RD23–2–000

August 10, 2023

August 10, 2023 | *9:00–4:30 p.m. Eastern*

NERC Atlanta Office, 3353 Peachtree Road NE, Suite 600—North Tower, Atlanta, GA 30326

Welcome and Opening Remarks (9:00–9:12 a.m.)

NERC Antitrust Compliance Guidelines and Commission Staff Disclaimer (9:12–9:15 a.m.)

Agenda

Introduction and Background (9:15–9:30 a.m.)

Commission and NERC staff will provide background information relevant to discussion during the technical conference, including on Reliability Standard CIP–014–3, the current physical security landscape, recent Commission activities on physical security, and the NERC report filed with the Commission in April.

Part 1: Effectiveness of Reliability Standard CIP–014–3

Part 1 of the technical conference will focus on Reliability Standard CIP–014–3, as it is enforced today as well as any potential revisions to the standard resulting in subsequent versions.

Panel 1—Applicability (9:30–10:50 a.m.)

This panel will explore the facilities subject to Reliability Standard CIP–014–3. While the NERC report filed with the Commission did not recommend revising the applicability section of the Standard at this time, the report determined that this could change based on additional information. Panelists will discuss whether the applicability section of Reliability Standard CIP–014–3 identifies the appropriate facilities to mitigate physical security risks to better assure reliable operation of the Bulk-Power System. Panelists will also discuss whether additional type(s) of substation configurations should be studied to determine risks and the possible need for required protections.

This panel may include a discussion of the following topics and questions:

1. Is the applicability Section of CIP–014–3 properly determining transmission station/substations to be assessed for instability, uncontrolled separation or cascading within the Interconnection? Specifically, are the correct facilities being assessed and what topology or characteristics should the applicable facilities have to be subject to CIP–014? For example, are there criteria other than those in Section 4.1.1 of CIP–014–3, such as connected to two vs. three other station/substations and exceeding the aggregated weighted value of 3000, changing the weighting value of the table in the applicability section, or including lower transmission voltages?

2. Given the changing threat landscape, are there specific transmission station/substation configurations that should be included in the applicability section of CIP–014–3, including combinations of stations/substations to represent coordinated attacks on multiple facilities? What would they be and why?

3. What other assessments (*e.g.,* a TPL–001 planning assessment) may be used to identify an at-risk facility or group of facilities that should be considered for applicability under CIP–014–3? How stringent are those assessments? Describe any procedural differences between those other assessments and the CIP–014–3 R1 Risk Assessment. Should CIP–014–3 apply to entities other than those transmission owners to which 4.1.1 applies or transmission operators to which 4.1.2 applies?

4. Should potential load loss or generation loss be considered? If so, why, and how would potential impact be determined (*e.g.,* how would potential load loss be determined in advance of running an assessment?)?

5. Should facilities that perform physical security monitoring functions that are not currently subject to CIP–014–3 (*e.g.,* security operation centers) be covered by CIP–014–3 as well? If so, what criteria should be used?

Panelists:

- Mark Rice, Pacific Northwest National Lab
- Representative, Office of Cybersecurity, Energy Security, and Emergency Response (Department of Energy)
- Adam Gerstnecker, Mitsubishi Electric Power Products, Inc.
- Jamie Calderon, NERC
- Lawrence Fitzgerald, TRC Companies

Break (10:50–11:00 a.m.)

Panel 2—Minimum Level of Physical Protection (11:00 a.m.–12:30 p.m.)

This panel will discuss the reliability goal to be achieved and based on that goal, what, if any, mandatory minimum resiliency or security protections should be required against facility attacks, *e.g.,* site hardening, ballistic protection, etc. This panel will discuss the scope of reliability, resilience, and security measures that are inclusive of a robust, effective, and risk-informed approach to reducing physical security risks. The panel will also consider whether any minimum protections should be tiered and discuss the appropriate criteria for a tiered approach.

This panel may include a discussion of the following topics and questions:

1. What is our reliability goal? What are we protecting against to ensure grid reliability beyond what is required in the current standards?

a. What are the specific physical security threats (both current and emerging) to all stations/substations on the bulk electric system?

b. As threats are continually evolving, how can we identify those specific threats?

c. How do threats vary across all stations/substations on the bulk electric system? How would defenses against those threats vary?

To what extent should simultaneous attacks at multiple sites be considered?

2. Do we need mandatory minimum protections? If so, what should they be?

a. Should there be flexible criteria or a bright line?

b. Should minimum protections be tiered (*i.e.,* stations/substations receive varying levels of protection according to their importance to the grid)? How should importance be quantified for these protections?

c. Should minimum protections be based on preventing instability, uncontrolled separation, or cascading or preventing loss of service to customers (*e.g.,* as in Moore County, NC) ? If minimum protections were to be based on something other than the instability, uncontrolled separation, or cascading, what burden would that have on various registered entities? If the focus is on loss of service, is it necessary to have state and local jurisdictions involved to implement a minimum set of protections?

d. In what areas should any minimum protections be focused?

i. Detection?

ii. Assessment?

iii. Response?

3. To what extent would minimum protections help mitigate the likelihood and/or reliability impact of simultaneous, multi-site attacks?

Panelists:

- Travis Moran, NERC/SERC
- Mike Melvin, Edison Electric Institute
- Kathy Judge, Edison Electric Institute
- Jackie Flowers, Tacoma Public Utilities
- Representative, American Public Power Association

Lunch (12:30–1:00 p.m.)

Part 2: Solutions Beyond CIP–014–3

Part 2 of the technical conference will focus on solutions for physical security beyond the requirements in Reliability Standard CIP–014–3.

Panel 3—Best Practices and Operational Preparedness (1:00–2:30 p.m.)

This panel will discuss physical security best practices for prevention, protection, response, and recovery. The discussion will include asset management strategies to prepare, incident training preparedness and response, and research and development needs.

This panel may include a discussion of the following topics and questions:

1. What is the physical security threat landscape for each of your companies? What best practices have been implemented to mitigate the risks and vulnerabilities of physical attacks on energy infrastructure?

2. What asset management and preparedness best practices have your member companies implemented to prevent, protect against, respond to, and recover from physical attacks on their energy infrastructure?

3. What research and development efforts are underway or needed for understanding and mitigating physical security risks to critical energy electrical infrastructure?

4. What research and development efforts, including the development of tools, would you like to see the National Labs undertake to assist your companies in addressing physical threats to your critical electrical infrastructure?

5. What do you need or would like to see from the energy industry to improve your ability and accuracy in addressing physical security risks to critical energy electrical infrastructure?

6. What best practices are in place to accelerate electric utility situational awareness of an incident and to involve local jurisdiction responders?

7. What can the federal and state regulators do to assist the energy industry in improving their physical security posture?

8. What training improvements can NERC and the Regional Entities implement to system operators to aid in real-time identification and recovery procedures from physical attacks?

9. What changes could be made to improve information sharing between the federal government and industry?

Panelists:

- Gupta Vinit, ITC Holdings Corp.
- Randy Horton, Electric Power Research Institute
- Craig Lawton, Sandia National Lab
- Michael Ball, Berkshire Hathaway Energy
- Thomas Galloway, North American Transmission Forum
- Scott Aaronson, Edison Electric Institute

Break (2:30–2:40 p.m.)

Panel 4—Grid Planning To Respond to and Recover From Physical and Cyber Security Threats and Potential Obstacles (2:40–4:10 p.m.)

This panel will explore planning to respond to and recovery from physical and cyber security threats and potential obstacles to developing and implementing such plans. This discussion will focus on how best to integrate cyber and physical security with engineering, particularly in the planning phase. The panel will discuss whether critical stations could be reduced through best practices and how to determine whether to mitigate the risk of a critical station or protect it. Finally, the panel will consider the implications of the changing resource mix on vulnerability of the grid and its resilience to disruptions.

This panel may include a discussion of the following topics and questions:

1. How can cyber and physical security be integrated with engineering, particularly planning? What aspects of cyber and physical security need to be incorporated into the transmission planning process?

2. What modifications could be made to TPL–001 to bring in broader attack focus (*e.g.,* coordinated attack)? What sensitivities or examined contingencies might help identify vulnerabilities to grid attacks?

3. Currently, if a CIP–014–3 R1 assessment deems a transmission station/substation as ''critical'' that station/substation must be physically protected. Are there best practices for reconfiguring facilities so as to reduce the criticality of stations/substations?

4. When prioritizing resources, how should entities determine which ''critical'' stations/substations to remove from the list and which to protect? If the project is extensive and may have a long lead time to construct, to what degree does the station/substation need to be protected during the interim period?

5. How will the development of the grid to accommodate the interconnection of future renewable generation affect the resilience of the grid to attack? Will the presence of future additional renewable generation itself add to or detract from the resilience of the grid to physical attack?

6. What are the obstacles to developing a more resilient grid? What strategies can be used to address these obstacles?

a. Cost?

b. Siting?

c. Regulatory Barriers?

d. Staffing/training?

Panelists:

- Ken Seiler, PJM Interconnection
- Tracy McCrory, Tennessee Valley Authority
- Daniel Sierra, Burns and McDonnell

Closing Remarks (4:10–4:30 p.m.)

[FR Doc. 2023–16474 Filed 8–1–23; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

Combined Notice of Filings

Take notice that the Commission has received the following Natural Gas and Oil Pipeline Rate and Refund Report filings:

Filings Instituting Proceedings

Docket Numbers: RP23–913–000.
Applicants: Granite State Gas Transmission, Inc.
Description: § 4(d) Rate Filing: A Limited Section 4 Rate Change to be effective 9/1/2023.
Filed Date: 7/27/23.
Accession Number: 20230727–5023.
Comment Date: 5 p.m. ET 8/8/23.

Any person desiring to intervene, to protest, or to answer a complaint in any of the above proceedings must file in accordance with Rules 211, 214, or 206 of the Commission's Regulations (18 CFR 385.211, 385.214, or 385.206) on or before 5:00 p.m. Eastern time on the specified comment date. Protests may be considered, but intervention is necessary to become a party to the proceeding.

Filings in Existing Proceedings

Docket Numbers: RP21–993–000.
Applicants: Cove Point LNG, LP.
Description: Report Filing: Cove Point—2023 Report of Operational Sales and Purchases of Gas to be effective N/A.
Filed Date: 7/27/23.
Accession Number: 20230727–5015.
Comment Date: 5 p.m. ET 8/8/23.

Any person desiring to protest in any the above proceedings must file in accordance with Rule 211 of the Commission's Regulations (18 CFR 385.211) on or before 5:00 p.m. Eastern time on the specified comment date.

The filings are accessible in the Commission's eLibrary system (*https://elibrary.ferc.gov/idmws/search/fercgensearch.asp*) by querying the docket number.

eFiling is encouraged. More detailed information relating to filing requirements, interventions, protests, service, and qualifying facilities filings can be found at: *http://www.ferc.gov/docs-filing/efiling/filing-req.pdf.* For other information, call (866) 208–3676 (toll free). For TTY, call (202) 502–8659.

The Commission's Office of Public Participation (OPP) supports meaningful public engagement and participation in Commission proceedings. OPP can help members of the public, including landowners, environmental justice communities, Tribal members and others, access publicly available information and navigate Commission processes. For public inquiries and assistance with making filings such as interventions, comments, or requests for rehearing, the public is encouraged to contact OPP at (202) 502–6595 or *OPP@ferc.gov.*

Dated: July 27, 2023.

Kimberly D. Bose,

Secretary.

[FR Doc. 2023–16471 Filed 8–1–23; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

Combined Notice of Filings #1

Take notice that the Commission received the following exempt wholesale generator filings:
Docket Numbers: EG23–242–000.
Applicants: Eleven Mile Solar Center, LLC.
Description: Eleven Mile Solar Center, LLC submits Notice of Self–Certification of Exempt Wholesale Generator Status.
Filed Date: 7/27/23.
Accession Number: 20230727–5106.
Comment Date: 5 p.m. ET 8/17/23.

Take notice that the Commission received the following Complaints and Compliance filings in EL Dockets:
Docket Numbers: EL23–84–000; QF18–1454–001; QF18–1455–001; QF18–1456–001.
Applicants: ALLCO FINANCE LIMITED, ALLCO FINANCE LIMITED, ALLCO FINANCE LIMITED, ALLCO FINANCE LIMITED.
Description: Petition for Enforcement Pursuant to Section 210(h) of the Public Utility Regulatory Policies Act of 1978 of Allco Finance Limited.
Filed Date: 7/24/23.
Accession Number: 20230724–5096.
Comment Date: 5 p.m. ET 8/14/23.

Take notice that the Commission received the following electric rate filings:
Docket Numbers: ER10–1427–006; ER10–2917–025; ER10–2922–025; ER11–2383–021; ER12–161–027; ER14–25–022; ER14–1964–017; ER16–287–011; ER17–482–011; ER19–529–012; ER19–1074–012; ER19–1075–012; ER20–1447–007; ER20–2028–002; ER22–192–006; ER22–1010–004.
Applicants: TerraForm IWG Acquisition Holdings II, LLC, Evolugen Trading and Marketing LP, Bitter Ridge Wind Farm, LLC, Brookfield Energy Marketing U.S. LLC, Brookfield Renewable Energy Marketing U.S. LLC, Brookfield Energy Marketing Inc., Brookfield Renewable Trading and Marketing LP, BREG Aggregator LLC, BIF III Holtwood LLC, BIF II Safe Harbor Holdings, LLC, Prairie Breeze Wind Energy LLC, Bishop Hill Energy LLC, Safe Harbor Water Power Corporation, Hawks Nest Hydro LLC, Brookfield Power Piney & Deep Creek LLC, Brookfield Energy Marketing LP.
Description: Notice of Non-Material Change in Status of Brookfield Energy Marketing LP, et al.
Filed Date: 7/26/23.
Accession Number: 20230726–5127.
Comment Date: 5 p.m. ET 8/16/23.
Docket Numbers: ER23–2494–000.
Applicants: ISO New England Inc., The Narragansett Electric Company.
Description: § 205(d) Rate Filing: ISO New England Inc. submits tariff filing per 35.13(a)(2)(iii): ISO–NE/The Narragansett Electric Company; Second Revised LGIA–ISONE/NEP–15–03 to be effective 1/1/2023.
Filed Date: 7/26/23.
Accession Number: 20230726–5136.
Comment Date: 5 p.m. ET 8/16/23.
Docket Numbers: ER23–2495–000.
Applicants: Southwest Power Pool, Inc.
Description: § 205(d) Rate Filing: 3317R2 WAPA & East River Electric Power Interconnection Agr to be effective 7/26/2023.
Filed Date: 7/27/23.
Accession Number: 20230727–5005.
Comment Date: 5 p.m. ET 8/17/23.
Docket Numbers: ER23–2496–000.
Applicants: Niagara Mohawk Power Corporation, New York Independent System Operator, Inc.
Description: § 205(d) Rate Filing: Niagara Mohawk Power Corporation submits tariff filing per 35.13(a)(2)(iii): Niagara Mohawk 205: E&P Agreement between NMPC and Sithe SA2791 to be effective 7/12/2023.
Filed Date: 7/27/23.
Accession Number: 20230727–5054.
Comment Date: 5 p.m. ET 8/17/23.
Docket Numbers: ER23–2497–000.
Applicants: Midcontinent Independent System Operator, Inc., Great River Energy.
Description: § 205(d) Rate Filing: Midcontinent Independent System Operator, Inc. submits tariff filing per 35.13(a)(2)(iii): 2023–07–27_SA 3741 GRE–MRES–WMMPA Amendment No. 1 to be effective 9/26/2023.
Filed Date: 7/27/23.
Accession Number: 20230727–5068.
Comment Date: 5 p.m. ET 8/17/23.
Docket Numbers: ER23–2498–000.
Applicants: PJM Interconnection, L.L.C.
Description: § 205(d) Rate Filing: Original ISA, Service Agreement No.

7012; Queue No. AF1–098 to be effective 6/27/2023.

Filed Date: 7/27/23.

Accession Number: 20230727–5082.

Comment Date: 5 p.m. ET 8/17/23.

Docket Numbers: ER23–2499–000.

Applicants: Southwest Power Pool, Inc.

Description: § 205(d) Rate Filing: Revisions to Extend Tariff Administration between SPP and SPA through 12/31/2024 to be effective 7/1/2023.

Filed Date: 7/27/23.

Accession Number: 20230727–5087.

Comment Date: 5 p.m. ET 8/17/23.

Docket Numbers: ER23–2500–000.

Applicants: PJM Interconnection, L.L.C.

Description: § 205(d) Rate Filing: Amendment to ISA, SA No. 5958; Queue No. AC1–074/AC2–075 to be effective 9/26/2023.

Filed Date: 7/27/23.

Accession Number: 20230727–5101.

Comment Date: 5 p.m. ET 8/17/23.

The filings are accessible in the Commission's eLibrary system (*https://elibrary.ferc.gov/idmws/search/fercgensearch.asp*) by querying the docket number.

Any person desiring to intervene, to protest, or to answer a complaint in any of the above proceedings must file in accordance with Rules 211, 214, or 206 of the Commission's Regulations (18 CFR 385.211, 385.214, or 385.206) on or before 5:00 p.m. Eastern time on the specified comment date. Protests may be considered, but intervention is necessary to become a party to the proceeding.

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Dated: July 27, 2023.

Kimberly D. Bose,

Secretary.

[FR Doc. 2023–16473 Filed 8–1–23; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. ER23–2492–000]

Gunvor USA LLC; Supplemental Notice That Initial Market-Based Rate Filing Includes Request for Blanket Section 204 Authorization

This is a supplemental notice in the above-referenced proceeding of Gunvor USA LLC's application for market-based rate authority, with an accompanying rate tariff, noting that such application includes a request for blanket authorization, under 18 CFR part 34, of future issuances of securities and assumptions of liability.

Any person desiring to intervene or to protest should file with the Federal Energy Regulatory Commission, 888 First Street NE, Washington, DC 20426, in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211 and 385.214). Anyone filing a motion to intervene or protest must serve a copy of that document on the Applicant.

Notice is hereby given that the deadline for filing protests with regard to the applicant's request for blanket authorization, under 18 CFR part 34, of future issuances of securities and assumptions of liability, is August 16, 2023.

The Commission encourages electronic submission of protests and interventions in lieu of paper, using the FERC Online links at *http://www.ferc.gov.* To facilitate electronic service, persons with internet access who will eFile a document and/or be listed as a contact for an intervenor must create and validate an eRegistration account using the eRegistration link. Select the eFiling link to log on and submit the intervention or protests.

Persons unable to file electronically may mail similar pleadings to the Federal Energy Regulatory Commission, 888 First Street NE, Washington, DC 20426. Hand delivered submissions in docketed proceedings should be delivered to Health and Human Services, 12225 Wilkins Avenue, Rockville, Maryland 20852.

In addition to publishing the full text of this document in the **Federal Register**, the Commission provides all interested persons an opportunity to view and/or print the contents of this document via the internet through the Commission's Home Page (*http://www.ferc.gov*) using the ''eLibrary'' link. Enter the docket number excluding the last three digits in the docket number field to access the document. At this time, the Commission has suspended access to the Commission's Public Reference Room, due to the proclamation declaring a National Emergency concerning the Novel Coronavirus Disease (COVID–19), issued by the President on March 13, 2020. For assistance, contact the Federal Energy Regulatory Commission at *FERCOnlineSupport@ferc.gov* or call toll-free, (886) 208–3676 or TYY, (202) 502–8659.

The Commission's Office of Public Participation (OPP) supports meaningful public engagement and participation in Commission proceedings. OPP can help members of the public, including landowners, environmental justice communities, Tribal members and others, access publicly available information and navigate Commission processes. For public inquiries and assistance with making filings such as interventions, comments, or requests for rehearing, the public is encouraged to contact OPP at (202) 502–6595 or *OPP@ferc.gov.*

Dated: July 27, 2023.

Kimberly D. Bose,

Secretary.

[FR Doc. 2023–16472 Filed 8–1–23; 8:45 am]

BILLING CODE 6717–01–P

ENVIRONMENTAL PROTECTION AGENCY

[EPA–HQ–ORD–2021–0562; FRL–11245–01–ORD]

Availability of the Draft IRIS Toxicological Review of Perfluorohexane Sulfonate (PFHxS) (PFHxS) and Related Salts; Correction

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice of public comment period; correction.

SUMMARY: The Environmental Protection Agency (EPA) published a document in the **Federal Register** of July 24, 2023, concerning request for comments on the release of the draft IRIS Toxicological Review of Perfluorohexane Sulfonate (PFHxS) and Related Salts. The document contained the incorrect chemical name six times, including the document heading.

DATES: The public comment period began on July 24, 2023. Comments must be received on or before September 22, 2023.

FOR FURTHER INFORMATION CONTACT: For information on the public comment period, contact the ORD Docket at the EPA Headquarters Docket Center; telephone: 202–566–1752; facsimile: 202–566–9744; or email: *Docket_ORD@epa.gov.*

For technical information on the draft IRIS Toxicological Review of Perfluorohexanesulfonic acid (PFHxS) and Related Salts, contact the IRIS Hotline; email: *IRIS_HOTLINE@epa.gov.* The IRIS Program will provide updates through the IRIS website (*https://www.epa.gov/iris*) and via EPA's IRIS listserv. To register for the IRIS listserv, visit the IRIS website (*https://www.epa.gov/iris*) or visit *https://www.epa.gov/iris/forms/staying-connected-integrated-risk-information-system#connect.*

For questions about the peer review, please contact: Laurie Waite, ERG, by email at *peerreview@erg.com* (subject line: EPA PFAS assessments peer review); or by phone: (781) 674–7362.

SUPPLEMENTARY INFORMATION:

Correction

In the **Federal Register** issue of July 24, 2023, in FR Doc. 2023–15613, on page 47496, make the following corrections:

1. In the first column correct the document heading to read:

Availability of the Draft IRIS Toxicological Review of Perfluorohexanesulfonic Acid (PFHxS) and Related Salts

2. In the first and second columns remove the text ''Perfluorohexane Sulfonate'' five times and add in its place the text ''Perfluorohexanesulfonic Acid''.

Wayne Cascio,

Director, Center for Public Health and Environmental Assessment.

[FR Doc. 2023–16404 Filed 8–1–23; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[EPA–HQ–OPPT–2022–0905; FRL–10798–04–OCSPP]

1,4-Dioxane; Draft Supplement to the TSCA Risk Evaluation; Science Advisory Committee on Chemicals (SACC) Meeting; Amended Notice of Public Meeting

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: The Environmental Protection Agency (EPA) is announcing a 4-day virtual public meeting on September 12–15, 2023, from 10 a.m. to approximately 5:00 p.m. (EDT), via a webcast platform such as ''*Zoomgov.com*'' and audio teleconference for the Science Advisory Committee on Chemicals (SACC) to review EPA's ''2023 Draft Supplement to the 1,4-Dioxane Risk Evaluation'' prepared under the Toxic Substances Control Act (TSCA). This September 2023 meeting was previously announced in the **Federal Register** of March 23, 2023, and in the **Federal Register** of July 10, 2023, EPA announced the availability of the supplement and related documents for public comment. This notice provides additional details regarding the meeting, including meeting times.

DATES: The following is a chronological listing of the dates for the specific activities that are described in more detail under **SUPPLEMENTARY INFORMATION.**

September 1, 2023—Deadline for submitting a request for special accommodations to allow EPA time to process the request before the meeting.

September 8, 2023—Deadline for providing written comments on the draft supplement.

September 8, 2023—Deadline for registering to be listed on the meeting agenda to make oral comments during the virtual meeting.

September 12–15, 2023—Meeting to be held from 10:00 a.m. to approximately 5:00 p.m. (EDT).

September 15, 2023—Deadline for those not making oral comments to register to receive the links to observe the meeting.

ADDRESSES:

To comment: Submit written comments, identified by docket identification (ID) number EPA–HQ–OPPT–2022–0905, through the Federal eRulemaking Portal at *https://www.regulations.gov.* Follow the online instructions for submitting comments. Do not electronically submit any information you consider to be Confidential Business Information (CBI) or other information whose disclosure is restricted by statute. Copyrighted material will not be posted without explicit permission from the copyright holder. Members of the public should also be aware that personal information included in any written comments may be posted on the internet at *https://www.regulations.gov.* Additional information on commenting or visiting the docket, along with more information about dockets generally, is available at *https://www.epa.gov/dockets.*

To register for the meeting: For information on how to register and access the virtual public meeting, please refer to the SACC website at *https://www.epa.gov/tsca-peer-review.* EPA intends to announce registration instructions on the SACC website by the end of August 2023. You may also subscribe to the following listserv for alerts regarding this and other SACC-related activities at *https://public.govdelivery.com/accounts/USAEPAOPPT/subscriber/new?topic_id=USAEPAOPPT_101.*

To request special accommodations: For information on access or services for individuals with disabilities, and to request accommodation for a disability, please contact the Designated Federal Official (DFO) listed under **FOR FURTHER INFORMATION CONTACT.**

To join the Virtual meeting: The meeting will be virtual, held via a webcast platform such as ''*Zoomgov.com*'' and audio teleconference. Please register to obtain access information.

FOR FURTHER INFORMATION CONTACT: The DFO, Dr. Alaa Kamel, Mission Support Division, Office of Program Support, Office of Chemical Safety and Pollution Prevention, Environmental Protection Agency; telephone number: (202) 564–5336 or SACC main office number: (202) 564–8450; email address: *kamel.alaa@epa.gov.*

SUPPLEMENTARY INFORMATION:

I. Virtual Public Meeting of the SACC

A. What is the purpose of this public meeting?

The purpose of the 4-day virtual public meeting is the SACC peer review of methodologies that have not been previously peer reviewed and are utilized in the 2023 Draft Supplement to the 1,4-Dioxane Risk Evaluation. Feedback from this review will be considered in the development of the final Supplement to the Risk Evaluation for 1,4-Dioxane. In addition, SACC reviewer feedback may help refine

EPA's methods for conducting release assessments and evaluating general population exposures in risk evaluations of other chemicals under TSCA.

This September 2023 meeting was previously announced in the **Federal Register** of March 23, 2023 (88 FR 17566 (FRL–10798–01–OCSPP)), and in the **Federal Register** of July 10, 2023 (88 FR 43562 (FRL–10798–02–OCSPP)), EPA announced the availability of the supplement and related documents for public comment. Please see the **Federal Register** of July 10, 2023, for additional details regarding the topic for this meeting.

EPA intends to provide a meeting agenda for each day of the meeting, and as needed, may provide updated times for each day in the meeting agenda that will be posted in the docket and on the SACC website.

B. How can I provide comments for the SACC's consideration?

To ensure proper receipt of comments it is imperative that you identify docket ID No. EPA–HQ–OPPT–2022–0905 in the subject line on the first page of your comments and follow the instructions listed below.

1. Written Comments

The Agency encourages written comments for this meeting be submitted by the deadlines set in the **DATES** section of this document. Submit comments as instructed under **ADDRESSES** and this unit.

2. Oral Comments

The Agency encourages each individual or group wishing to make brief oral comments to the SACC during the peer review virtual public meeting to follow the registration instructions that will be announced on the SACC website by the end of August 2023. You should email a written copy of your oral comments or presentation and any supporting materials to the DFO listed under **FOR FURTHER INFORMATION CONTACT** by the deadline listed in DATES for distribution to the SACC by the DFO. Oral comments before the SACC during the peer review virtual public meeting are limited to 5 minutes.

3. Submitting CBI

Contact the DFO listed under **FOR FURTHER INFORMATION CONTACT** for instructions before submitted CBI or other sensitive information. Do not submit this information to EPA through *https://www.regulations.gov* or email. Clearly mark the part or all of the information that you claim to be CBI. For confidential information in a disk or CD–ROM that you mail to EPA, mark the outside of the disk or CD–ROM as CBI and then identify electronically within the disk or CD–ROM the specific information that is claimed as CBI. In addition to one complete version of the comment that includes information claimed as CBI, a copy of the comment that does not contain the information claimed as CBI must be submitted for inclusion in the public docket. Information so marked will not be disclosed except in accordance with procedures set forth in 40 CFR part 2.

4. Tips for Preparing Your Comments

When preparing and submitting your comments, see the commenting tips at *https://www.epa.gov/dockets/commenting-epa-dockets.*

C. How can I participate in the virtual public meeting?

The virtual public meeting will be held via a webcast platform such as ''*Zoomgov.com*'' and audio teleconference. You must register online to receive the webcast meeting link and audio teleconference information. Please follow the registration instructions stated in **ADDRESSES**.

Authority: 15 U.S.C. 2625(o); 5 U.S.C. 10.

Dated: July 28, 2023.

Michal Freedhoff,

Assistant Administrator, Office of Chemical Safety and Pollution Prevention.

[FR Doc. 2023–16456 Filed 8–1–23; 8:45 am]

BILLING CODE P

FEDERAL MARITIME COMMISSION

Notice of Agreements Filed

The Commission hereby gives notice of filing of the following agreements under the Shipping Act of 1984. Interested parties may submit comments, relevant information, or documents regarding the agreements to the Secretary by email at *Secretary@fmc.gov,* or by mail, Federal Maritime Commission, 800 North Capitol Street, Washington, DC 20573. Comments will be most helpful to the Commission if received within 12 days of the date this notice appears in the **Federal Register**, and the Commission requests that comments be submitted within 7 days on agreements that request expedited review. Copies of agreements are available through the Commission's website (*www.fmc.gov*) or by contacting the Office of Agreements at (202)–523–5793 or *tradeanalysis@fmc.gov.*

Agreement No.: 201407.

Agreement Name: HMM Yang Ming PSX Space Charter Agreement.

Parties: HMM Co. Ltd.; Yang Ming Marine Transport Corp.; Yang Ming (UK) Ltd.; and Yang Ming (Singapore) Pte. Ltd.

Filing Party: Joshua Stein; Cozen O'Connor.

Synopsis: The Agreement authorizes HMM to charter space to Yang Ming Lines on HMM's service in the trade between the Republic of Korea and China, on the one hand, and the U.S. Pacific Coast, on the other.

Proposed Effective Date: 7/24/2023.

Location: https://www2.fmc.gov/FMC.Agreements.Web/Public/AgreementHistory/84503.

Dated: July 28, 2023.

JoAnne O'Bryant,

Program Analyst.

[FR Doc. 2023–16435 Filed 8–1–23; 8:45 am]

BILLING CODE 6730–02–P

FEDERAL MEDIATION AND CONCILIATION SERVICE

Succession Plan for the FMCS

AGENCY: Federal Mediation and Conciliation Service (FMCS).

ACTION: Notice of succession plan for the FMCS.

SUMMARY: The Federal Mediation and Conciliation Service (FMCS), is issuing this notice to inform the public of the succession plan for the Federal Mediation and Conciliation Service (FMCS) provided by the Director of FMCS. This notice supersedes all prior succession plans issued by the agency for officials performing the functions and duties of the Director of FMCS.

DATES: This Succession Plan for the FMCS is effective August 2, 2023.

FOR FURTHER INFORMATION CONTACT: For specific questions related to this notice, please contact Gregory Goldstein, 202–606–8111, *ggoldstein@fmcs.gov.*

SUPPLEMENTARY INFORMATION: By the authority vested in the Director of the Federal Mediation and Conciliation Service (FMCS) by 29 U.S.C. 172, and to provide for the continuity of essential operations of the FMCS in all circumstances, this Notice provides the succession plan of officials authorized to perform the functions and duties of the Director of the Federal Mediation and Conciliation Service. The following is the succession plan of officials hereby ordered:

Order of Succession

During any period in which the Director has died, resigned, or otherwise become unable to perform the functions and duties of the Office of the Director,

and there is no Acting Director serving under the Federal Vacancies Reform Act of 1998, 5 U.S.C. 3345–3349d, the following officers of the FMCS, in the order listed, are hereby delegated the authority to perform the functions and duties of the Director, to the extent permitted by law:

1. Principal Deputy, Chief Operating Officer;
2. Deputy Director, Field Operations;
3. Deputy Director for Policy and Strategy;
4. Director, Procurement and Operational Support;
5. General Counsel;
6. Associate Deputy Director for Field Operations, National;
7. Associate Deputy Director for Field Operations, Regional;
8. Director, Human Resources; and
9. Director, Budget.

No individual who is serving in an office listed in this order in an acting capacity, by virtue of so serving, shall be delegated the functions and duties of the Director.

Dated: July 28, 2023.

Gregory Goldstein,

FMCS Acting Director.

[FR Doc. 2023–16421 Filed 8–1–23; 8:45 am]

BILLING CODE 6732–01–P

FEDERAL MEDIATION AND CONCILIATION SERVICE

Notice of Fee Increase for Arbitration Services

AGENCY: Federal Mediation and Conciliation Service (FMCS).

ACTION: Notice.

SUMMARY: The Federal Mediation and Conciliation Service (FMCS), is issuing this notice to inform the public that it will increase fees associated with its arbitration services.

DATES: Fee increases will begin on October 1, 2023.

FOR FURTHER INFORMATION CONTACT: Arthur Pearlstein, Federal Mediation and Conciliation Service, One Independence Square, 250 E St. SW, Washington, DC 20427; *arbitration@fmcs.gov.*

SUPPLEMENTARY INFORMATION:

I. Background

Pursuant to FMCS's enabling statutes, 29 U.S.C. 172 and 173, and 29 CFR part 1404, FMCS has long maintained a roster of qualified, private labor arbitrators to hear disputes arising under collective bargaining agreements and provide fact finding and interest arbitration. 29 U.S.C. 173(f) authorizes FMCS to establish and collect fees for arbitration services.

II. Discussion

FMCS periodically reviews its arbitration program to access its efficiency. FMCS's last review occurred in 2019, which resulted in updating its arbitration regulations and a modest increase in user fees that had previously remained unchanged for more than eight years prior. FMCS has conducted a similar review and determined that the current user fees require additional adjustment to attain full-cost recovery for FMCS's arbitration services.

The following fees for FMCS's arbitration services will change:

- *Annual listing fee for arbitrators who have completed less than 5 years on the Roster:* Change from $150 to $200 for first address, Change from $50 to $75 for each additional address.
- *Annual listing fee for arbitrators who have completed 5 or more years on the Roster:* Change from $250 to $300 for first address and change from $100 to $125 for each additional address.
- *A Request for a Panel of arbitrators (up to 7) processed online:* Change from $35 to $100.
- *Request for Panel of arbitrators (up to 13) processed manually by FMCS staff:* Change from $70 to $175.
- *Request for List of arbitrators (up to 13) processed manually by FMCS staff:* Change from $35 to $175.
- *Direct manual appointment of an arbitrator when a panel is not used:* Change from $30 to $100.

As a reminder, payment is through *Pay.gov* at *http://www.pay.gov* which includes payment by debit, credit card, or electronic funds transfer (e-check). Although an electronic payment is preferred, if *Pay.gov* submission creates an undue hardship, payees may contact *payments@fmcs.gov* to explain the circumstances and receive assistance.

FMCS will continue to review the user fees periodically and will revise it as necessary. Any changes in the fees and their effective date will be announced in the **Federal Register**.

Dated: July 28, 2023.

Anna Davis,

General Counsel.

[FR Doc. 2023–16431 Filed 8–1–23; 8:45 am]

BILLING CODE 6732–01–P

FEDERAL TRADE COMMISSION

Agency Information Collection Activities; Proposed Collection; Comment Request; Extension

AGENCY: Federal Trade Commission.

ACTION: Notice.

SUMMARY: The Federal Trade Commission (''FTC'' or ''Commission'') is seeking public comments on its proposal to extend for an additional three years the current Paperwork Reduction Act (''PRA'') clearance for information collection requirements contained in the FTC's Business Opportunity Rule (''Rule''). That clearance expires on January 31, 2024.

DATES: Comments must be filed by October 2, 2023.

ADDRESSES: Interested parties may file a comment online or on paper, by following the instructions in the Request for Comment part of the **SUPPLEMENTARY INFORMATION** section below. Write ''Business Opportunity Rule Paperwork Comment, FTC File No. P114408'' on your comment, and file your comment online at *https://www.regulations.gov* by following the instructions on the web-based form. If you prefer to file your comment on paper, mail your comment to the following address: Federal Trade Commission, Office of the Secretary, 600 Pennsylvania Avenue NW, Suite CC–5610 (Annex J), Washington, DC 20580, or deliver your comment to the following address: Federal Trade Commission, Office of the Secretary, Constitution Center, 400 7th Street SW, 5th Floor, Suite 5610 (Annex J), Washington, DC 20024.

FOR FURTHER INFORMATION CONTACT: Christine M. Todaro, Attorney, Division of Marketing Practices, Bureau of Consumer Protection, 600 Pennsylvania Avenue NW, CC–6316, Washington, DC 20580, (202) 326–3711.

SUPPLEMENTARY INFORMATION:

Title: Disclosure Requirements Concerning Business Opportunities, 16 CFR part 437.

OMB Control Number: 3084–0142.

Type of Review: Extension without change of currently approved collection.

Abstract: The Business Opportunity Rule requires business opportunity sellers to furnish prospective purchasers a disclosure document that provides information regarding the seller, the seller's business, and the nature of the proposed business opportunity, as well as additional information to substantiate any claims about actual or potential sales, income, or profits for a prospective business opportunity purchaser. The seller must also preserve information that forms a reasonable basis for such claims.

The Rule is designed to ensure that prospective purchasers receive information to help them evaluate business opportunities. Sellers must

disclose five key items of information in a simple, one-page document: (1) The seller's identifying information; (2) whether the seller makes a claim about the purchaser's likely earnings (and, if yes, the seller must provide information supporting any such claims); (3) whether the seller, its affiliates, or key personnel have been involved in certain legal actions (and, if yes, the seller must provide a separate list of those actions); (4) whether the seller has a cancellation or refund policy (and, if yes, the seller must provide a separate document stating the material terms of such policies); and (5) a list of persons who have purchased the business opportunity within the previous three years. Misrepresentations and omissions are prohibited under the Rule, and for sales conducted in languages other than English, all disclosures must be provided in the language in which the sale is conducted.

Affected Public: Private Sector: Businesses and other for-profit entities.

Estimated Annual Burden Hours: 10,065.

Estimated Annual Labor Costs: $792,518.

Estimated Annual Non-Labor Costs: $3,361,014.

As required by section 3506(c)(2)(A) of the PRA, 44 U.S.C. 3506(c)(2)(A), the FTC is providing this opportunity for public comment before requesting that OMB extend the existing clearance for the information collection requirements contained in the Rule.

Burden Statement

FTC staff estimates there are approximately 3,050 business opportunity sellers covered by the Rule, including vending machine, rack display, work-at-home, and other opportunity sellers. Of this total, staff estimates that on an annual basis approximately 90 percent are established sellers and the remaining 10 percent are new entrants (*i.e.,* 2,745 existing business opportunity sellers plus 305 new entrants). In addition, staff estimates that approximately 61 business opportunity sellers market business opportunities in Spanish (in addition to English) and another 61 sellers market business opportunities in languages other than English or Spanish (in addition to English).[1]

A. Estimated Hours Burden

Compliance burdens will vary depending on a business opportunity seller's prior experience with the Rule. Appendices A and B to the Rule provide models of the required disclosure documents in both English and Spanish, reducing the potential burden that sellers may incur to provide the required disclosures. FTC staff estimates that 2,745 existing business opportunity sellers will require approximately two hours to update their disclosure documents annually. This yields a total annual burden of 5,490 hours for established sellers. FTC staff also projects that 305 new business opportunity sellers will require approximately five hours to develop their initial disclosure documents. This yields a total annual burden of approximately 1,525 hours. In addition, FTC staff estimates that all business opportunity sellers will require approximately one hour to file and store required records for a total of 3,050 hours. This yields a cumulative total of 10,065 hours.

B. Estimated Labor Cost

FTC staff determines estimated labor costs by applying applicable wage rates to the burden hours discussed above. FTC staff assumes that an attorney likely would prepare or update required disclosure documents at an approximate hourly rate of $78.74.[2] Accordingly, FTC staff estimates that cumulative labor costs are $792,518 (10,065 hours × $78.74 per hour).

C. Estimated Non-Labor Costs

1. Printing and Mailing of the Disclosure Document

Business opportunity sellers may also incur costs to print and distribute the single-page disclosure document, plus any attachments. These costs vary based upon the length of the attachments and the number of copies produced to meet the expected demand. Commission staff estimates that 3,050 business opportunity sellers will print and mail approximately 1,000 disclosure documents per year at a cost of $1.10 per document, for a total cost of $3,355,000. Conceivably, many business opportunity sellers will elect to furnish disclosures electronically; thus, the total cost could be much less.

2. Translating the Required Disclosures Into a Language Other Than English

The costs associated with translating the disclosures will vary depending upon a business opportunity seller's prior experience and the language the seller uses to market business opportunities. Because Appendices A and B to the Rule provide illustrations of the required disclosure documents in both English and Spanish, business opportunity sellers marketing in Spanish will not incur costs to translate their disclosure documents. Existing sellers who market business opportunities in either Spanish or another non-English language may incur translation costs to update their disclosures over time. New entrants that market business opportunities in languages other than English or Spanish will incur costs to translate Appendix A into other languages.

Informed by Census data, FTC staff estimates that 61 sellers market business opportunities in Spanish and an additional 61 sellers market business opportunities in languages other than English or Spanish. This includes an estimated 6 new entrants annually that market business opportunities in Spanish and 6 new entrants that market business opportunities in languages other than English or Spanish.

FTC staff estimates that approximately 122 business opportunity sellers are marketing business opportunities in languages other than English. FTC staff estimates these sellers will require on average approximately 250 words (about one standard, double-spaced page) to update and create initial disclosures. Therefore, FTC staff estimates the total cost to translate sellers' disclosures is approximately $5,490 [122 sellers × (18 cents per word[3] × 250 words)].

In addition, staff estimates that new entrant business opportunity sellers marketing in languages other than English or Spanish will incur burden to translate the required disclosures. There are 485 words in Appendix A to the Rule. Therefore, FTC staff estimates that the average annual cost burden for new business opportunity sellers to translate the required disclosures into a language

[1] FTC staff bases these estimates on census data. *See* American Community Survey, *Household Language Table K201601 (2021),* at *https://data.census.gov/table?q=K201601:+HOUSEHOLD+LANGUAGE&tid=ACSSE2021.K201601.* The census data indicates that approximately 2 percent of U.S. households speak Spanish and are classified as limited English-speaking households. In addition, the data indicates that approximately 2 percent of the United States population speaks a language other than Spanish or English at home and are classified as limited English-speaking households. FTC staff estimates that approximately 2 percent of all entities selling business opportunities market in Spanish and 2 percent of all such entities market in languages other than English or Spanish.

[2] This figure is derived from the mean hourly wage for Lawyers. See ''Occupational Employment and Wages—May 2022,'' Bureau of Labor Statistics, U.S. Department of Labor, Table 1 (''National employment and wage data from the Occupational Employment Statistics survey by occupation, May 2022''), available at *https://www.bls.gov/news.release/ocwage.t01.htm.*

[3] FTC staff estimates that this represents the current market rate per word to translate the disclosure documents into the language the sellers use to market business opportunities.

other than English or Spanish will be approximately $524 [6 sellers × (18 cents per word × 485 words)].

Thus, cumulative estimated non-labor costs are $3,361,014 ($3,355,000 + $5,490 + $524).

Request for Comment

Pursuant to section 3506(c)(2)(A) of the PRA, the FTC invites comments on: (1) whether the disclosure and recordkeeping requirements are necessary, including whether the information will be practically useful; (2) the accuracy of our burden estimates, including whether the methodology and assumptions used are valid; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) ways to minimize the burden of the collection of information.

For the FTC to consider a comment, we must receive it on or before October 2, 2023. Your comment, including your name and your state, will be placed on the public record of this proceeding, including the *https://www.regulations.gov* website.

You can file a comment online or on paper. Due to heightened security screening, postal mail addressed to the Commission will be subject to delay. We encourage you to submit your comments online through the *https://www.regulations.gov* website.

If you file your comment on paper, write ''Business Opportunity Rule Paperwork Comment, FTC File No. P114408'' on your comment and on the envelope, and mail it to the following address: Federal Trade Commission, Office of the Secretary, 600 Pennsylvania Avenue NW, Suite CC–5610 (Annex J), Washington, DC 20580, or deliver your comment to the following address: Federal Trade Commission, Office of the Secretary, Constitution Center, 400 7th Street SW, 5th Floor, Suite 5610 (Annex J), Washington, DC 20024.

Because your comment will become publicly available at *https://www.regulations.gov,* you are solely responsible for making sure that your comment does not include any sensitive or confidential information. In particular, your comment should not include any sensitive personal information, such as your or anyone else's Social Security number; date of birth; driver's license number or other state identification number, or foreign country equivalent; passport number; financial account number; or credit or debit card number. You are also solely responsible for making sure that your comment does not include any sensitive health information, such as medical records or other individually identifiable health information. In addition, your comment should not include any ''trade secret or any commercial or financial information which . . . is privileged or confidential''—as provided by Section 6(f) of the FTC Act, 15 U.S.C. 46(f), and FTC Rule 4.10(a)(2), 16 CFR 4.10(a)(2)—including, in particular, competitively sensitive information, such as costs, sales statistics, inventories, formulas, patterns, devices, manufacturing processes, or customer names.

Comments containing material for which confidential treatment is requested must (1) be filed in paper form, (2) be clearly labeled ''Confidential,'' and (3) comply with FTC Rule 4.9(c). In particular, the written request for confidential treatment that accompanies the comment must include the factual and legal basis for the request and must identify the specific portions of the comment to be withheld from the public record. *See* FTC Rule 4.9(c). Your comment will be kept confidential only if the General Counsel grants your request in accordance with the law and the public interest. Once your comment has been posted publicly at *www.regulations.gov,* we cannot redact or remove your comment unless you submit a confidentiality request that meets the requirements for such treatment under FTC Rule 4.9(c), and the General Counsel grants that request.

The FTC Act and other laws that the Commission administers permit the collection of public comments to consider and use in this proceeding as appropriate. The Commission will consider all timely and responsive public comments that it receives on or before October 2, 2023. For information on the Commission's privacy policy, including routine uses permitted by the Privacy Act, see *https://www.ftc.gov/site-information/privacy-policy.*

Josephine Liu,

Assistant General Counsel for Legal Counsel.

[FR Doc. 2023–16454 Filed 8–1–23; 8:45 am]

BILLING CODE 6750–01–P

GENERAL SERVICES ADMINISTRATION

[Notice–MRB–2023–04; Docket No. GAPFAC–2022–0001; Sequence No. 3]

GSA Acquisition Policy Federal Advisory Committee; Notification of Upcoming Web-Based Public Subcommittee Meetings—Update

AGENCY: Office of Government-wide Policy (OGP), General Services Administration (GSA).

ACTION: Meeting notice.

SUMMARY: Notice of these Web-based subcommittee meetings is being provided in accordance with GSA Policy. This notice provides the updated schedule for a series of Web-based meetings for three subcommittees of the GSA Acquisition Policy Federal Advisory Committee (GAP FAC): the Acquisition Workforce Subcommittee, the Industry Partnerships Subcommittee, and the Policy and Practice Subcommittee. It is GSA policy that subcommittee meetings are open for the public to observe. Information on attending and providing written public comment is under the **SUPPLEMENTARY INFORMATION** section.

DATES: The three Subcommittees will hold recurring Web-based meetings 3:00 p.m. to 5:00 p.m., Eastern Standard Time (EST) on the following dates:

Acquisition workforce subcommittee	Industry partnerships subcommittee	Policy and practice subcommittee
8/1/23	8/2/23	8/3/23
8/29/23	8/30/23	8/31/23
9/26/23	9/27/23	9/28/23
10/24/23	10/25/23	10/26/23
12/12/23	12/13/23	12/14/23

ADDRESSES: The meetings will be accessible via webcast. Registrants will receive the webcast information before the meeting.

FOR FURTHER INFORMATION CONTACT: Boris Arratia, Designated Federal Officer, OGP, 703–795–0816, or email: *boris.arratia@gsa.gov;* or Stephanie Hardison, OGP, 202–258–6823, or email: *stephanie.hardison@gsa.gov.* Additional *information about* the subcommittees and the Committee, including meeting materials and agendas, will be available on-line at *https://gsa.gov/policy-regulations/policy/acquisition-policy/gsa-acquisition-policy-federal-advisory-committee.*

SUPPLEMENTARY INFORMATION: The previous notice can be found here: *https://www.federalregister.gov/documents/2023/02/21/2023-03554/gsa-acquisition-policy-federal-advisory-committee-notification-of-upcoming-web-based-public.*

Meeting Registration

The subcommittee meetings are open to the public and will be accessible by webcast. All public attendees will need to register to obtain the meeting webcast information. Registration information is located on the GAP FAC website: *https://www.gsa.gov/policy-regulations/policy/acquisition-policy/gsa-*

acquisition-policy-federal-advisory-committee. All registrants will be asked to provide their name, affiliation, and email address. After registration, individuals will receive webcast access information via email.

Public Comments

Written public comments are being accepted via email at *gapfac@gsa.gov.* To submit a written public comment, please email at *gapfac.gsa.gov* and include your name, organization name (if applicable), and include ''GAPFAC–2022–0001'' on any attached document(s) (if applicable).

Jeffrey A. Koses,

Senior Procurement Executive, Office of Acquisition Policy, Office of Government-wide Policy.

[FR Doc. 2023–16369 Filed 8–1–23; 8:45 am]

BILLING CODE 6820–RV–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Submission for Office of Management and Budget Review; Case Plan Requirement, Title IV–E of the Social Security Act

AGENCY: Children's Bureau, Administration for Children and Families, United States Department of Health, and Human Services.

ACTION: Request for public comments.

SUMMARY: The Administration for Children and Families (ACF), is requesting a 3-year extension of the information collection Case Plan Requirement, Title IV–E of the Social Security Act, (Office of Management and Budget (OMB) #0970–0428, expiration September 30, 2023). There are no changes to the requirements, but burden estimates have been updated to reflect current numbers of children in foster care.

DATES: *Comments due within 30 days of publication.* OMB must make a decision about the collection of information between 30 and 60 days after publication of this document in the **Federal Register**. Therefore, a comment is best assured of having its full effect if OMB receives it within 30 days of publication.

ADDRESSES: Written comments and recommendations for the proposed information collection should be sent within 30 days of publication of this notice to *www.reginfo.gov/public/do/PRAMain.* Find this particular information collection by selecting ''Currently under 30-day Review-Open for Public Comments'' or by using the search function. You can also obtain copies of the proposed collection of information by emailing *infocollection@acf.hhs.gov.* Identify all emailed requests by the title of the information collection.

SUPPLEMENTARY INFORMATION:

Description: The case plan information collection is authorized in sections 422(b)(8)(A)(ii) and 471(a)(16), and defined in sections 475 and 475A of the Social Security Act (the Act). Statutory requirements in the Act mandate that states, territories, and tribes with an approved title IV–E plan develop a case review system and case plan for each child in the foster care system for whom the state, territory, or tribe receives title IV–E reimbursement of foster care maintenance payments. The case review system assures that each child has a case plan designed to achieve placement in a safe setting that is the least restrictive, most family-like setting available and in close proximity to the child's parental home, consistent with the best interest and special needs of the child. States, territories, and tribes meeting these requirements also partly comply with title IV–B, section 422(b), of the Act, which assures certain protections for children in foster care. The case plan is a written document that provides a narrative description of the child-specific program of care. Federal regulations at 45 CFR 1356.21(g) and sections 475 and 475A of the Act delineate the specific information that must be addressed in the case plan. ACF does not specify a format for the case plan nor does ACF require submission of the document to the federal government. Case plan information is recorded in a format developed and maintained by the state, territorial, or tribal title IV–E agency.

Burden estimates have been adjusted to reflect two additional agencies, a decreased number of children entering foster care and an increased number of children exiting foster care.

Respondents: State, territorial, and tribal title IV–E agencies.

ANNUAL BURDEN ESTIMATES

Instrument	Total number of respondents	Total number of responses per respondent	Average burden hours per response	Total burden hours	Annual burden hours
Case Plan	66	23,039	4.8	7,298,755	2,432,918

Estimated Total Annual Burden Hours: 2,432,918.

Authority: 42 U.S.C. 622; 42 U.S.C. 671; 42 U.S.C. 675; 42 U.S.C. 675a.

Mary B. Jones,

ACF/OPRE Certifying Officer.

[FR Doc. 2023–16340 Filed 8–1–23; 8:45 am]

BILLING CODE 4184–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Submission for Office of Management and Budget Review; Administration for Children and Families Generic for Information Collections Related to Gatherings (New Collection)

AGENCY: Office of Planning, Research, and Evaluation, Administration for Children and Families, United States Department of Health and Human Services.

ACTION: Request for public comments.

SUMMARY: The Administration for Children and Families (ACF) at the U.S. Department of Health and Human Services intends to request approval from the Office of Management and Budget (OMB) for a generic clearance to request information from potential participants at ACF gatherings, such as meetings or conferences. The planning for these gatherings is most often on a quick timeline and the standard timeline to comply with a full request

under the Paperwork Reduction Act (PRA) would inhibit the ability to collect information to inform these activities. Therefore, an umbrella generic is requested to allow for quick turnaround requests for similar information collections related to these activities.

DATES: *Comments due within 30 days of publication.* OMB must make a decision about the collection of information between 30 and 60 days after publication of this document in the **Federal Register**. Therefore, a comment is best assured of having its full effect if OMB receives it within 30 days of publication.

ADDRESSES: Written comments and recommendations for the proposed information collection should be sent within 30 days of publication of this notice to *www.reginfo.gov/public/do/PRAMain.* Find this particular information collection by selecting ''Currently under 30-day Review—Open for Public Comments'' or by using the search function. You can also obtain copies of the proposed collection of information by emailing *OPREinfocollection@acf.hhs.gov.* Identify all requests by the title of the information collection.

SUPPLEMENTARY INFORMATION:

Description: ACF hosts a variety of gatherings for many different purposes. This may include large scale conferences, meetings for grantees or contractors, workshops, trainings, poster sessions, and other in-person and virtual gatherings for individuals with interest in ACF programs (clients, researchers, policymakers, etc.), among others. To ensure ACF has adequate information to plan these activities, the Agency must often collect information from potential participants such as basic contact information, preferences for attendance (mode, special requests, etc.), organizational affiliation, feedback about meeting content, etc. Additionally, some activities require ACF to have additional information to have the means to select the most appropriate participants for attendance according to the type or purpose of a given activity, or to group participants into the most appropriate category or activity during an event. This may include information about poster presentations, speaking panels, training courses, professional perspectives, or experiences, etc. In addition, attendees may be asked to submit an application or abstract for prescreening to be selected for attendance.

The purposes of the collections under this umbrella generic information collection are to gather appropriate information to plan ACF gatherings. Example information collection activities could include:

- Registration forms
  - Information collected on these types of forms could include name, contact information, organization/affiliation, basic demographics, attendance needs, etc.
- Applications for panels, posters, or other presentation formats
  - Information collected on these types of applications could include title, author(s), institution/organization, abstract describing presentation or poster, instructions, etc.
- Pre-meeting surveys
  - Information collected on these types of surveys could include content preferences, scheduling needs and preferences, pre-meeting knowledge, etc.
- Post-Meeting/-Workshop/-Training Evaluation Surveys
  - Information collected on these types of surveys could include requests for feedback on the overall activity, feedback on content, post-meeting knowledge, post-meeting uses of content, preferences for future activities, etc.

As part of this generic, ACF requests OMB provide a response on individual generic information collections within 5 business days.

Note that this generic is primarily for information collected in connection with closed ACF meetings, as information collected in connection with public ACF meetings are not considered ''information'' under PRA per 44 U.S.C., 5 CFR ch. 11 (1–1–99 edition), 1320.3: Definitions.

Respondents: Potential respondents may include researchers, individuals with expertise in ACF program areas, individuals with interest in ACF program areas, those receiving ACF services, ACF grantees or contractors, among others with involvement or interest in ACF activities.

TOTAL BURDEN ESTIMATES

Example types of information collections	Total number of respondents	Total number of responses per respondent	Average burden hours per response	Total burden hours	Average hourly wage	Total annual cost
Registration Forms	30,000	1	.167	5,010	$64	$320,640
Applications	5,000	1	1.5	7,500	64	480,000
Pre- and Post-activity Surveys	20,000	1	.5	10,000	64	640,000
Other Activities	14,000	1	.5	7,000	64	448,000
Estimated Totals	69,000		*.428	29,510		1,888,640

* Average.

Mary B. Jones,

ACF/OPRE Certifying Officer.

[FR Doc. 2023–16436 Filed 8–1–23; 8:45 am]

BILLING CODE 4184–79–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Community Living

Agency Information Collection Activities; Proposed Collection; Comment Request; National Survey of Older Americans Act Participants [OMB 0985–0023]

AGENCY: Administration for Community Living, HHS.

ACTION: Notice.

SUMMARY: The Administration for Community Living (ACL) is announcing an opportunity for the public to comment on the proposed collection of information listed above. Under the Paperwork Reduction Act of 1995 (the PRA), Federal agencies are required to publish a notice in the **Federal Register** concerning each proposed collection of information, including each proposed

extension of an existing collection of information, and to allow 60 days for public comment in response to the notice. This notice solicits comments on the Proposed Extension without Change and the information collection requirements related to the National Survey of Older Americans Act Participants.

DATES: Comments on the collection of information must be submitted electronically by 11:59 p.m. (EST) or postmarked by October 2, 2023.

ADDRESSES: Submit electronic comments on the collection of information to *Kristen.Robinson@acl.hhs.gov.* Submit written comments on the collection of information to Administration for Community Living, Washington, DC 20201, Attention: Kristen Robinson.

FOR FURTHER INFORMATION CONTACT: Kristen Robinson, Administration for Community Living, Washington, DC 20201, by email at *Kristen.Robinson@acl.hhs.gov,* or by telephone at 202–795–7428.

SUPPLEMENTARY INFORMATION: Under the PRA (44 U.S.C. 3501–3520), Federal agencies must obtain approval from the Office of Management and Budget (OMB) for each collection of information they conduct or sponsor. ''Collection of information'' is defined in 44 U.S.C. 3502(3) and 5 CFR 1320.3(c) and includes agency requests or requirements that members of the public submit reports, keep records, or provide information to a third party. Section 3506(c)(2)(A) of the PRA (44 U.S.C. 3506(c)(2)(A)) requires Federal agencies to provide a 60-day notice in the **Federal Register** concerning each proposed collection of information, including each proposed extension of an existing collection of information, before submitting the collection to OMB for approval. To comply with this requirement, ACL is publishing a notice of the proposed collection of information set forth in this document. With respect to the following collection of information, ACL invites comments on our burden estimates or any other aspect of this collection of information, including:

(1) whether the proposed collection of information is necessary for the proper performance of ACL's functions, including whether the information will have practical utility;

(2) the accuracy of ACL's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used to determine burden estimates;

(3) ways to enhance the quality, utility, and clarity of the information to be collected; and

(4) ways to minimize the burden of the collection of information on respondents, including using automated collection techniques when appropriate, and other forms of information technology. The National Survey of Older Americans Act (OAA) Participants information collection includes consumer assessment surveys for the Congregate and Home-delivered meal nutrition programs; Case Management, Homemaker, and Transportation Services; and the National Family Caregiver Support Program. This survey builds on earlier national pilot studies and surveys, as well as performance measurement tools developed by ACL grantees in the Performance Outcomes Measures Project (POMP). Changes identified as a result of these initiatives were incorporated into the last data collection package that was approved by OMB and are included in this proposed extension of a currently approved collection.

This information will be used by ACL to track performance outcome measures; support budget requests; comply with the GPRA Modernization Act of 2010 (GPRMA) reporting requirements; provide national benchmark information; and inform program development and management initiatives.

Copies of the survey instruments and data from previous National Surveys of OAA Participants can be found and queried using the Aging, Independence, and Disability (AGID) Program Data Portal at *https://agid.acl.gov/.* The proposed data collection tools may be found on the ACL website at *https://www.acl.gov/about-acl/public-input.*

Estimated Program Burden: ACL estimates the annual burden associated with this collection of information as follows:

Respondent/data collection activity	Number of respondents	Responses per respondent	Hours per response	Annual burden hours
Area Agency on Aging: Respondent selection process	300	1	4.0	1,200
Service recipients (i.e., Congregate and Home-Delivered Meal nutrition programs, Case Management, Homemaker, Transportation services) + Rotating Module	4,000	1	0.75	3,000
National Family Caregiver Support Program clients + Rotating Module	2,000	1	0.75	1,500
Total	6,300	1	*0.90	5,700

*(weighted mean).

Dated: July 28, 2023.

Alison Barkoff,

Acting Administrator and Assistant Secretary for Aging.

[FR Doc. 2023–16419 Filed 8–1–23; 8:45 am]

BILLING CODE 4154–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. FDA–2004–N–0451]

Food and Drug Administration Modernization Act of 1997: Modifications to the List of Recognized Standards, Recognition List Number: 059

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA or Agency) is announcing a publication containing modifications the Agency is making to the list of standards FDA recognizes for use in premarket reviews (FDA Recognized Consensus Standards). This publication, entitled ''Modifications to the List of Recognized Standards, Recognition List Number: 059'' (Recognition List Number: 059), will assist manufacturers who elect to declare conformity with consensus standards to meet certain requirements for medical devices.

DATES: Submit either electronic or written comments on the notice at any time. These modifications to the list of recognized standards are applicable August 2, 2023.

ADDRESSES: You may submit comments on the current list of FDA Recognized Consensus Standards at any time as follows:

Electronic Submissions

Submit electronic comments in the following way:

- *Federal eRulemaking Portal: https://www.regulations.gov.* Follow the instructions for submitting comments. Comments submitted electronically, including attachments, to *https://www.regulations.gov* will be posted to the docket unchanged. Because your comment will be made public, you are solely responsible for ensuring that your comment does not include any confidential information that you or a third party may not wish to be posted, such as medical information, your or anyone else's Social Security number, or confidential business information, such as a manufacturing process. Please note that if you include your name, contact information, or other information that identifies you in the body of your comments, that information will be posted on *https://www.regulations.gov.*
- If you want to submit a comment with confidential information that you do not wish to be made available to the public, submit the comment as a written/paper submission and in the manner detailed (see ''Written/Paper Submissions'' and ''Instructions'').

Written/Paper Submissions

Submit written/paper submissions as follows:

- *Mail/Hand delivery/Courier (for written/paper submissions):* Dockets Management Staff (HFA–305), Food and Drug Administration, 5630 Fishers Lane, Rm. 1061, Rockville, MD 20852.
- For written/paper comments submitted to the Dockets Management Staff, FDA will post your comment, as well as any attachments, except for information submitted, marked and identified, as confidential, if submitted as detailed in ''Instructions.''

Instructions: All submissions received must include the Docket No. FDA–2004–N–0451 for ''Food and Drug Administration Modernization Act of 1997: Modifications to the List of Recognized Standards, Recognition List Number: 059.'' Received comments will be placed in the docket and, except for those submitted as ''Confidential Submissions,'' publicly viewable at *https://www.regulations.gov* or at the Dockets Management Staff between 9 a.m. and 4 p.m., Monday through Friday, 240–402–7500. FDA will consider any comments received in determining whether to amend the current listing of modifications to the list of recognized standards, Recognition List Number: 059.

- Confidential Submissions—To submit a comment with confidential information that you do not wish to be made publicly available, submit your comments only as a written/paper submission. You should submit two copies total. One copy will include the information you claim to be confidential with a heading or cover note that states ''THIS DOCUMENT CONTAINS CONFIDENTIAL INFORMATION.'' The Agency will review this copy, including the claimed confidential information, in its consideration of comments. The second copy, which will have the claimed confidential information redacted/blacked out, will be available for public viewing and posted on *https://www.regulations.gov.* Submit both copies to the Dockets Management Staff. If you do not wish your name and contact information to be made publicly available, you can provide this information on the cover sheet and not in the body of your comments and you must identify this information as ''confidential.'' Any information marked as ''confidential'' will not be disclosed except in accordance with 21 CFR 10.20 and other applicable disclosure law. For more information about FDA's posting of comments to public dockets, see 80 FR 56469, September 18, 2015, or access the information at: *https://www.govinfo.gov/content/pkg/FR-2015-09-18/pdf/2015-23389.pdf.*

Docket: For access to the docket to read background documents or the electronic and written/paper comments received, go to *https://www.regulations.gov* and insert the docket number, found in brackets in the heading of this document, into the ''Search'' box and follow the prompts and/or go to the Dockets Management Staff, 5630 Fishers Lane, Rm. 1061, Rockville, MD 20852, 240–402–7500.

An electronic copy of Recognition List Number: 059 is available on the internet at *https://www.fda.gov/MedicalDevices/DeviceRegulationandGuidance/Standards/ucm123792.htm.* See section IV for electronic access to the searchable database for the current list of FDA-recognized consensus standards, including Recognition List Number: 059 modifications and other standards-related information. Submit written requests for a single hard copy of the document entitled ''Modifications to the List of Recognized Standards, Recognition List Number: 059'' to Jianchao Zeng, Center for Devices and Radiological Health, Food and Drug Administration, 10903 New Hampshire Ave., Bldg. 66, Rm. 5572, Silver Spring, MD 20993, 301–796–6580. Send one self-addressed adhesive label to assist that office in processing your request, or fax your request to 301–847–8144.

FOR FURTHER INFORMATION CONTACT: Jianchao Zeng, Center for Devices and Radiological Health, Food and Drug Administration, 10903 New Hampshire Ave., Bldg. 66, Rm. 5572, Silver Spring, MD 20993, 301–796–6580, *CDRHStandardsStaff@fda.hhs.gov.*

SUPPLEMENTARY INFORMATION:

I. Background

Section 204 of the Food and Drug Administration Modernization Act of 1997 (Pub. L. 105–115) amended section 514 of the Federal Food, Drug, and Cosmetic Act (FD&C Act) (21 U.S.C. 360d). Amended section 514 of the FD&C Act allows FDA to recognize consensus standards developed by international and national organizations for use in satisfying portions of device premarket review submissions or other requirements.

In the **Federal Register** of September 14, 2018 (83 FR 46738), FDA announced the availability of a guidance entitled ''Appropriate Use of Voluntary Consensus Standards in Premarket Submissions for Medical Devices.'' The guidance describes how FDA has implemented its standards recognition program and is available at *https://www.fda.gov/regulatory-information/search-fda-guidance-documents/appropriate-use-voluntary-consensus-standards-premarket-submissions-medical-devices.* Modifications to the initial list of recognized standards, as published in the **Federal Register**, can be accessed at *https://www.fda.gov/medical-devices/standards-and-conformity-assessment-program/federal-register-documents.*

These notices describe the addition, withdrawal, and revision of certain standards recognized by FDA. The Agency maintains on its website HTML and PDF versions of the list of FDA Recognized Consensus Standards, available at *https://www.fda.gov/medical-devices/standards-and-conformity-assessment-program/federal-register-documents.* Additional information on the Agency's Standards and Conformity Assessment Program is available at *https://www.fda.gov/medical-devices/device-advice-comprehensive-regulatory-assistance/standards-and-conformity-assessment-program.*

II. Modifications to the List of Recognized Standards, Recognition List Number: 059

FDA is announcing the addition, withdrawal, correction, and revision of certain consensus standards the Agency is recognizing for use in premarket submissions and other requirements for devices. FDA is incorporating these modifications to the list of FDA Recognized Consensus Standards in the Agency's searchable database. FDA is using the term ''Recognition List Number: 059'' to identify the current modifications.

In table 1, FDA describes the following modifications: (1) the withdrawal of standards and their replacement by others, if applicable; (2) the correction of errors made by FDA in listing previously recognized standards; and (3) the changes to the supplementary information sheets of recognized standards that describe revisions to the applicability of the standards.

In section III, FDA lists modifications the Agency is making that involve new entries and consensus standards added as modifications to the list of recognized standards under Recognition List Number: 059.

TABLE 1—MODIFICATIONS TO THE LIST OF RECOGNIZED STANDARDS

Old recognition No.	Replacement recognition No.	Title of standard [1]	Change
A. Anesthesiology			
1–67	1–153	NFPA 99:2021 Health Care Facilities Code	Withdrawn and replaced with newer version.
1–78	1–154	ASME PVHO–1–2019 Safety Standard for Pressure Vessels for Human Occupancy.	Withdrawn and replaced with newer version.
1–132	1–155	ISO 10079–2 Fourth edition 2022–03 Medical suction equipment—Part 2: Manually powered suction equipment.	Withdrawn and replaced with newer version.
1–133	1–156	ISO 10079–3 Fourth edition 2022–03 Medical suction equipment—Part 3: Suction equipment powered from a vacuum or positive pressure gas source.	Withdrawn and replaced with newer version.
1–142	1–157	ISO 10079–1 Fourth edition 2022–03 Medical suction equipment—Part 1: Electrically powered suction equipment.	Withdrawn and replaced with newer version.
B. Biocompatibility			
2–93	2–297	ASTM F763–22 Standard Practice for Short-Term Intramuscular Screening of Implantable Medical Device Materials.	Withdrawn and replaced with newer version.
2–276	2–298	ISO 10993–18 Second edition 2020–01 Amendment 1:2022–05 Biological evaluation of medical devices—Part 18: Chemical characterization of medical device materials within a risk management process [Including Amendment 1 (2022)].	Withdrawn and replaced with newer version, including amendment.
2–289	.....	ISO 10993–12 Fifth edition 2021–01 Biological evaluation of medical devices—Part 12: Sample preparation and reference materials.	Transition period extended.
2–296	.....	ISO 10993–10 Fourth edition 2021–11 Biological evaluation of medical devices—Part 10: Tests for skin sensitization.	Transition period extended.
C. Cardiovascular			
No new entries at this time.			
D. Dental/Ear, Nose, and Throat			
4–234	4–294	ANSI/ADA Standard No. 139–2020 Dental Base Polymers	Withdrawn and replaced with newer version.
E. General I (Quality Systems/Risk Management) (QS/RM)			
15–135	5–135	ISO 20417 First edition 2021–04 Corrected version 2021–12 Medical devices—Information to be supplied by the manufacturer.	New recognition number.
5–99	5–136	ASTM D4332–22 Standard Practice for Conditioning Containers, Packages, or Packaging Components for Testing.	Withdrawn and replaced with newer version.
5–104	5–137	IEC TR 60878 Edition 4.0 2022–11 Graphical symbols for electrical equipment in medical practice.	Withdrawn and replaced with newer version.
5–118	5–138	AAMI TIR66:2017/(R)2020 Guidance for the creation of physiologic data and waveform databases to demonstrate reasonable assurance of the safety and effectiveness of alarm system algorithms.	New recognition number.
5–119	5–139	ISO 18250–3 First edition 2018–06 Medical devices—Connectors for reservoir delivery systems for healthcare applications—Part 3: Enteral application.	New recognition number.
F. General II (Electrical Safety/Electromagnetic Compatibility) (ES/EMC)			
19–29	19–48	IEEE ANSI/USEMCSC C63.27 American National Standard for Evaluation of Wireless Coexistence.	Withdrawn and replaced with newer version.

TABLE 1—MODIFICATIONS TO THE LIST OF RECOGNIZED STANDARDS—Continued

Old recognition No.	Replacement recognition No.	Title of standard [1]	Change
G. General Hospital/General Plastic Surgery (GH/GPS)			
6–390	.....	IEC 80601–2–35 Edition 2.1 2016–04 CONSOLIDATED VERSION Medical electrical equipment-Part—2–35: Particular requirements for the basic safety and essential performance of heating devices using blankets, pads or mattresses and intended for heating in medical use [Including Amendment 1 (2016)].	Withdrawn. See 6–483.
6–460	6–484	ASTM F3502–22a Standard Specification for Barrier Face Coverings	Extent of recognition. Withdrawn and replaced with a newer version.
H. In Vitro Diagnostics (IVD)			
7–291	7–313	CLSI EP27 2nd Edition Constructing and Interpreting an Error Grid for Quantitative Measurement Procedures.	Extent of recognition. Withdrawn and replaced with newer version.
7–303	.....	CLSI M60 2nd Edition Performance Standards for Antifungal Susceptibility Testing of Yeast.	Withdrawn. See 7–314.
I. Materials			
8–61	8–594	ISO 5832–6 Third Edition 2022–03 Implants for surgery—Metallic materials—Part 6: Wrought cobalt-nickel-chromium-molybdenum alloy.	Withdrawn and replaced with newer version.
8–123	8–595	ISO 5832–5 Fourth Edition 2022–03 Implants for surgery—Metallic materials—Part 5: Wrought cobalt-chromium-tungsten-nickel.	Withdrawn and replaced with newer version.
8–559	8–596	ASTM D412–16(2021) Standard Test Methods for Vulcanized Rubber and Thermoplastic Elastomers—Tension.	Withdrawn and replaced with newer version.
J. Nanotechnology			
18–4	18–21	ISO/TS 80004–6 Second edition 2021–03 Nanotechnologies—Vocabulary—Part 6: Nano-object characterization.	Withdrawn and replaced with newer version.
18–12	18–22	ISO 17200 First edition 2020–09 Nanotechnology—Nanoparticles in powder form—Characteristics and measurements.	Withdrawn and replaced with newer version.
K. Neurology			
No new entries at this time.			
L. Obstetrics-Gynecology/Gastroenterology/Urology (OB-Gyn/G/Urology)			
9–89	.....	ISO 8638 Third edition 2010–07–01 Cardiovascular implants and extracorporeal systems—Extracorporeal blood circuit for hemodialyzers, hemodialfilters, and hemofilters.	Withdrawn. See 9–140.
M. Ophthalmic			
10–37	10–132	ISO 10942 Third edition 2022–01 Ophthalmic instruments—Direct ophthalmoscopes.	Extent of recognition. Withdrawn and replaced with newer version.
10–91	10–133	ISO 11979–10 Second edition 2018–03 Ophthalmic implants—Intraocular lenses—Part 10: Clinical investigations of intraocular lenses for correction of ametropia in phakic eyes.	Withdrawn and replaced with newer version.
N. Orthopedic			
11–264	11–394	ASTM F1820–22 Standard Test Method for Determining the Forces for Disassembly of Modular Acetabular Devices.	Withdrawn and replaced with newer version.
11–306	11–395	ASTM F1814–22 Standard Guide for Evaluating Modular Hip and Knee Joint Components.	Withdrawn and replaced with newer version.
11–320	11–396	ISO 7206–13 First edition 2016–07–01 [Including AMD1:2022] Implants for surgery—Partial and total hip joint prostheses—Part 13: Determination of resistance to torque of head fixation of stemmed femoral components [Including Amendment 1 (2022)].	Withdrawn and replaced with newer version including amendment.
O. Physical Medicine			
16–191	.....	ISO 7176–16 Second edition 2012–12–01 Wheelchairs—Part 16: Resistance to ignition of postural support devices.	Withdrawn. See 16–233.
P. Radiology			
12–113	12–346	ISO 12005 Third edition 2022–05 Lasers and laser-related equipment—Test methods for laser beam parameters—Polarization.	Withdrawn and replaced with newer version.

TABLE 1—MODIFICATIONS TO THE LIST OF RECOGNIZED STANDARDS—Continued

Old recognition No.	Replacement recognition No.	Title of standard [1]	Change
12–295	12–347	IEC 60601–2–33 Edition 4.0 2022–08 Medical electrical equipment—Part 2–33: Particular requirements for the basic safety and essential performance of magnetic resonance equipment for medical diagnosis.	Extent of recognition. Withdrawn and replaced with newer version.
12–317	12–348	IEC 60601–2–54 Edition 2.0 2022–09 Medical electrical equipment—Part 2–54: Particular requirements for the basic safety and essential performance of X-ray equipment for radiography and radioscopy.	Extent of recognition. Withdrawn and replaced with newer version.
12–342	12–349	NEMA Digital Imaging and Communications in Medicine (DICOM) Set PS3.1–3.20 2022d.	Withdrawn and replaced with newer version.
Q. Software/Informatics			
13–109	13–121	ANSI/AAMI/UL 2800–1:2022 Standard for Medical Device Interoperability	Withdrawn and replaced with newer version. See 13–125, 13–126, 13–127.
R. Sterility			
14–409	14–580	ISO 11137–2 Third edition 2013–06 [Including AMD1:2022] Sterilization of health care products—Radiation—Part 2: Establishing the sterilization dose [Including Amendment 1 (2022)].	Withdrawn and replaced with newer version.
14–527	14–581	ASTM F2638–22 Standard Test Method for Using Aerosol Filtration for Measuring the Performance of Porous Packaging Materials as a Surrogate Microbial Barrier.	Withdrawn and replaced with newer version.
S. Tissue Engineering			
No new entries at this time.			

[1] All standard titles in this table conform to the style requirements of the respective organizations.

III. Listing of New Entries

In table 2, FDA provides the listing of new entries and consensus standards added as modifications to the list of recognized standards under Recognition List Number: 059. These entries are of standards not previously recognized by FDA.

TABLE 2—NEW ENTRIES TO THE LIST OF RECOGNIZED STANDARDS

Recognition No.	Title of standard [1]	Reference No. and date
A. Anesthesiology		
1–158	Medical suction equipment—Part 4: General requirements	ISO 10079–4 First edition 2021–08.
1–159	Respiratory equipment—Particular requirements for basic safety and essential performance of infant cardiorespiratory monitors.	ISO 18778 Second edition 2022–06.
1–160	Medical electrical equipment—Part 2–84: Particular requirements for the basic safety and essential performance of ventilators for the emergency medical services environment.	ISO 80601–2–84 First edition 2020–07.
B. Biocompatibility		
No new entries at this time.		
C. Cardiovascular		
3–183	Cardiovascular implants and extracorporeal systems—Blood/tissue contact surface modifications for extracorporeal perfusion systems.	ISO 11658 First edition 2012–05–15.
D. Dental/ENT		
4–295	Evaluation of biocompatibility of medical devices used in dentistry	ANSI/ADA Standard No. 41–2020.
4–296	Dentistry—Intra-oral mirrors	ISO 9873 Fourth edition 2019–03.
4–297	Dentistry—Manual toothbrushes—General requirements and test methods	ISO 20126 Third edition 2022–03.
E. General I (QS/RM)		
5–140	Standard for verification and validation in computational solid mechanics	ASME V&V 10–2019.
5–141	Standard for verification and validation in computational fluid dynamics and heat transfer.	ASME V&V 20–2009 (R2021).

TABLE 2—NEW ENTRIES TO THE LIST OF RECOGNIZED STANDARDS—Continued

Recognition No.	Title of standard [1]	Reference No. and date
	F. General II (ES/EMC)	
	No new entries at this time.	
	G. GH/GPS	
6–483	Medical electrical equipment—Part 2–35: Particular requirements for the basic safety and essential performance of heating devices using blankets, pads and mattresses and intended for heating in medical use.	IEC 60601–2–35 Edition 2.0 2020–09.
6–485	Sterile hypodermic syringes for single use—Part 4: Syringes with re-use prevention feature.	ISO 7886–4 Second Edition 2018–11.
	H. IVD	
7–314	Performance Standards for Antifungal Susceptibility Testing of Yeasts	CLSI M27M44S, 3rd Edition.
	I. Materials	
	No new entries at this time.	
	J. Nanotechnology	
	No new entries at this time.	
	K. Neurology	
	No new entries at this time.	
	L. OB-Gyn/G/Urology	
9–140	Extracorporeal systems for blood purification—Part 2: Extracorporeal blood circuit for hemodialyzers, hemodiafilters and hemofilters.	ISO 8637–2 First Edition 2018–07.
9–141	Extracorporeal systems for blood purification—Part 3: Plasmafilters	ISO 8637–3 First Edition 2018–07.
9–142	Standard test method for static and kinetic coefficients of friction of plastic film and sheeting.	ASTM D1894–14.
9–143	Sterile urethral catheters for single use	ISO 20696 First edition 2018–06 Corrected 2019–12.
9–144	Sterile drainage catheters and accessory devices for single use	ISO 20697 First edition 2018–06 Corrected 2019–09.
	M. Ophthalmic	
	No new entries at this time.	
	N. Orthopedic	
11–397	Standard test method for fatigue testing of total knee femoral components under closing conditions.	ASTM F3210–22e1.
11–398	Standard test methods for sacroiliac joint fusion devices	ASTM F3574–22.
	O. Physical Medicine	
16–233	Wheelchair seating—Part 10: Resistance to ignition of postural support devices—Requirements and test method.	ISO 16840–10 Second edition 2021–06 Corrected version 2022–01.
	P. Radiology	
	No new entries at this time.	
	Q. Software/Informatics	
13–122	Health software and health IT systems safety, effectiveness and security—Part 5–1: Security—Activities in the product life cycle.	IEC 81001–5–1 Edition 1.0 2021–12.
13–123	Manufacturer disclosure statement for medical device security	ANSI/NEMA HN 1–2019.
13–124	Guidance on the application of ISO 14971 to artificial intelligence and machine learning.	AAMI CR34971:2022.
13–125	Standard for risk concerns for interoperable medical products	ANSI/AAMI/UL 2800–1–1:2022.
13–126	Standard for interoperable item development life cycle	ANSI/AAMI/UL 2800–1–2:2022.
13–127	Standard for Interoperable item integration life cycle	ANSI/AAMI/UL 2800–1–3:2022.
13–128	IEEE/UL Standard for wireless diabetes device security: Information security requirements for connected diabetes solutions.	IEEE Std 2621.2–2022/UL 2621–2:2022.

TABLE 2—NEW ENTRIES TO THE LIST OF RECOGNIZED STANDARDS—Continued

Recognition No.	Title of standard [1]	Reference No. and date
R. Sterility		
14–582	Sterilization of health care products—Radiation—Part 4: Guidance on process control	ISO/TS 11137–4 First edition 2020–06.
14–583	Cleaning validation of health care products—Requirements for development and validation of a cleaning process for medical devices..	ANSI/AAMI ST98:2022.
S. Tissue Engineering		
No new entries at this time.		

[1] All standard titles in this table conform to the style requirements of the respective organizations.

IV. List of Recognized Standards

FDA maintains the current list of FDA Recognized Consensus Standards in a searchable database that may be accessed at *https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfStandards/search.cfm.* Such standards are those that FDA has recognized by notice published in the **Federal Register** or that FDA has decided to recognize but for which recognition is pending (because a periodic notice has not yet appeared in the **Federal Register**). FDA will announce additional modifications and revisions to the list of recognized consensus standards, as needed, in the **Federal Register** once a year, or more often if necessary.

V. Recommendation of Standards for Recognition by FDA

Any person may recommend consensus standards as candidates for recognition under section 514 of the FD&C Act by submitting such recommendations, with reasons for the recommendation, to *CDRHStandardsStaff@fda.hhs.gov*. To be considered, such recommendations should contain, at a minimum, the information available at *https://www.fda.gov/medical-devices/device-advice-comprehensive-regulatory-assistance/standards-and-conformity-assessment-program#process.*

Dated: July 28, 2023.

Lauren K. Roth,

Associate Commissioner for Policy.

[FR Doc. 2023–16418 Filed 8–1–23; 8:45 am]

BILLING CODE 4164–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. FDA–2023–N–2780]

Agency Information Collection Activities; Proposed Collection; Comment Request; Premarket Notification for a New Dietary Ingredient

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA or Agency) is announcing an opportunity for public comment on the proposed collection of certain information by the Agency. Under the Paperwork Reduction Act of 1995 (PRA), Federal Agencies are required to publish notice in the **Federal Register** concerning each proposed collection of information and to allow 60 days for public comment in response to the notice. This notice solicits comments on the procedure by which a manufacturer or distributor of a new dietary ingredient or of a dietary supplement containing a new dietary ingredient is to submit to FDA information upon which it has based its conclusion that a dietary supplement containing the new dietary ingredient will reasonably be expected to be safe.

DATES: Either electronic or written comments on the collection of information must be submitted by October 2, 2023.

ADDRESSES: You may submit comments as follows. Please note that late, untimely filed comments will not be considered. The *https://www.regulations.gov* electronic filing system will accept comments until 11:59 p.m. Eastern Time at the end of October 2, 2023. Comments received by mail/hand delivery/courier (for written/paper submissions) will be considered timely if they are received on or before that date.

Electronic Submissions

Submit electronic comments in the following way:

- *Federal eRulemaking Portal: https://www.regulations.gov.* Follow the instructions for submitting comments. Comments submitted electronically, including attachments, to *https://www.regulations.gov* will be posted to the docket unchanged. Because your comment will be made public, you are solely responsible for ensuring that your comment does not include any confidential information that you or a third party may not wish to be posted, such as medical information, your or anyone else's Social Security number, or confidential business information, such as a manufacturing process. Please note that if you include your name, contact information, or other information that identifies you in the body of your comments, that information will be posted on *https://www.regulations.gov.*
- If you want to submit a comment with confidential information that you do not wish to be made available to the public, submit the comment as a written/paper submission and in the manner detailed (see ''Written/Paper Submissions'' and ''Instructions'').

Written/Paper Submissions

Submit written/paper submissions as follows:

- *Mail/Hand Delivery/Courier (for written/paper submissions):* Dockets Management Staff (HFA–305), Food and Drug Administration, 5630 Fishers Lane, Rm. 1061, Rockville, MD 20852.
- For written/paper comments submitted to the Dockets Management Staff, FDA will post your comment, as well as any attachments, except for information submitted, marked and identified, as confidential, if submitted as detailed in ''Instructions.''

Instructions: All submissions received must include the Docket No. FDA–2023–N–2780 for ''Agency Information Collection Activities; Proposed Collection; Comment Request; Premarket Notification for a New

Dietary Ingredient.'' Received comments, those filed in a timely manner (see **ADDRESSES**), will be placed in the docket and, except for those submitted as ''Confidential Submissions,'' publicly viewable at *https://www.regulations.gov* or at the Dockets Management Staff between 9 a.m. and 4 p.m., Monday through Friday, 240–402–7500.

- Confidential Submissions—To submit a comment with confidential information that you do not wish to be made publicly available, submit your comments only as a written/paper submission. You should submit two copies total. One copy will include the information you claim to be confidential with a heading or cover note that states ''THIS DOCUMENT CONTAINS CONFIDENTIAL INFORMATION.'' The Agency will review this copy, including the claimed confidential information, in its consideration of comments. The second copy, which will have the claimed confidential information redacted/blacked out, will be available for public viewing and posted on *https://www.regulations.gov.* Submit both copies to the Dockets Management Staff. If you do not wish your name and contact information to be made publicly available, you can provide this information on the cover sheet and not in the body of your comments and you must identify this information as ''confidential.'' Any information marked as ''confidential'' will not be disclosed except in accordance with 21 CFR 10.20 and other applicable disclosure law. For more information about FDA's posting of comments to public dockets, see 80 FR 56469, September 18, 2015, or access the information at: *https://www.govinfo.gov/content/pkg/FR-2015-09-18/pdf/2015-23389.pdf.*

Docket: For access to the docket to read background documents or the electronic and written/paper comments received, go to *https://www.regulations.gov* and insert the docket number, found in brackets in the heading of this document, into the ''Search'' box and follow the prompts and/or go to the Dockets Management Staff, 5630 Fishers Lane, Rm. 1061, Rockville, MD 20852, 240–402–7500.

FOR FURTHER INFORMATION CONTACT: JonnaLynn Capezzuto, Office of Operations, Food and Drug Administration, Three White Flint North, 10A–12M, 11601 Landsdown St., North Bethesda, MD 20852, 301–796–3794, *PRAStaff@fda.hhs.gov.*

SUPPLEMENTARY INFORMATION: Under the PRA (44 U.S.C. 3501–3521), Federal Agencies must obtain approval from the Office of Management and Budget (OMB) for each collection of information they conduct or sponsor. ''Collection of information'' is defined in 44 U.S.C. 3502(3) and 5 CFR 1320.3(c) and includes Agency requests or requirements that members of the public submit reports, keep records, or provide information to a third party. Section 3506(c)(2)(A) of the PRA (44 U.S.C. 3506(c)(2)(A)) requires Federal Agencies to provide a 60-day notice in the **Federal Register** concerning each proposed collection of information before submitting the collection to OMB for approval. To comply with this requirement, FDA is publishing notice of the proposed collection of information set forth in this document.

With respect to the following collection of information, FDA invites comments on these topics: (1) whether the proposed collection of information is necessary for the proper performance of FDA's functions, including whether the information will have practical utility; (2) the accuracy of FDA's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques, when appropriate, and other forms of information technology.

Premarket Notification for a New Dietary Ingredient—21 CFR 190.6

OMB Control Number 0910–0330—Revision

This information collection supports Agency regulation, guidance, and associated Form FDA 3880. Under section 413(a)(2) of the Federal Food, Drug, and Cosmetic Act (FD&C Act) (21 U.S.C. 350b(a)(2)), the manufacturer or distributor of a new dietary ingredient (NDI) or a dietary supplement that contains the NDI, must submit an NDI notification (NDIN) to FDA (as delegate for the Secretary of Health and Human Services) at least 75 days before introducing the product into interstate commerce, unless the NDI and any other dietary ingredients in the dietary supplement ''have been present in the food supply as an article used for food in a form in which the food has not been chemically altered'' (21 U.S.C. 350b(a)(1)).

The notification must contain the information, including any citation to published articles, which provides the basis on which the manufacturer or distributor of the NDI or dietary supplement (the notifier) has concluded that the dietary supplement containing the NDI will reasonably be expected to be safe (21 U.S.C. 350b(a)(2)). If the required premarket notification is not submitted to FDA, section 413(a) of the FD&C Act provides that the dietary supplement containing the NDI is deemed to be adulterated under section 402(f) of the FD&C Act (21 U.S.C. 342(f)). Even if the notification is submitted as required, the dietary supplement containing the NDI is adulterated under section 402(f) unless there is a history of use or other evidence of safety establishing that the NDI, when used under the conditions recommended or suggested in the labeling of the dietary supplement, will reasonably be expected to be safe.

Section 190.6 (21 CFR 190.6) specifies the information a notifier must include in its NDIN and establishes the administrative procedures for these notifications. Section 190.6(a) requires each manufacturer or distributor of an NDI, or of a dietary supplement containing an NDI, to submit to the Center for Food Safety and Applied Nutrition's (CFSAN's) Office of Dietary Supplement Programs (ODSP) notification of the basis for their conclusion that said supplement or ingredient will reasonably be expected to be safe. Section 190.6(b) requires that the notification include the following: (1) the complete name and address of the manufacturer or distributor, (2) the name of the NDI, (3) a description of the dietary supplement(s) that contain the NDI, including the level of the new dietary ingredient in the dietary supplement and the dietary supplement's conditions of use, (4) the history of use or other evidence of safety establishing that the dietary ingredient will reasonably be expected to be safe when used under the conditions recommended or suggested in the labeling of the dietary supplement, and (5) the signature of a responsible person designated by the manufacturer or distributor.

These NDIN requirements are designed to enable us to monitor the introduction into the marketplace of NDIs and dietary supplements that contain NDIs in order to protect consumers from ingredients and products whose safety is unknown. We use the information collected in the NDINs to evaluate more efficiently the safety of NDIs in dietary supplements and to support regulatory action against ingredients and products that are potentially unsafe.

FDA developed guidance to further assist industry with NDINs. In the **Federal Register** of July 5, 2011 (76 FR

39111), we announced the availability of a draft guidance for industry entitled ''Dietary Supplements: New Dietary Ingredient Notifications and Related Issues'' (the 2011 draft guidance). We gave interested parties an opportunity to submit comments on the substance of the guidance by October 3, 2011. In the **Federal Register** of September 9, 2011 (76 FR 55927), we extended the comment period to December 2, 2011. We received numerous comments on the 2011 draft guidance. Based on those comments and our meetings with industry and other stakeholders, we revised the 2011 draft guidance. In the **Federal Register** of August 12, 2016 (81 FR 53486), we announced the availability of a revised draft guidance for industry with the same title (the 2016 revised draft guidance) that supersedes the 2011 draft guidance (available at *https://www.fda.gov/regulatory-information/search-fda-guidance-documents/draft-guidance-industry-new-dietary-ingredient-notifications-and-related-issues*). We gave interested parties another opportunity to submit comments on the substance of the guidance by October 11, 2016. In the **Federal Register** of October 4, 2016 (81 FR 68434), we extended the comment period to December 12, 2016. It is with this notice that we solicit comments on the information collection in the guidance.

The 2016 revised draft guidance, when finalized, is intended to provide instruction and further assist industry in deciding when a premarket safety notification for a dietary supplement containing an NDI is necessary and in preparing an NDIN. The draft guidance discusses in question-and-answer format FDA's views on what qualifies as an NDI, when an NDIN is required, the types of data and information that manufacturers and distributors should consider when they evaluate the safety of a dietary supplement containing an NDI, and what should be included in an NDIN as well as other topics. We intend to divide the 2016 revised draft guidance into discrete sections for ease of use, consistent with stakeholder requests (including from industry) submitted in the form of comments to the docket for the draft guidance, and issue a series of several guidances. These guidances will reflect, among other things, public comments submitted to the docket in response to the 2011 draft guidance and the 2016 revised draft guidance. Sections of the 2016 revised draft guidance that FDA is prioritizing to issue at this time address administrative procedures, identity, safety, and master files. Per our standard process, FDA will announce guidance documents we plan to issue within a calendar year via our FDA Foods Program Guidance Agenda, available at: *https://www.fda.gov/food/guidance-documents-regulatory-information-topic-food-and-dietary-supplements/foods-program-guidance-under-development.* The following sections discuss the various topics related to NDINs, all of which were previously referenced or discussed in the 2016 revised draft guidance.

1. Administrative Procedures

The recommendations found in section V, NDI Notification Procedures and Timeframes, of the 2016 revised draft guidance and certain recommendations in section IV.C., Other Questions About When an NDI Notification Is Necessary, provide instruction for certain ways manufacturers and distributors can reduce the number of NDINs they must file and provide some clarification with regard to when data and information from a previous NDIN may be used in a notification. We recommend that certain information should be provided in list form for ease of reference and to help ensure completeness.

Certain recommendations found in the 2016 revised draft guidance, section IV.C., Determining Whether a New Dietary Ingredient (NDI) Notification Is Required; Other Questions About When an NDI Notification Is Necessary, discusses information that should be included if referring to non-public information from a previous notification. Such information to include with a notification could involve written authorization to reference information from another firm. The option to reference certain information from a previous notification should reduce notifiers' burden for preparing and submitting identity, manufacturing, and safety information.

We encourage manufacturers or distributors of NDIs to submit their NDINs electronically via the CFSAN Online Submission Module (COSM). Although we encourage electronic submission, notifiers also have the option of submitting a paper NDIN for us to review. The recommendations found in the 2016 revised draft guidance, section V, Recommended Template for Organizing an NDI Notification, recommends that information in a paper NDIN should be organized in a specific manner, and that some information should be provided in list form, for ease of reference and to ensure completeness. Doing so will help notifiers provide a complete, well-organized NDIN, which should facilitate an efficient and timely FDA review.

These sections of the 2016 revised draft guidance provide instruction and help dietary supplement manufacturers and distributors understand what to expect when submitting an NDIN and enhance industry's ability to submit a complete notification that FDA can efficiently review.

2. Identity Information About the NDI and the Dietary Supplement

Certain recommendations found in the 2016 revised draft guidance, section VI.A., What to Include in an NDI Notification; Identity Information About the NDI and the Dietary Supplement, provide instruction and discuss information that is important in describing the identity of an NDI and the dietary supplement containing the NDI. We will recommend that certain information should be provided in table form for ease of reference and to help ensure completeness.

3. History of Use or Other Evidence of Safety

Certain recommendations in the 2016 revised draft guidance, sections VI.B., History of Use or Other Evidence of Safety, and VI.C, Summary of the Basis for Your Conclusion of Safety, as well as table 3, the Safety Testing Recommendations Matrix, provide instruction and discuss information that is important in describing the basis for which a dietary supplement containing the NDI will reasonably be expected to be safe. While the FD&C Act does not specify the type or amount of information that must be included in an NDIN, the notification should include a dietary supplement safety narrative containing the objective evaluation of the history of use or other evidence of safety cited in the notification, along with an explanation of how the evidence of safety provides a basis to conclude that the dietary supplement containing the NDI, when used under the conditions described in the NDIN, will reasonably be expected to be safe. Once finalized, the recommendations will instruct and help dietary supplement manufacturers and distributors understand what to consider when evaluating the safety of a dietary supplement containing an NDI and what should be included in an NDIN in this regard.

4. Electronic Submission

We developed an electronic portal that respondents may use to electronically submit their notifications to ODSP via COSM. COSM assists respondents filing regulatory

submissions and is specifically designed to aid users wishing to file submissions with CFSAN. COSM allows safety and other information to be uploaded and submitted online via Form FDA 3880. This form provides a standard format to describe the history of use or other evidence of safety on which the manufacturer or distributor bases its conclusion that the NDI is reasonably expected to be safe under the conditions of use recommended or suggested in the labeling of the dietary supplement, as well as a description of the ingredient and other information. Firms that prefer to submit a paper notification in a format of their own choosing have the option to do so; however, Form FDA 3880 prompts a notifier to input the elements of an NDIN in a standard format that we will be able to review efficiently. Form FDA 3880 may be accessed at *https://www.fda.gov/food/new-dietary-ingredients-ndi-notification-process/how-submit-notifications-new-dietary-ingredient.*

Description of Respondents: The respondents to this collection of information are certain manufacturers and distributors in the dietary supplement industry.

FDA estimates the burden of this collection of information as follows:

TABLE 1—ESTIMATED ANNUAL REPORTING BURDEN [1]

Activity; type of respondent; citation	Number of respondents	Number of responses per respondent	Total annual responses	Average burden per response	Total hours
NDIN submission; § 190.6	55	1	55	20	1,100
List Form and Template; Administrative Procedures; Section V	1	1	1	1	1
Written Authority; Master Files; Section IV.C.1 and 4	10	1	10	0.4 (24 minutes)	4
Table Form; Identity Specifications; Section VI.A	55	1	55	1	55
Manufacturing Process Information; Identity Information; Section VI.B and C.	55	1	55	5	275
Total					1,435

[1] There are no capital costs or operating and maintenance costs associated with this collection of information.

Our estimate is based on our experience with information collections related to past NDIN submissions. The estimated burden also reflects an industry average, although burden associated with individual submissions may vary depending on the complexity of the notification. Due to a program change we are revising this information collection request to include recommendations found in the 2016 revised draft guidance. Therefore, we have increased our total burden hour estimate by 335. However, the number of respondents remains the same.

We estimate that 55 respondents each submits 1 NDIN annually. We estimate that extracting and summarizing the relevant information from what exists in the company's files and presenting it in a format that meets the requirements of § 190.6 will take approximately 20 hours of work per notification. We believe that the burden of the premarket notification requirement is reasonable because we are requesting only safety and identity information that the manufacturer or distributor should already have developed to satisfy itself that a dietary supplement containing the NDI is in compliance with the FD&C Act. If the required premarket notification is not submitted to FDA, section 413(a) of the FD&C Act provides that the dietary supplement containing the NDI is deemed to be adulterated under section 402(f) of the FD&C Act. Even if the notification is submitted as required, the dietary supplement containing the NDI is adulterated under section 402(f) of the FD&C Act unless there is a history of use or other evidence of safety establishing that the NDI, when used under the conditions recommended or suggested in the labeling of the dietary supplement, will reasonably be expected to be safe. This requirement is separate from and additional to the requirement to submit a premarket notification for the NDI.

FDA's regulation on NDINs, § 190.6(a), requires the manufacturer or distributor of the NDI or dietary supplement containing the NDI to submit to FDA the information that forms the basis for its conclusion that the NDI, or dietary supplement containing the NDI, will reasonably be expected to be safe. Thus, § 190.6 only requires the manufacturer or distributor to extract and summarize information that should have already been developed to meet the safety requirement in section 413(a)(2) of the FD&C Act.

We estimate that 95 percent of respondents submit electronically, leaving about 3 who submit their NDIN in paper format (5% × 55 = 2.75, rounded up to 3). However, we have seen a trend of decreased paper submissions over the past 2 years and expect usage to remain low. Thus, we estimate only one NDIN will be submitted in paper format. We estimate that information in this NDIN regarding the table of contents, names of contacts, and reference lists will be provided in list form. Because the underlying information should be already readily available, we estimate that it will take about 60 minutes to prepare the information in list form, which would create a burden of 1 hour (1 × 1 hour).

We estimate that 10 notifiers will each reference information once from a previous notification and will provide written authorization to do so. We estimate that it will take about 24 minutes to prepare a written authorization. We calculate that the burden for this activity will be 4 hours annually (10 notifiers × 1 authorization × 0.4 hour).

We estimate that 55 notifiers each will provide identity specifications in table form with their NDIN submissions. Because the underlining information should be already readily available, we estimate that it will take about 1 hour to prepare the information in table form, which would create a burden of 55 hours (55 tables × 1 hour).

We estimate that 55 notifiers each will provide information about the manufacturing process with their NDIN submissions. We estimate that it will take about 5 hours to prepare this information, which would create a burden of 275 hours (55 manufacturing process × 5 hours).

Dated: July 28, 2023.

Lauren K. Roth,

Associate Commissioner for Policy.

[FR Doc. 2023–16434 Filed 8–1–23; 8:45 am]

BILLING CODE 4164–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. FDA–2023–N–2564]

Agency Information Collection Activities; Proposed Collection; Comment Request; Channels of Trade Policy for Commodities With Residues of Pesticide Chemicals, for Which Tolerances Have Been Revoked, Suspended, or Modified by the Environmental Protection Agency Pursuant to Dietary Risk Considerations

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA, the Agency, or we) is announcing an opportunity for public comment on the proposed collection of certain information by the Agency. Under the Paperwork Reduction Act of 1995 (PRA), Federal Agencies are required to publish notice in the **Federal Register** concerning each proposed collection of information, including each proposed extension of an existing collection of information, and to allow 60 days for public comment in response to the notice. This notice solicits comments on the information collection provisions of FDA's guidance for industry entitled ''Channels of Trade Policy for Commodities With Residues of Pesticide Chemicals, for Which Tolerances Have Been Revoked, Suspended, or Modified by the Environmental Protection Agency Pursuant to Dietary Risk Considerations.''

DATES: Either electronic or written comments on the collection of information must be submitted by October 2, 2023.

ADDRESSES: You may submit comments as follows. Please note that late, untimely filed comments will not be considered. The *https://www.regulations.gov* electronic filing system will accept comments until 11:59 p.m. Eastern Time at the end of October 2, 2023. Comments received by mail/hand delivery/courier (for written/paper submissions) will be considered timely if they are received on or before that date.

Electronic Submissions

Submit electronic comments in the following way:

- *Federal eRulemaking Portal: https://www.regulations.gov.* Follow the instructions for submitting comments. Comments submitted electronically, including attachments, to *https://www.regulations.gov* will be posted to the docket unchanged. Because your comment will be made public, you are solely responsible for ensuring that your comment does not include any confidential information that you or a third party may not wish to be posted, such as medical information, your or anyone else's Social Security number, or confidential business information, such as a manufacturing process. Please note that if you include your name, contact information, or other information that identifies you in the body of your comments, that information will be posted on *https://www.regulations.gov.*
- If you want to submit a comment with confidential information that you do not wish to be made available to the public, submit the comment as a written/paper submission and in the manner detailed (see ''Written/Paper Submissions'' and ''Instructions'').

Written/Paper Submissions

Submit written/paper submissions as follows:

- *Mail/Hand Delivery/Courier (for written/paper submissions):* Dockets Management Staff (HFA–305), Food and Drug Administration, 5630 Fishers Lane, Rm. 1061, Rockville, MD 20852.
- For written/paper comments submitted to the Dockets Management Staff, FDA will post your comment, as well as any attachments, except for information submitted, marked and identified, as confidential, if submitted as detailed in ''Instructions.''

Instructions: All submissions received must include the Docket No. FDA–2023–N–2564 for ''Agency Information Collection Activities; Proposed Collection; Comment Request; Channels of Trade Policy for Commodities With Residues of Pesticide Chemicals, for Which Tolerances Have Been Revoked, Suspended, or Modified by the Environmental Protection Agency Pursuant to Dietary Risk Considerations.'' Received comments, those filed in a timely manner (see **ADDRESSES**), will be placed in the docket and, except for those submitted as ''Confidential Submissions,'' publicly viewable at *https://www.regulations.gov* or at the Dockets Management Staff between 9 a.m. and 4 p.m., Monday through Friday, 240–402–7500.

- Confidential Submissions—To submit a comment with confidential information that you do not wish to be made publicly available, submit your comments only as a written/paper submission. You should submit two copies total. One copy will include the information you claim to be confidential with a heading or cover note that states ''THIS DOCUMENT CONTAINS CONFIDENTIAL INFORMATION.'' The Agency will review this copy, including the claimed confidential information, in its consideration of comments. The second copy, which will have the claimed confidential information redacted/blacked out, will be available for public viewing and posted on *https://www.regulations.gov.* Submit both copies to the Dockets Management Staff. If you do not wish your name and contact information to be made publicly available, you can provide this information on the cover sheet and not in the body of your comments and you must identify this information as ''confidential.'' Any information marked as ''confidential'' will not be disclosed except in accordance with 21 CFR 10.20 and other applicable disclosure law. For more information about FDA's posting of comments to public dockets, see 80 FR 56469, September 18, 2015, or access the information at: *https://www.govinfo.gov/content/pkg/FR-2015-09-18/pdf/2015-23389.pdf.*

Docket: For access to the docket to read background documents or the electronic and written/paper comments received, go to *https://www.regulations.gov* and insert the docket number, found in brackets in the heading of this document, into the ''Search'' box and follow the prompts and/or go to the Dockets Management Staff, 5630 Fishers Lane, Rm. 1061, Rockville, MD 20852, 240–402–7500.

FOR FURTHER INFORMATION CONTACT: Amber Sanford, Office of Operations, Food and Drug Administration, Three White Flint North, 10A–12M, 11601 Landsdown St., North Bethesda, MD 20852, 301–796–8867, *PRAStaff@fda.hhs.gov.*

SUPPLEMENTARY INFORMATION: Under the PRA (44 U.S.C. 3501–3521), Federal Agencies must obtain approval from the Office of Management and Budget (OMB) for each collection of information they conduct or sponsor. ''Collection of information'' is defined in 44 U.S.C. 3502(3) and 5 CFR 1320.3(c) and includes Agency requests or requirements that members of the public submit reports, keep records, or provide information to a third party. Section 3506(c)(2)(A) of the PRA (44 U.S.C. 3506(c)(2)(A)) requires Federal Agencies to provide a 60-day notice in the **Federal Register** concerning each proposed collection of information, including each proposed extension of an existing collection of information, before submitting the collection to OMB for approval. To comply with this requirement, FDA is publishing notice

of the proposed collection of information set forth in this document.

With respect to the following collection of information, FDA invites comments on these topics: (1) whether the proposed collection of information is necessary for the proper performance of FDA's functions, including whether the information will have practical utility; (2) the accuracy of FDA's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques, when appropriate, and other forms of information technology.

Channels of Trade Policy for Commodities With Residues of Pesticide Chemicals, for Which Tolerances Have Been Revoked, Suspended, or Modified by the Environmental Protection Agency Pursuant to Dietary Risk Considerations

OMB Control Number 0910–0562—Extension

This information collection supports FDA guidance. The Food Quality Protection Act of 1996 (Pub. L. 104–170), which amended the Federal Insecticide, Fungicide, and Rodenticide Act (FIFRA) (Pub. L. 80–104) and the Federal Food, Drug, and Cosmetic Act (FD&C Act), established a new safety standard for pesticide residues in food, with an emphasis on protecting the health of infants and children. The Environmental Protection Agency (EPA) is responsible for regulating the use of pesticides (under FIFRA) and for establishing tolerances or exemptions from the requirement for tolerances for residues of pesticide chemicals in food commodities (under the FD&C Act). EPA may, for various reasons, *e.g.,* as part of a systematic review or in response to new information concerning the safety of a specific pesticide, reassess whether a tolerance for a pesticide residue continues to meet the safety standard in section 408 of the FD&C Act (21 U.S.C. 346a). When EPA determines that a pesticide's tolerance level does not meet that safety standard, the registration for the pesticide may be canceled under FIFRA for all or certain uses. In addition, the tolerances for that pesticide may be lowered or revoked for the corresponding food commodities.

Under section 408(l)(2) of the FD&C Act, when the registration for a pesticide is canceled or modified due to, in whole or in part, dietary risks to humans posed by residues of that pesticide chemical on food, the effective date for the revocation of such tolerance (or exemption in some cases) must be no later than 180 days after the date such cancellation becomes effective or 180 days after the date on which the use of the canceled pesticide becomes unlawful under the terms of the cancellation, whichever is later.

When EPA takes such actions, food derived from a commodity that was lawfully treated with the pesticide may not have cleared the channels of trade by the time the revocation or new tolerance level takes effect. The food could be found by FDA, the Agency that is responsible for monitoring pesticide residue levels and enforcing the pesticide tolerances in most foods (the U.S. Department of Agriculture has responsibility for monitoring residue levels and enforcing pesticide tolerances in meat, poultry, catfish, and certain egg products), to contain a residue of that pesticide that does not comply with the revoked or lowered tolerance. We would normally deem such food to be in violation of the law by virtue of it bearing an illegal pesticide residue. The food would be subject to FDA enforcement action as an ''adulterated'' food. However, the channels of trade provision of the FD&C Act addresses the circumstances under which a food is not unsafe solely due to the presence of a residue from a pesticide chemical for which the tolerance has been revoked, suspended, or modified by EPA. The channels of trade provision (section 408(l)(5) of the FD&C Act) states that food containing a residue of such a pesticide shall not be deemed ''adulterated'' by virtue of the residue, if the residue is within the former tolerance, and the responsible party can demonstrate to FDA's satisfaction that the residue is present as the result of an application of the pesticide at a time and in a manner that were lawful under FIFRA.

To assist respondents with the information collection, we have developed the guidance document entitled ''Channels of Trade Policy for Commodities With Residues of Pesticide Chemicals, for Which Tolerances Have Been Revoked, Suspended, or Modified by the Environmental Protection Agency Pursuant to Dietary Risk Considerations'' (May 2005). The guidance represents FDA's current thinking on its planned enforcement approach to the channels of trade provision of the FD&C Act and how that provision relates to FDA-regulated products with residues of pesticide chemicals for which tolerances have been revoked, suspended, or modified by EPA under dietary risk considerations. The guidance can be found at the following link: *https://www.fda.gov/regulatory-information/search-fda-guidance-documents/guidance-industry-channels-trade-policy-commodities-residues-pesticide-chemicals-which-tolerances.*

We anticipate that food bearing lawfully applied residues of pesticide chemicals that are the subject of future EPA action to revoke, suspend, or modify their tolerances, will remain in the channels of trade after the applicable tolerance is revoked, suspended, or modified. If we encounter food bearing a residue of a pesticide chemical for which the tolerance has been revoked, suspended, or modified, we intend to address the situation in accordance with provisions of the guidance. In general, we anticipate that the party responsible for food found to contain pesticide chemical residues (within the former tolerance) after the tolerance for the pesticide chemical has been revoked, suspended, or modified will be able to demonstrate that such food was handled, *e.g.,* packed or processed, during the acceptable timeframes cited in the guidance by providing appropriate documentation to FDA as discussed in the guidance document. We are not suggesting that firms maintain an inflexible set of documents where anything less or different would likely be considered unacceptable. Rather, we are leaving it to each firm's discretion to maintain appropriate documentation to demonstrate that the food was so handled during the acceptable timeframes. Examples of documentation that we anticipate will serve this purpose consist of documentation associated with packing codes, batch records, and inventory records. These are types of documents that many food processors routinely generate as part of their basic food-production operations.

Description of Respondents: The likely respondents to this collection of information are firms in the produce and food processing industries that handle food products that may contain residues of pesticide chemicals after the tolerances for the pesticide chemicals have been revoked, suspended, or modified.

We estimate the burden of this collection of information as follows:

TABLE 1—ESTIMATED ANNUAL REPORTING BURDEN [1]

Activity	No. of respondents	No. of responses per respondent	Total annual responses	Average burden per response	Total hours
Submission of documentation	1	1	1	3	3

[1] There are no capital costs or operating and maintenance costs associated with this collection of information.

We expect the total number of pesticide tolerances that are revoked, suspended, or modified by EPA under dietary risk considerations in the next 3 years to remain at a low level, as there have been no changes to the safety standard for pesticide residues in food since 1996. Thus, we expect the number of submissions we receive under the guidance document to also remain at a low level. However, to avoid counting this burden as zero, we have estimated the burden at one respondent making one submission a year for a total of one annual submission.

TABLE 2—ESTIMATED ANNUAL RECORDKEEPING BURDEN [1]

Activity	No. of record-keepers	No. of records per record-keeper	Total annual records	Average burden per record	Total hours
Develop documentation process	1	1	1	16	16

[1] There are no capital costs or operating and maintenance costs associated with this collection of information.

Based on a review of the information collection since our last request for OMB approval, we have made no adjustments to our burden estimate.

Dated: July 28, 2023.

Lauren K. Roth,

Associate Commissioner for Policy.

[FR Doc. 2023–16422 Filed 8–1–23; 8:45 am]

BILLING CODE 4164–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Maternal and Child Health Workforce Development Center Program

AGENCY: Health Resources and Services Administration (HRSA), Department of Health and Human Services.

ACTION: Announcing HRSA-initiated supplemental award.

SUMMARY: HRSA will provide up to $825,000 in fiscal year 2023 supplemental funds to the current Maternal and Child Health (MCH) Workforce Development Center Program recipient for the period of September 1, 2023, to August 31, 2024. This funding will support coordinating fellowships for faculty at minority serving institutions (MSI) in MCH education, research, and practice. Faculty fellowships will contribute to building capacity and developing a diverse MCH workforce that is able to build and sustain academic-practice partnerships and support communities that are historically underserved.

FOR FURTHER INFORMATION CONTACT: Michelle Tissue, Division of MCH Workforce Development, Maternal and Child Health Bureau, Health Resources and Services Administration, at *MTissue@hrsa.gov* and 301–443–6853.

SUPPLEMENTARY INFORMATION:

Intended Recipient of the Award: UNC-Chapel Hill.

Amount of Non-Competitive Award(s): One award for up to $825,000; supplemental funding for similar activities may be considered in future years, subject to the availability of funding for the activity and the satisfactory performance of the recipient.

Project Period: September 1, 2023, to August 31, 2024.

Assistance Listing (CFDA) Number: 93.110.

Award Instrument: Supplement for workforce and capacity building.

Authority: 42 U.S.C. 701(a)(2) (Title V, § 501(a)(2) of the Social Security Act).

TABLE 1—RECIPIENTS AND AWARD AMOUNTS

Grant No.	Award recipient name	City, state	Award amount
UE7MC26282	University of North Carolina at Chapel Hill	NC	$825,000

Justification: The purpose of this supplemental funding is to develop MCH faculty capacity in MSIs by supporting faculty fellowships in MCH public health education, research, and practice. Faculty fellowships will contribute to developing a diverse MCH workforce that is able to build and sustain academic-practice partnerships, as outlined in HRSA–21–043, and support communities that are historically underserved.

- Up to $825,000 in supplemental funding will be awarded to the current MCH Workforce Development Center recipient for the period September 1, 2023, to August 31, 2024.
- Providing supplemental funding for the MCH Workforce Development Center Program will leverage the recipient's expertise in coordinating and supporting academic faculty fellowships and in developing partnerships between Title V MCH agencies and MCH faculty. Supplemental activities are within scope of the current project and will support the recipient to expand capacity

building activities to include faculty at MSIs.

Carole Johnson,

Administrator.

[FR Doc. 2023–16375 Filed 8–1–23; 8:45 am]

BILLING CODE 4165–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Library of Medicine; Notice of Closed Meetings

Pursuant to section 1009 of the Federal Advisory Committee Act, as amended, notice is hereby given of a meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable materials, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Library of Medicine Special Emphasis Panel; New Review for Scholarly Works Program (Part II).

Date: September 7, 2023.

Time: 3:00 p.m. to 4:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Library of Medicine, 6705 Rockledge Drive, Bethesda, MD 20892, (Video Assisted Meeting).

Contact Person: Ali Sharma, Ph.D., Scientific Review Officer, National Library of Medicine, NIH, 6705 Rockledge Drive, Suite 500, Bethesda, MD 20892–7968, *ali.sharma@nih.gov*.

(Catalogue of Federal Domestic Assistance Program No. 93.879, Medical Library Assistance, National Institutes of Health, HHS)

Dated: July 28, 2023.

Miguelina Perez,

Program Analyst, Office of Federal Advisory Committee Policy.

[FR Doc. 2023–16425 Filed 8–1–23; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute on Aging; Notice of Closed Meeting

Pursuant to section 1009 of the Federal Advisory Committee Act, as amended, notice is hereby given of the following meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Institute on Aging Special Emphasis Panel; Estimates of Monetary Costs of Dementia in the United States.

Date: September 14, 2023.

Time: 11:00 a.m. to 4:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institute on Aging, Gateway Building, 7201 Wisconsin Avenue, Bethesda, MD 20892 (Virtual Meeting).

Contact Person: Rajasri Roy, Ph.D., Scientific Review Officer, Scientific Review Branch, National Institutes of Health, National Institute on Aging, 7201 Wisconsin Avenue, Bethesda, MD 20892, (301) 496–9666, *rajasri.roy@nih.gov*.

(Catalogue of Federal Domestic Assistance Program Nos. 93.866, Aging Research, National Institutes of Health, HHS)

Dated: July 28, 2023.

Miguelina Perez,

Program Analyst, Office of Federal Advisory Committee Policy.

[FR Doc. 2023–16424 Filed 8–1–23; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of Neurological Disorders and Stroke; Notice of Meeting

Pursuant to section 1009 of the Federal Advisory Committee Act, as amended, notice is hereby given of a meeting of the National Advisory Neurological Disorders and Stroke Council. The meeting will be open to the public as indicated below, with attendance limited to space available. The open session of the meeting will also be videocast. Individuals who plan to attend or participate and need special assistance, such as sign language interpretation or other reasonable accommodations, should notify the Contact Person listed below in advance of the meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5, U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Advisory Neurological Disorders and Stroke Council.

Date: September 6–7, 2023.

Open: September 6, 2023, 10:00 a.m. to 4:00 p.m.

Agenda: Report by the Director, NINDS; Report by the Director, Division of Extramural Activities; and Administrative and Program Developments.

Open session will be videocast from this link: https://videocast.nih.gov/.

Closed: September 6, 2023, 4:00 p.m. to 5:30 p.m.; September 7, 2023, 9:30 a.m. to 12:30 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, 6001 Executive Boulevard, Room 1131, Rockville, Maryland 20852.

Contact Person: Robert Finkelstein, Ph.D., Director of Extramural Research, National Institute of Neurological Disorders and Stroke, NIH, 6001 Executive Blvd., 5th Floor, MSC 9531, Bethesda, MD 20892, (301) 496–9248, *finkelsr@ninds.nih.gov*.

Any interested person may file written comments with the committee by forwarding the statement to the Contact Person listed on this notice at least 10 days in advance of the meeting. The statement should include the name, address, telephone number and when applicable, the business or professional affiliation of the interested person.

Information is also available on the Institute's/Center's home page: *www.ninds.nih.gov,* where an agenda and any additional information for the meeting will be posted when available.

In the interest of security, NIH has procedures at *https://www.nih.gov/about-nih/visitor-information/campus-access-security* for entrance into on-campus and off-campus facilities. All visitor vehicles, including taxicabs, hotel, and airport shuttles will be inspected before being allowed on campus. Visitors attending a meeting on campus or at an off-campus federal facility will be asked to show one form of identification (for example, a government-issued photo ID, driver's license, or passport) and to state the purpose of their visit.

(Catalogue of Federal Domestic Assistance Program Nos. 93.853, Clinical Research Related to Neurological Disorders; 93.854, Biological Basis Research in the Neurosciences, National Institutes of Health, HHS)

Dated: July 27, 2023.

Tyeshia M. Roberson-Curtis,

Program Analyst, Office of Federal Advisory Committee Policy.

[FR Doc. 2023–16379 Filed 8–1–23; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Library of Medicine; Notice of Closed Meeting

Pursuant to section 1009 of the Federal Advisory Committee Act, as amended, notice is hereby given of a meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable materials, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: Biomedical Informatics, Library and Data Sciences Review Committee (BILDS).

Date: November 2–3, 2023.

Time: November 2, 2023, 10:00 a.m. to 6:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Library of Medicine, 6701 Rockledge Drive, Room 270 A&B, Bethesda, MD 20892.

Time: November 3, 2023, 10:00 a.m. to 5:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Library of Medicine, 6701 Rockledge Drive, Room 270 A&B, Bethesda, MD 20892.

Contact Person: Zoe E. Huang, MD, Chief Scientific Review Officer, Scientific Review Office, Extramural Programs, National Library of Medicine, National Institutes of Health (NIH), 6705 Rockledge Drive, Suite 500, Bethesda, MD 20892–7968, 301–594–4937, *huangz@mail.nih.gov.*

(Catalogue of Federal Domestic Assistance Program No. 93.879, Medical Library Assistance, National Institutes of Health, HHS)

Dated: July 28, 2023.

Miguelina Perez,

Program Analyst, Office of Federal Advisory Committee Policy.

[FR Doc. 2023–16423 Filed 8–1–23; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Scientific Advisory Committee on Alternative Toxicological Methods; Notice of Public Meeting; Request for Public Input

AGENCY: National Institutes of Health, HHS.

ACTION: Notice.

SUMMARY: This notice announces the next meeting of the Scientific Advisory Committee on Alternative Toxicological Methods (SACATM). SACATM is a federally chartered external advisory group of scientists from the public and private sectors, including representatives of regulated industry and national animal protection organizations. SACATM advises the Interagency Coordinating Committee on the Validation of Alternative Methods (ICCVAM), the National Toxicology Program (NTP) Interagency Center for the Evaluation of Alternative Toxicological Methods (NICEATM), and the Director of the National Institute of Environmental Health Sciences (NIEHS) and NTP regarding statutorily mandated duties of ICCVAM and activities of NICEATM. Interested individuals may attend the meeting in person or view the meeting webcast. Registration is required to attend in person and/or present oral comments. Written public comments will be accepted. Information about the meeting and registration are available at *https://ntp.niehs.nih.gov/go/32822.*

DATES:

Meeting: September 21 and 22, 2023, 10:00 a.m. to approximately 4:00 p.m. EDT both days.

Registration for Onsite Meeting: Deadline is September 14, 2023, 5:00 p.m. EDT.

Registration for Oral Statements: Deadline is September 14, 2023, 5:00 p.m. EDT.

Registration is required to attend in person and/or to present oral public comments.

ADDRESSES:

Meeting Location: Rodbell Auditorium, Rall Building, National Institute of Environmental Health Sciences (NIEHS), Research Triangle Park, NC 27709.

Meeting Web Page: The preliminary agenda, registration, and other meeting materials will be available at *https://ntp.niehs.nih.gov/go/32822.*

Virtual Meeting: A link to access the meeting webcast will be available on the meeting web page by noon the day before the meeting.

FOR FURTHER INFORMATION CONTACT: Dr. Milene Brownlow, Designated Federal Officer for SACATM, Office of Policy, Review, and Outreach, Division of Translational Toxicology, NIEHS. Phone: 984–287–3364. Email: *milene.brownlow@nih.gov.*

SUPPLEMENTARY INFORMATION:

Meeting and Registration: SACATM will provide input to ICCVAM, NICEATM, and NIEHS on programmatic activities and issues. Preliminary agenda items for the upcoming meeting include: (1) progress toward implementing the recommendations of the ICCVAM Strategic Roadmap (83 FR 7487; *https://ntp.niehs.nih.gov/go/natl-strategy*) in the areas of replacing acute toxicity tests and advancing validation approaches, (2) the role of new approach methodologies in improving environmental health protection, and (3) update on NICEATM computational resources.

The preliminary agenda, roster of SACATM members, background materials, public comments, and any additional information will be posted when available on the SACATM meeting web page (*https://ntp.niehs.nih.gov/go/32822*) or may be requested from the Designated Federal Officer for SACATM. Individuals are encouraged to visit this web page often to stay abreast of the most current information regarding the meeting. Following the meeting, summary minutes will be prepared and made available on the SACATM meeting web page. Slides and video from the meeting will also be posted on this page once they have been formatted to meet government accessibility standards.

This meeting is open to the public. The public may attend the meeting at NIEHS, where attendance is limited only by the space available, or view remotely by webcast. Those planning to attend the meeting in person are required to register at *https://ntp.niehs.nih.gov/go/32822* by September 14, 2023, to facilitate planning for appropriate meeting space. A link to access the meeting webcast will be available on the meeting web page by noon the day before the meeting. Individuals are encouraged to visit the meeting web page often to stay abreast of the most current information regarding the meeting.

NIEHS visitor and security information is available at *https://www.niehs.nih.gov/about/visiting/index.cfm.* Individuals with disabilities who need accommodation to participate in this event should contact Robbin Guy

at phone: 984–287–3136 or email: *robbin.guy@nih.gov.* TTY users should contact the Federal TTY Relay Service at 800–877–8339. Requests should be made at least five business days in advance of the event.

Request for Public Comments: The preliminary agenda allows for several public comment periods, each allowing up to six commenters a maximum of five minutes per speaker. Registration for those wishing to provide oral public comments is required and is open through September 14, 2023, 5:00 p.m. EDT, at *https://ntp.niehs.nih.gov/go/32822.* Registration is on a first-come, first-served basis. If the maximum number of speakers per comment period is exceeded, individuals registering to submit an oral comment for the topic will be placed on a wait list and notified should an opening become available. Commenters will be notified after September 14, 2023, to provide logistical information for their presentations. Submitters will be identified by their name and affiliation and/or sponsoring organization, if applicable. If possible, oral public commenters should send a copy of their slides and/or statement or talking points to Robbin Guy by email: *robbin.guy@nih.gov* by September 14, 2023, 5:00 p.m. EDT.

Written statements on topics relevant to ICCVAM's mission may be submitted to support an oral public comment or as standalone documents. These should be emailed to *robbin.guy@nih.gov* by September 14, 2023, 5:00 p.m. EDT. Materials submitted to accompany oral public statements or standalone written statements should include the submitter's name, affiliation (if any), mailing address, telephone, email, and sponsoring organization (if any) with the document. Guidelines for public statements are at *http://ntp.niehs.nih.gov/ntp/about_ntp/guidelines_public_comments_508.pdf.*

Responses to this notice are voluntary. No proprietary, classified, confidential, or sensitive information should be included in statements submitted in response to this notice or presented during the meeting. This request for input is for planning purposes only and is not a solicitation for applications or an obligation on the part of the U.S. Government to provide support for any ideas identified in response to the request. Please note that the U.S. Government will not pay for the preparation of any information submitted or for its use of that information.

Background Information on ICCVAM, NICEATM, and SACATM: ICCVAM is an interagency committee composed of representatives from 17 federal regulatory and research agencies that require, use, generate, or disseminate toxicological and safety testing information. ICCVAM conducts technical evaluations of new, revised, and alternative safety testing methods and integrated testing strategies with regulatory applicability. ICCVAM also promotes the scientific validation and regulatory acceptance of testing methods that more accurately assess the safety and hazards of chemicals and products and replace, reduce, or refine animal use.

The ICCVAM Authorization Act of 2000 (42 U.S.C. 285*l*–3) establishes ICCVAM as a permanent interagency committee of the National Institute of Environmental Health Sciences and provides the authority for ICCVAM involvement in activities relevant to the development of alternative test methods. Additional information about ICCVAM can be found at *https://ntp.niehs.nih.gov/go/iccvam.*

NICEATM administers ICCVAM, provides scientific and operational support for ICCVAM-related activities, and conducts and publishes analyses and evaluations of data from new, revised, and alternative testing approaches. NICEATM and ICCVAM work collaboratively to evaluate new and improved testing approaches applicable to the needs of U.S. federal agencies. NICEATM and ICCVAM welcome the public nomination of new, revised, and alternative test methods and strategies for validation studies and technical evaluations. Additional information about NICEATM can be found at *https://ntp.niehs.nih.gov/go/niceatm.*

SACATM, established by the ICCVAM Authorization Act [Section 285*l*–3(d)], provides advice on priorities and activities related to the development, validation, scientific review, regulatory acceptance, implementation, and national and international harmonization of new, revised, and alternative toxicological test methods to ICCVAM, NICEATM, and Director of NIEHS and NTP. Additional information about SACATM, including link to the charter, roster, and records of past meetings, can be found at *http://ntp.niehs.nih.gov/go/167.*

SACATM is governed by the provisions of the Federal Advisory Committee Act, as amended (5 U.S.C. ch.10), which sets forth standards for the formation and use of advisory committees.

Dated: July 27, 2023.

Richard P. Woychik,

Director, National Institute of Environmental Health Sciences and National Toxicology Program, National Institutes of Health.

[FR Doc. 2023–16427 Filed 8–1–23; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of Allergy and Infectious Diseases; Notice of Closed Meeting

Pursuant to section 1009 of the Federal Advisory Committee Act, as amended, notice is hereby given of the following meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Institute of Allergy and Infectious Diseases Special Emphasis Panel; NIAID Investigator Initiated Clinical Trial Applications and program projects.

Date: August 28, 2023.

Time: 1:00 p.m. to 4:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institute of Allergy and Infectious Diseases, National Institutes of Health, 5601 Fishers Lane, Room 3E71, Rockville, MD 20892, (Virtual Meeting).

Contact Person: Samita S. Andreansky, Ph.D., Scientific Review Officer, Scientific Review Program, Division of Extramural Activities, National Institute of Allergy and Infectious Diseases, National Institutes of Health, 5601 Fishers Lane, Room 3E71, Rockville, MD 20852, 240–669–2915, *samita.andreansky@nih.gov.*

(Catalogue of Federal Domestic Assistance Program Nos. 93.855, Allergy, Immunology, and Transplantation Research; 93.856, Microbiology and Infectious Diseases Research, National Institutes of Health, HHS)

Dated: July 28, 2023.

Tyeshia M. Roberson-Curtis,

Program Analyst, Office of Federal Advisory Committee Policy.

[FR Doc. 2023–16460 Filed 8–1–23; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of Allergy and Infectious Diseases; Notice of Closed Meeting

Pursuant to section 1009 of the Federal Advisory Committee Act, as amended, notice is hereby given of the following meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The contract proposals and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the contract proposals, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Institute of Allergy and Infectious Diseases Special Emphasis Panel; NIAID 2023 DMID Omnibus BAA (HHS–NIH–NIAID–BAA2023–1), Research Area 004—Development of In Vitro Diagnostics for Biodefense, Antimicrobial Resistant Infections, and Emerging Infectious Diseases (N01).

Date: August 24–25, 2023.

Time: 9:30 a.m. to 1:30 p.m.

Agenda: To review and evaluate contract proposals.

Place: National Institute of Allergy and Infectious Diseases, National Institutes of Health, 5601 Fishers Lane, Room 3G13, Rockville, MD 20892 (Virtual Meeting).

Contact Person: Patricia A. Gonzales Hurtado, Ph.D., Scientific Review Officer, Scientific Review Program, Division of Extramural Activities, National Institute of Allergy and Infectious Diseases, National Institutes of Health, 5601 Fishers Lane, Room 3G13, Rockville, MD 20852, 240–627–3556, *Patricia.Gonzales@nih.gov.*

(Catalogue of Federal Domestic Assistance Program Nos. 93.855, Allergy, Immunology, and Transplantation Research; 93.856, Microbiology and Infectious Diseases Research, National Institutes of Health, HHS)

Dated: July 25, 2023.

Tyeshia M. Roberson-Curtis,

Program Analyst, Office of Federal Advisory Committee Policy.

[FR Doc. 2023–16380 Filed 8–1–23; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of Allergy and Infectious Diseases; Notice of Closed Meeting

Pursuant to section 1009 of the Federal Advisory Committee Act, as amended, notice is hereby given of the following meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Institute of Allergy and Infectious Diseases Special Emphasis Panel; NIAID Investigator Initiated Program Project Applications (P01 Clinical Trial Not Allowed).

Date: August 25, 2023.

Time: 12:00 p.m. to 2:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institute of Allergy and Infectious Diseases, National Institutes of Health, 5601 Fishers Lane, Room 3F40, Rockville, MD 20892 (Virtual Meeting).

Contact Person: Robert C. Unfer, Ph.D., Scientific Review Officer, Scientific Review Program, Division of Extramural Activities, National Institute of Allergy and Infectious Diseases, National Institutes of Health, 5601 Fishers Lane, Room 3F40, Rockville, MD 20852, 240–669–5035, *unferrc@nih.gov.*

(Catalogue of Federal Domestic Assistance Program Nos. 93.855, Allergy, Immunology, and Transplantation Research; 93.856, Microbiology and Infectious Diseases Research, National Institutes of Health, HHS)

Dated: July 28, 2023.

Tyeshia M. Roberson-Curtis,

Program Analyst, Office of Federal Advisory Committee Policy.

[FR Doc. 2023–16461 Filed 8–1–23; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

Fiscal Year (FY) 2023 Notice of Supplemental Funding Opportunity

AGENCY: Substance Abuse and Mental Health Services Administration, Department of Health and Human Services (HHS).

ACTION: Notice of intent to award supplemental funding.

SUMMARY: This notice is a notice of intent to award supplemental funding to the eight Minority Fellowship Program (MFP) recipients funded in FY 2018 under Notice of Funding Opportunity (NOFO) SM–18–002 and TI–18–013. This is to inform the public that the Substance Abuse and Mental Health Services Administration (SAMHSA) is supporting supplements, which are consistent with the initial award, up to $1,776,319 for seven Minority Fellowship Program (MFP) recipients funded under NOFO SM–18–002, and up to $1,247,286 for one MFP recipient funded under TI–18–013, for a total of $13,662,335. These recipients have a project end date of September 29, 2023. The supplemental funding will extend the project period by one-year and the recipients will continue to enhance and increase the behavioral health workforce knowledge related to prevention, treatment, and recovery support for mental illness and substance use disorders among racial and ethnic minority populations by providing specialized training among the MFP professional organizations

FOR FURTHER INFORMATION CONTACT:

Sheryl Crawford, telephone: (240) 276–1063, email: *sheryl.crawford@samhsa.hhs.gov.*

Azeb Berhane, telephone: (240) 276–2239, email: *azeb.berhane@samhsa.hhs.gov.*

SUPPLEMENTARY INFORMATION:

Funding Opportunity Title: FY 2018 MFP NOFO SM–18–002 and TI–18–013.

Assistance Listing Number: 93.243.

Authority: The MFP is authorized under section 597 of the Public Health Service Act, as amended.

Justification: Eligibility for this supplemental funding is limited to the eight MFP organizations funded in FY 2018. These organizations are currently providing the specialized training to increase behavioral health professionals' knowledge related to prevention, treatment, and recovery support for mental illness and substance use disorders among racial and ethnic minority populations.

This is not a formal request for application. Assistance will only be provided to the eight MFP grant recipients, based on the receipt of a satisfactory application and associated budget.

Dated: July 28, 2023.

Ann Ferrero,

Public Health Analyst.

[FR Doc. 2023–16429 Filed 8–1–23; 8:45 am]

BILLING CODE 4162–20–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

Meeting of the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention National Advisory Council

AGENCY: Substance Abuse and Mental Health Services Administration, HHS.

ACTION: Notice.

SUMMARY: Notice is hereby given for the meeting on August 29, 2023, of the Center for Substance Abuse Prevention National Advisory Council (CSAP NAC). The meeting is open to the public and can also be accessed virtually. Agenda with call-in information will be posted on the SAMHSA website prior to the meeting at: *https://www.samhsa.gov/about-us/advisory-councils/meetings* . The meeting will include, but not be limited to, remarks from the Assistant Secretary for Mental Health and Substance Use; approval of the meeting minutes of April 25, 2023; planned CSAP activities and programming for Fiscal Year 2024; presentations on substance use prevention priorities; Council discussion and public comments.

DATES: August 29, 2023, 9:00 a.m. to approximately 4:00 p.m. EDT, Open.

ADDRESSES: 5600 Fishers Lane, Rockville, Maryland 20857 (Room 5N54).

FOR FURTHER INFORMATION CONTACT: Michelle McVay, Designated Federal Official; Substance Abuse and Mental Health Service Administration, CSAP National Advisory Council, 5600 Fishers Lane, Rockville, Maryland 20857 (mail); telephone: (240) 276–0446; email: *michelle.mcvay@samhsa.hhs.gov*.

SUPPLEMENTARY INFORMATION: The CSAP NAC was established to advise the Secretary, Department of Health and Human Services (HHS), and the Assistant Secretary for Mental Health and Substance Use, SAMHSA; and the Director, CSAP, concerning matters relating to the activities carried out by and through the Center and the policies respecting such activities.

Interested persons may present data, information, or views orally or in writing, on issues pending before the Council. Written submissions must be forwarded to the contact person no later than 7 days before the meeting. Oral presentations from the public will be scheduled for the public comment section at the end of the council discussion. Individuals interested in making oral presentations must notify the contact person by 1:00 p.m. (EDT), August 22, 2023. Up to three minutes will be allotted for each presentation, and as time permits, as these are presented in the order received. Public comments received will become part of the meeting records.

To obtain the call-in number, access code, and/or web access link; submit written or brief oral comments; or request special accommodations for persons with disabilities, please register on-line at: *https://snacregister.samhsa.gov,* or communicate with the contact person. Meeting information and a roster of Council members may be obtained either by accessing the CSAP Council's website at *https://www.samhsa.gov/about-us/advisory-councils,* or by contacting Michelle McVay.

Dated: July 27, 2023.

Carlos Castillo,

Committee Management Officer.

[FR Doc. 2023–16319 Filed 8–1–23; 8:45 am]

BILLING CODE 4162–20–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Internal Agency Docket No. FEMA–4671–DR; Docket ID FEMA–2023–0001]

Puerto Rico; Amendment No. 17 to Notice of a Major Disaster Declaration

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: This notice amends the notice of a major disaster declaration for the Commonwealth of Puerto Rico (FEMA–4671–DR), dated September 21, 2022, and related determinations.

DATES: This change occurred on May 6, 2023.

FOR FURTHER INFORMATION CONTACT: Dean Webster, Office of Response and Recovery, Federal Emergency Management Agency, 500 C Street SW, Washington, DC 20472, (202) 646–2833.

SUPPLEMENTARY INFORMATION: The Federal Emergency Management Agency (FEMA) hereby gives notice that pursuant to the authority vested in the Administrator, under Executive Order 12148, as amended, DuWayne Tewes, of FEMA is appointed to act as the Federal Coordinating Officer for this disaster.

This action terminates the appointment of Nancy M. Casper as Federal Coordinating Officer for this disaster.

The following Catalog of Federal Domestic Assistance Numbers (CFDA) are to be used for reporting and drawing funds: 97.030, Community Disaster Loans; 97.031, Cora Brown Fund; 97.032, Crisis Counseling; 97.033, Disaster Legal Services; 97.034, Disaster Unemployment Assistance (DUA); 97.046, Fire Management Assistance Grant; 97.048, Disaster Housing Assistance to Individuals and Households In Presidentially Declared Disaster Areas; 97.049, Presidentially Declared Disaster Assistance—Disaster Housing Operations for Individuals and Households; 97.050, Presidentially Declared Disaster Assistance to Individuals and Households—Other Needs; 97.036, Disaster Grants—Public Assistance (Presidentially Declared Disasters); 97.039, Hazard Mitigation Grant.

Deanne Criswell,

Administrator, Federal Emergency Management Agency.

[FR Doc. 2023–16325 Filed 8–1–23; 8:45 am]

BILLING CODE 9111–23–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Internal Agency Docket No. FEMA–4681–DR; Docket ID FEMA–2023–0001]

Havasupai Tribe; Amendment No. 1 to Notice of a Major Disaster Declaration

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: This notice amends the notice of a major disaster declaration for the Havasupai Tribe (FEMA–4681–DR), dated December 30, 2022, and related determinations.

DATES: This change occurred on June 20, 2023.

FOR FURTHER INFORMATION CONTACT: Dean Webster, Office of Response and Recovery, Federal Emergency Management Agency, 500 C Street SW, Washington, DC 20472, (202) 646–2833.

SUPPLEMENTARY INFORMATION: The Federal Emergency Management Agency (FEMA) hereby gives notice that pursuant to the authority vested in the Administrator, under Executive Order 12148, as amended, Maona N. Ngwira, of FEMA is appointed to act as the Federal Coordinating Officer for this disaster.

This action terminates the appointment of Benigno B. Ruiz as Federal Coordinating Officer for this disaster.

The following Catalog of Federal Domestic Assistance Numbers (CFDA) are to be used

for reporting and drawing funds: 97.030, Community Disaster Loans; 97.031, Cora Brown Fund; 97.032, Crisis Counseling; 97.033, Disaster Legal Services; 97.034, Disaster Unemployment Assistance (DUA); 97.046, Fire Management Assistance Grant; 97.048, Disaster Housing Assistance to Individuals and Households In Presidentially Declared Disaster Areas; 97.049, Presidentially Declared Disaster Assistance—Disaster Housing Operations for Individuals and Households; 97.050, Presidentially Declared Disaster Assistance to Individuals and Households—Other Needs; 97.036, Disaster Grants—Public Assistance (Presidentially Declared Disasters); 97.039, Hazard Mitigation Grant.

Deanne Criswell,

Administrator, Federal Emergency Management Agency.

[FR Doc. 2023–16326 Filed 8–1–23; 8:45 am]

BILLING CODE 9111–23–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Internal Agency Docket No. FEMA–4716–DR; Docket ID FEMA–2023–0001]

Commonwealth of the Northern Mariana Islands; Amendment No. 1 to Notice of a Major Disaster Declaration

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: This notice amends the notice of a major disaster declaration for the Commonwealth of the Northern Mariana Islands (FEMA–4716–DR), dated June 2, 2023, and related determinations.

DATES: This amendment was issued June 22, 2023.

FOR FURTHER INFORMATION CONTACT: Dean Webster, Office of Response and Recovery, Federal Emergency Management Agency, 500 C Street SW, Washington, DC 20472, (202) 646–2833.

SUPPLEMENTARY INFORMATION: Notice is hereby given that the incident period for this disaster is closed effective May 29, 2023.

The following Catalog of Federal Domestic Assistance Numbers (CFDA) are to be used for reporting and drawing funds: 97.030, Community Disaster Loans; 97.031, Cora Brown Fund; 97.032, Crisis Counseling; 97.033, Disaster Legal Services; 97.034, Disaster Unemployment Assistance (DUA); 97.046, Fire Management Assistance Grant; 97.048, Disaster Housing Assistance to Individuals and Households In Presidentially Declared Disaster Areas; 97.049, Presidentially Declared Disaster Assistance—Disaster Housing Operations for Individuals and Households; 97.050, Presidentially Declared Disaster Assistance to Individuals and Households—Other Needs; 97.036, Disaster Grants—Public Assistance (Presidentially Declared Disasters); 97.039, Hazard Mitigation Grant.

Deanne Criswell,

Administrator, Federal Emergency Management Agency.

[FR Doc. 2023–16356 Filed 8–1–23; 8:45 am]

BILLING CODE 9111–23–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Internal Agency Docket No. FEMA–4701–DR; Docket ID FEMA–2023–0001]

Tennessee; Amendment No. 1 to Notice of a Major Disaster Declaration

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: This notice amends the notice of a major disaster declaration for the State of Tennessee (FEMA–4701–DR), dated April 7, 2023, and related determinations.

DATES: This amendment was issued May 17, 2023.

FOR FURTHER INFORMATION CONTACT: Dean Webster, Office of Response and Recovery, Federal Emergency Management Agency, 500 C Street SW, Washington, DC 20472, (202) 646–2833.

SUPPLEMENTARY INFORMATION: The notice of a major disaster declaration for the State of Tennessee is hereby amended to include permanent work under the Public Assistance program for those areas determined to have been adversely affected by the event declared a major disaster by the President in his declaration of April 7, 2023.

Giles, Johnson, and Morgan Counties for Public Assistance.

Cannon, Hardeman, Hardin, Haywood, Lewis, McNairy, Tipton, and Wayne Counties for permanent work [Categories C–G] (already designated for Individual Assistance and assistance for debris removal and emergency protective measures [Categories A and B], including direct federal assistance, under the Public Assistance program).

The following Catalog of Federal Domestic Assistance Numbers (CFDA) are to be used for reporting and drawing funds: 97.030, Community Disaster Loans; 97.031, Cora Brown Fund; 97.032, Crisis Counseling; 97.033, Disaster Legal Services; 97.034, Disaster Unemployment Assistance (DUA); 97.046, Fire Management Assistance Grant; 97.048, Disaster Housing Assistance to Individuals and Households In Presidentially Declared Disaster Areas; 97.049, Presidentially Declared Disaster Assistance—Disaster Housing Operations for Individuals and Households; 97.050 Presidentially Declared Disaster Assistance to Individuals and Households—Other Needs; 97.036, Disaster Grants—Public Assistance (Presidentially Declared Disasters); 97.039, Hazard Mitigation Grant.

Deanne Criswell,

Administrator, Federal Emergency Management Agency.

[FR Doc. 2023–16332 Filed 8–1–23; 8:45 am]

BILLING CODE 9111–23–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Internal Agency Docket No. FEMA–4714–DR; Docket ID FEMA–2023–0001]

Soboba Band of Luiseño Indians; Major Disaster and Related Determinations

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: This is a notice of the Presidential declaration of a major disaster for the Soboba Band of Luiseño Indians (FEMA–4714–DR), dated May 25, 2023, and related determinations.

DATES: The declaration was issued May 25, 2023.

FOR FURTHER INFORMATION CONTACT: Dean Webster, Office of Response and Recovery, Federal Emergency Management Agency, 500 C Street SW, Washington, DC 20472, (202) 646–2833.

SUPPLEMENTARY INFORMATION: Notice is hereby given that, in a letter dated May 25, 2023 the President issued a major disaster declaration under the authority of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121 *et seq.* (the ''Stafford Act''), as follows:

I have determined that the damage to the lands associated with the Soboba Band of Luiseño Indians resulting from a severe storm and flooding during the period of March 11 to March 16, 2023, is of sufficient severity and magnitude to warrant a major disaster declaration under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121 *et seq.* (the ''Stafford Act''). Therefore, I declare that such a major disaster exists for the Soboba Band of Luiseño Indians.

In order to provide Federal assistance, you are hereby authorized to allocate from funds available for these purposes such amounts as you find necessary for Federal disaster assistance and administrative expenses.

You are authorized to provide Public Assistance and Hazard Mitigation for the Soboba Band of Luiseño Indians. Consistent with the requirement that Federal assistance

be supplemental, any Federal funds provided under the Stafford Act for Public Assistance and Hazard Mitigation will be limited to 75 percent of the total eligible costs.

Further, you are authorized to make changes to this declaration for the approved assistance to the extent allowable under the Stafford Act.

The Federal Emergency Management Agency (FEMA) hereby gives notice that pursuant to the authority vested in the Administrator, under Executive Order 12148, as amended, Benigno Bern Ruiz, of FEMA is appointed to act as the Federal Coordinating Officer for this major disaster.

The following areas have been designated as adversely affected by this major disaster:

Soboba Band of Luiseño Indians for Public Assistance.

The Soboba Band of Luiseño Indians is eligible to apply for assistance under the Hazard Mitigation Grant Program.

The following Catalog of Federal Domestic Assistance Numbers (CFDA) are to be used for reporting and drawing funds: 97.030, Community Disaster Loans; 97.031, Cora Brown Fund; 97.032, Crisis Counseling; 97.033, Disaster Legal Services; 97.034, Disaster Unemployment Assistance (DUA); 97.046, Fire Management Assistance Grant; 97.048, Disaster Housing Assistance to Individuals and Households In Presidentially Declared Disaster Areas; 97.049, Presidentially Declared Disaster Assistance—Disaster Housing Operations for Individuals and Households; 97.050, Presidentially Declared Disaster Assistance to Individuals and Households—Other Needs; 97.036, Disaster Grants—Public Assistance (Presidentially Declared Disasters); 97.039, Hazard Mitigation Grant.

Deanne Criswell,

Administrator, Federal Emergency Management Agency.

[FR Doc. 2023–16349 Filed 8–1–23; 8:45 am]

BILLING CODE 9111–23–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Internal Agency Docket No. FEMA–4715–DR; Docket ID FEMA–2023–0001]

Guam; Amendment No. 3 to Notice of a Major Disaster Declaration

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: This notice amends the notice of a major disaster declaration for the territory of Guam (FEMA–4715–DR), dated May 25, 2023, and related determinations.

DATES: This amendment was issued June 9, 2023.

FOR FURTHER INFORMATION CONTACT: Dean Webster, Office of Response and Recovery, Federal Emergency Management Agency, 500 C Street SW, Washington, DC 20472, (202) 646–2833.

SUPPLEMENTARY INFORMATION: The notice of a major disaster declaration for the territory of Guam is hereby amended to include permanent work under the Public Assistance program for those areas determined to have been adversely affected by the event declared a major disaster by the President in his declaration of May 25, 2023.

The territory of Guam for debris removal [Category A] and permanent work [Categories C–G] (already designated for Individual Assistance and assistance for emergency protective measures [Category B], including direct federal assistance, under the Public Assistance program).

The following Catalog of Federal Domestic Assistance Numbers (CFDA) are to be used for reporting and drawing funds: 97.030, Community Disaster Loans; 97.031, Cora Brown Fund; 97.032, Crisis Counseling; 97.033, Disaster Legal Services; 97.034, Disaster Unemployment Assistance (DUA); 97.046, Fire Management Assistance Grant; 97.048, Disaster Housing Assistance to Individuals and Households In Presidentially Declared Disaster Areas; 97.049, Presidentially Declared Disaster Assistance—Disaster Housing Operations for Individuals and Households; 97.050 Presidentially Declared Disaster Assistance to Individuals and Households—Other Needs; 97.036, Disaster Grants—Public Assistance (Presidentially Declared Disasters); 97.039, Hazard Mitigation Grant.

Deanne Criswell,

Administrator, Federal Emergency Management Agency.

[FR Doc. 2023–16354 Filed 8–1–23; 8:45 am]

BILLING CODE 9111–23–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Internal Agency Docket No. FEMA–4716–DR; Docket ID FEMA–2023–0001]

Commonwealth of the Northern Mariana Islands; Amendment No. 2 to Notice of a Major Disaster Declaration

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: This notice amends the notice of a major disaster declaration for the Commonwealth of the Northern Mariana Islands (FEMA–4716–DR), dated June 2, 2023, and related determinations.

DATES: This amendment was issued July 10, 2023.

FOR FURTHER INFORMATION CONTACT: Dean Webster, Office of Response and Recovery, Federal Emergency Management Agency, 500 C Street SW, Washington, DC 20472, (202) 646–2833.

SUPPLEMENTARY INFORMATION: The notice of a major disaster declaration for the Commonwealth of the Northern Mariana Islands is hereby amended to include the Hazard Mitigation Grant Program for those areas determined to have been adversely affected by the event declared a major disaster by the President in his declaration of June 2, 2023.

The island of Rota for debris removal [Category A] and permanent work [Categories C–G] (already designated for emergency protective measures [Category B], including direct federal assistance under the Public Assistance program).

The islands of Saipan and Tinian for emergency protective measures and permanent work (Categories B–G), including direct federal assistance, under the Public Assistance program.

All areas within the Commonwealth of the Northern Mariana Islands are eligible for assistance under the Hazard Mitigation Grant Program.

The following Catalog of Federal Domestic Assistance Numbers (CFDA) are to be used for reporting and drawing funds: 97.030, Community Disaster Loans; 97.031, Cora Brown Fund; 97.032, Crisis Counseling; 97.033, Disaster Legal Services; 97.034, Disaster Unemployment Assistance (DUA); 97.046, Fire Management Assistance Grant; 97.048, Disaster Housing Assistance to Individuals and Households In Presidentially Declared Disaster Areas; 97.049, Presidentially Declared Disaster Assistance—Disaster Housing Operations for Individuals and Households; 97.050 Presidentially Declared Disaster Assistance to Individuals and Households—Other Needs; 97.036, Disaster Grants—Public Assistance (Presidentially Declared Disasters); 97.039, Hazard Mitigation Grant.

Deanne Criswell,

Administrator, Federal Emergency Management Agency.

[FR Doc. 2023–16357 Filed 8–1–23; 8:45 am]

BILLING CODE 9111–23–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Internal Agency Docket No. FEMA–4702–DR; Docket ID FEMA–2023–0001]

Kentucky; Amendment No. 1 to Notice of a Major Disaster Declaration

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: This notice amends the notice of a major disaster declaration for the Commonwealth of Kentucky (FEMA–4702–DR), dated April 10, 2023, and related determinations.

DATES: This amendment was issued May 16, 2023.

FOR FURTHER INFORMATION CONTACT: Dean Webster, Office of Response and Recovery, Federal Emergency Management Agency, 500 C Street SW, Washington, DC 20472, (202) 646–2833.

SUPPLEMENTARY INFORMATION: The notice of a major disaster declaration for the Commonwealth of Kentucky is hereby amended to include the following areas among those areas determined to have been adversely affected by the event declared a major disaster by the President in his declaration of April 10, 2023.

Boyle, Clinton, Fayette, Henderson, Jefferson, McCreary, Mercer, Pulaski, Russell, Shelby, Wayne, and Woodford Counties for Public Assistance.

The following Catalog of Federal Domestic Assistance Numbers (CFDA) are to be used for reporting and drawing funds: 97.030, Community Disaster Loans; 97.031, Cora Brown Fund; 97.032, Crisis Counseling; 97.033, Disaster Legal Services; 97.034, Disaster Unemployment Assistance (DUA); 97.046, Fire Management Assistance Grant; 97.048, Disaster Housing Assistance to Individuals and Households In Presidentially Declared Disaster Areas; 97.049, Presidentially Declared Disaster Assistance—Disaster Housing Operations for Individuals and Households; 97.050 Presidentially Declared Disaster Assistance to Individuals and Households—Other Needs; 97.036, Disaster Grants—Public Assistance (Presidentially Declared Disasters); 97.039, Hazard Mitigation Grant.

Deanne Criswell,

Administrator, Federal Emergency Management Agency.

[FR Doc. 2023–16333 Filed 8–1–23; 8:45 am]

BILLING CODE 9111–23–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Internal Agency Docket No. FEMA–4713–DR; Docket ID FEMA–2023–0001]

Soboba Band of Luiseno Indians; Major Disaster and Related Determinations

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: This is a notice of the Presidential declaration of a major disaster for the Soboba Band of Luiseno Indians (FEMA–4713–DR), dated May 18, 2023, and related determinations.

DATES: The declaration was issued May 18, 2023.

FOR FURTHER INFORMATION CONTACT: Dean Webster, Office of Response and Recovery, Federal Emergency Management Agency, 500 C Street SW, Washington, DC 20472, (202) 646–2833.

SUPPLEMENTARY INFORMATION: Notice is hereby given that, in a letter dated May 18, 2023 the President issued a major disaster declaration under the authority of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121 *et seq.* (the ''Stafford Act''), as follows:

I have determined that the damage to the lands associated with the Soboba Band of Luiseño Indians resulting from a severe winter storm and flooding during the period of February 23 to February 26, 2023, is of sufficient severity and magnitude to warrant a major disaster declaration under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121 *et seq.* (the ''Stafford Act''). Therefore, I declare that such a major disaster exists for the Soboba Band of Luiseño Indians.

In order to provide Federal assistance, you are hereby authorized to allocate from funds available for these purposes such amounts as you find necessary for Federal disaster assistance and administrative expenses.

You are authorized to provide Public Assistance and Hazard Mitigation for the Soboba Band of Luiseño Indians. Consistent with the requirement that Federal assistance be supplemental, any Federal funds provided under the Stafford Act for Public Assistance and Hazard Mitigation will be limited to 75 percent of the total eligible costs.

Further, you are authorized to make changes to this declaration for the approved assistance to the extent allowable under the Stafford Act.

The Federal Emergency Management Agency (FEMA) hereby gives notice that pursuant to the authority vested in the Administrator, under Executive Order 12148, as amended, Benigno Bern Ruiz, of FEMA is appointed to act as the Federal Coordinating Officer for this major disaster.

The following areas have been designated as adversely affected by this major disaster:

Soboba Band of Luiseno Indians for Public Assistance.

The Soboba Band of Luiseno Indians is eligible to apply for assistance under the Hazard Mitigation Grant Program.

The following Catalog of Federal Domestic Assistance Numbers (CFDA) are to be used for reporting and drawing funds: 97.030, Community Disaster Loans; 97.031, Cora Brown Fund; 97.032, Crisis Counseling; 97.033, Disaster Legal Services; 97.034, Disaster Unemployment Assistance (DUA); 97.046, Fire Management Assistance Grant; 97.048, Disaster Housing Assistance to Individuals and Households In Presidentially Declared Disaster Areas; 97.049, Presidentially Declared Disaster Assistance—Disaster Housing Operations for Individuals and Households; 97.050, Presidentially Declared Disaster Assistance to Individuals and Households—Other Needs; 97.036, Disaster Grants—Public Assistance (Presidentially Declared Disasters); 97.039, Hazard Mitigation Grant.

Deanne Criswell,

Administrator, Federal Emergency Management Agency.

[FR Doc. 2023–16347 Filed 8–1–23; 8:45 am]

BILLING CODE 9111–23–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Internal Agency Docket No. FEMA–4715–DR; Docket ID FEMA–2023–0001]

Guam; Major Disaster and Related Determinations

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: This is a notice of the Presidential declaration of a major disaster for the territory of Guam (FEMA–4715–DR), dated May 25, 2023, and related determinations.

DATES: The declaration was issued May 25, 2023.

FOR FURTHER INFORMATION CONTACT: Dean Webster, Office of Response and Recovery, Federal Emergency Management Agency, 500 C Street SW, Washington, DC 20472, (202) 646–2833.

SUPPLEMENTARY INFORMATION: Notice is hereby given that, in a letter dated May 25, 2023, the President issued a major disaster declaration under the authority of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121 *et seq.* (the ''Stafford Act''), as follows:

I have determined that the damage in the territory of Guam resulting from Typhoon Mawar beginning on May 22, 2023, and continuing, is of sufficient severity and magnitude to warrant a major disaster declaration under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121 *et seq.* (the ''Stafford Act''). Therefore, I declare that such a major disaster exists in the territory of Guam.

In order to provide Federal assistance, you are hereby authorized to allocate from funds available for these purposes such amounts as you find necessary for Federal disaster assistance and administrative expenses.

You are authorized to provide assistance for emergency protective measures (Category B), including direct Federal assistance, under

the Public Assistance program in the designated areas, Hazard Mitigation throughout the Territory, and any other forms of assistance under the Stafford Act that you deem appropriate subject to completion of Preliminary Damage Assessments (PDAs).

Consistent with the requirement that Federal assistance is supplemental, any Federal funds provided under the Stafford Act for Public Assistance and Hazard Mitigation will be limited to 75 percent of the total eligible cost.

Further, you are authorized to make changes to this declaration for the approved assistance to the extent allowable under the Stafford Act.

The Federal Emergency Management Agency (FEMA) hereby gives notice that pursuant to the authority vested in the Administrator, under Executive Order 12148, as amended, Benigno B. Ruiz, of FEMA is appointed to act as the Federal Coordinating Officer for this major disaster.

The following areas of the territory of Guam have been designated as adversely affected by this major disaster:

The territory of Guam for emergency protective measures (Category B), including direct federal assistance under the Public Assistance program.

All areas within the territory of Guam are eligible for assistance under the Hazard Mitigation Grant Program.

The following Catalog of Federal Domestic Assistance Numbers (CFDA) are to be used for reporting and drawing funds: 97.030, Community Disaster Loans; 97.031, Cora Brown Fund; 97.032, Crisis Counseling; 97.033, Disaster Legal Services; 97.034, Disaster Unemployment Assistance (DUA); 97.046, Fire Management Assistance Grant; 97.048, Disaster Housing Assistance to Individuals and Households In Presidentially Declared Disaster Areas; 97.049, Presidentially Declared Disaster Assistance—Disaster Housing Operations for Individuals and Households; 97.050, Presidentially Declared Disaster Assistance to Individuals and Households—Other Needs; 97.036, Disaster Grants—Public Assistance (Presidentially Declared Disasters); 97.039, Hazard Mitigation Grant.

Deanne Criswell,

Administrator, Federal Emergency Management Agency.

[FR Doc. 2023–16351 Filed 8–1–23; 8:45 am]

BILLING CODE 9111–23–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Internal Agency Docket No. FEMA–4719–DR; Docket ID FEMA–2023–0001]

Maine; Major Disaster and Related Determinations

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: This is a notice of the Presidential declaration of a major disaster for the State of Maine (FEMA–4719–DR), dated July 6, 2023, and related determinations.

DATES: The declaration was issued July 6, 2023.

FOR FURTHER INFORMATION CONTACT: Dean Webster, Office of Response and Recovery, Federal Emergency Management Agency, 500 C Street SW, Washington, DC 20472, (202) 646–2833.

SUPPLEMENTARY INFORMATION: Notice is hereby given that, in a letter dated July 6, 2023, the President issued a major disaster declaration under the authority of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121 *et seq.* (the ''Stafford Act''), as follows:

I have determined that the damage in certain areas of the State of Maine resulting from a severe storm and flooding during the period of April 30 to May 1, 2023, is of sufficient severity and magnitude to warrant a major disaster declaration under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121 *et seq.* (the ''Stafford Act''). Therefore, I declare that such a major disaster exists in the State of Maine.

In order to provide Federal assistance, you are hereby authorized to allocate from funds available for these purposes such amounts as you find necessary for Federal disaster assistance and administrative expenses.

You are authorized to provide Public Assistance in the designated areas and Hazard Mitigation throughout the State. Consistent with the requirement that Federal assistance be supplemental, any Federal funds provided under the Stafford Act for Public Assistance and Hazard Mitigation will be limited to 75 percent of the total eligible costs.

Further, you are authorized to make changes to this declaration for the approved assistance to the extent allowable under the Stafford Act.

The Federal Emergency Management Agency (FEMA) hereby gives notice that pursuant to the authority vested in the Administrator, under Executive Order 12148, as amended, William F. Roy, of FEMA is appointed to act as the Federal Coordinating Officer for this major disaster.

The following areas of the State of Maine have been designated as adversely affected by this major disaster:

Franklin, Kennebec, Knox, Lincoln, Oxford, Sagadahoc, Somerset, and Waldo Counties for Public Assistance.

All areas within the State of Maine are eligible for assistance under the Hazard Mitigation Grant Program.

The following Catalog of Federal Domestic Assistance Numbers (CFDA) are to be used for reporting and drawing funds: 97.030, Community Disaster Loans; 97.031, Cora Brown Fund; 97.032, Crisis Counseling; 97.033, Disaster Legal Services; 97.034, Disaster Unemployment Assistance (DUA); 97.046, Fire Management Assistance Grant; 97.048, Disaster Housing Assistance to Individuals and Households In Presidentially Declared Disaster Areas; 97.049, Presidentially Declared Disaster Assistance—Disaster Housing Operations for Individuals and Households; 97.050, Presidentially Declared Disaster Assistance to Individuals and Households—Other Needs; 97.036, Disaster Grants—Public Assistance (Presidentially Declared Disasters); 97.039, Hazard Mitigation Grant.

Deanne Criswell,

Administrator, Federal Emergency Management Agency.

[FR Doc. 2023–16360 Filed 8–1–23; 8:45 am]

BILLING CODE 9111–23–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Internal Agency Docket No. FEMA–3593–EM; Docket ID FEMA–2023–0001]

Commonwealth of the Northern Mariana Islands; Emergency and Related Determinations

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: This is a notice of the Presidential declaration of an emergency for the Commonwealth of the Northern Mariana Islands (FEMA–3593–EM), dated May 22, 2023, and related determinations.

DATES: The declaration was issued May 22, 2023.

FOR FURTHER INFORMATION CONTACT: Dean Webster, Office of Response and Recovery, Federal Emergency Management Agency, 500 C Street SW, Washington, DC 20472, (202) 646–2833.

SUPPLEMENTARY INFORMATION: Notice is hereby given that, in a letter dated May 22, 2023, the President issued an emergency declaration under the authority of the Robert T. Stafford Disaster Relief and Emergency

Assistance Act, 42 U.S.C. 5121–5207 (the Stafford Act), as follows:

I have determined that the emergency conditions in certain areas of the Commonwealth of the Northern Mariana Islands resulting from Typhoon Mawar beginning on May 22, 2023, and continuing, are of sufficient severity and magnitude to warrant an emergency declaration under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121 *et seq.* (''the Stafford Act''). Therefore, I declare that such an emergency exists in the Commonwealth of the Northern Mariana Islands.

You are authorized to provide appropriate assistance for required emergency measures, authorized under Title V of the Stafford Act, to save lives and to protect property and public health and safety, and to lessen or avert the threat of a catastrophe in the designated areas. Specifically, you are authorized to provide assistance for emergency protective measures (Category B), limited to direct Federal assistance, under the Public Assistance program.

Consistent with the requirement that Federal assistance be supplemental, any Federal funds provided under the Stafford Act for Public Assistance will be limited to 75 percent of the total eligible costs. In order to provide Federal assistance, you are hereby authorized to allocate from funds available for these purposes such amounts as you find necessary for Federal emergency assistance and administrative expenses.

Further, you are authorized to make changes to this declaration for the approved assistance to the extent allowable under the Stafford Act.

The Federal Emergency Management Agency (FEMA) hereby gives notice that pursuant to the authority vested in the Administrator, Department of Homeland Security, under Executive Order 12148, as amended, Benigno B. Ruiz, of FEMA is appointed to act as the Federal Coordinating Officer for this declared emergency.

The following areas of the Commonwealth of the Northern Mariana Islands have been designated as adversely affected by this declared emergency:

The islands of Agrihan, Alamagan, Pagan, Rota, Saipan, and Tinian for emergency protective measures (Category B), limited to direct federal assistance, under the Public Assistance program.

The following Catalog of Federal Domestic Assistance Numbers (CFDA) are to be used for reporting and drawing funds: 97.030, Community Disaster Loans; 97.031, Cora Brown Fund; 97.032, Crisis Counseling; 97.033, Disaster Legal Services; 97.034, Disaster Unemployment Assistance (DUA); 97.046, Fire Management Assistance Grant; 97.048, Disaster Housing Assistance to Individuals and Households In Presidentially Declared Disaster Areas; 97.049, Presidentially Declared Disaster Assistance—Disaster Housing Operations for Individuals and Households; 97.050, Presidentially Declared Disaster Assistance to Individuals and Households—Other Needs; 97.036, Disaster Grants—Public Assistance (Presidentially Declared Disasters); 97.039, Hazard Mitigation Grant.

Deanne Criswell,

Administrator, Federal Emergency Management Agency.

[FR Doc. 2023–16320 Filed 8–1–23; 8:45 am]

BILLING CODE 9111–23–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Internal Agency Docket No. FEMA–4705–DR; Docket ID FEMA–2023–0001]

Texas; Amendment No. 2 to Notice of a Major Disaster Declaration

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: This notice amends the notice of a major disaster declaration for the State of Texas (FEMA–4705–DR), dated April 21, 2023, and related determinations.

DATES: This amendment was issued May 22, 2023.

FOR FURTHER INFORMATION CONTACT: Dean Webster, Office of Response and Recovery, Federal Emergency Management Agency, 500 C Street SW, Washington, DC 20472, (202) 646–2833.

SUPPLEMENTARY INFORMATION: The notice of a major disaster declaration for the State of Texas is hereby amended to include the following area among those areas determined to have been adversely affected by the event declared a major disaster by the President in his declaration of April 21, 2023.

Franklin County for Public Assistance.

The following Catalog of Federal Domestic Assistance Numbers (CFDA) are to be used for reporting and drawing funds: 97.030, Community Disaster Loans; 97.031, Cora Brown Fund; 97.032, Crisis Counseling; 97.033, Disaster Legal Services; 97.034, Disaster Unemployment Assistance (DUA); 97.046, Fire Management Assistance Grant; 97.048, Disaster Housing Assistance to Individuals and Households In Presidentially Declared Disaster Areas; 97.049, Presidentially Declared Disaster Assistance—Disaster Housing Operations for Individuals and Households; 97.050 Presidentially Declared Disaster Assistance to Individuals and Households—Other Needs; 97.036, Disaster Grants—Public Assistance (Presidentially Declared Disasters); 97.039, Hazard Mitigation Grant.

Deanne Criswell,

Administrator, Federal Emergency Management Agency.

[FR Doc. 2023–16336 Filed 8–1–23; 8:45 am]

BILLING CODE 9111–23–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Internal Agency Docket No. FEMA–4707–DR; Docket ID FEMA–2023–0001]

Hoopa Valley Tribe; Amendment No. 1 to Notice of a Major Disaster Declaration

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: This notice amends the notice of a major disaster declaration for the Hoopa Valley Tribe (FEMA–4707–DR), dated April 25, 2023, and related determinations.

DATES: This amendment was issued May 23, 2023.

FOR FURTHER INFORMATION CONTACT: Dean Webster, Office of Response and Recovery, Federal Emergency Management Agency, 500 C Street SW, Washington, DC 20472, (202) 646–2833.

SUPPLEMENTARY INFORMATION: The notice of a major disaster declaration for the Hoopa Valley Tribe is hereby amended to include the Individual Assistance program for the following area adversely affected by the event declared a major disaster by the President in his declaration of April 25, 2023.

Hoopa Valley Tribe for Individual Assistance.

The following Catalog of Federal Domestic Assistance Numbers (CFDA) are to be used for reporting and drawing funds: 97.030, Community Disaster Loans; 97.031, Cora Brown Fund; 97.032, Crisis Counseling; 97.033, Disaster Legal Services; 97.034, Disaster Unemployment Assistance (DUA); 97.046, Fire Management Assistance Grant; 97.048, Disaster Housing Assistance to Individuals and Households In Presidentially Declared Disaster Areas; 97.049, Presidentially Declared Disaster Assistance—Disaster Housing Operations for Individuals and Households; 97.050 Presidentially Declared Disaster Assistance to Individuals and Households—Other Needs; 97.036, Disaster Grants—Public Assistance

(Presidentially Declared Disasters); 97.039, Hazard Mitigation Grant.

Deanne Criswell,

Administrator, Federal Emergency Management Agency.

[FR Doc. 2023–16341 Filed 8–1–23; 8:45 am]

BILLING CODE 9111–23–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Internal Agency Docket No. FEMA–3594–EM; Docket ID FEMA–2023–0001]

Guam; Emergency and Related Determinations

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: This is a notice of the Presidential declaration of an emergency for the territory of Guam (FEMA–3594–EM), dated May 22, 2023, and related determinations.

DATES: The declaration was issued May 22, 2023.

FOR FURTHER INFORMATION CONTACT: Dean Webster, Office of Response and Recovery, Federal Emergency Management Agency, 500 C Street SW, Washington, DC 20472, (202) 646–2833.

SUPPLEMENTARY INFORMATION: Notice is hereby given that, in a letter dated May 22, 2023, the President issued an emergency declaration under the authority of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121–5207 (the Stafford Act), as follows:

I have determined that the emergency conditions in the territory of Guam resulting from Typhoon Mawar beginning on May 22, 2023, and continuing, are of sufficient severity and magnitude to warrant an emergency declaration under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121 *et seq.* (''the Stafford Act''). Therefore, I declare that such an emergency exists in the territory of Guam.

You are authorized to provide appropriate assistance for required emergency measures, authorized under Title V of the Stafford Act, to save lives and to protect property and public health and safety, and to lessen or avert the threat of a catastrophe in the designated areas. Specifically, you are authorized to provide assistance for emergency protective measures (Category B), limited to direct Federal assistance, under the Public Assistance program.

Consistent with the requirement that Federal assistance be supplemental, any Federal funds provided under the Stafford Act for Public Assistance will be limited to 75 percent of the total eligible costs. In order to provide Federal assistance, you are hereby authorized to allocate from funds available for these purposes such amounts as you find necessary for Federal emergency assistance and administrative expenses.

Further, you are authorized to make changes to this declaration for the approved assistance to the extent allowable under the Stafford Act.

The Federal Emergency Management Agency (FEMA) hereby gives notice that pursuant to the authority vested in the Administrator, Department of Homeland Security, under Executive Order 12148, as amended, Benigno B. Ruiz, of FEMA is appointed to act as the Federal Coordinating Officer for this declared emergency.

The following areas of the territory of Guam have been designated as adversely affected by this declared emergency:

The territory of Guam for emergency protective measures (Category B), limited to direct federal assistance, under the Public Assistance program.

The following Catalog of Federal Domestic Assistance Numbers (CFDA) are to be used for reporting and drawing funds: 97.030, Community Disaster Loans; 97.031, Cora Brown Fund; 97.032, Crisis Counseling; 97.033, Disaster Legal Services; 97.034, Disaster Unemployment Assistance (DUA); 97.046, Fire Management Assistance Grant; 97.048, Disaster Housing Assistance to Individuals and Households In Presidentially Declared Disaster Areas; 97.049, Presidentially Declared Disaster Assistance—Disaster Housing Operations for Individuals and Households; 97.050, Presidentially Declared Disaster Assistance to Individuals and Households—Other Needs; 97.036, Disaster Grants—Public Assistance (Presidentially Declared Disasters); 97.039, Hazard Mitigation Grant.

Deanne Criswell,

Administrator, Federal Emergency Management Agency.

[FR Doc. 2023–16322 Filed 8–1–23; 8:45 am]

BILLING CODE 9111–23–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Internal Agency Docket No. FEMA–4711–DR; Docket ID FEMA–2023–0001]

Kentucky; Major Disaster and Related Determinations

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: This is a notice of the Presidential declaration of a major disaster for the Commonwealth of Kentucky (FEMA–4711–DR), dated May 9, 2023, and related determinations.

DATES: The declaration was issued May 9, 2023.

FOR FURTHER INFORMATION CONTACT: Dean Webster, Office of Response and Recovery, Federal Emergency Management Agency, 500 C Street SW, Washington, DC 20472, (202) 646–2833.

SUPPLEMENTARY INFORMATION: Notice is hereby given that, in a letter dated May 9, 2023, the President issued a major disaster declaration under the authority of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121 *et seq.* (the ''Stafford Act''), as follows:

I have determined that the damage in certain areas of the Commonwealth of Kentucky resulting from severe storms, straight-line winds, flooding, landslides, and mudslides during the period of February 15 to February 20, 2023, is of sufficient severity and magnitude to warrant a major disaster declaration under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121 *et seq.* (the ''Stafford Act''). Therefore, I declare that such a major disaster exists in the Commonwealth of Kentucky.

In order to provide Federal assistance, you are hereby authorized to allocate from funds available for these purposes such amounts as you find necessary for Federal disaster assistance and administrative expenses.

You are authorized to provide Public Assistance in the designated areas and Hazard Mitigation throughout the Commonwealth. Consistent with the requirement that Federal assistance be supplemental, any Federal funds provided under the Stafford Act for Public Assistance and Hazard Mitigation will be limited to 75 percent of the total eligible costs.

Further, you are authorized to make changes to this declaration for the approved assistance to the extent allowable under the Stafford Act.

The Federal Emergency Management Agency (FEMA) hereby gives notice that pursuant to the authority vested in the Administrator, under Executive Order 12148, as amended, Myra M. Shird, of FEMA is appointed to act as the Federal Coordinating Officer for this major disaster.

The following areas of the Commonwealth of Kentucky have been designated as adversely affected by this major disaster:

Bell, Breathitt, Caldwell, Carter, Clay, Elliott, Floyd, Harlan, Hart, Johnson, Knott, Lawrence, Lee, Leslie, Letcher, Magoffin, Morgan, Owsley, Perry, Powell, Whitley, and Wolfe Counties for Public Assistance.

All areas within the Commonwealth of Kentucky are eligible for assistance under the Hazard Mitigation Grant Program.

The following Catalog of Federal Domestic Assistance Numbers (CFDA) are to be used for reporting and drawing funds: 97.030,

Community Disaster Loans; 97.031, Cora Brown Fund; 97.032, Crisis Counseling; 97.033, Disaster Legal Services; 97.034, Disaster Unemployment Assistance (DUA); 97.046, Fire Management Assistance Grant; 97.048, Disaster Housing Assistance to Individuals and Households In Presidentially Declared Disaster Areas; 97.049, Presidentially Declared Disaster Assistance—Disaster Housing Operations for Individuals and Households; 97.050, Presidentially Declared Disaster Assistance to Individuals and Households—Other Needs; 97.036, Disaster Grants—Public Assistance (Presidentially Declared Disasters); 97.039, Hazard Mitigation Grant.

Deanne Criswell,

Administrator, Federal Emergency Management Agency.

[FR Doc. 2023–16345 Filed 8–1–23; 8:45 am]

BILLING CODE 9111–23–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Internal Agency Docket No. FEMA–4704–DR; Docket ID FEMA–2023–0001]

Indiana; Amendment No. 2 to Notice of a Major Disaster Declaration

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: This notice amends the notice of a major disaster declaration for the State of Indiana (FEMA–4704–DR), dated April 15, 2023, and related determinations.

DATES: This amendment was issued June 1, 2023.

FOR FURTHER INFORMATION CONTACT: Dean Webster, Office of Response and Recovery, Federal Emergency Management Agency, 500 C Street SW, Washington, DC 20472, (202) 646–2833.

SUPPLEMENTARY INFORMATION: The notice of a major disaster declaration for the State of Indiana is hereby amended to include Public Assistance for the following areas among those areas determined to have been adversely affected by the event declared a major disaster by the President in his declaration of April 15, 2023.

Benton, Clinton, Johnson, Monroe, Morgan, Owen, Sullivan, and White Counties for Public Assistance (already designated for Individual Assistance).

Brown County for Public Assistance.

The following Catalog of Federal Domestic Assistance Numbers (CFDA) are to be used for reporting and drawing funds: 97.030, Community Disaster Loans; 97.031, Cora Brown Fund; 97.032, Crisis Counseling; 97.033, Disaster Legal Services; 97.034, Disaster Unemployment Assistance (DUA); 97.046, Fire Management Assistance Grant; 97.048, Disaster Housing Assistance to Individuals and Households In Presidentially Declared Disaster Areas; 97.049, Presidentially Declared Disaster Assistance—Disaster Housing Operations for Individuals and Households; 97.050 Presidentially Declared Disaster Assistance to Individuals and Households—Other Needs; 97.036, Disaster Grants—Public Assistance (Presidentially Declared Disasters); 97.039, Hazard Mitigation Grant.

Deanne Criswell,

Administrator, Federal Emergency Management Agency.

[FR Doc. 2023–16335 Filed 8–1–23; 8:45 am]

BILLING CODE 9111–23–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Internal Agency Docket No. FEMA–4699–DR; Docket ID FEMA–2023–0001]

California; Amendment No. 5 to Notice of a Major Disaster Declaration

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: This notice amends the notice of a major disaster declaration for the State of California (FEMA–4699–DR), dated April 3, 2023, and related determinations.

DATES: This amendment was issued June 30, 2023.

FOR FURTHER INFORMATION CONTACT: Dean Webster, Office of Response and Recovery, Federal Emergency Management Agency, 500 C Street SW, Washington, DC 20472, (202) 646–2833.

SUPPLEMENTARY INFORMATION: The notice of a major disaster declaration for the State of California is hereby amended to include the following area among those areas determined to have been adversely affected by the event declared a major disaster by the President in his declaration of April 3, 2023.

Nevada County for Individual Assistance (already designated for Public Assistance).

The following Catalog of Federal Domestic Assistance Numbers (CFDA) are to be used for reporting and drawing funds: 97.030, Community Disaster Loans; 97.031, Cora Brown Fund; 97.032, Crisis Counseling; 97.033, Disaster Legal Services; 97.034, Disaster Unemployment Assistance (DUA); 97.046, Fire Management Assistance Grant; 97.048, Disaster Housing Assistance to Individuals and Households In Presidentially Declared Disaster Areas; 97.049, Presidentially Declared Disaster Assistance—Disaster Housing Operations for Individuals and Households; 97.050 Presidentially Declared Disaster Assistance to Individuals and Households—Other Needs; 97.036, Disaster Grants—Public Assistance (Presidentially Declared Disasters); 97.039, Hazard Mitigation Grant.

Deanne Criswell,

Administrator, Federal Emergency Management Agency.

[FR Doc. 2023–16331 Filed 8–1–23; 8:45 am]

BILLING CODE 9111–23–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Internal Agency Docket No. FEMA–4703–DR; Docket ID FEMA–2023–0001]

Navajo Nation; Amendment No.1 to Notice of a Major Disaster Declaration

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: This notice amends the notice of a major disaster declaration for the Navajo Nation (FEMA–4703–DR), dated April 11, 2023, and related determinations.

DATES: This change occurred on June 20, 2023.

FOR FURTHER INFORMATION CONTACT: Dean Webster, Office of Response and Recovery, Federal Emergency Management Agency, 500 C Street SW, Washington, DC 20472, (202) 646–2833.

SUPPLEMENTARY INFORMATION: The Federal Emergency Management Agency (FEMA) hereby gives notice that pursuant to the authority vested in the Administrator, under Executive Order 12148, as amended, Maona N. Ngwira, of FEMA is appointed to act as the Federal Coordinating Officer for this disaster.

This action terminates the appointment of Benigno B. Ruiz as Federal Coordinating Officer for this disaster.

The following Catalog of Federal Domestic Assistance Numbers (CFDA) are to be used for reporting and drawing funds: 97.030, Community Disaster Loans; 97.031, Cora Brown Fund; 97.032, Crisis Counseling; 97.033, Disaster Legal Services; 97.034, Disaster Unemployment Assistance (DUA); 97.046, Fire Management Assistance Grant; 97.048, Disaster Housing Assistance to Individuals and Households In Presidentially Declared Disaster Areas; 97.049, Presidentially Declared Disaster Assistance—Disaster Housing Operations for Individuals and Households; 97.050 Presidentially Declared Disaster Assistance to Individuals and Households—Other Needs; 97.036, Disaster Grants—Public Assistance

(Presidentially Declared Disasters); 97.039, Hazard Mitigation Grant.

Deanne Criswell,

Administrator, Federal Emergency Management Agency.

[FR Doc. 2023–16334 Filed 8–1–23; 8:45 am]

BILLING CODE 9111–23–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Internal Agency Docket No. FEMA–4712–DR; Docket ID FEMA–2023–0001]

Tennessee; Major Disaster and Related Determinations

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: This is a notice of the Presidential declaration of a major disaster for the State of Tennessee (FEMA–4712–DR), dated May 17, 2023, and related determinations.

DATES: The declaration was issued May 17, 2023.

FOR FURTHER INFORMATION CONTACT: Dean Webster, Office of Response and Recovery, Federal Emergency Management Agency, 500 C Street SW, Washington, DC 20472, (202) 646–2833.

SUPPLEMENTARY INFORMATION: Notice is hereby given that, in a letter dated May 17, 2023, the President issued a major disaster declaration under the authority of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121 *et seq.* (the ''Stafford Act''), as follows:

I have determined that the damage in certain areas of the State of Tennessee resulting from severe storms, straight-line winds, and tornado during the period of March 1 to March 3, 2023, is of sufficient severity and magnitude to warrant a major disaster declaration under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121 *et seq.* (the ''Stafford Act''). Therefore, I declare that such a major disaster exists in the State of Tennessee.

In order to provide Federal assistance, you are hereby authorized to allocate from funds available for these purposes such amounts as you find necessary for Federal disaster assistance and administrative expenses.

You are authorized to provide Public Assistance in the designated areas and Hazard Mitigation throughout the State. Consistent with the requirement that Federal assistance be supplemental, any Federal funds provided under the Stafford Act for Public Assistance and Hazard Mitigation will be limited to 75 percent of the total eligible costs.

Further, you are authorized to make changes to this declaration for the approved assistance to the extent allowable under the Stafford Act.

The Federal Emergency Management Agency (FEMA) hereby gives notice that pursuant to the authority vested in the Administrator, under Executive Order 12148, as amended, Andrew D. Friend, of FEMA is appointed to act as the Federal Coordinating Officer for this major disaster.

The following areas of the State of Tennessee have been designated as adversely affected by this major disaster:

Benton, Bledsoe, Campbell, Carroll, Cheatham, Clay, Crockett, Davidson, Decatur, Dickson, Fentress, Gibson, Giles, Grundy, Hamilton, Hardin, Haywood, Henderson, Henry, Hickman, Houston, Humphreys, Jackson, Lake, Lauderdale, Lawrence, Lewis, Macon, Madison, Marion, Meigs, Monroe, Montgomery, Moore, Obion, Perry, Pickett, Polk, Rhea, Robertson, Stewart, Sumner, Tipton, Wayne, and White Counties for Public Assistance.

All areas within the State of Tennessee are eligible for assistance under the Hazard Mitigation Grant Program.

The following Catalog of Federal Domestic Assistance Numbers (CFDA) are to be used for reporting and drawing funds: 97.030, Community Disaster Loans; 97.031, Cora Brown Fund; 97.032, Crisis Counseling; 97.033, Disaster Legal Services; 97.034, Disaster Unemployment Assistance (DUA); 97.046, Fire Management Assistance Grant; 97.048, Disaster Housing Assistance to Individuals and Households In Presidentially Declared Disaster Areas; 97.049, Presidentially Declared Disaster Assistance—Disaster Housing Operations for Individuals and Households; 97.050, Presidentially Declared Disaster Assistance to Individuals and Households—Other Needs; 97.036, Disaster Grants—Public Assistance (Presidentially Declared Disasters); 97.039, Hazard Mitigation Grant.

Deanne Criswell,

Administrator, Federal Emergency Management Agency.

[FR Doc. 2023–16346 Filed 8–1–23; 8:45 am]

BILLING CODE 9111–23–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Internal Agency Docket No. FEMA–4714–DR; Docket ID FEMA–2023–0001]

Soboba Band of Luiseño Indians; Amendment No. 1 to Notice of a Major Disaster Declaration

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: This notice amends the notice of a major disaster declaration for the Soboba Band of Luiseño Indians (FEMA–4713–DR), dated May 25, 2023, and related determinations.

DATES: This change occurred on June 20, 2023.

FOR FURTHER INFORMATION CONTACT: Dean Webster, Office of Response and Recovery, Federal Emergency Management Agency, 500 C Street SW, Washington, DC 20472, (202) 646–2833.

SUPPLEMENTARY INFORMATION: The Federal Emergency Management Agency (FEMA) hereby gives notice that pursuant to the authority vested in the Administrator, under Executive Order 12148, as amended, Andrew F. Grant, of FEMA is appointed to act as the Federal Coordinating Officer for this disaster.

This action terminates the appointment of Benigno B. Ruiz as Federal Coordinating Officer for this disaster.

The following Catalog of Federal Domestic Assistance Numbers (CFDA) are to be used for reporting and drawing funds: 97.030, Community Disaster Loans; 97.031, Cora Brown Fund; 97.032, Crisis Counseling; 97.033, Disaster Legal Services; 97.034, Disaster Unemployment Assistance (DUA); 97.046, Fire Management Assistance Grant; 97.048, Disaster Housing Assistance to Individuals and Households In Presidentially Declared Disaster Areas; 97.049, Presidentially Declared Disaster Assistance—Disaster Housing Operations for Individuals and Households; 97.050, Presidentially Declared Disaster Assistance to Individuals and Households—Other Needs; 97.036, Disaster Grants—Public Assistance (Presidentially Declared Disasters); 97.039, Hazard Mitigation Grant.

Deanne Criswell,

Administrator, Federal Emergency Management Agency.

[FR Doc. 2023–16350 Filed 8–1–23; 8:45 am]

BILLING CODE 9111–23–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Internal Agency Docket No. FEMA–4699–DR; Docket ID FEMA–2023–0001]

California; Amendment No. 4 to Notice of a Major Disaster Declaration

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: This notice amends the notice of a major disaster declaration for the State of California (FEMA–4699–DR), dated April 3, 2023, and related determinations.

DATES: This amendment was issued June 8, 2023.

FOR FURTHER INFORMATION CONTACT: Dean Webster, Office of Response and Recovery, Federal Emergency Management Agency, 500 C Street SW, Washington, DC 20472, (202) 646–2833.

SUPPLEMENTARY INFORMATION: The notice of a major disaster declaration for the State of California is hereby amended to include the following areas among those areas determined to have been adversely affected by the event declared a major disaster by the President in his declaration of April 3, 2023.

San Luis Obispo County for Individual Assistance (already designated for Public Assistance).

Plumas, Solano, and Sonoma Counties for Public Assistance.

The following Catalog of Federal Domestic Assistance Numbers (CFDA) are to be used for reporting and drawing funds: 97.030, Community Disaster Loans; 97.031, Cora Brown Fund; 97.032, Crisis Counseling; 97.033, Disaster Legal Services; 97.034, Disaster Unemployment Assistance (DUA); 97.046, Fire Management Assistance Grant; 97.048, Disaster Housing Assistance to Individuals and Households In Presidentially Declared Disaster Areas; 97.049, Presidentially Declared Disaster Assistance—Disaster Housing Operations for Individuals and Households; 97.050 Presidentially Declared Disaster Assistance to Individuals and Households—Other Needs; 97.036, Disaster Grants—Public Assistance (Presidentially Declared Disasters); 97.039, Hazard Mitigation Grant.

Deanne Criswell,

Administrator, Federal Emergency Management Agency.

[FR Doc. 2023–16330 Filed 8–1–23; 8:45 am]

BILLING CODE 9111–23–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Internal Agency Docket No. FEMA–3594–EM; Docket ID FEMA–2023–0001]

Guam; Amendment No. 1 to Notice of an Emergency Declaration

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: This notice amends the notice of an emergency declaration for the territory of Guam (FEMA–3594–EM), dated May 22, 2023, and related determinations.

DATES: This amendment was issued June 7, 2023.

FOR FURTHER INFORMATION CONTACT: Dean Webster, Office of Response and Recovery, Federal Emergency Management Agency, 500 C Street SW, Washington, DC 20472, (202) 646–2833.

SUPPLEMENTARY INFORMATION: Notice is hereby given that the incident period for this emergency is closed effective May 29, 2023.

The following Catalog of Federal Domestic Assistance Numbers (CFDA) are to be used for reporting and drawing funds: 97.030, Community Disaster Loans; 97.031, Cora Brown Fund; 97.032, Crisis Counseling; 97.033, Disaster Legal Services; 97.034, Disaster Unemployment Assistance (DUA); 97.046, Fire Management Assistance Grant; 97.048, Disaster Housing Assistance to Individuals and Households In Presidentially Declared Disaster Areas; 97.049, Presidentially Declared Disaster Assistance—Disaster Housing Operations for Individuals and Households; 97.050, Presidentially Declared Disaster Assistance to Individuals and Households—Other Needs; 97.036, Disaster Grants—Public Assistance (Presidentially Declared Disasters); 97.039, Hazard Mitigation Grant.

Deanne Criswell,

Administrator, Federal Emergency Management Agency.

[FR Doc. 2023–16323 Filed 8–1–23; 8:45 am]

BILLING CODE 9111–23–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Internal Agency Docket No. FEMA–4715–DR; Docket ID FEMA–2023–0001]

Guam; Amendment No. 1 to Notice of a Major Disaster Declaration

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: This notice amends the notice of a major disaster declaration for the territory of Guam (FEMA–4715–DR), dated May 25, 2023, and related determinations.

DATES: This amendment was issued May 28, 2023.

FOR FURTHER INFORMATION CONTACT: Dean Webster, Office of Response and Recovery, Federal Emergency Management Agency, 500 C Street SW, Washington, DC 20472, (202) 646–2833.

SUPPLEMENTARY INFORMATION: The notice of a major disaster declaration for the territory of Guam is hereby amended to include Individual Assistance for the following areas among those areas determined to have been adversely affected by the event declared a major disaster by the President in his declaration of May 25, 2023.

The territory of Guam for Individual Assistance (already designated for emergency protective measures [Category B], including direct federal assistance under the Public Assistance program).

The following Catalog of Federal Domestic Assistance Numbers (CFDA) are to be used for reporting and drawing funds: 97.030, Community Disaster Loans; 97.031, Cora Brown Fund; 97.032, Crisis Counseling; 97.033, Disaster Legal Services; 97.034, Disaster Unemployment Assistance (DUA); 97.046, Fire Management Assistance Grant; 97.048, Disaster Housing Assistance to Individuals and Households In Presidentially Declared Disaster Areas; 97.049, Presidentially Declared Disaster Assistance—Disaster Housing Operations for Individuals and Households; 97.050 Presidentially Declared Disaster Assistance to Individuals and Households—Other Needs; 97.036, Disaster Grants—Public Assistance (Presidentially Declared Disasters); 97.039, Hazard Mitigation Grant.

Deanne Criswell,

Administrator, Federal Emergency Management Agency.

[FR Doc. 2023–16352 Filed 8–1–23; 8:45 am]

BILLING CODE 9111–23–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Internal Agency Docket No. FEMA–3593–EM Docket ID FEMA–2023–0001]

Commonwealth of the Northern Mariana Islands; Amendment No. 1 to Notice of an Emergency Declaration

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: This notice amends the notice of an emergency declaration for the Commonwealth of the Northern Mariana Islands (FEMA–3593–EM), dated May 22, 2023, and related determinations.

DATES: This amendment was issued June 22, 2023.

FOR FURTHER INFORMATION CONTACT: Dean Webster, Office of Response and Recovery, Federal Emergency Management Agency, 500 C Street SW, Washington, DC 20472, (202) 646–2833.

SUPPLEMENTARY INFORMATION: Notice is hereby given that the incident period for this emergency is closed effective May 29, 2023.

The following Catalog of Federal Domestic Assistance Numbers (CFDA) are to be used for reporting and drawing funds: 97.030, Community Disaster Loans; 97.031, Cora Brown Fund; 97.032, Crisis Counseling; 97.033, Disaster Legal Services; 97.034, Disaster Unemployment Assistance (DUA); 97.046, Fire Management Assistance Grant;

97.048, Disaster Housing Assistance to Individuals and Households In Presidentially Declared Disaster Areas; 97.049, Presidentially Declared Disaster Assistance—Disaster Housing Operations for Individuals and Households; 97.050, Presidentially Declared Disaster Assistance to Individuals and Households—Other Needs; 97.036, Disaster Grants—Public Assistance (Presidentially Declared Disasters); 97.039, Hazard Mitigation Grant.

Deanne Criswell,

Administrator, Federal Emergency Management Agency.

[FR Doc. 2023–16321 Filed 8–1–23; 8:45 am]

BILLING CODE 9111–23–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Internal Agency Docket No. FEMA–4718–DR; Docket ID FEMA–2023–0001]

South Dakota; Major Disaster and Related Determinations

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: This is a notice of the Presidential declaration of a major disaster for the State of South Dakota (FEMA–4718–DR), dated July 6, 2023, and related determinations.

DATES: The declaration was issued July 6, 2023.

FOR FURTHER INFORMATION CONTACT: Dean Webster, Office of Response and Recovery, Federal Emergency Management Agency, 500 C Street SW, Washington, DC 20472, (202) 646–2833.

SUPPLEMENTARY INFORMATION: Notice is hereby given that, in a letter dated July 6, 2023, the President issued a major disaster declaration under the authority of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121 *et seq.* (the ''Stafford Act''), as follows:

I have determined that the damage in certain areas of the State of South Dakota resulting from flooding during the period of April 9 to May 5, 2023, is of sufficient severity and magnitude to warrant a major disaster declaration under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121 *et seq.* (the ''Stafford Act''). Therefore, I declare that such a major disaster exists in the State of South Dakota.

In order to provide Federal assistance, you are hereby authorized to allocate from funds available for these purposes such amounts as you find necessary for Federal disaster assistance and administrative expenses.

You are authorized to provide Public Assistance in the designated areas and Hazard Mitigation throughout the State. Consistent with the requirement that Federal assistance be supplemental, any Federal funds provided under the Stafford Act for Public Assistance and Hazard Mitigation will be limited to 75 percent of the total eligible costs.

Further, you are authorized to make changes to this declaration for the approved assistance to the extent allowable under the Stafford Act.

The Federal Emergency Management Agency (FEMA) hereby gives notice that pursuant to the authority vested in the Administrator, under Executive Order 12148, as amended, Kenneth G. Clark, of FEMA is appointed to act as the Federal Coordinating Officer for this major disaster.

The following areas of the State of South Dakota have been designated as adversely affected by this major disaster:

Brown, Clark, Codington, Day, Faulk, Grant, Hand, Marshall, Potter, and Roberts Counties and the Sisseton-Wahpeton Oyate of the Lake Traverse Reservation for Public Assistance.

All areas within the State of South Dakota are eligible for assistance under the Hazard Mitigation Grant Program.

The following Catalog of Federal Domestic Assistance Numbers (CFDA) are to be used for reporting and drawing funds: 97.030, Community Disaster Loans; 97.031, Cora Brown Fund; 97.032, Crisis Counseling; 97.033, Disaster Legal Services; 97.034, Disaster Unemployment Assistance (DUA); 97.046, Fire Management Assistance Grant; 97.048, Disaster Housing Assistance to Individuals and Households In Presidentially Declared Disaster Areas; 97.049, Presidentially Declared Disaster Assistance—Disaster Housing Operations for Individuals and Households; 97.050, Presidentially Declared Disaster Assistance to Individuals and Households—Other Needs; 97.036, Disaster Grants—Public Assistance (Presidentially Declared Disasters); 97.039, Hazard Mitigation Grant.

Deanne Criswell,

Administrator, Federal Emergency Management Agency.

[FR Doc. 2023–16359 Filed 8–1–23; 8:45 am]

BILLING CODE 9111–23–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Internal Agency Docket No. FEMA–4706–DR; Docket ID FEMA–2023–0001]

Oklahoma; Amendment No. 2 to Notice of a Major Disaster Declaration

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: This notice amends the notice of a major disaster declaration for the State of Oklahoma (FEMA–4706–DR), dated April 24, 2023, and related determinations.

DATES: This amendment was issued May 25, 2023.

FOR FURTHER INFORMATION CONTACT: Dean Webster, Office of Response and Recovery, Federal Emergency Management Agency, 500 C Street SW, Washington, DC 20472, (202) 646–2833.

SUPPLEMENTARY INFORMATION: The notice of a major disaster declaration for the State of Oklahoma is hereby amended to include permanent work under the Public Assistance program for those areas determined to have been adversely affected by the event declared a major disaster by the President in his declaration of April 24, 2023.

McClain and Pottawatomie Counties for permanent work [Categories C–G] (already designated for Individual Assistance and assistance for debris removal and emergency protective measures [Categories A and B], including direct federal assistance, under the Public Assistance program).

The following Catalog of Federal Domestic Assistance Numbers (CFDA) are to be used for reporting and drawing funds: 97.030, Community Disaster Loans; 97.031, Cora Brown Fund; 97.032, Crisis Counseling; 97.033, Disaster Legal Services; 97.034, Disaster Unemployment Assistance (DUA); 97.046, Fire Management Assistance Grant; 97.048, Disaster Housing Assistance to Individuals and Households In Presidentially Declared Disaster Areas; 97.049, Presidentially Declared Disaster Assistance—Disaster Housing Operations for Individuals and Households; 97.050 Presidentially Declared Disaster Assistance to Individuals and Households—Other Needs; 97.036, Disaster Grants—Public Assistance (Presidentially Declared Disasters); 97.039, Hazard Mitigation Grant.

Deanne Criswell,

Administrator, Federal Emergency Management Agency.

[FR Doc. 2023–16339 Filed 8–1–23; 8:45 am]

BILLING CODE 9111–23–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Internal Agency Docket No. FEMA–4692–DR; Docket ID FEMA–2023–0001]

Bear River Band of the Rohnerville Rancheria; Amendment No.1 to Notice of a Major Disaster Declaration

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: This notice amends the notice of a major disaster declaration for the Bear River Band of the Rohnerville Rancheria (FEMA–4692–DR), dated March 8, 2023, and related determinations.

DATES: This change occurred on June 20, 2023.

FOR FURTHER INFORMATION CONTACT: Dean Webster, Office of Response and Recovery, Federal Emergency Management Agency, 500 C Street SW, Washington, DC 20472, (202) 646–2833.

SUPPLEMENTARY INFORMATION: The Federal Emergency Management Agency (FEMA) hereby gives notice that pursuant to the authority vested in the Administrator, under Executive Order 12148, as amended, Andrew F. Grant, of FEMA is appointed to act as the Federal Coordinating Officer for this disaster.

This action terminates the appointment of Benigno B. Ruiz as Federal Coordinating Officer for this disaster.

The following Catalog of Federal Domestic Assistance Numbers (CFDA) are to be used for reporting and drawing funds: 97.030, Community Disaster Loans; 97.031, Cora Brown Fund; 97.032, Crisis Counseling; 97.033, Disaster Legal Services; 97.034, Disaster Unemployment Assistance (DUA); 97.046, Fire Management Assistance Grant; 97.048, Disaster Housing Assistance to Individuals and Households In Presidentially Declared Disaster Areas; 97.049, Presidentially Declared Disaster Assistance—Disaster Housing Operations for Individuals and Households; 97.050, Presidentially Declared Disaster Assistance to Individuals and Households—Other Needs; 97.036, Disaster Grants—Public Assistance (Presidentially Declared Disasters); 97.039, Hazard Mitigation Grant.

Deanne Criswell,

Administrator, Federal Emergency Management Agency.

[FR Doc. 2023–16328 Filed 8–1–23; 8:45 am]

BILLING CODE 9111–23–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Internal Agency Docket No. FEMA–4705–DR; Docket ID FEMA–2023–0001]

Texas; Amendment No. 4 to Notice of a Major Disaster Declaration

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: This notice amends the notice of a major disaster declaration for the State of Texas (FEMA–4705–DR), dated April 21, 2023, and related determinations.

DATES: This amendment was issued June 30, 2023.

FOR FURTHER INFORMATION CONTACT: Dean Webster, Office of Response and Recovery, Federal Emergency Management Agency, 500 C Street SW, Washington, DC 20472, (202) 646–2833.

SUPPLEMENTARY INFORMATION: The notice of a major disaster declaration for the State of Texas is hereby amended to include the following area among those areas determined to have been adversely affected by the event declared a major disaster by the President in his declaration of April 21, 2023.

Comal County for Public Assistance.

The following Catalog of Federal Domestic Assistance Numbers (CFDA) are to be used for reporting and drawing funds: 97.030, Community Disaster Loans; 97.031, Cora Brown Fund; 97.032, Crisis Counseling; 97.033, Disaster Legal Services; 97.034, Disaster Unemployment Assistance (DUA); 97.046, Fire Management Assistance Grant; 97.048, Disaster Housing Assistance to Individuals and Households In Presidentially Declared Disaster Areas; 97.049, Presidentially Declared Disaster Assistance—Disaster Housing Operations for Individuals and Households; 97.050 Presidentially Declared Disaster Assistance to Individuals and Households—Other Needs; 97.036, Disaster Grants—Public Assistance (Presidentially Declared Disasters); 97.039, Hazard Mitigation Grant.

Deanne Criswell,

Administrator, Federal Emergency Management Agency.

[FR Doc. 2023–16338 Filed 8–1–23; 8:45 am]

BILLING CODE 9111–23–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Internal Agency Docket No. FEMA–4717–DR; Docket ID FEMA–2023–0001]

North Dakota; Major Disaster and Related Determinations

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: This is a notice of the Presidential declaration of a major disaster for the State of North Dakota (FEMA–4717–DR), dated July 5, 2023, and related determinations.

DATES: The declaration was issued July 5, 2023.

FOR FURTHER INFORMATION CONTACT: Dean Webster, Office of Response and Recovery, Federal Emergency Management Agency, 500 C Street SW, Washington, DC 20472, (202) 646–2833.

SUPPLEMENTARY INFORMATION: Notice is hereby given that, in a letter dated July 5, 2023, the President issued a major disaster declaration under the authority of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121 *et seq.* (the ''Stafford Act''), as follows:

I have determined that the damage in certain areas of the State of North Dakota resulting from flooding on during the period of April 10 to May 6, 2023, is of sufficient severity and magnitude to warrant a major disaster declaration under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121 *et seq.* (the ''Stafford Act''). Therefore, I declare that such a major disaster exists in the State of North Dakota.

In order to provide Federal assistance, you are hereby authorized to allocate from funds available for these purposes such amounts as you find necessary for Federal disaster assistance and administrative expenses.

You are authorized to provide Public Assistance in the designated areas and Hazard Mitigation throughout the State. Consistent with the requirement that Federal assistance be supplemental, any Federal funds provided under the Stafford Act for Public Assistance and Hazard Mitigation will be limited to 75 percent of the total eligible costs.

Further, you are authorized to make changes to this declaration for the approved assistance to the extent allowable under the Stafford Act.

The Federal Emergency Management Agency (FEMA) hereby gives notice that pursuant to the authority vested in the Administrator, under Executive Order 12148, as amended, Kenneth G. Clark, of FEMA is appointed to act as the Federal Coordinating Officer for this major disaster.

The following areas of the State of North Dakota have been designated as adversely affected by this major disaster:

Barnes, Burke, Dickey, Dunn, Golden Valley, Grand Forks, Hettinger, LaMoure, McHenry, Mercer, Morton, Mountrail, Nelson, Pembina, Ransom, Richland, Sargent, Steele, Towner, Walsh, and Wells Counties for Public Assistance.

All areas within the State of North Dakota are eligible for assistance under the Hazard Mitigation Grant Program.

The following Catalog of Federal Domestic Assistance Numbers (CFDA) are to be used for reporting and drawing funds: 97.030, Community Disaster Loans; 97.031, Cora Brown Fund; 97.032, Crisis Counseling; 97.033, Disaster Legal Services; 97.034, Disaster Unemployment Assistance (DUA); 97.046, Fire Management Assistance Grant; 97.048, Disaster Housing Assistance to Individuals and Households In Presidentially Declared Disaster Areas; 97.049, Presidentially Declared Disaster Assistance—Disaster Housing Operations for Individuals

and Households; 97.050, Presidentially Declared Disaster Assistance to Individuals and Households—Other Needs; 97.036, Disaster Grants—Public Assistance (Presidentially Declared Disasters); 97.039, Hazard Mitigation Grant.

Deanne Criswell,

Administrator, Federal Emergency Management Agency.

[FR Doc. 2023–16358 Filed 8–1–23; 8:45 am]

BILLING CODE 9111–23–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Internal Agency Docket No. FEMA–4710–DR; Docket ID FEMA–2023–0001]

Alabama; Major Disaster and Related Determinations

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: This is a notice of the Presidential declaration of a major disaster for the State of Alabama (FEMA–4710–DR), dated May 5, 2023, and related determinations.

DATES: The declaration was issued May 5, 2023.

FOR FURTHER INFORMATION CONTACT: Dean Webster, Office of Response and Recovery, Federal Emergency Management Agency, 500 C Street SW, Washington, DC 20472, (202) 646–2833.

SUPPLEMENTARY INFORMATION: Notice is hereby given that, in a letter dated May 5, 2023, the President issued a major disaster declaration under the authority of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121 *et seq.* (the ''Stafford Act''), as follows:

I have determined that the damage in certain areas of the State of Alabama resulting from severe storms, straight-line winds, and tornadoes during the period of March 24 to March 27, 2023, is of sufficient severity and magnitude to warrant a major disaster declaration under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121 *et seq.* (the ''Stafford Act''). Therefore, I declare that such a major disaster exists in the State of Alabama.

In order to provide Federal assistance, you are hereby authorized to allocate from funds available for these purposes such amounts as you find necessary for Federal disaster assistance and administrative expenses.

You are authorized to provide Public Assistance in the designated areas and Hazard Mitigation throughout the State. Consistent with the requirement that Federal assistance be supplemental, any Federal funds provided under the Stafford Act for Public Assistance and Hazard Mitigation will be limited to 75 percent of the total eligible costs.

Further, you are authorized to make changes to this declaration for the approved assistance to the extent allowable under the Stafford Act.

The Federal Emergency Management Agency (FEMA) hereby gives notice that pursuant to the authority vested in the Administrator, under Executive Order 12148, as amended, Kevin A. Wallace, Sr., of FEMA is appointed to act as the Federal Coordinating Officer for this major disaster.

The following areas of the State of Alabama have been designated as adversely affected by this major disaster:

Chambers, Colbert, Coosa, Elmore, Lauderdale, Macon, Marion, Morgan, Randolph, and Tallapoosa Counties for Public Assistance.

All areas within the State of Alabama are eligible for assistance under the Hazard Mitigation Grant Program.

The following Catalog of Federal Domestic Assistance Numbers (CFDA) are to be used for reporting and drawing funds: 97.030, Community Disaster Loans; 97.031, Cora Brown Fund; 97.032, Crisis Counseling; 97.033, Disaster Legal Services; 97.034, Disaster Unemployment Assistance (DUA); 97.046, Fire Management Assistance Grant; 97.048, Disaster Housing Assistance to Individuals and Households In Presidentially Declared Disaster Areas; 97.049, Presidentially Declared Disaster Assistance—Disaster Housing Operations for Individuals and Households; 97.050, Presidentially Declared Disaster Assistance to Individuals and Households—Other Needs; 97.036, Disaster Grants—Public Assistance (Presidentially Declared Disasters); 97.039, Hazard Mitigation Grant.

Deanne Criswell,

Administrator, Federal Emergency Management Agency.

[FR Doc. 2023–16344 Filed 8–1–23; 8:45 am]

BILLING CODE 9111–23–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Internal Agency Docket No. FEMA–4705–DR; Docket ID FEMA–2023–0001]

Texas; Amendment No. 3 to Notice of a Major Disaster Declaration

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: This notice amends the notice of a major disaster declaration for the State of Texas (FEMA–4705–DR), dated April 21, 2023, and related determinations.

DATES: This change occurred on June 2, 2023.

FOR FURTHER INFORMATION CONTACT: Dean Webster, Office of Response and Recovery, Federal Emergency Management Agency, 500 C Street SW, Washington, DC 20472, (202) 646–2833.

SUPPLEMENTARY INFORMATION: The Federal Emergency Management Agency (FEMA) hereby gives notice that pursuant to the authority vested in the Administrator, under Executive Order 12148, as amended, Benjamin Abbott, of FEMA is appointed to act as the Federal Coordinating Officer for this disaster.

This action terminates the appointment of Gerard M. Stolar as Federal Coordinating Officer for this disaster.

The following Catalog of Federal Domestic Assistance Numbers (CFDA) are to be used for reporting and drawing funds: 97.030, Community Disaster Loans; 97.031, Cora Brown Fund; 97.032, Crisis Counseling; 97.033, Disaster Legal Services; 97.034, Disaster Unemployment Assistance (DUA); 97.046, Fire Management Assistance Grant; 97.048, Disaster Housing Assistance to Individuals and Households In Presidentially Declared Disaster Areas; 97.049, Presidentially Declared Disaster Assistance—Disaster Housing Operations for Individuals and Households; 97.050, Presidentially Declared Disaster Assistance to Individuals and Households—Other Needs; 97.036, Disaster Grants—Public Assistance (Presidentially Declared Disasters); 97.039, Hazard Mitigation Grant.

Deanne Criswell,

Administrator, Federal Emergency Management Agency.

[FR Doc. 2023–16337 Filed 8–1–23; 8:45 am]

BILLING CODE 9111–23–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Internal Agency Docket No. FEMA–4716–DR; Docket ID FEMA–2023–0001]

Commonwealth of the Northern Mariana Islands; Major Disaster and Related Determinations

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: This is a notice of the Presidential declaration of a major disaster for the Commonwealth of the Northern Mariana Islands (FEMA–4716–DR), dated June 2, 2023, and related determinations.

DATES: The declaration was issued June 2, 2023.

FOR FURTHER INFORMATION CONTACT: Dean Webster, Office of Response and Recovery, Federal Emergency Management Agency, 500 C Street SW, Washington, DC 20472, (202) 646–2833.

SUPPLEMENTARY INFORMATION: Notice is hereby given that, in a letter dated June 2, 2023, the President issued a major disaster declaration under the authority of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121 *et seq.* (the ''Stafford Act''), as follows:

I have determined that the damage in the Commonwealth of the Northern Mariana Islands resulting from Typhoon Mawar beginning on May 22, 2023, and continuing, is of sufficient severity and magnitude to warrant a major disaster declaration under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121 *et seq.* (the ''Stafford Act''). Therefore, I declare that such a major disaster exists in the Commonwealth of Northern Mariana Islands.

In order to provide Federal assistance, you are hereby authorized to allocate from funds available for these purposes such amounts as you find necessary for Federal disaster assistance and administrative expenses.

You are authorized to provide assistance for emergency protective measures (Category B), including direct Federal assistance, under the Public Assistance program in the designated areas and any other forms of assistance under the Stafford Act that you deem appropriate subject to completion of Preliminary Damage Assessments (PDAs).

Consistent with the requirement that Federal assistance is supplemental, any Federal funds provided under the Stafford Act for Public Assistance will be limited to 75 percent of the total eligible cost.

Further, you are authorized to make changes to this declaration for the approved assistance to the extent allowable under the Stafford Act.

The Federal Emergency Management Agency (FEMA) hereby gives notice that pursuant to the authority vested in the Administrator, under Executive Order 12148, as amended, Benigno B. Ruiz, of FEMA is appointed to act as the Federal Coordinating Officer for this major disaster.

The following areas of the Commonwealth of the Northern Mariana Islands have been designated as adversely affected by this major disaster:

The island of Rota for emergency protective measures (Category B), including direct federal assistance under the Public Assistance program.

The following Catalog of Federal Domestic Assistance Numbers (CFDA) are to be used for reporting and drawing funds: 97.030, Community Disaster Loans; 97.031, Cora Brown Fund; 97.032, Crisis Counseling; 97.033, Disaster Legal Services; 97.034, Disaster Unemployment Assistance (DUA); 97.046, Fire Management Assistance Grant; 97.048, Disaster Housing Assistance to Individuals and Households In Presidentially Declared Disaster Areas; 97.049, Presidentially Declared Disaster Assistance—Disaster Housing Operations for Individuals and Households; 97.050, Presidentially Declared Disaster Assistance to Individuals and Households—Other Needs; 97.036, Disaster Grants—Public Assistance (Presidentially Declared Disasters); 97.039, Hazard Mitigation Grant.

Deanne Criswell,

Administrator, Federal Emergency Management Agency.

[FR Doc. 2023–16355 Filed 8–1–23; 8:45 am]

BILLING CODE 9111–23–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Internal Agency Docket No. FEMA–4683–DR; Docket ID FEMA–2023–0001]

California; Amendment No. 10 to Notice of a Major Disaster Declaration

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: This notice amends the notice of a major disaster declaration for the State of California (FEMA–4683–DR), dated January 14, 2023, and related determinations.

DATES: This amendment was issued May 25, 2023.

FOR FURTHER INFORMATION CONTACT: Dean Webster, Office of Response and Recovery, Federal Emergency Management Agency, 500 C Street SW, Washington, DC 20472, (202) 646–2833.

SUPPLEMENTARY INFORMATION: The notice of a major disaster declaration for the State of California is hereby amended to include the following area among those areas determined to have been adversely affected by the event declared a major disaster by the President in his declaration of January 14, 2023.

Santa Clara County for Individual Assistance (already designated for Public Assistance). The following Catalog of Federal Domestic Assistance Numbers (CFDA) are to be used for reporting and drawing funds: 97.030, Community Disaster Loans; 97.031, Cora Brown Fund; 97.032, Crisis Counseling; 97.033, Disaster Legal Services; 97.034, Disaster Unemployment Assistance (DUA); 97.046, Fire Management Assistance Grant; 97.048, Disaster Housing Assistance to Individuals and Households In Presidentially Declared Disaster Areas; 97.049, Presidentially Declared Disaster Assistance—Disaster Housing Operations for Individuals and Households; 97.050 Presidentially Declared Disaster Assistance to Individuals and Households—Other Needs; 97.036, Disaster Grants—Public Assistance (Presidentially Declared Disasters); 97.039, Hazard Mitigation Grant.

Deanne Criswell,

Administrator, Federal Emergency Management Agency.

[FR Doc. 2023–16327 Filed 8–1–23; 8:45 am]

BILLING CODE 9111–23–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Internal Agency Docket No. FEMA–4707–DR; Docket ID FEMA–2023–0001]

Hoopa Valley Tribe; Amendment No. 3 to Notice of a Major Disaster Declaration

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: This notice amends the notice of a major disaster declaration for the Hoopa Valley Tribe (FEMA–4707–DR), dated April 25, 2023, and related determinations.

DATES: This amendment was issued July 6, 2023.

FOR FURTHER INFORMATION CONTACT: Dean Webster, Office of Response and Recovery, Federal Emergency Management Agency, 500 C Street SW, Washington, DC 20472, (202) 646–2833.

SUPPLEMENTARY INFORMATION: The notice of a major disaster declaration for the Hoopa Valley Tribe is hereby amended to include Crisis Counseling, Disaster Unemployment Assistance, Disaster Legal Services, and Disaster Case Management under the Individual Assistance program for those areas determined to have been adversely affected by the event declared a major disaster by the President in his declaration of April 25, 2023.

Hoopa Valley Tribe for Crisis Counseling, Disaster Unemployment Assistance, Disaster Legal Services, and Disaster Case Management under the Individual Assistance program (already designated for the Individuals and Households program and Public Assistance).

The following Catalog of Federal Domestic Assistance Numbers (CFDA) are to be used for reporting and drawing funds: 97.030, Community Disaster Loans; 97.031, Cora Brown Fund; 97.032, Crisis Counseling; 97.033, Disaster Legal Services; 97.034, Disaster Unemployment Assistance (DUA); 97.046, Fire Management Assistance Grant; 97.048, Disaster Housing Assistance to Individuals and Households In Presidentially Declared Disaster Areas; 97.049, Presidentially Declared Disaster Assistance—Disaster Housing Operations for Individuals and Households; 97.050 Presidentially

Declared Disaster Assistance to Individuals and Households—Other Needs; 97.036, Disaster Grants—Public Assistance (Presidentially Declared Disasters); 97.039, Hazard Mitigation Grant.

Deanne Criswell,

Administrator, Federal Emergency Management Agency.

[FR Doc. 2023–16343 Filed 8–1–23; 8:45 am]

BILLING CODE 9111–23–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Internal Agency Docket No. FEMA–4699–DR; Docket ID FEMA–2023–0001]

California; Amendment No. 3 to Notice of a Major Disaster Declaration

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: This notice amends the notice of a major disaster declaration for the State of California (FEMA–4699–DR), dated April 3, 2023, and related determinations.

DATES: This amendment was issued May 25, 2023.

FOR FURTHER INFORMATION CONTACT: Dean Webster, Office of Response and Recovery, Federal Emergency Management Agency, 500 C Street SW, Washington, DC 20472, (202) 646–2833.

SUPPLEMENTARY INFORMATION: The notice of a major disaster declaration for the State of California is hereby amended to include the following areas among those areas determined to have been adversely affected by the event declared a major disaster by the President in his declaration of April 3, 2023.

Butte County for Individual Assistance (already designated for Public Assistance).

El Dorado, Humboldt, Lake, Marin, Napa, Nevada, Sacramento, San Luis Obispo, Santa Barbara, Santa Clara, and Shasta Counties for Public Assistance.

Mono County for Public Assistance (already designated for Individual Assistance).

The following Catalog of Federal Domestic Assistance Numbers (CFDA) are to be used for reporting and drawing funds: 97.030, Community Disaster Loans; 97.031, Cora Brown Fund; 97.032, Crisis Counseling; 97.033, Disaster Legal Services; 97.034, Disaster Unemployment Assistance (DUA); 97.046, Fire Management Assistance Grant; 97.048, Disaster Housing Assistance to Individuals and Households In Presidentially Declared Disaster Areas; 97.049, Presidentially Declared Disaster Assistance—Disaster Housing Operations for Individuals and Households; 97.050 Presidentially Declared Disaster Assistance to Individuals and Households—Other Needs; 97.036, Disaster Grants—Public Assistance (Presidentially Declared Disasters); 97.039, Hazard Mitigation Grant.

Deanne Criswell,

Administrator, Federal Emergency Management Agency.

[FR Doc. 2023–16329 Filed 8–1–23; 8:45 am]

BILLING CODE 9111–23–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Internal Agency Docket No. FEMA–4707–DR; Docket ID FEMA–2023–0001]

Hoopa Valley Tribe; Amendment No. 2 to Notice of a Major Disaster Declaration

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: This notice amends the notice of a major disaster declaration for the Hoopa Valley Tribe (FEMA–4707–DR), dated April 25, 2023, and related determinations.

DATES: This change occurred on June 20, 2023.

FOR FURTHER INFORMATION CONTACT: Dean Webster, Office of Response and Recovery, Federal Emergency Management Agency, 500 C Street SW, Washington, DC 20472, (202) 646–2833.

SUPPLEMENTARY INFORMATION: The Federal Emergency Management Agency (FEMA) hereby gives notice that pursuant to the authority vested in the Administrator, under Executive Order 12148, as amended, Andrew F. Grant, of FEMA is appointed to act as the Federal Coordinating Officer for this disaster.

This action terminates the appointment of Benigno B. Ruiz as Federal Coordinating Officer for this disaster.

The following Catalog of Federal Domestic Assistance Numbers (CFDA) are to be used for reporting and drawing funds: 97.030, Community Disaster Loans; 97.031, Cora Brown Fund; 97.032, Crisis Counseling; 97.033, Disaster Legal Services; 97.034, Disaster Unemployment Assistance (DUA); 97.046, Fire Management Assistance Grant; 97.048, Disaster Housing Assistance to Individuals and Households In Presidentially Declared Disaster Areas; 97.049, Presidentially Declared Disaster Assistance—Disaster Housing Operations for Individuals and Households; 97.050, Presidentially Declared Disaster Assistance to Individuals and Households—Other Needs; 97.036, Disaster Grants—Public Assistance (Presidentially Declared Disasters); 97.039, Hazard Mitigation Grant.

Deanne Criswell,

Administrator, Federal Emergency Management Agency.

[FR Doc. 2023–16342 Filed 8–1–23; 8:45 am]

BILLING CODE 9111–23–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Internal Agency Docket No. FEMA–4713–DR; Docket ID FEMA–2023–0001]

Soboba Band of Luiseño Indians; Amendment No. 1 to Notice of a Major Disaster Declaration

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: This notice amends the notice of a major disaster declaration for the Soboba Band of Luiseño Indians (FEMA–4713–DR), dated May 18, 2023, and related determinations.

DATES: This change occurred on June 20, 2023.

FOR FURTHER INFORMATION CONTACT: Dean Webster, Office of Response and Recovery, Federal Emergency Management Agency, 500 C Street SW, Washington, DC 20472, (202) 646–2833.

SUPPLEMENTARY INFORMATION: The Federal Emergency Management Agency (FEMA) hereby gives notice that pursuant to the authority vested in the Administrator, under Executive Order 12148, as amended, Andrew F. Grant, of FEMA is appointed to act as the Federal Coordinating Officer for this disaster.

This action terminates the appointment of Benigno B. Ruiz as Federal Coordinating Officer for this disaster.

The following Catalog of Federal Domestic Assistance Numbers (CFDA) are to be used for reporting and drawing funds: 97.030, Community Disaster Loans; 97.031, Cora Brown Fund; 97.032, Crisis Counseling; 97.033, Disaster Legal Services; 97.034, Disaster Unemployment Assistance (DUA); 97.046, Fire Management Assistance Grant; 97.048, Disaster Housing Assistance to Individuals and Households In Presidentially Declared Disaster Areas; 97.049, Presidentially Declared Disaster Assistance—Disaster Housing Operations for Individuals and Households; 97.050, Presidentially Declared Disaster Assistance to Individuals and Households—Other Needs; 97.036, Disaster Grants—Public Assistance

(Presidentially Declared Disasters); 97.039, Hazard Mitigation Grant.

Deanne Criswell,

Administrator, Federal Emergency Management Agency.

[FR Doc. 2023–16348 Filed 8–1–23; 8:45 am]

BILLING CODE 9111–23–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Internal Agency Docket No. FEMA–4715–DR; Docket ID FEMA–2023–0001]

Guam; Amendment No. 2 to Notice of a Major Disaster Declaration

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: This notice amends the notice of a major disaster declaration for the territory of Guam (FEMA–4715–DR), dated May 25, 2023, and related determinations.

DATES: This amendment was issued June 7, 2023.

FOR FURTHER INFORMATION CONTACT: Dean Webster, Office of Response and Recovery, Federal Emergency Management Agency, 500 C Street SW, Washington, DC 20472, (202) 646–2833.

SUPPLEMENTARY INFORMATION: Notice is hereby given that the incident period for this disaster is closed effective May 29, 2023.

The following Catalog of Federal Domestic Assistance Numbers (CFDA) are to be used for reporting and drawing funds: 97.030, Community Disaster Loans; 97.031, Cora Brown Fund; 97.032, Crisis Counseling; 97.033, Disaster Legal Services; 97.034, Disaster Unemployment Assistance (DUA); 97.046, Fire Management Assistance Grant; 97.048, Disaster Housing Assistance to Individuals and Households In Presidentially Declared Disaster Areas; 97.049, Presidentially Declared Disaster Assistance—Disaster Housing Operations for Individuals and Households; 97.050, Presidentially Declared Disaster Assistance to Individuals and Households—Other Needs; 97.036, Disaster Grants—Public Assistance (Presidentially Declared Disasters); 97.039, Hazard Mitigation Grant.

Deanne Criswell,

Administrator, Federal Emergency Management Agency.

[FR Doc. 2023–16353 Filed 8–1–23; 8:45 am]

BILLING CODE 9111–23–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Internal Agency Docket No. FEMA–4611–DR; Docket ID FEMA–2023–0001]

Louisiana; Amendment No. 8 to Notice of a Major Disaster Declaration

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: This notice amends the notice of a major disaster declaration for the State of Louisiana (FEMA–4611–DR), dated August 29, 2021, and related determinations.

DATES: This change occurred on May 18, 2023.

FOR FURTHER INFORMATION CONTACT: Dean Webster, Office of Response and Recovery, Federal Emergency Management Agency, 500 C Street SW, Washington, DC 20472, (202) 646–2833.

SUPPLEMENTARY INFORMATION: The Federal Emergency Management Agency (FEMA) hereby gives notice that pursuant to the authority vested in the Administrator, under Executive Order 12148, as amended, Sandra L. Eslinger, of FEMA is appointed to act as the Federal Coordinating Officer for this disaster.

This action terminates the appointment of Benjamin Abbott as Federal Coordinating Officer for this disaster.

The following Catalog of Federal Domestic Assistance Numbers (CFDA) are to be used for reporting and drawing funds: 97.030, Community Disaster Loans; 97.031, Cora Brown Fund; 97.032, Crisis Counseling; 97.033, Disaster Legal Services; 97.034, Disaster Unemployment Assistance (DUA); 97.046, Fire Management Assistance Grant; 97.048, Disaster Housing Assistance to Individuals and Households In Presidentially Declared Disaster Areas; 97.049, Presidentially Declared Disaster Assistance—Disaster Housing Operations for Individuals and Households; 97.050, Presidentially Declared Disaster Assistance to Individuals and Households—Other Needs; 97.036, Disaster Grants—Public Assistance (Presidentially Declared Disasters); 97.039, Hazard Mitigation Grant.

Deanne Criswell,

Administrator, Federal Emergency Management Agency.

[FR Doc. 2023–16324 Filed 8–1–23; 8:45 am]

BILLING CODE 9111–23–P

DEPARTMENT OF HOMELAND SECURITY

Notice Regarding the Uyghur Forced Labor Prevention Act Entity List

AGENCY: Department of Homeland Security.

ACTION: Notice.

SUMMARY: The U.S. Department of Homeland Security (DHS), as the Chair of the Forced Labor Enforcement Task Force (FLETF), announces the publication and availability of the updated Uyghur Forced Labor Prevention Act (UFLPA) Entity List, a consolidated register of the four lists required to be developed and maintained pursuant to section 2(d)(2)(B) of the UFLPA, on the DHS UFLPA website. The updated UFLPA Entity List is also published as an appendix to this notice. This update adds one entity to the section 2(d)(2)(B)(ii) list of the UFLPA, which identifies entities working with the government of the Xinjiang Uyghur Autonomous Region to recruit, transport, transfer, harbor or receive forced labor or Uyghurs, Kazakhs, Kyrgyz, or members of other persecuted groups out of the Xinjiang Uyghur Autonomous Region. This update also adds one entity and one subsidiary to the section 2(d)(2)(B)(v) list of the UFLPA, which identifies facilities and entities, including the Xinjiang Production and Construction Corps, that source material from the Xinjiang Uyghur Autonomous Region or from persons working with the government of the Xinjiang Uyghur Autonomous Region or the Xinjiang Production and Construction Corps for purposes of the ''poverty alleviation'' program or the ''pairing-assistance'' program or any other government labor scheme that uses forced labor. Details related to the process for revising the UFLPA Entity List are included in this **Federal Register** notice.

DATES: This notice announces the publication and availability of the UFLPA Entity List updated as of August 2, 2023, included as an appendix to this notice.

ADDRESSES: Persons seeking additional information on the UFLPA Entity List should email the FLETF at *FLETF.UFLPA.EntityList@hq.dhs.gov.*

FOR FURTHER INFORMATION CONTACT: Cynthia Echeverria, Director of Trade Policy, Trade and Economic Security, Office of Strategy, Policy, and Plans, DHS. Phone: (202) 938–6365, Email: *FLETF.UFLPA.EntityList@hq.dhs.gov*

SUPPLEMENTARY INFORMATION: The U.S. Department of Homeland Security

(DHS), on behalf of the Forced Labor Enforcement Task Force (FLETF), is announcing the publication of the updated UFLPA Entity List, a consolidated register of the four lists required to be developed and maintained pursuant to section 2(d)(2)(B) of the Uyghur Forced Labor Prevention Act (Pub. L. 117–78) (UFLPA), to *https://www.dhs.gov/uflpa-entity-list.* The UFLPA Entity List is available as an appendix to this notice. This update adds one entity to the section 2(d)(2)(B)(ii) list of the UFLPA, which identifies entities working with the government of the Xinjiang Uyghur Autonomous Region to recruit, transport, transfer, harbor or receive forced labor or Uyghurs, Kazakhs, Kyrgyz, or members of other persecuted groups out of the Xinjiang Uyghur Autonomous Region. This update also adds one entity and one subsidiary to the section 2(d)(2)(B)(v) list of the UFLPA, which identifies facilities and entities, including the Xinjiang Production and Construction Corps, that source material from the Xinjiang Uyghur Autonomous Region or from persons working with the government of the Xinjiang Uyghur Autonomous Region or the Xinjiang Production and Construction Corps for purposes of the ''poverty alleviation'' program or the ''pairing-assistance'' program or any other government labor scheme that uses forced labor. Future revisions to the UFLPA Entity List, which may include additions, removals or technical corrections, will be published to *https://www.dhs.gov/uflpa-entitylist* and in the appendices of future **Federal Register** notices. *See* Appendix 1.

Beginning on June 21, 2022, the UFLPA requires the Commissioner of U.S. Customs and Border Protection to apply a rebuttable presumption that goods mined, produced, or manufactured by entities on the UFLPA Entity List are made with forced labor, and therefore, prohibited from importation into the United States under 19 U.S.C. 1307. *See* section 3(a) of the UFLPA. As the FLETF revises the UFLPA Entity List, including by making additions, removals, or technical corrections, DHS, on its behalf, will post such revisions to the DHS UFLPA website (*https://www.dhs.gov/uflpa-entity-list*) and also publish the revised UFLPA Entity List as an appendix to a **Federal Register** notice.

Background

A. The Forced Labor Enforcement Task Force

Section 741 of the United States-Mexico-Canada Agreement Implementation Act established the FLETF to monitor United States enforcement of the prohibition under section 307 of the Tariff Act of 1930, as amended (19 U.S.C. 1307). *See* 19 U.S.C. 4681. Pursuant to DHS Delegation Order No. 23034, the DHS Under Secretary for Strategy, Policy, and Plans serves as Chair of the FLETF, an interagency task force that includes the Department of Homeland Security, the Office of the U.S. Trade Representative, and the Departments of Labor, State, Justice, the Treasury, and Commerce (member agencies).[1] *See* 19 U.S.C. 4681; Executive Order 13923 (May 15, 2020). In addition, the FLETF includes six observer agencies: the Departments of Energy and Agriculture, the U.S. Agency for International Development, the National Security Council, U.S. Customs and Border Protection, and U.S. Immigration and Customs Enforcement Homeland Security Investigations.

B. The Uyghur Forced Labor Prevention Act: Preventing Goods Made With Forced Labor in the People's Republic of China From Being Imported Into the United States

The UFLPA requires, among other things, that the FLETF, in consultation with the Secretary of Commerce and the Director of National Intelligence, develop a strategy (UFLPA section 2(c)) for supporting enforcement of section 307 of the Tariff Act of 1930, to prevent the importation into the United States of goods, wares, articles, and merchandise mined, produced, or manufactured wholly or in part with forced labor in the People's Republic of China. As required by the UFLPA, the *Strategy to Prevent the Importation of Goods Mined, Produced, or Manufactured with Forced Labor in the People's Republic of China,* which was published on the DHS website on June 17, 2022 (*see https://www.dhs.gov/uflpa-strategy*), includes the initial UFLPA Entity List, a consolidated register of the four lists required to be developed and maintained pursuant to the UFLPA. *See* UFLPA section 2(d)(2)(B).

C. UFLPA Entity List

The UFLPA Entity List addresses distinct requirements set forth in clauses (i), (ii), (iv), and (v) of section 2(d)(2)(B) of the UFLPA that the FLETF identify and publish the following four lists:

(1) a list of entities in Xinjiang that mine, produce, or manufacture wholly or in part any goods, wares, articles, and merchandise with forced labor;

(2) a list of entities working with the government of Xinjiang to recruit, transport, transfer, harbor or receive forced labor or Uyghurs, Kazakhs, Kyrgyz, or members of other persecuted groups out of Xinjiang;

(3) a list of entities that exported products made by entities in lists 1 and 2 from the PRC into the United States; and

(4) a list of facilities and entities, including the Xinjiang Production and Construction Corps, that source material from Xinjiang or from persons working with the government of Xinjiang or the Xinjiang Production and Construction Corps for purposes of the ''poverty alleviation'' program or the ''pairing-assistance'' program or any other government-labor scheme that uses forced labor.

The UFLPA Entity List is a consolidated register of the above four lists. In accordance with section 3(e) of the UFLPA, effective June 21, 2022, entities on the UFLPA Entity List (listed entities) are subject to the UFLPA's rebuttable presumption, and products they produce, wholly or in part, are prohibited from entry into the United States under 19 U.S.C. 1307. The UFLPA Entity List is described in Appendix 1 to this notice. The UFLPA Entity List should not be interpreted as an exhaustive list of entities engaged in the practices described in clauses (i), (ii), (iv), or (v) of section 2(d)(2)(B) of the UFLPA.

Revisions to the UFLPA Entity List, including all additions, removals, and technical corrections, will be published on the DHS UFLPA website (*https://www.dhs.gov/uflpa-entity-list*) and as an Appendix to a notice that will be published in the **Federal Register**. *See* Appendix 1. The FLETF will consider future additions to, or removals from, the UFLPA Entity List based on criteria described in clauses (i), (ii), (iv), or (v) of section 2(d)(2)(B) of the UFLPA. Any FLETF member agency may submit a recommendation(s) to add, remove or make technical corrections to an entry on the UFLPA Entity List. FLETF member agencies will review and vote on revisions to the UFLPA Entity List accordingly.

Additions to the Entity List

The FLETF will consider future additions to the UFLPA Entity List based on the criteria described in clauses (i), (ii), (iv), or (v) of section 2(d)(2)(B) of the UFLPA. Any FLETF member agency may submit a

[1] The U.S. Department of Homeland Security, as the FLETF Chair, has the authority to invite representatives from other executive departments and agencies, as appropriate. *See* Executive Order 13923 (May 15, 2020). The U.S. Department of Commerce is a member of the FLETF as invited by the Chair.

recommendation to the FLETF Chair to add an entity to the UFLPA Entity List. Following review of the recommendation by the FLETF member agencies, the decision to add an entity to the UFLPA Entity List will be made by majority vote of the FLETF member agencies.

Requests for Removal From the Entity List

Any listed entity may submit a request for removal (removal request) from the UFLPA Entity List along with supporting information to the FLETF Chair at *FLETF.UFLPA.EntityList@hq.dhs.gov.* In the removal request, the entity (or its designated representative) should provide information that demonstrates that the entity no longer meets or does not meet the criteria described in the applicable clause ((i), (ii), (iv), or (v)) of section 2(d)(B) of the UFLPA. The FLETF Chair will refer all such removal requests and supporting information to FLETF member agencies. Upon receipt of the removal request, the FLETF Chair or the Chair's designated representative may contact the entity on behalf of the FLETF regarding questions on the removal request and may request additional information. Following review of the removal request by the FLETF member agencies, the decision to remove an entity from the UFLPA Entity List will be made by majority vote of the FLETF member agencies.

Listed entities may request a meeting with the FLETF after submitting a removal request in writing to the FLETF Chair at *FLETF.UFLPA.EntityList@hq.dhs.gov.* Following its review of a removal request, the FLETF may accept the meeting request at the conclusion of the review period and, if accepted, will hold the meeting prior to voting on the entity's removal request. The FLETF Chair will advise the entity in writing of the FLETF's decision on its removal request. While the FLETF's decision on a removal request is not appealable, the FLETF will consider new removal requests if accompanied by new information.

Robert Silvers,

Under Secretary, Office of Strategy, Policy, and Plans, U.S. Department of Homeland Security.

Appendix 1

This notice supersedes the UFLPA Entity List published in the **Federal Register** on June 12, 2023 (88 FR 38080). The UFLPA Entity List as of August 2, 2023 is available in this appendix and is published on *https://www.dhs.gov/uflpa-entity-list.* This update adds one entity to the section 2(d)(2)(B)(ii) list of the UFLPA, which identifies entities working with the government of the Xinjiang Uyghur Autonomous Region to recruit, transport, transfer, harbor or receive forced labor or Uyghurs, Kazakhs, Kyrgyz, or members of other persecuted groups out of the Xinjiang Uyghur Autonomous Region:

- Camel Group Co., Ltd.

This update also adds one entity and one subsidiary to the section 2(d)(2)(B)(v) list of the UFLPA, which identifies facilities and entities, including the Xinjiang Production and Construction Corps, that source material from the Xinjiang Uyghur Autonomous Region or from persons working with the government of the Xinjiang Uyghur Autonomous Region or the Xinjiang Production and Construction Corps for purposes of the ''poverty alleviation'' program or the ''pairing-assistance'' program or any other government labor scheme that uses forced labor:

- Chenguang Biotech Group Co., Ltd. and its subsidiary Chenguang Biotechnology Group Yanqi Co. Ltd.

No technical corrections or removals are being made to the UFLPA Entity List at this time.

The UFPLA Entity List is a consolidated register of the four lists that are required to be developed and maintained pursuant to section 2(d)(2)(B) of the UFLPA. Twenty-four entities that meet the criteria set forth in the four required lists (*see* sections 2(d)(2)(B)(i), (ii), (iv), and (v) of the UFLPA) are specified on the UFLPA Entity List.

UFLPA Entity List August 2, 2023

UFLPA Section 2 (d)(2)(B)(i) A List of Entities in Xinjiang That Mine, Produce, or Manufacture Wholly or in Part any Goods, Wares, Articles, and Merchandise With Forced Labor

Baoding LYSZD Trade and Business Co., Ltd.
Changji Esquel Textile Co. Ltd. (and one alias: Changji Yida Textile)
Hetian Haolin Hair Accessories Co. Ltd. (and two aliases: Hotan Haolin Hair Accessories; and Hollin Hair Accessories)
Hetian Taida Apparel Co., Ltd (and one alias: Hetian TEDA Garment)
Hoshine Silicon Industry (Shanshan) Co., Ltd (including one alias: Hesheng Silicon Industry (Shanshan) Co.) and subsidiaries
Xinjiang Daqo New Energy, Co. Ltd (including three aliases: Xinjiang Great New Energy Co., Ltd.; Xinjiang Daxin Energy Co., Ltd.; and Xinjiang Daqin Energy Co., Ltd.)
Xinjiang East Hope Nonferrous Metals Co. Ltd. (including one alias: Xinjiang Nonferrous)
Xinjiang GCL New Energy Material Technology, Co. Ltd (including one alias: Xinjiang GCL New Energy Materials Technology Co.)
Xinjiang Junggar Cotton and Linen Co., Ltd.
Xinjiang Production and Construction Corps (including three aliases: XPCC; Xinjiang Corps; and Bingtuan) and its subordinate and affiliated entities

UFLPA Section 2 (d)(2)(B)(ii) A List of Entities Working With the Government of Xinjiang To Recruit, Transport, Transfer, Harbor or Receive Forced Labor or Uyghurs, Kazakhs, Kyrgyz, or Members of Other Persecuted Groups Out of Xinjiang

Aksu Huafu Textiles Co.—(including two aliases: Akesu Huafu and Aksu Huafu Dyed Melange Yarn)
Camel Group Co., Ltd.
Hefei Bitland Information Technology Co., Ltd. (including three aliases: Anhui Hefei Baolongda Information Technology; Hefei Baolongda Information Technology Co., Ltd.; and Hefei Bitland Optoelectronic Technology Co., Ltd.)
Hefei Meiling Co. Ltd. (including one alias: Hefei Meiling Group Holdings Limited).
KTK Group (including three aliases: Jiangsu Jinchuang Group; Jiangsu Jinchuang Holding Group; and KTK Holding).
Lop County Hair Product Industrial Park
Lop County Meixin Hair Products Co., Ltd.
Nanjing Synergy Textiles Co., Ltd. (including two aliases: Nanjing Xinyi Cotton Textile Printing and Dyeing; and Nanjing Xinyi Cotton Textile).
Ninestar Corporation and its eight Zhuhai-based subsidiaries, which include Zhuhai Ninestar Information Technology Co. Ltd., Zhuhai Pantum Electronics Co. Ltd., Zhuhai Apex Microelectronics Co., Ltd., Geehy Semiconductor Co., Ltd., Zhuhai Pu-Tech Industrial Co., Ltd., Zhuhai G&G Digital Technology Co., Ltd., Zhuhai Seine Printing Technology Co., Ltd., and Zhuhai Ninestar Management Co., Ltd.
No. 4 Vocation Skills Education Training Center (VSETC)
Tanyuan Technology Co. Ltd. (including five aliases: Carbon Yuan Technology; Changzhou Carbon Yuan Technology Development; Carbon Element Technology; Jiangsu Carbon Element Technology; and Tanyuan Technology Development).
Xinjiang Production and Construction Corps (XPCC) and its subordinate and affiliated entities
Xinjiang Zhongtai Chemical Co. Ltd.

UFLPA Section 2 (d)(2)(B)(iv) A List of Entities That Exported Products Described in Clause (iii) From the PRC Into the United States

Entities identified in sections (i) and (ii) above may serve as both manufacturers and exporters. The FLETF has not identified additional exporters at this time but will continue to investigate and gather information about additional entities that meet the specified criteria.

UFLPA Section 2 (d)(2)(B)(v) A List of Facilities and Entities, Including the Xinjiang Production and Construction Corps, That Source Material From Xinjiang or From Persons Working With the Government of Xinjiang or the Xinjiang Production and Construction Corps for Purposes of the ''Poverty Alleviation'' Program or the ''Pairing-Assistance'' Program or any Other Government Labor Scheme That Uses Forced Labor

Baoding LYSZD Trade and Business Co., Ltd.
Chenguang Biotech Group Co., Ltd. and its subsidiary Chenguang Biotechnology Group Yanqi Co. Ltd.

Hefei Bitland Information Technology Co. Ltd.
Hetian Haolin Hair Accessories Co. Ltd.
Hetian Taida Apparel Co., Ltd.
Hoshine Silicon Industry (Shanshan) Co., Ltd., and Subsidiaries
Xinjiang Junggar Cotton and Linen Co., Ltd.
Lop County Hair Product Industrial Park
Lop County Meixin Hair Products Co., Ltd.
No. 4 Vocation Skills Education Training Center (VSETC)
Xinjiang Production and Construction Corps (XPCC) and its subordinate and affiliated entities
Yili Zhuowan Garment Manufacturing Co., Ltd.

[FR Doc. 2023–16361 Filed 8–1–23; 8:45 am]

BILLING CODE 9110–9M–P

DEPARTMENT OF THE INTERIOR

Bureau of Indian Affairs

[234A2100DD/AAKC001030/A0A501010.999900]

Rate Adjustments for Indian Irrigation Projects

AGENCY: Bureau of Indian Affairs, Interior.

ACTION: Notice.

SUMMARY: The Bureau of Indian Affairs (BIA) owns or has an interest in irrigation projects located on or associated with various Indian reservations throughout the United States. We are required to establish irrigation assessment rates to recover the costs to administer, operate, maintain, and rehabilitate these projects. We are notifying you that we have adjusted the irrigation assessment rates at several of our irrigation projects and facilities to reflect current costs of administration, operation, maintenance, and rehabilitation.

DATES: The 2024 Irrigation Assessment Rates are effective on January 1, 2024.

FOR FURTHER INFORMATION CONTACT: Leslie Underwood, Program Specialist, Division of Water and Power, Office of Trust Services, (406) 657–5985. For details about a particular BIA irrigation project, please use the tables in the **SUPPLEMENTARY INFORMATION** section to contact the BIA regional or local office where the irrigation project is located.

SUPPLEMENTARY INFORMATION: A Notice of Proposed Rate Adjustment was published in the **Federal Register** on January 18, 2023 (88 FR 2965) to propose adjustments to the irrigation assessment rates at several BIA irrigation projects. The public and interested parties were provided an opportunity to submit written comments during the 60-day period that ended March 20, 2023.

Did BIA defer or change any proposed rate increases?

No. BIA did not defer or change any proposed rate increases.

Did BIA receive any comments on the proposed irrigation assessment rate adjustments?

Yes. BIA received three (3) written comments related to the proposed 2024 irrigation assessment rate adjustments for the Flathead Indian Irrigation Project (FIIP) and Wapato Irrigation Project (WIP). Comments were received by letter and email.

What issues were of concern to the commenters?

BIA's summary of the issues and responses are provided below. Commenters raised concerns on the proposed rate adjustment about the following issues:

The following comments are specific to the Flathead Indian Irrigation Project (FIIP)

Comment: Commenters state a general opposition to the FIIP 2024 rate increase, along with a specific concern that the project is understaffed and personnel costs should not increase until personnel are hired.

Response: As noted when rates were proposed in the **Federal Register** on January 18, 2023 (88 FR 2965), BIA is required to establish irrigation assessment rates that recover the costs to administer, operate, maintain, and rehabilitate our projects. As owner of FIIP, it is BIA's responsibility to ensure adequate resources are made available to meet the requirements noted above. BIA's authority to assess rates is codified at 25 U.S.C. 381 *et seq.* and is addressed in BIA's regulations at 25 CFR part 171. *See also* February 29, 2008 (73 FR 11028 at 11039–11041). Additionally, the repayment contracts between the respective irrigation districts and the Department of the Interior explicitly state that operation and maintenance (O&M) expenses ''shall be paid . . . as provided . . . by rules made or to be made . . . by the Secretary of the Interior.'' The procedures followed by BIA in adjusting its irrigation assessment rates are consistent with applicable law and past practice, and the methodology used by BIA to determine the O&M assessment rates for FIIP is reasonable.

The proposed 2024 irrigation assessment adjustments for FIIP's basic per acre rate categories are necessary and justified due to the increased costs associated with administering, operating, maintaining, and rehabilitating FIIP. In accordance with BIA financial guidelines and 25 CFR part 171, BIA developed the FIIP budget for 2024 expenditures and income approximately two years in advance. BIA relied on financial reports generated by the Financial and Business Management System and procurement files to review past expenditures and project a future budget. The FIIP Project Manager also used his discretion to assess and anticipate upcoming financial needs and priorities. The 2024 expenses were then divided by the total assessable acres within FIIP. The $3.50 per acre assessment increase for the ''basic per acre—A'' rate category, as well as the $1.75 per acre assessment increase for the ''basic per acre—B'' rate category, are necessary to ensure FIIP can pay its anticipated expenses for 2024.

Following BIA policy, the FIIP Project Manager held semiannual water user meetings on December 13, 2022 and May 15, 2023. Attendees included individual water users, Flathead Irrigation District representatives, Mission Irrigation District representatives, Jocko Irrigation District representatives, and a representative for the Confederated Salish and Kootenai Tribes. During these meetings, BIA presented details supporting the 2024 budget, upcoming expenses, and the proposed O&M assessment increase from $35.50 to $39.00 per acre.

FIIP provides irrigation service commensurate with its resources which means the $3.50 per acre assessment increase is needed to improve the project's quality of service. The quality of irrigation service will improve as funding becomes available to fill additional personnel positions, while also retaining and increasing experience levels of existing FIIP staff.

Due to a variety of reasons, recruitment for FIIP positions has proved to be challenging over the past few years. To address these challenges, BIA recently decided to hire three Human Resources (HR) personnel dedicated to providing hiring services and employee relations to FIIP and the two other BIA irrigation projects—Wapato and Fort Hall—in the BIA Northwest Region. The three irrigation projects will jointly fund these new HR personnel. Under this HR framework, BIA aims to rapidly fill FIIP's vacancies in 2024. FIIP's organizational chart contains 58 positions total, of which 37 are currently filled. The 2024 budget includes personnel salary, benefits, and overtime for FIIP's existing personnel and 11 vacant positions. The remaining 10 vacant positions in FIIP's organizational chart are not funded in the 2024 budget.

Comment: The Mission and Jacko Irrigation Districts request an audit of FIIP to determine what happened to the Cooperative Management Entity's supposed $6.5 million of financial assets.

Response: In 2014, BIA reassumed O&M of FIIP from the dissolved Cooperative Management Entity (CME). From March 2014 through June 2015, BIA acquired the CME's property and financial assets. BIA has records of all reassumption acquisitions, which clearly show CME's financial assets totaled around $2 million. Because we have records of all reassumption acquisitions and subsequent BIA expenditures on authorized purposes, an audit is not warranted.

The Following Comments Are Specific to the Wapato Irrigation Project (WIP)

Comment: The Yakama Nation objects to WIP's assessment increase because it will have negative economic consequences on farmers and associated agricultural activities.

Response: As explained above, BIA is required to establish irrigation assessment rates that recover the costs to administer, operate, maintain, and rehabilitate our projects. BIA's projects are important economic contributors to the local communities they serve, and they contribute millions of dollars in crop value annually. Unfortunately, the costs associated with operating and maintaining an irrigation project may increase independently of prices and costs that are realized by the irrigators. Historically, BIA tempered irrigation rates to demonstrate sensitivity to the economic impact on water users, but that past practice resulted in a rate deficiency at some irrigation projects. Therefore, funding to operate and maintain these projects needs to come from the water users served by those projects.

BIA's irrigation program has been the subject of serval Office of Inspector General (OIG) and U.S. Government Accountability Office (GAO) audits. In the most recent OIG audit, No. 96–I–641, March 1996, the OIG concluded:

> Operation and maintenance revenues were insufficient to maintain the projects, and some projects had deteriorated to the extent that their continued capability to deliver water was in doubt. This occurred because operation and maintenance rates were not based on the full cost of delivering irrigation water, including the costs of systematically rehabilitating and replacing project facilities and equipment, and because project personnel did not seek regular rate increases to cover the full cost of project operation.

A previous OIG audit performed on WIP, No. 95–I–1402, September 1995, reached the same conclusion. To address the issues noted in these audits, BIA must systematically review and evaluate irrigation assessment rates and adjust them, when necessary, to reflect the full cost to operate and perform all appropriate maintenance on the irrigation project or facility infrastructure to ensure safe and reliable operation. If this review and adjustment is not accomplished, a rate deficiency can accumulate over time. Rate deficiencies force BIA to raise irrigation assessment rates in larger increments over shorter periods than would have been otherwise necessary.

WIP's assessment rates have remained the same from 2016 through 2023. Although assessments have not changed, all O&M expenses have increased due in part to inflation, rising construction costs, and spiking energy and fuel costs. Additionally, WIP needs to increase revenues to fill vacancies (further details below) and complete rehabilitation activities pursuant to our modernization studies. O&M revenues must supplement nonreimbursable appropriated funding for large upcoming rehabilitation expenses, including reconstruction of the Wapato Diversion and improvement of fish passage on the Yakima River, as well as repairs to the Drop 1 Pumping Plant that services the Main Canal, Main Canal Extension, and Highline Canal. After eight years of a stagnant budget, WIP must increase revenues to address its backlog of deferred maintenance. BIA has projected this rate increase for several years and anticipated increasing the assessment rate in 2024. The WIP budget was prepared in accordance with BIA financial guidelines. Based on increased costs associated with administering, operating, and maintaining, and rehabilitating WIP, the need for the proposed rate increase is clear and justified.

Comment: The Yakama Nation states WIP is chronically understaffed and requests a larger and better trained staff to improve water delivery operations.

Response: BIA is committed to filling vacancies in WIP's 87-position organizational chart. The 2024 budget includes personnel salary, benefits, and overtime for 65 employees, which is an increase of 16 WIP employees above the current 2023 staffing levels. The remaining 22 vacant positions in WIP's organizational chart are not accounted for in the 2024 O&M budget. As explained above, WIP will soon receive hiring assistance from HR staff dedicated to filling irrigation vacancies in the BIA Northwest Region. Under this new HR framework, WIP aims to aggressively fill its vacancies in 2024.

The quality of irrigation service will improve as funding becomes available to fill additional personnel positions, while also retaining and increasing experience levels of existing WIP staff. BIA provides routine training to its staff on topics including, but not limited to, financial management, safety and security, water measurement, herbicide application, defensive driving, and heavy equipment operations.

Comment: The Yakama Nation requests consultation on the justification for the 2024 proposed annual irrigation assessment rates in addition to frequent opportunities to consult and receive updates on WIP's operations and upgrades.

Response: To fulfill its consultation responsibility to Tribes and Tribal organizations, BIA communicates, coordinates, and consults on a continuing basis with these entities on issues of water delivery, water availability, and costs of administration, operation, maintenance, and rehabilitation of projects that concern them. This is accomplished at the individual irrigation project by project, agency, and regional representatives, as appropriate, and through semiannual water user meetings. This notice is one component of our overall coordination and consultation process to provide notice to, and request comments from, these entities when we adjust irrigation assessment rates.

For several years, the WIP Project Manager has advised water users that a rate increase is necessary. Most recently, WIP held its semiannual water user meetings on November 2, 2022 and March 20, 2023. Attendees included the Yakama Reservation Irrigation District board members, individual water users, Yakama Nation employees, and a member of the Yakama Nation's Tribal Council Committee on Roads, Irrigation, and Lands. Additionally, the WIP Project Administrator met with the Yakama Nation Tribal Council on March 5, 2021 and April 5, 2023. At all of these meetings, BIA explained upcoming project expenses and the basis for increasing WIP's 2024 irrigation assessment rates. Attendees' comments and questions have been taken into consideration. We appreciate the Yakama Nation's participation in our meetings and comments regarding how to improve WIP, and we have sent a follow-up letter to the Yakama Nation with additional details.

Does this notice affect me?

This notice affects you if you own or lease land within the assessable acreage of one of our irrigation projects or if you

have a carriage agreement with one of our irrigation projects.

Where can I get information on the regulatory and legal citations in this notice?

You can contact the appropriate office(s) stated in the tables for the irrigation project that serves you, or you can use the internet site for the Government Publishing Office at *www.gpo.gov*.

What authorizes you to issue this notice?

Our authority to issue this notice is vested in the Secretary of the Interior (Secretary) by 5 U.S.C. 301 and the Act of August 14, 1914 (38 Stat. 583; 25 U.S.C. 385). The Secretary has in turn delegated this authority to the Assistant Secretary—Indian Affairs under Part 209, Chapter 8.1A, of the Department of the Interior's Departmental Manual.

Whom can I contact for further information?

The following tables are the regional and project/agency contacts for our irrigation facilities.

Project name	Project/agency
Northwest Region Contacts	
Bryan Mercier, Regional Director, Bureau of Indian Affairs, Northwest Regional Office, 911 NE 11th Avenue, Portland, OR 97232–4169. Telephone: (503) 231–6702.	
Flathead Indian Irrigation Project	Larry Nelson, Acting Irrigation Project Manager, 220 Project Drive, St. Ignatius, MT 59865. Telephone: (406) 745–2661
Fort Hall Irrigation Project	David Bollinger, Irrigation Project Manager, 36 Bannock Avenue, Fort Hall, ID 83203–0220. Telephone: (208) 238–1992.
Wapato Irrigation Project	Pete Plant, Project Administrator, 413 South Camas Avenue, Wapato, WA 98951–0220. Telephone: (509) 877–3155.
Rocky Mountain Region Contacts	
Susan Messerly, Regional Director, Bureau of Indian Affairs, Rocky Mountain Regional Office, 2021 4th Avenue North, Billings, MT 59101. Telephone: (406) 247–7943.	
Blackfeet Irrigation Project	Kenneth Bird, Superintendent, Greg Tatsey, Irrigation Project Manager, P.O. Box 880, Browning, MT 59417. Telephones: Superintendent (406) 338–7544; Irrigation Project Manager (406) 338–7519.
Crow Irrigation Project	Clifford Serawop, Superintendent, Jim Gappa, Acting Irrigation Project Manager (BIA), (Project O&M performed by Water Users Association), P.O. Box 69, Crow Agency, MT 59022. Telephones: Superintendent (406) 638–2672; Acting Irrigation Project Manager (406) 247–7998.
Fort Belknap Irrigation Project	Mark Azure, Superintendent, Jim Gappa, Acting Irrigation Project Manager (BIA), (Project O&M contracted to Tribes under Pub. L. 93–638), 158 Tribal Way, Suite B, Harlem, MT 59526. Telephones: Superintendent (406) 353–2901; Irrigation Project Manager, Tribal Office (406) 353–8454.
Fort Peck Irrigation Project	Anna Eder, Superintendent, Jim Gappa, Acting Irrigation Project Manager (BIA), (Project O&M performed by Fort Peck Water Users Association), P.O. Box 637, Poplar, MT 59255. Telephones: Superintendent (406) 768–5312; Acting Irrigation Project Manager (406) 247–7998.
Wind River Irrigation Project	Leslie Shakespeare, Superintendent, Jim Gappa, Acting Irrigation Project Manager (BIA), (Project O&M for Little Wind, Johnstown, and Lefthand Units contracted to Tribes under Pub. L. 93–638; Little Wind-Ray and Upper Wind Units O&M performed by Ray Canal, A Canal, and Crowheart Water Users Associations), P.O. Box 158, Fort Washakie, WY 82514. Telephones: Superintendent (307) 332–7810; Acting Irrigation Project Manager (406) 247–7998.
Southwest Region Contacts	
Patricia L. Mattingly, Regional Director, Bureau of Indian Affairs, Southwest Regional Office, 1001 Indian School Road NW, Albuquerque, NM 87104. Telephone: (505) 563–3100.	
Pine River Irrigation Project	Priscilla Bancroft, Superintendent, Vickie Begay, Irrigation Project Manager, P.O. Box 315, Ignacio, CO 81137–0315. Telephones: Superintendent (970) 563–4511; Irrigation Project Manager (970) 563–9484.
Western Region Contacts	
Jessie Durham, Regional Director, Bureau of Indian Affairs, Western Regional Office, 2600 North Central Avenue, 4th Floor Mailroom, Phoenix, AZ 85004. Telephone: (602) 379–6600.	
Colorado River Irrigation Project	Davetta Ameelyenah, Superintendent, Gary Colvin, Irrigation Project Manager, 12124 1st Avenue, Parker, AZ 85344. Telephones: Superintendent (928) 669–7111; (928) 662–4392 Irrigation Project Manager.
Duck Valley Irrigation Project	Micah Runels, Acting Superintendent, (Project O&M compacted to Shoshone-Paiute Tribes under Pub. L. 93–638), 2719 Argent Avenue, Suite 4, Gateway Plaza, Elko, NV 89801. Telephones: Superintendent (775) 738–5165; Tribal Office (208) 759–3100.
Yuma Project, Indian Unit	Denni Shields, Superintendent, (Bureau of Reclamation (BOR) owns the Project and is responsible for O&M), 256 South Second Avenue, Suite D, Yuma, AZ 85364. Telephones: Superintendent (928) 782–1202; BOR Area Office Manager (928) 343–8100.
San Carlos Irrigation Project (Indian Works and Joint Works).	Ferris Begay, Project Manager (BIA), Clarence Begay, Supervisory Civil Engineer (BIA), (Portions of Indian Works O&M compacted to Gila River Indian Community under Pub. L. 93–638), 13805 North Arizona Boulevard, Coolidge, AZ 85128. Telephones: Project Manager (520) 723–6225; Supervisory Civil Engineer (520) 723–6203; Gila River Indian Irrigation & Drainage District (520) 562–6720.

Project name	Project/agency
Uintah Irrigation Project	Antonio Pingree, Superintendent, Ken Asay, Irrigation System Manager (BIA), (Project O&M performed by Uintah Indian Irrigation Project Operation and Maintenance Company), P.O. Box 130, Fort Duchesne, UT 84026. Telephones: Superintendent (435) 722–4300; Irrigation System Manager (435) 722–4344; Uintah Indian Irrigation Operation and Maintenance Company (435) 724–5200.
Walker River Irrigation Project	Colleen Labelle, Superintendent, 311 East Washington Street, Carson City, NV 89701. Telephone: (775) 887–3500.

What irrigation assessments or charges are adjusted by this notice?

The rate table below contains final rates for the 2023 and 2024 calendar years for all irrigation projects where we recover costs of administering, operating, maintaining, and rehabilitating them. An asterisk immediately following the rate category notes irrigation projects where 2023 rates are different from the 2024 rates.

Project name	Rate category	Final 2023 rate	Final 2024 rate
Northwest Region Rate Table			
Flathead Irrigation Project	Basic per acre—A *	$35.50	$39.00
	Basic per acre—B *	17.75	19.50
	Minimum Charge per tract	75.00	75.00
Fort Hall Irrigation Project	Basic per acre *	64.50	65.50
	Minimum Charge per tract	41.00	41.00
Fort Hall Irrigation Project—Minor Units	Basic per acre	45.00	45.00
	Minimum Charge per tract	41.00	41.00
Fort Hall Irrigation Project—Michaud Unit	Basic per acre *	73.50	75.00
	Pressure per acre *	114.00	116.50
	Minimum Charge per tract	41.00	41.00
Wapato Irrigation Project—Toppenish/Simcoe Units	Minimum Charge per bill *	25.00	28.00
	Basic per acre *	25.00	28.00
Wapato Irrigation Project—Ahtanum Units	Minimum Charge per bill *	30.00	35.00
	Basic per acre *	30.00	35.00
Wapato Irrigation Project—Satus Unit	Minimum Charge per bill *	79.00	100.00
	"A" Basic per acre *	79.00	86.00
	"B" Basic per acre *	85.00	92.00
Wapato Irrigation Project—Additional Works	Minimum Charge per bill *	80.00	100.00
	Basic per acre *	80.00	87.00
Wapato Irrigation Project—Water Rental	Minimum Charge per bill *	90.00	100.00
	Basic per acre *	90.00	100.00
Rocky Mountain Region Rate Table			
Blackfeet Irrigation Project	Basic-per acre *	20.50	21.50
Crow Irrigation Project—Willow Creek O&M (includes Agency, Lodge Grass #1, Lodge Grass #2, Reno, Upper Little Horn, and Forty Mile Units).	Basic-per acre *	29.00	30.00
Crow Irrigation Project—All Others (includes Bighorn, Soap Creek, and Pryor Units).	Basic-per acre *	29.00	30.00
Crow Irrigation Project—Two Leggins Unit	Basic-per acre *	14.00	15.00
Crow Irrigation Two Leggins Drainage District	Basic-per acre *	2.00	3.00
Fort Belknap Irrigation Project	Basic-per acre *	19.00	20.00
Fort Peck Irrigation Project	Basic-per acre *	28.00	29.00
Wind River Irrigation Project—Units 2, 3 and 4	Basic-per acre *	25.00	26.00
Wind River Irrigation Project—Unit 6	Basic-per acre *	22.00	23.00
Wind River Irrigation Project—LeClair District (See Note #1)	Basic-per acre	47.00	47.00
Wind River Irrigation Project—Crow Heart Unit	Basic-per acre	16.50	16.50
Wind River Irrigation Project—A Canal Unit	Basic-per acre	16.50	16.50
Wind River Irrigation Project—Riverton Valley Irrigation District (See Note #1).	Basic-per acre	30.65	30.65
Southwest Region Rate Table			
Pine River Irrigation Project	Minimum Charge per tract	75.00	75.00
	Basic-per acre *	23.00	23.50
Western Region Rate Table			
Colorado River Irrigation Project	Basic per acre up to 5.75 acre-feet	64.00	64.00
	Excess Water per acre-foot over 5.75 acre-feet.	18.00	18.00
Duck Valley Irrigation Project	Basic per acre	5.30	5.30
Yuma Project, Indian Unit (See Note #2)	Basic per acre up to 5.0 acre-feet	161.00	(+)

Project name	Rate category	Final 2023 rate	Final 2024 rate
	Excess Water per acre-foot over 5.0 acre-feet.	30.00	(+)
	Basic per acre up to 5.0 acre-feet (Ranch 5).	161.00	(+)
San Carlos Irrigation Project (Joint Works) (See Note #3)	Basic per acre	$26.00	$26.00

Final 2024 Construction Water Rate Schedule:

	Off project construction	On project construction—gravity water	On project construction—pump water
Administrative Fee.	$300.00	$300.00	$300.00.
Usage Fee	$250.00 per month.	No Fee	$100.00 per acre foot.
Excess Water Rate †.	$5.00 per 1,000 gal.	No Charge	No Charge.

Project name	Rate category	Final 2023 rate	Final 2024 rate
San Carlos Irrigation Project (Indian Works) (See Note #4)	Basic per acre *	$90.50	$99.62
Uintah Irrigation Project	Basic per acre	23.00	23.00
	Minimum Bill	25.00	25.00
Walker River Irrigation Project	Basic per acre	31.00	31.00

* Notes irrigation projects where rates are adjusted.
+ These rates have not yet been determined.
† The excess water rate applies to all water used in excess of 50,000 gallons in any one month.

Note #1: O&M rates for LeClair and Riverton Valley Irrigation Districts apply to Trust lands that are serviced by each irrigation district. The annual O&M rates are based on budgets submitted by LeClair and Riverton Valley Irrigation Districts, respectively.

Note #2: The O&M rate for the Yuma Project, Indian Unit has two components. The first component of the O&M rate is established by the Bureau of Reclamation (BOR), the owner and operator of the Project. BOR's rate, which is based upon the annual budget submitted by BOR is $157.00 for 2023 but has not been established for 2024. The second component of the O&M rate is established by BIA to cover administrative costs, which includes billing and collections for the Project. The final 2023 and 2024 BIA rate component is $4.00 per acre.

Note #3: The Construction Water Rate Schedule identifies fees assessed for use of irrigation water for non-irrigation purposes.

Note #4: The O&M rate for the San Carlos Irrigation Project—Indian Works has three components. The first component is established by BIA San Carlos Irrigation Project—Indian Works, the owner and operator of the Project; the 2023 rate is $56.50 per acre, and final 2024 rate is $55.85 per acre. The second component is established by BIA San Carlos Irrigation Project—Joint Works; the 2023 rate is $26.00 per acre, and final 2024 rate is $26.00 per acre. The third component is established by the San Carlos Irrigation Project Joint Control Board (comprised of representatives from the Gila River Indian Community and the San Carlos Irrigation and Drainage District); the 2023 rate is $8.00 per acre (revised from $16.94 per acre), and 2024 rate is $17.77 per acre.

Consultation and Coordination With Tribal Governments (Executive Order 13175)

The Department of the Interior strives to strengthen its government-to-government relationship with Indian Tribes through a commitment to consultation with Indian Tribes and recognition of their right to self-governance and Tribal sovereignty. We have evaluated this notice under the Department's consultation policy and under the criteria of Executive Order 13175 and have determined there to be substantial direct effects on federally recognized Tribes because the irrigation projects are located on or associated with Indian reservations. To fulfill its consultation responsibility to Tribes and Tribal organizations, BIA communicates, coordinates, and consults on a continuing basis with these entities on issues of water delivery, water availability, and costs of administration, operation, maintenance, and rehabilitation of projects that concern them. This is accomplished at the individual irrigation project by project, agency, and regional representatives, as appropriate, in accordance with local protocol and procedures. This notice is one component of our overall coordination and consultation process to provide notice to, and request comments from, these entities when we adjust irrigation assessment rates.

Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution, or Use (Executive Order 13211)

These rate adjustments are not a significant energy action under the definition in Executive Order 13211. A Statement of Energy Effects is not required.

Regulatory Planning and Review (Executive Order 12866, as Amended by E.O. 14094)

These rate adjustments are not a significant regulatory action and do not need to be reviewed by the Office of Management and Budget under Executive Order 12866, as amended by E.O. 14094.

Regulatory Flexibility Act

These rate adjustments are not a rule for the purposes of the Regulatory Flexibility Act because they establish ''a rule of particular applicability relating to rates.'' 5 U.S.C. 601(2).

Unfunded Mandates Reform Act of 1995

These rate adjustments do not impose an unfunded mandate on state, local, or Tribal governments in the aggregate, or on the private sector, of more than $130 million per year. They do not have a significant or unique effect on State,

local, or Tribal governments or the private sector. Therefore, the Department is not required to prepare a statement containing the information required by the Unfunded Mandates Reform Act (2 U.S.C. 1531 *et seq.*).

Takings (Executive Order 12630)

These rate adjustments do not effect a taking of private property or otherwise have ''takings'' implications under Executive Order 12630. The rate adjustments do not deprive the public, State, or local governments of rights or property.

Federalism (Executive Order 13132)

Under the criteria in section 1 of Executive Order 13132, these rate adjustments do not have sufficient federalism implications to warrant the preparation of a federalism summary impact statement because they will not affect the States, the relationship between the national government and the States, or the distribution of power and responsibilities among the various levels of government. A federalism summary impact statement is not required.

Civil Justice Reform (Executive Order 12988)

This notice complies with the requirements of Executive Order 12988. Specifically, in issuing this notice, the Department has taken the necessary steps to eliminate drafting errors and ambiguity, minimize potential litigation, and provide a clear legal standard for affected conduct as required by section 3 of Executive Order 12988.

Paperwork Reduction Act of 1995

These rate adjustments do not affect the collections of information which have been approved by the Office of Information and Regulatory Affairs, Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995. The OMB Control Number is 1076–0141 and expires March 31, 2026.

National Environmental Policy Act

The Department has determined that these rate adjustments do not constitute a major Federal action significantly affecting the quality of the human environment and that no detailed statement is required under the National Environmental Policy Act of 1969, 42 U.S.C. 4321–4370(d)), pursuant to 43 CFR 46.210(i). In addition, the rate adjustments do not present any of the 12 extraordinary circumstances listed at 43 CFR 46.215.

Bryan Newland,

Assistant Secretary—Indian Affairs.

[FR Doc. 2023–16399 Filed 8–1–23; 8:45 am]

BILLING CODE 4337–15–P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[234 LLUTG02000 L12200000.PM00000]

Notice of Public Meetings, San Rafael Swell Recreation Area Advisory Council, Utah

AGENCY: Bureau of Land Management, Interior.

ACTION: Notice of public meetings.

SUMMARY: In accordance with the Federal Land Policy and Management Act, the Federal Advisory Committee Act, and the Federal Lands Recreation Enhancement Act, the U.S. Department of the Interior, Bureau of Land Management's (BLM) San Rafael Swell Recreation Area Advisory Council (Council) will meet as indicated below.

DATES: The Council will hold an in-person public meeting with a virtual participation option on August 31, 2023, at the Castle Valley Special Service District Building from 9:00 a.m. to 1:30 p.m. MT with public comments accepted at 12:00 p.m.

The Council will hold an in-person field tour on March 6, 2024, from 9:30 a.m. to 4:00 p.m. MT and a public meeting with a virtual participation option on March 7, 2024, at the Castle Valley Special Service District Building from 8:30 a.m. to 12:30 p.m. MT with public comments accepted at 11:30 a.m. The meetings and field tour are open to the public.

ADDRESSES: The August 31, 2023, meeting will be held at the Castle Valley Special Service District Building 20 South 100 East, Castle Dale, Utah 84513. The March 6, 2024, field tour will commence and conclude at the Castle Valley Special Service Building and the March 7, 2024, meeting will also be held at the Castle Valley Special Service District Building 20 South 100 East, Castle Dale, Utah 84513. Individuals that prefer to participate virtually in the meetings must register in advance. Registration information will be posted 2 weeks in advance of each meeting at *https://www.blm.gov/get-involved/resource-advisory-council/near-you/utah/San-Rafael-Swell-RAC.*

Written comments may be sent prior to each meeting either by mail to the BLM Green River District, Attn: Lance Porter, 170 South 500 West, Vernal, UT 84078, or by email: *utprmail@blm.gov,* with the subject line ''San Rafael Swell Recreation Area Advisory Council Meeting.''

FOR FURTHER INFORMATION CONTACT: BLM Green River District Manager Lance Porter, telephone: (435) 781–4400 or email: *utprmail@blm.gov.* Persons in the United States who are deaf, deafblind, hard of hearing, or have a speech disability may dial 711 (TTY, TDD, or TeleBraille) to access telecommunications relay services. Individuals outside the United States should use the relay services offered within their country to make international calls to the point-of-contact in the United States.

SUPPLEMENTARY INFORMATION: The John D. Dingell, Jr. Conservation, Management, and Recreation Act (Pub. L. 116–9) established the San Rafael Swell Recreation Area Advisory Council to advise the Secretary of the Interior, through the BLM, in planning and managing the San Rafael Swell Recreation Area. The seven-member Council represents a wide range of interests including local government, recreational users, grazing allotment permittees, conservation organizations, people with expertise in historical uses of the recreation area, and Tribal Nations.

Individuals who need special assistance, such as sign language interpretation and other reasonable accommodations, also should contact the person listed in the **FOR FURTHER INFORMATION CONTACT** section of this notice. Agenda items for the August 31, 2023, meeting include an overview of the San Rafael Swell Recreation Area, history of Council recommendations, planning updates, and other topics as appropriate. The March 6 field tour is to various points within the San Rafael Swell Recreation Area and will include discussions of BLM management of public lands including Areas of Critical Environmental Concern, the Special Recreation Management Area, recreation facilities, grazing, and more. Members of the public are welcome on the field tour but must provide their own transportation and meals. Individuals who plan to attend must RSVP to the BLM Green River District Office at least 2 weeks in advance of the field tour to the contact listed in the **FOR FURTHER INFORMATION CONTACT** section of this notice. Agenda items for the March 7, 2024, meeting include spring/summer visitor information updates, travel management plan updates, and other topics as needed.

Detailed meeting minutes will be maintained in the BLM Green River District Office and will be made available for public inspection and reproduction during regular business hours within 90 days following each meeting. Minutes will also be posted to the Council's web page at *https://www.blm.gov/get-involved/resource-advisory-council/near-you/utah/San-Rafael-Swell-RAC.* The amount of time for individual oral comments may be limited depending on the total number of commenters. Written comments may also be sent to the BLM Green River District Manager at the address listed in the **ADDRESSES** section of this notice. All comments received will be provided to the Council.

Please make requests in advance for sign language interpreter services, assistive listening devices, or other reasonable accommodations. We ask that you contact the person listed in the **FOR FURTHER INFORMATION CONTACT** section of this notice at least 7 business days prior to the meeting to give the BLM sufficient time to process your request. All reasonable accommodation requests are managed on a case-by-case basis.

Public Disclosure of Comments: Before including your address, phone number, email address, or other personal identifying information in your comment, you should be aware that your entire comment, including your personal identifying information, may be made publicly available at any time. While you can ask in your comment to withhold your personal identifying information from public review, we cannot guarantee that we will be able to do so.

Authority: 5 U.S.C. ch. 10.

Gregory Sheehan,

State Director.

[FR Doc. 2023–16479 Filed 8–1–23; 8:45 am]

BILLING CODE 4331–25–P

INTERNATIONAL TRADE COMMISSION

[Investigation Nos. 701–TA–573–574 and 731–TA–1349–1358 (Review)]

Carbon and Certain Alloy Steel Wire Rod from Belarus, Italy, Russia, South Africa, South Korea, Spain, Turkey, Ukraine, the United Arab Emirates, and the United Kingdom

Determinations

On the basis of the record [1] developed in the subject five-year reviews, the United States International Trade Commission (''Commission'') determines, pursuant to the Tariff Act of 1930 (''the Act''), that revocation of the countervailing duty orders on carbon and certain alloy steel wire rod from Italy and Turkey and the antidumping duty orders on carbon and certain alloy steel wire rod from Belarus, Italy, Russia, South Africa, South Korea, Spain, Turkey, Ukraine, the United Arab Emirates, and the United Kingdom would be likely to lead to continuation or recurrence of material injury to an industry in the United States within a reasonably foreseeable time.

Background

The Commission instituted these reviews on December 1, 2022 (87 FR 73789) and determined on March 6, 2023 that it would conduct expedited reviews (88 FR 22069, April 12, 2023).

The Commission made these determinations pursuant to section 751(c) of the Act (19 U.S.C. 1675(c)). It completed and filed its determinations in these reviews on July 27, 2023. The views of the Commission are contained in USITC Publication 5449 (August 2023), entitled *Carbon and Certain Alloy Steel Wire Rod from Belarus, Italy, Russia, South Africa, South Korea, Spain, Turkey, Ukraine, the United Arab Emirates, and the United Kingdom: Investigation Nos. 701–TA–573–574 and 731–TA–1349–1358 (Review).*

By order of the Commission.
Issued: July 27, 2023.

Sharon Bellamy,

Acting Supervisory Hearings and Information Officer.

[FR Doc. 2023–16394 Filed 8–1–23; 8:45 am]

BILLING CODE 7020–02–P

[1] The record is defined in § 207.2(f) of the Commission's Rules of Practice and Procedure (19 CFR 207.2(f)).

INTERNATIONAL TRADE COMMISSION

[Investigation Nos. 731–TA–1334–1337 (Review)]

Emulsion Styrene-Butadiene Rubber From Brazil, Mexico, Poland, and South Korea; Determinations

On the basis of the record [1] developed in the subject five-year reviews, the United States International Trade Commission (''Commission'') determines, pursuant to the Tariff Act of 1930 (''the Act''), that revocation of the antidumping duty orders on emulsion styrene-butadiene rubber (ESBR) from Brazil, Mexico, Poland, and South Korea would be likely to lead to continuation or recurrence of material injury to an industry in the United States within a reasonably foreseeable time.[2]

Background

The Commission instituted these reviews on August 1, 2022 (87 FR 47001) and determined on November 4, 2022 that it would conduct full reviews (87 FR 76509, December 14, 2022). Notice of the scheduling of the Commission's reviews and of a public hearing to be held in connection therewith was given by posting copies of the notice in the Office of the Secretary, U.S. International Trade Commission, Washington, DC, and by publishing the notice in the **Federal Register** on December 28, 2022 (87 FR 79905). The Commission conducted its hearing on May 23, 2023. All persons who requested the opportunity were permitted to participate.

The Commission made these determinations pursuant to section 751(c) of the Act (19 U.S.C. 1675(c)). It completed and filed its determinations in these reviews on July 27, 2023. The views of the Commission are contained in USITC Publication 5447 (July 2023), entitled *Emulsion Styrene-Butadiene Rubber from Brazil, Mexico, Poland, and South Korea: Investigation Nos. 731–TA–1334–1337 (Review).*

By order of the Commission.
Issued: July 27, 2023.

Sharon Bellamy,

Acting Supervisory Hearings and Information Officer.

[FR Doc. 2023–16376 Filed 8–1–23; 8:45 am]

BILLING CODE 7020–02–P

[1] The record is defined in § 207.2(f) of the Commission's Rules of Practice and Procedure (19 CFR 207.2(f)).

[2] Commissioner Randolph J. Stayin not participating.

DEPARTMENT OF JUSTICE

[OMB Number 1105–0NEW]

Agency Information Collection Activities; Proposed eCollection eComments Requested; New Collection; Crime Victims' Rights Act Complaint Form

AGENCY: Executive Office for United States Attorneys, Department of Justice.

ACTION: 60-Day notice.

SUMMARY: The Office of the Victims' Rights Ombuds, Executive Office for United States Attorneys (EOUSA), Department of Justice (DOJ), will be submitting the following information collection request to the Office of Management and Budget (OMB) for review and approval in accordance with the Paperwork Reduction Act of 1995.

DATES: Comments are encouraged and will be accepted for 60 days until October 2, 2023.

FOR FURTHER INFORMATION CONTACT: If you have additional comments especially on the estimated public burden or associated response time, suggestions, or need a copy of the proposed information collection instrument with instructions or additional information, please contact Ellen FitzGerald, Victims' Rights Ombudsman, Executive Office for United States Attorneys, 950 Pennsylvania Avenue NW, Room 2261, Washington, DC 20530 (Email: *USAEO.RegulatoryComments@usdoj.gov* or telephone: 202–252–1010).

SUPPLEMENTARY INFORMATION: Written comments and suggestions from the public and affected agencies concerning the proposed collection of information are encouraged. Your comments should address one or more of the following four points:

—Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;

—Evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;

—Evaluate whether and if so how the quality, utility, and clarity of the information to be collected can be enhanced; and

—Minimize the burden of the collection 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.

Abstract: The Crime Victims' Rights Act of 2004, 18 U.S.C. 3771 (CVRA), sets forth the rights of a Federal crime victim to file a complaint against any Department of Justice employee who violated or failed to provide rights established under the CVRA. The Department of Justice has created the Office of the Victims' Rights Ombudsman to receive and investigate complaints filed by Federal crime victims against its employees and has implemented ''Procedures to Promote Compliance with Crime Victims' Rights Obligations,'' 28 CFR 45.10. The complaint process is not designed for the correction of specific victims' rights violations but is instead used to request corrective or disciplinary action against Department of Justice employees who may have failed to provide rights to crime victims. The Department of Justice will investigate the allegations in the complaint to determine whether the employee used his or her ''best efforts'' to provide crime victim rights. The Office of the Crime Victims Rights Ombudsman does not administer crime victim funds or provide services.

Overview of This Information Collection

1. *Type of Information Collection:* New information collection request.

2. *The Title of the Form/Collection:* Crime Victims' Rights Act Complaint Form.

3. *The agency form number, if any, and the applicable component of the Department sponsoring the collection:* Not applicable.

4. *Affected public who will be asked or required to respond, as well as the obligation to respond:* The affected public are individuals. The obligation to respond is voluntary.

5. *An estimate of the total number of respondents and the amount of time estimated for an average respondent to respond:* It is estimated that 100 respondents will complete the form annually. The time to complete the form is approximately 45 minutes.

6. *An estimate of the total annual burden (in hours) associated with the collection:* The total annual burden hours for this collection is 75 hours.

7. An estimate of the total annual cost burden associated with the collection, if applicable:

TOTAL BURDEN HOURS

Activity	Number of respondents	Frequency	Total annual responses	Time per response (min.)	Total annual burden (hours)
Complaint Form (completed by individuals)	100	Annually	100	45	75
Unduplicated Totals	100		100		75

If additional information is required contact: Darwin Arceo, Department Clearance Officer, United States Department of Justice, Justice Management Division, Policy and Planning Staff, Two Constitution Square, 145 N Street NE, 4W–218, Washington, DC.

Dated: July 25, 2023.

Darwin Arceo,

Department Clearance Officer for PRA, U.S. Department of Justice.

[FR Doc. 2023–16432 Filed 8–1–23; 8:45 am]

BILLING CODE 4410–07–P

OFFICE OF MANAGEMENT AND BUDGET

Request for Comments on Proposed Guidance for Assessing Changes in Environmental and Ecosystem Services in Benefit-Cost Analysis

AGENCY: Office of Management and Budget.

ACTION: Notice of availability and request for comments.

SUMMARY: The Office of Management and Budget (OMB) is requesting comments on proposed guidance for assessing changes in environmental and ecosystem services in benefit-cost analysis.

DATES: Comments are requested on the proposed Circular on or before September 18, 2023.

ADDRESSES: The proposed Guidance is available at *https://www.whitehouse.gov/wp-content/uploads/2023/08/DraftESGuidance.pdf.*

Please submit comments via *http://www.regulations.gov,* a Federal website that allows the public to find, review, and submit comments on documents that agencies have published in the **Federal Register** and that are open for comment. Simply type ''OMB–2022–0016'' in the search box, click ''Search,'' click the ''Comment'' button underneath ''Request for Comments on Proposed Guidance for Assessing Changes in Environmental and Ecosystem Services in Benefit-Cost Analysis,'' and follow the instructions for submitting comments. All comments received will be posted to *http://www.regulations.gov,* so commenters should not include information they do not wish to be posted (*e.g.,* personal or confidential business information).

FOR FURTHER INFORMATION CONTACT: Office of Management and Budget, Office of Information and Regulatory Affairs, at *MBX.OMB.OIRA.ESGuidancePCQ@omb.eop.gov.*

SUPPLEMENTARY INFORMATION:

Background: In the process of designing appropriate regulations, agencies prepare regulatory impact analyses (RIAs) for certain rules—consistent with Office of Management and Budget (OMB) Circular A–4—that sometimes involve environmental and ecosystem services (collectively ''ecosystem services''). Agencies also prepare benefit-cost analyses of public investments—consistent with OMB Circular A–94—that can involve ecosystem services, which are all relevant contributions to human welfare from the environment or ecosystems. In order to encourage continued improvements in valuing changes to ecosystem services in benefit-cost analyses of regulations or public investments, OMB's Office of Information and Regulatory Affairs (OIRA) is releasing proposed Guidance for Assessing Changes in Environmental and Ecosystem Services in Benefit-Cost Analysis (Guidance). OMB, in consultation with the Office of Science and Technology Policy as well as relevant agencies and Executive Office of the President components, has drafted and proposes this Guidance. OMB now invites public comment on this proposed Guidance and is simultaneously initiating a peer review process with respect to it.

OMB believes that the benefits of this proposed Guidance will be substantial. Many benefit-cost analyses involve ecosystem services, and standardized guidance on how to assess relevant changes and how to value such services will help promote consistency and predictability in these analyses. The Guidance also aims to make incorporating ecosystem-service considerations easier for agencies conducting these analyses, resulting in lower analytic burdens for agencies and more sound analysis. While there are costs associated with performing more robust analyses of ecosystem-service effects—as well as with drafting and transitioning to new guidance—OMB believes that the benefits of better analysis and better-informed public discourse resulting from this proposed Guidance are likely to well exceed those costs.

Some of the motivations for the proposed Guidance, and some considerations that OMB would like to highlight, are elaborated below. OMB requests comments on all aspects of the proposed Guidance. And OMB specifically requests comment on various aspects of the proposed Guidance as detailed later in this Notice.

Origins of, and Reasons for, the Proposed Guidance: To manage resources optimally, agencies should assess the full suite of important impacts their actions have on the nation's natural assets, including benefits and costs to both the assets that an agency manages directly and to those managed by others, including, for example, other agencies; State, Tribal, Territorial, and local governments; and private resource managers. Interest in thoughtfully managing natural assets has a long history in the United States, from the recent Executive Order (E.O.) 14072 [1] to similar calls dating back well over a century.[2] This interest has resulted in a variety of agency efforts over the years to better analyze effects on natural assets and on the ecosystem services that they deliver.[3] These efforts are generally consistent with one another, but sometimes differ with respect to scope and focus, highlighting the need for government-wide guidance to help facilitate interagency consistency and coordination on ecosystem service analyses in the context of benefit-cost analysis. Given that certain agencies have developed their own ecosystem-service guidance documents—based on their own programs and statutory authorities—but others have not, a government-wide guidance will also help additional agencies develop their own expertise more quickly, so that they too can engage on ecosystem-service questions when relevant.

The importance of standardized guidance for ecosystem-service analyses is reflected in E.O. 14072, which calls for OMB to ''issue guidance related to the valuation of ecosystem and environmental services and natural assets in Federal regulatory decision-making, consistent with the efforts to modernize regulatory review required by my Presidential Memorandum of January 20, 2021 (Modernizing Regulatory Review).'' [4] That Presidential Memorandum, in turn, ''reaffirms the basic principles set forth in'' E.O. 12866 and E.O. 13563.[5] These longstanding principles include assessing environmental costs and benefits, including ecosystem service effects.[6] Since then, E.O. 14094 again

[1] Executive Order No. 14072, *Strengthening the Nation's Forests, Communities, and Local Economies,* 87 FR 24,851 (Apr. 27, 2022).

[2] *See, e.g.,* Theodore Roosevelt, *Message to the Senate and House of Representatives* (Dec. 8, 1908), *https://history.state.gov/historicaldocuments/frus1908/message-of-the-president.*

[3] *See, e.g.,* Env't Prot. Agency, Metrics for National and Regional Assessment of Aquatic, Marine, and Terrestrial Final Ecosystem Goods and Services (2020), *https://nepis.epa.gov/Exe/ZyPDF.cgi/P1010Y7B.PDF?Dockey=P1010Y7B.PDF;* U.S. Forest Serv., Integrating Ecosystem Services into National Forest Service Policy and Operations (2017), *https://www.fs.usda.gov/research/treesearch/53358;* U.S. Army Corp of Engrs., Using Information on Ecosystem Goods and Services in Corps Planning: An Examination on Authorities, Policies, Guidance, and Practices (2013), *https://www.iwr.usace.army.mil/portals/70/docs/iwrreports/egs_policy_review_2013-r-07.pdf.*

[4] *Id.* § 4(b), 87 FR at 24,854.

[5] Memorandum of January 20, 2021, *Modernizing Regulatory Review* § 1, 86 FR 7223, 7223 (Jan. 26, 2021).

[6] Executive Order No. 12866, *Regulatory Planning and Review* § 1, 58 FR 51,735, 51,735 (Oct. 4, 1993) (''[I]n choosing among alternative regulatory approaches, agencies should select those approaches that maximize net benefits (including . . . environmental . . . advantages . . .), unless a statute requires another regulatory approach.''); Executive Order No. 13563, *Improving Regulation and Regulatory Review* § 1(b), 76 FR 3821, 3821 (Jan. 21, 2011) (reaffirming the same); *see also* Memorandum of January 20, 2021 § 2(a), 86 FR at 7223 (listing ''environmental stewardship'' as one of the values that the regulatory review process should promote).

emphasized a commitment to these principles.[7]

The Presidential Memorandum and these executive orders all emphasize considering impacts on the environment when assessing benefits and costs, but they do not provide detailed direction to agencies regarding how they should incorporate ecosystem service impacts into benefit-cost analyses. Actions affecting a natural asset or an associated ecosystem service often interact with natural, built, and social systems to yield benefits, costs, and transfers. Agencies currently vary in how they consider these dynamics and how they define, analyze, and report the resulting impacts. The call for additional guidance regarding ecosystem services from E.O. 14072 section 4(b)[8] follows other, recent calls for similar guidance to address these questions.[9] The proposed Guidance seeks to clarify the existing guidance provided in Circulars A–4 and A–94, with the goal of yielding more predictable, robust, and consistent treatment of ecosystem services in benefit-cost analyses. Through harmonized guidance, it also aims to achieve: improved consistency and predictability in benefit-cost analyses that involve ecosystem services, lower burdens to incorporating ecosystem-service considerations into analyses, and better information to help guide agency decisions when ecosystem services are involved.

Relationship with Other Guidance: The proposed Guidance is intended to be fully consistent with—and a faithful application of—the principles and guidelines in Circulars A–4 and A–94. Much in the proposed Guidance cross-references applicable sections in Circular A–4—and, per a paragraph on page 1, analogous sections of Circular A–94 [10]—to address certain analytical steps.

Many analytical steps that are important for assessing impacts on ecosystem services are covered within Circulars A–4 and A–94. Therefore, what this Guidance covers in the greatest depth is not necessarily what is most important for ecosystem-service analysis. For example, deciding on appropriate valuation methods—such as stated-preference or revealed-preference methods—is often a challenging step when valuing ecosystem services. To avoid duplication, this proposed Guidance generally directs readers to Circulars A–4 and A–94 on this topic, as valuation techniques are discussed there. The proposed Guidance instead focuses on highlighting examples of such methodologies that may be applied to analyses of ecosystem services. Similarly, choosing a discount rate or analytical time horizon is important to valuing ecosystem services, but most pertinent considerations to make such decisions are in Circulars A–4 and A–94; the proposed Guidance devotes little space to discussing those topics, instead referencing those circulars.

As noted above, the proposed Guidance explains that it references sections in Circular A–4; agencies conducting analyses consistent with Circular A–94 instead of Circular A–4 should reference analogous sections within the applicable circular. OMB proposes this arrangement for brevity and to avoid undue repetition by avoiding references to two documents every time the proposed Guidance mentions one. OMB welcomes comment on whether that arrangement is sufficiently clear for practitioners preparing analyses consistent with Circular A–94. OMB also welcomes comment on opportunities for tailoring the proposed Guidance more carefully to the context of such analyses. For example, are there issues that are particularly relevant to valuing ecosystem services in the public-investment context that would benefit from additional detail in the proposed Guidance?

On April 6, 2023, OMB separately released proposed revisions to Circulars A–4 and A–94 and called for public comment on them. The proposed Guidance is intended to be consistent with current versions of those Circulars as well as the proposed updates to them. Stated differently, nothing in the proposed Guidance is meant to depend on any of the proposed changes to either Circular A–4 or Circular A–94. The proposed updates to both Circulars cross-reference the final version of this proposed Guidance for further guidance on valuing ecosystem services.

In addition to Circulars A–4 and A–94, as noted above and in the proposed Guidance, many agencies also have internal guidelines for analyzing ecosystem services. The proposed Guidance represents OMB's recommended best practices for such analyses in benefit-cost analysis and should be generally consistent with more specific agency guidance. Insofar as this Guidance, when finalized, conflicts with any internal guidance, agencies should consult with OMB. Moreover, agencies should always refer to their operative statutory authorities and, if their authorities are inconsistent with the proposed Guidance, should defer to the relevant statute.

Requests for Comment: While OMB invites comment on any aspect of the proposed Guidance, OMB specifically solicits comment on the following aspects:

(1) whether addressing any further topics related to ecosystem services would be useful;

(2) whether the material could be presented more clearly for affected public stakeholders, including how the proposed Guidance discusses its preference for monetization when feasible, and when not, then quantification when feasible, and when not, then qualitive description;

(3) whether the discussion of especially difficult-to-quantify and difficult-to-monetize ecosystem services, such as cultural services and existence value, is appropriate and sufficient;

(4) whether methodologies to quantify or describe ecosystem services that cannot be monetized are sufficiently described;

(5) whether integration with and references to Circulars A–4 and A–94 efficiently cross-reference the relevant details in the related documents;

(6) whether and how the proposed Guidance conflicts with other related guidance documents from OMB or agencies;

(7) whether to refine guidance on potential double-counting of effects; and

(8) whether to refine guidance on accounting for stocks versus flows.

Richard L. Revesz,

Administrator, Office of Information and Regulatory Affairs.

[FR Doc. 2023–16272 Filed 8–1–23; 8:45 am]

BILLING CODE 3110–01–P

[7] Executive Order No. 14094, *Modernizing Regulatory Review* § 1(a), 88 FR 21,879, 21,879 (Apr. 11, 2023).

[8] Executive Order No. 14072 § 4(b), 87 FR at 24,854.

[9] *See* Shaun Donovan, Christina Goldfuss & John Holdren, *M–16–01: Incorporating Ecosystem Services into Federal Decision Making* (Oct. 7, 2015), *https://www.whitehouse.gov/wp-content/uploads/legacy_drupal_files/omb/memoranda/2016/m-16-01.pdf*.

[10] For example, where the proposed Guidance references the Circular A–4 section ''Discount Rates,'' readers performing analyses consistent with Circular A–94 should refer to the Circular A–94 section ''Discount Rate Policy.''

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION

[Notice 23–078]

Notice of Intent To Grant an Exclusive, Co-Exclusive or Partially Exclusive Patent License

AGENCY: National Aeronautics and Space Administration.

ACTION: Notice of intent to grant exclusive, co-exclusive or partially exclusive patent license.

SUMMARY: NASA hereby gives notice of its intent to grant an exclusive, co-exclusive or partially exclusive patent license to practice the inventions

described and claimed in the patents and/or patent applications listed in **SUPPLEMENTARY INFORMATION** below.

DATES: The prospective exclusive, co-exclusive or partially exclusive license may be granted unless NASA receives written objections including evidence and argument, no later than August 17, 2023 that establish that the grant of the license would not be consistent with the requirements regarding the licensing of federally owned inventions as set forth in the Bayh-Dole Act and implementing regulations. Competing applications completed and received by NASA no later than August 17, 2023 will also be treated as objections to the grant of the contemplated exclusive, co-exclusive or partially exclusive license. Objections submitted in response to this notice will not be made available to the public for inspection and, to the extent permitted by law, will not be released under the Freedom of Information Act.

Objections and Further Information: Written objections relating to the prospective license or requests for further information may be submitted to Agency Counsel for Intellectual Property, NASA Headquarters at Email: *hq-patentoffice@mail.nasa.gov.* Questions may be directed to Phone: (202) 358–0646.

SUPPLEMENTARY INFORMATION: NASA intends to grant an exclusive, co-exclusive, or partially exclusive patent license in the United States to practice the inventions described and claimed in U.S. Patent No. 11,581,104 for an invention titled ''Multi-layer Structure of Nuclear Thermionic Avalanche Cells'' to Mobile Defense, LLC having its principal place of business in 89 Sandy Bay Drive, Poquoson, VA 23662. The fields of use may be limited. NASA has not yet made a final determination to grant the requested license and may deny the requested license even if no objections are submitted within the comment period.

This notice of intent to grant an exclusive, co-exclusive or partially exclusive patent license is issued in accordance with 35 U.S.C. 209(e) and 37 CFR 404.7(a)(1)(i). The patent rights in these inventions have been assigned to the United States of America as represented by the Administrator of the National Aeronautics and Space Administration. The prospective license will comply with the requirements of 35 U.S.C. 209 and 37 CFR 404.7.

Information about other NASA inventions available for licensing can be found online at *http://technology.nasa.gov.*

Trenton Roche,

Agency Counsel for Intellectual Property.

[FR Doc. 2023–16450 Filed 8–1–23; 8:45 am]

BILLING CODE 7510–13–P

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION

[Notice (23–079)]

Notice of Intent To Grant an Exclusive, Co-Exclusive or Partially Exclusive Patent License

AGENCY: National Aeronautics and Space Administration.

ACTION: Notice of intent to grant exclusive, co-exclusive or partially exclusive patent license.

SUMMARY: NASA hereby gives notice of its intent to grant an exclusive, co-exclusive or partially exclusive patent license to practice the inventions described and claimed in the patents and/or patent applications listed in **SUPPLEMENTARY INFORMATION** below.

DATES: The prospective exclusive, co-exclusive or partially exclusive license may be granted unless NASA receives written objections including evidence and argument, no later than August 17, 2023 that establish that the grant of the license would not be consistent with the requirements regarding the licensing of federally owned inventions as set forth in the Bayh-Dole Act and implementing regulations. Competing applications completed and received by NASA no later than August 17, 2023 will also be treated as objections to the grant of the contemplated exclusive, co-exclusive or partially exclusive license. Objections submitted in response to this notice will not be made available to the public for inspection and, to the extent permitted by law, will not be released under the Freedom of Information Act.

Objections and Further Information: Written objections relating to the prospective license or requests for further information may be submitted to Agency Counsel for Intellectual Property, NASA Headquarters at Email: *hq-patentoffice@mail.nasa.gov.* Questions may be directed to Phone: (202) 358–0646.

SUPPLEMENTARY INFORMATION: NASA intends to grant an exclusive, co-exclusive, or partially exclusive patent license in the United States to practice the inventions described and claimed in: U.S. Patent Application Number 16/906,319 titled ''Additively Manufactured Oxide Dispersion Strengthened Medium Entropy Alloys for High Temperature Applications'' and U.S. Patent Application Number 17/000,466 titled ''Novel Fabrication Technique for Oxide Dispersion Strengthened (ODS) Alloys'' to Praxair Surface Technologies, Inc., having its principal place of business in Indianapolis, Indiana. The fields of use may be limited. NASA has not yet made a final determination to grant the requested license and may deny the requested license even if no objections are submitted within the comment period.

This notice of intent to grant an exclusive, co-exclusive or partially exclusive patent license is issued in accordance with 35 U.S.C. 209(e) and 37 CFR 404.7(a)(1)(i). The patent rights in these inventions have been assigned to the United States of America as represented by the Administrator of the National Aeronautics and Space Administration. The prospective license will comply with the requirements of 35 U.S.C. 209 and 37 CFR 404.7.

Information about other NASA inventions available for licensing can be found online at *http://technology.nasa.gov.*

Trenton Roche,

Agency Counsel for Intellectual Property.

[FR Doc. 2023–16451 Filed 8–1–23; 8:45 am]

BILLING CODE 7510–13–P

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION

[Notice (23–080)]

Notice of Intent To Grant an Exclusive, Co-Exclusive or Partially Exclusive Patent License

AGENCY: National Aeronautics and Space Administration.

ACTION: Notice of intent to grant exclusive, co-exclusive or partially exclusive patent license.

SUMMARY: NASA hereby gives notice of its intent to grant an exclusive, co-exclusive or partially exclusive patent license to practice the inventions described and claimed in the patents and/or patent applications listed in **SUPPLEMENTARY INFORMATION** below.

DATES: The prospective exclusive, co-exclusive or partially exclusive license may be granted unless NASA receives written objections including evidence and argument, no later than August 17, 2023 that establish that the grant of the license would not be consistent with the requirements regarding the licensing of federally owned inventions as set forth in the Bayh-Dole Act and implementing regulations. Competing applications

completed and received by NASA no later than August 17, 2023 will also be treated as objections to the grant of the contemplated exclusive, co-exclusive or partially exclusive license. Objections submitted in response to this notice will not be made available to the public for inspection and, to the extent permitted by law, will not be released under the Freedom of Information Act.

Objections and Further Information: Written objections relating to the prospective license or requests for further information may be submitted to Agency Counsel for Intellectual Property, NASA Headquarters at Email: *hq-patentoffice@mail.nasa.gov.* Questions may be directed to Phone: (202) 358–0646.

SUPPLEMENTARY INFORMATION: NASA intends to grant an exclusive, co-exclusive, or partially exclusive patent license in the United States to practice the inventions described and claimed in: U.S. Patent No. 9,455,374 B2 entitled ''Integrated Multi-Color Light Emitting Device Made with Hybrid Crystal Structure,'' and U.S. Patent No. 9,711,680 B2 entitled ''Integrated Multi-Color Light Emitting Device Made with Hybrid Crystal Structure'' to Global Photonics Solutions LLC having its principal place of business at 166 Valley Street, Building 6M, Providence Rhode Island, 02909. The fields of use may be limited. NASA has not yet made a final determination to grant the requested license and may deny the requested license even if no objections are submitted within the comment period.

This notice of intent to grant an exclusive, co-exclusive or partially exclusive patent license is issued in accordance with 35 U.S.C. 209(e) and 37 CFR 404.7(a)(1)(i). The patent rights in these inventions have been assigned to the United States of America as represented by the Administrator of the National Aeronautics and Space Administration. The prospective license will comply with the requirements of 35 U.S.C. 209 and 37 CFR 404.7.

Information about other NASA inventions available for licensing can be found online at *http://technology.nasa.gov.*

Trenton Roche,

Agency Counsel for Intellectual Property.

[FR Doc. 2023–16453 Filed 8–1–23; 8:45 am]

BILLING CODE 7510–13–P

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION

[Notice (23–080)]

Notice of Intent To Grant an Exclusive, Co-Exclusive or Partially Exclusive Patent License

AGENCY: National Aeronautics and Space Administration.

ACTION: Notice of intent to grant exclusive, co-exclusive or partially exclusive patent license.

SUMMARY: NASA hereby gives notice of its intent to grant an exclusive, co-exclusive or partially exclusive patent license to practice the inventions described and claimed in the patents and/or patent applications listed in **SUPPLEMENTARY INFORMATION** below.

DATES: The prospective exclusive, co-exclusive or partially exclusive license may be granted unless NASA receives written objections including evidence and argument, no later than August 17, 2023 that establish that the grant of the license would not be consistent with the requirements regarding the licensing of federally owned inventions as set forth in the Bayh-Dole Act and implementing regulations. Competing applications completed and received by NASA no later than August 17, 2023 will also be treated as objections to the grant of the contemplated exclusive, co-exclusive or partially exclusive license. Objections submitted in response to this notice will not be made available to the public for inspection and, to the extent permitted by law, will not be released under the Freedom of Information Act.

Objections and Further Information: Written objections relating to the prospective license or requests for further information may be submitted to Agency Counsel for Intellectual Property, NASA Headquarters at Email: *hq-patentoffice@mail.nasa.gov.* Questions may be directed to Phone: (202) 358–0646.

SUPPLEMENTARY INFORMATION: NASA intends to grant an exclusive, co-exclusive, or partially exclusive patent license in the United States to practice the inventions described and claimed in U.S. Patent No. 11,581,104 for an invention titled ''Multi-layer Structure of Nuclear Thermionic Avalanche Cells'' to Tamer Space, LLC having its principal place of business in 89 Sandy Bay Drive, Poquoson, VA 23662. The fields of use may be limited. NASA has not yet made a final determination to grant the requested license and may deny the requested license even if no objections are submitted within the comment period.

This notice of intent to grant an exclusive, co-exclusive or partially exclusive patent license is issued in accordance with 35 U.S.C. 209(e) and 37 CFR 404.7(a)(1)(i). The patent rights in these inventions have been assigned to the United States of America as represented by the Administrator of the National Aeronautics and Space Administration. The prospective license will comply with the requirements of 35 U.S.C. 209 and 37 CFR 404.7.

Information about other NASA inventions available for licensing can be found online at *http://technology.nasa.gov.*

Trenton Roche,

Agency Counsel for Intellectual Property.

[FR Doc. 2023–16452 Filed 8–1–23; 8:45 am]

BILLING CODE 7510–13–P

NATIONAL SCIENCE FOUNDATION

Agency Information Collection Activities: Comment Request; Survey of Graduate Students and Postdoctorates in Science and Engineering

AGENCY: National Science Foundation.

ACTION: Submission for OMB Review; comment request.

SUMMARY: The National Science Foundation (NSF) has submitted the following request for revision of the approved collection of research and development data in accordance with the Paperwork Reduction Act of 1995. This is the second notice for public comment; the first was published in the **Federal Register** and no comments were received. NSF is forwarding the proposed renewal submission to the Office of Management and Budget (OMB) for clearance simultaneously with the publication of this second notice.

DATES: Written comments and recommendations for the proposed information collection should be sent within 30 days of publication of this notice to *www.reginfo.gov/public/do/PRAmain.* Find this particular information collection by selecting ''Currently under 30-day Review—Open for Public Comments'' or by using the search function.

FOR FURTHER INFORMATION CONTACT: Suzanne H. Plimpton, Reports Clearance Officer, National Science Foundation, 2415 Eisenhower Avenue, Alexandria, VA 22314; or send email to *splimpto@nsf.gov.* Individuals who use a telecommunications device for the deaf (TDD) may call the Federal Information Relay Service (FIRS) at 1–800–877–

8339, which is accessible 24 hours a day, 7 days a week, 365 days a year (including federal holidays).

SUPPLEMENTARY INFORMATION: NSF may not conduct or sponsor a collection of information unless the collection of information displays a currently valid OMB control number and the agency informs potential persons who are to respond to the collection of information that such persons are not required to respond to the collection of information unless it displays a currently valid OMB control number.

Title of Collection: Survey of Graduate Students and Postdoctorates in Science and Engineering.

OMB Control Number: 3145–0062.

Expiration Date of Current Approval: August 31, 2023.

Type of Request: Intent to seek approval to extend an information collection for three years.

The Survey of Graduate Students and Postdoctorates in Science and Engineering (GSS), sponsored by the NCSES within NSF and the National Institutes of Health, is designed to comply with legislative mandates by providing information on the characteristics of academic graduate enrollments in science, engineering, and health fields. This request to extend the information collection for three years is to cover the 2023, 2024, and 2025 GSS survey cycles. The information collected by the GSS is solicited under the authority of the National Science Foundation Act of 1950, as amended and the America COMPETES Reauthorization Act of 2010. Data collection starts each fall in October and data are obtained primarily through a Web survey. Data are disseminated annually. All information will be used for statistical purposes only. Participation in the survey is voluntary.

To improve coverage of postdocs, the GSS periodically collects information on postdocs employed in Federally Funded Research and Development Centers (FFRDCs). This survey of postdocs at FFRDCs will be conducted as part of the 2023 and 2025 GSS survey cycles.

Additional details regarding this survey are provided in an earlier **Federal Register** Notice, at 88 FR 10386.

Use of the Information: The GSS data are routinely provided to Congress, other parts of NSF, other Federal agencies, the GSS institutions themselves, and several professional societies. In addition, the National Institutes of Health (NIH) publish GSS data annually in the NIH Data Book *https://report.nih.gov/nihdatabook/*.

Expected Respondents: The GSS is an annual census of all eligible academic institutions in the U.S. with graduate programs in science, engineering, and health fields. The response rate is calculated based on the number of reporting units (departments, programs, research centers, and health care facilities) that respond to the survey. For reference, in 2021, the GSS population was 21,365 units reported from 787 schools at 699 academic institutions. Based on recent cycles NCSES expects the annual response rate to be around 96 percent.

Estimate of Burden: The total estimated respondent burden of the GSS, including 2,000 hours for potential methodological studies to improve the survey procedures, will be 60,367 hours over the three-cycle survey clearance period. NCSES may review and revise this burden estimate based on completion time data collected during the 2022 GSS survey cycle, which is ongoing.

TABLE 1—GSS ESTIMATED RESPONSE BURDEN

Category	Respondents (number of school coordinators)	Total burden (hours)
Total burden for 2023:	919	19,442
GSS institutions	876	19,352
FFRDCs	43	90
Total burden for 2024	881	19,396
Total burden for 2025:	929	19,529
GSS institutions	886	19,439
FFRDCs	43	90
Potential future methodological studies (across all 3 survey cycles)	.....	2,000
Total estimated burden	2,729	60,367
Estimated average annual burden	910	20,123

Comments: As required by 5 CFR 1320.8(d), comments on the information collection activities as part of this study were solicited through publication of a 60-Day Notice in the **Federal Register** on February 17, 2023, at 88 FR 10386. NCSES received no comments.

Dated: July 27, 2023.

Suzanne H. Plimpton,

Reports Clearance Officer, National Science Foundation.

[FR Doc. 2023–16401 Filed 8–1–23; 8:45 am]

BILLING CODE 7555–01–P

NEIGHBORHOOD REINVESTMENT CORPORATION

Sunshine Act Meetings; Special Audit Committee Meeting

TIME AND DATE: 11:00 a.m., Thursday, August 3, 2023.

PLACE: Via ZOOM.

STATUS: Parts of this meeting will be open to the public. The rest of the meeting will be closed to the public.

MATTERS TO BE CONSIDERED: Audit Committee Meeting.

The General Counsel of the Corporation has certified that in his opinion, one or more of the exemptions set forth in the Government in the Sunshine Act, 5 U.S.C. 552b (c)(2) and (4) permit closure of the following portion(s) of this meeting:

- Executive Session

Agenda

I. Call to Order

II. Approval Government in Sunshine Act Notice to Waiver for a Meeting of the Audit Committee of the Board of Directors

III. Sunshine Act Approval of Executive (Closed) Session; Executive (Closed) Session

IV. External Auditor Discussion/Review

V. Discussion with Chief Audit Executive
VI. Adjournment

CONTACT PERSON FOR MORE INFORMATION: Lakeyia Thompson, Special Assistant, (202) 524–9940; *lthompson@nw.org.*

Lakeyia Thompson,

Special Assistant.

[FR Doc. 2023–16616 Filed 7–31–23; 4:15 pm]

BILLING CODE 7570–02–P

NUCLEAR REGULATORY COMMISSION

[NRC–2023–0079]

Proposed Revision to Standard Review Plan Section 15.0, ''Introduction—Transient and Accident Analyses''

AGENCY: Nuclear Regulatory Commission.

ACTION: Standard review plan-draft section revision; request for comment.

SUMMARY: The U.S. Nuclear Regulatory Commission (NRC) is soliciting public comment on draft NUREG–0800, ''Standard Review Plan for the Review of Safety Analysis Reports for Nuclear Power Plants: LWR Edition,'' Section 15.0, Revision 4, ''Introduction—Transient and Accident Analyses.'' The NRC seeks comments on the proposed draft section revision of the Standard Review Plan (SRP), concerning the evaluation of the safety of a nuclear power plant that requires analyses of the plant's responses to postulated equipment failures or malfunctions. Such analyses help to determine the limiting conditions for operation, limiting safety system settings, and design specifications for components and systems to protect public health and safety.

DATES: Submit comments by October 2, 2023. Comments received after this date will be considered, if it is practical to do so, but the Commission is able to ensure consideration only for comments received on or before this date.

ADDRESSES: You may submit comments by any of the following methods; however, the NRC encourages electronic comment submission through the Federal rulemaking website:

- *Federal rulemaking website:* Go to *https://www.regulations.gov* and search for Docket ID NRC–2023–0079. Address questions about Docket IDs in *Regulations.gov* to Stacy Schumann; telephone: 301–415–0624; email: *Stacy.Schumann@nrc.gov.* For technical questions, contact the individuals listed in the ''For Further Information Contact'' section of this document.
- *Mail comments to:* Office of Administration, Mail Stop: TWFN–7–A60M, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001, ATTN: Program Management, Announcements and Editing Staff.

For additional direction on obtaining information and submitting comments, see ''Obtaining Information and Submitting Comments'' in the **SUPPLEMENTARY INFORMATION** section of this document.

FOR FURTHER INFORMATION CONTACT: Ekaterina Lenning, Office of Nuclear Reactor Regulation, telephone: 301–415–3151, email: *Ekaterina.Lenning@nrc.gov* and Brent Ballard, Office of Nuclear Reactor Regulation, telephone: 301–415–0680, email: *Brent.Ballard@nrc.gov.* Both are staff of the U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001.

SUPPLEMENTARY INFORMATION:

I. Obtaining Information and Submitting Comments

A. Obtaining Information

Please refer to Docket ID NRC–2023–0079 when contacting the NRC about the availability of information for this action. You may obtain publicly available information related to this action by any of the following methods:

- *Federal Rulemaking Website:* Go to *https://www.regulations.gov* and search for Docket ID NRC–2023–0079.
- *NRC's Agencywide Documents Access and Management System (ADAMS):* You may obtain publicly available documents online in the ADAMS Public Documents collection at *https://www.nrc.gov/reading-rm/adams.html.* To begin the search, select ''Begin Web-based ADAMS Search.'' For problems with ADAMS, please contact the NRC's Public Document Room (PDR) reference staff at 1–800–397–4209, at 301–415–4737, or by email to *PDR.Resource@nrc.gov.* The draft SRP Section 15.0, Revision 4, ''Introduction—Transient and Accident Analyses'' is available in ADAMS under Accession No. ML22319A149.
- *NRC's PDR:* You may examine and purchase copies of public documents, by appointment, at the NRC's PDR, Room P1 B35, One White Flint North, 11555 Rockville Pike, Rockville, Maryland 20852. To make an appointment to visit the PDR, please send an email to *PDR.Resource@nrc.gov* or call 1–800–397–4209 or 301–415–4737, between 8 a.m. and 4 p.m. eastern time (ET), Monday through Friday, except Federal holidays.

B. Submitting Comments

The NRC encourages electronic comment submission through the Federal rulemaking website (*https://www.regulations.gov*). Please include Docket ID NRC–2023–0079 in your comment submission.

The NRC cautions you not to include identifying or contact information that you do not want to be publicly disclosed in your comment submission. The NRC will post all comment submissions at *https://www.regulations.gov* as well as enter the comment submissions into ADAMS. The NRC does not routinely edit comment submissions to remove identifying or contact information.

If you are requesting or aggregating comments from other persons for submission to the NRC, then you should inform those persons not to include identifying or contact information that they do not want to be publicly disclosed in their comment submission. Your request should state that the NRC does not routinely edit comment submissions to remove such information before making the comment submissions available to the public or entering the comment into ADAMS.

II. Discussion

The NRC seeks public comment on the proposed draft section revision of SRP Section 15.0, ''Introduction—Transient and Accident Analyses.'' This section has been developed to assist the NRC staff in the evaluation of the safety of a nuclear power plant that requires analyses of the plant's responses to postulated equipment failures or malfunctions. The effects of anticipated process disturbances and postulated component failures are examined to determine their consequences and to evaluate the capability built into the plant to control or accommodate such failures and situations. Additionally, such analyses help determine the limiting conditions for operation, limiting safety system settings, and design specifications for components and systems to protect public health and safety under parts 50 and 52 of title 10 of the *Code of Federal Regulations* (10 CFR).

Following the NRC staff evaluation of public comments, the NRC intends to finalize SRP Section 15.0, Revision 4, ''Introduction—Transient and Accident Analyses Review,'' in ADAMS and post it on the NRC's public website at *https://www.nrc.gov/reading-rm/doc-collections/nuregs/staff/sr0800.* The SRP is guidance for the NRC staff. The SRP is not a substitute for the NRC

regulations, and compliance with the SRP is not required.

III. Backfitting, Issue Finality, and Forward Fitting

The guidance in this draft SRP is updated to ensure alignment of the acceptance criteria with the regulations and provide staff guidance related to the Commission's policies for new passive light-water power reactors. Issuance of this draft SRP, if finalized, would not constitute backfitting as defined in 10 CFR 50.109 (the Backfit Rule) and as described in NRC Management Directive 8.4, ''Management of Backfitting, Forward Fitting, Issue Finality, and Information Requests''; would not affect the issue finality of an approval under 10 CFR part 52; and would not constitute forward fitting as that term is defined and described in MD 8.4. The staff's position is based upon the following considerations:

1. The draft SRP positions, if finalized, would not constitute backfitting or forward fitting or affect issue finality, inasmuch as the SRP would be internal guidance to the NRC staff.

The SRP provides guidance to the NRC staff on how to review an application for NRC regulatory approval in the form of licensing. Changes in internal staff guidance, without further NRC action, are not matters that meet the definition of backfitting or forward fitting or affect the issue finality of a 10 CFR part 52 approval.

2. Current or future applicants are not—with limited exceptions not applicable here—within the scope of the backfitting and issue finality regulations and forward fitting policy.

Applicants are not, with certain exceptions, within the scope of the Backfit Rule or any issue finality provisions under 10 CFR part 52. The backfitting and issue finality regulations include language delineating when those provisions begin; in general, they begin after the issuance of a license, permit, or other approval. Furthermore, neither the Backfit Rule nor the issue finality provisions under 10 CFR part 52—with certain exclusions discussed in this notice—were intended to apply to NRC actions that substantially change the expectations of current and future applicants.

The exceptions to the general principle are applicable when an applicant references a 10 CFR part 52 license (*e.g.,* an early site permit) and/or NRC regulatory approval (*e.g.,* a design certification rule) with specified issue finality provisions or a construction permit under 10 CFR part 50. The NRC staff does not, at this time, intend to impose the positions represented in the draft SRP (if finalized) in a manner that would constitute backfitting or affect the issue finality of a 10 CFR part 52 approval. If, in the future, the staff seeks to impose a position in the draft SRP (if finalized) in a manner that constitutes backfitting or affects the issue finality of a 10 CFR part 52 approval, then the staff would need to address the Backfit Rule or the criteria described in the applicable issue finality provision.

The Commission's forward fitting policy generally does not apply when an applicant files an initial licensing action for a new facility. Nevertheless, the NRC staff does not, at this time, intend to impose the positions represented in the draft SRP (if finalized) in a manner that would constitute forward fitting. If, in the future, the staff seeks to impose a position in the draft SRP (if finalized) in a manner that constitutes forward fitting, then the staff would need to address the forward fitting criteria in MD 8.4.

Dated: July 27, 2023.

For the Nuclear Regulatory Commission.

Gerond A. George,

Chief, Licensing Project Branch, Division of Operating Reactors, Office of Nuclear Reactor Regulation.

[FR Doc. 2023–16398 Filed 8–1–23; 8:45 am]

BILLING CODE 7590–01–P

NUCLEAR REGULATORY COMMISSION

[Docket No. 52–026; NRC–2008–0252]

Southern Nuclear Operating Company, Inc.; Vogtle Electric Generating Plant, Unit 4; Operation Under a Combined License

AGENCY: Nuclear Regulatory Commission.

ACTION: Finding that the acceptance criteria in the combined license are met.

SUMMARY: The U.S. Nuclear Regulatory Commission (NRC) found pursuant to its regulations that the acceptance criteria in the combined license for Vogtle Electric Generating Plant (VEGP), Unit 4 are met. Because of this action, operation of the facility is allowed in accordance with the terms and conditions of the license.

DATES: The finding that the acceptance criteria in the combined license are met became effective on July 28, 2023.

ADDRESSES: Please refer to Docket ID NRC–2008–0252 when contacting the NRC about the availability of information regarding this document. You may obtain publicly available information related to this document using any of the following methods:

- *Federal Rulemaking website:* Go to *https://www.regulations.gov* and search for Docket ID NRC–2008–0252. Address questions about Docket IDs in *Regulations.gov* to Stacy Schumann; telephone: 301–415–0624; email: *Stacy.Schumann@nrc.gov*. For technical questions, contact the individual listed in the ''For Further Information Contact'' section of this document.
- *NRC's Agencywide Documents Access and Management System (ADAMS):* You may obtain publicly available documents online in the ADAMS Public Documents collection at *https://www.nrc.gov/reading-rm/adams.html*. To begin the search, select ''Begin Web-based ADAMS Search.'' For problems with ADAMS, please contact the NRC's Public Document Room (PDR) reference staff at 1–800–397–4209, at 301–415–4737, or by email to *PDR.Resource@nrc.gov*. For the convenience of the reader, instructions about obtaining materials referenced in this document are provided in the ''Availability of Documents'' section.
- *NRC's PDR:* The PDR, where you may examine and order copies of publicly available documents, is open by appointment. To make an appointment to visit the PDR, please send an email to *PDR.Resource@nrc.gov* or call 1–800–397–4209 or 301–415–4737, between 8 a.m. and 4 p.m. ET, Monday through Friday, except Federal holidays.

FOR FURTHER INFORMATION CONTACT: Cayetano Santos, Office of Nuclear Reactor Regulation, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001; telephone: 301–415–7270; email: *Cayetano.Santos@nrc.gov*.

SUPPLEMENTARY INFORMATION: Under section 2.106 of title 10 of the *Code of Federal Regulations* (10 CFR), ''Notice of issuance,'' the NRC is providing notice that it has found that the acceptance criteria in the combined license for VEGP, Unit 4 are met. Section 185b. (42 U.S.C. 2235(b)) of the Atomic Energy Act of 1954, as amended (AEA), and 10 CFR 52.97(b) require that the Commission identify within the combined license the inspections, tests, and analyses, including those applicable to emergency planning, that the licensee shall perform, and the acceptance criteria that, if met, are necessary and sufficient to provide reasonable assurance that the facility has been constructed and will be operated in conformity with the license, the provisions of the AEA, and the Commission's rules and regulations. In compliance with these requirements,

the Commission included inspections, tests, analyses, and acceptance criteria (ITAAC) in Appendix C to VEGP, Unit 4 combined license No. NPF–92.

Section 185b. of the AEA also requires, in part, that following issuance of the combined license, the Commission shall ensure that the prescribed inspections, tests, and analyses are performed, and before operation of the facility, find that the prescribed acceptance criteria are met. The NRC codified the requirement to ensure completion of the inspections, tests, and analyses in 10 CFR 52.99(e) and codified the requirement regarding the finding that the acceptance criteria are met in 10 CFR 52.103(g).

The NRC staff has determined that the inspections, tests, and analyses have been successfully completed and found that all specified acceptance criteria in the VEGP, Unit 4 combined license No. NPF–92 are met. This finding was made on July 28, 2023, and was effective on July 28, 2023. The principal basis for the staff's 10 CFR 52.103(g) finding was the staff's review of the licensee's ITAAC notifications under 10 CFR 52.99(c) and the staff's inspection of ITAAC-related activities conducted by the licensee. The staff explained the basis for its finding in the document titled ''10 CFR 52.103(g) Basis Document Vogtle Electric Generating Plant, Unit 4.'' Because of the NRC's finding that the acceptance criteria are met, operation of the facility is allowed in accordance with the terms and conditions of the license.

I. Availability of Documents

The documents identified in the following table are available to interested persons through the ADAMS Public Documents collection and the NRC's PDR. The files are also available online at *https://www.nrc.gov/reactors/new-reactors/col-holder/vog4.html*.

Document description	ADAMS accession No.
VEGP, Unit 4 Combined License No. NPF–92.	ML14100A135
VEGP, Unit 4 Finding that the Acceptance Criteria in the Combined License Are Met.	ML22348A093
10 CFR 52.103(g) Basis Document Vogtle Electric Generating Plant, Unit 4.	ML22348A088

Dated: July 28, 2023.

For the Nuclear Regulatory Commission.

Andrea D. Veil,

Director, Office of Nuclear Reactor Regulation.

[FR Doc. 2023–16408 Filed 8–1–23; 8:45 am]

BILLING CODE 7590–01–P

POSTAL REGULATORY COMMISSION

[Docket Nos. MC2023–201 and CP2023–205]

New Postal Products

AGENCY: Postal Regulatory Commission.

ACTION: Notice.

SUMMARY: The Commission is noticing a recent Postal Service filing for the Commission's consideration concerning a negotiated service agreement. This notice informs the public of the filing, invites public comment, and takes other administrative steps.

DATES: *Comments are due:* August 4, 2023.

ADDRESSES: Submit comments electronically via the Commission's Filing Online system at *http://www.prc.gov*. Those who cannot submit comments electronically should contact the person identified in the **FOR FURTHER INFORMATION CONTACT** section by telephone for advice on filing alternatives.

FOR FURTHER INFORMATION CONTACT: David A. Trissell, General Counsel, at 202–789–6820.

SUPPLEMENTARY INFORMATION:

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I. Introduction
II. Docketed Proceeding(s)

I. Introduction

The Commission gives notice that the Postal Service filed request(s) for the Commission to consider matters related to negotiated service agreement(s). The request(s) may propose the addition or removal of a negotiated service agreement from the Market Dominant or the Competitive product list, or the modification of an existing product currently appearing on the Market Dominant or the Competitive product list.

Section II identifies the docket number(s) associated with each Postal Service request, the title of each Postal Service request, the request's acceptance date, and the authority cited by the Postal Service for each request. For each request, the Commission appoints an officer of the Commission to represent the interests of the general public in the proceeding, pursuant to 39 U.S.C. 505 (Public Representative). Section II also establishes comment deadline(s) pertaining to each request.

The public portions of the Postal Service's request(s) can be accessed via the Commission's website (*http://www.prc.gov*). Non-public portions of the Postal Service's request(s), if any, can be accessed through compliance with the requirements of 39 CFR 3011.301.[1]

The Commission invites comments on whether the Postal Service's request(s) in the captioned docket(s) are consistent with the policies of title 39. For request(s) that the Postal Service states concern Market Dominant product(s), applicable statutory and regulatory requirements include 39 U.S.C. 3622, 39 U.S.C. 3642, 39 CFR part 3030, and 39 CFR part 3040, subpart B. For request(s) that the Postal Service states concern Competitive product(s), applicable statutory and regulatory requirements include 39 U.S.C. 3632, 39 U.S.C. 3633, 39 U.S.C. 3642, 39 CFR part 3035, and 39 CFR part 3040, subpart B. Comment deadline(s) for each request appear in section II.

II. Docketed Proceeding(s)

1. *Docket No(s).:* MC2023–201 and CP2023–205; *Filing Title:* USPS Request to Add Priority Mail & USPS Ground Advantage Contract 9 to Competitive Product List and Notice of Filing Materials Under Seal; *Filing Acceptance Date:* July 27, 2023; *Filing Authority:* 39 U.S.C. 3642, 39 CFR 3040.130 through 3040.135, and 39 CFR 3035.105; *Public Representative:* Gregory S. Stanton; *Comments Due:* August 4, 2023.

This Notice will be published in the **Federal Register**.

Erica A. Barker,

Secretary.

[FR Doc. 2023–16437 Filed 8–1–23; 8:45 am]

BILLING CODE 7710–FW–P

[1] *See* Docket No. RM2018–3, Order Adopting Final Rules Relating to Non-Public Information, June 27, 2018, Attachment A at 19–22 (Order No. 4679).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–98008; File No. SR–CBOE–2023–020]

Self-Regulatory Organizations; Cboe Exchange, Inc.; Order Instituting Proceedings To Determine Whether To Approve or Disapprove Proposed Rule Change To Make the Nonstandard Expirations Pilot Program Permanent

July 27, 2023.

I. Introduction

On April 11, 2023, Cboe Exchange, Inc. (''Exchange'' or ''Cboe Options'') filed with the Securities and Exchange Commission (''Commission''), pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 (''Act'') [1] and Rule 19b–4 thereunder,[2] a proposed rule change to make permanent the operation of its pilot program (''Program'') that permits the Exchange to list broad-based index options with nonstandard expirations. The proposed rule change was published for comment in the **Federal Register** on May 1, 2023.[3] On June 9, 2023, pursuant to Section 19(b)(2) of the Act,[4] the Commission designated a longer period within which to approve the proposed rule change, disapprove the proposed rule change, or institute proceedings to determine whether to disapprove the proposed rule change.[5] The Commission did not receive any comment letters on the proposed rule change. The Commission is instituting proceedings pursuant to Section 19(b)(2)(B) of the Act [6] to determine whether to approve or disapprove the proposed rule change.

II. Description of the Proposed Rule Change

The Exchange proposes to make permanent a pilot program that permits the Exchange to list p.m.-settled options on broad-based indexes that expire (1) on the last day of the trading month (''EOM''), and (2) any Monday, Wednesday, or Friday (other than the third Friday-of-the-month or days that coincide with an EOM expiration) and, with respect to S&P 500 index options (''SPX'') and mini-S&P 500 index options (''XSP''), on any Tuesday or Thursday (other than days that coincide with an EOM expiration) (''Weekly'').

In September 2010, the Commission approved a rule change that established the Program under which the Exchange was permitted to list p.m-settled options on broad-based indexes to expire on any Friday of the month, other than the third Friday-of-the-month, and the last trading day of the month.[7] The Commission subsequently approved proposed rule changes to amend the Program to allow the Exchange to also list: (1) p.m.-settled Monday [8] and Wednesday [9] expirations on broad-based indexes, and (2) p.m.-settled Tuesday and Thursday expirations on SPX [10] and XSP.[11] In approving the Program, the Commission noted its concern about the potential impact on the market at expiration for the underlying component stocks for a p.m.-settled, cash-settled index options.[12] However, the Commission has also recognized the potential impact was unclear.[13] The Commission approved the Program on a pilot basis to allow the Exchange and the Commission to monitor for and assess any potential for adverse market effects.[14] In order to facilitate this assessment, the Exchange committed to provide the Commission with data and analysis in connection with the Program.[15] The Exchange has filed to extend the operation of the Program on multiple occasions [16] and it is currently set to expire on the earlier of November 6, 2023, or the date on which the Program is approved on a permanent basis.[17]

Since the Program's inception in 2010, the Exchange has submitted reports to the Commission regarding the Program that detail the Exchange's experience with the Program, pursuant to the various approval orders.[18] Specifically, the Exchange states it has submitted annual pilot reports to the Commission that contain an analysis of volume, open interest, and trading patterns.[19] Additionally, for series that exceed certain minimum open interest parameters, the annual reports provide analysis of index price volatility and, if needed, share trading activity. The Exchange states it has also submitted periodic interim reports that contain some, but not all, of the information contained in the annual reports (together with the annual reports, the ''pilot reports'').[20] The Exchange states that, during the course of the Program, it has provided the Commission with any additional data or analyses the Commission requested if it deemed such data or analyses necessary to determine whether the Program was consistent with the Exchange Act.[21] The Exchange states it has made public on its website data and analyses previously submitted to the Commission under the Program, and will continue to make public any data and analyses it submits to the Commission while the Program is still in effect.[22]

As set forth more fully in the Notice, the Exchange concludes that the Program does not negatively impact market quality or raise any unique or prohibitive regulatory concerns.[23] The Exchange states it has not identified any evidence from the pilot data indicating that the trading of Weekly and EOM options has any adverse impact on fair and orderly markets on the third Friday-of-the-month for the underlying indexes or the underlying securities comprising the underlying indexes, nor have there been any observations of abnormal market movements attributable to Weekly and EOM options from any market participants that have come to

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] *See* Securities Exchange Act Release No. 97371 (April 25, 2023), 88 FR 26621 (''Notice'').

[4] 15 U.S.C. 78s(b)(2).

[5] *See* Securities Exchange Act Release No. 97679, 88 FR 3931 (June 15, 2023). The Commission designated July 30, 2023, as the date by which the Commission shall approve or disapprove, or institute proceedings to determine whether to approve or disapprove, the proposed rule change.

[6] 15 U.S.C. 78s(b)(2)(B).

[7] *See* Securities Exchange Act Release No. 62911 (September 14, 2010), 75 FR 57539 (September 21, 2010) (SR–CBOE–2009–075) (''Nonstandards Approval Order'').

[8] *See* Securities Exchange Act Release No. 78531 (August 10, 2016), 81 FR 54643 (August 16, 2016) (SR–CBOE–2016–046).

[9] *See* Securities Exchange Act Release No. 76909 (January 14, 2016), 81 FR 3512 (January 21, 2016) (SR–CBOE–2015–106).

[10] *See* Securities Exchange Act Release No. 94682 (April 12, 2022), 87 FR 22993 (SR–CBOE–2022–005).

[11] *See* Securities Exchange Act Release No. 95795 (September 21, 2022) (order approving SR–CBOE–2022–039).

[12] *See* Nonstandards Approval Order, 75 FR at 57540. *See also* Securities Exchange Act Release Nos. 64599 (June 3, 2011), 76 FR 33798, 33801–02 (June 9, 2011) (order instituting proceedings to determine whether to approve or disapprove a proposed rule change to allow the listing and trading of SPXPM options); 65256 (September 2, 2011), 76 FR 55969, 55970–76 (September 9, 2011) (order approving proposed rule change to establish a pilot program to list and trade SPXPM options); *and* 68888 (February 8, 2013), 78 FR 10668, 10669 (February 14, 2013) (order approving the listing and trading of SPXPM on CBOE) (''SPXPM Approval Order'').

[13] *See e.g.,* SPXPM Approval Order, 78 FR at 10669.

[14] *See e.g.,* Nonstandards Approval Order, 75 FR at 57549; *and* Securities Exchange Act Release No. 94682 (April 12, 2022), 87 FR 22993 at 22995 (SR–CBOE–2022–005).

[15] *Id.*

[16] *See, e.g.,* Securities Exchange Act Release Nos. 65741 (November 14, 2011), 76 FR 72016 (November 21, 2011); *and* 96223 (November 3, 2022), 87 FR 67728 (November 9, 2022).

[17] *See* Securities Exchange Act Release No. 97445 (May 5, 2023), 88 FR 30368(May 11, 2023).

[18] *See supra* notes 7–11.

[19] *See* Notice, 88 FR at 26623.

[20] *See id.*

[21] *See* Notice, 88 FR at 26624.

[22] *See id.* Available at *https://www.cboe.com/aboutcboe/legal-regulatory/national-market-system-plans/pm-settlement-spxpm-data.*

[23] *See* Notice, 88 FR at 26624.

the attention of the Exchange.[24] In order to support its overall assessment of the Program, the Exchange includes both an assessment of an analysis conducted at the direction of the staff of the Commission's Division of Economic and Risk Analysis and the Exchange's review and analysis of pilot data.[25] Among other things, the Notice includes the Exchange's analysis of end of day volatility as well as a comparison of the impact of quarterly index rebalancing versus p.m.-settled expirations.[26]

The Exchange also completed an analysis intended to evaluate whether the Program impacted the quality of the a.m.-settled options market.[27] Specifically, the Exchange compared values of key market quality indicators (specifically, the bid-ask spread [28] and effective spread [29]) in p.m.-settled SPX options (''SPXW'') both before and after the introduction of Tuesday expirations and Thursday expirations for SPXW options on April 18 and May 11, 2022, respectively.[30] The Exchange believes analyzing the impact of new SPXW options on then-existing SPXW options provides a reasonable substitute to evaluate whether the introduction of Weekly and EOM options impacted the market quality of any corresponding a.m.-settled options when the Program began.[31]

Finally, the Exchange states that the significant changes in the closing procedures of the primary markets in recent decades, including considerable advances in trading systems and technology, have significantly minimized risks of any potential impact of Weekly or EOM options on the underlying cash markets.[32]

III. Proceedings To Determine Whether To Approve or Disapprove SR–CBOE–2023–020, and Grounds for Disapproval Under Consideration

The Commission is instituting proceedings pursuant to Section 19(b)(2)(B) of the Act [33] to determine whether the proposed rule change should be approved or disapproved. Institution of such proceedings is appropriate at this time in view of the legal and policy issues raised by the proposed rule change. Institution of proceedings does not indicate that the Commission has reached any conclusions with respect to any of the issues involved. Rather, as described below, the Commission seeks and encourages interested persons to provide additional comment on the proposed rule change to inform the Commission's analysis of whether to approve or disapprove the proposed rule change.

Pursuant to Section 19(b)(2)(B) of the Act,[34] the Commission is providing notice of the grounds for disapproval under consideration. As described above, the Exchange has proposed to make permanent a pilot program that permits the listing and trading of p.m.-settled Weekly and EOM expirations. The Commission is instituting proceedings to allow for additional analysis of, and input from commenters with respect to, the proposed rule change's consistency with the Act, and in particular, Section 6(b)(5) of the Act, which requires, among other things, that the rules of a national securities exchange be designed to prevent fraudulent and manipulative acts and practices, to promote just and equitable principles of trade, to remove impediments to and perfect the mechanism of a free and open market and a national market system, and, in general, to protect investors and the public interest.[35]

IV. Procedure: Request for Written Comments

The Commission requests that interested persons provide written submissions of their data, views, and arguments with respect to the issues identified above, as well as any other concerns they may have with the proposal. In particular, the Commission invites the written views of interested persons concerning whether the proposed rule change, is consistent with Sections 6(b)(5) or any other provision of the Act, or the rules and regulations thereunder. Although there do not appear to be any issues relevant to approval or disapproval that would be facilitated by an oral presentation of data, views, and arguments, the Commission will consider, pursuant to Rule 19b–4 under the Act,[36] any request for an opportunity to make an oral presentation.[37]

Interested persons are invited to submit written data, views, and arguments regarding whether the proposed rule change should be approved or disapproved by August 23, 2023. Any person who wishes to file a rebuttal to any other person's submission must file that rebuttal by September 6, 2023. The Commission asks that commenters address the sufficiency of the Exchange's statements in support of the proposal, in addition to any other comments they may wish to submit about the proposed rule change.

Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's internet comment form (*https://www.sec.gov/rules/sro.shtml*); or
- Send an email to *rule-comments@sec.gov*. Please include file number SR–CBOE–2023–020 on the subject line.

Paper Comments

- Send paper comments in triplicate to Secretary, Securities and Exchange Commission, 100 F Street NE, Washington, DC 20549–1090.

All submissions should refer to file number SR–CBOE–2023–020. This file number should be included on the subject line if email is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's internet website (*https://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule

[24] *See id.*

[25] *See* Notice, 88 FR at 26624–26.

[26] *See* Notice, 88 FR at 26625–26. The Exchange states that although this analysis specifically evaluated SPX options, the Exchange believes it is appropriate to extrapolate the data to apply to the Weekly and EOM options (which include SPX options) because Weekly and EOM options may only overly broad-based index options. *See* Notice, 88 FR at 26627.

[27] *See* Notice, 88 FR at 26364.

[28] The Exchange calculated for each of SPXW options (with Monday, Wednesday, and Friday expirations) and weekly options on the Standard & Poor's Depositary Receipts S&P 500 ETF (''SPY'') (with Monday, Wednesday, and Friday expirations) the daily time-weighted bid-ask spread on the Exchange during its regular trading hours session, adjusted for the difference in size between SPXW options and SPY options (SPXW options are approximately ten times the value of SPY options).

[29] The Exchange calculated the volume-weighted average daily effective spread for simple trades for each of SPXW options (with Monday, Wednesday, and Friday expirations) and SPY weekly options (with Monday, Wednesday, and Friday expirations) as twice the amount of the absolute value of the difference between an order execution price and the midpoint of the national best bid and offer at the time of execution, adjusted for the difference in size between SPXW options and SPY options.

[30] For purposes of comparison, the Exchange paired SPXW options and SPY options with the same moneyness and same days to expiration.

[31] *See* Notice, 88 FR at 26626.

[32] *See* Notice, 88 FR at 26628.

[33] 15 U.S.C. 78s(b)(2)(B).

[34] *Id.*

[35] 15 U.S.C. 78f(b)(5).

[36] 17 CFR 240.19b–4.

[37] Section 19(b)(2) of the Act, as amended by the Securities Acts Amendments of 1975, Public Law 94–29 (Jun. 4, 1975), grants to the Commission flexibility to determine what type of proceeding—either oral or notice and opportunity for written comments—is appropriate for consideration of a particular proposal by a self-regulatory organization. *See* Securities Acts Amendments of 1975, Senate Comm. on Banking, Housing & Urban Affairs, S. Rep. No. 75, 94th Cong., 1st Sess. 30 (1975).

change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for website viewing and printing in the Commission's Public Reference Room, 100 F Street NE, Washington, DC 20549, on official business days between the hours of 10 a.m. and 3 p.m. Copies of the filing also will be available for inspection and copying at the principal office of the Exchange. Do not include personal identifiable information in submissions; you should submit only information that you wish to make available publicly. We may redact in part or withhold entirely from publication submitted material that is obscene or subject to copyright protection. All submissions should refer to file number SR–CBOE–2023–020 and should be submitted by August 23, 2023. Rebuttal comments should be submitted by September 6, 2023.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[38]

Sherry R. Haywood,

Assistant Secretary.

[FR Doc. 2023–16388 Filed 8–1–23; 8:45 am]

BILLING CODE 8011–01–P

SECURITIES AND EXCHANGE COMMISSION

[Investment Company Act Release No. 34966; File No. 812–15423]

Alpha Alternative Assets Fund and Alpha Growth Management LLC

July 27, 2023.

AGENCY: Securities and Exchange Commission (''Commission'' or ''SEC'').

ACTION: Notice.

Notice of an application for an order pursuant to section 6(c) of the Investment Company Act of 1940 (the ''Act'') for an exemption from sections 18(a)(2), 18(c), and 18(i) of the Act, pursuant to sections 6(c) and 23(c) of the Act for certain exemptions from rule 23c–3 under the Act, and pursuant to section 17(d) of the Act and rule 17d–1 thereunder.

Summary of Application: Applicants request an order to permit certain registered closed-end management investment companies to issue multiple classes of common shares of beneficial interest with varying sales loads and asset-based service and/or distribution fees and to impose early withdrawal charges.

Applicants: Alpha Alternative Assets Fund and Alpha Growth Management LLC.

Filing Dates: The application was filed on January 17, 2023, and amended on May 25, 2023.

Hearing or Notification of Hearing: An order granting the requested relief will be issued unless the Commission orders a hearing. Interested persons may request a hearing on any application by emailing the SEC's Secretary at *Secretarys-Office@sec.gov* and serving the Applicants with a copy of the request by email, if an email address is listed for the relevant Applicant below, or personally or by mail, if a physical address is listed for the relevant Applicant below. Hearing requests should be received by the Commission by 5:30 p.m. on August 21, 2023, and should be accompanied by proof of service on Applicants, in the form of an affidavit or, for lawyers, a certificate of service. Pursuant to rule 0–5 under the Act, hearing requests should state the nature of the writer's interest, any facts bearing upon the desirability of a hearing on the matter, the reason for the request, and the issues contested. Persons who wish to be notified of a hearing may request notification by emailing the Commission's Secretary at *Secretarys-Office@sec.gov*.

ADDRESSES: The Commission: *Secretarys-Office@sec.gov.* Applicants: Gobind Sahney, Alpha Growth Management LLC, 500 Newport Center Drive, Ste. 680, Newport Beach, CA 92660; Andrew Davalla, Thompson Hine LLP, *Andrew.Davalla@ThompsonHine.com.*

FOR FURTHER INFORMATION CONTACT: Christine Y. Greenlees, Senior Counsel, or Lisa Reid Ragen, Branch Chief, at (202) 551–6825 (Division of Investment Management, Chief Counsel's Office).

SUPPLEMENTARY INFORMATION: For Applicants' representations, legal analysis, and conditions, please refer to Applicants' first amended and restated application, dated May 25, 2023, which may be obtained via the Commission's website by searching for the file number at the top of this document, or for an Applicant using the Company name search field, on the SEC's EDGAR system. The SEC's EDGAR system may be searched at *http://www.sec.gov/edgar/searchedgar/legacy/companysearch.html.* You may also call the SEC's Public Reference Room at (202) 551–8090.

For the Commission, by the Division of Investment Management, under delegated authority.

Sherry R. Haywood,

Assistant Secretary.

[FR Doc. 2023–16397 Filed 8–1–23; 8:45 am]

BILLING CODE 8011–01–P

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–98009; File No. SR–LCH SA–2023–004]

Self-Regulatory Organizations; LCH SA; Order Approving Proposed Rule Change Relating to Triparty Collateral Mechanism

July 27, 2023.

I. Introduction

On May 30, 2023, Banque Centrale de Compensation, which conducts business under the name LCH SA (''LCH SA''), filed with the Securities and Exchange Commission (''Commission''), pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 (''Act'')[1] and Rule 19b–4 thereunder,[2] a proposed rule change (''Proposed Rule Change'') to amend its Credit Default Swap Clearing Procedures (''Procedures'') and Credit Default Swap Clearing Rule Book (''Rule Book'') to reflect the introduction of a triparty collateral mechanism to the CDSClear service. The Proposed Rule Change was published for comment in the **Federal Register** on June 16, 2023.[3] The Commission has not received any comments on the Proposed Rule Change. For the reasons discussed below, the Commission is approving the Proposed Rule Change.

II. Description of the Proposed Rule Change

LCH SA is a clearing agency registered with the Commission for the purpose of clearing security-based swaps (specifically, credit-default swaps or ''CDS''). LCH SA has procedures in place to deal with the default of a clearing member who participates in its CDS clearing business. In order to minimize the contagion risk of such a default, LCH SA calculates margin requirements for each clearing member and requires each member to transfer collateral to LCH SA to meet their respective margin requirements.

Currently, LCH SA requires members participating in its CDSClear service

[38] 17 CFR 200.30–3(a)(12).

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] Securities Exchange Act Release No. 97706 (June 12, 2023), 88 FR 39492 (June 16, 2023) (File No. SR–LCH–2023–004) (''Notice'').

(the ''Clearing Members'') to manage the pledging and transfer of collateral to LCH SA on a bilateral basis. For LCH SA's non-U.S. business lines (*e.g.,* its repo clearing business), LCH SA offers a ''triparty collateral'' mechanism where LCH SA and a clearing member may authorize an agent to enter settlement instructions on the clearing member's behalf into the LCH SA's securities settlement system.[4] LCH SA states that members benefit because such a triparty process is more efficient operationally.[5] LCH SA members requested that LCH SA harmonize collateral management processes across business lines by introducing a triparty collateral management process into LCH SA's CDS business.[6]

LCH SA now proposes to offer the triparty collateral mechanism to its members participating in CDSClear.[7] LCH SA is not changing collateral eligibility or concentration limits, but rather, is merely providing for a different process for posting acceptable collateral. To effectuate the change, LCH SA proposes the following changes to its rules.

A. Amendments to Rule Book

LCH SA is proposing to modify Section 1.1.1 (Terms defined in the CDS Clearing Rule Book) to include a new term, ''Triparty Documentation,'' which refers to the documentation of the agreement entered into between LCH SA, the relevant triparty agent, and a Clearing Member having exercised its option to transfer Eligible Collateral [8] on a full title transfer basis to LCH SA through a Triparty Documentation pursuant to Section 3 of the Procedures. Section 3 includes procedures related to collateral, variation margin, and cash payment.

LCH SA also proposes to amend section 2 of its Rule Book to add a new subsection (xxiv) to Section 2.2.1.1, to provide for a new membership requirement where the triparty applicant shall accept to comply with the performance of its obligations pursuant to a Triparty Documentation. Further, LCH SA proposes to amend Section 2.2.2.1 to add a new subsection (vii) to require a Clearing Member to comply with the performance of the obligations pursuant to a Triparty Documentation.[9]

LCH SA proposes to make several amendments to Section 4 of the Rule Book, which addresses risk management and collateral requirements. Since the Triparty Documentation will provide for the haircut that will apply to the relevant collateral, LCH SA proposes to add a reference to the Triparty Documentation in Section 4.2.6.4 which currently provides, among others, that LCH SA may apply haircuts to Eligible Collateral as set out on the LCH SA website. LCH SA also proposes to add the failure of a Clearing Member to perform its obligations in accordance with, or a breach of, any Triparty Documentation to the list of Events provided for in Section 4.3.1.1, which describes events that might constitute a Clearing Member default, as this is currently the case in respect of the CDS Clearing Documentation and the Pledge Agreement.

LCH SA also proposes to make the following conforming Rule Book changes that are not related to the implementation of the Triparty Documentation solution for the CDSClear service. Specifically, the definition of ''Pledged Eligible Collateral'' in Section 1.1.1 (Terms defined in the CDS Clearing Rule Book) would be amended by removing a reference to a Clearing Notice, because the list of Eligible Currencies and collateral is already set out in Section 3 of the Procedures in accordance with Section 4.2.6.1, and the proposed amended Section 3 of the Procedures would provide where the list of collateral (including Pledged Eligible Collateral) could be found. Section 2.2.2.1 would be amended to correct a cross-reference in subsection (iv). Finally, LCH SA would amend Section 4.2.6.1 by making a reference to Section 3 of the Procedures regarding the conditions that will govern the notification of any change in eligible currencies and collateral.

B. Amendments to Procedures

LCH SA proposes to modify Section 3 of the Procedures, which covers the topics of collateral, variation margin, and cash payments, to incorporate terms for implementing the triparty collateral mechanism. The Proposed Rule Change amends Section 3.10 (Eligible Collateral transferred with full title) to include securities transferred pursuant to a Triparty Documentation, by adding a new paragraph to Section 3.10.2 (Eligible Collateral provided pursuant to a Triparty Documentation) and a new introductory paragraph stating that Eligible Collateral transferred with full title may be provided by a Clearing Member either on a bilateral basis or pursuant to a Triparty Documentation in accordance.

The Proposed Change will move current Section 3.10 under a new paragraph in Section 3.10.1 entitled ''Eligible Collateral provided on a bilateral basis,'' and any reference to collateral provided with full title transfer in this new paragraph in Section 3.10.1 will be clarified by adding that such Eligible Collateral is provided on a bilateral basis. LCH SA proposes to replace any cross-reference to Section 3.10 in Section 3 of the Procedures with a cross-reference to a new paragraph in Section 3.10.1 where necessary. As a result of the new paragraph in Section 3.10.2, a cross-reference to subsection (d) will be added to each section referring to the return of any type of collateral. This cross-reference allows for Eligible Collateral to be transferred with full title pursuant to a Triparty Documentation.

The new paragraph in Section 3.10.2, as further described below, will mainly replicate the paragraph in Section 3.10.1, but will amend the content to refer to the Triparty Documentation. The new amendments would include the requirement for a Clearing Member to enter into the Triparty Documentation, as set out in a new sub-paragraph (a) and the reference to triparty accounts to be used by LCH SA. However, due to the use of a triparty agent for managing Clearing Member Collateral posted with LCH SA, there will be some differences in the timelines applicable to the Clearing Member for the purposes of transferring, or requesting return of, securities subject to the Triparty Documentation, as described below.

Subsection (a) of Section 3.10.2 (General information) states that the Clearing Member, a triparty agent (either Euroclear Bank or Euroclear France), and LCH SA may enter into the relevant Triparty Documentation, whose documentation is available upon request to the CDSClear Business Development & Relationship Management team. Under the Triparty Documentation, the relevant triparty agent will be authorized by LCH SA and the Clearing

[4] The agent's ability to enter settlement instructions on the clearing member's behalf would be done for the purposes of transferring collateral to LCH SA or releasing such collateral, and would affect movements of securities between a clearing member account and LCH SA by the relevant triparty agent on a full title transfer basis.

[5] *See* Notice, 88 FR at 39493.

[6] To facilitate the use of a triparty collateral mechanism, the clearing member, the relevant triparty agents, and LCH SA must enter into a specific contractual arrangement.

[7] LCH SA is proposing to offer the triparty collateral mechanism as an optional collateral management tool, but does not intend to obligate its members to use the tri-party mechanism.

[8] Eligible Collateral is defined by LCH as ''Such securities and other types of non Cash Collateral as are set out in Section 3 of the Procedures as being acceptable by LCH SA for the purposes of satisfying a Clearing Member's Margin Requirements and/or novating Original Transactions, as applicable.''

[9] The subsequent subsections would also need to be renumbered for both amendments.

Member to enter settlement instructions on their behalf into the relevant securities settlement system to transfer with full title securities as Eligible Collateral between LCH SA and the Clearing Member.

Sub-paragraph (b) (Securities accounts) states that LCH SA will hold collateral in security accounts at the relevant triparty agent(s) as applicable for the Clearing Member's house activity, and separately, client activity (excluding any FCM Clients, since the provision of securities pursuant to this triparty collateral solution will not be permitted for FCM Clients pursuant to new sub-paragraph (c) of new paragraph 3.1.0.2, indent (ii)).[10]

Sub-paragraph (c) will include provisions describing the transfer of Eligible Collateral pursuant to a Triparty Documentation; the purpose of such transfer is either for transferring additional collateral or substituting such collateral for any alternative collateral recorded in its collateral accounts. To transfer collateral on a specific business day, a Clearing Member would need to notify LCH SA of its request to transfer such Eligible Collateral pursuant to a Triparty Documentation by no later than 16:00 CET on the prior business day. If the Clearing Member notifies LCH SA that the collateral will move client accounts, the member must specify which client account shall record Eligible Collateral; otherwise, LCH SA will not accept the transfer request.[11]

Sub-paragraph (d) addresses the applicable conditions for returning collateral to a Clearing Member. A Clearing Member must request a return of collateral no later than 12:00 CET on the business day before they want to receive the collateral. LCH SA would transfer the requested collateral between 12:25 and 12:55 CET on the requested day.[12] Any return request received by LCH SA shall be deemed firm and irrevocable. By 12:00 CET on the day the collateral is returned, LCH SA will re-calculate the value of the Eligible Collateral to be returned (the ''Eligible Triparty Collateral Value''). If LCH SA holds sufficient collateral (other than that which is to be returned) to cover the relevant margin requirement, it will return the collateral. If LCH SA does not hold sufficient collateral (other than that which is to be returned) to cover the relevant margin requirement, LCH SA will attempt to debit an amount of Euros equal to the Eligible Triparty Collateral Value from the TARGET2 [13] Account(s) of the Clearing Member (or its TARGET2 Payment Agent), after which LCH SA would return the collateral.[14] LCH SA would instruct the triparty agent(s) to return the collateral between 13:00 and 15:00 CET, in advance of the relevant Central Securities Depository/ International Central Securities Depository cut-off time (except in exceptional circumstances, as determined in an objective and commercially reasonable manner). The last paragraph of new paragraph 3.10.2 will provide for exceptional time limits for notification of transfer and return requests in cases of atypical market conditions.

Current Section 3.9 of the Procedures addresses Eligible Collateral. In this section, LCH SA proposes to insert language stating that additional eligibility criteria and concentration limits apply for Triparty Documentation.[15] LCH SA also proposes to insert language stating that it may amend the list of eligible securities by publication of a Clearing Notice, and add new eligibility criteria and concentration limits for Eligible collateral transferred with full title pursuant to a Triparty Documentation, subject to the prior consent of the relevant triparty agent. As a result, the reference to a Clearing Notice mentioned in Section 3.13 applicable to Eligible Collateral pursuant to the Pledge Agreement will be removed, as there will be no Clearing Notice which describes such Eligible Collateral; all relevant information will be found on the LCH SA website.

LCH SA also proposes changes to Section 3.9 to clarify that Eligible Collateral transferred with full title may be provided on a bilateral or trilateral basis, where necessary. LCH SA is proposing to amend sub-paragraph (c) (Events affecting the eligibility of Eligible Collateral) to exclude securities transferred pursuant to the triparty collateral solution from the current management process applicable to Collateral Events.[16] Such Collateral Events will be managed by the relevant triparty agent in accordance with the Triparty Documentation. Consequently, the scope of Section 3.12 is reduced to Eligible Collateral transferred with full title on a bilateral basis.

LCH SA proposes other amendments to Section 3 of the Procedures in order to correct some cross-references or typographical errors.

III. Discussion and Commission Findings

Section 19(b)(2)(C) of the Act requires the Commission to approve a proposed rule change of a self-regulatory organization if it finds that the Proposed Rule Change is consistent with the requirements of the Act and the rules and regulations thereunder applicable to the organization.[17] For the reasons given below, the Commission finds that the Proposed Rule Change is consistent with Section 17A(b)(3)(F) of the Act [18] and Rule 17Ad–22(e)(21) thereunder.[19]

A. Consistency with Section 17A(b)(3)(F) of the Act

Under Section 17A(b)(3)(F) of the Act, LCH SA's rules, among other things, must be ''designed to promote the prompt and accurate clearance and settlement of . . . derivative agreements, contracts, and transactions . . .'' [20] Based on its review of the record, and for the reasons discussed below, the Commission believes that LCH SA's changes are consistent with Section 17A(b)(3)(F) of the Act because LCH SA is offering an additional clearing mechanism to its members.

LCH SA is proposing to allow CDSClear Clearing Members to cover their margins with eligible securities through the use of a triparty agent. Clearing Members are under no obligation to use this solution. This change will broaden the solutions for Clearing Members to manage collateral posted to LCH SA. The introduction of the triparty mechanism would align collateral management practices for members across LCH SA business lines and enable the transfer of securities as collateral in a more efficient and automated way than on a bilateral basis. Offering a more efficient and automated

[10] LCH SA may invest eligible collateral provided to LCH SA with full title pursuant to a triparty arrangement in accordance with Paragraph 3.11(b).

[11] LCH SA makes intra-day margin calls throughout the day. Whether the collateral will be taken into account with regard to a specific intra-day margin call is dependent on when LCH SA received confirmation from a Clearing Member's triparty agent. Proposed section 3.10.02(c) describes how confirmation timing affects margin calculations in more detail.

[12] Section 3.7(c) of the Procedures defines the timing of collateral calls, and specifies the 12:25 to 12:55 CET period as a window to be use for the purpose of collateral substitutions upon a Clearing Member's request, which LCH SA refers to as the ''Additional Specific Collateral Slot.''

[13] TARGET2 is the system known as Trans-European Automated Real-time Gross Settlement Express Transfer 2.

[14] If LCH SA cannot debit the required amount of Euros, it would not return the requested collateral.

[15] The triparty documentation would only be able to add requirements, and could not reduce the eligibility criteria or concentration limits specified in LCH SA's rules.

[16] A ''Collateral Event'' is defined as either a suspension from trading of such security by an exchange or the public announcement of a take-over bid, public exchange offer, split or reverse split involving the entity issuing such security.

[17] 15 U.S.C. 78s(b)(2)(C).

[18] 15 U.S.C. 78q–1(b)(3)(F).

[19] 17 CFR 240.17Ad–22(e)(21).

[20] 15 U.S.C. 78q–1(b)(3)(F).

process may, for members who choose to use it, reduce the overall cost of clearing. Reducing the overall cost of clearing could, in turn, lead Clearing Members to clear more products. Thus, these changes would contribute to the prompt and accurate clearance process and settlement of securities transactions and derivative agreements, contracts, and transactions and to assure the safeguarding of securities, which is consistent with the requirements of Section 17(A)(b)(3)(F).[21]

The Commission believes, therefore, that the Proposed Rule Change is consistent with the requirements of Section 17A(b)(3)(F) of the Act.[22]

B. Consistency With Rule 17Ad–22(e)(21) Under the Act

Rule 17Ad–22(e)(21) requires covered clearing agencies to establish, implement, maintain, and enforce written policies and procedures reasonably designed to be efficient and effective in meeting the requirements of its participants and the markets it serves, and have the covered clearing agency's management regularly review the efficiency and effectiveness of its clearing and settlement arrangements; operating structure, including risk management policies, procedures, and systems; scope of products, cleared or settled; and use of technology and communication procedures.[23] In adopting Rule 17Ad–22(e)(21), the Commission provided guidance that a covered clearing agency generally should consider in establishing and maintaining policies and procedures that address efficiency and effectiveness, stating that it should consider whether its design meets the needs of its participants, particularly with regard to choice of operating structure and use of technology and procedures.[24]

LCH SA's members expressed interest in using the triparty mechanism to the CDSClear business to harmonize their operational process across all clearing services of LCH SA.[25] The triparty collateral mechanism is an optional solution that would reduce the number of manual actions necessary in the processing of non-cash collateral deposit and release for both the clearing agency and the Clearing Members. Reliance on the triparty mechanism could reduce the manual steps necessary for a Clearing Member to allocate a basket of securities in LCH SA's system with an automatic process for the settlement of margin calls and handling of coupons. Such automation would increase efficiency and allows for additional use of technology with the settlement of margin call.

The Commission believes, therefore, that the Proposed Rule Change is consistent with the requirements of Rule 17Ad–22(e)(21) under the Act.[26]

IV. Conclusion

On the basis of the foregoing, the Commission finds that the Proposed Rule Change is consistent with the requirements of the Act, and in particular, Section 17A(b)(3)(F) of the Act[27] and Rule 17Ad–22(e)(21) thereunder.[28]

It Is Therefore Ordered pursuant to Section 19(b)(2) of the Act that the Proposed Rule Change (SR–LCH SA–2023–004) be, and hereby is, approved.[29]

For the Commission by the Division of Trading and Markets, pursuant to delegated authority.[30]

Sherry R. Haywood,

Assistant Secretary.

[FR Doc. 2023–16389 Filed 8–1–23; 8:45 am]

BILLING CODE 8011–01–P

[21] 15 U.S.C. 78q–1(b)(3)(F).

[22] 15 U.S.C. 78q–1(b)(3)(F).

[23] 17 CFR 240.17Ad–22(e)(21).

[24] *See* Standards for Covered Clearing Agencies, Securities Exchange Act Release No. 78961 (Sept. 28, 2016), 81 FR 70786, 70841 (Oct. 13, 2016).

[25] *See* Notice, 88 FR at 39493.

[26] 17 CFR 240.17Ad–22(e)(21).

[27] 15 U.S.C. 78q–1(b)(3)(F).

[28] 17 CFR 240.17Ad–22(e)(21).

[29] In approving the Proposed Rule Change, the Commission considered the proposal's impacts on efficiency, competition, and capital formation. 15 U.S.C. 78c(f).

[30] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Investment Company Act Release No. 34967; 812–15472]

Polen Credit Opportunities Fund and Polen Capital Credit, LLC

July 27, 2023.

AGENCY: Securities and Exchange Commission (''Commission'' or ''SEC'').

ACTION: Notice.

Notice of an application under section 6(c) of the Investment Company Act of 1940 (the ''Act'') for an exemption from sections 18(a)(2), 18(c) and 18(i) of the Act, under sections 6(c) and 23(c) of the Act for an exemption from rule 23c–3 under the Act, and for an order pursuant to section 17(d) of the Act and rule 17d–1 under the Act.

SUMMARY OF APPLICATION: Applicants request an order to permit certain registered closed-end investment companies to issue multiple classes of shares and to impose asset-based distribution and/or service fees and early withdrawal charges.

APPLICANTS: Polen Credit Opportunities Fund and Polen Capital Credit, LLC.

FILING DATES: The application was filed on May 31, 2023 and amended on July 10, 2023.

HEARING OR NOTIFICATION OF HEARING: An order granting the requested relief will be issued unless the Commission orders a hearing. Interested persons may request a hearing on any application by emailing the SEC's Secretary at *Secretarys-Office@sec.gov* and serving the Applicants with a copy of the request by email, if an email address is listed for the relevant Applicant below, or personally or by mail, if a physical address is listed for the relevant Applicant below. Hearing requests should be received by the Commission by 5:30 p.m. on August 21, 2023, and should be accompanied by proof of service on the Applicants, in the form of an affidavit, or, for lawyers, a certificate of service. Pursuant to rule 0–5 under the Act, hearing requests should state the nature of the writer's interest, any facts bearing upon the desirability of a hearing on the matter, the reason for the request, and the issues contested. Persons who wish to be notified of a hearing may request notification by emailing the Commission's Secretary.

ADDRESSES: The Commission: *Secretarys-Office@sec.gov.* Applicants: Lisa Nosal, Esq., Kirkland & Ellis LLP, *lisa.nosal@kirkland.com;* Nicole M. Runyan, Esq., Kirkland & Ellis LLP, *nicole.runyan@kirkland.com; with a copy to Joshua L. McCarthy, Esq., Polen Capital Credit, LLC, jlmccarthy@polencapital.com.*

FOR FURTHER INFORMATION CONTACT: Trace W. Rakestraw, Senior Special Counsel, at (202) 551–6825 (Division of Investment Management, Chief Counsel's Office).

SUPPLEMENTARY INFORMATION: For Applicants' representations, legal analysis, and condition, please refer to Applicants' application, dated July 10, 2023, which may be obtained via the Commission's website by searching for the file number at the top of this document, or for an Applicant using the Company name search field on the SEC's EDGAR system. The SEC's EDGAR system may be searched at *https://www.sec.gov/edgar/searchedgar/legacy/companysearch.html.* You may also call the SEC's Public Reference Room at (202) 551–8090.

For the Commission, by the Division of Investment Management, under delegated authority.

Sherry R. Haywood,

Assistant Secretary.

[FR Doc. 2023–16403 Filed 8–1–23; 8:45 am]

BILLING CODE 8011–01–P

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–98013; File No. SR–NYSEAMER–2023–27]

Self-Regulatory Organizations; NYSE American LLC; Order Granting Approval of a Proposed Rule Change To Amend Rule 915 (Criteria for Underlying Securities) To Accelerate the Listing of Options on Certain IPOs

July 27, 2023.

I. Introduction

On April 21, 2023, NYSE American LLC (''NYSE American'' or ''Exchange'') filed with the Securities and Exchange Commission (''Commission''), pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 (''Act'') [1] and Rule 19b–4 thereunder,[2] a proposed rule change to amend NYSE American Rule 915 (Criteria for Underlying Securities) to reduce the time to market for the listing and trading of options on certain covered securities following their initial public offering (''IPO''). The proposed rule change was published for comment in the **Federal Register** on May 1, 2023.[3] One comment letter was received on the proposed rule change.[4]

On June 13, 2023, pursuant to Section 19(b)(2) of the Act,[5] the Commission designated a longer period within which to approve the proposed rule change, disapprove the proposed rule change, or institute proceedings to determine whether to disapprove the proposed rule change.[6] This order grants approval of the proposed rule change.

II. Description of the Proposal

The Exchange proposes to modify Commentary .01(4)(a) of NYSE American Rule 915 to reduce the time for it to begin listing and trading options on certain covered securities following their IPO.[7] NYSE American Rule 915 establishes requirements that underlying securities must meet in order for the Exchange to list and trade option contracts on them. Commentary .01 of that rule sets forth certain guidelines for the Exchange to consider in evaluating potential underlying securities.

One such guideline is a minimum market price per share that an underlying security must trade at before the Exchange can list options on it.[8] Specifically, Commentary .01(4)(a) to NYSE American Rule 915 requires the market price per share of an underlying covered security to have been at least $3.00 for the previous three consecutive business days preceding the date on which the Exchange submits a certificate to The Options Clearing Corporation (''OCC'') to list and trade options on it (''three-day lookback period'').[9] Under the current rule, if an IPO occurs on a Monday, the earliest date the Exchange could submit its listing certificate to OCC would be Thursday, with the market price determined by the closing price over the three-day lookback period from Monday through Wednesday. An option on the security would then be eligible for trading on the Exchange on Friday (*i.e.,* within four business days following the IPO inclusive of the day the listing certificate is submitted to OCC).

The Exchange proposes to waive the three-day lookback period in Commentary .01(4)(a) for certain covered securities following their IPO and accelerate the listing of options on such securities by up to two days.[10] As proposed, the Exchange would permit options to be listed and traded on a new IPO with a market capitalization of at least $3 billion based upon its offering price starting on or after the second business day following the covered security's IPO day (*i.e.,* not inclusive of the day of the IPO).[11] For example, under the proposed rule, if an IPO for a company with a market capitalization of $3 billion (based upon its offering price) occurs on a Monday, the Exchange could submit a listing certificate to OCC (to allow it to list and trade options on the IPO security) on Tuesday if all of the requirements for options listing are satisfied. Options on the IPO security could then list and begin trading on the Exchange on Wednesday (*i.e.,* starting on or after the second business day following the IPO day, not inclusive of the IPO day). In this way, the proposal could accelerate the listing and trading of options on IPO securities by up to two days.

III. Discussion and Commission's Findings

After careful review of the proposed rule change, the Commission finds that the proposal is consistent with the requirements of the Act and the rules and regulations thereunder that are applicable to a national securities exchange.[12] Specifically, the Commission finds that the proposed rule change is consistent with Section 6(b)(5) of the Act,[13] which requires that the rules of a national securities exchange be designed, among other things, to prevent fraudulent and manipulative acts and practices, to promote just and equitable principles of trade, to foster cooperation and coordination with persons engaged in regulating, clearing, settling, processing information with respect to, and facilitating transactions in securities, to remove impediments to and perfect the mechanism of a free and open market and a national market system, and, in general, to protect investors and the public interest.

As discussed above, the Exchange proposes to reduce the time to market for the listing and trading of options on underlying covered securities following their IPO if they have a market capitalization of at least $3 billion based upon the offering price. By waiving the three-day lookback period for such covered securities in Commentary .01(4)(a), the proposed rule change could reduce the time to market of options on such securities by up to two days, as options on such securities

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] *See* Securities Exchange Act Release No. 97374 (Apr. 25, 2023), 88 FR 26634 (''Notice'').

[4] *See* Letter from Ellen Greene, Managing Director, Equities & Options Market Structure, SIFMA, to Vanessa Countryman, Secretary, Commission (May 16, 2023), *available at https://www.sec.gov/comments/sr-nyseamer-2023-27/srnyseamer202327.htm.*

[5] 15 U.S.C. 78s(b)(2).

[6] *See* Securities Exchange Act Release No. 97717, 88 FR 39895 (June 20, 2023).

[7] *See* 15 U.S.C. 77r(b)(1)(A) (defining ''covered security'').

[8] NYSE American Rule 915(a) requires that, for underlying securities to be eligible for options listing, such securities must be duly registered and be an ''NMS stock,'' as defined in Rule 600 of Regulation NMS under the Act, and be characterized by having a substantial number of outstanding shares which are widely held and actively traded. *See* NYSE American Rules 915(a)(1) and (2).

[9] The Exchange states that the Options Listing Procedures Plan (''OLPP'') requires that the listing certificate be provided to OCC no earlier than 12:01 a.m. and no later than 11:00 a.m. (Chicago time) on the trading day prior to the day on which trading is to begin. *See* the OLPP, at p. 3, *available at: https://ncuoccblobdev.blob.core.windows.net/media/theocc/media/clearing-services/services/options_listing_procedures_plan.pdf.*

[10] *See* Notice, *supra* note 3, 88 FR at 26635.

[11] *See* proposed Commentary .01(4)(a)(ii) to NYSE American Rule 915. The Exchange also proposes a non-substantive change to number the existing and proposed criteria for covered securities as (i) and (ii) of paragraph (4)(a). *See* proposed Commentary .01(4)(a)(i) and (ii) to NYSE American Rule 915.

[12] In approving this proposed rule change, the Commission has considered the rule's impact on efficiency, competition, and capital formation. *See* 15 U.S.C. 78c(f).

[13] 15 U.S.C. 78f(b)(5).

would be permitted to be listed and traded starting on or after the second business day following the IPO (not including the day of the IPO) once all listing criteria are satisfied.

The proposed rule change would only waive the three-day lookback period for covered securities following their IPO if they have a substantial market capitalization of at least $3 billion based upon their IPO offering price. According to the Exchange, based upon data from 2017 to present, all underlying securities with an IPO market capitalization of $3 billion would have also met the $3.00 market price per share three-day lookback period requirement.[14]

The Commission believes the proposed waiver of the three-day lookback period requirement is appropriate for underlying covered securities that have a market capitalization of at least $3 billion based on the IPO offering price because those securities would likely satisfy the lookback requirement, in which case the minimum $3.00 price test would be met. Further, the proposed market capitalization requirement of $3 billion based on the IPO offering price would ensure an objective qualification process for the waiver that would prevent market participants from being able to influence whether an IPO security qualifies for the waiver through trading in the security, which could be a concern if the threshold price were based on the market price of the shares following the IPO. In accelerating the time to market for options on these types of large, and likely high profile IPOs, the proposal does not materially change the listing process for options, nor does it propose to change any other listing criteria.

In addition, the Exchange represents that trading in IPO securities is subject to surveillances administered by the Exchange and cross-market surveillances administered by the Financial Industry Regulatory Authority (''FINRA'') on behalf of the Exchange that are designed to detect violations of Exchange rules and applicable federal securities laws.[15] The Exchange represents that those surveillances are adequate to reasonably monitor Exchange trading of IPO securities.[16] Vigilant surveillance can help deter and detect violations of Exchange rules and the federal securities rules and regulations, and in so doing can help prevent fraudulent and manipulative acts and practices, and, in general, protect investors and the public interest.[17]

The Commission received one comment letter that recommended approval of the proposed rule change. The commenter asserted that the proposed rule change would ''benefit both investors and the market by allowing for increased efficiency in portfolio and risk management while continuing to provide for investor protection.'' [18]

The Commission finds that the proposal to accelerate the listing and trading of options on certain covered securities following their IPO by up to two days if they have a market capitalization of at least $3 billion based upon their IPO offering price, without modifying any other aspect of the options listing process, should facilitate transactions in securities. Accordingly, the Commission finds that the proposed rule change is consistent with the requirements of the Act.[19]

IV. Conclusion

It is therefore ordered, pursuant to Section 19(b)(2) of the Act,[20] that the proposed rule change (SR–NYSEAMER–2023–27), be, and it hereby is, approved.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[21]

Sherry R. Haywood,

Assistant Secretary.

[FR Doc. 2023–16393 Filed 8–1–23; 8:45 am]

BILLING CODE 8011–01–P

[14] *See* Notice, *supra* note 3, 88 FR at 26635.

[15] *See id.* According to the Exchange, FINRA conducts cross-market surveillances on behalf of the Exchange pursuant to a regulatory services agreement. The Exchange is responsible for FINRA's performance under this regulatory services agreement. *See id.* at 26635, n.9.

[16] *See id.* at 26635.

[17] 15 U.S.C. 78f(b)(5).

[18] *See supra* note 4, at 2.

[19] 15 U.S.C. 78f(b)(5).

[20] 15 U.S.C. 78s(b)(2).

[21] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–98011; File No. SR–CboeEDGX–2023–050]

Self-Regulatory Organizations; Cboe EDGX Exchange, Inc.; Notice of Filing and Immediate Effectiveness of a Proposed Rule Change to Update its Fees Schedule

July 27, 2023.

Pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 (''Act''),[1] and Rule 19b–4 thereunder,[2] notice is hereby given that on July 26, 2023, Cboe EDGX Exchange, Inc. (''Exchange'' or ''EDGX'') filed with the Securities and Exchange Commission (''Commission'') the proposed rule change as described in Items I, II, and III below, which Items have been prepared by the Exchange. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

Cboe EDGX Exchange, Inc. (the ''Exchange'' or ''EDGX'') proposes to update its Fees Schedule. The text of the proposed rule change is provided in Exhibit 5.

The text of the proposed rule change is also available on the Exchange's website (*http://markets.cboe.com/us/options/regulation/rule_filings/edgx/*), at the Exchange's Office of the Secretary, and at the Commission's Public Reference Room.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the Exchange included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. The Exchange has prepared summaries, set forth in sections A, B, and C below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

The Exchange proposes to amend the Market Data section of its Fees Schedule. [3] Particularly, the Exchange proposes to (i) adopt a New External Credit applicable to EDGX Options Top, (ii) adopt a credit towards the monthly Distribution fees for EDGX Options Top, (iii) modify the EDGX Options Top

[3] The Exchange initially filed the proposed fee changes on March 1, 2023 (SR–CboeEDGX–2023–017). On March 3, 2023, the Exchange withdrew that filing and submitted SR–CboeEDGX–2023–018. On March 10, 2023, the Exchange withdrew that filing and submitted SR–CboeEdgx-2023–021. On March 16, 2023, the Exchange withdrew that filing and submitted SR–CboeEDGX–2023–022. On May 15, 2023, the Exchange withdrew that filing and submitted SR–CboeEDGX–2023–037. On July 14, 2023, the Exchange withdrew that filing and submitted SR–CboeEDGX–2023–047. On July 26, 2023, the Exchange withdrew that filing and submitted this proposal.

Enterprise Fee; and (iv) establish fees for Cboe One Options Feed.

EDGX Top Data

By way of background, the Exchange offers the EDGX Options Top Data feed, which is an uncompressed data feed that offers top-of-book quotations and last sale information based on options orders entered into the Exchange's System. The EDGX Options Top Data feed benefits investors by facilitating their prompt access to real-time top-of-book information contained in EDGX Options Top Data. The Exchange's affiliated options exchanges (*i.e.,* Cboe Exchange, Inc. (''Cboe Options''), Cboe BZX Exchange, Inc. (''BZX Options''), and Cboe C2 Exchange, Inc. (''C2 Options'') (collectively, ''Affiliates'' and together with the Exchange, ''Cboe Options Exchanges'') also offer similar top-of-book data feeds.[4] Particularly, each of the Exchange's Affiliates offer top-of-book quotation and last sale information based on their own quotation and trading activity that is substantially similar to the information provided by the Exchange through the EDGX Options Top. The Exchange proposes to make the following fee changes relating to EDGX Options Top.

New External Distributor Credit

The Exchange first proposes to adopt a New External Distributor Credit which will provide that new External Distributors of the EDGX Options Top feed will not be charged an External Distributor Fee for their first three (3) months in order to incentivize External Distributors to enlist new users to receive EDGX Options Top feed.[5] The Exchange notes that other exchanges, including the Exchange's affiliated equities exchanges, offer similar credits for similar market data products. For example, Cboe's equities exchanges currently offer a one (1) month New External Distributor Credit applicable to External Distributors of top-of-book data feeds.[6] They also offer a three (3) month new External Credit applicable to External Distributors of summary depth-of-book feeds.[7]

Distributor Fee Credit

The Exchange also proposes to provide that each External Distributor will receive a credit against its monthly External Distributor Fee for the EDGX Options Top equal to the amount of its monthly User Fees up to a maximum of the Distributor Fee for the EDGX Options Top feed.[8] The proposed Enterprise Fees discussed below would also be counted towards the Distributor Fee credit, equal to the amount of an External Distributor's monthly EDGX Options Top External Distribution fee. For example, an External Distributor will be subject to a $500 monthly Distributor Fee where they elect to receive the EDGX Options Top. If that External Distributor reports User quantities totaling $500 or more of monthly usage of the EDGX Options Top, it will pay no net Distributor Fee, whereas if that same External Distributor were to report User quantities totaling $400 of monthly usage, it will pay a net of $100 for the Distributor Fee.[9] External Distributors will remain subject to the per User fees applicable to EDGX Options Top. External Distributors who choose to purchase an Enterprise license as an alternative to paying User Fees will get a credit in the amount of the External Distribution Fee, which is currently $500 since the proposed Enterprise Fees are in excess of the External Distribution fee. In every case the Exchange will receive at least $500 in connection with the distribution of the EDGX Options Top (through a combination of the External Distribution Fee and per User Fees or Enterprise Fees, as applicable). The Exchange notes that its affiliated equities exchanges offer a similar credit for a similar market data product.[10]

Enterprise Fee Tiers

The Exchange currently offers Distributors the ability to purchase a monthly (and optional) Enterprise license to receive the EDGX Options Top Feed for distribution to an unlimited number of Professional[11] and Non-Professional[12] Users. The Enterprise Fee is an alternative to Professional and Non-Professional User fees and permits a Distributor to pay a flat fee for an unlimited number of Professional and Non-Professional Users and is in addition to the Distribution fees. The Exchange currently assesses a flat monthly Enterprise fee of $20,000. The Exchange proposes to modify the current Enterprise Fee and adopt a tiered structure based on the number of Users a Distributor has. The Exchange proposes to adopt the following monthly Enterprise Fees: $20,000 for up to 1,500,000 Users (Tier 1), $40,000 for 1,500,001 to 2,500,000 Users (Tier 2) and $60,000 for 2,500,001 or greater Users (Tier 3). The proposed fees are non-progressive (*e.g.,* if a Distributor has 2,000,000 Users, it will be subject to $40,000 for Tier 2). The Enterprise Fee may provide an opportunity to reduce fees. For example, if a Distributor has 1 million Non-Professional Users who each receive EDGX Options Top at $0.10 per month, then that Distributor will pay $100,000 per month in Non-Professional Users fees. If the Distributor instead were to purchase the proposed Enterprise license (tier 1), it

[4] *See* Cboe Options Fees Schedule, C2 Options Fees Schedule, and BZX Rule 21.15.

[5] Any applicable User fees or Enterprise fee will continue to apply during this three-month period. The New External Distributor Credit will not apply during an External Distributor's trial usage period for EDGX Options Top. External Distributors who receive EDGX Options Top on a trial basis are still eligible for the New Distributor Credit and such free trial basis will not count towards the three (3) months. For example, if an External Distributor has a trial usage period from June 1 through June 30, the New External Distributor Credit will apply for July, August and September. Additionally, pursuant to the EDGX Options Fees Schedule, a Distributor that distributes EDGX Options Top may receive, at no additional charge, access to any or all [sic] of the other market data products on the EDGX Options Fees Schedule. The New External Distributor Credit applies only to the External Distribution Fee for EDGX Options Top and therefore any External Distributor that also distributes any other exchange market data product would still be subject to the External Distribution Fee.

[6] *See e.g.,* EDGX Equities Exchange Fees Schedule, Market Data Fees.

[7] *See e.g.,* EDGX Equities Exchange Fees Schedule, Market Data Fees.

[8] The Distributor Fee Credit does not apply during any such time that an External Distributor is receiving the New External Distributor Credit or during a trial usage period for EDGX Options Top. The Exchange also proposes to update the Trial Usage section of the Fees Schedule to make clear that first time Users and Distributors of Exchange Market Data Products will not receive any applicable credits during their trial usage period.

[9] As noted above, pursuant to the EDGX Options Fees Schedule, a Distributor that distributes EDGX Options Top may receive, at no additional charge, access to any or all [sic] of the other market data products on the EDGX Options Fees Schedule. The Distributor Fee Credit applies only to the External Distribution Fee for EDGX Options Top and therefore any External Distributor that also distributes any other exchange market data product would still be subject to the entirety of the External Distribution Fee for those other products.

[10] *See e.g.,* EDGX Equities Exchange Fees Schedule, Id.

[11] A Professional User of an Exchange Market Data product is any User other than a Non-Professional User.

[12] A ''Non-Professional User'' of an Exchange Market Data product is a natural person or qualifying trust that uses Data only for personal purposes and not for any commercial purpose and, for a natural person who works in the United States, is not: (i) registered or qualified in any capacity with the Securities and Exchange Commission, the Commodities Futures Trading Commission, any state securities agency, any securities exchange or association, or any commodities or futures contract market or association; (ii) engaged as an ''investment adviser'' as that term is defined in Section 202(a)(11) of the Investment Advisors Act of 1940 (whether or not registered or qualified under that Act); or (iii) employed by a bank or other organization exempt from registration under federal or state securities laws to perform functions that would require registration or qualification if such functions were performed for an organization not so exempt; or, for a natural person who works outside of the United States, does not perform the same functions as would disqualify such person as a Non-Professional User if he or she worked in the United States.

would alternatively pay a flat fee of $20,000 for up to 1.5 million Professional and Non-Professional Users. A Distributor that pays the Tier 1 or Tier 2 Enterprise Fee will have to report its number of such Users on a monthly basis. A Distributor that pays the Tier 3 Enterprise Fee will only have to report the number of its Users every six months.[13] The Exchange notes that if the reported number of Users exceed the Enterprise Tier a Distributor has purchased, the higher Tier will apply (*e.g.,* if a Distributor purchases Tier 1, but reports 1,600,000 Users for a month, the Distributor will be assessed the Tier 2 fee).

The Exchange also proposes to allow Distributors to purchase the Enterprise Fee on a monthly or annual basis. Annual licenses will receive a 5% discount off the applicable Enterprise Tier fee.[14] The Exchange notes that the purchase of an Enterprise license is voluntary, and a firm may elect to instead use the per User structure and benefit from the proposed per User Fees described above. For example, a firm that does not have a sufficient number of Users to benefit from purchase of a license need not do so.

Cboe One Options Feed

By way of background, the Exchange recently adopted a new market data product called Cboe One Options Feed, which launched March 1, 2023.[15] Cboe One Options Feed will provide top-of-book quotation and last sale information based on the quotation and trading activity on the Exchange and each of its Affiliates, which the Exchange believes offers a comprehensive and highly representative view of US options pricing to market participants. More specifically, Cboe One Options Feed will contain the aggregate best bid and offer (''BBO'') of all displayed orders for options traded on the Exchange and its Affiliates, as well as individual last sale information and volume, which includes the price, time of execution and individual Cboe options exchange on which the trade was executed.

The Cboe One Options Feed will also consist of Symbol Summary,[16] Market Status,[17] Trading Status,[18] and Trade Break [19] messages for the Exchange and each of its Affiliates.

The Exchange will use the following data feeds to create the Cboe One Options Feed, each of which is available to other vendors and/or distributors: Cboe Options Top Data, C2 Options Top Data, EDGX Options Top and BZX Options Top. A vendor and/or distributor that wishes to create a product like the Cboe One Options Feed could instead subscribe to each of the aforementioned data feeds. Any entity that receives, or elects to receive, the individual data feeds or the feeds that may be used to create a product like the Cboe One Options Feed would be able to, if it so chooses, to create a data feed with the same information included in the Cboe One Options Feed and sell and distribute it to its clients so that it could be received by those clients as quickly as the Cboe One Options Feed would be received by those same clients.

The Exchange proposes to amend its fee schedule to incorporate fees related to the Cboe One Options Feed. The Exchange has taken into consideration its affiliated relationship with its Affiliates in its design of the Cboe One Options Feed to assure that vendors [20] would be able to offer a similar product on the same terms as the Exchange from a cost perspective. Although Cboe Options Exchanges are the exclusive distributors of the individual data feeds from which certain data elements would be taken to create the Cboe One Options Feed, the Exchange would not be the exclusive distributor of the aggregated and consolidated information that compose the proposed Cboe One Options Feed. Distributors and/or vendors would be able, if they chose, to create a data feed with the same information as the Cboe One Options Feed and distribute it to their clients on a level-playing field with respect to latency and cost as compared to the Exchange's proposed Cboe One Options Feed. The pricing the Exchange proposes to charge for the Cboe One Options Feed, as described more fully below, is not lower than the cost to a distributor or vendor to obtain the underlying data feeds. In fact, the Distribution and User (Professional and Non-Professional) fees, as well as the optional Enterprise Fees, that the Exchange proposes to adopt for the Cboe One Options Feed are equal to the respective combined fees for subscribing to each individual data feed. The Exchange also proposes to adopt a ''Data Consolidation Fee,'' which would reflect the value of the aggregation and consolidation function the Exchange performs in creating the Cboe One Options Feed. Therefore, Distributors would be enabled to create a competing product based on the individual data feeds and charge their clients a fee that they believe reflects the value of the aggregation and consolidation function that is competitive with Cboe One Options Feed pricing. For these reasons, the Exchange believes that Distributors, including vendors, could readily offer a product similar to the Cboe One Options Feed on a competitive basis at a similar cost.

The proposed Cboe One Options Feed fees include the following, each of which are described in further detail below: (i) Distributor Fees; (ii) User Fees for both Professional and Non-Professional Users; (iii) Enterprise Fees; and (iv) a Data Consolidation Fee. The Exchange also proposes to adopt a New External Distributor credit and a credit

[13] *See* Cboe Global Markets North American Data Policies, which provides that Distributors that have obtained an Enterprise license are required to report quantities monthly unless they reach the highest Enterprise Tier available (*i.e.,* Tier 3), in which case they are required to report user quantities only every six months).

[14] The discount will be taken off the fee for the applicable Enterprise Tier each month. For example, if a Distributor elects to purchase an annual license and is in Tier 1 for any 9 months of the year and Tier 2 for any 3 months of the year, the total amount of fees paid for one year will be $285,000 ($20,000—5% × 9 months + $40,000—5% × 3 months) as compared to $300,000 ($20,000 × 9 months + $40,000 × 3 months).

[15] *See* SR–CboeEDGX–2023–013.

[16] The Symbol Summary message will include the total executed volume across all Cboe Options Exchanges.

[17] The Market Status message is disseminated to reflect a change in the status of one of the Cboe Options Exchanges. For example, the Market Status message will indicate whether one of the Cboe Options Exchanges is experiencing a systems issue or disruption and quotation or trade information from that market is not currently being disseminated via the Cboe One Options Feed as part of the aggregated BBO. The Market Status message will also indicate when a Cboe Options Exchange is no longer experiencing a systems issue or disruption to properly reflect the status of the aggregated BBO.

[18] The Trade Break message will indicate when an execution on a Cboe Options Exchange is broken in accordance with the individual Cboe Options Exchange's rules (*e.g.,* Cboe Options Rule 6.5, C2 Option Rule 6.5, BZX Options Rule 20.6, EDGX Options Rule 20.6).

[19] The Trading Status message will indicate the current trading status of an option contract on each individual Cboe Options Exchange. A Trading Status message will also be sent whenever a security's trading status changes. For example, a Trading Status message will be sent when a symbol is open for trading or when a symbol is subject to a trading halt or when it resumes trading.

[20] For purposes of this filing, a ''vendor'', which is a type of distributor, will refer to any entity that receives an exchange market data product directly from the exchange or indirectly from another entity (for example, from an extranet) and then resell that data to a third-party customer (*e.g.,* a data provider that resells exchange market data to a retail brokerage firm). The term ''distributor'' herein, will refer to any entity that receives an exchange market data product, directly from the exchange or indirectly from another entity (*e.g.,* from a data vendor) and then distributes to individual internal or external end-users (*e.g.,* a retail brokerage firm who distributes exchange data to its individual employees and/or customers). An example of a vendor's ''third-party customer'' or ''customer'' is an institutional broker dealer or a retail broker dealer, who then may in turn distribute the data to their customers who are individual internal or external end-users.

against the monthly External Distribution Fee equal to the amount of monthly User Fees or Enterprise Fees up to a maximum of the External Distributor Fee. To ensure consistency across the Cboe Options Exchanges, Cboe Options, C2 Options, and BZX Options will be filing companion proposals to reflect this proposal in their respective fee schedules.

Distributor Fees

As proposed, each Internal Distributor that receives the Cboe One Options Feed shall pay a fee of $15,000 per month. The proposed Internal Distribution Fee equals the combined monthly Internal Distribution fees for the underlying individual data feeds of the Cboe Options Exchanges (*i.e.,* the monthly Internal Distribution fees are $3,000 for BZX Options Top, $500 for EDGX Options Top, $2,500 for C2 Options Top and $9,000 for Cboe Options Top). The Exchange also proposes to assess External Distributors a monthly fee of $10,000. The proposed External Distribution fee equals the combined monthly External Distribution fees for the underlying individual data feeds of the Cboe Options Exchanges (*i.e.,* the monthly External Distribution fees are $5,000 per month for the Cboe Options Top, $2,500 per month for C2 Options Top, $2,000 per month for BZX Options Top, and $500 for EDGX Options Top). As noted above, the Exchange is proposing to charge Internal Distributors an Internal Distribution Fee, and External Distributors an External Distribution Fee, that equals the combined respective Distribution fees of each individual Top feed to ensure the combined cost of subscribing to Cboe Options, C2 Options, BZX Options and EDGX Options Top feeds are no greater than the amount that would be charged to subscribe to the Cboe One Options feed, thereby ensuring that vendors could compete with the Exchange by creating the same product as the Cboe One Options Feed to sell to their clients.

User Fees

In addition to Internal and External Distributor Fees, the Exchange proposes to assess Professional User and Non-Professional User Fees. The proposed monthly Professional User fee for the Cboe Options Exchanges is $30.50 per Professional User, which equals the combined monthly Professional User fees of the underlying individual Cboe Options Exchanges Top feeds (*i.e.,* $15.50 per Professional User for the Cboe Options Top, $5 per Professional User for C2 Options Top, $5 per Professional User for BZX Options Top, and $5 per Professional User for EDGX Options Top). The Exchange also proposes to adopt a monthly Non-Professional User fee of $0.60 per Non-Professional User, which similarly represents the combined total Non-Professional User fee for the individual data feeds of the Cboe Options (*i.e.,* $0.30 per Non-Professional User for Cboe Options Top, $0.10 per Non-Professional User for C2 Options Top, $0.10 per Non-Professional User for BZX Options Top, and $0.10 per Non-Professional User for EDGX Options Top). Similar to the individual underlying feeds, Distributors that receive Cboe One Options Feed will be required to count Professional and Non-Professional Users to which they provide the data feed. The Exchange is proposing to charge Professional and Non-Professional User fees that equal the combined respective Professional and Non-Professional User fees of each individual Top feed to ensure the combined cost of subscribing to Cboe Options, C2 Options, BZX Options and EDGX Options Top feeds are no greater than the amount that would be charged to subscribe to the Cboe One Options feed, thereby ensuring that vendors could compete with the Exchange by creating the same product as the Cboe One Options Feed to sell to their clients.

Enterprise Fees

The Exchange also proposes to establish Enterprise Fees that will permit a Distributor to purchase a monthly (and optional) Enterprise license to receive the Cboe One Options Feed for distribution to a specified number of Professional and Non-Professional Users. The Enterprise Fee will be an alternative to Professional and Non-Professional User fees and will permit a Distributor to pay a flat fee to receive the data for a specified number of Professional and Non-Professional Users, which the Exchange proposes to make clear in the Fee Schedule. Like User fees, the Enterprise Fee would be assessed in addition to the Distribution Fees. The Exchange proposes to adopt the following monthly Enterprise Fees: $350,000 for up to 1,500,000 Users (Tier 1), $550,000 for 1,500,001 to 2,500,000 Users (Tier 2) and $750,000 for 2,500,001 or greater Users (Tier 3). The proposed fee amounts for each Tier equals the combined Enterprise Fees for the respective tiers for the underlying individual Cboe Options Exchanges Top feeds (*i.e.,* $300,000, $450,000 and $600,000 for Tiers 1, 2 and 3 respectively for the Cboe Options Top; $10,000, $20,000 and $30,000 for Tiers 1, 2 and 3 respectively for C2 Options Top; $20,000, $40,000 and $60,000 for Tiers 1, 2 and 3 respectively for BZX Options Top; and $20,000, $40,000 and $60,000 for Tiers 1, 2 and 3 respectively for EDGX Options Top). The proposed fees are non-progressive (*e.g.,* if a Distributor has 2,000,000 Users, it will be subject to $550,000 for Tier 2). The Enterprise Fee may provide an opportunity to reduce fees. For example, if a Distributor has 1 million Non-Professional Users who each receive Cboe One Options Feed at $0.60 per month (as proposed), then that Distributor will pay $600,000 per month in Non-Professional Users fees. If the Distributor instead were to purchase the proposed Enterprise license (Tier 1), it would alternatively pay a flat fee of $350,000 for up to 1.5 million Professional and Non-Professional Users. A Distributor must pay a separate Enterprise Fee for each entity that controls the display of Cboe One Options Feed if it wishes for such Users to be covered by an Enterprise Fee rather than by per User fees.[21] A Distributor that pays the Tier 1 or Tier 2 Enterprise Fee will have to report its number of such Users on a monthly basis. A Distributor that pays the Tier 3 Enterprise Fee will only have to report the number of its Users every six months.[22] The Exchange notes that if the reported number of Users exceed the Enterprise Tier a Distributor has purchased, the higher Tier will apply (*e.g.,* if a Distributor purchases Tier 1, but reports 1,600,000 Users for a month, the Distributor will be assessed the Tier 2 fee).

The Exchange also proposes to allow Distributors to purchase the Enterprise Fee on a monthly or annual basis. Annual licenses will receive a 5% discount off the applicable Enterprise Fee tier.[23] The Exchange notes that the purchase of an Enterprise license is voluntary, and a firm may elect to instead use the per User structure and benefit from the proposed per User Fees

[21] For example, if a Distributor that distributes EDGX Options Top to Retail Brokerage Firm A and Retail Brokerage Firm B and wishes to have the Users under each firm covered by an Enterprise license, the Distributor would be subject to two Enterprise Fees.

[22] *See* Cboe Global Markets North American Data Policies, which provides that Distributors that have obtained an Enterprise license are required to report quantities monthly unless they reach the highest Enterprise Tier available (*i.e.,* Tier 3), in which case they are required to report user quantities only every six months).

[23] The discount will be taken off the applicable fee assessed for the applicable Enterprise Tier each month. For example, if a Distributor elects to purchase an annual license and is in Tier 1 for any 9 months of the year and Tier 2 for any 3 months of the year, the total amount of fees paid for one year will be $4,560,00 ($350,000—5% × 9 months + $550,000—5% × 3 months) as compared to $4,800,000 ($350,000 × 9 months + $550,000 × 3 months). 3150000 [sic]

described above. For example, a firm that does not have a sufficient number of Users to benefit from purchase of a license need not do so. The Exchange is proposing to charge Enterprise Fees that equal the combined respective Enterprise Fees of each individual Top feed and is also is proposing to adopt a 5% discount for those that purchase an Annual license for Cboe Options Top (with a corresponding change will also be proposed by the Exchange's Affiliates) to ensure the combined cost of subscribing to Cboe Options, C2 Options, BZX Options and EDGX Options Top feeds will be the same as those that would be charged to subscribe to the Cboe One Options feed, thereby ensuring that vendors could compete with the Exchange by creating the same product as the Cboe One Options Feed to sell to their clients.

New External Distributor Credit

The Exchange proposes to adopt a New External Distributor Credit which would provide that new External Distributors of the Cboe One Options Feed will not be charged an External Distributor Fee for their first three (3) months in order to incentivize them to enlist new Users to receive the Cboe One Options Feed.[24] The Exchange notes that other exchanges, including the Exchange's affiliated equities exchanges offer similar credits for similar market data products. For example, Cboe's equities exchanges currently offer a one (1) month New External Distributor Credit applicable to the Cboe One Summary Feed and a three (3) month New External Distributor Credit applicable to the distribution of the Cboe One Premium Feed.[25] To alleviate any competitive issues that may arise with a vendor seeking to offer a product similar to the Cboe One Options Feed based on the underlying data feeds, the Exchange is proposing, as discussed above, to also adopt a three-month New External Distributor Credit for the underlying top-of-book data feeds for the Cboe Options Exchanges. The respective proposals to adopt a three-month credit ensures the proposed New External Distributor Credit for Cboe One Options will not cause the combined cost of subscribing to Cboe Options, C2 Options, BZX Options and EDGX Options Top feeds for new External Distributors to be greater than those that would be charged to subscribe to the Cboe One Options feed, thereby ensuring that vendors could compete with the Exchange by creating the same product as the Cboe One Options Feed to sell to their clients.

Distributor Fee Credit

The Exchange also proposes to provide that each External Distributor will receive a credit against its monthly External Distributor Fee for the Cboe One Options Feed equal to the amount of its monthly User Fees up to a maximum of the External Distributor Fee for the Cboe One Options Feed.[26] The proposed Enterprise Fees discussed above would also be counted towards the Distributor Fee credit, equal to the amount of its monthly Cboe One Options External Distribution fee. For example, an External Distributor will be subject to a $10,000 monthly Distributor Fee where they elect to receive the Cboe One Options Feed. If that External Distributor reports User quantities totaling $10,000 or more of monthly User fees of the Cboe Options One Feed, it will pay no net Distributor Fee, whereas if that same External Distributor were to report User quantities totaling $9,000 of monthly usage, it will pay a net of $1,000 for the Distributor Fee. External Distributors will remain subject to the per User fees discussed above. External Distributors who choose to purchase an Enterprise license as an alternative to paying User Fees will get a credit in the amount of the External Distribution Fee, which is currently $10,000, since the proposed Enterprise Fees are in excess of the External Distribution fee. In every case the Exchange will receive at least $10,000 in connection with the distribution of the Cboe One Options Feed (through a combination of the External Distribution Fee and per User Fees or the Enterprise Fees, as applicable). The Exchange notes that its affiliated equities exchanges offer a similar credit for a similar market data product.[27] The proposal to adopt a Distributor Fee Credit for Cboe One Options Feed ensures the proposed credit for Cboe One Options will not cause the combined cost of subscribing to Cboe Options, C2 Options, BZX Options and EDGX Options Top feeds for External Distributors to be greater than the amount that would be charged to subscribe to the Cboe One Options feed, thereby ensuring that vendors could compete with the Exchange by creating the same product as the Cboe One Options Feed to sell to their clients.

Data Consolidation Fee

The Exchange also proposes to charge Distributors of the Cboe One Options Feed a separate Data Consolidation Fee, which reflects the value of the aggregation and consolidation function the Exchange performs in creating the Cboe One Options Feed.[28] As stated above, the Exchange creates the Cboe One Options Feed from data derived from the Cboe Options Top, C2 Options Top, BZX Options Top, and EDGX Options Top Feeds. Distributors (including vendors) could similarly create a competing product to the Cboe One Options Feed based on these individual data feeds offered by the Exchanges, and could charge its clients a fee that it believes reflects the value of the aggregation and consolidation function. Accordingly, the Exchange believes that vendors could readily offer a product similar to the Cboe One Options Feed on a competitive basis at a similar cost.

2. Statutory Basis

The Exchange believes the proposed rule change is consistent with the Securities Exchange Act of 1934 (the ''Act'') and the rules and regulations thereunder applicable to the Exchange and, in particular, the requirements of Section 6(b) of the Act.[29] Specifically, the Exchange believes the proposed rule change is consistent with the Section 6(b)(5)[30] requirements that the rules of an exchange be designed to prevent fraudulent and manipulative acts and practices, to promote just and equitable principles of trade, to foster cooperation and coordination with persons engaged in regulating, clearing, settling, processing information with respect to, and facilitating transactions in securities, to remove impediments to and perfect the mechanism of a free and open market and a national market system, and, in general, to protect investors and the public interest. Additionally, the Exchange believes the proposed rule change is consistent with

[24] Any applicable User fees will continue to apply during this three-month period. The New External Distributor Credit will not apply during an External Distributor's trial usage period for Cboe One Options and such free trial basis will not count towards the three (3) months. For example, if an External Distributor has a trial usage period from June 1 through June 30, the New External Distributor Credit will apply for July, August and September.

[25] *See e.g.,* EDGX Equities Exchange Fees Schedule, Market Data Fees.

[26] The Distributor Fee Credit does not apply during any such time that an External Distributor is receiving the New External Distributor Credit or during a trial usage period for Cboe One Options.

[27] *See e.g.,* EDGX Equities Exchange Fees Schedule, Market Data Fees.

[28] If a vendor distributes the Cboe One Options Feed to another firm, who then re-distributes the Cboe One Options Feed, both entities would be subject to the Data Consolidation Fee. A vendor will only be assessed a single Data Consolidated Fee, even if it distributes Cboe One Options Feed to more than one entity.

[29] 15 U.S.C. 78f(b).

[30] 15 U.S.C. 78f(b)(5).

the Section 6(b)(5) requirement that the rules of an exchange not be designed to permit unfair discrimination between customers, issuers, brokers, or dealers. The Exchange also believes this proposal is consistent with Section 6(b)(8) of the Act, which requires that the rules of an exchange not impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act.[31] In addition, the Exchange believes that the proposed rule change is consistent with Section 11(A) of the Act as it supports (i) fair competition among brokers and dealers, among exchange markets, and between exchange markets and markets other than exchange markets, and (ii) the availability to brokers, dealers, and investors of information with respect to quotations for and transactions in securities.[32] The Exchange also believes the proposed rule change is consistent with Section 6(b)(4) of the Act,[33] which requires that Exchange rules provide for the equitable allocation of reasonable dues, fees, and other charges among its Trading Permit Holders and other persons using its facilities.

The Exchange first notes that it operates in a highly competitive environment. Indeed, there are currently 16 registered options exchanges that trade options. Based on publicly available information, no single options exchange has more than 18% of the market share.[34] The Exchange believes top-of-book quotation and transaction data is highly competitive as national securities exchanges compete vigorously with each other to provide efficient, reliable, and low-cost data to a wide range of investors and market participants. Indeed, there are several competing products offered by other national securities exchanges today, not counting products offered by the Exchange's affiliates, and each of the Exchange's affiliated U.S. options exchanges also offers similar top-of-book data.[35] Each of those exchanges offer top-of-book quotation and last sale information based on their own quotation and trading activity that is substantially similar to the information provided by the Exchange through the EDGX Options Top Data Feed. Further, the quote and last sale data contained in the EDGX Data Feed is identical to the data sent to OPRA for redistribution to the public.[36] Accordingly, Exchange top-of-book data is widely available today from a number of different sources.

Moreover, the EDGX Options Top Data Feed and Cboe One Options Feeds are distributed and purchased on a voluntary basis, in that neither the Exchange nor market data distributors are required by any rule or regulation to make these data products available. Accordingly, Distributors (including vendors) and Users can discontinue use at any time and for any reason, including due to an assessment of the reasonableness of fees charged. Further, the Exchange is not required to make any proprietary data products available or to offer any specific pricing alternatives to any customers. Moreover, persons (including broker-dealers) who subscribe to any exchange proprietary data feed must also have equivalent access to consolidated Options Information [37] from OPRA for the same classes or series of options that are included in the proprietary data feed, and proprietary data feeds cannot be used to meet that particular requirement.[38] As such, all proprietary data feeds are optional.

The Commission has repeatedly expressed its preference for competition over regulatory intervention in determining prices, products, and services in the securities markets. Particularly, in Regulation NMS, the Commission highlighted the importance of market forces in determining prices and SRO revenues and, also, recognized that current regulation of the market system ''has been remarkably successful in promoting market competition in its broader forms that are most important to investors and listed companies.'' [39] Making similar data products available to market participants fosters competition in the marketplace, and constrains the ability of exchanges to charge supracompetitive fees. In the event that a market participant views one exchange's data product as more or less attractive than the competition they can and do switch between similar products. The proposed fees are a result of the competitive environment, as the Exchange seeks to adopt fees to attract purchasers of EDGX Options Top Data and Cboe One Options Feed.

The Exchange has also taken into consideration its affiliated relationship with its Affiliates in its design of the Cboe One Options Feed to ensure that vendors would be able to offer a similar product on the same terms as the Exchange from a cost perspective. While the Cboe Options Exchanges are the exclusive distributors of the individual data feeds from which certain data elements may be taken to create the Cboe One Options Feed, they are not the exclusive distributors of the aggregated and consolidated information that comprises the Cboe One Options Feed. Any entity that receives, or elects to receive, the individual data feeds would be able to, if it so chooses, to create a data feed with the same information included in the Cboe One Options Feed and sell and distribute it to its clients so that it could be received by those clients as quickly as the Cboe One Options Feed would be received by those same clients with no greater cost than the Exchange.

In addition, vendors and Distributors that do not wish to purchase the Cboe One Options Feed may separately purchase the individual underlying products, and if they so choose, perform a similar aggregation and consolidation function that the Exchange performs in creating the Cboe One Options Feed. To enable such competition, the Exchange is offering the Cboe One Options Feed on terms that a vendor of those underlying feeds could offer a competing product if it so chooses.

In addition, the fees that are the subject of this rule filing are constrained by competition. Particularly, the Exchange competes with other exchanges (and their affiliates) that may choose to offer similar market data products. If another exchange (or its affiliate) were to charge less to consolidate and distribute a similar product than the Exchange charges to consolidate and distribute the Cboe One

[31] 15 U.S.C. 78f(b)(8).

[32] 15 U.S.C. 78k–1.

[33] 15 U.S.C. 78f(b)(4).

[34] *See* Cboe Global Markets U.S. Options Market Month-to-Date Volume Summary (April 24, 2023), available at *https://markets.cboe.com/us/options/market_statistics/*.

[35] *See e.g.,* NYSE Arca Options Proprietary Market Data Fees Schedule, MIAX Options Exchange, Fee Schedule, Section 6 (Market Data Fees), Nasdaq PHLX Options 7 Pricing Schedule, Section 10 (Proprietary Data Feed Fees) and Cboe Data Services, LLC Fees Schedule.

[36] The Exchange makes available the top-of-book data and last sale data that is included in the EDGX Options Top Data Feed no earlier than the time at which the Exchange sends that data to OPRA.

[37] ''Consolidated Options Information'' means consolidated Last Sale Reports combined with either consolidated Quotation Information or the BBO furnished by OPRA. Access to consolidated Options Information is deemed ''equivalent'' if both kinds of information are equally accessible on the same terminal or work station. See Limited Liability Company Agreement of Options Price Reporting Authority, LLC (''OPRA Plan''), Section 5.2(c)(iii). The Exchange notes that this requirement under the OPRA Plan is also reiterated under the Cboe Global Markets Global Data Agreement and Cboe Global Markets North American Data Policies, which subscribers to any exchange proprietary product must sign and are subject to, respectively. Additionally, the Exchange's Data Order Form (used for requesting the Exchange's market data products) requires confirmation that the requesting market participant receives data from OPRA.

[38] *Id.*

[39] *See* Securities Exchange Act Release No. 51808 (June 9, 2005), 70 FR 37496, 37499 (June 29, 2005) (''Regulation NMS Adopting Release'').

Options Feed, prospective Users likely could choose to not subscribe to, or would cease subscribing to, the Cboe One Options Feed. In addition, the Exchange would compete with unaffiliated market data vendors who would be in a position to consolidate and distribute the same data that comprises the Cboe One Options Feed into the vendor's own comparable market data product. If the third-party vendor is able to provide the exact same data for a lower cost, prospective Users would avail themselves of that lower cost and elect not to take the Cboe One Options Feed.

For these reasons, the Exchange believes that the proposed fees are reasonable, equitable, and not unfairly discriminatory.

User Fees. The Exchange believes that the proposed Professional and Non-Professional User fees for the Cboe One Options Feed are reasonable because they represent the combined monthly fees for Professional and Non-Professional User fees, respectively for the underlying individual data feeds, which have previously been filed with the Commission. The Exchange believes that the proposed fees are equitable and not unfairly discriminatory because they will be charged uniformly to Distributors. Combining the Professional and Non-Professional User fees, of each individual Top feed, respectively, further ensures vendors can compete with the Exchange by creating the same product as the Cboe One Options Feed to sell to their clients. Moreover, the proposed fee structure of differentiated Professional and Non-Professional fees that are paid by both Internal and External Distributors has long been used by other exchanges, including the Exchange, for their proprietary data products, and by the OPRA plan in order to reduce the price of data to retail investors and make it more broadly available.[40] The Exchange also believes offering Cboe One Options Feed to Non-Professional Users at a lower cost than Professional Users results in greater equity among data recipients, as Professional Users are categorized as such based on their employment and participation in financial markets, and thus, are compensated to participate in the markets. Although Non-Professional Users too can receive significant financial benefits through their participation in the markets, the Exchange believes it is reasonable to charge more to those Users who are more directly engaged in the markets.

Enterprise Fee. The Exchange believes the proposed Enterprise Fees for the Cboe One Options Feed and proposed changes to the Enterprise Fee for the EDGX Options Top feed are reasonable as the fees proposed could result in a fee reduction for Distributors of the respective products with a large number of Professional and Non-Professional Users. If a Distributor has a smaller number of Professional or Non-Professional Users of the Cboe One Options Feed or EDGX Options Top Feed, then it may continue using the per User structure and benefit from the per User Fee reductions for each respective product. By reducing prices for Distributors with a large number of Professional and Non-Professional Users, the Exchange believes that more firms may choose to receive and to distribute the Cboe One Options or EDGX Options Top feeds, thereby expanding the distribution of this market data for the benefit of investors. The Exchange believes it is reasonable, equitable and not unfairly discriminatory to assess incrementally higher fees for higher tiers, because such tier covers a higher number of users (and indeed for those in Tier 3, an unlimited number of users). The Exchange believes it's reasonable to require monthly reporting only for proposed Tiers 1 and 2 because such tiers cover a defined number of Users that need to be accounted for billing purposes, as compared to Tier 3 which covers unlimited Users. Also as described above, the Enterprise Fees are entirely optional. A firm that does not have a sufficient number of Users to benefit from purchase of a license, or purchase of a specific tier level, need not do so. The Exchange believes the proposed discount for an Annual license is also reasonable, equitable and not unfairly discriminatory as it provides Distributors an opportunity to be assessed lower fees and is available to any Distributor who chooses to make a one-year commitment via the Annual license. The Exchange believes the proposed 5% discount will attract Distributors to purchase and make available Cboe Options Top Data and Cboe One Options Feed for at least one year, thereby fostering and expanding the distribution of these market data products for the benefit of investors, and particularly retail investors. The Exchange lastly notes that the proposed Enterprise Fees for Cboe One Options and the proposed 5% discount for an Annual license equal the combined respective Enterprise Fees and discount, respectively, of each individual Top feed, thereby ensuring that vendors can compete with the Exchange by creating the same product as the Cboe One Options Feed to sell to their clients.

Distributor Fees. The Exchange believes that the proposed Distributor fees for the Cboe One Options Feed are reasonable because they represent the combined monthly fees for Internal and External Distributor fees, respectively for the underlying individual data feeds, which have previously been filed with the Commission. The Exchange believes that the proposed fees are equitable and not unfairly discriminatory because they will be charged uniformly to Internal and External Distributors. The Exchange believes that it is also fair and equitable, and not unfairly discriminatory to charge different fees for internal and external distribution of the Cboe One Options Feed. Although the proposed distribution fee charged to External Distributors will be lower than the distribution fee charged to Internal Distributors, External Distributors are subject to Non-Professional user fees to which Internal Distributors are not subject, in addition to Professional User fees (or alternatively the proposed Enterprise Fee). The Exchange also notes that Cboe One Options Feed, like the underlying top-of-book feeds, are more likely to be distributed externally as such data is expected to be used more frequently by Non-Professional Users who, by definition, do not receive the data for commercial purposes (*e.g.,* retail investors) and are therefore not internal. The Exchange therefore believes that the proposed reduced fee for External Distributors is reasonable because it may encourage more distributors to choose to offer the Cboe One Options, thereby expanding the distribution of this market data for the benefit of investors, and particularly retail investors.

The proposed Distributor Fees for the Cboe One Options Feed are also designed to ensure that vendors could compete with the Exchange by creating a similar product as the Cboe One Options Feed. The Exchange believes that the proposed Distributor Fees are equitable and reasonable as they equal the combined fee of subscribing to each individual data feed of the Cboe Options Exchanges, which have been previously published by the Commission.

New External Distributor Credit. In addition, the Exchange believes it is

[40] *See, e.g.,* Securities Exchange Act Release No. 59544 (March 9, 2009), 74 FR 11162 (March 16, 2009) (SR–NYSE–2008–131) (establishing the $15 Non-Professional User Fee (Per User) for NYSE OpenBook); *See, e.g.,* Securities Exchange Act Release No. 67589 (August 2, 2012), 77 FR 47459 (August 8, 2012) (revising OPRA's definition of the term ''Nonprofessional''); and *See* Securities Exchange Act Release No. 70683 (October 15, 2013), 78 FR 62798 (October 22, 2013) (SR–CBOE–2013–087) (establishing Professional and Non-Professional User fees for Cboe Options COB Data Feed).

reasonable to not charge External Distributors of EDGX Options Top and Cboe One Options Feed a Distribution Fee during their first three (3) months because such Distributors will not be subject to any External Distribution fees for those months.[41] Additionally, the Exchange's affiliated equities exchanges offer a similar credit for a similar market data product.[42] The proposed credit is also intended to incentivize new External Distributors to enlist Users to subscribe to the EDGX Options Top or Cboe One Options feeds in an effort to broaden the products' distribution. While this incentive is not available to Internal Distributors of these products, the Exchange believes it is appropriate as Internal Distributors have no Users outside of their own firm. Furthermore, External Distributors are subject to higher risks of launch as the data is provided outside their own firm. For these reasons, the Exchange believes it is appropriate to provide this incentive so that External Distributors have sufficient time to test the data within their own systems prior to going live externally. Similarly, the Exchange believes its reasonable and not unfairly discriminatory to not extend the proposed New External Distribution Credit to other market data products (*i.e.,* any External Distributor of EDGX Options Top that also distributes any other exchange market data product would still be subject to the External Distribution Fee) because the New External Distribution Credit is intended to incentivize external distribution of EDGX Options Top specifically, and if a Distributor wishes to distribute other products the Exchange believes it's reasonable to continue to charge for such products. The Exchange also does not believe the proposed credit would inhibit a vendor from creating a competing product and offer a similar free period as the Exchange. Specifically, a vendor seeking to create the Cboe One Options Feed could do so by subscribing to the underlying individual data feeds, all of which will also include a New External Distributor Credit identical to that proposed for the Cboe One Options Feed. As a result, a competing vendor would incur similar costs as the Exchange in offering such free period for a competing product and may do so on the same terms as the Exchange.

Distributor Fee Credit. The Exchange believes the proposal to provide External Distributors a credit against their monthly External Distribution Fee equal to the amount of its monthly Usage Fee or Enterprise Fees, is reasonable as it could result in the External Distributor paying a discounted, or no, External Distribution fee.[43] The Exchange notes that its affiliated equities exchanges offer a similar credit for a similar market data product.[44] Further, in every case the Exchange will receive at least the amount of the External Distribution fee for EDGX Options Top or Cboe One Options, as applicable, in connection with the distribution of each respective feed (through a combination of the External Distribution Fee and per User Fees or Enterprise Fees, as applicable). The Exchange believes it is also equitable and not unfairly discriminatory to apply the credit to External Distributors only because, like the free three-month credit described above, it is also intended to incentivize new External Distributors to enlist Users, including Non-Professional Users such as retail investors, to subscribe to the EDGX Options Top or Cboe One Options Feed in an effort to broaden the products' distribution. While this incentive is not available to Internal Distributors of these products, the Exchange believes it is appropriate as Internal Distributors have no Users outside of their own firm. Furthermore, External Distributors are subject to higher risks of launch as the data is provided outside their own firm. For these reasons, the Exchange believes it is appropriate to provide this incentive to only External Distributors. Similarly, the Exchange believes its reasonable and not unfairly discriminatory to not extend the proposed Distribution Fee Credit to other market data products (*i.e.,* any External Distributor of EDGX Options Top that also distributes any other exchange market data product would still be subject to the full External Distribution Fee) because the proposed credit is intended to incentivize distribution of EDGX Options Top specifically, and if a Distributor wishes to distribute other products the Exchange believes it's reasonable to continue to charge for such products.

The proposal to adopt a Distributor Fee Credit for Cboe One Options Feed in particular also ensures the proposed credit for Cboe One Options will not cause the combined cost of subscribing to Cboe Options, C2 Options, BZX Options and EDGX Options Top feeds for External Distributors to be greater than the amount that would be charged to subscribe to the Cboe One Options feed, thereby ensuring that vendors can compete with the Exchange by creating the same product as the Cboe One Options Feed (*i.e.,* purchasing the underlying data feeds and aggregating the feeds themselves) to sell to their clients.

The Exchange also believes updating the Trial Usage section avoids potential confusion as to whether new Users or Distributors would be entitled to any credits, including the proposed Distributor Fee Credit (and New External Distributor Credit), during the trial usage period. The Exchange believes its reasonable not to provide such credits as such new users are not paying assessed any fees during their trial period.

Data Consolidation Fee. The Exchange believes that the proposed $500 per month Data Consolidation Fee charged to Distributors (including vendors) who receive the Cboe One Options Feed is reasonable because it represents the value of the data aggregation and consolidation function that the Exchange performs. The Exchange further believes the proposed Data Consolidation Fee is not designed to permit unfair discrimination because all Distributors who obtain the Cboe One Options Feed will be charged the same fee. Accordingly, the Exchange believes that Distributors could readily offer a product similar to the Cboe One Options Feed on a competitive basis at a similar cost. Therefore, the Exchange believes the proposed application of the Data Consolidation Fee is reasonable would not permit unfair discrimination.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange does not believe that the proposed rule change would result in any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act. The Exchange operates in a highly competitive environment, and its ability to price top-of-book data is constrained by competition among exchanges that offer similar data products to their customers. Top-of-book data is broadly disseminated by competing U.S. options exchanges. In this competitive environment potential Distributors are free to choose which competing product to purchase to satisfy their respective needs for market information. Often, the choice comes down to price, as market data participants look to purchase

[41] As noted above, Distributors are additionally not assessed any Distribution fee during any trial usage period, under the existing Trial Usage period offered by the Exchange.

[42] *See e.g.,* EDGX Equities Exchange Fees Schedule, Market Data Fees.

[43] A Distributor that does not qualify to receive the New External Distributor Credit, does not need to wait three months to be eligible to receive the Distributor Fee Credit (*i.e.,* the Distributor would be eligible to receive the credit immediately).

[44] *See e.g.,* EDGX Equities Exchange Fees Schedule, Market Data Fees.

cheaper data products, and quality, as market participants seek to purchase data that represents significant market liquidity.

The Exchange believes that the proposed fees do not impose a burden on competition or on other SROs that is not necessary or appropriate in furtherance of the purposes of the Act. In particular, market participants are not forced to subscribe to EDGX Options Top, Cboe One Options Feed or any of the Exchange's data feeds, as described above. As noted, the quote and last sale data contained in the Exchange's EDGX Options Top feed is identical to the data sent to OPRA for redistribution to the public. Accordingly, Exchange top-of-book data is widely available today from a number of different sources.

The Exchange believes that the proposed fees do not put any market participants at a relative disadvantage compared to other market participants. As discussed, the proposed waiver, credits and Enterprise Fees would apply to all similarly situated Distributors of EDGX Options Top on an equal and non-discriminatory basis. Because market data customers can find suitable substitute feeds, an exchange that overprices its market data products stands a high risk that users may substitute another product. These competitive pressures ensure that no one exchange's market data fees can impose an undue burden on competition, and the Exchange's proposed fees do not do so here.

Additionally, the Cboe One Options Feed will enhance competition because it provides investors with an alternative option for receiving market data. Although the Cboe Options Exchanges are the exclusive distributors of the individual data feeds from which certain data elements would be taken to create the Cboe One Options Feed, the Exchange would not be the exclusive distributor of the aggregated and consolidated information that would compose the proposed Cboe One Options Feed. Any entity that receives, or elects to receive, the underlying data feeds would be able to, if it so chooses, to create a data feed with the same information included in the Cboe One Options Feed and sell and distribute it to its clients so that it could be received by those clients as quickly as the Cboe One Options Feed would be received by those same clients and at a similar cost.

The proposed pricing the Exchange would charge for the Cboe One Options Feed compared to the cost of the individual data feeds from the Cboe Options Exchanges would enable a vendor to receive the underlying individual data feeds and offer a similar product on a competitive basis and with no greater cost than the Exchange. The pricing the Exchange proposes to charge for the Cboe One Options Feed is not lower than the cost to a vendor of receiving the underlying data feeds. Indeed, the proposed pricing equals the combined costs of the respective fees, and the proposed waivers are also being proposed for the underlying individual feeds as well, thereby enabling a vendor to receive the underlying data feeds and offer a similar product on a competitive basis and with no greater cost than the Exchange.

The Exchange further believes that its proposed monthly Data Consolidation Fee would be pro-competitive because a vendor could create a competing product, perform a similar aggregating and consolidating function, and similarly charge for such service. The Exchange notes that a competing vendor might engage in a different analysis of assessing the cost of a competing product. For these reasons, the Exchange believes the proposed pricing, fee waiver and credit, would enable a vendor to create a competing product based on the individual data feeds and charge its clients a fee that it believes reflects the value of the aggregation and consolidation function that is competitive with Cboe One Options Feed pricing.

In establishing the proposed fees, the Exchange considered the competitiveness of the market for proprietary data and all of the implications of that competition. The Exchange believes that it has considered all relevant factors and has not considered irrelevant factors in order to establish fair, reasonable, and not unreasonably discriminatory fees and an equitable allocation of fees among all users.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

The Exchange has not solicited, and does not intend to solicit, comments on this proposed rule change. The Exchange has not received any written comments from members or other interested parties.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

The foregoing rule change has become effective pursuant to Section 19(b)(3)(A) of the Act [45] and paragraph (f) of Rule 19b–4 [46] thereunder. At any time within 60 days of the filing of the proposed rule change, the Commission summarily may temporarily suspend such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act. If the Commission takes such action, the Commission will institute proceedings to determine whether the proposed rule change should be approved or disapproved.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's internet comment form (*https://www.sec.gov/rules/sro.shtml*); or
- Send an email to *rule-comments@sec.gov.* Please include file number SR–CboeEDGX–2023–050 on the subject line.

Paper Comments

- Send paper comments in triplicate to Secretary, Securities and Exchange Commission, 100 F Street NE, Washington, DC 20549–1090.

All submissions should refer to file number SR–CboeEDGX–2023–050. This file number should be included on the subject line if email is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's internet website (*https://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for website viewing and printing in the Commission's Public Reference Room, 100 F Street NE, Washington, DC 20549, on official business days between the hours of 10 a.m. and 3 p.m. Copies of the filing also will be available for inspection and copying at the principal office of the Exchange. Do not include personal identifiable information in submissions; you should submit only information

[45] 15 U.S.C. 78s(b)(3)(A).

[46] 17 CFR 240.19b–4(f).

that you wish to make available publicly. We may redact in part or withhold entirely from publication submitted material that is obscene or subject to copyright protection. All submissions should refer to file number SR–CboeEDGX–2023–050 and should be submitted on or before August 23, 2023.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[47]

Sherry R. Haywood,

Assistant Secretary.

[FR Doc. 2023–16391 Filed 8–1–23; 8:45 am]

BILLING CODE 8011–01–P

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–98010; File No. SR–EMERALD–2023–16]

Self-Regulatory Organizations; MIAX Emerald, LLC; Notice of Filing and Immediate Effectiveness of a Proposed Rule Change To Make Minor, Non-Substantive Edits to Rules 100, 515A, and 521

July 27, 2023.

Pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 (''Act''),[1] and Rule 19b–4 thereunder,[2] notice is hereby given that on July 17, 2023, MIAX Emerald, LLC (''MIAX Emerald'' or ''Exchange'') filed with the Securities and Exchange Commission (''Commission'') the proposed rule change as described in Items I and II below, which Items have been prepared by the Exchange. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The Exchange proposes to make a number of minor, non-substantive edits to Interpretations and Policies .01(b) of Exchange Rule 100, Definitions, Exchange Rule 515A, MIAX Emerald Price Improvement Mechanism (''PRIME'') and PRIME Solicitation Mechanism, and Interpretations and Policies .03 of Exchange Rule 521, Nullification and Adjustment of Options Transactions Including Obvious Errors.

The text of the proposed rule change is available on the Exchange's website at *https://www.miaxglobal.com/markets/us-options/emerald-options/rule-filings,* at MIAX Emerald's principal office, and at the Commission's Public Reference Room.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the Exchange included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. The Exchange has prepared summaries, set forth in sections A, B, and C below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

Amendment to Exchange Rule 515A

The Exchange proposes to amend Exchange Rule 515A to make minor, non-substantive edits and clarifying changes to provide accuracy and precision within the rule text.

Specifically, the Exchange proposes to amend current subparagraphs (a)(1)(ii) and (a)(1)(iii) to remove the periods at the end of the sentences and replace them with semicolons for grammatical correctness and clarity in the Rule text. Additionally, the Exchange proposes to remove the word ''and'' at the end of subparagraph (a)(1)(i) and add the word ''and'' at the end of subparagraph (a)(1)(iii). Furthermore, the Exchange proposes to amend current subparagraph (a)(1)(iii) by changing the first word ''With'' to lowercase at the beginning of the sentence. Accordingly, with the proposed changes, subparagraphs (a)(1)(i) through (a)(1)(iv) will read as follows:

(i) the Agency Order is in a class designated as eligible for PRIME as determined by the Exchange and within the designated Auction order eligibility size parameters as such size parameters are determined by the Exchange;

(ii) the Initiating Member must stop the entire Agency Order as principal or with a solicited order at the better of the NBBO or the Agency Order's limit price (if the order is a limit order);

(iii) with respect to Agency Orders that have a size of less than 50 contracts, if at the time of receipt of the Agency Order, the NBBO has a bid/ask differential of $0.01, the System will reject the Agency Order; and

(iv) Post-only OQs may not participate in PRIME as an Agency Order, principal interest or solicited interest.

Amendment to the Interpretations and Policies of Exchange Rules 100 and 521

The Exchange proposes to amend the Interpretations and Policies of Exchange Rules 100 and 521 to make minor, non-substantive edits and clarifying changes to provide accuracy and precision within the Interpretations and Policies of the Rule text.

Specifically, the Exchange proposes to amend current subparagraph .01(b) of the Interpretations and Policies of Exchange Rule 100 to replace the capitalized word ''Complex'' with the lowercase word ''complex'' at the beginning of the second sentence. Accordingly, with the proposed changes, subparagraph .01(b) will provide as follows:

(b) Complex orders comprised of eight (8) options legs or fewer shall be counted as a single order. For complex orders comprised of nine (9) options legs or more, each leg shall count as its own separate order.

Similarly, the Exchange proposes to amend current paragraph ''.03 Complex Orders'' of the Interpretations and Policies of Exchange Rule 521 to replace all the capitalized occurrences of the word ''Complex'' with the lowercase word ''complex''. Accordingly, with the proposed changes, paragraph ''.03 Complex Orders'' will provide as follows:

.03 Complex Orders.

(a) If a complex order executes against individual legs and at least one of the legs qualifies as an Obvious Error under paragraph (c)(1) or a Catastrophic Error under paragraph (d)(1), then the leg(s) that is an Obvious or Catastrophic Error will be adjusted in accordance with paragraphs (c)(4)(A) or (d)(3), respectively, regardless of whether one of the parties is a Customer. However, any Customer order subject to this paragraph (a) will be nullified if the adjustment would result in an execution price higher (for buy transactions) or lower (for sell transactions) than the Customer's limit price on the complex order or individual leg(s). If any leg of a complex order is nullified, the entire transaction is nullified.

[47] 17 CFR 200.30–3(a)(12).

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

(b) If a complex order executes against another complex order and at least one of the legs qualifies as an Obvious Error under paragraph (c)(1) or a Catastrophic Error under paragraph (d)(1), then the leg(s) that is an Obvious or Catastrophic Error will be adjusted or busted in accordance with paragraph (c)(4) or (d)(3), respectively, so long as either: (i) the width of the National Spread Market for the complex order strategy just prior to the erroneous transaction was equal to or greater than the amount set forth in the wide quote table of paragraph (b)(3), or

(ii) the net execution price of the complex order is higher (lower) than the offer (bid) of the National Spread Market for the complex order strategy just prior to the erroneous transaction by an amount equal to at least the amount shown in the table in paragraph (c)(1). If any leg of a complex order is nullified, the entire transaction is nullified. For purposes of this Rule 521, the National Spread Market for a complex order strategy is determined by the National Best Bid/Offer of the individual legs of the strategy.

The purpose of all these proposed changes is to provide consistency and uniformity within the Exchange's Rulebook.

2. Statutory Basis

The Exchange believes that the proposed rule changes are consistent with Section 6(b) of the Act [3] in general, and furthers the objectives of Section 6(b)(1) of the Act [4] in particular, in that they are designed to enforce compliance by its Members [5] and persons associated with its Members, with the provisions of the rules of the Exchange. In particular, the Exchange believes that the proposed rule changes will provide greater clarity to Members and the public regarding the Exchange's Rules by correcting grammatical errors and providing consistency within the Exchange's Rulebook. The proposed changes will also make it easier for Members to interpret the Exchange's Rulebook.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange does not believe that the proposed rule changes will impose any burden on competition not necessary or appropriate in furtherance of the purposes of the Act. Specifically, the Exchange believes the proposed changes will not impose any burden on intra-market competition as there is no functional change to the Exchange's System [6] and because the rules of the Exchange apply to all MIAX Emerald participants equally. The Exchange believes the proposed rule changes will not impose any burden on intra-market competition as the proposed changes are not designed to address any competitive issue but rather are designed to remedy minor non-substantive issues and provide added precision and accuracy to the rule text of Exchange Rule 515A and the Interpretations and Policies of Exchange Rules 100 and 521. In addition, the Exchange does not believe the proposal will impose any burden on inter-market competition as the proposal does not address any competitive issues and is intended to protect investors by providing further transparency and precision for referencing the Exchange's Rules.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

Written comments were neither solicited nor received.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

The Exchange has filed the proposed rule change pursuant to Section 19(b)(3)(A)(iii) of the Act [7] and Rule 19b–4(f)(6) thereunder.[8] Because the proposed rule change does not: (i) significantly affect the protection of investors or the public interest; (ii) impose any significant burden on competition; and (iii) become operative prior to 30 days from the date on which it was filed, or such shorter time as the Commission may designate, if consistent with the protection of investors and the public interest, the proposed rule change has become effective pursuant to Section 19(b)(3)(A) of the Act [9] and Rule 19b–4(f)(6)(iii) thereunder.[10]

At any time within 60 days of the filing of such proposed rule change, the Commission summarily may temporarily suspend such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act. If the Commission takes such action, the Commission shall institute proceedings under Section 19(b)(2)(B) [11] of the Act to determine whether the proposed rule change should be approved or disapproved.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's internet comment form (*https://www.sec.gov/rules/sro.shtml*); or
- Send an email to *rule-comments@sec.gov*. Please include file number SR–EMERALD–2023–16 on the subject line.

Paper Comments

- Send paper comments in triplicate to Secretary, Securities and Exchange Commission, 100 F Street NE, Washington, DC 20549–1090.

All submissions should refer to file number SR–EMERALD–2023–16. This file number should be included on the subject line if email is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's internet website (*https://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for website viewing and printing in the Commission's Public Reference Room, 100 F Street NE, Washington, DC 20549, on official business days between the hours of 10 a.m. and 3 p.m. Copies of the filing also will be available for inspection and copying at the principal office of the Exchange. Do not include personal identifiable information in submissions; you should submit only information that you wish to make available publicly. We may redact in part or

[3] 15 U.S.C. 78f(b).

[4] 15 U.S.C. 78f(b)(1).

[5] The term ''Member'' means an individual or organization approved to exercise the trading rights associated with a Trading Permit. Members are deemed ''members'' under the Exchange Act. *See* Exchange Rule 100.

[6] The term ''System'' means the automated trading system used by the Exchange for the trading of securities. *See* Exchange Rule 100.

[7] 15 U.S.C. 78s(b)(3)(A)(iii).

[8] 17 CFR 240.19b–4(f)(6).

[9] 15 U.S.C. 78s(b)(3)(A).

[10] 17 CFR 240.19b–4(f)(6). In addition, Rule 19b–4(f)(6) requires a self-regulatory organization to give the Commission written notice of its intent to file the proposed rule change, along with a brief description and text of the proposed rule change, at least five business days prior to the date of filing of the proposed rule change, or such shorter time as designated by the Commission. The Exchange has satisfied this requirement.

[11] 15 U.S.C. 78s(b)(2)(B).

withhold entirely from publication submitted material that is obscene or subject to copyright protection. All submissions should refer to file number SR–EMERALD–2023–16 and should be submitted on or before August 23, 2023.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[12]

Sherry R. Haywood,

Assistant Secretary.

[FR Doc. 2023–16390 Filed 8–1–23; 8:45 am]

BILLING CODE 8011–01–P

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–98012; File No. SR–OPRA–2023–01]

Options Price Reporting Authority; Notice of Filing and Immediate Effectiveness of Proposed Amendment To Modify the OPRA Fee Schedule Regarding Caps on Certain Port Fees

July 27, 2023.

Pursuant to Section 11A of the Securities Exchange Act of 1934 (''Act'')[1] and Rule 608 thereunder,[2] notice is hereby given that on July 17, 2023, the Options Price Reporting Authority (''OPRA'') filed with the Securities and Exchange Commission (''Commission'') a proposed amendment to the Plan for Reporting of Consolidated Options Last Sale Reports and Quotation Information (''OPRA Plan'').[3] The proposed OPRA Plan amendment (''Amendment'') would amend the OPRA Fee Schedule. The Commission is publishing this notice to provide interested persons an opportunity to submit written comments on the Amendment.

The Amendment has been filed by the Participants pursuant to Rule 608(b)(2) under Regulation NMS.[4] The Commission is publishing this notice to solicit comments from interested persons on the proposed Amendment. Set forth in Section I, which was prepared and filed with the Commission by the Participants, is the statement of the purpose and summary of the Amendment, along with information pursuant to Rule 608(a) under the Act.[5] A copy of the OPRA Fee Schedule, marked to show the proposed Amendment, is Attachment A to this notice.

I. Rule 608(a)

(a) Statement of Purpose

The purpose of the amendment is to amend the OPRA Fee Schedule to provide public notice of the fact that OPRA negotiated terms in the 2021 Processor Services Agreement (the ''2021 Processor Agreement'') between OPRA and the Securities Industry Automation Corporation (''SIAC'') which impose caps on certain port fees that can be charged per month when SIAC, either directly or through a third party, provides direct access to OPRA data to any person authorized by OPRA to receive direct access to OPRA data.

Under the 2021 Processor Agreement, SIAC is OPRA's ''processor,'' meaning that SIAC gathers the last sale and quote information from each of the OPRA members, consolidates that information, and disseminates the consolidated OPRA data. As the processor, SIAC works directly with OPRA members and data vendors to provide connectivity to SIAC. Connectivity to SIAC is currently provided by an affiliate of SIAC, the ICE Global Network (''IGN''), and IGN both sets and charges the port fees associated with that connectivity. OPRA, in contrast, does not provide access ports, it does not charge any port fees, it does not collect any fees on behalf of OPRA members in connection with access to SIAC, and it does not receive any portion of port fees charged by other entities. As a result, OPRA does not believe that the caps that OPRA negotiated with SIAC concerning the amount of port fees that can be charged either (1) establishes or changes a fee or charge collected on behalf of the members of the OPRA Plan in connection with access to, or use of, any OPRA facilities or (2) represents a fee or charge imposed by OPRA as contemplated by Rule 608(a)(5)(ii) of Regulation NMS.[6] Nonetheless, OPRA is submitting this proposed plan amendment because OPRA wishes to provide the public with notice of the contractual fee caps that it negotiated with SIAC and because Commission Staff requested that it do so.

In 2014, OPRA was engaged in a competitive bidding process involving firms that were seeking to become OPRA's data processor for a five-year term to begin in 2015. As part of that process, OPRA was considering many factors raised by the materials submitted by several entities in response to OPRA's request for proposals. Although OPRA does not own, or have any control over, the myriad locations where a data recipient might choose to receive OPRA data and OPRA has no role in setting the port connection fees that might be charged by the entities that control access at those locations, OPRA requested that the two finalist bidders each outline any commitments that they could make to cap the 10G and 40G network connection fees that might be charged to data recipients and to the OPRA members during the term of the new processor agreement. In response, SIAC, the bidder that was eventually selected to continue as the OPRA processor, stated its expectation that the 10G port fee would not rise above the then current rate of $16,000 per month (including the cross-connect) and that the 40G port fee would not rise above the then current rate of $20,500 per month (including the cross-connect).

As OPRA negotiated the terms of a new processor agreement with SIAC, OPRA's Management Committee requested that SIAC's expectation that port fees would not increase above the existing levels be included in the agreement, and SIAC agreed. SIAC also agreed to the inclusion of a provision providing that, whenever higher capacity ports might become available during the term of the agreement, OPRA would have the right to approve a cap on the port fees that could be charged for those higher capacity ports.

Effective as of January 1, 2015, OPRA and SIAC entered into a new Processor Agreement for a term ending on December 31, 2020 (the ''2015 Processor Agreement''). Consistent with the parties' negotiations, the 2015 Processor Agreement contained the following provision:

> During the Term, SIAC will provide, directly or through a third party, access to OPRA Data to any person authorized by OPRA to receive direct access to OPRA Data for total fees not to exceed $16,000 per month per 10G port and $20,500 per month per 40G port, in each case, inclusive of cross-connect (whether or not such fees also cover direct access to data in addition to the OPRA Data). If and when during the Term, direct access to the OPRA Data becomes available via higher capacity ports, SIAC will provide, directly or through a third party, access to OPRA Data to any person authorized by OPRA to receive direct access to OPRA Data for total fees not to exceed an amount approved by OPRA (such approval not to be unreasonably withheld) and not inconsistent with the 10G and 40G port rates.

[12] 17 CFR 200.30–3(a)(12).

[1] 15 U.S.C. 78k–1.

[2] 17 CFR 242.608.

[3] The OPRA Plan is a national market system plan approved by the Commission pursuant to Section 11A of the Act and Rule 608 thereunder. *See* Securities Exchange Act Release No. 17638 (March 18, 1981), 22 S.E.C. Docket 484 (March 31, 1981). The full text of the OPRA Plan and a list of its participants are available at *https://www.opraplan.com/*. The OPRA Plan provides for the collection and dissemination of last sale and quotation information on options that are traded on the participant exchanges.

[4] 17 CFR 242.608(b)(2).

[5] 17 CFR 242.801(a).

[6] 17 CFR 242.608(a)(5)(ii).

In sum, although OPRA does not set or charge port fees, OPRA used the negotiation process as an opportunity to ensure that SIAC's ability to increase the amount of port fees would be capped during the term of the 2015 Processor Agreement for all OPRA data recipients, including OPRA members, who were authorized to receive direct access to OPRA data.

In 2019, as the end of the term of the 2015 Processor Agreement approached, OPRA engaged in another competitive process of soliciting and considering bids from interested entities to act as OPRA's data processor. Among the many factors assessed by OPRA, OPRA considered the port fees that bidders proposed to charge, and SIAC agreed to maintain the existing terms of the 2015 Processor Agreement regarding the port fee cap provisions applicable to OPRA direct data recipients, including OPRA members.

Effective as of January 1, 2021, OPRA and SIAC entered into the 2021 Processor Agreement, which runs for a term ending on January 1, 2026. In the 2021 Processor Agreement, the parties agreed as follows:

Port Fees

During the Term of the Agreement, SIAC will provide, directly or through a third party, access to OPRA Data to any person authorized by OPRA to receive direct access to OPRA Data for total fees not to exceed $16,000 per month per 10G port and $20,500 per month per 40G port, in each case, inclusive of cross-connect (whether or not such fees also cover direct access to data in addition to the OPRA Data). If and when during the Term, direct access to OPRA Data becomes available via higher capacity ports, SIAC will provide, directly or through a third party, access to OPRA Data to any person authorized by OPRA to receive direct access to OPRA Data for total fees not to exceed an amount approved by OPRA (such approval not to be unreasonably withheld) and not inconsistent with the 10G and 40G port rates.

There will be no One-Time Fee charged for existing OPRA Members and data Customers as of the Effective Date. Ongoing charges for connecting to the IGN will continue to apply at their then-current rates.

In the provision quoted above, OPRA and SIAC agreed that SIAC, and any third-parties that SIAC utilized to provide direct access to OPRA data, would continue to abide by the port fee caps that were originally established in the 2015 Processor Agreement through December 31, 2026.

In September 2021, SIAC, in accordance with the terms of the 2021 Processor Agreement, notified OPRA that OPRA data would become available over 100G ports. SIAC also requested that OPRA approve a $30,000 per month port fee cap, inclusive of cross connect, for such 100G ports.

In 2021, after OPRA's Technical Committee considered SIAC's request and approved it, OPRA's Management Committee also approved a $30,000 per month port fee cap with respect to 100G ports. Following that approval, Commission Staff, which attends the meetings of OPRA's Management Committee, informed OPRA that it should submit a filing to the Commission with respect to the port fee caps. Although, as noted above, OPRA does not believe that the contractual port fee caps represent a fee charged by OPRA that falls within the scope of Rule 608(a)(5)(ii), OPRA is making this filing because it would like to provide notice to the public of the existence of the port fee caps that it has negotiated with SIAC. In connection with this filing, OPRA requested that SIAC confirm that it has complied with its obligations under the contractual port fee cap provisions contained in both the 2015 Processor Agreement and in the 2021 Processor Agreement and SIAC confirmed that it has complied with those provisions.

The text of the amendment to the OPRA Plan is available at OPRA, the Commission's Public Reference Room, the OPRA website at *http://opradata.com,* and on the Commission's website at *www.sec.gov.*

(b) Manner of Implementation of Amendment

OPRA proposes to add the proposed amendment to the OPRA Fee Schedule following Commission approval of the amendment pursuant to paragraph (b)(1) and (b)(2) of Rule 608 of Regulation NMS under the Act. OPRA states that the monthly caps on 10G and 40G port fees have been in effect since 2015 and the contractual cap on 100G port fees has been in effect since 2021.

(c) Phases of Development and Implementation

Not applicable.

(d) Impact on Competition

OPRA believes that the proposed amendment will impose no burdens on competition that are not justified in light of the purposes of the Act.

(e) Written Understandings or Agreements Among Plan Members

Not applicable.

(f) Approval of Proposed Amendment

OPRA represents that the proposed amendments to the OPRA Fee Schedule were approved in accordance with the provisions of the OPRA Plan.

II. Solicitation of Comments

The Commission seeks comment on the Amendment. Interested persons are invited to submit written data, views and arguments concerning the foregoing, including whether the Amendment is consistent with the Act and the rules thereunder. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's internet comment form (*https://www.sec.gov/rules/sro.shtml*); or
- Send an email to *rule-comments@sec.gov.* Please include file number SR–OPRA–2023–01 on the subject line.

Paper Comments

- Send paper comments in triplicate to Secretary, Securities and Exchange Commission, 100 F Street NE, Washington, DC 20549–1090.

All submissions should refer to file number SR–OPRA–2023–01. This file number should be included on the subject line if email is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's internet website (*https://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for website viewing and printing in the Commission's Public Reference Room, 100 F Street NE, Washington, DC 20549, on official business days between the hours of 10 a.m. and 3 p.m. Copies of the filing also will be available for inspection and copying at the principal office of the Exchange. Do not include personal identifiable information in submissions; you should submit only information that you wish to make available

publicly. We may redact in part or withhold entirely from publication submitted material that is obscene or subject to copyright protection. All submissions should refer to file number SR–OPRA–2023–01 and should be submitted on or before August 23, 2023.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[7]

Sherry R. Haywood,

Assistant Secretary.

Attachment A—Proposed Changes to Options Price Reporting Authority Fee Schedule

ATTACHMENT A

PROPOSED CHANGES TO THE OPTIONS PRICE REPORTING AUTHORITY FEE SCHEDULE

[Additions are *italicized;* Deletions are [bracketed].]

Description	Basic Service [1]
Professional Subscriber Device-Based Fees (Monthly fee applicable to persons that enter into Professional Subscriber Agreements directly with OPRA): These fees are subject to written policies, which are available at *www.opradata.com.*[2] [3] [4]	$30.50 per display device commencing January 1, 2017 $31.50 per display device commencing January 1, 2018
Nonprofessional Subscriber Fees: Monthly fees payable by every vendor that furnishes OPRA Data to nonprofessional subscribers (other than nonprofessional subscribers in respect of whom a vendor elects to pay usage-based vendor fees).	Up to 75,000: $1.25 per nonprofessional subscriber (''nonpro'') 75,001–150,000: $1.15 per nonpro 150,001–250,000: $1.00 per nonpro 250,001–500,000: $0.75 per nonpro 500,001 +: $0.60 per nonpro
Usage-based Vendor Fee (Applicable in respect of professional subscribers who enter into Subscriber Agreements with Vendors in place of Professional Subscriber Agreements with OPRA, and in respect of nonprofessional subscribers to Basic Service in place of flat monthly Nonprofessional Subscriber Fee): Monthly fee payable in arrears by a vendor with respect to the use of OPRA Data by persons that enter into Subscriber Agreements with vendors. Usage-based vendor fees apply to each ''quote packet'' or, if elected in writing by the vendor with respect to the Basic Service, to each ''options chain.''[5] All inquiries are counted for purposes of calculating usage-based fees, except that requests for ''delayed'' and ''historical'' OPRA Data are not counted.[6]	$0.0075 per ''quote packet'' or $0.03 per ''options chain'', subject to a stated maximum amount per month [7]
Redistribution Fee: Monthly fee payable by every vendor that redistributes OPRA Data to any person, whether on a current or delayed basis, except that this fee does not apply to a Vendor whose redistribution of OPRA Data is limited solely to ''historical'' OPRA Data.	$1,500; $650 (Query service only) [8]
Subscriber Indirect Access Fee: A monthly fee payable by every professional subscriber that receives indirect access to OPRA Data via a data feed transmission from an OPRA vendor. This fee shall not apply to a subscriber (i) that receives a data feed transmission on a single, stand-alone computer for the sole purpose of providing a single-screen display of OPRA Data for the subscriber's internal use, (ii) whose access and entitlement to OPRA Data received via a data feed transmission is controlled by an authorized control service provider or by the vendor furnishing the data feed transmission, or (iii) that receives a data feed transmission solely for any Non-Display Use.	$600
Direct Access Fee: Monthly fee payable by every vendor and professional subscriber that has been authorized by OPRA to receive OPRA Data directly from OPRA's processor. This charge includes one primary and one back-up circuit connection at the processor. Additional circuit connections are available at a monthly charge of $100 per connection.	$1,000
Monthly Non-Display Use Fees: [9]	
Category 1 Non-Display Use:	$2000 per Enterprise [10]
Category 2 Non-Display Use:	$2000 per Enterprise [10]
Category 3 Non-Display Use:	$2000 per Platform [11]
Voice-Synthesized Market Data Service Fee: Monthly fee payable in arrears by every vendor or professional subscriber that offers a voice-synthesized market data service. (To offer such a service, a professional subscriber must enter into a Voice-Synthesized Market Data Service Rider to its Professional Subscriber Agreement.) The fee is based on the number of active simultaneously accessible ports of the voice- synthesized computer facility of the vendor or professional subscriber through which the service is furnished. Alternatively, a vendor (but not a professional subscriber) may elect in writing to pay a usage-based fee for OPRA Data accessed over vendor's voice-synthesized market data service as an alternative to the port-based fee. All inquiries are counted for purposes of calculating usage-based fees, except that requests for ''delayed'' and ''historical'' OPRA Data are not counted.	Port-based fee, same as device-based Professional Subscriber Fee treating each port as one device; or usage-based fee at a rate of $0.005 per ''quote packet'' or $0.02 per ''options chain''.
Control Service Fee: A monthly fee payable by every authorized control service provider that offers a market information electronic data control service to OPRA subscribers and in connection therewith has entered into a Data Control Service Agreement with OPRA.	$2,800
Television Display Fee: A monthly fee payable by every Vendor that has entered into a Television Dissemination Rider with OPRA.	$0.50 per 1,000 households reached [12]

[7] 17 CFR 200.30–3(a)(85).

PROPOSED CHANGES TO THE OPTIONS PRICE REPORTING AUTHORITY FEE SCHEDULE—Continued

[Additions are *italicized;* Deletions are [bracketed].]

Description	Basic Service [1]
Hosted Solution Fee: Monthly fee payable by each Vendor with respect to Hosted Solutions that it administers on behalf of third parties. (The term ''Hosted Solution'' is defined in OPRA's document entitled ''Policy with respect to Hosted Solutions.'') The Current Data ''Enterprise'' alternative entitles the Vendor to provide to third parties an unlimited number of Hosted Solutions disseminating current and/or delayed OPRA Data; the Delayed Data ''Enterprise'' alternative entitles the Vendor to provide to third parties an unlimited number of Hosted Solutions disseminating delayed OPRA Data.	• Current Data: $100 per Hosted Solution or $10,000 Enterprise • Delayed Data: $50 per Hosted Solution or $5000 Enterprise

Third Party Fee Caps

The fees in the table above are charged by OPRA itself for OPRA Data.

[1] OPRA's Basic Service includes all last sale and quotation information pertaining to equity options and index options, including foreign currency index options.

[2] Copies of these Policies will be mailed to any Subscriber upon request. Among other things, these Policies describe the circumstances in which a Professional Subscriber may count ''User IDs'' that are capable of receiving OPRA information as a surrogate for counting ''devices,'' that display OPRA information, and pay OPRA's Professional Subscriber Fees based on the number of its User IDs rather than on the number of its devices.

[3] OPRA offers new Professional Subscribers the opportunity to receive OPRA's Basic Service on a ''free trial'' basis—that is, without payment of Professional Subscriber Device-Based Fees—for the first 30 days. In order to qualify for the 30-day free trial, a new Subscriber must sign a Professional Subscriber Agreement and indicate on the Agreement that it wishes to subscribe for a 30-day free trial period. Unless the Subscriber notifies OPRA in writing before the end of the 30-day trial period that it wishes to cancel its subscription to OPRA's Basic Service, the Subscriber will be obligated to pay access fees to OPRA at the device-based rate (or the alternative Enterprise Rate) commencing on the 31st day following the day its subscription to the Basic Service was initiated.

[4] As an alternative to the Device-Based Professional Subscriber Fee, OPRA's Enterprise Rate Professional Subscriber Fee is available to those Subscribers that (i) are members or associate members in good standing of one or more of the exchanges that are parties to the OPRA Plan, and (ii) elect to pay Subscriber Fees at the Enterprise Rate by signing the Enterprise Rate Amendment to the Subscriber Agreement. The Enterprise Rate Subscriber Fee in effect commencing January 1, 2017, is a monthly fee of $30.50 times the number of a Subscriber's registered representatives based in the United States, its territories and possessions as reported by FINRA, subject to a minimum monthly fee of $6,100 per subscriber, and commencing January 1, 2018, the monthly fee becomes $31.50 per registered representative as so reported subject to a minimum monthly fee of $6,300; in each case subject to adjustment in accordance with the Enterprise Rate Amendment to the Subscriber Agreement. (In reporting the number of its registered representatives, Subscriber need not include persons previously registered as representatives who are at the time of the report legally prohibited from acting as registered representatives (because, for example, their registrations have lapsed, been suspended, or terminated) and who are not so acting.) Payment of the Enterprise Rate Professional Subscriber Fee entitles Subscriber to access OPRA's Basic Service at any of its locations in the United States, its territories and possessions, except that Subscribers who pay the Enterprise Rate Professional Subscriber Fee on the basis of more than 7,000 registered representatives (*i.e.,* a monthly fee in excess of $213,500 in 2017 and $220,500 in 2018) are entitled to access OPRA's Basic Service at any of their locations worldwide. In addition, payment of the Enterprise Rate Professional Subscriber Fee by a Subscriber allows OPRA's Basic Service to be made available to independent investment advisers who are under contract with the Subscriber to provide investment advisory services to the Subscriber's customers. All such investment advisers will be deemed to be registered representatives of the Subscriber for purposes of calculating the Subscriber's Enterprise Rate Professional Subscriber Fee.

[5] A ''quote packet'' consists of any one or more of the following values: last sale, bid/ask, and related market data for a single series of options or a related index; an ''options chain'' consists of last sale, bid/ask, and related market data for up to all series of put and call options on the same underlying security or index.

[6] OPRA Data becomes ''delayed'' after at least 15 minutes have passed since the information was first transmitted by OPRA, OPRA's processor or an OPRA Participant to vendors. OPRA Data derived from a given trading day of an options market becomes ''historical'' upon the opening of trading on the next succeeding trading day of that market.

[7] Usage-based Vendor Fees for Basic Service may not exceed the following maximum monthly amounts: For a professional subscriber, the monthly fee is capped at the highest per-device fee applicable to a professional subscriber times the number of the professional subscriber's authorized user IDs; for a nonprofessional subscriber, the monthly fee is capped at $1.25.

[8] A Vendor's Service qualifies for the ''Query service only'' rate if the Vendor's Service provides access to OPRA Data only on a ''query'' basis without any auto-refreshing capability and does not redistribute OPRA Data via dedicated lines or to the systems of one or more other Vendors (sometimes referred to as ''downstream Vendors'') or to one or more Hosted Solutions.

[9] Non-Display Use refers to the accessing, processing or consuming by an OPRA data recipient (either an OPRA vendor or an OPRA professional subscriber that has entered into a Professional Subscriber Agreement directly with OPRA) of OPRA market data, whether delivered directly from OPRA's processor and/or indirectly from an OPRA vendor, for a purpose other than in support of the data recipient's display or further internal or external redistribution of the OPRA data, and whether or not the use of the OPRA data is made on a device that is also displaying the OPRA data. Non-Display Use includes, without limitation, trading (such as in a ''black box'' or a trading engine that performs automated trading, algorithmic trading or program trading, or generates arbitrage or program trading orders); automated order or quote generation and/or order pegging; price referencing for algorithmic trading; operations control programs; investment analysis; order verification; surveillance programs; risk management; compliance; and portfolio valuation.

OPRA recognizes three categories of Non-Display Use. Category 1 applies when a data recipient's Non-Display Use is on its own behalf. Category 2 applies when a data recipient's Non-Display Use is on behalf of its clients. Category 3 applies when a data recipient's Non-Display Use is for the purpose of internally matching buy and sell orders within the data recipient. Matching buy and sell orders includes matching customer orders on the data recipient's own behalf and/or on behalf of its clients. Category 3 includes, but is not limited to, use in trading platform(s), such as exchanges, alternative trading systems (''ATSs''), broker crossing networks, broker crossing systems not filed as ATSs, dark pools, multilateral trading facilities, and systematic internalization systems. The Category 1 Non-Display Fee shall not apply in the case of an OPRA data recipient during any complete calendar month during which the data recipient (i) has a single UserID (a single natural person) that uses OPRA data for Non-Display Use for the benefit of that UserID and (ii) is not a broker-dealer and does not place more than 390 orders in listed options per day on average during the calendar month (counting orders for this purpose in accordance with the rules of the OPRA Participant exchanges to which it submits orders during the month) for its own beneficial account(s).

The Non-Display Use charges apply separately for each of the three categories of Non-Display Use. One, two or three categories of Non-Display Use may apply to one organization. Professional Subscriber servers and other devices that are used solely for Non-Display Use are not subject to Professional Subscriber Device-Based Fees, but if a Professional Subscriber uses a server or other device for a Non-Display Use and also to display OPRA data the Professional Subscriber will be subject to the applicable Non-Display Use fees and to the Professional Subscriber Device-Based Fee.

An organization that uses data for Category 3 Non-Display Use must count each ''Platform'' (this term is defined in footnote 12) that uses data on a non-display basis. For example, an organization that uses OPRA Data for the purposes of operating an ATS and also for operating a broker crossing system not registered as an ATS would be required to pay two Category 3 Non-Display Use fees.

An OPRA data recipient must make a declaration to OPRA of its Non-Display Use of OPRA data upon commencing the Non-Display Use and thereafter upon any change in the recipient's Non-Display Use. In addition, each OPRA data recipient will be required to make an annual declaration to OPRA of its Non-Display Use of OPRA data. OPRA will not require monthly reporting with respect to Non-Display Use of OPRA data.

[10] An ''Enterprise'' is an OPRA data recipient together with the wholly-owned subsidiaries of the data recipient.

[11] A ''Platform'' is a platform for internally matching buy and sell orders. Matching buy and sell orders includes matching customer orders on a data recipient's own behalf and/or on behalf of its clients. The term ''Platform'' includes, but is not restricted to, exchanges, alternative trading systems (ATSs), broker crossing networks, broker crossing systems not filed as ATSs, dark pools, multilateral trading facilities, and systematic internalization systems.

In addition, in order to directly access OPRA Data as made available by OPRA's processor, the Securities Industry Automation Corporation (''SIAC''), direct data recipients must procure connectivity to the OPRA Data at a location where SIAC, or a third party utilized by SIAC, makes it available. OPRA has contractually capped the connectivity or ''port'' fees that SIAC, or any third party utilized by SIAC, may charge to provide direct connectivity to OPRA Data. The port fee caps are:

- *$16,000 per month per 10 Gb port*
- *$20,500 per month per 40 Gb port*
- *$30,000 per month per 100 Gb port*

Each of these fee caps is inclusive of cross-connect fees and apply regardless of whether or not such fees also cover direct access to other data in addition to OPRA Data.

These connectivity fees are not charged, collected, or retained by OPRA. OPRA is including these port fee caps in its Fee Schedule so that market participants can better ascertain the recurring costs associated with obtaining direct access to OPRA Data.

[FR Doc. 2023–16392 Filed 8–1–23; 8:45 am]

BILLING CODE 8011–01–P

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–98005; File No. SR–CBOE–2023–019]

Self-Regulatory Organizations; Cboe Exchange, Inc.; Order Instituting Proceedings To Determine Whether To Approve or Disapprove Proposed Rule Change To Make Permanent the Operation of its Pilot Program That Allows the Exchange to List P.M.-Settled Third Friday-of-the-Month Mini-SPX Index Options and Mini-Russell 2000 Index Options Series

July 27, 2023.

I. Introduction

On April 19, 2023, Cboe Exchange, Inc. (''Exchange'' or ''Cboe Options'') filed with the Securities and Exchange Commission (''Commission''), pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 (''Act'') [1] and Rule 19b–4 thereunder,[2] a proposed rule change to make permanent the operation of its pilot program (''Program'') that permits the Exchange to list p.m.-settled third Friday-of-the-month Mini-SPX Index (''XSP'') options and Mini-Russell 2000 Index (''MRUT''). The proposed rule change was published for comment in the **Federal Register** on April 28, 2023.[3] On June 9, 2023, pursuant to Section 19(b)(2) of the Act,[4] the Commission designated a longer period within which to approve the proposed rule change, disapprove the proposed rule change, or institute proceedings to determine whether to disapprove the proposed rule change.[5] The Commission did not receive any comment letters on the proposed rule change. The Commission is instituting proceedings pursuant to Section 19(b)(2)(B) of the Act [6] to determine whether to approve or disapprove the proposed rule change.

II. Description of the Proposed Rule Change

The Exchange proposes to make permanent a pilot program that permits the Exchange to list and trade cash-settled XSP and MRUT options with third Friday-of-the-month expiration dates (''Expiration Friday'') whose exercise settlement value is derived from closing prices on the last trading day prior to expiration (''p.m.-settled XSP'' and ''p.m.-settled MRUT,'' respectively, and collectively, the ''Pilot Products'').

In July 2013, the Commission approved the Program to list and trade p.m.-settled XSP options on a pilot basis.[7] In February 2021, the Commission approved a rule change that amended the Program to allow the exchange to list and trade p.m.-settled MRUT options.[8] In approving the Program, the Commission noted its concern about the potential impact on the market at expiration for the underlying component stocks for a p.m.-settled, cash-settled index options.[9] However, the Commission also recognized the potential impact was unclear.[10] The Commission approved the Program on a pilot basis to allow the Exchange and the Commission to monitor for and assess any potential for adverse market effects.[11] In order to facilitate this assessment, the Exchange committed to provide the Commission with data and analysis in connection with the Program.[12] The Exchange has filed to extend the operation of the Program on multiple occasions [13] and it is currently set to expire on the earlier of November 6, 2023, or the date on which the Program is approved on a permanent basis.[14]

Since the Program's inception in 2013 for XSP and 2021 for MRUT, the Exchange has submitted reports to the Commission regarding the Program that detail the Exchange's experience with the Program, pursuant to the XSP and MRUT Approval Orders.[15] Specifically, the Exchange states it has submitted annual pilot reports to the Commission that contain an analysis of volume, open interest, and trading patterns.[16] The analysis examines trading in the Pilot Products, as well as trading in the securities that comprise the underlying indexes. Additionally, for series that exceed certain minimum open interest parameters, the annual reports provide analysis of index price volatility and share trading activity. The Exchange states it has also submitted periodic interim reports that contain some, but not all, of the information contained in the annual reports (together with the annual reports, the ''pilot reports'').[17] The Exchange states that, during the course of the Program, it has provided

[12] The term ''households reached'' is defined in the Television Dissemination Rider. Prorating of the ''per 1,000 households reached'' fee (but not the monthly maximum) is permitted if Vendor displays OPRA Data for less than its entire business day, based upon the number of minutes current OPRA Data is displayed by Vendor divided by 390 (or such other number as OPRA. reasonably designates from time to time to represent the number of minutes that the U.S. markets are open for trading). Vendor may simulcast over multiple television channels and not be charged more than once for households reached that have access to multiple simulcast channels.

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] *See* Securities Exchange Act Release No. 97366 (April 24, 2023), 88 FR 26359 (''Notice'').

[4] 15 U.S.C. 78s(b)(2).

[5] *See* Securities Exchange Act Release No. 97678, 88 FR 39285 (June 15, 2023). The Commission designated July 27, 2023, as the date by which the Commission shall approve or disapprove, or institute proceedings to determine whether to approve or disapprove, the proposed rule change.

[6] 15 U.S.C. 78s(b)(2)(B).

[7] *See* Securities Exchange Act Release No. 70087 (July 31, 2013), 78 FR 47809 (August 6, 2013) (SR–CBOE–2013–055) (''XSP Approval Order'').

[8] *See* Securities Exchange Act Release No. 91067 (February 5, 2021) 86 FR 9108 (February 11, 2021) (SR–CBOE–2020–116) (''MRUT Approval Order'').

[9] *See* XSP Approval Order, 78 FR at 47811; *and* MRUT Approval Order, 86 FR at 9109. *See also* Securities Exchange Act Release Nos. 64599 (June 3, 2011), 76 FR 33798, 33801–02 (June 9, 2011) (order instituting proceedings to determine whether to approve or disapprove a proposed rule change to allow the listing and trading of SPXPM options); 65256 (September 2, 2011), 76 FR 55969, 55970–76 (September 9, 2011) (order approving proposed rule change to establish a pilot program to list and trade SPXPM options); *and* 68888 (February 8, 2013), 78 FR 10668, 10669 (February 14, 2013) (order approving the listing and trading of SPXPM on CBOE).

[10] *See* XSP Approval Order, 78 FR at 47811; *and* MRUT Approval Order, 86 FR at 9109.

[11] *See* XSP Approval Order, 78 FR at 47811; *and* MRUT Approval Order, 86 FR at 9109.

[12] *Id.*

[13] *See, e.g.,* Securities Exchange Act Release Nos. 71424 (January 28, 2014), 79 FR 6249 (February 3, 2014) (SR–CBOE–2014–004); *and* 96222 (November 3, 2022), 87 FR 67736 (November 9, 2022) (SR–CBOE–2022–054).

[14] *See* Securities Exchange Act Release No. 97446 (May 5, 2023), 88 FR 30365 (May 11, 2023).

[15] *See supra* note 12.

[16] *See* Notice, 88 FR at 26361.

[17] *See id.*

the Commission with any additional data or analyses the Commission requested if it deemed such data or analyses necessary to determine whether the Program was consistent with the Exchange Act.[18] The Exchange states it has made public on its website data and analyses previously submitted to the Commission under the Program,[19] and will continue to make public any data and analyses it submits to the Commission while the Program is still in effect.[20]

As set forth more fully in the Notice, the Exchange concludes that the Program does not negatively impact market quality or raise any unique or prohibitive regulatory concerns.[21] The Exchange states it has not identified any evidence from the pilot data indicating that the trading of p.m.-settled XSP or MRUT options has any adverse impact on fair and orderly markets on Expiration Fridays for the Mini-SPX Index, the Mini-RUT Index or the underlying securities comprising the underlying indexes, nor have there been any observations of abnormal market movements attributable to p.m.-settled XSP or MRUT options from any market participants that have come to the attention of the Exchange.[22] In order to support its overall assessment of the Program, the Exchange includes both an assessment of an analysis conducted at the direction of the staff of the Commission's Division of Economic and Risk Analysis and the Exchange's review and analysis of pilot data.[23] Among other things, the Notice includes the Exchange's analysis of end of day volatility as well as a comparison of the impact of quarterly index rebalancing versus p.m.-settled expirations.[24]

The Exchange also completed an analysis intended to evaluate whether the Program impacted the quality of the a.m.-settled options market.[25] Specifically, the Exchange compared values of key market quality indicators (specifically, the bid-ask spread [26] and effective spread [27]) in p.m.-settled SPX options (''SPXW'') both before and after the introduction of Tuesday expirations and Thursday expirations for SPXW options on April 18 and May 11, 2022, respectively.[28] The Exchange believes analyzing the impact of new SPXW options on then-existing SPXW options permit the Exchange to extrapolate that it is unlikely the introduction of the Pilot Products significantly impacted the market quality of a.m.-settled options, such as a.m.-settled SPX or Russell 2000 index options, respectively, when the Program began.[29]

Finally, the Exchange states that the significant changes in the closing procedures of the primary markets in recent decades, including considerable advances in trading systems and technology, have significantly minimized risks of any potential impact of p.m.-, cash-settled XSP or MRUT options on the underlying cash markets.[30]

III. Proceedings To Determine Whether To Approve or Disapprove SR–CBOE–2023–019, and Grounds for Disapproval Under Consideration

The Commission is instituting proceedings pursuant to Section 19(b)(2)(B) of the Act [31] to determine whether the proposed rule change should be approved or disapproved. Institution of proceedings is appropriate at this time in view of the legal and policy issues raised by the proposed rule change. Institution of proceedings does not indicate that the Commission has reached any conclusions with respect to any of the issues involved. Rather, as described below, the Commission seeks and encourages interested persons to provide additional comment on the proposed rule change to inform the Commission's analysis of whether to approve or disapprove the proposed rule change.

Pursuant to Section 19(b)(2)(B) of the Act,[32] the Commission is providing notice of the grounds for disapproval under consideration. As described above, the Exchange has proposed to make permanent a pilot program that permits the listing and trading of p.m.-settled XSP and MRUT options with third Friday-of-the-month-expirations. The Commission is instituting proceedings to allow for additional analysis of, and input from commenters with respect to, the proposed rule change's consistency with the Act, and in particular, Section 6(b)(5) of the Act, which requires, among other things, that the rules of a national securities exchange be designed to prevent fraudulent and manipulative acts and practices, to promote just and equitable principles of trade, to remove impediments to and perfect the mechanism of a free and open market and a national market system, and, in general, to protect investors and the public interest.[33]

IV. Procedure: Request for Written Comments

The Commission requests that interested persons provide written submissions of their data, views, and arguments with respect to the issues identified above, as well as any other concerns they may have with the proposal. In particular, the Commission invites the written views of interested persons concerning whether the proposed rule change, is consistent with Sections 6(b)(5) or any other provision of the Act, or the rules and regulations thereunder. Although there do not appear to be any issues relevant to approval or disapproval that would be facilitated by an oral presentation of data, views, and arguments, the Commission will consider, pursuant to Rule 19b–4 under the Act,[34] any request for an opportunity to make an oral presentation.[35]

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[18] *See* Notice, 88 FR at 26361–62.

[19] *See* Notice, 88 FR at 26362. Available at *https://www.cboe.com/aboutcboe/legal-regulatory/national-market-system-plans/pm-settlement-spxpm-data.*

[20] *See* Notice, 88 FR at 26362.

[21] *See id.*

[22] *See id.*

[23] *See* Notice, 88 FR at 26362–65.

[24] *See* Notice, 88 FR at 26363–64. The Exchange states that although its study specifically evaluated options on the S&P 500 index (''SPX options''), because XSP options overly the same index comprised of the same securities (just one tenth the size) and MRUT is also a broad-based index, the Exchange believes it is appropriate to extrapolate the data to apply the Pilot Products. *See* Notice, 88 FR at 26365.

[25] *See* Notice, 88 FR at 26364.

[26] The Exchange calculated for each of SPXW options (with Monday, Wednesday, and Friday expirations) and weekly options on the Standard & Poor's Depositary Receipts S&P 500 ETF (''SPY'') (with Monday, Wednesday, and Friday expirations) the daily time-weighted bid-ask spread on the Exchange during its regular trading hours session, adjusted for the difference in size between SPXW options and SPY options (SPXW options are approximately ten times the value of SPY options).

[27] The Exchange calculated the volume-weighted average daily effective spread for simple trades for each of SPXW options (with Monday, Wednesday, and Friday expirations) and SPY weekly options (with Monday, Wednesday, and Friday expirations) as twice the amount of the absolute value of the difference between an order execution price and the midpoint of the national best bid and offer at the time of execution, adjusted for the difference in size between SPXW options and SPY options.

[28] For purposes of comparison, the Exchange paired SPXW options and SPY options with the same moneyness and same days to expiration.

[29] *See* Notice, 88 FR at 26365.

[30] *See* Notice, 88 FR at 26364.

[31] 15 U.S.C. 78s(b)(2)(B).

[32] *Id.*

[33] 15 U.S.C. 78f(b)(5).

[34] 17 CFR 240.19b–4.

[35] Section 19(b)(2) of the Act, as amended by the Securities Acts Amendments of 1975, Public Law 94–29 (Jun. 4, 1975), grants to the Commission flexibility to determine what type of proceeding—either oral or notice and opportunity for written comments—is appropriate for consideration of a particular proposal by a self-regulatory organization. *See* Securities Acts Amendments of 1975, Senate Comm. on Banking, Housing & Urban Affairs, S. Rep. No. 75, 94th Cong., 1st Sess. 30 (1975).

Interested persons are invited to submit written data, views, and arguments regarding whether the proposed rule change should be approved or disapproved by August 23, 2023. Any person who wishes to file a rebuttal to any other person's submission must file that rebuttal by September 6, 2023. The Commission asks that commenters address the sufficiency of the Exchange's statements in support of the proposal, in addition to any other comments they may wish to submit about the proposed rule change.

Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's internet comment form (*https://www.sec.gov/rules/sro.shtml*); or
- Send an email to *rule-comments@sec.gov.* Please include file number SR–CBOE–2023–019 on the subject line.

Paper Comments

- Send paper comments in triplicate to Secretary, Securities and Exchange Commission, 100 F Street NE, Washington, DC 20549–1090.

All submissions should refer to file number SR–CBOE–2023–019. This file number should be included on the subject line if email is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's internet website (*https://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for website viewing and printing in the Commission's Public Reference Room, 100 F Street NE, Washington, DC 20549, on official business days between the hours of 10 a.m. and 3 p.m. Copies of the filing also will be available for inspection and copying at the principal office of the Exchange. Do not include personal identifiable information in submissions; you should submit only information that you wish to make available publicly. We may redact in part or withhold entirely from publication submitted material that is obscene or subject to copyright protection. All submissions should refer to file number SR–CBOE–2023–019 and should be submitted on or before August 23, 2023. Rebuttal comments should be submitted by September 6, 2023.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[36]

Sherry R. Haywood,

Assistant Secretary.

[FR Doc. 2023–16387 Filed 8–1–23; 8:45 am]

BILLING CODE 8011–01–P

SELECTIVE SERVICE SYSTEM

Performance Review Board Membership

AGENCY: Selective Service System.

ACTION: Notice.

SUMMARY: Notice is hereby given of the names of the members of the Performance Review Board.

FOR FURTHER INFORMATION CONTACT: Lee Levells, Human Resources Officer, Selective Service System, 1515 Wilson Blvd. (Suite 600), Arlington, VA 22209, telephone: 703–605–4011.

SUPPLEMENTARY INFORMATION: Sec. 4314(c)(1) through (5) of title 5, U.S.C., requires each agency to establish, in accordance with regulations prescribed by the Office of Personnel Management, one or more performance review boards. The board shall review and evaluate the initial appraisal of a senior executive's performance by the supervisor, along with any recommendations to the appointing authority relative to the performance of the senior executive.

The Members of the Performance Review Board Are

1. Mark Blythe, Director of Field Service, U.S. Railroad Retirement Board
2. Peggy Gartner, Deputy Office Head, Office of Information and Resource Management, National Science Foundation
3. Leslie Bayless, Chief Operating Officer, Federal Mine Safety and Health Review Commission

Daniel A. Lauretano, Sr.,

General Counsel.

[FR Doc. 2023–16467 Filed 8–1–23; 8:45 am]

BILLING CODE 8015–01–P

[36] 17 CFR 200.30–3(a)(12).

SMALL BUSINESS ADMINISTRATION

Data Collection Available for Public Comments

ACTION: 60-Day notice and request for comments

SUMMARY: The Small Business Administration (SBA) intends to request approval, from the Office of Management and Budget (OMB) for the collection of information described below. The Paperwork Reduction Act (PRA) requires federal agencies to publish a notice in the **Federal Register** concerning each proposed collection of information before submission to OMB, and to allow 60 days for public comment in response to the notice. This notice complies with that requirement.

DATES: Submit comments on or before October 2, 2023.

ADDRESSES: Send all comments to, Scott Reynders-Byars, and OFFICE, Small Business Administration.

FOR FURTHER INFORMATION CONTACT: Scott Reynders-Byars, *scott.reynders-byars@sba.gov;* 817–438–1812 Curtis B. Rich, Agency Clearance Officer *curtis.rich@sba.gov* 202–205–7030.

SUPPLEMENTARY INFORMATION: The Small Business Administration's Covid EIDL Servicing Center Borrower Request Forms provide the borrower with easily completed fillable forms that can be emailed or mailed to SBA's Covid EIDL Servicing Center. Covid EIDL borrowers will use these forms to request servicing actions such as seeking financial assistance in the form of a subordination, deferment, re-amortization, accommodation, change in ownership, change in collateral, or relocation of their business. The information collected helps the Agency to make eligibility assessments and approvals for servicing actions. It also provides the borrower a road map to follow when requesting a modification of their loan.

Solicitation of Public Comments

SBA is requesting comments on (a) Whether the collection of information is necessary for the agency to properly perform its functions; (b) whether the burden estimates are accurate; (c) whether there are ways to minimize the burden, including through the use of automated techniques or other forms of information technology; and (d) whether there are ways to enhance the quality, utility, and clarity of the information.

Summary of Information Collection

PRA NUMBER: 3245–

(1) *Title:* Covid EIDL Servicing Center Borrower Request Forms.

Description of Respondents: Respondents would be the businesses who applied for, approved and received COVID Economic Injury Loans (EIDL) from the Small Business Administration between January 31, 2020, and May 16, 2023. Businesses eligible to apply were Sole Proprietorships, Limited Liability Partnerships, Partnerships, Limited Liability Companies and Corporations.

Form Number: N/A.

Total Estimated Annual Responses: The newly formed Covid EIDL Servicing Center (CESC) currently has an active and current loan portfolio of 2,586,163. As a newly formed servicing office we do not have historical data to base this estimate. We have submitted our estimates using historical data from the Small Business Administration Office of Capital Access, Office of Disaster Assistance Servicing Offices which estimates we will perform actions on approximately 35% of our active portfolio per year or 905,157 estimated responses per year.

Total Estimated Annual Hour Burden: The CESC estimates the forms will take an average of 30 minutes per document to complete. 30 minutes times 905,157 the total estimated annual hour burden of 425,578 hours per year.

Curtis B. Rich,

Agency Clearance Officer.

[FR Doc. 2023–16368 Filed 8–1–23; 8:45 am]

BILLING CODE 8026–09–P

SMALL BUSINESS ADMINISTRATION

[Disaster Declaration #18026 and #18027; VERMONT Disaster Number VT–00047]

Presidential Declaration Amendment of a Major Disaster for Public Assistance Only for the State of Vermont

AGENCY: U.S. Small Business Administration.

ACTION: Amendment 1.

SUMMARY: This is an amendment of the Presidential declaration of a major disaster for Public Assistance Only for the State of Vermont (FEMA–4720–DR), dated 07/14/2023.

Incident: Severe Storms, Flooding, Landslides, and Mudslides.

Incident Period: 07/07/2023 and continuing.

DATES: Issued on 07/26/2023.

Physical Loan Application Deadline Date: 09/12/2023.

Economic Injury (EIDL) Loan Application Deadline Date: 04/15/2024.

ADDRESSES: Submit completed loan applications to: U.S. Small Business Administration, Processing and Disbursement Center, 14925 Kingsport Road, Fort Worth, TX 76155.

FOR FURTHER INFORMATION CONTACT: A. Escobar, Office of Disaster Recovery & Resilience, U.S. Small Business Administration, 409 3rd Street SW, Suite 6050, Washington, DC 20416, (202) 205–6734.

SUPPLEMENTARY INFORMATION: The notice of the President's major disaster declaration for Private Non-Profit organizations in the State of Vermont, dated 07/14/2023, is hereby amended to include the following areas as adversely affected by the disaster.

Primary Counties: Addison, Caledonia, Chittenden, Lamoille, Orleans, Rutland, Windham, Windsor.

All other information in the original declaration remains unchanged.

(Catalog of Federal Domestic Assistance Number 59008)

Francisco Sánchez, Jr.,

Associate Administrator, Office of Disaster Recovery & Resilience.

[FR Doc. 2023–16372 Filed 8–1–23; 8:45 am]

BILLING CODE 8026–09–P

SMALL BUSINESS ADMINISTRATION

[Disaster Declaration #18016 and #18017; VERMONT Disaster Number VT–00046]

Presidential Declaration Amendment of a Major Disaster for the State of Vermont

AGENCY: U.S. Small Business Administration.

ACTION: Amendment 2.

SUMMARY: This is an amendment of the Presidential declaration of a major disaster for the State of Vermont (FEMA–4720–DR), dated 07/14/2023.

Incident: Severe Storms, Flooding, Landslides, and Mudslides.

Incident Period: 07/07/2023 and continuing.

DATES: Issued on 07/26/2023.

Physical Loan Application Deadline Date: 09/12/2023.

Economic Injury (EIDL) Loan Application Deadline Date: 04/15/2024.

ADDRESSES: Submit completed loan applications to: U.S. Small Business Administration, Processing and Disbursement Center, 14925 Kingsport Road, Fort Worth, TX 76155.

FOR FURTHER INFORMATION CONTACT: A. Escobar, Office of Disaster Recovery & Resilience, U.S. Small Business Administration, 409 3rd Street SW, Suite 6050, Washington, DC 20416, (202) 205–6734.

SUPPLEMENTARY INFORMATION: The notice of the President's major disaster declaration for the State of Vermont, dated 07/14/2023, is hereby amended to include the following areas as adversely affected by the disaster:

Primary Counties (Physical Damage and Economic Injury Loans): Orleans.

Contiguous Counties (Economic Injury Loans Only):

All other information in the original declaration remains unchanged.

(Catalog of Federal Domestic Assistance Number 59008)

Francisco Sánchez, Jr.,

Associate Administrator, Office of Disaster Recovery & Resilience.

[FR Doc. 2023–16371 Filed 8–1–23; 8:45 am]

BILLING CODE 8026–09–P

SMALL BUSINESS ADMINISTRATION

Reporting and Recordkeeping Requirements Under OMB Review

AGENCY: Small Business Administration.

ACTION: 30-Day notice.

SUMMARY: The Small Business Administration (SBA) is seeking approval from the Office of Management and Budget (OMB) for the information collection described below. In accordance with the Paperwork Reduction Act and OMB procedures, SBA is publishing this notice to allow all interested member of the public an additional 30 days to provide comments on the proposed collection of information.

DATES: Submit comments on or before September 1, 2023.

ADDRESSES: Written comments and recommendations for this information collection request should be sent within 30 days of publication of this notice to *www.reginfo.gov/public/do/PRAMain.* Find this particular information collection request by selecting ''Small Business Administration''; ''Currently Under Review,'' then select the ''Only Show ICR for Public Comment'' checkbox. This information collection can be identified by title and/or OMB Control Number.

FOR FURTHER INFORMATION CONTACT: You may obtain a copy of the information collection and supporting documents from the Agency Clearance Office at *Curtis.Rich@sba.gov;* (202) 205–7030, or from *www.reginfo.gov/public/do/PRAMain.*

SUPPLEMENTARY INFORMATION: Small business owners or advocates who have

been nominated for an SBA recognition award submit this information for use in evaluating nominee's eligibility for an award: Verifying accuracy of information submitted and determining whether there are any actual or potential conflicts of interest. Awards are presented to winners during the Presidentially declared Small Business Week.

Solicitation of Public Comments

Comments may be submitted on (a) whether the collection of information is necessary for the agency to properly perform its functions; (b) whether the burden estimates are accurate; (c) whether there are ways to minimize the burden, including through the use of automated techniques or other forms of information technology; and (d) whether there are ways to enhance the quality, utility, and clarity of the information.

OMB Control 3245–0360

Title: U.S. Small Business Administration Award Nominations.

Description of Respondents: Nominated Small Business Owners or Advocates.

SBA Form Numbers: 3300–3315/2023 Nomination Guidelines.

Estimated Number of Respondents: Nominated Small Business Owners or Advocates.

Estimated Annual Responses: 600.

Estimated Annual Hour Burden: 1,200.

Curtis Rich,

Agency Clearance Officer.

[FR Doc. 2023–16444 Filed 8–1–23; 8:45 am]

BILLING CODE 8026–09–P

DEPARTMENT OF STATE

[Public Notice: 12137]

Notice of Determinations; Culturally Significant Objects Being Imported for Exhibition—Determinations: ''Vertigo of Color: Matisse, Derain, and the Origins of Fauvism'' Exhibition

SUMMARY: Notice is hereby given of the following determinations: I hereby determine that certain objects being imported from abroad pursuant to agreements with their foreign owners or custodians for temporary display in the exhibition ''Vertigo of Color: Matisse, Derain, and the Origins of Fauvism'' at The Metropolitan Museum of Art, New York, New York; the Museum of Fine Arts, Houston, in Houston, Texas; and at possible additional exhibitions or venues yet to be determined, are of cultural significance, and, further, that their temporary exhibition or display within the United States as aforementioned is in the national interest. I have ordered that Public Notice of these determinations be published in the **Federal Register**.

FOR FURTHER INFORMATION CONTACT: Reed Liriano, Program Coordinator, Office of the Legal Adviser, U.S. Department of State (telephone: 202–632–6471; email: *section2459@state.gov*). The mailing address is U.S. Department of State, L/PD, 2200 C Street NW (SA–5), Suite 5H03, Washington, DC 20522–0505.

SUPPLEMENTARY INFORMATION: The foregoing determinations were made pursuant to the authority vested in me by the Act of October 19, 1965 (79 Stat. 985; 22 U.S.C. 2459), E.O. 12047 of March 27, 1978, the Foreign Affairs Reform and Restructuring Act of 1998 (112 Stat. 2681, *et seq.;* 22 U.S.C. 6501 note, *et seq.*), Delegation of Authority No. 234 of October 1, 1999, Delegation of Authority No. 236–3 of August 28, 2000, and Delegation of Authority No. 523 of December 22, 2021.

Nicole L. Elkon,

Deputy Assistant Secretary for Professional and Cultural Exchanges, Bureau of Educational and Cultural Affairs, Department of State.

[FR Doc. 2023–16414 Filed 8–1–23; 8:45 am]

BILLING CODE 4710–05–P

DEPARTMENT OF STATE

[Public Notice: 12136]

Notice of Determinations; Culturally Significant Objects Being Imported for Exhibition—Determinations: ''William Blake: Visionary'' Exhibition

SUMMARY: Notice is hereby given of the following determinations: I hereby determine that certain objects being imported from abroad pursuant to an agreement with their foreign owner or custodian for temporary display in the exhibition ''William Blake: Visionary'' at the J. Paul Getty Museum at the Getty Center, Los Angeles, California, and at possible additional exhibitions or venues yet to be determined, are of cultural significance, and, further, that their temporary exhibition or display within the United States as aforementioned is in the national interest. I have ordered that Public Notice of these determinations be published in the **Federal Register**.

FOR FURTHER INFORMATION CONTACT: Reed Liriano, Program Coordinator, Office of the Legal Adviser, U.S. Department of State (telephone: 202–632–6471; email: *section2459@state.gov*). The mailing address is U.S. Department of State, L/PD, 2200 C Street NW (SA–5), Suite 5H03, Washington, DC 20522–0505.

SUPPLEMENTARY INFORMATION: The foregoing determinations were made pursuant to the authority vested in me by the Act of October 19, 1965 (79 Stat. 985; 22 U.S.C. 2459), E.O. 12047 of March 27, 1978, the Foreign Affairs Reform and Restructuring Act of 1998 (112 Stat. 2681, *et seq.;* 22 U.S.C. 6501 note, *et seq.*), Delegation of Authority No. 234 of October 1, 1999, Delegation of Authority No. 236–3 of August 28, 2000, and Delegation of Authority No. 523 of December 22, 2021.

Nicole L. Elkon,

Deputy Assistant Secretary for Professional and Cultural Exchanges, Bureau of Educational and Cultural Affairs, Department of State.

[FR Doc. 2023–16413 Filed 8–1–23; 8:45 am]

BILLING CODE 4710–05–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

[Docket No. FAA–2023–1260; Summary Notice No. 2023–28]

Petition for Exemption; Summary of Petition Received; Embraer S.A.

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of petition for exemption received.

SUMMARY: This notice contains a summary of a petition seeking relief from specified requirements of Federal Aviation Regulations. The purpose of this notice is to improve the public's awareness of, and participation in, the FAA's exemption process. Neither publication of this notice nor the inclusion or omission of information in the summary is intended to affect the legal status of the petition or its final disposition.

DATES: Comments on this petition must identify the petition docket number and must be received on or before August 22, 2023.

ADDRESSES: Send comments identified by docket number FAA–2023–1260 using any of the following methods:

- *Federal eRulemaking Portal:* Go to *http://www.regulations.gov* and follow the online instructions for sending your comments electronically.
- *Mail:* Send comments to Docket Operations, M–30; U.S. Department of Transportation (DOT), 1200 New Jersey Avenue SE, Room W12–140, West Building Ground Floor, Washington, DC 20590–0001.

• *Hand Delivery or Courier:* Take comments to Docket Operations in Room W12–140 of the West Building Ground Floor at 1200 New Jersey Avenue SE, Washington, DC, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

• *Fax:* Fax comments to Docket Operations at 202–493–2251.

Privacy: In accordance with 5 U.S.C. 553(c), DOT solicits comments from the public to better inform its rulemaking process. DOT posts these comments, without edit, including any personal information the commenter provides, to *http://www.regulations.gov,* as described in the system of records notice (DOT/ALL–14 FDMS), which can be reviewed at *http://www.dot.gov/privacy.*

Docket: Background documents or comments received may be read at *http://www.regulations.gov* at any time. Follow the online instructions for accessing the docket or go to the Docket Operations in Room W12–140 of the West Building Ground Floor at 1200 New Jersey Avenue SE, Washington, DC, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

FOR FURTHER INFORMATION CONTACT: Daniel Gilbert, AIR–646, Federal Aviation Administration, phone 405–954–5833, email *daniel.gilbert@faa.gov.*

This notice is published pursuant to 14 CFR 11.85.

Issued in Los Angeles, CA, on July 28, 2023.

Thuan Nguyen,

Acting Manager, Technical Writing Section.

Petition for Exemption

Docket No.: FAA–2023–1260.

Petitioner: Embraer S.A. (Embraer).

Section(s) of 14 CFR Affected: §§ 25.785(j), 25.810(a)(1), 25.813(b) and 25.851(a)(3).

Description of Relief Sought: Petitioner is seeking relief from the affected sections of 14 CFR to support the conversion of Model ERJ 190–100 airplanes from an all-passenger configuration to an all-cargo configuration with a Class E cargo compartment. The proposed cargo conversion will have provisions for one supernumerary onboard who will have access to the Class E cargo compartment during flight.

[FR Doc. 2023–16443 Filed 8–1–23; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

[Docket No. FAA–2022–1713; Summary Notice No. 2023–26]

Petition for Exemption; Summary of Petition Received; Textron eAviation

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of petition for exemption received.

SUMMARY: This notice contains a summary of a petition seeking relief from specified requirements of Federal Aviation Regulations. The purpose of this notice is to improve the public's awareness of, and participation in, the FAA's exemption process. Neither publication of this notice nor the inclusion or omission of information in the summary is intended to affect the legal status of the petition or its final disposition.

DATES: Comments on this petition must identify the petition docket number and must be received on or before August 22, 2023.

ADDRESSES: Send comments identified by docket number FAA–2022–1713 using any of the following methods:

• *Federal eRulemaking Portal:* Go to *http://www.regulations.gov* and follow the online instructions for sending your comments electronically.

• *Mail:* Send comments to Docket Operations, M–30; U.S. Department of Transportation (DOT), 1200 New Jersey Avenue SE, Room W12–140, West Building Ground Floor, Washington, DC 20590–0001.

• *Hand Delivery or Courier:* Take comments to Docket Operations in Room W12–140 of the West Building Ground Floor at 1200 New Jersey Avenue SE, Washington, DC, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

• *Fax:* Fax comments to Docket Operations at 202–493–2251.

Privacy: In accordance with 5 U.S.C. 553(c), DOT solicits comments from the public to better inform its rulemaking process. DOT posts these comments, without edit, including any personal information the commenter provides, to *http://www.regulations.gov,* as described in the system of records notice (DOT/ALL–14 FDMS), which can be reviewed at *http://www.dot.gov/privacy.*

Docket: Background documents or comments received may be read at *http://www.regulations.gov* at any time. Follow the online instructions for accessing the docket or go to the Docket Operations in Room W12–140 of the West Building Ground Floor at 1200 New Jersey Avenue SE, Washington, DC, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

FOR FURTHER INFORMATION CONTACT: Michael H. Harrison, AIR–646, Federal Aviation Administration, phone 206–231–3368, email *Michael.Harrison@faa.gov.*

This notice is published pursuant to 14 CFR 11.85.

Issued in El Segundo, CA on July 27, 2023.

Thuan Nguyen,

Manager, Technical Writing Section.

Petition for Exemption

Docket No.: FAA–2022–1713.

Petitioner: Textron eAviation.

Section of 14 CFR Affected: §§ 21.181(a)(3)(i), 21.181(a)(4), 21.190(a), 43.7(g), 43.7(h), 61 .23(c)(1)(iii), 61.31(I)(2)(vi), 61.89(b)(1), 61.303(b)(4), 61 .305(a)(2), 61.315(a), 61.315(c), 61.317, 61.321, 61.325, 61.327(b), 61.327(b)(2), 61.403(b), 61.411, 61.415, 61.415(e), 61.415(9), 61.417, 61.419, 61.423(a)(2)(iii)(A), 61.423(a)(2)(iii)(D), 61.423(a)(2)(iv), 61.423(a)(2)(iv)(A), 61.423(a)(2)(iv)(B), 61.423(b), and 61.429(c).

Description of Relief Sought: Textron eAviation (Textron) seeks an exemption from §§ 21.181(a)(3)(i), 21.181(a)(4), 21.190(a), 43.7(g), 43.7(h), 61 .23(c)(1)(iii), 61.31(I)(2)(vi), 61.89(b)(1), 61.303(b)(4), 61.305(a)(2), 61.315(a), 61.315(c), 61.317, 61.321, 61.325, 61.327(b), 61.327(b)(2), 61.403(b), 61.411, 61.415, 61.415(e), 61.415(9), 61.417, 61.419, 61.423(a)(2)(iii)(A), 61.423(a)(2)(iii)(D), 61.423(a)(2)(iv), 61.423(a)(2)(iv)(A), 61.423(a)(2)(iv)(B), 61.423(b), and 61.429(c) of Title 14, Code of Federal Regulations. This relief, if granted, would allow Textron to apply for an airworthiness certificate, maintain, and operate the Model Virus SW 128 light-sport airplane, which is equipped with an electric powerplant.

[FR Doc. 2023–16426 Filed 8–1–23; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Railroad Administration

[Docket Number FRA–2010–0029]

Amtrak's Request To Amend Its Positive Train Control Safety Plan and Positive Train Control System

AGENCY: Federal Railroad Administration (FRA), Department of Transportation (DOT).

ACTION: Notice of availability and request for comments.

SUMMARY: This document provides the public with notice that, on July 14, 2023, the National Railroad Passenger Corporation (Amtrak) submitted two requests for amendment (RFA). The first RFA is to Amtrak's FRA-approved Positive Train Control Safety Plan (PTCSP) and its Advanced Civil Speed Enforcement System II (ACSES II), which seeks FRA's approval to introduce modified safety server software to address a known defect and updates to type approval documentation. The second RFA is to Amtrak's FRA-certified positive train control (PTC) system for its ACSES II system, which seeks FRA's approval to install Construction Zone (CZ) transponders to support cutover activities on the Philadelphia to Washington (PW) line. As these RFAs may involve requests for FRA's approval of proposed material modifications to an FRA-certified PTC system, FRA is publishing this notice and inviting public comment on Amtrak's RFAs to its PTCSP and PTC system.

DATES: FRA will consider comments received by August 22, 2023. FRA may consider comments received after that date to the extent practicable and without delaying implementation of valuable or necessary modifications to a PTC system.

ADDRESSES:

Comments: Comments may be submitted by going to *https://www.regulations.gov* and following the online instructions for submitting comments.

Instructions: All submissions must include the agency name and the applicable docket number. The relevant PTC docket number for this host railroad is Docket No. FRA–2010–0029. For convenience, all active PTC dockets are hyperlinked on FRA's website at *https://railroads.dot.gov/research-development/program-areas/train-control/ptc/railroads-ptc-dockets.* All comments received will be posted without change to *https://www.regulations.gov;* this includes any personal information.

FOR FURTHER INFORMATION CONTACT: Gabe Neal, Staff Director, Signal, Train Control, and Crossings Division, telephone: 816–516–7168, email: *Gabe.Neal@dot.gov.*

SUPPLEMENTARY INFORMATION: In general, Title 49 United States Code (U.S.C.) Section 20157(h) requires FRA to certify that a host railroad's PTC system complies with Title 49 Code of Federal Regulations (CFR) part 236, subpart I, before the technology may be operated in revenue service. Before making certain changes to an FRA-certified PTC system or the associated FRA-approved PTCSP, a host railroad must submit, and obtain FRA's approval of, an RFA to its PTCSP under 49 CFR 236.1021.

Under 49 CFR 236.1021(e), FRA's regulations provide that FRA will publish a notice in the **Federal Register** and invite public comment in accordance with 49 CFR part 211, if an RFA includes a request for approval of a material modification or discontinuance of a signal and train control system. Accordingly, this notice informs the public that, on July 14, 2023, Amtrak submitted an RFA to its PTCSP and ACSES II PTC system, which seeks FRA's approval to introduce modified safety server software to address a known defect and updates to type approval documentation, and an RFA to its FRA-certified PTC system for its ACSES II system, which seeks FRA's approval to install CZ transponders to support cutover activities on the Philadelphia to Washington line. These RFAs are both available in Docket No. FRA–2010–0029.

Interested parties are invited to comment on Amtrak's RFAs to its PTCSP and PTC system by submitting written comments or data. During FRA's review of Amtrak's RFAs, FRA will consider any comments or data submitted within the timeline specified in this notice and to the extent practicable, without delaying implementation of valuable or necessary modifications to a PTC system. *See* 49 CFR 236.1021; *see also* 49 CFR 236.1011(e). Under 49 CFR 236.1021, FRA maintains the authority to approve, approve with conditions, or deny a railroad's RFA to its PTCSP at FRA's sole discretion.

Privacy Act Notice

In accordance with 49 CFR 211.3, FRA solicits comments from the public to better inform its decisions. DOT posts these comments, without edit, including any personal information the commenter provides, to *https://www.regulations.gov,* as described in the system of records notice (DOT/ALL–14 FDMS), which can be reviewed at *https://www.transportation.gov/privacy.* See *https://www.regulations.gov/privacy-notice* for the privacy notice of *regulations.gov.* To facilitate comment tracking, we encourage commenters to provide their name, or the name of their organization; however, submission of names is completely optional. If you wish to provide comments containing proprietary or confidential information, please contact FRA for alternate submission instructions.

Issued in Washington, DC.

Carolyn R. Hayward-Williams,

Director, Office of Railroad Systems and Technology.

[FR Doc. 2023–16407 Filed 8–1–23; 8:45 am]

BILLING CODE 4910–06–P

DEPARTMENT OF TRANSPORTATION

Federal Railroad Administration

[Docket Number FRA–2010–0031]

Long Island Rail Road's Request to Amend Its Positive Train Control System

AGENCY: Federal Railroad Administration (FRA), Department of Transportation (DOT).

ACTION: Notice of availability and request for comments.

SUMMARY: This document provides the public with notice that, on July 20, 2023, the Long Island Rail Road (LIRR) submitted a request for amendment (RFA) to its FRA-certified positive train control (PTC) system in order to establish an Advanced Civil Speed Enforcement System II (ACSES II) Construction Zone (CZ) to support the construction of an extension of the Patchogue Siding and associated signal system changes for LIRR's modification of the current track infrastructure. FRA is publishing this notice and inviting public comment on the railroad's RFA to its PTC system.

DATES: FRA will consider comments received by August 22, 2023. FRA may consider comments received after that date to the extent practicable and without delaying implementation of valuable or necessary modifications to a PTC system.

ADDRESSES: *Comments:* Comments may be submitted by going to *https://www.regulations.gov* and following the online instructions for submitting comments.

Instructions: All submissions must include the agency name and the applicable docket number. The relevant PTC docket number for this host railroad is Docket No. FRA–2010–0031. For convenience, all active PTC dockets are hyperlinked on FRA's website at *https://railroads.dot.gov/research-development/program-areas/train-control/ptc/railroads-ptc-dockets.* All comments received will be posted without change to *https://www.regulations.gov*; this includes any personal information.

FOR FURTHER INFORMATION CONTACT: Gabe Neal, Staff Director, Signal, Train Control, and Crossings Division,

telephone: 816–516–7168, email: *Gabe.Neal@dot.gov*.

SUPPLEMENTARY INFORMATION: In general, Title 49 United States Code (U.S.C.) Section 20157(h) requires FRA to certify that a host railroad's PTC system complies with Title 49 Code of Federal Regulations (CFR) part 236, subpart I, before the technology may be operated in revenue service. Before making certain changes to an FRA-certified PTC system or the associated FRA-approved PTC Safety Plan (PTCSP), a host railroad must submit, and obtain FRA's approval of, an RFA to its PTC system or PTCSP under 49 CFR 236.1021.

Under 49 CFR 236.1021(e), FRA's regulations provide that FRA will publish a notice in the **Federal Register** and invite public comment in accordance with 49 CFR part 211, if an RFA includes a request for approval of a material modification of a signal and train control system. Accordingly, this notice informs the public that, on July 20, 2023, LIRR submitted an RFA to its ACSES II PTC system which seeks FRA's approval for a three-month outage from September 15, 2023, to December 15, 2023, to support the construction of an extension of the Patchogue Siding and associated signal system changes. That RFA is available in Docket No. FRA–2010–0031.

Interested parties are invited to comment on LIRR's RFA to its PTC system by submitting written comments or data. During FRA's review of LIRR's RFA, FRA will consider any comments or data submitted within the timeline specified in this notice and to the extent practicable, without delaying implementation of valuable or necessary modifications to a PTC system. *See* 49 CFR 236.1021; *see also* 49 CFR 236.1011(e). Under 49 CFR 236.1021, FRA maintains the authority to approve, approve with conditions, or deny a railroad's RFA to its PTC system at FRA's sole discretion.

Privacy Act Notice

In accordance with 49 CFR 211.3, FRA solicits comments from the public to better inform its decisions. DOT posts these comments, without edit, including any personal information the commenter provides, to *https://www.regulations.gov,* as described in the system of records notice (DOT/ALL–14 FDMS), which can be reviewed at *https://www.transportation.gov/privacy*. See *https://www.regulations.gov/privacy-notice* for the privacy notice of regulations.gov. To facilitate comment tracking, we encourage commenters to provide their name, or the name of their organization; however, submission of names is completely optional. If you wish to provide comments containing proprietary or confidential information, please contact FRA for alternate submission instructions.

Issued in Washington, DC.

Carolyn R. Hayward-Williams,

Director, Office of Railroad Systems and Technology.

[FR Doc. 2023–16406 Filed 8–1–23; 8:45 am]

BILLING CODE 4910–06–P

DEPARTMENT OF TRANSPORTATION

Federal Railroad Administration

[Docket Number FRA–2023–0031]

Petition for Waiver of Compliance; Reopening of Comment Period

Under part 211 of title 49 Code of Federal Regulations (CFR), this document provides the public notice that by communication received July 7, 2023, Amtrak requested that the Federal Railroad Administration (FRA) re-open the period for public comment on Amtrak's request for a waiver of compliance from certain provisions of the Federal railroad safety regulations contained at 49 CFR parts 215 (Railroad Freight Car Safety Standards), 229 (Railroad Locomotive Safety Standards), 232 (Brake System Safety Standards for Freight and Other Non-Passenger Trains and Equipment; End-of-Train Devices), and 238 (Passenger Equipment Safety Standards). The relevant Docket Number is FRA–2023–0031.

Specifically, Amtrak requests to re-open the comment period regarding its petition to use virtual reality simulation assessments to satisfy the ''hands-on'' portion of periodic refresher training to remain qualified per § 215.11(b), § 229.5, § 232.203(b)(8), and § 238.109. Amtrak requested that FRA re-open the comment period for an additional 45 days ''to allow Amtrak more time to address some of the concerns the labor organizations outline in their comments.'' Previously, FRA had published a notice establishing a comment period open until July 5, 2023 (88 FR 29176, May 5, 2023).[1] By this notice, FRA grants Amtrak's request to re-open the comment period for 45 days.

A copy of the communication, the petition, as well as any written communications concerning the petition, are available for review online at *www.regulations.gov.*

Interested parties are invited to participate in these proceedings by submitting written views, data, or comments. FRA does not anticipate scheduling a public hearing in connection with these proceedings since the facts do not appear to warrant a hearing. If any interested party desires an opportunity for oral comment and a public hearing, they should notify FRA, in writing, before the end of the comment period and specify the basis for their request.

All communications concerning these proceedings should identify the appropriate docket number and may be submitted at *http://www.regulations.gov.* Follow the online instructions for submitting comments.

Communications received by September 18, 2023 will be considered by FRA before final action is taken. Comments received after that date will be considered if practicable.

Anyone can search the electronic form of any written communications and comments received into any of our dockets by the name of the individual submitting the comment (or signing the document, if submitted on behalf of an association, business, labor union, etc.). Under 5 U.S.C. 553(c), U.S. Department of Transportation (DOT) solicits comments from the public to better inform its processes. DOT posts these comments, without edit, including any personal information the commenter provides, to *www.regulations.gov,* as described in the system of records notice (DOT/ALL–14 FDMS), which can be reviewed at *https://www.transportation.gov/privacy.* See also *https://www.regulations.gov/privacy-notice* for the privacy notice of *regulations.gov.*

Issued in Washington, DC.

John Karl Alexy,

Associate Administrator for Railroad Safety, Chief Safety Officer.

[FR Doc. 2023–16457 Filed 8–1–23; 8:45 am]

BILLING CODE 4910–06–P

[1] *See https://www.regulations.gov/document/FRA-2023-0031-0002.*

DEPARTMENT OF TRANSPORTATION

Federal Transit Administration

FY 2023 Emergency Relief Grants for Public Transportation Systems Affected by Major Declared Disasters in Calendar Years 2017, 2020, 2021, and 2022

AGENCY: Federal Transit Administration (FTA), U.S. Department of Transportation (DOT).

ACTION: Notice of re-opening application submissions and revised requirements.

SUMMARY: The Federal Transit Administration (FTA) is re-opening the application period for grants under the Public Transportation Emergency Relief

Program (Emergency Relief Program) for States, Territories, local government authorities, Indian Tribes, and other FTA recipients affected by major declared disasters for 90 days.

DATES: Complete proposals must be submitted electronically to opportunity FTA–2023–011–TPM–ER through the *GRANTS.GOV* ''APPLY'' function by October 31, 2023. However, applications received within the first 30 days will be provided priority.

FOR FURTHER INFORMATION CONTACT: Thomas Wilson, Emergency Relief Program Manager, Office of Program Management, 1200 New Jersey Ave. SE, Washington, DC 20590, phone: (202) 366–5279, or email, *Thomas.Wilson@dot.gov*.

SUPPLEMENTARY INFORMATION:

On March 27, 2023, the Federal Transit Administration (FTA) announced the opportunity to apply for $212,301,048 in grants under the Public Transportation Emergency Relief Program (Emergency Relief Program) for States, Territories, local government authorities, Indian Tribes, and other FTA recipients affected by major declared disasters in calendar years 2017, 2020, 2021, and 2022 (88 FR 18210). The deadline for proposals was May 26, 2023. After the initial allocation of $102,325,551 in funding, $109,975,497 remains to be allocated to eligible recipients.

By this notice, FTA is re-opening the application submission period for 90 days. Applicants who submitted proposals prior to May 26, 2023, do not need to re-submit. Applications during this period must be submitted to opportunity FTA–2023–011–TPM–ER through GRANTS.GOV.

FTA will review applications and make additional funding allocations on a rolling basis, with the first review taking place for any application submitted within the first 30 days of the publication of this notice. If funding remains, additional applications will be evaluated after the final submission deadline of October 31, 2023.

The March 27, 2023, notice stated a maximum Federal share for all grants awarded via that notice would be 90 percent of the net project cost unless the project is in response to, or recovery from, a major declared disaster in an insular area, in which case the maximum Federal share would be 100 percent (48 U.S.C. 1469a). The notice also invited applicants from other than insular areas to request a waiver of the non-Federal share requirement (49 U.S.C. 5324(e)(3)). FTA noted its ability to provide a waiver and fully fund an applicant's request may depend on total requests from all applicants. By this notice, FTA is waiving the non-Federal match requirement for all prospective applicants and invites eligible applicants to apply for funding at 100 percent Federal share. Consistent with the March 27, 2023, notice, expenses related to COVID–19 response or recovery are not eligible.

All other eligibilities and requirements stated in the March 27, 2023 notice apply. Interested applicants should review that notice (88 FR 18210) for additional information. Further information, including a recording of the webinar held April 6, 2023, can be found on FTA's website at *https://www.transit.dot.gov/notices-funding/public-transportation-emergency-relief-funds-transit-systems-affected-major*.

Nuria I. Fernandez,

Administrator.

[FR Doc. 2023–16416 Filed 8–1–23; 8:45 am]

BILLING CODE 4910–57–P

DEPARTMENT OF THE TREASURY

Office of Foreign Assets Control

Notice of OFAC Sanctions Actions

AGENCY: Office of Foreign Assets Control, Department of the Treasury.

ACTION: Notice.

SUMMARY: The U.S. Department of the Treasury's Office of Foreign Assets Control (OFAC) is publishing the names of one or more persons whose property and interests in property have been unblocked and who have been removed from the Specially Designated Nationals and Blocked Persons List.

DATES: See **SUPPLEMENTARY INFORMATION** section for applicable date(s).

FOR FURTHER INFORMATION CONTACT: *OFAC:* Associate Director for Global Targeting, tel: 202–622–2420; Assistant Director for Licensing, tel.: 202–622–2480; Assistant Director for Regulatory Affairs, tel.: 202–622–4855; or Assistant Director for Sanctions Compliance & Evaluation, tel.: 202–622–2490.

SUPPLEMENTARY INFORMATION:

Electronic Availability

The Specially Designated Nationals and Blocked Persons List (SDN List) and additional information concerning OFAC sanctions programs are available on OFAC's website (*https://ofac.treasury.gov*).

Notice of OFAC Actions

On June 29, 2023, OFAC determined that the property and interests in property subject to U.S. jurisdiction of the following persons are unblocked and they have been removed from the SDN List.

Individual

1. APIKIAN, Philipp Paul Vartan; DOB 15 Jan 1969; POB Geneva, Switzerland; citizen Switzerland; Gender Male; Passport X0062329 (Switzerland) issued 27 Feb 2012 expires 26 Feb 2022 (individual) [VENEZUELA–EO13850].

Entity

1. SWISSOIL TRADING SA, Rue Pierre-Fatio 15, Geneva 1204, Switzerland; website *https://www.swissoil.trading/;* V.A.T. Number CHE–104.851.121 (Switzerland) [VENEZUELA–EO13850].

Dated: July 28, 2023.

Andrea M. Gacki,

Director, Office of Foreign Assets Control, U.S. Department of the Treasury.

[FR Doc. 2023–16439 Filed 8–1–23; 8:45 am]

BILLING CODE 4810–AL–P

DEPARTMENT OF THE TREASURY

Office of Foreign Assets Control

Notice of OFAC Sanctions Actions

AGENCY: Office of Foreign Assets Control, Treasury.

ACTION: Notice.

SUMMARY: The U.S. Department of the Treasury's Office of Foreign Assets Control (OFAC) is publishing the names of one or more persons whose property and interests in property have been unblocked and who have been removed from the Specially Designated Nationals and Blocked Persons List (SDN List).

DATES: See **SUPPLEMENTARY INFORMATION** section for applicable date(s).

FOR FURTHER INFORMATION CONTACT: OFAC: Andrea Gacki, Director, tel.: 202–622–2490; Associate Director for Global Targeting, tel.: 202–622–2420; Assistant Director for Licensing, tel.: 202–622–2480; Assistant Director for Regulatory Affairs, tel.: 202–622–4855; or the Assistant Director for Sanctions Compliance & Evaluation, tel.: 202–622–2490.

SUPPLEMENTARY INFORMATION:

Electronic Availability

The SDN List and additional information concerning OFAC sanctions programs are available on OFAC's website (*https://ofac.treasury.gov*).

Notice of OFAC Actions

On July 28, 2023, OFAC removed from the SDN List the persons listed below, whose property and interests in property were blocked pursuant to the relevant sanctions authorities listed

below. On July 28, 2023, OFAC determined that circumstances no longer warrant the inclusion of the following persons on the SDN List under the relevant authority.

Individuals

1. CASIMIRO, Didier, Moscow, Russia; DOB 15 Nov 1966; POB Vilvoorde, Belgium; Gender Male (individual) [VENEZUELA–EO13850] (Linked To: ROSNEFT TRADING S.A.).

Individual was designated, and property and interests in property blocked, pursuant to Executive Order 13850 of November 1, 2018, ''Blocking Property of Additional Persons Contributing to the Situation in Venezuela,'' as amended by Executive Order 13857 of January 25, 2019, ''Taking Additional Steps To Address the National Emergency With Respect to Venezuela.''

2. ROTONDARO COVA, Carlos Alberto (a.k.a. ROTONDARO COVA, Carlos; a.k.a. ROTONDARO, Carlos), Capital District, Venezuela; DOB 11 Sep 1965; citizen Venezuela; Gender Male; Cedula No. 6157070 (Venezuela); Passport 083445280 (Venezuela) expires 29 Jan 2019; alt. Passport 022740782 (Venezuela) expires 24 May 2014; Former President of the Board of Directors of the Venezuelan Institute of Social Security (IVSS) (individual) [VENEZUELA].

Individual was designated, and property and interests in property blocked, pursuant to Executive Order 13692 of March 8, 2015, ''Blocking Property and Suspending Entry of Certain Persons Contributing to the Situation in Venezuela.''

Dated: July 28, 2023.

Andrea M. Gacki,

Director, Office of Foreign Assets Control, U.S. Department of the Treasury.

[FR Doc. 2023–16459 Filed 8–1–23; 8:45 am]

BILLING CODE 4810–AL–P

DEPARTMENT OF THE TREASURY

Office of Foreign Assets Control

Notice of OFAC Sanctions Actions

AGENCY: Office of Foreign Assets Control, Treasury.

ACTION: Notice.

SUMMARY: The U.S. Department of the Treasury's Office of Foreign Assets Control (OFAC) is publishing the names of one or more persons that have been placed on OFAC's Specially Designated Nationals and Blocked Persons List (SDN List) based on OFAC's determination that one or more applicable legal criteria were satisfied. All property and interests in property subject to U.S. jurisdiction of these persons are blocked, and U.S. persons are generally prohibited from engaging in transactions with them.

DATES: See **SUPPLEMENTARY INFORMATION** section for applicable date.

FOR FURTHER INFORMATION CONTACT: OFAC: Andrea Gacki, Director, tel.: 202–622–2490; Associate Director for Global Targeting, tel.: 202–622–2420; Assistant Director for Licensing, tel.: 202–622–2480; Assistant Director for Regulatory Affairs, tel.: 202–622–4855; or the Assistant Director for Sanctions Compliance & Evaluation, tel.: 202–622–2490.

SUPPLEMENTARY INFORMATION:

Electronic Availability

The SDN List and additional information concerning OFAC sanctions programs are available on OFAC's website (*https://www.treasury.gov/ofac*).

Notice of OFAC Action(s)

On July 27, 2023, OFAC determined that the property and interests in property subject to U.S. jurisdiction of the following person are blocked under the relevant sanctions authority listed below.

Individual

1. YUSUF, Abdiweli Mohamed (a.k.a. AW–MAHAMUD, Abdiweli; a.k.a. WALAAC, Ina-Waran), Bari, Somalia; DOB 1982; alt. DOB 1981; alt. DOB 1980; nationality Somalia; Gender Male; Secondary sanctions risk: section 1(b) of Executive Order 13224, as amended by Executive Order 13886 (individual) [SDGT] (Linked To: ISIS–SOMALIA).

Designated pursuant to section 1(a)(iii)(A) of Executive Order 13224 of September 23, 2001, ''Blocking Property and Prohibiting Transactions With Persons Who Commit, Threaten to Commit, or Support Terrorism,'' 66 FR 49079, as amended by Executive Order 13886 of September 9, 2019, ''Modernizing Sanctions To Combat Terrorism,'' 84 FR 48041 (E.O. 13224, as amended), for having acted or purported to act for or on behalf of, directly or indirectly, ISIS–SOMALIA, a person whose property and interests in property are blocked pursuant to E.O. 13224.

Dated: July 27, 2023.

Andrea M. Gacki,

Director, Office of Foreign Assets Control, U.S. Department of the Treasury.

[FR Doc. 2023–16373 Filed 8–1–23; 8:45 am]

BILLING CODE 4810–AL–P

DEPARTMENT OF VETERANS AFFAIRS

[OMB Control No. 2900–0770]

Agency Information Collection Activity: Generic Clearance for the Collection of Qualitative Feedback on Agency Service Delivery (VBA, VHA, NCA)

AGENCY: Department of Veterans Affairs.

ACTION: Notice.

SUMMARY: The Department of Veterans Affairs (VA) is announcing an opportunity for public comment on the proposed collection of certain information by the agency. Under the Paperwork Reduction Act (PRA) of 1995, Federal agencies are required to publish notice in the **Federal Register** concerning each proposed collection of information, including each proposed extension of a currently approved collection, and allow 60 days for public comment in response to the notice.

DATES: Written comments and recommendations on the proposed collection of information should be received on or before October 2, 2023.

ADDRESSES: Submit written comments on the collection of information through Federal Docket Management System (FDMS) at *www.Regulations.gov* or to Maribel Aponte, Office of Enterprise and Integration, Data Governance Analytics (008), Department of Veterans Affairs, 810 Vermont Avenue NW, Washington, DC 20420 or email to *maribel.aponte@va.gov*. Please refer to ''OMB Control No. 2900–0770'' in any correspondence. During the comment period, comments may be viewed online through FDMS.

FOR FURTHER INFORMATION CONTACT: Maribel Aponte, Office of Enterprise and Integration, Data Governance Analytics (008), 810 Vermont Avenue NW, Washington, DC 20420, (202) 266–4688 or email *maribel.aponte@va.gov*. Please refer to ''OMB Control No. 2900–0770'' in any correspondence.

SUPPLEMENTARY INFORMATION:

Under the PRA of 1995, Federal agencies must obtain approval from the Office of Management and Budget (OMB) for each collection of information they conduct or sponsor. This request for comment is being made pursuant to section 3506(c)(2)(A) of the PRA.

With respect to the following collection of information, VA invites comments on: (1) whether the proposed collection of information is necessary for the proper performance of VA's functions, including whether the information will have practical utility; (2) the accuracy of VA's estimate of the burden of the proposed collection of information; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or the use of other forms of information technology.

Authority: Public Law 104–13; 44 U.S.C. 3501–3521.

Title: Generic Clearance for the Collection of Qualitative Feedback on Agency Service Delivery (VBA, VHA, NCA).

OMB Control Number: 2900–0770.

Type of Review: Revision of a currently approved collection.

Abstract: Executive Order 12862 directs Federal agencies to provide service to the public that matches or exceeds the best service available in the private sector. In order to work continuously to ensure that our programs are effective and meet our customers' needs, the Department of Veterans Affairs (VA) seeks to obtain OMB approval of a generic clearance to collect qualitative feedback on our service delivery for Veterans Benefits Administration (VBA); Veterans Health Administration (VHA); and National Cemetery Administration (NCA). By qualitative feedback, we mean information that provides useful insights on perceptions and opinions, but not statistical surveys that yield quantitative results that can be generalized to the population of study.

The proposed information collection activity provides a means to garner qualitative customer and stakeholder feedback in an efficient, timely manner, in accordance with the Administration's commitment to improving service delivery. This feedback will provide insights into customer or stakeholder perceptions, experiences and expectations, provide an early warning of issues with service, or focus attention on areas where communication, training, or changes in operations might improve delivery of products or services. These collections will allow for ongoing, collaborative, and actionable communications between the VA and its customers and stakeholders. It will also allow feedback to contribute directly to the improvement of program management.

The solicitation of feedback will target areas such as: timeliness, appropriateness, accuracy of information, courtesy, efficiency of service delivery, and resolution of issues with service delivery. Responses will be assessed to plan and inform efforts to improve or maintain the quality of service offered to the public. If this information is not collected, vital feedback from customers and stakeholders on the provision of services will be unavailable to the Agency.

The Agency will only submit information collections for approval under this generic clearance if it meets the following conditions:

- The collections are voluntary;
- The collections are low-burden for respondents (based on considerations of total burden hours, total number of respondents, or burden-hours per respondent) and are low-cost for both the respondents and the Federal Government;
- The collections are noncontroversial and do not raise issues of concern to other Federal agencies;
- Any collection is targeted to the solicitation of opinions from respondents who have experience with the program or may have experience with the program in the near future;
- Personally identifiable information (PII) is collected only to the extent necessary and is not retained;
- Information gathered will be used only internally for general service improvement and program management purposes and is not intended for release outside of the agency;
- Information gathered will not be used for the purpose of substantially informing influential policy decisions; and
- Information gathered will yield qualitative information; the collections will not be designed or expected to yield statistically reliable results or used as though the results are generalizable to the population of study.

The types of collections that this generic clearance covers include, but are not limited to, Program Satisfaction Surveys; Focus Groups; Customer Comment Cards; Small Discussion Groups of customers, potential customers, delivery partners, or other stakeholders; Cognitive Laboratory Studies, such as those used to refine questions or assess usability of a website; Qualitative Customer Satisfaction Surveys, such as post-transaction surveys and opt-out web surveys; In-person Observation Testing, such as website or software usability tests; and Patient Surveys. As a general matter, information collections under this clearance will not result in any new system of records containing privacy information and will not ask questions of a sensitive nature, such as sexual behavior and attitudes, religious beliefs, and other matters that are commonly considered private.

Affected Public: Individuals or Households; Businesses and Organizations; State, Local or Tribal Government.

Estimated Annual Burden: 256,000 total hours.

Program Satisfaction Surveys: 75,000.

Focus Groups: 32,000.

Customer Comment Cards: 7,500.

Small Discussion Groups: 2,750.

Cognitive Laboratory Studies: 30,000.

Qualitative Customer Satisfaction Surveys: 62,500.

In-Person Observation Testing: 6,000.

Patient Surveys: 40,250.

Estimated Average Burden Per Respondent:

Program Satisfaction Surveys: 30 minutes.

Focus Groups: 60 minutes.

Customer Comment Cards: 30 minutes.

Small Discussion Groups: 30 minutes.

Cognitive Laboratory Studies: 60 minutes.

Qualitative Customer Satisfaction Surveys: 30 minutes.

In-Person Observation Testing: 30 minutes.

Patient Surveys: 30 minutes.

Frequency of Response: Once.

Estimated Number of Respondents: 450,000 total.

Program Satisfaction Surveys: 150,000.

Focus Groups: 32,000.

Customer Comment Cards: 15,000.

Small Discussion Groups: 5,500.

Cognitive Laboratory Studies: 30,000.

Qualitative Customer Satisfaction Surveys: 125,000.

In-Person Observation Testing: 12,000.

Patient Surveys: 80,500.

By direction of the Secretary.

Maribel Aponte,

VA PRA Clearance Officer, Office of Enterprise and Integration/Data Governance Analytics, Department of Veterans Affairs.

[FR Doc. 2023–16415 Filed 8–1–23; 8:45 am]

BILLING CODE 8320–01–P

DEPARTMENT OF VETERANS AFFAIRS

Health Services Research and Development Service Scientific Merit Review Board, Notice of Meeting

The Department of Veterans Affairs (VA) gives notice under the Federal Advisory Committee Act, 5 U.S.C. ch. 10, that a meeting of the Health Services Research and Development Service Scientific Merit Review Board (hereinafter the Board) will be held August 30, 2023, via Webex. The meeting will be held between noon and 1:30 p.m. EST. The meeting will be partially closed to the public from 12:15–1:30 p.m. EST for the discussion, examination and reference to the research applications and scientific review. Discussions will involve reference to staff and consultant critiques of research proposals. Discussions will deal with scientific merit of each proposal and qualifications of personnel conducting

the studies, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy. Additionally, premature disclosure of research information could significantly obstruct implementation of proposed agency action regarding the research proposals. As provided by Public Law 92–463 subsection 10(d), as amended by Public Law 94–409, closing the committee meeting is in accordance with 5 U.S.C. 552b(c)(6) and (9)(B).

The objective of the Board is to provide for the fair and equitable selection of the most meritorious research projects for support by VA research funds and to offer advice for research program officials on program priorities and policies. The ultimate objective of the Board is to ensure that the VA Health Services Research and Development program promotes functional independence and improves the quality of life for impaired and disabled Veterans.

Board members advise the Director, Health Services Research and Development Service and the Chief Research and Development Officer on the scientific and technical merit, the mission relevance, and the protection of human subjects of Health Services Research and Development proposals. The Board does not consider grants, contracts, or other forms of extramural research.

Members of the public may attend the open portion of the meeting in listen-only mode as the time limited open agenda does not enable public comment presentations. To attend the open portion of the meeting (12:00–12:15 p.m. EST), the public may join by dialing the phone number 1–833–558–0712 and entering the meeting number (access code): 2761 510 0503.

Written public comments must be sent to Tiffin Ross-Shepard, Designated Federal Officer, Health Services Research and Development Service, Department of Veterans Affairs (14RDH), 810 Vermont Avenue NW, Washington, DC 20420, or to *Tiffin.Ross-Shepard@va.gov* at least five days before the meeting via the email listed above. The written public comments will be shared with the board members. The public may not attend the closed portion of the meeting as disclosure of research information could significantly obstruct implementation of proposed agency action regarding the research proposals (Pub. L. 92–463 subsection 10(d), as amended by Pub. L. 94–409, closing the committee meeting is in accordance with title 5 U.S.C. 552b(c)(6) and (9)(B).

Dated: July 28, 2023.

LaTonya L. Small,

Federal Advisory Committee Management Officer.

[FR Doc. 2023–16446 Filed 8–1–23; 8:45 am]

BILLING CODE P

FEDERAL REGISTER

Vol. 88 Wednesday,

No. 147 August 2, 2023

Part II

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Part 412

Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2024 and Updates to the IRF Quality Reporting Program; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 412

[CMS–1781–F]

RIN 0938–AV04

Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2024 and Updates to the IRF Quality Reporting Program

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

SUMMARY: This final rule updates the prospective payment rates for inpatient rehabilitation facilities (IRFs) for Federal fiscal year (FY) 2024. As required by statute, this final rule includes the classification and weighting factors for the IRF prospective payment system's case-mix groups and a description of the methodologies and data used in computing the prospective payment rates for FY 2024. It also rebases and revises the IRF market basket to reflect a 2021 base year. It also confirms when IRF units can become excluded and paid under the IRF PPS. This rule also includes updates for the IRF Quality Reporting Program (QRP).

DATES:

Effective date: These regulations are effective on October 1, 2023.

Applicability dates: The updated IRF prospective payment rates are applicable for IRF discharges occurring on or after October 1, 2023, and on or before September 30, 2024 (FY 2024).

FOR FURTHER INFORMATION CONTACT: Kim Schwartz, (410) 786–2571, for general information.

Catie Cooksey, (410) 786–0179, for information about the IRF payment policies and payment rates.

Kim Schwartz, (410) 786–2571, for information about the IRF coverage policies.

Ariel Cress, (410) 786–8571, for information about the IRF quality reporting program.

SUPPLEMENTARY INFORMATION:

Availability of Certain Information Through the Internet on the CMS Website

The IRF prospective payment system (IRF PPS) Addenda along with other supporting documents and tables referenced in this final rule are available through the internet on the CMS website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS.*

We note that prior to 2020, each rule or notice issued under the IRF PPS has included a detailed reiteration of the various regulatory provisions that have affected the IRF PPS over the years. That discussion, along with detailed background information for various other aspects of the IRF PPS, is now available on the CMS website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS.*

I. Executive Summary

A. Purpose

This final rule updates the prospective payment rates for IRFs for FY 2024 (that is, for discharges occurring on or after October 1, 2023, and on or before September 30, 2024) as required under section 1886(j)(3)(C) of the Social Security Act (the Act). As required by section 1886(j)(5) of the Act, this final rule includes the classification and weighting factors for the IRF PPS's case-mix groups (CMGs), and a description of the methodologies and data used in computing the prospective payment rates for FY 2024. It also rebases and revises the IRF market basket to reflect a 2021 base year. It also confirms when an IRF unit can be excluded and paid under the IRF PPS. This final rule includes several updates to the IRF QRP for the FY 2025 IRF QRP and FY 2026 IRF QRP. This final rule will add two new measures to the IRF QRP, remove three measures from the IRF QRP, and modify one measure in the IRF QRP. This final rule also finalizes the public reporting schedule of four measures. In addition, this final rule includes a summary of the comments received on Centers for Medicare and Medicaid Services' (CMS') update on our efforts to close the health equity gap and on the request for information on principles CMS would use to select and prioritize IRF QRP quality measures in future years.

B. Summary of Major Provisions

In this final rule, we use the methods described in the FY 2023 IRF PPS final rule (87 FR 47038) to update the prospective payment rates for FY 2024 using updated FY 2022 IRF claims and the most recent available IRF cost report data, which is FY 2021 IRF cost report data. It also rebases and revises the IRF market basket to reflect a 2021 base year. It also modifies the regulation governing when an IRF unit can be excluded and paid under the IRF PPS.

Beginning with the FY 2025 IRF QRP, IRFs will be required to submit data on a modified version of the COVID–19 Vaccination Coverage among Healthcare Personnel measure and the Discharge Function Score measure. Beginning with the FY 2025 IRF QRP, IRFs will no longer be required to submit data on the Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function, the IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (CBE #2633), and the IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (CBE #2634) measures. Beginning with the FY 2026 IRF QRP, IRFs will be required to submit data on the COVID–19 Vaccine: Percent of Patients/Residents Who Are Up to Date measure. This final rule also adopts policies to begin public reporting of the Transfer of Health Information to the Patient-Post-Acute Care (PAC) and Transfer of Health Information to the Provider-PAC measures, the Discharge Function Score measure, and the COVID–19 Vaccine: Percent of Patients/Residents Who Are Up to Date measure. Finally, we provide a summary of the comments received from interested parties on principles for selecting and prioritizing IRF QRP quality measures and concepts as well as a summary of the comments received on our continued efforts to close the health equity gap.

C. Summary of Impact

TABLE 1: Cost and Benefit

Provision Description	Transfers/Costs
FY 2024 IRF PPS payment rate update	The overall economic impact of this final rule is an estimated $355 million in increased payments from the Federal Government to IRFs during FY 2024.
FY 2025 through FY 2026 IRF QRP changes	The overall economic impact of this final rule is an estimated increase in cost to IRFs of $31,412.56 beginning with the FY 2025 IRF QRP.

II. Background

A. Statutory Basis and Scope for IRF PPS Provisions

Section 1886(j) of the Act provides for the implementation of a per-discharge PPS for inpatient rehabilitation hospitals and inpatient rehabilitation units of a hospital (collectively, hereinafter referred to as IRFs). Payments under the IRF PPS encompass inpatient operating and capital costs of furnishing covered rehabilitation services (that is, routine, ancillary, and capital costs), but not direct graduate medical education costs, costs of approved nursing and allied health education activities, bad debts, and other services or items outside the scope of the IRF PPS. A complete discussion of the IRF PPS provisions appears in the original FY 2002 IRF PPS final rule (66 FR 41316) and the FY 2006 IRF PPS final rule (70 FR 47880) and we provided a general description of the IRF PPS for FYs 2007 through 2019 in the FY 2020 IRF PPS final rule (84 FR 39055 through 39057). A general description of the IRF PPS for FYs 2020 through 2023, along with detailed background information for various other aspects of the IRF PPS, is now available on the CMS website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS.*

Under the IRF PPS from FY 2002 through FY 2005, the prospective payment rates were computed across 100 distinct CMGs, as described in the FY 2002 IRF PPS final rule (66 FR 41316). We constructed 95 CMGs using rehabilitation impairment categories (RICs), functional status (both motor and cognitive), and age (in some cases, cognitive status and age may not be a factor in defining a CMG). In addition, we constructed five special CMGs to account for very short stays and for patients who expire in the IRF.

For each of the CMGs, we developed relative weighting factors to account for a patient's clinical characteristics and expected resource needs. Thus, the weighting factors accounted for the relative difference in resource use across all CMGs. Within each CMG, we created tiers based on the estimated effects that certain comorbidities would have on resource use.

We established the Federal PPS rates using a standardized payment conversion factor (formerly referred to as the budget-neutral conversion factor). For a detailed discussion of the budget-neutral conversion factor, please refer to our FY 2004 IRF PPS final rule (68 FR 45684 through 45685). In the FY 2006 IRF PPS final rule (70 FR 47880), we discussed in detail the methodology for determining the standard payment conversion factor.

We applied the relative weighting factors to the standard payment conversion factor to compute the unadjusted prospective payment rates under the IRF PPS from FYs 2002 through 2005. Within the structure of the payment system, we then made adjustments to account for interrupted stays, transfers, short stays, and deaths. Finally, we applied the applicable adjustments to account for geographic variations in wages (wage index), the percentage of low-income patients, location in a rural area (if applicable), and outlier payments (if applicable) to the IRFs' unadjusted prospective payment rates.

For cost reporting periods that began on or after January 1, 2002, and before October 1, 2002, we determined the final prospective payment amounts using the transition methodology prescribed in section 1886(j)(1) of the Act. Under this provision, IRFs transitioning into the PPS were paid a blend of the Federal IRF PPS rate and the payment that the IRFs would have received had the IRF PPS not been implemented. This provision also allowed IRFs to elect to bypass this blended payment and immediately be paid 100 percent of the Federal IRF PPS rate. The transition methodology expired as of cost reporting periods beginning on or after October 1, 2002 (FY 2003), and payments for all IRFs now consist of 100 percent of the Federal IRF PPS rate.

Section 1886(j) of the Act confers broad statutory authority upon the Secretary to propose refinements to the IRF PPS. In the FY 2006 IRF PPS final rule (70 FR 47880) and in correcting amendments to the FY 2006 IRF PPS final rule (70 FR 57166), we finalized a number of refinements to the IRF PPS case-mix classification system (the CMGs and the corresponding relative weights) and the case-level and facility-level adjustments. These refinements included the adoption of the Office of Management and Budget's (OMB's) Core-Based Statistical Area (CBSA) market definitions; modifications to the CMGs, tier comorbidities; and CMG relative weights, implementation of a new teaching status adjustment for IRFs; rebasing and revising the market basket used to update IRF payments, and updates to the rural, low-income percentage (LIP), and high-cost outlier adjustments. Beginning with the FY 2006 IRF PPS final rule (70 FR 47908 through 47917), the market basket used to update IRF payments was a market basket reflecting the operating and capital cost structures for freestanding IRFs, freestanding inpatient psychiatric facilities (IPFs), and long-term care hospitals (LTCHs) (hereinafter referred to as the rehabilitation, psychiatric, and long-term care (RPL) market basket). Any reference to the FY 2006 IRF PPS final rule in this final rule also includes the provisions effective in the correcting amendments. For a detailed discussion of the final key policy changes for FY 2006, please refer to the FY 2006 IRF PPS final rule.

The regulatory history previously included in each rule or notice issued under the IRF PPS, including a general description of the IRF PPS for FYs 2007 through 2020, is available on the CMS website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS.*

In late 2019,[1] the United States began responding to an outbreak of a virus named ''SARS-CoV–2'' and the disease it causes, which is named ''coronavirus disease 2019'' (abbreviated ''COVID–19''). Due to our prioritizing efforts in

[1] Patel A, Jernigan DB. Initial Public Health Response and Interim Clinical Guidance for the 2019 Novel Coronavirus Outbreak—United States, December 31, 2019–February 4, 2020. MMWR Morb Mortal Wkly Rep 2020;69:140–146. DOI *http://dx.doi.org/10.15585/mmwr.mm6905e1.*

support of containing and combatting the Public Health Emergency (PHE) for COVID–19, and devoting significant resources to that end, we published two interim final rules with comment period affecting IRF payment and conditions for participation. The interim final rule with comment period (IFC) entitled, ''Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency,'' published on April 6, 2020 (85 FR 19230) (hereinafter referred to as the April 6, 2020 IFC), included certain changes to the IRF PPS medical supervision requirements at 42 CFR 412.622(a)(3)(iv) and 412.29(e) during the PHE for COVID–19. In addition, in the April 6, 2020 IFC, we removed the post-admission physician evaluation requirement at § 412.622(a)(4)(ii) for all IRFs during the PHE for COVID–19. In the FY 2021 IRF PPS final rule, to ease documentation and administrative burden, we also removed the post-admission physician evaluation documentation requirement at § 412.622(a)(4)(ii) permanently beginning in FY 2021.

A second IFC entitled, ''Medicare and Medicaid Programs, Basic Health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program'' was published on May 8, 2020 (85 FR 27550) (hereinafter referred to as the May 8, 2020 IFC). Among other changes, the May 8, 2020 IFC included a waiver of the ''3-hour rule'' at § 412.622(a)(3)(ii) to reflect the waiver required by section 3711(a) of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) (Pub. L. 116–136, enacted on March 27, 2020). In the May 8, 2020 IFC, we also modified certain IRF coverage and classification requirements for freestanding IRF hospitals to relieve acute care hospital capacity concerns in States (or regions, as applicable) experiencing a surge during the PHE for COVID–19. In addition to the policies adopted in our IFCs, we responded to the PHE with numerous blanket waivers [2] and other flexibilities,[3] some of which are applicable to the IRF PPS. CMS finalized these policies in the Calendar Year 2023 Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems final rule with comment period (87 FR 71748).

B. Provisions of the Patient Protection and the Affordable Care Act and the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) Affecting the IRF PPS in FY 2012 and Beyond

The Patient Protection and the Affordable Care Act (the Affordable Care Act or ACA) (Pub. L. 111–148) was enacted on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152), which amended and revised several provisions of the Patient Protection and Affordable Care Act, was enacted on March 30, 2010. In this final rule, we refer to the two statutes collectively as the ''Affordable Care Act'' or ''ACA''.

The ACA included several provisions that affect the IRF PPS in FYs 2012 and beyond. In addition to what was previously discussed, section 3401(d) of the ACA also added section 1886(j)(3)(C)(ii)(I) of the Act (providing for a ''productivity adjustment'' for FY 2012 and each subsequent FY). The productivity adjustment for FY 2024 is discussed in section VI.D. of this final rule. Section 1886(j)(3)(C)(ii)(II) of the Act provides that the application of the productivity adjustment to the market basket update may result in an update that is less than 0.0 for a FY and in payment rates for a FY being less than such payment rates for the preceding FY.

Section 3004(b) of the ACA and section 411(b) of the MACRA (Pub. L. 114–10, enacted on April 16, 2015) also addressed the IRF PPS. Section 3004(b) of ACA reassigned the previously designated section 1886(j)(7) of the Act to section 1886(j)(8) of the Act and inserted a new section 1886(j)(7) of the Act, which contains requirements for the Secretary to establish a QRP for IRFs. Under that program, data must be submitted in a form and manner and at a time specified by the Secretary. Beginning in FY 2014, section 1886(j)(7)(A)(i) of the Act requires the application of a 2-percentage point reduction to the market basket increase factor otherwise applicable to an IRF (after application of paragraphs (C)(iii) and (D) of section 1886(j)(3) of the Act) for a FY if the IRF does not comply with the requirements of the IRF QRP for that FY. Application of the 2-percentage point reduction may result in an update that is less than 0.0 for a FY and in payment rates for a FY being less than such payment rates for the preceding FY. Reporting-based reductions to the market basket increase factor are not cumulative; they only apply for the FY involved. Section 411(b) of the MACRA amended section 1886(j)(3)(C) of the Act by adding paragraph (iii), which required us to apply for FY 2018, after the application of section 1886(j)(3)(C)(ii) of the Act, an increase factor of 1.0 percent to update the IRF prospective payment rates.

C. Operational Overview of the Current IRF PPS

As described in the FY 2002 IRF PPS final rule (66 FR 41316), upon the admission and discharge of a Medicare Part A fee-for-service (FFS) patient, the IRF is required to complete the appropriate sections of a Patient Assessment Instrument (PAI), designated as the IRF–PAI. In addition, beginning with IRF discharges occurring on or after October 1, 2009, the IRF is also required to complete the appropriate sections of the IRF–PAI upon the admission and discharge of each Medicare Advantage (MA) patient, as described in the FY 2010 IRF PPS final rule (74 FR 39762) and the FY 2010 IRF PPS correction notice (74 FR 50712). All required data must be electronically encoded into the IRF–PAI software product. Generally, the software product includes patient classification programming called the Grouper software. The Grouper software uses specific IRF–PAI data elements to classify (or group) patients into distinct CMGs and account for the existence of any relevant comorbidities.

The Grouper software produces a five-character CMG number. The first character is an alphabetic character that indicates the comorbidity tier. The last four characters are numeric characters that represent the distinct CMG number. A free download of the Grouper software is available on the CMS website at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Software.html.* The Grouper software is also embedded in the internet Quality Improvement and Evaluation System (iQIES) User tool available in iQIES at *https://www.cms.gov/medicare/quality-safety-oversight-general-information/iqies.*

Once a Medicare Part A FFS patient is discharged, the IRF submits a Medicare claim as a Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Pub. L. 104–191, enacted on August 21, 1996)—compliant electronic claim or, if the Administrative Simplification Compliance Act of 2002 (ASCA) (Pub. L.

[2] CMS, ''COVID–19 Emergency Declaration Blanket Waivers for Health Care Providers,'' (updated Feb. 19 2021) (available at *https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf*).

[3] CMS, ''COVID–19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing,'' (updated March 5, 2021) (available at *https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf*).

107–105, enacted on December 27, 2002) permits, a paper claim (a UB–04 or a CMS–1450 as appropriate) using the five-character CMG number and sends it to the appropriate Medicare Administrative Contractor (MAC). In addition, once a MA patient is discharged, in accordance with the Medicare Claims Processing Manual, chapter 3, section 20.3 (Pub. 100–04), hospitals (including IRFs) must submit to their MAC an informational-only bill (type of bill (TOB) 111) that includes Condition Code 04. This will ensure that the MA days are included in the hospital's Supplemental Security Income (SSI) ratio (used in calculating the IRF LIP adjustment) for FY 2007 and beyond. Claims submitted to Medicare must comply with both ASCA and HIPAA.

Section 3 of the ASCA amended section 1862(a) of the Act by adding paragraph (22), which requires the Medicare program, subject to section 1862(h) of the Act, to deny payment under Part A or Part B for any expenses for items or services for which a claim is submitted other than in an electronic form specified by the Secretary. Section 1862(h) of the Act, in turn, provides that the Secretary shall waive such denial in situations in which there is no method available for the submission of claims in an electronic form or the entity submitting the claim is a small provider. In addition, the Secretary also has the authority to waive such denial in such unusual cases as the Secretary finds appropriate. For more information, see the ''Medicare Program; Electronic Submission of Medicare Claims'' final rule (70 FR 71008). Our instructions for the limited number of Medicare claims submitted on paper are available at *http://www.cms.gov/manuals/downloads/clm104c25.pdf.*

Section 3 of the ASCA operates in the context of the administrative simplification provisions of HIPAA, which include, among others, the requirements for transaction standards and code sets codified in 45 CFR part 160 and part 162, subparts A and I through R (generally known as the Transactions Rule). The Transactions Rule requires covered entities, including covered healthcare providers, to conduct covered electronic transactions according to the applicable transaction standards. (See the CMS program claim memoranda at *http://www.cms.gov/ElectronicBillingEDITrans/* and listed in the addenda to the Medicare Intermediary Manual, Part 3, section 3600).

The MAC processes the claim through its software system. This software system includes pricing programming called the ''Pricer'' software. The Pricer software uses the CMG number, along with other specific claim data elements and provider-specific data, to adjust the IRF's prospective payment for interrupted stays, transfers, short stays, and deaths, and then applies the applicable adjustments to account for the IRF's wage index, percentage of low-income patients, rural location, and outlier payments. For discharges occurring on or after October 1, 2005, the IRF PPS payment also reflects the teaching status adjustment that became effective as of FY 2006, as discussed in the FY 2006 IRF PPS final rule (70 FR 47880).

D. Advancing Health Information Exchange

The Department of Health and Human Services (HHS) has a number of initiatives designed to encourage and support the adoption of interoperable health information technology and to promote nationwide health information exchange to improve health care and patient access to their digital health information.

To further interoperability in post-acute care settings, CMS and the Office of the National Coordinator for Health Information Technology (ONC) participate in the Post-Acute Care Interoperability Workgroup (PACIO) to facilitate collaboration with interested parties to develop Health Level Seven International® (HL7) Fast Healthcare Interoperability Resource® (FHIR) standards. These standards could support the exchange and reuse of patient assessment data derived from the post-acute care (PAC) setting assessment tools, such as the minimum data set (MDS), inpatient rehabilitation facility-patient assessment instrument (IRF–PAI), Long-Term Care Hospital (LTCH) continuity assessment record and evaluation (CARE) Data Set (LCDS), outcome and assessment information set (OASIS), and other sources.[4] [5] The PACIO Project has focused on HL7 FHIR implementation guides for: functional status, cognitive status and new use cases on advance directives, re-assessment timepoints, and Speech, language, swallowing, cognitive communication and hearing (SPLASCH) pathology.[6] We encourage PAC provider and health IT vendor participation as the efforts advance.

The CMS Data Element Library (DEL) continues to be updated and serves as a resource for PAC assessment data elements and their associated mappings to health IT standards such as Logical Observation Identifiers Names and Codes (LOINC) and Systematized Nomenclature of Medicine Clinical Terms (SNOMED).[7] The DEL furthers CMS' goal of data standardization and interoperability. Standards in the DEL can be referenced on the CMS website and in the ONC Interoperability Standards Advisory (ISA). The 2023 ISA is available at *https://www.healthit.gov/sites/isa/files/inline-files/2023%20Reference%20Edition_ISA_508.pdf.*

We are also working with ONC to advance the United States Core Data for Interoperability (USCDI), a standardized set of health data classes and constituent data elements for nationwide, interoperable health information exchange.[8] We are collaborating with ONC and other Federal agencies to define and prioritize additional data standardization needs and develop consensus on recommendations for future versions of the USCDI. We are also directly collaborating with ONC to build requirements to support data standardization and alignment with requirements for quality measurement. ONC has launched the USCDI+ initiative to support the identification and establishment of domain specific datasets that build on the core USCDI foundation.[9] The USCDI+ quality measurement domain currently being developed aims to support defining additional data specifications for quality measurement that harmonize, where possible, with other Federal agency data needs and inform supplemental standards necessary to support quality measurement, including the needs of programs supporting quality measurement for long-term and post-acute care.

The 21st Century Cures Act (Cures Act) (Pub. L. 114–255, enacted December 13, 2016) required HHS and ONC to take steps to promote adoption and use of electronic health record (EHR) technology.[10] Specifically,

[4] HL7 FHIR Release 4. Available at *https://www.hl7.org/fhir/.*

[5] HL7 FHIR. PACIO Functional Status Implementation Guide. Available at *https://paciowg.github.io/functional-status-ig/.*

[6] PACIO Project. Available at *http://pacioproject.org/about/.*

[7] Centers for Medicare & Medicaid Services. Newsroom. Fact sheet: CMS Data Element Library Fact Sheet. June 21, 2018. Available at *https://www.cms.gov/newsroom/fact-sheets/cms-data-element-library-fact-sheet.*

[8] USCDI. Available at *https://www.healthit.gov/isa/united-states-core-data-interoperability-uscdi.*

[9] USCDI+. Available at *https://www.healthit.gov/topic/interoperability/uscdi-plus.*

[10] Sections 4001 through 4008 of Public Law 114–255. Available at *https://www.govinfo.gov/content/*

Continued

section 4003(b) of the Cures Act required ONC to take steps to advance interoperability through the development of a Trusted Exchange Framework and Common Agreement aimed at establishing full network-to-network exchange of health information nationally. On January 18, 2022, ONC announced a significant milestone by releasing the Trusted Exchange Framework [11] and Common Agreement Version 1.[12] The Trusted Exchange Framework is a set of non-binding principles for health information exchange, and the Common Agreement is a contract that advances those principles. The Common Agreement and the Qualified Health Information Network Technical Framework Version 1 (incorporated by reference into the Common Agreement) establish the technical infrastructure model and governing approach for different health information networks and their users to securely share clinical information with each other, all under commonly agreed to terms. The technical and policy architecture of how exchange occurs under the Common Agreement follows a network-of-networks structure, which allows for connections at different levels and is inclusive of many different types of entities at those different levels, such as health information networks, healthcare practices, hospitals, public health agencies, and Individual Access Services (IAS) Providers.[13] On February 13, 2023, HHS marked a new milestone during an event at HHS headquarters,[14] which recognized the first set of applicants accepted for onboarding to the Common Agreement as Qualified Health Information Networks (QHINs). QHINs will be entities that will connect directly to each other to serve as the core for nationwide interoperability.[15] For more information, we refer readers to *https://www.healthit.gov/topic/interoperability/trusted-exchange-framework-and-common-agreement.*

We invited providers to learn more about these important developments and how they are likely to affect IRFs.

III. Summary of Provisions of the Proposed Rule

In the FY 2024 IRF PPS proposed rule, we proposed to update the IRF PPS for FY 2024 and the IRF QRP for FY 2025 and FY 2026.

The proposed policy changes and updates to the IRF prospective payment rates for FY 2024 are as follows:

- Update the CMG relative weights and average length of stay values for FY 2024, in a budget neutral manner, as discussed in section IV. of the FY 2024 IRF PPS proposed rule (88 FR 20954 through 20959).
- Update the IRF PPS payment rates for FY 2024 by the market basket increase factor, based upon the most current data available, with a productivity adjustment required by section 1886(j)(3)(C)(ii)(I) of the Act, as described in section V. of the FY 2024 IRF PPS proposed rule (88 FR 20959, 20973 through 20974).
- Rebase and revise the IRF market basket to reflect a 2021 base year, as discussed in section V. of the FY 2024 IRF PPS proposed rule (88 FR 20959 through 20973).
- Update the FY 2024 IRF PPS payment rates by the FY 2024 wage index and the labor-related share in a budget-neutral manner, as discussed in section V. of the FY 2024 IRF PPS proposed rule (88 FR 20974 through 20977).
- Describe the calculation of the IRF standard payment conversion factor for FY 2024, as discussed in section V. of the FY 2024 IRF PPS proposed rule (88 FR 20977).
- Update the outlier threshold amount for FY 2024, as discussed in section VI. of the FY 2024 IRF PPS proposed rule (88 FR 20980 through 20981).
- Update the cost-to-charge ratio (CCR) ceiling and urban/rural average CCRs for FY 2024, as discussed in section VI. of the FY 2024 IRF PPS proposed rule (88 FR 20981).
- Describe the proposed modification to the regulation for IRF units to become excluded and paid under the IRF PPS as discussed in section VII. of the FY 2024 IRF PPS proposed rule (88 FR 20981 through 20984).

We also proposed updates to the IRF QRP and requested information in section VIII. of the FY 2024 IRF PPS proposed rule as follows:

- Modify the COVID–19 Vaccination Coverage among Healthcare Personnel measure beginning with the FY 2025 IRF QRP.
- Adopt the Discharge Function Score measure beginning with the FY 2025 IRF QRP.
- Remove the Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function measure beginning with the FY 2025 IRF QRP.
- Remove the IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633) measure beginning with the FY 2025 IRF QRP.
- Remove the IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634) measure beginning with the FY 2025 IRF QRP.
- Adopt the COVID–19 Vaccine: Percent of Patients/Residents Who Are Up to Date measure beginning with the FY 2026 IRF QRP.
- Request information on principles for selecting and prioritizing IRF QRP quality measures and concepts.
- Provide an update on our continued efforts to close the health equity gap.

IV. Analysis of and Responses to Public Comments

We received 45 timely responses from the public, many of which contained multiple comments on the FY 2024 IRF PPS proposed rule (88 FR 20950). We received comments from various trade associations, inpatient rehabilitation facilities, individual physicians, therapists, clinicians, health care industry organizations, and health care consulting firms. The following sections, arranged by subject area, include a summary of the public comments that we received, and our responses.

pkg/PLAW-114publ255/html/PLAW-114publ255.htm.

[11] The Trusted Exchange Framework (TEF): Principles for Trusted Exchange (Jan. 2022). Available at *https://www.healthit.gov/sites/default/files/page/2022-01/Trusted_Exchange_Framework_0122.pdf.*

[12] Common Agreement for Nationwide Health Information Interoperability Version 1 (Jan. 2022). Available at *https://www.healthit.gov/sites/default/files/page/2022-01/Common_Agreement_for_Nationwide_Health_Information_Interoperability_Version_1.pdf.*

[13] The Common Agreement defines Individual Access Services (IAS) as ''with respect to the Exchange Purposes definition, the services provided utilizing the Connectivity Services, to the extent consistent with Applicable Law, to an Individual with whom the QHIN, Participant, or Subparticipant has a Direct Relationship to satisfy that Individual's ability to access, inspect, or obtain a copy of that Individual's Required Information that is then maintained by or for any QHIN, Participant, or Subparticipant.'' The Common Agreement defines ''IAS Provider'' as: ''Each QHIN, Participant, and Subparticipant that offers Individual Access Services.'' *See* Common Agreement for Nationwide Health Information Interoperability Version 1, at 7 (Jan. 2022), *https://www.healthit.gov/sites/default/files/page/2022-01/Common_Agreement_for_Nationwide_Health_Information_Interoperability_Version_1.pdf.*

[14] ''Building TEFCA,'' Micky Tripathi and Mariann Yeager, Health IT Buzz Blog. February 13, 2023. *https://www.healthit.gov/buzz-blog/electronic-health-and-medical-records/interoperability-electronic-health-and-medical-records/building-tefca.*

[15] The Common Agreement defines a QHIN as ''to the extent permitted by applicable SOP(s), a Health Information Network that is a U.S. Entity that has been Designated by the RCE and is a party to the Common Agreement countersigned by the RCE.'' *See* Common Agreement for Nationwide Health Information Interoperability Version 1, at 10 (Jan. 2022), *https://www.healthit.gov/sites/default/files/page/2022-01/Common_Agreement_for_Nationwide_Health_Information_Interoperability_Version_1.pdf.*

A. General Comments on the FY 2024 IRF PPS Proposed Rule

In addition to the comments, we received on specific proposals contained within the proposed rule (which we address later in this final rule), commenters also submitted more general observations on the IRF PPS and IRF care generally.

Comment: We received several comments that were outside the scope of the FY 2024 IRF PPS proposed rule. Specifically, we received comments regarding the inclusion of recreational therapy in the IRF intensity of therapy requirement, disclosures of ownership and additional disclosable parties' information in the skilled nursing facility setting, the ''low wage index policy,'' Medicare Advantage rules, waiving the ''three-hour rule,'' and the IRF Review Choice Demonstration. We also received comments about making refinements to our measures to address the impact of COVID–19 and social determinants of health, to change the HCP COVID–19 measure specifications to annual data submission, and concerns of being inappropriately penalized for NHSN technical errors.

Response: We thank the commenters for bringing these issues to our attention and will take these comments into consideration for potential policy refinements or direct the comments to the appropriate subject matter experts.

V. Update to the Case-Mix Group (CMG) Relative Weights and Average Length of Stay (ALOS) Values for FY 2024

As specified in § 412.620(b)(1), we calculate a relative weight for each CMG that is proportional to the resources needed by an average inpatient rehabilitation case in that CMG. For example, cases in a CMG with a relative weight of 2, on average, will cost twice as much as cases in a CMG with a relative weight of 1. Relative weights account for the variance in cost per discharge due to the variance in resource utilization among the payment groups, and their use helps to ensure that IRF PPS payments support beneficiary access to care, as well as provider efficiency.

In the proposed rule, we proposed to update the CMG relative weights and ALOS values for FY 2024. Typically, we use the most recent available data to update the CMG relative weights and ALOS values. For FY 2024, we proposed to use the FY 2022 IRF claims and FY 2021 IRF cost report data. These data are the most current and complete data available at this time. Currently, only a small portion of the FY 2022 IRF cost report data are available for analysis, but the majority of the FY 2022 IRF claims data are available for analysis. We also proposed that if more recent data became available after the publication of the proposed rule and before the publication of the final rule, we would use such data to determine the FY 2024 CMG relative weights and ALOS values in the final rule.

We proposed to apply these data using the same methodologies that we have used to update the CMG relative weights and ALOS values each FY since we implemented an update to the methodology. The detailed CCR data from the cost reports of IRF provider units of primary acute care hospitals is used for this methodology, instead of CCR data from the associated primary care hospitals, to calculate IRFs' average costs per case, as discussed in the FY 2009 IRF PPS final rule (73 FR 46372). In calculating the CMG relative weights, we use a hospital-specific relative value method to estimate operating (routine and ancillary services) and capital costs of IRFs. The process to calculate the CMG relative weights for this final rule is as follows:

Step 1. We estimate the effects that comorbidities have on costs.

Step 2. We adjust the cost of each Medicare discharge (case) to reflect the effects found in the first step.

Step 3. We use the adjusted costs from the second step to calculate CMG relative weights, using the hospital-specific relative value method.

Step 4. We normalize the FY 2024 CMG relative weights to the same average CMG relative weight from the CMG relative weights implemented in the FY 2023 IRF PPS final rule (87 FR 47038).

Consistent with the methodology that we have used to update the IRF classification system in each instance in the past, we proposed to update the CMG relative weights for FY 2024 in such a way that total estimated aggregate payments to IRFs for FY 2024 are the same with or without the changes (that is, in a budget-neutral manner) by applying a budget neutrality factor to the standard payment amount. We note that, as we typically do, we updated our data between the FY 2024 IRF PPS proposed and final rules to ensure that we use the most recent available data in calculating IRF PPS payments. This updated data reflects a more complete set of claims for FY 2022 and additional cost report data for FY 2021. To calculate the appropriate budget neutrality factor for use in updating the FY 2024 CMG relative weights, we use the following steps:

Step 1. Calculate the estimated total amount of IRF PPS payments for FY 2024 (with no changes to the CMG relative weights).

Step 2. Calculate the estimated total amount of IRF PPS payments for FY 2024 by applying the changes to the CMG relative weights (as discussed in this final rule).

Step 3. Divide the amount calculated in step 1 by the amount calculated in step 2 to determine the budget neutrality factor of 1.0002 that would maintain the same total estimated aggregate payments in FY 2024 with and without the changes to the CMG relative weights.

Step 4. Apply the budget neutrality factor from step 3 to the FY 2024 IRF PPS standard payment amount after the application of the budget-neutral wage adjustment factor.

In section VI.G. of this final rule, we discuss the use of the existing methodology to calculate the standard payment conversion factor for FY 2024.

In Table 2, ''Relative Weights and Average Length of Stay Values for Case-Mix Groups,'' we present the CMGs, the comorbidity tiers, the corresponding relative weights, and the ALOS values for each CMG and tier for FY 2024. The ALOS for each CMG is used to determine when an IRF discharge meets the definition of a short-stay transfer, which results in a per diem case level adjustment.

TABLE 2: Relative Weights and Average Length of Stay Values for the Case-Mix Groups

CMG	CMG Description (M=motor, A=age)	Relative Weight				Average Length of Stay			
		Tier 1	Tier 2	Tier 3	No Comorbidity Tier	Tier 1	Tier 2	Tier 3	No Comorbidity Tier
0101	Stroke M >=72.50	0.9840	0.8414	0.7763	0.7348	9	10	9	9
0102	Stroke M >=63.50 and M <72.50	1.2601	1.0774	0.9941	0.9409	12	11	11	11
0103	Stroke M >=50.50 and M <63.50	1.6264	1.3907	1.2830	1.2144	14	14	14	13
0104	Stroke M >=41.50 and M <50.50	2.0857	1.7834	1.6454	1.5574	17	18	17	17
0105	Stroke M <41.50 and A >=84.50	2.5400	2.1718	2.0038	1.8966	24	21	20	20
0106	Stroke M <41.50 and A <84.50	2.9022	2.4816	2.2895	2.1671	25	25	23	22
0201	Traumatic brain injury M >=73.50	1.0814	0.8600	0.7832	0.7312	10	11	9	8
0202	Traumatic brain injury M >=61.50 and M <73.50	1.3878	1.1036	1.0051	0.9383	12	12	11	11
0203	Traumatic brain injury M >=49.50 and M <61.50	1.7187	1.3668	1.2447	1.1621	15	15	13	13
0204	Traumatic brain injury M >=35.50 and M <49.50	2.1379	1.7001	1.5483	1.4455	18	18	16	16
0205	Traumatic brain injury M <35.50	2.7326	2.1730	1.9790	1.8476	30	23	19	18
0301	Non-traumatic brain injury M >=65.50	1.2082	0.9506	0.8859	0.8275	10	10	10	9
0302	Non-traumatic brain injury M >=52.50 and M <65.50	1.5486	1.2184	1.1355	1.0606	13	13	12	12
0303	Non-traumatic brain injury M >=42.50 and M <52.50	1.8539	1.4586	1.3593	1.2697	15	15	14	13
0304	Non-traumatic brain injury M <42.50 and A >=78.50	2.1918	1.7245	1.6071	1.5011	19	17	16	15
0305	Non-traumatic brain injury M <42.50 and A <78.50	2.3908	1.8810	1.7530	1.6374	20	19	17	17
0401	Traumatic spinal cord injury M >=56.50	1.3571	1.0692	1.0384	0.9679	13	11	11	12
0402	Traumatic spinal cord injury M >=47.50 and M <56.50	1.7196	1.3548	1.3159	1.2265	16	15	14	13
0403	Traumatic spinal cord injury M >=41.50 and M <47.50	2.0713	1.6319	1.5849	1.4772	19	17	16	16
0404	Traumatic spinal cord injury M <31.50 and A <61.50	3.2583	2.5671	2.4932	2.3239	22	25	27	20
0405	Traumatic spinal cord injury M >=31.50 and M <41.50	2.6613	2.0967	2.0364	1.8980	21	22	22	20
0406	Traumatic spinal cord injury M >=24.50 and M <31.50 and A >=61.50	3.3419	2.6329	2.5572	2.3835	24	28	27	24
0407	Traumatic spinal cord injury M <24.50 and A >=61.50	4.4849	3.5334	3.4318	3.1986	44	36	33	35
0501	Non-traumatic spinal cord injury M >=60.50	1.2596	0.9985	0.9390	0.8577	12	11	10	10
0502	Non-traumatic spinal cord injury M >=53.50 and M <60.50	1.5508	1.2294	1.1561	1.0560	14	13	12	12
0503	Non-traumatic spinal cord injury M >=48.50 and M <53.50	1.7794	1.4107	1.3266	1.2117	16	14	14	13
0504	Non-traumatic spinal cord injury M >=39.50 and M <48.50	2.1413	1.6975	1.5963	1.4581	19	16	17	16
0505	Non-traumatic spinal cord injury M <39.50	3.0130	2.3886	2.2462	2.0517	28	25	23	21
0601	Neurological M >=64.50	1.3401	1.0161	0.9510	0.8567	11	10	10	9
0602	Neurological M >=52.50 and M <64.50	1.6602	1.2588	1.1781	1.0613	13	13	12	11
0603	Neurological M >=43.50 and M <52.50	1.9713	1.4946	1.3989	1.2601	15	14	14	13
0604	Neurological M <43.50	2.4621	1.8667	1.7472	1.5739	20	18	17	16
0701	Fracture of lower extremity M >=61.50	1.2031	0.9557	0.9124	0.8349	12	11	10	10

CMG	CMG Description (M=motor, A=age)	Relative Weight				Average Length of Stay			
		Tier 1	Tier 2	Tier 3	No Comorbidity Tier	Tier 1	Tier 2	Tier 3	No Comorbidity Tier
0702	Fracture of lower extremity M >=52.50 and M <61.50	1.4908	1.1842	1.1306	1.0345	13	13	12	12
0703	Fracture of lower extremity M >=41.50 and M <52.50	1.8376	1.4598	1.3937	1.2753	16	15	15	14
0704	Fracture of lower extremity M <41.50	2.2805	1.8116	1.7296	1.5826	18	18	18	16
0801	Replacement of lower-extremity joint M >=63.50	1.1836	0.9450	0.8786	0.8082	10	9	9	9
0802	Replacement of lower-extremity joint M >=57.50 and M <63.50	1.3462	1.0748	0.9992	0.9192	10	11	10	10
0803	Replacement of lower-extremity joint M >=51.50 and M <57.50	1.4961	1.1945	1.1105	1.0216	13	13	11	11
0804	Replacement of lower-extremity joint M >=42.50 and M <51.50	1.6858	1.3459	1.2513	1.1511	15	14	13	12
0805	Replacement of lower-extremity joint M <42.50	2.1040	1.6798	1.5617	1.4367	17	17	16	15
0901	Other orthopedic M >=63.50	1.2309	0.9485	0.8910	0.8136	11	10	10	9
0902	Other orthopedic M >=51.50 and M <63.50	1.5655	1.2064	1.1332	1.0348	14	12	12	11
0903	Other orthopedic M >=44.50 and M <51.50	1.8159	1.3994	1.3145	1.2004	15	14	14	13
0904	Other orthopedic M <44.5	2.1953	1.6917	1.5892	1.4512	19	17	16	15
1001	Amputation lower extremity M >=64.50	1.1998	0.9933	0.9080	0.8286	10	10	10	10
1002	Amputation lower extremity M >=55.50 and M <64.50	1.5279	1.2650	1.1564	1.0552	14	14	12	12
1003	Amputation lower extremity M >=47.50 and M <55.50	1.8004	1.4905	1.3626	1.2433	15	16	14	13
1004	Amputation lower extremity M <47.50	2.3361	1.9340	1.7680	1.6133	19	19	18	17
1101	Amputation non-lower extremity M >=58.50	1.2738	1.2738	1.0263	0.9729	12	14	11	10
1102	Amputation non-lower extremity M >=52.50 and M <58.50	1.4606	1.4606	1.1769	1.1156	13	16	12	11
1103	Amputation non-lower extremity M <52.50	2.0037	2.0037	1.6145	1.5304	17	18	16	13
1201	Osteoarthritis M >=61.50	1.3299	1.0296	0.9247	0.8605	12	11	10	10
1202	Osteoarthritis M >=49.50 and M <61.50	1.6836	1.3034	1.1707	1.0894	14	14	12	11
1203	Osteoarthritis M <49.50 and A >=74.50	2.1218	1.6426	1.4753	1.3729	17	17	17	14
1204	Osteoarthritis M <49.50 and A <74.50	2.2013	1.7042	1.5306	1.4244	18	18	16	15
1301	Rheumatoid other arthritis M >=62.50	1.3766	1.1049	0.9921	0.9182	10	11	10	10
1302	Rheumatoid other arthritis M >=51.50 and M <62.50	1.6431	1.3189	1.1842	1.0960	12	13	12	11
1303	Rheumatoid other arthritis M >=44.50 and M <51.50 and A >=64.50	1.8570	1.4906	1.3383	1.2387	13	12	15	12
1304	Rheumatoid other arthritis M <44.50 and A >=64.50	2.1954	1.7621	1.5822	1.4644	15	17	16	16
1305	Rheumatoid other arthritis M <51.50 and A <64.50	2.2065	1.7711	1.5902	1.4718	15	16	17	14
1401	Cardiac M >=68.50	1.1256	0.9099	0.8407	0.7768	10	10	9	9
1402	Cardiac M >=55.50 and M <68.50	1.4063	1.1368	1.0504	0.9705	12	12	11	11
1403	Cardiac M >=45.50 and M <55.50	1.7014	1.3753	1.2708	1.1742	15	14	13	12
1404	Cardiac M <45.50	2.1231	1.7162	1.5858	1.4651	18	17	16	15
1501	Pulmonary M >=68.50	1.2909	1.0412	1.0044	0.9516	13	10	10	10
1502	Pulmonary M >=56.50 and M <68.50	1.5272	1.2318	1.1883	1.1258	12	12	12	11

CMG	CMG Description (M=motor, A=age)	Relative Weight				Average Length of Stay			
		Tier 1	Tier 2	Tier 3	No Comorbidity Tier	Tier 1	Tier 2	Tier 3	No Comorbidity Tier
1503	Pulmonary M >=45.50 and M <56.50	1.8121	1.4616	1.4100	1.3358	15	14	13	13
1504	Pulmonary M <45.50	2.2346	1.8024	1.7386	1.6472	22	17	16	16
1601	Pain syndrome M >=65.50	1.1354	0.8523	0.8417	0.7736	10	10	9	10
1602	Pain syndrome M >=58.50 and M <65.50	1.4932	1.1209	1.1069	1.0174	9	11	12	11
1603	Pain syndrome M >=43.50 and M <58.50	1.7332	1.3011	1.2849	1.1810	10	13	13	13
1604	Pain syndrome M <43.50	2.1412	1.6074	1.5873	1.4590	11	15	17	15
1701	Major multiple trauma without brain or spinal cord injury M >=57.50	1.3697	1.0394	0.9843	0.8977	12	11	10	10
1702	Major multiple trauma without brain or spinal cord injury M >=50.50 and M <57.50	1.6534	1.2547	1.1881	1.0836	15	14	13	12
1703	Major multiple trauma without brain or spinal cord injury M >=41.50 and M <50.50	1.9589	1.4866	1.4077	1.2839	16	16	15	14
1704	Major multiple trauma without brain or spinal cord injury M >=36.50 and M <41.50	2.2563	1.7122	1.6214	1.4788	20	18	16	16
1705	Major multiple trauma without brain or spinal cord injury M <36.50	2.5847	1.9614	1.8574	1.6941	20	20	19	18
1801	Major multiple trauma with brain or spinal cord injury M >=67.50	1.0999	0.9202	0.8490	0.7684	11	11	10	9
1802	Major multiple trauma with brain or spinal cord injury M >=55.50 and M <67.50	1.3990	1.1704	1.0799	0.9774	14	13	12	11
1803	Major multiple trauma with brain or spinal cord injury M >=45.50 and M <55.50	1.7472	1.4617	1.3487	1.2207	13	16	14	14
1804	Major multiple trauma with brain or spinal cord injury M >=40.50 and M <45.50	2.0441	1.7101	1.5779	1.4282	19	18	16	16
1805	Major multiple trauma with brain or spinal cord injury M >=30.50 and M <40.50	2.4427	2.0435	1.8855	1.7066	22	23	19	18
1806	Major multiple trauma with brain or spinal cord injury M <30.50	3.5910	3.0042	2.7719	2.5089	38	32	29	24
1901	Guillain-Barré M >=66.50	1.2641	0.9028	0.8741	0.8392	12	12	11	10
1902	Guillain-Barré M >=51.50 and M <66.50	1.7885	1.2772	1.2367	1.1874	20	14	13	14
1903	Guillain-Barré M >=38.50 and M <51.50	2.5024	1.7871	1.7303	1.6613	25	19	19	18
1904	Guillain-Barré M <38.50	4.2456	3.0319	2.9356	2.8187	40	34	29	26
2001	Miscellaneous M >=66.50	1.1905	0.9557	0.8911	0.8082	11	10	10	9
2002	Miscellaneous M >=55.50 and M <66.50	1.4767	1.1855	1.1054	1.0025	13	12	12	11
2003	Miscellaneous M >=46.50 and M <55.50	1.7534	1.4075	1.3124	1.1903	15	14	13	13
2004	Miscellaneous M <46.50 and A >=77.50	2.0884	1.6765	1.5632	1.4177	18	17	16	15
2005	Miscellaneous M <46.50 and A <77.50	2.2394	1.7978	1.6763	1.5203	19	18	16	16
2101	Burns M >=52.50	1.5172	1.2785	1.1385	1.0176	17	15	12	11
2102	Burns M <52.50	2.4552	2.0690	1.8425	1.6468	24	21	18	18
5001	Short-stay cases, length of stay is 3 days or fewer	0.0000	0.0000	0.0000	0.1730	0	0	0	3

CMG	CMG Description (M=motor, A=age)	Relative Weight				Average Length of Stay			
		Tier 1	Tier 2	Tier 3	No Comorbidity Tier	Tier 1	Tier 2	Tier 3	No Comorbidity Tier
5101	Expired, orthopedic, length of stay is 13 days or fewer	0.0000	0.0000	0.0000	0.7794	0	0	0	8
5102	Expired, orthopedic, length of stay is 14 days or more	0.0000	0.0000	0.0000	1.8794	0	0	0	18
5103	Expired, not orthopedic, length of stay is 15 days or fewer	0.0000	0.0000	0.0000	0.8818	0	0	0	8
5104	Expired, not orthopedic, length of stay is 16 days or more	0.0000	0.0000	0.0000	2.3549	0	0	0	25

Generally, updates to the CMG relative weights result in some increases and some decreases to the CMG relative weight values. Table 2 shows how we estimate that the application of the revisions for FY 2024 would affect particular CMG relative weight values, which would affect the overall distribution of payments within CMGs and tiers. We note that, because we implement the CMG relative weight revisions in a budget-neutral manner (as previously described), total estimated aggregate payments to IRFs for FY 2024 are not affected as a result of the CMG relative weight revisions. However, the revisions affect the distribution of payments within CMGs and tiers.

TABLE 3: Distributional Effects of the Changes to the CMG Relative Weights

Percentage Change in CMG Relative Weights	Number of Cases Affected	Percentage of Cases Affected
Increased by 15% or more	65	0.0%
Increased by between 5% and 15%	1,195	0.4%
Changed by less than 5%	326,336	99.4%
Decreased by between 5% and 15%	599	0.2%
Decreased by 15% or more	0	0.0%

As shown in Table 3, 99.4 percent of all IRF cases are in CMGs and tiers that would experience less than a 5 percent change (either increase or decrease) in the CMG relative weight value as a result of the revisions for FY 2024. The changes in the ALOS values for FY 2024, compared with the FY 2023 ALOS values, are small and do not show any particular trends in IRF length of stay patterns.

We invited public comment on our proposed updates to the CMG relative weights and ALOS values for FY 2024.

The following is a summary of the public comments received on the proposed revisions to update the CMG relative weights and ALOS values for FY 2024 and our responses.

Comment: Commenters were generally supportive of the proposed updates to the relative weights and ALOS values and encouraged CMS to use the latest available data to update these values in the final rule. A few commenters expressed concern regarding reductions in certain relative weight values associated with traumatic spinal cord injury, major multiple traumas with brain or spinal cord injury, and Guillain-Barré. A few commenters also expressed concerns related to the increase of the ALOS for CMG 0404. These commenters noted that CMS did not propose a similar increase in reimbursement for this CMG and suggested the change may be due to distortions in the data rather than actual care changes.

Response: We appreciate these commenters' support for updating the relative weights and ALOS values for FY 2024. The CMG relative weights are updated each year in a budget neutral manner, thus leading to increases in some CMG relative weights and corresponding decreases in other CMG relative weights. We note that, as we typically do, we have updated our data between the FY 2024 IRF PPS proposed and this final rule to ensure that we use the most recent available data in calculating IRF PPS payments. The relative weights associated with these CMGs include both increases and decreases, and the variation for FY 2024 is similar to the typical year-to-year variation that we observe. The relative weight values are updated each year to ensure that the IRF case mix system is as reflective as possible of the current IRF population, thereby ensuring that IRF payments appropriately reflect the relative costs of caring for all types of IRF patients.

Additionally, the ALOS values are updated annually to be as reflective as possible of recent IRF utilization. The ALOS values are only used to determine which cases qualify for the short-stay transfer policy and are not used to determine payments for the non-short-stay transfer cases.

Comment: A commenter expressed concern that decreases to the CMG relative weights and ALOS values do not reflect the medical complexity of the patients and suggested that CMS should revise the CMG relative weights and ALOS values to ensure adequate coverage and reimbursement for the services required to treat patients in IRF settings.

Response: We believe that these data accurately reflect the severity of the IRF patient population and the associated costs of caring for these patients in the IRF setting. The CMG relative weights are updated each year based on the most recent available data for the full population of IRF Medicare fee-for-service beneficiaries. This ensures that the IRF case mix system is as reflective

as possible of changes in the IRF patient populations and the associated coding practices.

After consideration of the comments we received, we are finalizing our proposal to update the CMG relative weights and ALOS values for FY 2024, as shown in Table 2 of this final rule. These updates are effective for FY 2024, that is, for discharges occurring on or after October 1, 2023, and on or before September 30, 2024.

VI. FY 2024 IRF PPS Payment Update

A. Background

Section 1886(j)(3)(C) of the Act requires the Secretary to establish an increase factor that reflects changes over time in the prices of an appropriate mix of goods and services for which payment is made under the IRF PPS. According to section 1886(j)(3)(A)(i) of the Act, the increase factor shall be used to update the IRF prospective payment rates for each FY. Section 1886(j)(3)(C)(ii)(I) of the Act requires the application of a productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act. Thus, we proposed to update the IRF PPS payments for FY 2024 by a market basket increase percentage as required by section 1886(j)(3)(C) of the Act based upon the most current data available, with a productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act.

We have utilized various market baskets through the years in the IRF PPS. For a discussion of these market baskets, we refer readers to the FY 2016 IRF PPS final rule (80 FR 47046).

In FY 2016, we finalized the use of a 2012-based IRF market basket, using Medicare cost report data for both freestanding and hospital-based IRFs (80 FR 47049 through 47068). In FY 2020, we finalized a rebased and revised IRF market basket to reflect a 2016 base year. The FY 2020 IRF PPS final rule (84 FR 39071 through 39086) contains a complete discussion of the development of the 2016-based IRF market basket. Beginning with FY 2024, we proposed to rebase and revise the IRF market basket to reflect a 2021 base year. In the following discussion, we provide an overview of the market basket and describe the methodologies used to determine the operating and capital portions of the 2021-based IRF market basket.

B. Overview of the 2021-Based IRF Market Basket

The 2021-based IRF market basket is a fixed-weight, Laspeyres-type price index. A Laspeyres price index measures the change in price, over time, of the same mix of goods and services purchased in the base period. Any changes in the quantity or mix of goods and services (that is, intensity) purchased over time relative to the base period are not measured.

The index itself is constructed in three steps. First, a base period is selected (for the proposed IRF market basket in the proposed rule, we proposed to use 2021 as the base period) and total base period costs are estimated for a set of mutually exclusive and exhaustive cost categories. Each category is calculated as a proportion of total costs. These proportions are called cost weights. Second, each cost category is matched to an appropriate price or wage variable, referred to as a price proxy. In almost every instance, these price proxies are derived from publicly available statistical series that are published on a consistent schedule (preferably at least on a quarterly basis). Finally, the cost weight for each cost category is multiplied by the level of its respective price proxy. The sum of these products (that is, the cost weights multiplied by their price index levels) for all cost categories yields the composite index level of the market basket in a given time period. Repeating this step for other periods produces a series of market basket levels over time. Dividing an index level for a given period by an index level for an earlier period produces a rate of growth in the input price index over that timeframe.

As noted, the market basket is described as a fixed-weight index because it represents the change in price over time of a constant mix (quantity and intensity) of goods and services needed to provide IRF services. The effects on total costs resulting from changes in the mix of goods and services purchased subsequent to the base period are not measured. For example, an IRF hiring more nurses after the base period to accommodate the needs of patients would increase the volume of goods and services purchased by the IRF but would not be factored into the price change measured by a fixed-weight IRF market basket. Only when the index is rebased would changes in the quantity and intensity be captured, with those changes being reflected in the cost weights. Therefore, we rebase the market basket periodically so that the cost weights reflect recent changes in the mix of goods and services that IRFs purchase to furnish inpatient care between base periods.

C. Rebasing and Revising of the IRF PPS Market Basket

As discussed in the FY 2020 IRF PPS final rule (84 FR 39071 through 39086), the 2016-based IRF market basket cost weights reflect the 2016 Medicare cost report data submitted by both freestanding and hospital-based facilities.

Beginning with FY 2024, we proposed to rebase and revise the 2016-based IRF market basket cost weights to a 2021 base year reflecting the 2021 Medicare cost report data submitted by both freestanding and hospital-based IRFs. Below we provide a detailed description of our methodology used to develop the 2021-based IRF market basket. This proposed methodology is generally similar to the methodology used to develop the 2016-based IRF market basket.

We invited public comment on our proposed methodology for developing the 2021-based IRF market basket.

Comment: Many commenters supported the rebasing and revising of the IRF market basket from a 2016 base year to a 2021 base year as proposed. Some of these commenters encouraged CMS to focus greater attention on the costs and data needed to support payment changes in the future.

Several commenters, while supporting moving forward with a 2021 base year, requested that CMS consider rebasing the IRF market basket to a later base year, such as 2022 or 2023, when the data become available, to more fully incorporate changes to IRF cost structures. One commenter stated that inflationary pressures and cost increases seem to have moderated somewhat during FY 2023 and therefore, using FY 2023 in future rulemaking would better align permanent changes that have occurred in more recent years. One commenter stated that they believe that using FY 2023 data, when available, may more accurately capture costs being incurred by IRFs and they requested that CMS update the IRF market basket cost weights with the most recently available data in the final rule.

Response: We appreciate the commenters' support to rebase and revise the IRF market basket. As discussed in section VI.A of this final rule, the market basket used to update IRF PPS payments has been periodically rebased and revised over the history of the IRF PPS to reflect more recent data on IRF cost structures. For the FY 2024 IRF PPS proposed rule, we proposed to rebase and revise the IRF market basket using 2021 Medicare cost reports, the most recent year of complete data available at the time of rulemaking, which showed an increase in the Compensation cost weight from 2016 to 2021. Data for 2022 and 2023 are incomplete at this time. Because complete 2022 IRF cost report data are

currently unavailable, we believe it is more appropriate to update the base year cost weights to 2021 to reflect changes over this period rather than to delay the rebasing. It has been our longstanding practice to rebase the market basket on a regular basis to ensure it reflects the input cost structure of IRFs. As stated in the FY 2024 IRF PPS proposed rule (88 FR 20960), given the potential impact of the PHE on the Medicare cost report data, we will continue to monitor the Medicare cost report data as they become available and, if appropriate, propose any changes to the IRF market basket in future rulemaking.

We provide a summary of the more detailed public comments received on our proposed methodology for developing the 2021-based IRF market basket and our responses in the following sections.

1. Development of Cost Categories and Weights for the 2021-Based IRF Market Basket

a. Use of Medicare Cost Report Data

We proposed a 2021-based IRF market basket that consists of seven major cost categories and a residual derived from the 2021 Medicare cost reports (CMS Form 2552–10, OMB No. 0938–0050) for freestanding and hospital-based IRFs. The seven major cost categories are Wages and Salaries, Employee Benefits, Contract Labor, Pharmaceuticals, Professional Liability Insurance (PLI), Home Office/Related Organization Contract Labor, and Capital. The residual category reflects all remaining costs not captured in the seven cost categories. The 2021 cost reports include providers whose cost reporting period began on or after October 1, 2020, and before October 1, 2021. As noted previously, the current IRF market basket is based on 2016 Medicare cost reports and, therefore, reflects the 2016 cost structure for IRFs. As described in the FY 2023 IRF PPS final rule (87 FR 47049 through 47050), we received comments on the FY 2023 IRF PPS proposed rule where interested parties expressed concern that the proposed market basket update was inadequate relative to input price inflation experienced by IRFs, particularly as a result of the COVID–19 PHE. These commenters stated that the PHE, along with inflation, has significantly driven up operating costs. Specifically, some commenters noted changes to the labor markets that led to the use of more contract labor, a trend that we verified in analyzing the Medicare cost reports through 2021. Therefore, we believe it is appropriate to incorporate more recent data to reflect updated cost structures for IRFs, and so we proposed to use 2021 as the base year because we believe that the Medicare cost reports for this year represent the most recent, complete set of Medicare cost report data available for developing the proposed IRF market basket at the time of this rulemaking. Given the potential impact of the PHE on the Medicare cost report data, we will continue to monitor these data going forward and any changes to the IRF market basket will be proposed in future rulemaking.

Since our goal is to establish cost weights that are reflective of case mix and practice patterns associated with the services IRFs provide to Medicare beneficiaries, as we did for the 2016-based IRF market basket, we proposed to limit the cost reports used to establish the 2021-based IRF market basket to those from facilities that had a Medicare ALOS that was relatively similar to their facility ALOS. We believe that this requirement eliminates statistical outliers and ensures a more accurate market basket that reflects the costs generally incurred during a Medicare-covered stay. The Medicare ALOS for freestanding IRFs is calculated from data reported on line 14 of Worksheet S–3, part I. The Medicare ALOS for hospital-based IRFs is calculated from data reported on line 17 of Worksheet S–3, part I. We proposed to include the cost report data from IRFs with a Medicare ALOS within 15 percent (that is, 15 percent higher or lower) of the facility ALOS to establish the sample of providers used to estimate the 2021-based IRF market basket cost weights. We proposed to apply this ALOS edit to the data for IRFs to exclude providers that serve a population whose ALOS would indicate that the patients served are not consistent with an ALOS of a typical Medicare patient. We note that this is the same ALOS edit that we applied to develop the 2016-based IRF market basket. This process resulted in the exclusion of about nine percent of the freestanding and hospital-based IRF Medicare cost reports. Of those excluded, about 15 percent were freestanding IRFs and 85 percent were hospital-based IRFs. This ratio is relatively consistent with the universe of freestanding and hospital-based IRF cost reports where freestanding IRFs represent about 30 percent of the total.

We then proposed to use the cost reports for IRFs that met this ALOS edit requirement to calculate the costs for the seven major cost categories (Wages and Salaries, Employee Benefits, Contract Labor, Professional Liability Insurance, Pharmaceuticals, Home Office/Related Organization Contract Labor, and Capital) for the market basket. These are the same categories used for the 2016-based IRF market basket. Also, as described in section V.C.1.d. of the proposed rule, and as done for the 2016-based IRF market basket, we also proposed to use the Medicare cost report data to calculate the detailed capital cost weights for the Depreciation, Interest, Lease, and Other Capital-Related cost categories. We note that we proposed to rename the Home Office Contract Labor cost category to the Home Office/Related Organization Contract Labor cost category to be more consistent with the Medicare cost report instructions.

Similar to the 2016-based IRF market basket major cost weights, for the majority of the 2021-based IRF market basket cost weights, we proposed to divide the 2021 costs for each cost category by the 2021 total Medicare allowable costs (routine, ancillary and capital) that are eligible for reimbursement through the IRF PPS (we note that we use total facility medical care costs as the denominator to derive both the PLI and Home Office/Related Organization Contract Labor cost weights). We next describe our proposed methodology for deriving the cost levels used to derive the 2021-based IRF market basket.

(1) Total Medicare Allowable Costs

For freestanding IRFs, we proposed that total Medicare allowable costs would be equal to the sum of total costs for the Medicare allowable cost centers as reported on Worksheet B, part I, column 26, lines 30 through 35, 50 through 76 (excluding 52 and 75), 90 through 91, and 93.

For hospital-based IRFs, we proposed that total Medicare allowable costs would be equal to the total costs for the IRF inpatient unit after the allocation of overhead costs (Worksheet B, part I, column 26, line 41) and a proportion of total ancillary costs reported on Worksheet B, part I, column 26, lines 50 through 76 (excluding 52 and 75), 90 through 91, and 93.

We proposed to calculate total ancillary costs attributable to the hospital-based IRF by first deriving an ''IRF ancillary ratio'' for each ancillary cost center. The IRF ancillary ratio is defined as the ratio of IRF Medicare ancillary costs for the cost center (as reported on Worksheet D–3, column 3 for hospital-based IRFs) to total Medicare ancillary costs for the cost center (equal to the sum of Worksheet D–3, column 3 for all relevant prospective payment systems (PPS) [that is, inpatient prospective payment

system (IPPS), IRF PPS, inpatient psychiatric facilities (IPF) PPS and skilled nursing facility (SNF) PPS]). For example, if hospital-based IRF Medicare physical therapy costs represent about 30 percent of the total Medicare physical therapy costs for the entire facility, then the IRF ancillary ratio for physical therapy costs would be 30 percent. We believe it is appropriate to use only a portion of the ancillary costs in the market basket cost weight calculations since the hospital-based IRF only utilizes a portion of the facility's ancillary services. We believe the ratio of reported IRF Medicare costs to reported total Medicare costs provides a reasonable estimate of the ancillary services utilized, and costs incurred, by the hospital-based IRF. We proposed that this IRF ancillary ratio for each cost center also be used to calculate Wages and Salaries and Capital costs, as described in section VI.C.1.a.(2) of this final rule.

Then for each ancillary cost center, we proposed to multiply the IRF ancillary ratio for the given cost center by the total facility ancillary costs for that specific cost center (as reported on Worksheet B, part I, column 26) to derive IRF ancillary costs. For example, the 30 percent IRF ancillary ratio for physical therapy cost center would be multiplied by the total ancillary costs for physical therapy (Worksheet B, part I, column 26, line 66). The IRF ancillary costs for each cost center are then added to total costs for the IRF inpatient unit after the allocation of overhead costs (Worksheet B, part I, column 26, line 41) to derive total Medicare allowable costs.

We proposed to use these methods to derive levels of total Medicare allowable costs for IRF providers. This is the same methodology used for the 2016-based IRF market basket. We proposed that these total Medicare allowable costs for the IRF will be the denominator for the cost weight calculations for the Wages and Salaries, Employee Benefits, Contract Labor, Pharmaceuticals, and Capital cost weights. With this work complete, we then set about deriving cost levels for the seven major cost categories and then derive a residual cost weight reflecting all other costs not classified.

(2) Wages and Salaries Costs

For freestanding IRFs, we proposed to derive Wages and Salaries costs as the sum of routine inpatient salaries (Worksheet A, column 1, lines 30 through 35), ancillary salaries (Worksheet A, column 1, lines 50 through 76 (excluding 52 and 75), 90 through 91, and 93), and a proportion of overhead (or general service cost centers in the Medicare cost reports) salaries. Since overhead salary costs are attributable to the entire IRF, we only include the proportion attributable to the Medicare allowable cost centers. We proposed to estimate the proportion of overhead salaries that are attributed to Medicare allowable costs centers by multiplying the ratio of Medicare allowable area salaries (Worksheet A, column 1, lines 30 through 35, 50 through 76 (excluding 52 and 75), 90 through 91, and 93) to total non-overhead salaries (Worksheet A, column 1, line 200 less Worksheet A, column 1, lines 4 through 18) times total overhead salaries (Worksheet A, column 1, lines 4 through 18). This is a similar methodology as used in the 2016-based IRF market basket.

For hospital-based IRFs, we proposed to derive Wages and Salaries costs as the sum of the following salaries attributable to the hospital-based IRF: inpatient routine salary costs (Worksheet A, column 1, line 41); overhead salary costs; ancillary salary costs; and a portion of overhead salary costs attributable to the ancillary departments.

(a) Overhead Salary Costs

We proposed to calculate the portion of overhead salary costs attributable to hospital-based IRFs by first calculating an IRF overhead salary ratio, which is equal to the ratio of total facility overhead salaries (as reported on Worksheet A, column 1, lines 4–18) to total facility noncapital overhead costs (as reported on Worksheet A, column 1 and 2, lines 4–18). We then proposed to multiply this IRF overhead salary ratio by total noncapital overhead costs (sum of Worksheet B, part I, columns 4 through 18, line 41, less Worksheet B, part II, columns 4 through 18, line 41). This methodology assumes the proportion of total costs related to salaries for the overhead cost center is similar for all inpatient units (that is, acute inpatient or inpatient rehabilitation).

(b) Ancillary Salary Costs

We proposed to calculate hospital-based IRF ancillary salary costs for a specific cost center (Worksheet A, column 1, lines 50 through 76 (excluding 52 and 75), 90 through 91, and 93) as salary costs from Worksheet A, column 1, multiplied by the IRF ancillary ratio for each cost center as described in section V.C.1.a.(1) of the proposed rule. The sum of these costs represents hospital-based IRF ancillary salary costs.

(c) Overhead Salary Costs for Ancillary Cost Centers

We proposed to calculate the portion of overhead salaries attributable to each ancillary department (lines 50 through 76 (excluding 52 and 75), 90 through 91, and 93) by first calculating total noncapital overhead costs attributable to each specific ancillary department (sum of Worksheet B, part I, columns 4–18 less, Worksheet B, part II, column 26). We then identify the portion of these total noncapital overhead costs for each ancillary department that is attributable to the hospital-based IRF by multiplying these costs by the IRF ancillary ratio as described in section V.C.1.a.(1) of the proposed rule. We then sum these estimated IRF Medicare allowable noncapital overhead costs for all ancillary departments (cost centers 50 through 76, 90 through 91, and 93). Finally, we then identify the portion of these IRF Medicare allowable noncapital overhead costs that are attributable to Wages and Salaries by multiplying these costs by the IRF overhead salary ratio as described in section V.C.1.a.(2)(a) of the proposed rule. This is the same methodology used to derive the 2016-based IRF market basket.

(3) Employee Benefits Costs

Effective with the implementation of CMS Form 2552–10, we began collecting Employee Benefits and Contract Labor data on Worksheet S–3, part V.

For the 2021 Medicare cost report data, 54 percent of providers reported Employee Benefits data on Worksheet S–3, part V; particularly, approximately 57 percent of freestanding IRFs and 53 percent of hospital-based IRFs reported Employee Benefits data on Worksheet S–3, part V. For comparison, for 2016, about 45 percent of providers reported Employee Benefits data on Worksheet S–3, part V. Again, we continue to encourage all providers to report these data on the Medicare cost report.

For freestanding IRFs, we proposed Employee Benefits costs would be equal to the data reported on Worksheet S–3, part V, column 2, line 2. We note that while not required to do so, freestanding IRFs also may report Employee Benefits data on Worksheet S–3, part II, which is applicable to only IPPS providers. Similar to the method for the 2016-based IRF market basket, for those freestanding IRFs that report Worksheet S–3, part II, data, but not Worksheet S–3, part V, we proposed to use the sum of Worksheet S–3, part II, lines 17, 18, 20, and 22, to derive Employee Benefits costs.

For hospital-based IRFs, we proposed to calculate total benefit costs as the sum of inpatient unit benefit costs, a portion of ancillary departments benefit costs, and a portion of overhead benefits attributable to both the routine inpatient unit and the ancillary departments. For those hospital-based IRFs that report Worksheet S–3, part V data, we proposed inpatient unit benefit costs be equal to Worksheet S–3, part V, column 2, line 4. Given the limited reporting on Worksheet S–3, part V, we proposed that for those hospital-based IRFs that do not report these data, we calculate inpatient unit benefits costs using a portion of benefits costs reported for Excluded areas on Worksheet S–3, part II. We proposed to calculate the ratio of inpatient unit salaries (Worksheet A, column 1, line 41) to total excluded area salaries (sum of Worksheet A, column 1, lines 20, 23, 40 through 42, 44, 45, 46, 94, 95, 98 through 101, 105 through 112, 114, 115 through 117, 190 through 194). We then proposed to apply this ratio to Excluded area benefits (Worksheet S–3, part II, column 4, line 19) to derive inpatient unit benefits costs for those providers that do not report benefit costs on Worksheet S–3, part V.

We proposed the ancillary departments benefits and overhead benefits (attributable to both the inpatient unit and ancillary departments) costs are derived by first calculating the sum of hospital-based IRF overhead salaries as described in section V.C.1.a.(2)(a) of the proposed rule, hospital-based IRF ancillary salaries as described in section V.C.1.a.(2)(b) of the proposed rule and hospital-based IRF overhead salaries for ancillary cost centers as described in section V.C.1.a.(2)(c) of the proposed rule. This sum is then multiplied by the ratio of total facility benefits to total facility salaries, where total facility benefits is equal to the sum of Worksheet S–3, part II, column 4, lines 17–25, and total facility salaries is equal to Worksheet S–3, part II, column 4, line 1.

(4) Contract Labor Costs

Contract Labor costs are primarily associated with direct patient care services. Contract labor costs for other services such as accounting, billing, and legal are calculated separately using other government data sources as described in section V.C.1.c. of the proposed rule. To derive contract labor costs using Worksheet S–3, part V, data, for freestanding IRFs, we proposed Contract Labor costs be equal to Worksheet S–3, part V, column 1, line 2. As we noted for Employee Benefits, freestanding IRFs also may report Contract Labor data on Worksheet S–3, part II, which is applicable to only IPPS providers. For those freestanding IRFs that report Worksheet S–3, part II data, but not Worksheet S–3, part V, we proposed to use the sum of Worksheet S–3, part II, column 4, lines 11 and 13, to derive Contract Labor costs.

For hospital-based IRFs, we proposed that Contract Labor costs would be equal to Worksheet S–3, part V, column 1, line 4. For 2021 Medicare cost report data, 30 percent of providers reported Contract Labor data on Worksheet S–3, part V; particularly, approximately 56 percent of freestanding IRFs and 18 percent of hospital-based IRFs reported data on Worksheet S–3, part V. For comparison, for the 2016-based IRF market basket, about 26 percent of providers reported Contract Labor data on Worksheet S–3, part V. We continue to encourage all providers to report these data on the Medicare cost report.

Given the limited reporting on Worksheet S–3, part V, we proposed that for those hospital-based IRFs that do not report these data, we calculate Contract Labor costs using a portion of contract labor costs reported on Worksheet S–3, part II. We proposed to calculate the ratio of contract labor costs (Worksheet S–3, part II, column 4, lines 11 and 13) to PPS salaries (Worksheet S–3, part II, column 4, line 1 less the sum of Worksheet S–3, part II, column 4, lines 3, 401, 5, 6, 7, 701, 8, 9, 10 less Worksheet A, column 1, line 20 and 23). We then proposed to apply this ratio to total inpatient routine salary costs (Worksheet A, column 1, line 41) to derive contract labor costs for those providers that do not report contract labor costs on Worksheet S–3, part V.

(5) Pharmaceuticals Costs

For freestanding IRFs, we proposed to calculate pharmaceuticals costs using non-salary costs reported on Worksheet A, column 7, less Worksheet A, column 1, for the pharmacy cost center (line 15) and drugs charged to patients cost center (line 73).

For hospital-based IRFs, we proposed to calculate pharmaceuticals costs as the sum of a portion of the non-salary pharmacy costs and a portion of the non-salary drugs charged to patient costs reported for the total facility. We proposed that non-salary pharmacy costs attributable to the hospital-based IRF would be calculated by multiplying total pharmacy costs attributable to the hospital-based IRF (as reported on Worksheet B, part I, column 15, line 41) by the ratio of total non-salary pharmacy costs (Worksheet A, column 2, line 15) to total pharmacy costs (sum of Worksheet A, columns 1 and 2 for line 15) for the total facility. We proposed that non-salary drugs charged to patient costs attributable to the hospital-based IRF would be calculated by multiplying total non-salary drugs charged to patient costs (Worksheet B, part I, column 0, line 73 plus Worksheet B, part I, column 15, line 73 less Worksheet A, column 1, line 73) for the total facility by the ratio of Medicare drugs charged to patient ancillary costs for the IRF unit (as reported on Worksheet D–3 for hospital-based IRFs, column 3, line 73) to total Medicare drugs charged to patient ancillary costs for the total facility (equal to the sum of Worksheet D–3, column 3, line 73 for all relevant PPS (that is, IPPS, IRF, IPF and SNF).

(6) Professional Liability Insurance Costs

For freestanding and hospital-based IRFs, we proposed that Professional Liability Insurance (PLI) costs (often referred to as malpractice costs) would be equal to premiums, paid losses and self-insurance costs reported on Worksheet S–2, columns 1 through 3, line 118—the same data used for the 2016-based IRF market basket. For hospital-based IRFs, we proposed to assume that the PLI weight for the total facility is similar to the hospital-based IRF unit since the only data reported on this worksheet is for the entire facility, as we currently have no means to identify the proportion of total PLI costs that are only attributable to the hospital-based IRF. However, when we derive the cost weight for PLI for both hospital-based and freestanding IRFs, we use the total facility medical care costs as the denominator as opposed to total Medicare allowable costs. For freestanding IRFs and hospital-based IRFs, we proposed to derive total facility medical care costs as the sum of total costs (Worksheet B, part I, column 26, line 202) less non-reimbursable costs (Worksheet B, part I, column 26, lines 190 through 201).

(7) Home Office/Related Organization Contract Labor Costs

For freestanding and hospital-based IRFs, we proposed to calculate the home office/related organization contract labor costs using data reported on Worksheet S–3, part II, column 4, lines 1401, 1402, 2550, and 2551. Similar to the PLI costs, these costs are for the entire facility. Therefore, when we derive the cost weight for Home Office/Related Organization Contract Labor costs, we use the total facility medical care costs as the denominator (reflecting the total facility costs less the non-reimbursable costs reported on lines 190 through 201). Our assumption is that the

same proportion of expenses are used among each unit of the hospital.

(8) Capital Costs

For freestanding IRFs, we proposed that capital costs would be equal to Medicare allowable capital costs as reported on Worksheet B, part II, column 26, lines 30 through 35, 50 through 76 (excluding 52 and 75), 90 through 91, and 93.

For hospital-based IRFs, we proposed that capital costs would be equal to IRF inpatient capital costs (as reported on Worksheet B, part II, column 26, line 41) and a portion of IRF ancillary capital costs. We calculate the portion of ancillary capital costs attributable to the hospital-based IRF for a given cost center by multiplying total facility ancillary capital costs for the specific ancillary cost center (as reported on Worksheet B, part II, column 26) by the IRF ancillary ratio as described in section V.C.1.a.(1) of the proposed rule. For example, if hospital-based IRF Medicare physical therapy costs represent 30 percent of the total Medicare physical therapy costs for the entire facility, then 30 percent of total facility physical therapy capital costs (as reported in Worksheet B, part II, column 26, line 66) would be attributable to the hospital-based IRF.

b. Final Major Cost Category Computation

After we derive costs for each of the major cost categories and total Medicare allowable costs for each provider using the Medicare cost report data as previously described, we proposed to address data outliers using the following steps. First, for the Wages and Salaries, Employee Benefits, Contract Labor, Pharmaceuticals, and Capital cost weights, we first divide the costs for each of these five categories by total Medicare allowable costs calculated for the provider to obtain cost weights for the universe of IRF providers. We then proposed to trim the data to remove outliers (a standard statistical process) by: (1) requiring that major expenses (such as Wages and Salaries costs) and total Medicare allowable operating costs be greater than zero; and (2) excluding the top and bottom 5 percent of the major cost weight (for example, Wages and Salaries costs as a percent of total Medicare allowable operating costs). We note that missing values are assumed to be zero consistent with the methodology for how missing values were treated in the 2016-based IRF market basket. After these outliers have been excluded, we sum the costs for each category across all remaining providers. We then divide this by the sum of total Medicare allowable costs across all remaining providers to obtain a cost weight for the 2021-based IRF market basket for the given category.

The proposed trimming methodology for the Home Office/Related Organization Contract Labor and PLI cost weights is slightly different than the proposed trimming methodology for the other five cost categories as described previously in this final rule. For these cost weights, since we are using total facility medical care costs rather than Medicare allowable costs associated with IRF services, we proposed to trim the freestanding and hospital-based IRF cost weights separately.

For the PLI cost weight, for each of the providers, we first divide the PLI costs by total facility medical care costs to obtain a PLI cost weight for the universe of IRF providers. We then proposed to trim the data to remove outliers by: (1) requiring that PLI costs are greater than zero and are less than total facility medical care costs; and (2) excluding the top and bottom 5 percent of the major cost weight trimming freestanding and hospital-based providers separately. After removing these outliers, we are left with a trimmed data set for both freestanding and hospital-based providers. We then proposed to separately sum the costs for each category (freestanding and hospital-based) across all remaining providers. We next divide this by the sum of total facility medical care costs across all remaining providers to obtain both a freestanding cost weight and hospital-based cost weight. Lastly, we proposed to weight these two cost weights together using the Medicare allowable costs from the sample of freestanding and hospital-based IRFs that passed the PLI trim (59 percent for hospital-based and 41 percent for freestanding IRFs) to derive a PLI cost weight for the 2021-based IRF market basket.

For the Home Office/Related Organization Contract Labor cost weight, for each of the providers, we first divide the home office/related organization contract labor costs by total facility medical care costs to obtain a Home Office/Related Organization Contract Labor cost weight for the universe of IRF providers. We then proposed to trim only the top 1 percent of providers to exclude outliers while also allowing providers who have reported zero home office costs to remain in the Home Office/Related Organization Contract Labor cost weight calculations as not all providers will incur home office/relation organization contract labor costs. After removing these outliers, we are left with a trimmed data set for both freestanding and hospital-based providers. We then proposed to separately sum the costs for each category (freestanding and hospital-based) across all remaining providers. We next divide this by the sum of total facility medical care costs across all remaining providers to obtain a freestanding cost weight and hospital-based cost weight. Lastly, we proposed to weight these two cost weights together using the Medicare allowable costs from the sample of freestanding and hospital-based IRFs that passed the Home Office/Related Organization Contract Labor cost weight trim (68 percent for hospital-based and 32 percent for freestanding IRFs) to derive a Home Office/Related Organization Contract Labor cost weight for the 2021-based IRF market basket.

Finally, we proposed to calculate the residual ''All Other'' cost weight that reflects all remaining costs that are not captured in the seven cost categories listed. See Table 4 for the resulting cost weights for these major cost categories that we obtain from the Medicare cost reports.

TABLE 4: Major Cost Categories as Derived from Medicare Cost Reports

Major Cost Categories	2021-Based IRF Market Basket (Percent)	2016-Based IRF Market Basket (Percent)
Wages and Salaries	46.6	47.1
Employee Benefits	11.6	11.3
Contract Labor	2.0	1.0
Professional Liability Insurance (Malpractice)	0.8	0.7
Pharmaceuticals	4.7	5.1
Home Office/Related Organization Contract Labor	5.4	3.7
Capital	8.6	9.0
All Other	20.4	22.2

*Total may not sum to 100 due to rounding.

As we did for the 2016-based IRF market basket, we proposed to allocate the Contract Labor cost weight to the Wages and Salaries and Employee Benefits cost weights based on their relative proportions under the assumption that contract labor costs are comprised of both wages and salaries and employee benefits. The Contract Labor allocation proportion for Wages and Salaries is equal to the Wages and Salaries cost weight as a percent of the sum of the Wages and Salaries cost weight and the Employee Benefits cost weight. For the proposed rule, the rounded percentage is 80 percent; therefore, we proposed to allocate 80 percent of the Contract Labor cost weight to the Wages and Salaries cost weight and 20 percent to the Employee Benefits cost weight. This allocation was 81/19 in the 2016-based IRF market basket (84 FR 39076). Table 5 shows the Wages and Salaries and Employee Benefit cost weights after Contract Labor cost weight allocation for both the 2021-based IRF market basket and 2016-based IRF market basket.

TABLE 5: Wages and Salaries and Employee Benefits Cost Weights After Contract Labor Allocation

Major Cost Categories	2021-Based IRF Market Basket	2016-Based IRF Market Basket
Wages and Salaries	48.2	47.9
Employee Benefits	11.9	11.4

The following is a summary of the public comments received on our proposed methodology for developing the major cost weights of the 2021-based IRF market basket and our responses.

Comment: A few commenters noted that their review of the market basket cost categories shows only modest increases, including with respect to labor and capital-related costs, despite their members experiencing much more significant actual increases in expenditures compared to 2016. One commenter requested that CMS consider increases in wages, salaries, benefits, and contract labor, among other categories, in its methodology.

One commenter supported the increase in proposed weights given the sustained labor increases and market challenges. However, the commenter stated that labor and supplies are significant stressors and requested CMS review pharmaceuticals and capital-related costs more closely before the final rule. The commenter stated that while they recognize that not all categories can increase, these components have all contributed to financial strain on the industry and stated that a decrease in their cost weights in the market basket does not reflect their current contribution to overall costs.

Response: As discussed previously, the major cost weights calculated from the Medicare cost reports for the 2021-based IRF market basket represent each cost category's share of total costs. Therefore, any changes in the cost weight from a prior base period will reflect the growth in the costs for that specific category relative to the growth in the costs for other categories. As a result, while costs for a particular category may have increased from 2016 to 2021 (such as capital-related costs as stated by the commenters), the Capital-Related cost weight would only increase if capital-related costs increased faster than the increase in total costs from 2016 to 2021. In response to the commenters' request that CMS consider increases in wages, salaries, benefits, and contract labor, among other categories, in its methodology, we believe that the proposed methodology to derive the major cost categories is detailed and robust. To allow for interested parties to evaluate this methodology, we have provided all of the detailed calculations and Medicare cost report fields so that commenters are able to replicate the methodology and provide specific comments on the derivation of these cost weights. We will continue to monitor the Medicare cost reports as new data becomes available for all of the major cost weights, including the categories mentioned by the commenter, and any changes to the IRF market basket will be proposed in future rulemaking.

We appreciate the commenter's request to review the pharmaceuticals and capital-related costs used in the proposed 2021-based IRF market basket more closely. We note that each of the cost weights in the market basket reflect a distribution and will change over time only when costs grow differently (either

higher or lower) than other costs. The Pharmaceuticals cost weight in the 2021-based IRF market basket is 4.7 percent compared to the 2016-based IRF market basket with 5.1 percent. We examined the Medicare cost report data in more detail and found that the Pharmaceuticals cost weight decreased, in aggregate, for both urban and rural IRFs, government and for-profit IRFs, and for freestanding and hospital-based IRFs. The median Pharmaceuticals cost weight also decreased from 5.0 percent to 4.4 percent. Therefore, we believe that the proposed Pharmaceuticals cost weight is appropriate and reflects its share of overall costs.

The Capital-Related cost weight in the 2021-based IRF market basket is 8.6 percent compared to the 2016-based IRF market basket with 9.0 percent. We examined the Medicare cost report data in more detail and found that the Capital-Related cost weight decreased, in aggregate, for both urban and rural IRFs and for all ownership-types. The median Capital-Related cost weight also decreased from 8.8 percent to 8.1 percent. We note that both pharmaceuticals and capital-related costs per day increased from 2016 to 2021; however, they increased at a slower rate than total Medicare allowable costs per day (which is the denominator in the cost weight calculation) resulting in slightly lower cost weights in 2021 compared to 2016. Therefore, we believe that the proposed Capital-Related cost weight is appropriate and reflects its share of overall costs.

Comment: A few commenters requested that CMS educate interested parties on the importance of reporting accurate and robust data on the Medicare cost reports. One commenter recognized that CMS is relying on the Medicare cost report data for the market basket cost weights, but noted that such data may not always be adequately recorded or prioritized for input. One commenter specifically noted that not all IRFs are properly reporting data for Employee Benefits and Contract Labor on the Medicare cost reports. The commenter stated that while all of their hospitals have reported these cost report line items, they urged CMS to emphasize their importance to ensure that the IRF sector understands the importance of accurately and fully reporting these line items to reduce data gaps for future updates.

Response: We recognize the commenters' concerns and reiterate that accurate and complete reporting of all data on the Medicare cost reports by IRFs help to ensure that the cost weights for the IRF market basket are reflective of the cost structure of IRFs. We also note that we analyze the Medicare cost report data to evaluate their representativeness; for example, we reweight the data reported by ownership type and urban/rural so that it reflects the universe of providers and compare it to the proposed cost weights that are based on reported data. Our analysis shows the proposed cost weights are representative across these dimensions. In addition, we also trim the data to eliminate outliers as described in section VI.C.1.b. of this final rule. As stated in the FY 2024 IRF PPS proposed rule (88 FR 20961) and previous IRF PPS rules, we continue to encourage all providers to report the Employee Benefits and Contract Labor data on the Medicare cost report. Going forward, we will continue to work with interested parties to communicate the importance of all providers filling out the Medicare cost report with accurate and complete data.

After consideration of the public comments, we are finalizing our methodology for developing the major cost weights and therefore, we are finalizing these major cost weights as proposed.

c. Derivation of the Detailed Operating Cost Weights

To further divide the ''All Other'' residual cost weight estimated from the 2021 Medicare cost report data into more detailed cost categories, we proposed to use the 2012 Benchmark Input-Output (I–O) ''Use Tables/Before Redefinitions/Purchaser Value'' for North American Industry Classification System (NAICS) 622000, Hospitals, published by the Bureau of Economic Analysis (BEA). This data is publicly available at *http://www.bea.gov/industry/io_annual.htm.* For the 2016-based IRF market basket, we also used the 2012 Benchmark I–O data, the most recent data available at the time (84 FR 39076).

The BEA Benchmark I–O data are scheduled for publication every 5 years with the most recent data available for 2012. The 2012 Benchmark I–O data are derived from the 2012 Economic Census and are the building blocks for BEA's economic accounts. Thus, they represent the most comprehensive and complete set of data on the economic processes or mechanisms by which output is produced and distributed.[16] BEA also produces Annual I–O estimates; however, while based on a similar methodology, these estimates reflect less comprehensive and less detailed data sources and are subject to revision when benchmark data becomes available. Instead of using the less detailed Annual I–O data, we proposed to inflate the 2012 Benchmark I–O data forward to 2021 by applying the annual price changes from the respective price proxies to the appropriate market basket cost categories that are obtained from the 2012 Benchmark I–O data. We repeat this practice for each year. We then proposed to calculate the cost shares that each cost category represents of the inflated 2012 data. These resulting 2021 cost shares are applied to the All Other residual cost weight to obtain the detailed cost weights for the 2021-based IRF market basket. For example, the cost for Food: Direct Purchases represents 5.0 percent of the sum of the ''All Other'' 2012 Benchmark I–O Hospital Expenditures inflated to 2021; therefore, the Food: Direct Purchases cost weight represents 5.0 percent of the 2021-based IRF market basket's ''All Other'' cost category (20.4 percent), yielding a ''final'' Food: Direct Purchases cost weight of 1.0 percent in the 2021-based IRF market basket (0.05 * 20.4 percent = 1.0 percent).

Using this methodology, we proposed to derive seventeen detailed IRF market basket cost category weights from the 2021-based IRF market basket residual cost weight (20.4 percent). These categories are: (1) Electricity and Other Non-Fuel Utilities, (2) Fuel: Oil and Gas (3) Food: Direct Purchases, (4) Food: Contract Services, (5) Chemicals, (6) Medical Instruments, (7) Rubber and Plastics, (8) Paper and Printing Products, (9) Miscellaneous Products, (10) Professional Fees: Labor-Related, (11) Administrative and Facilities Support Services, (12) Installation, Maintenance, and Repair Services, (13) All Other Labor-Related Services, (14) Professional Fees: Nonlabor-Related, (15) Financial Services, (16) Telephone Services, and (17) All Other Nonlabor-Related Services.

We did not receive any comments on our methodology to use the BEA I–O data to derive the detailed operating cost weights. We are finalizing this methodology as we proposed. We note that we did receive one comment on the derivation of the Professional Fees: Labor-Related cost weight which we discuss in section VI.E. of this final rule.

d. Derivation of the Detailed Capital Cost Weights

As described in section V.C.1.b. of the proposed rule, we proposed a Capital-Related cost weight of 8.6 percent as obtained from the 2021 Medicare cost reports for freestanding and hospital-based IRF providers. We proposed to

[16] *http://www.bea.gov/papers/pdf/IOmanual_092906.pdf.*

then separate this total Capital-Related cost weight into more detailed cost categories.

Using 2021 Medicare cost reports, we are able to group Capital-Related costs into the following categories: Depreciation, Interest, Lease, and Other Capital-Related costs. For each of these categories, we proposed to determine separately for hospital-based IRFs and freestanding IRFs what proportion of total capital-related costs the category represents.

For freestanding IRFs, using Medicare cost report data on Worksheet A–7 part III, we proposed to derive the proportions for Depreciation (column 9), Interest (column 11), Lease (column 10), and Other Capital-Related costs (column 12 through 14), which is similar to the methodology used for the 2016-based IRF market basket.

For hospital-based IRFs, data for these four categories are not reported separately for the hospital-based IRF; therefore, we proposed to derive these proportions using data reported on Worksheet A–7 for the total facility. We assumed the cost shares for the overall hospital are representative for the hospital-based IRF unit. For example, if depreciation costs make up 60 percent of total capital costs for the entire facility, we believe it is reasonable to assume that the hospital-based IRF would also have a 60 percent proportion because it is a unit contained within the total facility. This is the same methodology used for the 2016-based IRF market basket (84 FR 39077).

To combine each detailed capital cost weight for freestanding and hospital-based IRFs into a single capital cost weight for the 2021-based IRF market basket, we proposed to weight together the shares for each of the categories (Depreciation, Interest, Lease, and Other Capital-Related costs) based on the share of total capital costs each provider type represents of the total capital costs for all IRFs for 2021. Applying this methodology results in proportions of total capital-related costs for Depreciation, Interest, Lease and Other Capital-Related costs that are representative of the universe of IRF providers. This is the same methodology used for the 2016-based IRF market basket (84 FR 39077).

Lease costs are unique in that they are not broken out as a separate cost category in the 2021-based IRF market basket. Rather, we proposed to proportionally distribute these costs among the cost categories of Depreciation, Interest, and Other Capital-Related costs, reflecting the assumption that the underlying cost structure of leases is similar to that of capital-related costs in general. As was done under the 2016-based IRF market basket, we proposed to assume that 10 percent of the lease costs as a proportion of total capital-related costs represents overhead and assign those costs to the Other Capital-Related cost category accordingly. We proposed to distribute the remaining lease costs proportionally across the three cost categories (Depreciation, Interest, and Other Capital-Related) based on the proportion that these categories comprise of the sum of the Depreciation, Interest, and Other Capital-Related cost categories (excluding lease expenses). This would result in three primary capital-related cost categories in the 2021-based IRF market basket: Depreciation, Interest, and Other Capital-Related costs. This is the same methodology used for the 2016-based IRF market basket (84 FR 39077). The allocation of these lease expenses is shown in Table 6.

Finally, we proposed to further divide the Depreciation and Interest cost categories. We proposed to separate Depreciation into the following two categories: (1) Building and Fixed Equipment and (2) Movable Equipment. We proposed to separate Interest into the following two categories: (1) Government/Nonprofit and (2) For-profit.

To disaggregate the Depreciation cost weight, we need to determine the percent of total Depreciation costs for IRFs that is attributable to Building and Fixed Equipment, which we hereafter refer to as the ''fixed percentage.'' For the 2021-based IRF market basket, we proposed to use slightly different methods to obtain the fixed percentages for hospital-based IRFs compared to freestanding IRFs.

For freestanding IRFs, we proposed to use depreciation data from Worksheet A–7 of the 2021 Medicare cost reports. However, for hospital-based IRFs, we determined that the fixed percentage for the entire facility may not be representative of the hospital-based IRF unit due to the entire facility likely employing more sophisticated movable assets that are not utilized by the hospital-based IRF. Therefore, for hospital-based IRFs, we proposed to calculate a fixed percentage using: (1) building and fixture capital costs allocated to the hospital-based IRF unit as reported on Worksheet B, part I, column 1, line 41, and (2) building and fixture capital costs for the top five ancillary cost centers utilized by hospital-based IRFs accounting for 78 percent of hospital-based IRF ancillary total costs: Physical Therapy (Worksheet B, part I, column 1, line 66), Drugs Charged to Patients (Worksheet B, part I, column 1, line 73), Occupational Therapy (Worksheet B, part I, column 1, line 67), Laboratory (Worksheet B, part I, column 1, line 60) and Clinic (Worksheet B, part I, column 1, line 90). We proposed to weight these two fixed percentages (inpatient and ancillary) using the proportion that each capital cost type represents of total capital costs in the 2021-based IRF market basket. We proposed to then weight the fixed percentages for hospital-based and freestanding IRFs together using the proportion of total capital costs each provider type represents. For both freestanding and hospital-based IRFs, this is the same methodology used for the 2016-based IRF market basket (84 FR 39077).

To disaggregate the Interest cost weight, we determined the percent of total interest costs for IRFs that are attributable to government and nonprofit facilities, which is hereafter referred to as the ''nonprofit percentage,'' as price pressures associated with these types of interest costs tend to differ from those for for-profit facilities. For the 2021-based IRF market basket, we proposed to use interest costs data from Worksheet A–7 of the 2021 Medicare cost reports for both freestanding and hospital-based IRFs. We proposed to determine the percent of total interest costs that are attributed to government and nonprofit IRFs separately for hospital-based and freestanding IRFs. We then proposed to weight the nonprofit percentages for hospital-based and freestanding IRFs together using the proportion of total capital costs that each provider type represents.

Table 6 provides the detailed capital cost share composition estimated from the 2021 IRF Medicare cost reports. These detailed capital cost share composition percentages are applied to the total Capital-Related cost weight of 8.6 percent calculated using the methodology described in section V.C.1.a.(8) of the proposed rule.

TABLE 6: Capital Cost Share Composition for the 2021-based IRF Market Basket

	Capital Cost Share Composition before Lease Expense Allocation	Capital Cost Share Composition after Lease Expense Allocation
Depreciation	**48%**	**70%**
Building and Fixed Equipment	30%	44%
Movable Equipment	18%	26%
Interest	**10%**	**14%**
Government/Nonprofit	5%	7%
For Profit	5%	7%
Lease	34%	-
Other Capital-Related Costs	**8%**	**16%**

*Detail may not add to total due to rounding.

We did not receive any comments on our proposed methodology for developing the detailed capital cost weights of the 2021-based IRF market basket. We are finalizing these detailed capital cost weights as proposed.

e. 2021-Based IRF Market Basket Cost Categories and Weights

Table 7 compares the cost categories and weights for the 2021-based IRF market basket compared to the 2016-based IRF market basket.

TABLE 7: 2021-based IRF Market Basket Cost Weights Compared to 2016-based IRF Market Basket Cost Weights

Cost Category	2021-based IRF Market Basket Cost Weight	2016-based IRF Market Basket Cost Weight
Total	**100.0**	**100.0**
Compensation	**60.1**	**59.4**
Wages and Salaries	48.2	47.9
Employee Benefits	11.9	11.4
Utilities	**1.4**	**1.4**
Electricity and Other Non-Fuel Utilities	0.9	1.0
Fuel: Oil and Gas	0.5	0.4
Professional Liability Insurance	**0.8**	**0.7**
All Other Products and Services	**29.1**	**29.5**
All Other Products	**11.4**	**12.5**
Pharmaceuticals	4.7	5.1
Food: Direct Purchases	1.0	1.1
Food: Contract Services	1.2	1.2
Chemicals	0.4	0.4
Medical Instruments	2.5	2.9
Rubber and Plastics	0.4	0.4
Paper and Printing Products	0.6	0.6
Miscellaneous Products	0.8	0.8
All Other Services	**17.7**	**17.0**
Labor-Related Services	**9.5**	**9.2**
Professional Fees: Labor-Related	5.6	5.0
Administrative and Facilities Support Services	0.7	0.7
Installation, Maintenance, and Repair Services	1.5	1.6
All Other: Labor-Related Services	1.7	1.8
Nonlabor-Related Services	**8.2**	**7.9**
Professional Fees: Nonlabor-Related	5.9	5.4
Financial Services	0.9	0.9
Telephone Services	0.3	0.3
All Other: Nonlabor-Related Services	1.1	1.3
Capital-Related Costs	**8.6**	**9.0**
Depreciation	**6.0**	**6.5**
Building and Fixed Equipment	3.8	4.1
Movable Equipment	2.3	2.5
Interest Costs	**1.2**	**1.5**
Government/Nonprofit	0.6	0.9
For Profit	0.6	0.6
Other Capital-Related Costs	**1.3**	**1.0**

*Detail may not add to total due to rounding.

2. Selection of Price Proxies

After developing the cost weights for the 2021-based IRF market basket, we proposed to select the most appropriate wage and price proxies currently available to represent the rate of price change for each expenditure category. For the majority of the cost weights, we base the price proxies on U.S. Bureau of Labor Statistics (BLS) data and group them into one of the following BLS categories:

- *Employment Cost Indexes.* Employment Cost Indexes (ECIs) measure the rate of change in employment wage rates and employer costs for employee benefits per hour worked. These indexes are fixed-weight indexes and strictly measure the change in wage rates and employee benefits per hour. ECIs are superior to Average Hourly Earnings (AHE) as price proxies for input price indexes because they are not affected by shifts in occupation or industry mix, and because they measure pure price change and are available by both occupational group and by industry. The industry ECIs are based on the NAICS and the occupational ECIs are based on the Standard Occupational Classification System (SOC).
- *Producer Price Indexes.* Producer Price Indexes (PPIs) measure the average change over time in the selling prices received by domestic producers for their output. The prices included in the PPI are from the first commercial

transaction for many products and some services (*https://www.bls.gov/ppi/*).

• *Consumer Price Indexes.* Consumer Price Indexes (CPIs) measure the average change over time in the prices paid by urban consumers for a market basket of consumer goods and services (*https://www.bls.gov/cpi/*). CPIs are only used when the purchases are similar to those of retail consumers rather than purchases at the producer level, or if no appropriate PPIs are available.

We evaluated the price proxies using the criteria of reliability, timeliness, availability, and relevance:

• *Reliability.* Reliability indicates that the index is based on valid statistical methods and has low sampling variability. Widely accepted statistical methods ensure that the data were collected and aggregated in a way that can be replicated. Low sampling variability is desirable because it indicates that the sample reflects the typical members of the population. (Sampling variability is variation that occurs by chance because only a sample was surveyed rather than the entire population.)

• *Timeliness.* Timeliness implies that the proxy is published regularly, preferably at least once a quarter. The market baskets are updated quarterly, and therefore, it is important for the underlying price proxies to be up-to-date, reflecting the most recent data available. We believe that using proxies that are published regularly (at least quarterly, whenever possible) helps to ensure that we are using the most recent data available to update the market basket. We strive to use publications that are disseminated frequently, because we believe that this is an optimal way to stay abreast of the most current data available.

• *Availability.* Availability means that the proxy is publicly available. We prefer that our proxies are publicly available because this will help ensure that our market basket updates are as transparent to the public as possible. In addition, this enables the public to be able to obtain the price proxy data on a regular basis.

• *Relevance.* Relevance means that the proxy is applicable and representative of the cost category weight to which it is applied. The CPIs, PPIs, and ECIs that we have selected to propose in this regulation meet these criteria. Therefore, we believe that they continue to be the best measure of price changes for the cost categories to which they would be applied.

Below is a detailed explanation of the price proxies we proposed for each cost category weight.

a. Price Proxies for the Operating Portion of the 2021-Based IRF Market Basket

(1) Wages and Salaries

We proposed to continue to use the ECI for Wages and Salaries for All Civilian workers in Hospitals (BLS series code CIU1026220000000I) to measure the wage rate growth of this cost category. This is the same price proxy used in the 2016-based IRF market basket (84 FR 39080).

(2) Benefits

We proposed to continue to use the ECI for Total Benefits for All Civilian workers in Hospitals to measure price growth of this category. This ECI is calculated using the ECI for Total Compensation for All Civilian workers in Hospitals (BLS series code CIU1016220000000I) and the relative importance of wages and salaries within total compensation. This is the same price proxy used in the 2016-based IRF market basket (84 FR 39080).

(3) Electricity and Other Non-Fuel Utilities

We proposed to continue to use the PPI Commodity Index for Commercial Electric Power (BLS series code WPU0542) to measure the price growth of this cost category (which we proposed to rename from Electricity to Electricity and Other Non-Fuel Utilities). This is the same price proxy used in the 2016-based IRF market basket (84 FR 39080).

(4) Fuel: Oil and Gas

Similar to the 2016-based IRF market basket, for the 2021-based IRF market basket, we proposed to use a blend of the PPI for Petroleum Refineries and the PPI Commodity for Natural Gas. Our analysis of the Bureau of Economic Analysis' 2012 Benchmark Input-Output data (use table before redefinitions, purchaser's value for NAICS 622000 [Hospitals]), shows that Petroleum Refineries expenses account for approximately 90 percent and Natural Gas expenses account for approximately 10 percent of Hospitals' (NAICS 622000) total Fuel: Oil and Gas expenses. Therefore, we proposed to use a blend of 90 percent of the PPI for Petroleum Refineries (BLS series code PCU324110324110) and 10 percent of the PPI Commodity Index for Natural Gas (BLS series code WPU0531) as the price proxy for this cost category. This is the same blend that was used for the 2016-based IRF market basket (84 FR 39080).

(5) Professional Liability Insurance

We proposed to continue to use the CMS Hospital Professional Liability Index to measure changes in PLI premiums. To generate this index, we collect commercial insurance premiums for a fixed level of coverage while holding non-price factors constant (such as a change in the level of coverage). This is the same proxy used in the 2016-based IRF market basket (84 FR 39080).

(6) Pharmaceuticals

We proposed to continue to use the PPI for Pharmaceuticals for Human Use, Prescription (BLS series code WPUSI07003) to measure the price growth of this cost category. This is the same proxy used in the 2016-based IRF market basket (84 FR 39080).

(7) Food: Direct Purchases

We proposed to continue to use the PPI for Processed Foods and Feeds (BLS series code WPU02) to measure the price growth of this cost category. This is the same proxy used in the 2016-based IRF market basket (84 FR 39080).

(8) Food: Contract Purchases

We proposed to continue to use the CPI for Food Away From Home (BLS series code CUUR0000SEFV) to measure the price growth of this cost category. This is the same proxy used in the 2016-based IRF market basket (84 FR 39080).

(9) Chemicals

Similar to the 2016-based IRF market basket, we proposed to use a four-part blended PPI as the proxy for the chemical cost category in the 2021-based IRF market basket. The blend is composed of the PPI for Industrial Gas Manufacturing, Primary Products (BLS series code PCU325120325120P), the PPI for Other Basic Inorganic Chemical Manufacturing (BLS series code PCU32518–32518–), the PPI for Other Basic Organic Chemical Manufacturing (BLS series code PCU32519–32519–), and the PPI for Other Miscellaneous Chemical Product Manufacturing (BLS series code PCU325998325998). For the 2021-based IRF market basket, we proposed to derive the weights for the PPIs using the 2012 Benchmark I–O data.

Table 8 shows the weights for each of the four PPIs used to create the blended Chemical proxy for the 2021 IRF market basket. This is the same blend that was used for the 2016-based IRF market basket (84 FR 39080).

TABLE 8: Blended Chemical PPI Weights

Name	2021-based IRF Weights	NAICS
PPI for Industrial Gas Manufacturing	19%	325120
PPI for Other Basic Inorganic Chemical Manufacturing	13%	325180
PPI for Other Basic Organic Chemical Manufacturing	60%	325190
PPI for Other Miscellaneous Chemical Product Manufacturing	8%	325998

(10) Medical Instruments

We proposed to use a blended price proxy for the Medical Instruments category, as shown in Table 9. The 2012 Benchmark I–O data shows the majority of medical instruments and supply costs are for NAICS 339112—Surgical and medical instrument manufacturing costs (approximately 56 percent) and NAICS 339113—Surgical appliance and supplies manufacturing costs (approximately 43 percent). Therefore, we proposed to use a blend of these two price proxies. To proxy the price changes associated with NAICS 339112, we proposed using the PPI for Surgical and medical instruments (BLS series code WPU1562). This is the same price proxy we used in the 2016-based IRF market basket. To proxy the price changes associated with NAICS 339113, we proposed to use a 50/50 blend of the PPI for Medical and surgical appliances and supplies (BLS series code WPU1563) and the PPI for Miscellaneous products, Personal safety equipment and clothing (BLS series code WPU1571). We proposed to include the latter price proxy as it would reflect personal protective equipment including but not limited to face shields and protective clothing. The 2012 Benchmark I–O data does not provide specific expenses for these products; however, we recognize that this category reflects costs faced by IRFs.

TABLE 9: Blended Medical Instruments PPI Weights

Name	2021-based IRF Weights	NAICS
PPI - Commodity - Surgical and medical instruments	56%	339112
PPI - Commodity - Medical and surgical appliances and supplies	22%	339113
PPI - Commodity - Miscellaneous products-Personal safety equipment and clothing	22%	

(11) Rubber and Plastics

We proposed to continue to use the PPI for Rubber and Plastic Products (BLS series code WPU07) to measure price growth of this cost category. This is the same proxy used in the 2016-based IRF market basket (84 FR 39081).

(12) Paper and Printing Products

We proposed to continue to use the PPI for Converted Paper and Paperboard Products (BLS series code WPU0915) to measure the price growth of this cost category. This is the same proxy used in the 2016-based IRF market basket (84 FR 39081).

(13) Miscellaneous Products

We proposed to continue to use the PPI for Finished Goods Less Food and Energy (BLS series code WPUFD4131) to measure the price growth of this cost category. This is the same proxy used in the 2016-based IRF market basket (84 FR 39081).

(14) Professional Fees: Labor-Related

We proposed to continue to use the ECI for Total Compensation for Private Industry workers in Professional and Related (BLS series code CIU2010000120000I) to measure the price growth of this category. This is the same proxy used in the 2016-based IRF market basket (84 FR 39081).

(15) Administrative and Facilities Support Services

We proposed to continue to use the ECI for Total Compensation for Private Industry workers in Office and Administrative Support (BLS series code CIU2010000220000I) to measure the price growth of this category. This is the same proxy used in the 2016-based IRF market basket (84 FR 39081).

(16) Installation, Maintenance, and Repair Services

We proposed to continue to use the ECI for Total Compensation for Civilian workers in Installation, Maintenance, and Repair (BLS series code CIU1010000430000I) to measure the price growth of this cost category. This is the same proxy used in the 2016-based IRF market basket (84 FR 39081).

(17) All Other: Labor-Related Services

We proposed to continue to use the ECI for Total Compensation for Private Industry workers in Service Occupations (BLS series code CIU2010000300000I) to measure the price growth of this cost category. This is the same proxy used in the 2016-based IRF market basket (84 FR 39081).

(18) Professional Fees: Nonlabor-Related

We proposed to continue to use the ECI for Total Compensation for Private Industry workers in Professional and Related (BLS series code CIU2010000120000I) to measure the price growth of this category. This is the same proxy used in the 2016-based IRF market basket (84 FR 39081).

(19) Financial Services

We proposed to continue to use the ECI for Total Compensation for Private Industry workers in Financial Activities (BLS series code CIU201520A000000I) to measure the price growth of this cost category. This is the same proxy used in the 2016-based IRF market basket (84 FR 39081).

(20) Telephone Services

We proposed to continue to use the CPI for Telephone Services (BLS series code CUUR0000SEED) to measure the price growth of this cost category. This is the same proxy used in the 2016-based IRF market basket (84 FR 39081).

(21) All Other: Nonlabor-Related Services

We proposed to continue to use the CPI for All Items Less Food and Energy (BLS series code CUUR0000SA0L1E) to measure the price growth of this cost category. This is the same proxy used in the 2016-based IRF market basket (84 FR 39081).

The following is a summary of the public comments received on our proposed price proxies for the operating portion of the 2021-based IRF market basket and our responses.

Comment: A few commenters expressed concern that CMS's use of the IHS Global Inc. (IGI) forecast for determining the market basket update does not capture the specialized nature of IRF costs. The commenters stated that IGI's general forecasts for hospital goods and services likely are not accounting for the fact that IRFs are providing more specialized services compared to other hospital settings such as specialized staff, equipment, and drugs.

Response: As described previously, the IRF market basket measures price changes (including changes in the prices for wages and salaries) over time and would not reflect increases in costs associated with changes in the volume or intensity of input goods and services until the market basket is rebased. In this final rule, we are rebasing and revising the current 2016-based IRF market basket to reflect a 2021 base year. As stated previously, we believe the 2021-based IRF market basket appropriately reflects IRF cost structures. To reflect expected price growth for each of the cost categories in the IRF market basket, we rely on impartial economic forecasts of the price proxies used in the market basket from IGI; as previously discussed, we use the best available price proxies that would measure expected price growth of the goods and services purchased by IRFs. We have consistently used the IGI economic price proxy forecasts in the market baskets used to update the IRF PPS payments since the implementation of the IRF PPS. For example, to measure price growth for IRF wages and salaries costs in the IRF market basket, since IRF-specific information is unavailable, we proposed to use the ECI for Wages and Salaries for All Civilian workers in Hospitals. We believe that this ECI is the best available price proxy to account for the occupational skill mix within IRFs. We note that we reviewed the Bureau of Labor Statistics Occupational Employment and Wage Statistics (OEWS) data for NAICS 622100 (General Medical and Surgical Hospitals)—one of the primary data sources used to derive the weights for the ECI for Wages and Salaries for All Civilian workers in Hospitals—and found that in 2021, the updated base year of the IRF market basket, approximately 56 percent of total estimated salaries (total employment multiplied by mean annual wage) for NAICS 622100 was attributed to Health Professional and Technical occupations, and approximately 20 percent was attributed to Health Service occupations. Therefore, in the absence of an IRF-specific ECI, we believe that the highly skilled hospital workforce captured by the ECI for Wages and Salaries for All Civilian workers in Hospitals (inclusive of therapists, nurses, other clinicians, etc.) is a reasonable proxy for the compensation component of the IRF market basket. We would welcome any publicly available IRF-specific data that the commenters could provide regarding wage, benefits, or supplies prices.

Comment: One commenter encouraged CMS to explore other changes to the composition of the market basket to better capture evolving dynamics in the labor force. The commenter provided as an example that the ECI may no longer accurately capture the changing composition and cost structure of the hospital labor market given the large increases in short-term contract labor use and its growing costs.

Response: The purpose of the market basket is to measure the average change in the price of goods and services hospitals purchase in order to provide IRF medical services. We believe the ECI is an appropriate index to measure the price changes for Compensation costs as it holds occupational distribution constant. We note that the 2021-based IRF market basket cost weights show that contract labor costs account for about 3 percent of total compensation costs (reflecting employed and contract labor staff) for IRFs in 2021. In addition, an analysis of Medicare cost report data for IPPS hospitals shows that contract labor hours accounted for about 4 percent of total compensation hours (reflecting employed and contract labor staff) in 2021. Therefore, while we acknowledge that the ECI measures only reflect price changes for employed staff, we believe that the ECI for hospital workers is accurately reflecting the price change associated with the labor used to provide hospital care (as employed workers' hours account for 97 percent of hospital compensation hours). We will continue to monitor the trends in the ECI as well as the increased use of contract labor as a result of the PHE. We welcome any additional publicly available data that commenters can provide regarding alternative price indexes.

After consideration of the public comments, we are finalizing the price proxies for the operating portion of the 2021-based IRF market basket as proposed.

Table 11 lists all price proxies that we are finalizing for the 2021-based IRF market basket.

b. Price Proxies for the Capital Portion of the 2021-Based IRF Market Basket

(1) Capital Price Proxies Prior to Vintage Weighting

We proposed to continue to use the same price proxies for the capital-related cost categories in the 2021-based IRF market basket as were used in the 2016-based IRF market basket, which are provided in Table 11 and described below. Specifically, we proposed to proxy:

- *Depreciation:* Building and Fixed Equipment cost category by BEA's Chained Price Index for Nonresidential Construction for Hospitals and Special Care Facilities (BEA Table 5.4.4. Price Indexes for Private Fixed Investment in Structures by Type).
- *Depreciation:* Movable Equipment cost category by the PPI for Machinery and Equipment (BLS series code WPU11).
- Nonprofit Interest cost category by the average yield on domestic municipal bonds (Bond Buyer 20-bond index).
- For-profit Interest cost category by the iBoxx AAA Corporate Bond Yield index
- Other Capital-Related cost category by the CPI–U for Rent of Primary Residence (BLS series code CUUS0000SEHA).

We believe these are the most appropriate proxies for IRF capital-related costs that meet our selection criteria of relevance, timeliness, availability, and reliability. We also proposed to continue to vintage weight the capital price proxies for Depreciation and Interest to capture the long-term consumption of capital. This vintage weighting method is similar to the method used for the 2016-based IRF market basket (84 FR 39082) and is described below.

(2) Vintage Weights for Price Proxies

Because capital is acquired and paid for over time, capital-related expenses in any given year are determined by both past and present purchases of physical and financial capital. The vintage-weighted capital-related portion of the 2021-based IRF market basket is intended to capture the long-term

consumption of capital, using vintage weights for depreciation (physical capital) and interest (financial capital). These vintage weights reflect the proportion of capital-related purchases attributable to each year of the expected life of building and fixed equipment, movable equipment, and interest. We proposed to use vintage weights to compute vintage-weighted price changes associated with depreciation and interest expenses.

Capital-related costs are inherently complicated and are determined by complex capital-related purchasing decisions, over time, based on such factors as interest rates and debt financing. In addition, capital is depreciated over time instead of being consumed in the same period it is purchased. By accounting for the vintage nature of capital, we are able to provide an accurate and stable annual measure of price changes. Annual non-vintage price changes for capital are unstable due to the volatility of interest rate changes, and therefore, do not reflect the actual annual price changes for IRF capital-related costs. The capital-related component of the 2021-based IRF market basket reflects the underlying stability of the capital-related acquisition process.

The methodology used to calculate the vintage weights for the 2021-based IRF market basket is the same as that used for the 2016-based IRF market basket (84 FR 39082 through 39083) with the only difference being the inclusion of more recent data. To calculate the vintage weights for depreciation and interest expenses, we first need a time series of capital-related purchases for building and fixed equipment and movable equipment. We found no single source that provides an appropriate time series of capital-related purchases by hospitals for all of the above components of capital purchases. The early Medicare cost reports did not have sufficient capital-related data to meet this need. Data we obtained from the American Hospital Association (AHA) do not include annual capital-related purchases. However, we are able to obtain data on total expenses back to 1963 from the AHA. Consequently, we proposed to use data from the AHA Panel Survey and the AHA Annual Survey to obtain a time series of total expenses for hospitals. We then proposed to use data from the AHA Panel Survey supplemented with the ratio of depreciation to total hospital expenses obtained from the Medicare cost reports to derive a trend of annual depreciation expenses for 1963 through 2020, which is the latest year of AHA data available. We proposed to separate these depreciation expenses into annual amounts of building and fixed equipment depreciation and movable equipment depreciation as determined earlier. From these annual depreciation amounts, we derive annual end-of-year book values for building and fixed equipment and movable equipment using the expected life for each type of asset category. While data is not available that is specific to IRFs, we believe this information for all hospitals serves as a reasonable alternative for the pattern of depreciation for IRFs.

To continue to calculate the vintage weights for depreciation and interest expenses, we also need to account for the expected lives for Building and Fixed Equipment, Movable Equipment, and Interest for the 2021-based IRF market basket. We proposed to calculate the expected lives using Medicare cost report data from Worksheet A–7 part III for freestanding and hospital-based IRFs. The expected life of any asset can be determined by dividing the value of the asset (excluding fully depreciated assets) by its current year depreciation amount. This calculation yields the estimated expected life of an asset if the rates of depreciation were to continue at current year levels, assuming straight-line depreciation. We proposed to determine the expected life of building and fixed equipment separately for hospital-based IRFs and freestanding IRFs, and then weight these expected lives using the percent of total capital costs each provider type represents. We proposed to apply a similar method for movable equipment. Using these methods, we determined the average expected life of building and fixed equipment to be equal to 25 years, and the average expected life of movable equipment to be equal to 12 years. For the expected life of interest, we believe vintage weights for interest should represent the average expected life of building and fixed equipment because, based on previous research described in the FY 1997 IPPS final rule (61 FR 46198), the expected life of hospital debt instruments and the expected life of buildings and fixed equipment are similar. We note that for the 2016-based IRF market basket, the expected life of building and fixed equipment is 22 years, and the expected life of movable equipment is 11 years (84 FR 39082) using the 2016 Medicare cost report data for freestanding and hospital-based IRFs.

Multiplying these expected lives by the annual depreciation amounts results in annual year-end asset costs for building and fixed equipment and movable equipment. We then calculate a time series, beginning in 1964, of annual capital purchases by subtracting the previous year's asset costs from the current year's asset costs.

For the building and fixed equipment and movable equipment vintage weights, we proposed to use the real annual capital-related purchase amounts for each asset type to capture the actual amount of the physical acquisition, net of the effect of price inflation. These real annual capital-related purchase amounts are produced by deflating the nominal annual purchase amount by the associated price proxy as provided earlier in the proposed rule. For the interest vintage weights, we proposed to use the total nominal annual capital-related purchase amounts to capture the value of the debt instrument (including, but not limited to, mortgages and bonds). Using these capital-related purchase time series specific to each asset type, we proposed to calculate the vintage weights for building and fixed equipment, for movable equipment, and for interest.

The vintage weights for each asset type are deemed to represent the average purchase pattern of the asset over its expected life (in the case of building and fixed equipment and interest, 25 years, and in the case of movable equipment, 12 years). For each asset type, we used the time series of annual capital-related purchase amounts available from 2020 back to 1964. These data allow us to derive thirty-three 25-year periods of capital-related purchases for building and fixed equipment and interest, and 46 12-year periods of capital-related purchases for movable equipment. For each 25-year period for building and fixed equipment and interest, or 12-year period for movable equipment, we calculate annual vintage weights by dividing the capital-related purchase amount in any given year by the total amount of purchases over the entire 25-year or 12-year period. This calculation is done for each year in the 25-year or 12-year period and for each of the periods for which we have data. We then calculate the average vintage weight for a given year of the expected life by taking the average of these vintage weights across the multiple periods of data. The vintage weights for the capital-related portion of the 2021-based IRF market basket and the 2016-based IRF market basket are presented in Table 10.

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TABLE 10: The 2021-Based IRF Market Basket and 2016-based IRF Market Basket Vintage Weights for Capital-Related Price Proxies

Year*	Building and Fixed Equipment		Movable Equipment		Interest	
	2021-based 25 years	2016-based 22 years	2021 based 12 years	2016-based 11 years	2021 based 25 years	2016 based 22 years
1	0.031	0.035	0.066	0.071	0.018	0.021
2	0.032	0.036	0.068	0.075	0.019	0.023
3	0.033	0.038	0.071	0.080	0.021	0.025
4	0.034	0.038	0.076	0.085	0.023	0.026
5	0.035	0.040	0.080	0.087	0.024	0.029
6	0.036	0.042	0.082	0.091	0.026	0.031
7	0.035	0.042	0.084	0.095	0.026	0.033
8	0.036	0.041	0.088	0.099	0.028	0.033
9	0.036	0.042	0.091	0.102	0.029	0.036
10	0.039	0.043	0.094	0.105	0.033	0.038
11	0.040	0.046	0.098	0.110	0.035	0.042
12	0.040	0.047	0.101	--	0.037	0.045
13	0.042	0.048	--	--	0.040	0.048
14	0.042	0.049	--	--	0.042	0.052
15	0.042	0.050	--	--	0.044	0.055
16	0.043	0.050	--	--	0.046	0.057
17	0.044	0.051	--	--	0.049	0.060
18	0.045	0.053	--	--	0.052	0.065
19	0.045	0.053	--	--	0.054	0.068
20	0.045	0.053	--	--	0.055	0.069
21	0.045	0.052	--	--	0.057	0.070
22	0.045	0.052	--	--	0.058	0.072
23	0.045	--	--	--	0.060	
24	0.045	--	--	--	0.061	
25	0.044	--	--	--	0.062	
Total	1.000	1.000	1.000	1.000	1.000	1.000

Note: Numbers may not add to total due to rounding.

* Year 25 is applied to the most recent data point when creating the vintage-weighted price proxies.

The process of creating vintage-weighted price proxies requires applying the vintage weights to the price proxy index where the last applied vintage weight in Table 10 is applied to the most recent data point. We have provided on the CMS website an example of how the vintage weighting price proxies are calculated, using example vintage weights and example price indices. The example can be found at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketResearch.html* in the zip file titled ''Weight Calculations as described in the IPPS FY 2010 Proposed Rule.''

We did not receive any comments on our proposed price proxies for the capital portion of the 2021-based IRF market basket. We are finalizing these price proxies as proposed.

c. Summary of Price Proxies of the 2021-Based IRF Market Basket

Table 11 shows both the operating and capital price proxies that we are finalizing for the 2021-based IRF market basket.

TABLE 11: Price Proxies and Cost Weights for use in the 2021-based IRF Market Basket

Cost Description	Price Proxies	Weight
Total		**100.0**
Compensation		**60.1**
Wages and Salaries	ECI for Wages and Salaries for All Civilian workers in Hospitals	48.2
Employee Benefits	ECI for Total Benefits for All Civilian workers in Hospitals	11.9
Utilities		**1.4**
Electricity and Other Non-Fuel Utilities	PPI for Commercial Electric Power	0.9
Fuel: Oil and Gas	Blend of PPIs*	0.5
Professional Liability Insurance		**0.8**
Malpractice	CMS Hospital Professional Liability Insurance Premium Index	0.8
All Other Products and Services		**29.1**
All Other Products		**11.4**
Pharmaceuticals	PPI for Pharmaceuticals for Human Use, Prescription	4.7
Food: Direct Purchases	PPI for Processed Foods and Feeds	1.0
Food: Contract Services	CPI-U for Food Away From Home	1.2
Chemicals	Blend of PPIs*	0.4
Medical Instruments	Blend of PPIs*	2.5
Rubber and Plastics	PPI for Rubber and Plastic Products	0.4
Paper and Printing Products	PPI for Converted Paper and Paperboard Products	0.6
Miscellaneous Products	PPI for Finished Goods Less Food and Energy	0.8
All Other Services		**17.7**
Labor-Related Services		**9.5**
Professional Fees: Labor-Related	ECI for Total compensation for Private industry workers in Professional and related	5.6
Administrative and Facilities Support Services	ECI for Total compensation for Private industry workers in Office and administrative support	0.7
Installation, Maintenance & Repair Services	ECI for Total compensation for Civilian workers in Installation, maintenance, and repair	1.5
All Other: Labor-Related Services	ECI for Total compensation for Private industry workers in Service occupations	1.7
Nonlabor-Related Services		**8.2**
Professional Fees: Nonlabor-Related	ECI for Total compensation for Private industry workers in Professional and related	5.9
Financial services	ECI for Total compensation for Private industry workers in Financial activities	0.9
Telephone Services	CPI-U for Telephone Services	0.3
All Other: Nonlabor-Related Services	CPI-U for All Items Less Food and Energy	1.1
Capital-Related Costs		**8.6**
Depreciation		**6.0**
Fixed Assets	BEA chained price index for nonresidential construction for hospitals and special care facilities - vintage weighted (25 years)	3.8
Movable Equipment	PPI for machinery and equipment - vintage weighted (12 years)	2.3
Interest Costs		**1.2**
Government/Nonprofit	Average yield on domestic municipal bonds (Bond Buyer 20 bonds) - vintage weighted (25 years)	0.6
For Profit	Average Yield on iBoxx AAA Corporate Bonds – vintage weighted (25 years)	0.6
Other Capital-Related Costs	CPI-U for Rent of primary residence	**1.3**

Note: Totals may not sum to 100.0 percent due to rounding.

* Details on the series and weight for each price proxy used in the PPI blends is provided in section VI.C.2.

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After consideration of public comments, we are finalizing the 2021-based IRF market basket as proposed.

D. FY 2024 Market Basket Update and Productivity Adjustment

1. FY 2024 Market Basket Update

For FY 2024 (that is, beginning October 1, 2023, and ending September 30, 2024), we proposed to use an estimate of the 2021-based IRF market basket increase percentage to update the IRF PPS base payment rate as required by section 1886(j)(3)(C)(i) of the Act. Consistent with historical practice, we proposed to estimate the market basket update for the IRF PPS based on IHS Global Inc.'s (IGI's) forecast using the most recent available data. IGI is a nationally recognized economic and financial forecasting firm with which CMS contracts to forecast the components of the market baskets.

Based on IGI's fourth quarter 2022 forecast with historical data through the third quarter of 2022, the proposed 2021-based IRF market basket percentage increase for FY 2024 was 3.2 percent. Therefore, consistent with our historical practice of estimating market basket increases based on the best available data, we proposed a market basket increase percentage of 3.2 percent for FY 2024. We also proposed that if more recent data were subsequently available (for example, a more recent estimate of the market basket) we would use such data, if appropriate, to determine the FY 2024 update in the final rule.

Based on IGI's second quarter 2023 forecast with historical data through the first quarter of 2023, the 2021-based IRF market basket increase percentage for FY 2024 is 3.6 percent. Therefore, consistent with our historical practice of estimating market basket increases based on the best available data, we are finalizing a market basket increase percentage of 3.6 percent for FY 2024. For comparison, the current 2016-based IRF market basket is also projected to increase by 3.6 percent in FY 2024 based on IGI's second quarter 2023 forecast. Table 12 compares the 2021-based IRF market basket and the 2016-based IRF market basket percent changes. On average, the two indexes produce similar updates to one another, with the 4-year average historical growth rates (for FY 2019–FY 2022) of the 2021-based IRF market basket being equal to 3.2 percent compared to the 2016-based IRF market basket with 3.1 percent.

TABLE 12: The 2021-Based IRF Market Basket and 2016-Based IRF Market Basket Percent Changes, FY 2019 through FY 2026

	Fiscal Year (FY)	2021-Based IRF Market Basket Index Percent Change	2016-Based IRF Market Basket Index Percent Change
Historical data	FY 2019	2.4	2.3
	FY 2020	2.1	2.1
	FY 2021	2.8	2.7
	FY 2022	5.3	5.3
	Average 2019-2022	**3.2**	**3.1**
Forecast	FY 2023	4.9	4.8
	FY 2024	3.6	3.6
	FY 2025	3.1	3.1
	FY 2026	2.9	2.9
	Average 2023-2026	**3.6**	**3.6**

Note that these market basket percent changes do not include any further adjustments as may be statutorily required.

Source: IHS Global Inc. 2nd quarter 2023 forecast.

2. Productivity Adjustment

According to section 1886(j)(3)(C)(i) of the Act, the Secretary shall establish an increase factor based on an appropriate percentage increase in a market basket of goods and services. Section 1886(j)(3)(C)(ii) of the Act then requires that, after establishing the increase factor for a FY, the Secretary shall reduce such increase factor for FY 2012 and each subsequent FY, by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act. Section 1886(b)(3)(B)(xi)(II) of the Act sets forth the definition of this productivity adjustment. The statute defines the productivity adjustment to be equal to the 10-year moving average of changes in annual economy-wide, private nonfarm business multifactor productivity (as projected by the Secretary for the 10-year period ending with the applicable FY, year, cost reporting period, or other annual period) (the ''productivity adjustment''). The U.S. Department of Labor's Bureau of Labor Statistics (BLS) publishes the official measures of productivity for the U.S. economy. We note that previously the productivity measure referenced in section 1886(b)(3)(B)(xi)(II) of the Act, was published by BLS as private nonfarm business multifactor productivity. Beginning with the November 18, 2021 release of productivity data, BLS replaced the term multifactor productivity (MFP) with total factor productivity (TFP). BLS noted that this is a change in terminology only and will not affect the data or methodology. As a result of the BLS name change, the productivity measure referenced in section 1886(b)(3)(B)(xi)(II) is now published by BLS as private nonfarm business total factor productivity. However, as mentioned above, the data and methods are unchanged. Please see *www.bls.gov* for the BLS historical published TFP data. A complete description of IGI's TFP projection methodology is available on the CMS website at *https://www.cms.gov/Research-Statistics-Dataand-Systems/Statistics-Trends-andReports/MedicareProgramRatesStats/MarketBasketResearch*. In addition, in

the FY 2022 IRF final rule (86 FR 42374), we noted that effective with FY 2022 and forward, CMS changed the name of this adjustment to refer to it as the productivity adjustment rather than the MFP adjustment.

Using IGI's fourth quarter 2022 forecast, the 10-year moving average growth of TFP for FY 2024 was projected to be 0.2 percent. Thus, in accordance with section 1886(j)(3)(C) of the Act, we proposed to calculate the FY 2024 market basket update, which is used to determine the applicable percentage increase for the IRF payments, using IGI's fourth quarter 2022 forecast of the proposed 2021-based IRF market basket. We proposed to then reduce this percentage increase by the estimated productivity adjustment for FY 2024 of 0.2 percentage point (the 10-year moving average growth of TFP for the period ending FY 2024 based on IGI's fourth quarter 2022 forecast). Therefore, the proposed FY 2024 IRF update was equal to 3.0 percent (3.2 percent market basket update reduced by the 0.2 percentage point productivity adjustment). Furthermore, we proposed that if more recent data became available after the publication of the proposed rule and before the publication of the final rule (for example, a more recent estimate of the market basket and/or productivity adjustment), we would use such data, if appropriate, to determine the FY 2024 market basket update and productivity adjustment in the final rule.

Using IGI's second quarter 2023 forecast, the 10-year moving average growth of TFP for FY 2024 is projected to be 0.2 percent. Thus, in accordance with section 1886(j)(3)(C) of the Act, we calculate the FY 2024 market basket update, which is used to determine the applicable percentage increase for the IRF payments, using IGI's second quarter 2023 forecast of the 2021-based IRF market basket. We then reduce this percentage increase by the estimated productivity adjustment for FY 2024 of 0.2 percentage point (the 10-year moving average growth of TFP for the period ending FY 2024 based on IGI's second quarter 2023 forecast). Therefore, the FY 2024 IRF update is equal to 3.4 percent (3.6 percent market basket update reduced by the 0.2 percentage point productivity adjustment).

For FY 2024, the Medicare Payment Advisory Commission (MedPAC) recommends that we reduce IRF PPS payment rates by 3 percent. As discussed, and in accordance with sections 1886(j)(3)(C) and 1886(j)(3)(D) of the Act, the Secretary proposed to update the IRF PPS payment rates for FY 2024 by a productivity-adjusted IRF market basket increase percentage of 3.0 percent. Section 1886(j)(3)(C) of the Act does not provide the Secretary with the authority to apply a different update factor to IRF PPS payment rates for FY 2024.

We invited public comment on our proposals for the FY 2024 market basket update and productivity adjustment.

The following is a summary of the public comments received on the proposed FY 2024 market basket update and productivity adjustment:

Comment: Several commenters supported the proposed payment update for FY 2024 and the use of the latest available data. Many commenters expressed concern that the FY 2024 payment update does not adequately factor in the effects of many challenges faced by IRFs such as the impact of the PHE, inflationary pressure, higher patient acuity, sequestration, increasing labor costs due to labor shortages, and other increased costs such as PPE, drugs, and supplies. One commenter expressed concern over the accuracy of the forecast underlying the proposed 3.2 percent market basket update for FY 2024.

A few commenters requested that CMS reexamine the forecasting approach or consider other methods and data sources to calculate the final rule market basket update that better reflects the rapidly increasing input prices and costs facing IRFs. One commenter requested that CMS discuss in the final rule how the agency will account for the increased costs to hospitals that are not reflected in the recent market basket adjustments.

Response: We acknowledge and appreciate commenters' concerns regarding recent trends in inflation. We are required to update IRF PPS payments by the market basket update adjusted for productivity, as directed by section 1886(j)(3)(C) of the Act. Specifically, section 1886(j)(3)(C)(i) states that the increase factor shall be based on an appropriate percentage increase in a market basket of goods and services comprising services for which payment is made. In the FY 2024 IRF PPS proposed rule, we proposed to rebase and revise the current 2016-based IRF market basket to reflect a 2021 base year. See section VI.C. of this final rule for a description of this proposal, the comments received, and the final 2021-based IRF market basket. We believe the increase in the 2021-based IRF market basket adequately reflects the average change in the price of goods and services hospitals purchase in order to provide IRF medical services and is technically appropriate to use as the IRF payment update factor. The IRF market basket is a fixed-weight, Laspeyres-type index that measures the change in price over time of the same mix of goods and services purchased by IRFs in the base period. As we discussed in response to similar comments in the FY 2023 IRF PPS final rule, the IRF market basket update would reflect the prospective price pressures described by the commenters as increasing during a high inflation period (such as faster wage growth or higher energy prices) but would inherently not reflect other factors that might increase the level of costs, such as the quantity of labor used or any shifts between contract and staff nurses. We note that cost changes (that is, the product of price and quantities) would only be reflected when a market basket is rebased, and the base year weights are updated to a more recent time period. As stated previously, we are finalizing an IRF market basket that reflects a 2021 base year and therefore, any change in the cost structure for IRFs that occurred between 2016 and 2021 is now captured in the cost weights for this rebased market basket.

In response to the commenter's request that we reexamine the current forecasting approach for determining the IRF PPS market basket update, we provide the following information. As stated previously, IGI is a nationally recognized economic and financial forecasting firm with which CMS contracts to forecast the components of the market baskets. At the time of the FY 2024 IRF PPS proposed rule, based on IGI's fourth quarter 2022 forecast with historical data through the third quarter of 2022, the 2021-based IRF market basket update was forecasted to be 3.2 percent for FY 2024, reflecting forecasted compensation price growth of 3.9 percent (by comparison, compensation price growth in the IRF market basket averaged 2.4 percent from 2013–2022). In the FY 2024 IRF PPS proposed rule, we proposed that if more recent data became available, we would use such data, if appropriate, to derive the final FY 2024 IRF market basket update for the final rule. For this final rule, we now have an updated forecast of the price proxies underlying the market basket that incorporates more recent historical data and reflects a revised outlook regarding the U.S. economy and expected price inflation for FY 2024. Based on IGI's second quarter 2023 forecast with historical data through the first quarter of 2023, we are projecting a FY 2024 IRF market basket update of 3.6 percent (reflecting forecasted compensation price growth of 4.3 percent) and a productivity

adjustment of 0.2 percentage point. Therefore, for FY 2024 a final IRF productivity-adjusted market basket update of 3.4 percent (3.6 percent less 0.2 percentage point) will be applicable, compared to the 3.0 percent market basket update that was proposed.

We do acknowledge that FY 2022 compensation price growth for the 2016-based IRF market basket was higher (5.3 percent) than was forecasted at the time of the FY 2022 IRF PPS final rule (2.7 percent). We note that the lower projected FY 2024 IRF market basket percent increase relative to the FY 2022 historical increase and the FY 2023 projected increase reflects the expectation that wage and price pressures will lessen in FY 2024 relative to recent history.

Comment: Several commenters expressed concern about the continued application of the productivity adjustment to IRFs. The commenters noted that the PHE has resulted in further productivity challenges for IRFs and other healthcare providers. One commenter cited an article and data reporting declines in overall productivity in the economy and requested that CMS consider these developments in the update to the productivity adjustment in the IRF PPS final rule. A few commenters requested that CMS carefully monitor the impact that these productivity adjustments will have on the rehabilitation hospital sector, provide feedback to Congress as appropriate, and reduce the productivity adjustment. One commenter requested that CMS explore ways to use its authority to offset or waive these adjustments. One commenter requested that CMS suspend at least temporarily the productivity adjustment that reduces the market basket update due to recent declines in hospital productivity. One commenter requested that CMS use its exceptions and adjustments authority under section 1886(j)(3)(A)(v) of the Act to remove the productivity adjustment for any fiscal year that was covered under PHE determination, that is, 2020 (0.4 percent), 2021 (0.0 percent), 2022 (0.7 percent), and 2023 (0.3 percent), from the calculation of the market basket for FY 2024 and any year thereafter.

Response: Section 1886(j)(3)(C)(ii)(I) of the Act requires the application of the productivity adjustment, described in section 1886(b)(3)(xi)(II), to the IRF PPS market basket increase factor. As required by statute, the FY 2024 productivity adjustment is derived based on the 10-year moving average growth in economy-wide productivity for the period ending FY 2024. We recognize the concerns of the commenters regarding the appropriateness of the productivity adjustment; however, we are required pursuant to section 1886(j)(3)(C)(ii)(I) to apply the specific productivity adjustment described here. In addition, with respect to providing feedback to Congress, we note that MedPAC annually monitors various factors for Medicare providers in terms of profitability and beneficiary access to care and reports the findings to Congress on an annual basis. MedPAC did a full analysis of payment adequacy for IRF providers in its March 2023 Report to Congress (*https://www.medpac.gov/document/march-2023-report-to-the-congress-medicare-payment-policy/*). MedPAC stated that given the positive payment adequacy indicators for IRFs, they recommended that the IRF base payment rate be reduced by 3 percent for FY 2024. Additionally, we note that we did not propose to use our authority under section 1886(d)(5)(I)(i) of the Act to remove or offset the application of the productivity adjustment for FY 2024. As previously noted, we are required pursuant to section 1886(j)(3)(C)(ii)(I) of the Act to apply the productivity adjustment to the IRF PPS market basket increase factor.

Comment: A number of commenters requested that CMS deviate from its usual update and consider making one-time adjustments to the market basket update or applying a forecast error adjustment. One commenter stated CMS should apply a temporary payment adjustment or add-on payment to the IRF PPS in FY 2024 of 10 to 20 percent per discharge. Another commenter requested an adjustment to account for what the commenter described as CMS' ''underpayment'' of IRFs since 2020.

Response: As most recently discussed in the FY 2023 IRF PPS final rule, the IRF PPS market basket updates are set prospectively, which means that the market basket update relies on a mix of both historical data for part of the period for which the update is calculated and forecasted data for the remainder. For instance, the FY 2024 market basket update in this final rule reflects historical data through the first quarter of CY 2023 and forecasted data through the third quarter of CY 2024. While there is currently no mechanism to adjust for market basket forecast error in the IRF payment update, the forecast error for a market basket update is calculated as the actual market basket increase for a given year less the forecasted market basket increase. Due to the uncertainty regarding future price trends, forecast errors can be both positive and negative. In evaluating the difference between the forecast increase and later acquired actual data for the period from FY 2012 through FY 2020, we found the forecasted market basket updates for each payment year for IRFs were higher than the actual market basket updates. Therefore, we disagree with the suggestion that the FY 2024 base rates are too low based solely on the calculation of a forecast error over a short period of time (instead of considering forecast errors over longer periods). For this final rule, we have incorporated more recent historical data and forecasts to capture the price and wage pressures facing IRFs and believe it is the best available projection of inflation to determine the applicable percentage increase for the IRF payments in FY 2024.

After consideration of public comments, we are finalizing a FY 2024 IRF productivity-adjusted market basket increase of 3.4 percent based on the most recent data available.

E. Labor-Related Share for FY 2024

Section 1886(j)(6) of the Act specifies that the Secretary is to adjust the proportion (as estimated by the Secretary from time to time) of inpatient rehabilitation facilities' costs that are attributable to wages and wage-related costs, of the prospective payment rates computed under section 1886(j)(3) of the Act for area differences in wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the rehabilitation facility compared to the national average wage level for such facilities. The labor-related share is determined by identifying the national average proportion of total costs that are related to, influenced by, or vary with the local labor market. We proposed to continue to classify a cost category as labor-related if the costs are labor-intensive and vary with the local labor market. As stated in the FY 2020 IRF PPS final rule (84 FR 39087), the labor-related share was defined as the sum of the relative importance of Wages and Salaries, Employee Benefits, Professional Fees: Labor-Related Services, Administrative and Facilities Support Services, Installation, Maintenance, and Repair Services, All Other: Labor-Related Services, and a portion of the Capital-Related Costs from the 2016-based IRF market basket.

Based on our definition of the labor-related share and the cost categories in the 2021-based IRF market basket, we proposed to include in the labor-related share for FY 2024 the sum of the FY 2024 relative importance of Wages and Salaries, Employee Benefits, Professional Fees: Labor-Related,

Administrative and Facilities Support Services, Installation, Maintenance, and Repair Services, All Other: Labor-Related Services, and a portion of the Capital-Related cost weight from the 2021-based IRF market basket.

Similar to the 2016-based IRF market basket (84 FR 39087), the 2021-based IRF market basket includes two cost categories for nonmedical Professional Fees (including, but not limited to, expenses for legal, accounting, and engineering services). These are Professional Fees: Labor-Related and Professional Fees: Nonlabor-Related. For the 2021-based IRF market basket, we proposed to estimate the labor-related percentage of non-medical professional fees (and assign these expenses to the Professional Fees: Labor-Related services cost category) based on the same method that was used to determine the labor-related percentage of professional fees in the 2016-based IRF market basket.

As was done in the 2016-based IRF market basket (84 FR 39087), we proposed to determine the proportion of legal, accounting and auditing, engineering, and management consulting services that meet our definition of labor-related services based on a survey of hospitals conducted by us in 2008, a discussion of which can be found in the FY 2010 IPPS/LTCH PPS final rule (74 FR 43850 through 43856). Based on the weighted results of the survey, we determined that hospitals purchase, on average, the following portions of contracted professional services outside of their local labor market:

- 34 percent of accounting and auditing services.
- 30 percent of engineering services.
- 33 percent of legal services.
- 42 percent of management consulting services.

We proposed to apply each of these percentages to the respective Benchmark I–O cost category underlying the professional fees cost category to determine the Professional Fees: Nonlabor-Related costs. The Professional Fees: Labor-Related costs were determined to be the difference between the total costs for each Benchmark I–O category and the Professional Fees: Nonlabor-Related costs. This is the same methodology that we used to separate the 2016-based IRF market basket professional fees category into Professional Fees: Labor-Related and Professional Fees: Nonlabor-Related cost categories (84 FR 39087).

Effective for transmittal 18 (*https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Transmittals/r18p240i*), the hospital Medicare Cost Report (CMS Form 2552–10, OMB No. 0938–0050) is collecting information on whether a hospital purchased professional services (for example, legal, accounting, tax preparation, bookkeeping, payroll, advertising, and/or management/consulting services) from an unrelated organization and if the majority of these expenses were purchased from unrelated organizations located outside of the main hospital's local area labor market. We encourage all providers to provide this information so we can potentially use in future rulemaking to determine the labor-related share.

In the 2021-based IRF market basket, nonmedical professional fees that are subject to allocation based on these survey results represent 4.0 percent of total costs (and are limited to those fees related to Accounting & Auditing, Legal, Engineering, and Management Consulting services). Based on our survey results, we proposed to apportion approximately 2.6 percentage points of the 4.0 percentage point figure into the Professional Fees: Labor-Related share cost category and the remaining 1.4 percentage point into the Professional Fees: Nonlabor-Related cost category.

In addition to the professional services listed, for the 2021-based IRF market basket, we proposed to allocate a proportion of the Home Office/Related Organization Contract Labor cost weight, calculated using the Medicare cost reports as stated previously in this final rule, into the Professional Fees: Labor-Related and Professional Fees: Nonlabor-Related cost categories. We proposed to classify these expenses as labor-related and nonlabor-related as many facilities are not located in the same geographic area as their home office, and therefore, do not meet our definition for the labor-related share, which requires the services to be purchased in the local labor market.

Similar to the 2016-based IRF market basket, we proposed for the 2021-based IRF market basket to use the Medicare cost reports for both freestanding IRF providers and hospital-based IRF providers to determine the home office labor-related percentages. The Medicare cost report requires a hospital to report information regarding its home office provider. For the 2021-based IRF market basket, we proposed to start with the sample of IRF providers that passed the top 1 percent trim used to derive the Home Office/Related Organization Contract Labor cost weight as described in section V.C.1.b. of the proposed rule. Using information on the Medicare cost report, for freestanding and hospital-based providers separately, we first compare the location of the IRF with the location of the IRF's home office and classify an IRF based on whether its home office is located in the hospital facility's same Metropolitan Statistical Area. For both freestanding and hospital-based providers, we proposed to multiply each provider's Home Office/Related Organization Contract Labor cost weight (calculated using data from the total facility) by Medicare allowable total costs. We then calculate the proportion of Medicare allowable home office compensation costs that these IRFs represent of total Medicare allowable home office compensation costs. We proposed to multiply this percentage (45 percent) by the Home Office/Related Organization Contract Labor cost weight (5.4 percent) to determine the proportion of costs that should be allocated to the labor-related share. Therefore, we proposed to allocate 2.4 percentage points of the Home Office/Related Organization Contract Labor cost weight (5.4 percent times 45 percent) to the Professional Fees: Labor-Related cost weight and 3.0 percentage points of the Home Office/Related Organization Contract Labor cost weight to the Professional Fees: Nonlabor-Related cost weight (5.4 percent times 55 percent). For the 2016-based IRF market basket, we used a similar methodology (84 FR 39088) and determined that 42 percent of the 2016-based Home Office/Related Organization Contract Labor cost weight should be allocated to the labor-related share.

In summary, we apportioned 2.6 percentage points of the non-medical professional fees and 2.4 percentage points of the Home Office/Related Organization Contract Labor cost weight into the Professional Fees: Labor-Related cost category. This amount was added to the portion of professional fees that was identified to be labor-Related using the I–O data such as contracted advertising and marketing costs (approximately 0.6 percentage point of total costs) resulting in a Professional Fees: Labor-Related cost weight of 5.6 percent.

Comment: A few commenters supported the proposal to increase the labor-related share using data that better reflects increased labor costs as a percentage of IRFs' overall cost structure.

One commenter disagreed with CMS' proposal to exclude from the labor-related share the proportion of non-medical professional services fees presumed to have been purchased outside of the hospital's labor market. The commenter disagreed with CMS' assumption that services purchased

from national firms are not affected by the local labor market. The commenter stated that when hospitals seek professional services, the services they are seeking (for example accounting, engineering, management consulting) typically are not so unique that they could only be provided by regional or national firms. The commenter stated that CMS' own survey data support this conclusion, as approximately 65 percent of these services are sourced from firms in the local market. The commenter stated that costs of services purchased from firms outside the hospital's labor market should be included with the labor-related share of costs.

The commenter requested that CMS provide evidence that pricing for professional services provided by regional and national firms to hospitals is offered in a national market that is not subject to geographic cost variation. The commenter requested that CMS restore the 1.4 percentage points it proposes to reclassify to Professional Services: Nonlabor-Related to the Professional Services: Labor-Related category, if the agency cannot produce strong evidence that prices for professional services provided by firms outside of a hospital's local labor market are homogenous.

Response: We disagree with the commenter and believe it is appropriate that a proportion of Accounting & Auditing, Legal, Engineering, and Management Consulting services costs purchased by hospitals should be excluded from the labor-related share. Section 1886(j)(6) of the Act specifies that the Secretary is to adjust the proportion (as estimated by the Secretary from time to time) of IRFs' costs that are attributable to wages and wage-related costs, of the prospective payment rates computed under section 1886(j)(3) of the Act for area differences in wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the rehabilitation facility compared to the national average wage level for such facilities.

The purpose of the labor-related share is to reflect the proportion of the national PPS base payment rate that is adjusted by the hospital's wage index (representing the relative costs of their local labor market to the national average). Therefore, we include a cost category in the labor-related share if the costs are labor intensive and vary with the local labor market.

As acknowledged by the commenter and confirmed by the survey of hospitals conducted by CMS in 2008 (as stated previously in this final rule), professional services can be purchased from local firms as well as national and regional professional services firms. It is not necessarily the case, as asserted by the commenter, that these national and regional firms have fees that match those in the local labor market even though providers have the option to utilize those firms. That is, fees for services purchased from firms outside the local labor market may differ from those that would be purchased in the local labor market for any number of reasons (including but not limited to, the skill level of the contracted personnel, higher capital costs, etc.). As noted earlier in this section of this final rule, the definition for the labor-related share requires the services to be purchased in the local labor market; therefore, CMS' allocation of approximately 65 percent (2.6 percentage points of 4.0 percentage points) of the Professional Fees cost weight to Professional Fees: Labor-Related costs based on the 2008 survey results [17] is consistent with the commenter's assertion that not all Professional Fees services are purchased in the local labor market. We believe it is reasonable to conclude that the costs of those Professional Fees services purchased directly within the local labor market are directly related to local labor market conditions and, thus, should be included in the labor-related share. The remaining approximately 35 percent of Professional Fees costs, which are purchased outside the local labor market, reflect different and additional factors outside the local labor market and, thus, should be excluded from the labor-related share. In addition, we note the compensation costs of professional services provided by hospital employees (which would reflect the local labor market) are included in the labor-related share as they are included in the Wages and Salaries and Employee Benefits cost weights.

Therefore, for the reasons discussed, we believe our proposed methodology of continuing to allocate only a portion of Professional Fees to the Professional Fees: Labor-Related cost category is appropriate. As stated previously, effective for transmittal 18 (*https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Transmittals/r18p240i*), the hospital Medicare Cost Report (CMS Form 2552–10, OMB No. 0938–0050) is collecting information on whether a hospital purchased professional services (for example, legal, accounting, tax preparation, bookkeeping, payroll, advertising, and/or management/consulting services) from an unrelated organization and if the majority of these expenses were purchased from unrelated organizations located outside of the main hospital's local area labor market. We encourage all providers to provide this information so we can potentially use in future rulemaking to determine the labor-related share.

Comment: One commenter disagreed with the assumption that home office compensation costs that occur outside of a hospital's labor market are not subject to geographic wage variation and stated that they do not believe that the proposed reclassification to the Professional Fees: Non-Labor-Related cost category is justified. The commenters stated that the proposed methodology fails to consider that the home office is essentially a part of the hospital, and thus the hospital, along with its home office, is operating in multiple labor markets. The commenters stated that the home office's portion of the hospital's labor costs should not be excluded from the labor-related share simply because they are not in the same labor market as the hospital.

The commenter conducted their own analysis of the Medicare cost report data showing that providers with a home office outside of their local labor market had a wage index both below 1 as well as greater than 1. The commenter stated that those hospitals in a labor market with a wage index greater than 1 had mean home office average hourly wage costs that were greater than the mean home office average hourly wage costs of those hospitals in a labor market with a wage index less than 1. The commenter claimed that these data indicate that, contrary to CMS' assertion, home office salary, wage, and benefit costs for hospitals with home offices outside of their labor market are subject to geographic wage variation.

The commenter requested that CMS allocate the full 5.4 percentage points of the Home Office/Related Organization cost weight to the labor-related share.

Response: As previously stated, the purpose of the labor-related share is to determine the proportion of the national PPS base payment rate that is adjusted by the hospital's wage index (representing the relative costs of their local labor market to the national average). Therefore, we include a cost category in the labor-related share if the costs are labor intensive and vary with the local labor market.

As the commenter stated and as validated with the Medicare cost report, a hospital's home office can be located

[17] The 65 percent is based on a survey conducted by CMS in 2008 as detailed in the FY 2010 IPPS/LTCH PPS final rule (74 FR 43850 through 43856). This was also used to determine the Professional Fees: Labor-related cost weight in the 2016-based IRF market basket.

outside the hospital's local labor market. The proposed methodology for allocating 45 percent of the Home Office/Related Organization cost weight (reflecting compensation costs) is consistent with the intent of the statute to identify the proportion of costs likely to directly vary with the hospital's local labor market. Our methodology relies on the Medicare cost report data for hospitals reporting home office information to determine whether their home office is located in the same local labor market (which we define as the hospital's Metropolitan Statistical Area). As with professional services, we believe it is reasonable to conclude that costs of those home office services purchased directly within the local labor market are directly related to local labor market conditions while the remaining 55 percent of home office costs which are purchased outside the local labor market would reflect different and additional factors and, thus, should be excluded from the labor-related share.

Therefore, we believe our proposed methodology of continuing to allocate only a portion of the Home Office/Related Organization cost weight into the Professional Fees: Labor-Related cost weight is appropriate. In addition, we would note that the compensation costs for hospital employees (which would reflect the local labor market) performing the same tasks as home office personnel are included in the labor-related share as they are included in the Wages and Salaries and Employee Benefits cost weights.

As stated previously, we proposed to include in the labor-related share the sum of the relative importance of Wages and Salaries, Employee Benefits, Professional Fees: Labor-Related, Administrative and Facilities Support Services, Installation, Maintenance, and Repair Services, All Other: Labor-Related Services, and a portion of the Capital-Related cost weight from the 2021-based IRF market basket. The relative importance reflects the different rates of price change for these cost categories between the base year (2021) and FY 2024. Based on IGI's fourth quarter 2022 forecast for the proposed 2021-based IRF market basket, the sum of the FY 2024 relative importance for Wages and Salaries, Employee Benefits, Professional Fees: Labor-related, Administrative and Facilities Support Services, Installation Maintenance & Repair Services, and All Other: Labor-Related Services is 70.3 percent. The portion of Capital-Related costs that is influenced by the local labor market is estimated to be 46 percent, which is the same percentage applied to the 2016-based IRF market basket (84 FR 39088 through 39089). Since the relative importance of Capital-Related costs is 8.2 percent of the proposed 2021-based IRF market basket in FY 2024, we took 46 percent of 8.2 percent to determine the proposed labor-related share of Capital-Related costs for FY 2024 of 3.8 percent. Therefore, we proposed a total labor-related share for FY 2024 of 74.1 percent (the sum of 70.3 percent for the operating costs and 3.8 percent for the labor-related share of Capital-Related costs).

After consideration of public comments, we are finalizing the 2021-based IRF market basket labor-related cost categories and base year cost weights as proposed.

Based on IGI's second quarter 2023 forecast for the 2021-based IRF market basket, the sum of the FY 2024 relative importance for Wages and Salaries, Employee Benefits, Professional Fees: Labor-related, Administrative and Facilities Support Services, Installation Maintenance & Repair Services, and All Other: Labor-Related Services is 70.3 percent. The portion of Capital-Related costs that is influenced by the local labor market is estimated to be 46 percent, which is the same percentage applied to the 2016-based IRF market basket (84 FR 39088 through 39089). Since the relative importance for Capital is 8.2 percent of the 2021-based IRF market basket in FY 2024, we took 46 percent of 8.2 percent to determine the labor-related share of Capital-Related costs for FY 2024 of 3.8 percent. Therefore, the total labor-related share for FY 2024 based on more recent data is 74.1 percent (the sum of 70.3 percent for the operating costs and 3.8 percent for the labor-related share of Capital-Related costs).

Table 13 shows the FY 2024 labor-related share using the 2021-based IRF market basket relative importance and the FY 2023 labor-related share using the 2016-based IRF market basket relative importance.

TABLE 13: FY 2024 IRF Labor-Related Share and FY 2023 IRF Labor-Related Share

	FY 2024 Labor-Related Share [1]	FY 2023 Final Labor Related Share [2]
Wages and Salaries	49.0	48.7
Employee Benefits	11.8	11.3
Professional Fees: Labor-related [3]	5.5	4.9
Administrative and Facilities Support Services	0.7	0.8
Installation, Maintenance, and Repair Services	1.5	1.6
All Other: Labor-Related Services	1.8	1.9
Subtotal	**70.3**	**69.2**
Labor-related portion of Capital-Related costs (46%)	3.8	3.7
Total Labor-Related Share	**74.1**	**72.9**

[1] Based on the 2021-based IRF market basket, IHS Global, Inc. 2nd quarter 2023 forecast.

[2] Based on the 2016-based IRF market basket as published in the **Federal Register** (87 FR 47052).

[3] Includes all contract advertising and marketing costs and a portion of accounting, architectural, engineering, legal, management consulting, and home office/related organization contract labor costs.

The FY 2024 labor-related share using the 2021-based IRF market basket is 1.2 percentage point higher than the FY 2023 labor-related share using the 2016-based IRF market basket. This higher labor-related share is primarily due to the incorporation of the 2021 Medicare cost report data, which increased the Compensation cost weight by approximately 0.8 percentage point compared to the 2016-based IRF market basket as shown in Tables 4 and 5.

F. Wage Adjustment for FY 2024

1. Background

Section 1886(j)(6) of the Act requires the Secretary to adjust the proportion of rehabilitation facilities' costs attributable to wages and wage-related costs (as estimated by the Secretary from time to time) by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the rehabilitation facility compared to the national average wage level for those facilities. The Secretary is required to update the IRF PPS wage index on the basis of information available to the Secretary on the wages and wage-related costs to furnish rehabilitation services. Any adjustment or updates made under section 1886(j)(6) of the Act for a FY are made in a budget-neutral manner.

In the FY 2023 IRF PPS final rule (87 FR 47054 through 47056) we finalized a policy to apply a 5-percent cap on any decrease to a provider's wage index from its wage index in the prior year, regardless of the circumstances causing the decline. Additionally, we finalized a policy that a new IRF would be paid the wage index for the area in which it is geographically located for its first full or partial FY with no cap applied because a new IRF would not have a wage index in the prior FY. Also, in the FY 2023 IRF PPS final rule, we amended the regulations at § 412.624(e)(1)(ii) to reflect this permanent cap on wage index decreases. A full discussion of the adoption of this policy is found in the FY 2023 IRF PPS final rule.

For FY 2024, we proposed to maintain the policies and methodologies described in the FY 2023 IRF PPS final rule (87 FR 47038) related to the labor market area definitions and the wage index methodology for areas with wage data. Thus, we proposed to use the core based statistical areas (CBSAs) labor market area definitions and the FY 2024 pre-reclassification and pre-floor hospital wage index data. In accordance with section 1886(d)(3)(E) of the Act, the FY 2024 pre-reclassification and pre-floor hospital wage index is based on data submitted for hospital cost reporting periods beginning on or after October 1, 2019, and before October 1, 2020 (that is, FY 2020 cost report data).

The labor market designations made by the OMB include some geographic areas where there are no hospitals and, thus, no hospital wage index data on which to base the calculation of the IRF PPS wage index. We proposed to continue to use the same methodology discussed in the FY 2008 IRF PPS final rule (72 FR 44299) to address those geographic areas where there are no hospitals and, thus, no hospital wage index data on which to base the calculation for the FY 2024 IRF PPS wage index.

We invited public comment on our proposals regarding the Wage Adjustment for FY 2024.

The following is a summary of the public comments received on the proposals regarding the Wage Adjustment for FY 2024, with our responses:

Comment: Commenters stated support of the permanent 5-percent cap on wage index decreases. One commenter encouraged CMS to implement these caps in a non-budget neutral manner to mitigate volatility caused by wage index shifts.

Response: We appreciate the commenters' support of the permanent cap on wage index decreases. As for budget neutrality, we do not believe that the permanent 5-percent cap policy for the IRF wage index should be applied in a non-budget-neutral manner. Any adjustment or updates made under section 1886(j)(6) of the Act for a FY must be made in a manner that assures that the aggregated payments under this subsection in the FY are not greater or less than those that would have been made in the year without such adjustments. In accordance with section 1186(j)(6) of the Act, our longstanding historical practice has been to implement updates to the wage index under the IRF PPS in a budget neutral manner. We refer readers to the FY 2023 IRF PPS final rule (87 FR 47054 through 47056) for a detailed discussion and for responses to these and other comments relating to the wage index cap policy.

Comment: One commenter encouraged CMS to release provider-level wage index tables in the final rule that would indicate what wage index value each IRF would receive, including whether or not the IRF would receive a capped wage index value, in order to avoid errors in the payment rates established by the MACs. Commenters also requested that CMS release the necessary wage index tables and data to enable IRFs to crosswalk the IPPS values after application of the low-wage index adjustment to the IRF PPS wage indices. These commenters also requested that CMS detail what data it believes is necessary to enable use of the post-reclassification and post-floor IPPS wage index data in the IRF PPS.

Response: The wage index tables for IRF PPS are provided at the CBSA level. The 5-percent cap policy is applied at the provider level. Hence, when the 5-percent cap is applicable, each IRF should work directly with its MAC to understand how the 5-percent cap is applied. MACs have more detailed information about the location of each IRF and the applicability of the 5-percent cap to each IRF's situation, and CMS has provided careful instructions to the MACs on applying the 5-percent cap policy (see publication 100–04 Medicare Claims Processing Manual, chapter 3). Further, we are unable to provide crosswalk tables or data related to IPPS wage index policies. Data pertaining to the FY 2024 IPPS proposed rule is available at *https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps.* We do not have any additional data on this for the IRF PPS.

Comment: Commenters encouraged CMS to continue to reform the wage index policies. Commenters suggested that CMS revise the IRF wage index to adopt the IPPS policies such as geographic reclassification, rural floor, low wage adjustment, and the Outpatient PPS (OPPS) outmigration adjustments.

Response: We appreciate the commenters' suggestion to adopt the IPPS reclassification and rural floor policies, low wage, and the OPPS outmigration adjustments for the IRF wage index. The OPPS outmigration adjustment policy is a longstanding policy for that setting, and it should be noted that the wage index applied to the OPPS also includes the rural floor and any policies and adjustments applied to the IPPS wage index. As we do not have an IRF-specific wage index, we are unable to determine the degree, if any, to which these IPPS/OPPS policies under the IRF PPS would be appropriate. Data pertaining to any IPPS policies that are applied to the pre-reclassification/pre-floor wage index is available in the FY 2024 IPPS proposed rule at *https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps.* The rationale for our current wage index policies was most recently published in the FY 2022 IRF PPS final rule (86 FR 42377 through 42378) and fully described in the FY 2006 IRF PPS final rule (70 FR 47880, 47926 through 47928).

After consideration of the comments we received, we are finalizing our proposals regarding the Wage Adjustment for FY 2024.

2. Core-Based Statistical Areas (CBSAs) for the FY 2024 IRF Wage Index

The wage index used for the IRF PPS is calculated using the pre-reclassification and pre-floor inpatient PPS (IPPS) wage index data and is assigned to the IRF on the basis of the labor market area in which the IRF is geographically located. IRF labor market areas are delineated based on the CBSAs established by the OMB. The CBSA delineations (which were implemented for the IRF PPS beginning with FY 2016) are based on revised OMB delineations issued on February 28, 2013, in OMB Bulletin No. 13–01. OMB Bulletin No. 13–01 established revised delineations for Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas in the United States and Puerto Rico based on the 2010 Census, and provided guidance on the use of the delineations of these statistical areas using standards published in the June 28, 2010 **Federal Register** (75 FR 37246 through 37252). We refer readers to the FY 2016 IRF PPS final rule (80 FR 47068 through 47076) for a full discussion of our implementation of the OMB labor market area delineations beginning with the FY 2016 wage index.

Generally, OMB issues major revisions to statistical areas every 10 years, based on the results of the decennial census. Additionally, OMB occasionally issues updates and revisions to the statistical areas in between decennial censuses to reflect the recognition of new areas or the addition of counties to existing areas. In some instances, these updates merge formerly separate areas, transfer components of an area from one area to another, or drop components from an area. On July 15, 2015, OMB issued OMB Bulletin No. 15–01, which provides minor updates to and supersedes OMB Bulletin No. 13–01 that was issued on February 28, 2013. The attachment to OMB Bulletin No. 15–01 provides detailed information on the update to statistical areas since February 28, 2013. The updates provided in OMB Bulletin No. 15–01 are based on the application of the 2010 Standards for Delineating Metropolitan and Micropolitan Statistical Areas to Census Bureau population estimates for July 1, 2012 and July 1, 2013.

In the FY 2018 IRF PPS final rule (82 FR 36250 through 36251), we adopted the updates set forth in OMB Bulletin No. 15–01 effective October 1, 2017, beginning with the FY 2018 IRF wage index. For a complete discussion of the adoption of the updates set forth in OMB Bulletin No. 15–01, we refer readers to the FY 2018 IRF PPS final rule. In the FY 2019 IRF PPS final rule (83 FR 38527), we continued to use the OMB delineations that were adopted beginning with FY 2016 to calculate the area wage indexes, with updates set forth in OMB Bulletin No. 15–01 that we adopted beginning with the FY 2018 wage index.

On August 15, 2017, OMB issued OMB Bulletin No. 17–01, which provided updates to and superseded OMB Bulletin No. 15–01 that was issued on July 15, 2015. The attachments to OMB Bulletin No. 17–01 provide detailed information on the update to statistical areas since July 15, 2015, and are based on the application of the 2010 Standards for Delineating Metropolitan and Micropolitan Statistical Areas to Census Bureau population estimates for July 1, 2014 and July 1, 2015. In the FY 2020 IRF PPS final rule (84 FR 39090 through 39091), we adopted the updates set forth in OMB Bulletin No. 17–01 effective October 1, 2019, beginning with the FY 2020 IRF wage index.

On April 10, 2018, OMB issued OMB Bulletin No. 18–03, which superseded the August 15, 2017 OMB Bulletin No. 17–01, and on September 14, 2018, OMB issued OMB Bulletin No. 18–04, which superseded the April 10, 2018 OMB Bulletin No. 18–03. These bulletins established revised delineations for Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas, and provided guidance on the use of the delineations of these statistical areas. A copy of this bulletin may be obtained at *https://www.whitehouse.gov/wp-content/uploads/2018/09/Bulletin-18-04.pdf.*

To this end, as discussed in the FY 2021 IRF PPS proposed (85 FR 22075 through 22079) and final (85 FR 48434 through 48440) rules, we adopted the revised OMB delineations identified in OMB Bulletin No. 18–04 (available at *https://www.whitehouse.gov/wp-content/uploads/2018/09/Bulletin-18-04.pdf*) beginning October 1, 2020, including a 1-year transition for FY 2021 under which we applied a 5-percent cap on any decrease in an IRF's wage index compared to its wage index for the prior fiscal year (FY 2020). The updated OMB delineations more accurately reflect the contemporary urban and rural nature of areas across the country, and the use of such delineations allows us to determine more accurately the appropriate wage index and rate tables to apply under the IRF PPS. OMB issued further revised CBSA delineations in OMB Bulletin No. 20–01, on March 6, 2020 (available on the web at *https://www.whitehouse.gov/wp-content/uploads/2020/03/Bulletin-20-01.pdf*). However, we determined that the changes in OMB Bulletin No. 20–01 do not impact the CBSA-based labor market area delineations adopted in FY 2021. Therefore, CMS did not propose to adopt the revised OMB delineations identified in OMB Bulletin No. 20–01 for FY 2022 or 2023, and for these reasons CMS is likewise not making such a proposal for FY 2024.

3. IRF Budget-Neutral Wage Adjustment Factor Methodology

To calculate the wage-adjusted facility payment for the payment rates set forth in this final rule, we multiply the unadjusted Federal payment rate for IRFs by the FY 2024 labor-related share based on the 2021-based IRF market basket relative importance (74.1 percent) to determine the labor-related portion of the standard payment amount. (A full discussion of the calculation of the labor-related share appears in section VI.E. of this final rule.) We would then multiply the labor-related portion by the applicable IRF wage index. The wage index tables are available on the CMS website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/IRF-Rules-and-Related-Files.html.*

Adjustments or updates to the IRF wage index made under section 1886(j)(6) of the Act must be made in a budget-neutral manner. We calculate a budget-neutral wage adjustment factor as established in the FY 2004 IRF PPS final rule (68 FR 45689) and codified at § 412.624(e)(1), as described in the steps below. We use the listed steps to ensure that the FY 2024 IRF standard payment conversion factor reflects the update to the wage indexes (based on the FY 2020 hospital cost report data) and the update to the labor-related share, in a budget-neutral manner:

Step 1. Calculate the total amount of estimated IRF PPS payments using the labor-related share and the wage indexes from FY 2023 (as published in the FY 2023 IRF PPS final rule (87 FR 47038)).

Step 2. Calculate the total amount of estimated IRF PPS payments using the FY 2024 wage index values (based on updated hospital wage data and considering the permanent cap on wage index decreases policy) and the FY 2024 labor-related share of 74.1 percent.

Step 3. Divide the amount calculated in step 1 by the amount calculated in step 2. The resulting quotient is the FY

2024 budget-neutral wage adjustment factor of 1.0028.

Step 4. Apply the budget neutrality factor from step 3 to the FY 2024 IRF PPS standard payment amount after the application of the increase factor to determine the FY 2024 standard payment conversion factor.

We discuss the calculation of the standard payment conversion factor for FY 2024 in section VI.G. of this final rule.

We invited public comment on the proposed IRF wage adjustment for FY 2024.

We did not receive any comments on the proposed IRF budget-neutral wage adjustment factor methodology for FY 2024. Comments related to the budget neutral wage index cap policy are addressed in the Wage Adjustment section (VI.F) above.

We are finalizing our proposals regarding the IRF budget neutral wage adjustment factor methodology for FY 2024.

G. Description of the IRF Standard Payment Conversion Factor and Payment Rates for FY 2024

To calculate the standard payment conversion factor for FY 2024, as illustrated in Table 14, we begin by applying the increase factor for FY 2024, as adjusted in accordance with sections 1886(j)(3)(C) of the Act, to the standard payment conversion factor for FY 2023 ($17,878). Applying the 3.4 percent increase factor for FY 2024 to the standard payment conversion factor for FY 2023 of $17,878 yields a standard payment amount of $18,486. Then, we apply the budget neutrality factor for the FY 2024 wage index (taking into account the permanent cap on wage index decreases policy), and labor-related share of 1.0028, which results in a standard payment amount of $18,538. We next apply the budget neutrality factor for the CMG relative weights of 1.0002, which results in the standard payment conversion factor of $18,541 for FY 2024.

We invited public comment on the proposed FY 2024 standard payment conversion factor.

We did not receive any comments on the FY 2024 standard payment conversion factor, and therefore, we are finalizing the revisions as proposed.

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TABLE 14: Calculations to Determine the FY 2024 Standard Payment Conversion Factor

Explanation for Adjustment	Calculations	
Standard Payment Conversion Factor for FY 2023		$17,878
Market Basket Increase Factor for FY 2024 (3.6%), reduced by 0.2 percentage point for the productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act	x	1.034
Budget Neutrality Factor for the Updates to the Wage Index and Labor-Related Share	x	1.0028
Budget Neutrality Factor for the Revisions to the CMG Relative Weights	x	1.0002
FY 2024 Standard Payment Conversion Factor	=	$18,541

After the application of the CMG relative weights described in section V. of this final rule to the FY 2024 standard payment conversion factor ($18,541), the resulting unadjusted IRF prospective payment rates for FY 2024 are shown in Table 15.

TABLE 15: FY 2024 Payment Rates

CMG	Payment Rate Tier 1	Payment Rate Tier 2	Payment Rate Tier 3	Payment Rate No Comorbidity
0101	$ 18,244.34	$ 15,600.40	$ 14,393.38	$ 13,623.93
0102	$ 23,363.51	$ 19,976.07	$ 18,431.61	$ 17,445.23
0103	$ 30,155.08	$ 25,784.97	$ 23,788.10	$ 22,516.19
0104	$ 38,670.96	$ 33,066.02	$ 30,507.36	$ 28,875.75
0105	$ 47,094.14	$ 40,267.34	$ 37,152.46	$ 35,164.86
0106	$ 53,809.69	$ 46,011.35	$ 42,449.62	$ 40,180.20
0201	$ 20,050.24	$ 15,945.26	$ 14,521.31	$ 13,557.18
0202	$ 25,731.20	$ 20,461.85	$ 18,635.56	$ 17,397.02
0203	$ 31,866.42	$ 25,341.84	$ 23,077.98	$ 21,546.50
0204	$ 39,638.80	$ 31,521.55	$ 28,707.03	$ 26,801.02
0205	$ 50,665.14	$ 40,289.59	$ 36,692.64	$ 34,256.35
0301	$ 22,401.24	$ 17,625.07	$ 16,425.47	$ 15,342.68
0302	$ 28,712.59	$ 22,590.35	$ 21,053.31	$ 19,664.58
0303	$ 34,373.16	$ 27,043.90	$ 25,202.78	$ 23,541.51
0304	$ 40,638.16	$ 31,973.95	$ 29,797.24	$ 27,831.90
0305	$ 44,327.82	$ 34,875.62	$ 32,502.37	$ 30,359.03
0401	$ 25,161.99	$ 19,824.04	$ 19,252.97	$ 17,945.83
0402	$ 31,883.10	$ 25,119.35	$ 24,398.10	$ 22,740.54
0403	$ 38,403.97	$ 30,257.06	$ 29,385.63	$ 27,388.77
0404	$ 60,412.14	$ 47,596.60	$ 46,226.42	$ 43,087.43
0405	$ 49,343.16	$ 38,874.91	$ 37,756.89	$ 35,190.82
0406	$ 61,962.17	$ 48,816.60	$ 47,413.05	$ 44,192.47
0407	$ 83,154.53	$ 65,512.77	$ 63,629.00	$ 59,305.24
0501	$ 23,354.24	$ 18,513.19	$ 17,410.00	$ 15,902.62
0502	$ 28,753.38	$ 22,794.31	$ 21,435.25	$ 19,579.30
0503	$ 32,991.86	$ 26,155.79	$ 24,596.49	$ 22,466.13
0504	$ 39,701.84	$ 31,473.35	$ 29,597.00	$ 27,034.63
0505	$ 55,864.03	$ 44,287.03	$ 41,646.79	$ 38,040.57
0601	$ 24,846.79	$ 18,839.51	$ 17,632.49	$ 15,884.07
0602	$ 30,781.77	$ 23,339.41	$ 21,843.15	$ 19,677.56
0603	$ 36,549.87	$ 27,711.38	$ 25,937.00	$ 23,363.51
0604	$ 45,649.80	$ 34,610.48	$ 32,394.84	$ 29,181.68
0701	$ 22,306.68	$ 17,719.63	$ 16,916.81	$ 15,479.88
0702	$ 27,640.92	$ 21,956.25	$ 20,962.45	$ 19,180.66
0703	$ 34,070.94	$ 27,066.15	$ 25,840.59	$ 23,645.34
0704	$ 42,282.75	$ 33,588.88	$ 32,068.51	$ 29,342.99
0801	$ 21,945.13	$ 17,521.25	$ 16,290.12	$ 14,984.84
0802	$ 24,959.89	$ 19,927.87	$ 18,526.17	$ 17,042.89
0803	$ 27,739.19	$ 22,147.22	$ 20,589.78	$ 18,941.49
0804	$ 31,256.42	$ 24,954.33	$ 23,200.35	$ 21,342.55
0805	$ 39,010.26	$ 31,145.17	$ 28,955.48	$ 26,637.85
0901	$ 22,822.12	$ 17,586.14	$ 16,520.03	$ 15,084.96
0902	$ 29,025.94	$ 22,367.86	$ 21,010.66	$ 19,186.23
0903	$ 33,668.60	$ 25,946.28	$ 24,372.14	$ 22,256.62
0904	$ 40,703.06	$ 31,365.81	$ 29,465.36	$ 26,906.70
1001	$ 22,245.49	$ 18,416.78	$ 16,835.23	$ 15,363.07
1002	$ 28,328.79	$ 23,454.37	$ 21,440.81	$ 19,564.46
1003	$ 33,381.22	$ 27,635.36	$ 25,263.97	$ 23,052.03
1004	$ 43,313.63	$ 35,858.29	$ 32,780.49	$ 29,912.20
1101	$ 23,617.53	$ 23,617.53	$ 19,028.63	$ 18,038.54
1102	$ 27,080.98	$ 27,080.98	$ 21,820.90	$ 20,684.34
1103	$ 37,150.60	$ 37,150.60	$ 29,934.44	$ 28,375.15
1201	$ 24,657.68	$ 19,089.81	$ 17,144.86	$ 15,954.53
1202	$ 31,215.63	$ 24,166.34	$ 21,705.95	$ 20,198.57
1203	$ 39,340.29	$ 30,455.45	$ 27,353.54	$ 25,454.94

CMG	Payment Rate Tier 1	Payment Rate Tier 2	Payment Rate Tier 3	Payment Rate No Comorbidity
1204	$ 40,814.30	$ 31,597.57	$ 28,378.85	$ 26,409.80
1301	$ 25,523.54	$ 20,485.95	$ 18,394.53	$ 17,024.35
1302	$ 30,464.72	$ 24,453.72	$ 21,956.25	$ 20,320.94
1303	$ 34,430.64	$ 27,637.21	$ 24,813.42	$ 22,966.74
1304	$ 40,704.91	$ 32,671.10	$ 29,335.57	$ 27,151.44
1305	$ 40,910.72	$ 32,837.97	$ 29,483.90	$ 27,288.64
1401	$ 20,869.75	$ 16,870.46	$ 15,587.42	$ 14,402.65
1402	$ 26,074.21	$ 21,077.41	$ 19,475.47	$ 17,994.04
1403	$ 31,545.66	$ 25,499.44	$ 23,561.90	$ 21,770.84
1404	$ 39,364.40	$ 31,820.06	$ 29,402.32	$ 27,164.42
1501	$ 23,934.58	$ 19,304.89	$ 18,622.58	$ 17,643.62
1502	$ 28,315.82	$ 22,838.80	$ 22,032.27	$ 20,873.46
1503	$ 33,598.15	$ 27,099.53	$ 26,142.81	$ 24,767.07
1504	$ 41,431.72	$ 33,418.30	$ 32,235.38	$ 30,540.74
1601	$ 21,051.45	$ 15,802.49	$ 15,605.96	$ 14,343.32
1602	$ 27,685.42	$ 20,782.61	$ 20,523.03	$ 18,863.61
1603	$ 32,135.26	$ 24,123.70	$ 23,823.33	$ 21,896.92
1604	$ 39,699.99	$ 29,802.80	$ 29,430.13	$ 27,051.32
1701	$ 25,395.61	$ 19,271.52	$ 18,249.91	$ 16,644.26
1702	$ 30,655.69	$ 23,263.39	$ 22,028.56	$ 20,091.03
1703	$ 36,319.96	$ 27,563.05	$ 26,100.17	$ 23,804.79
1704	$ 41,834.06	$ 31,745.90	$ 30,062.38	$ 27,418.43
1705	$ 47,922.92	$ 36,366.32	$ 34,438.05	$ 31,410.31
1801	$ 20,393.25	$ 17,061.43	$ 15,741.31	$ 14,246.90
1802	$ 25,938.86	$ 21,700.39	$ 20,022.43	$ 18,121.97
1803	$ 32,394.84	$ 27,101.38	$ 25,006.25	$ 22,633.00
1804	$ 37,899.66	$ 31,706.96	$ 29,255.84	$ 26,480.26
1805	$ 45,290.10	$ 37,888.53	$ 34,959.06	$ 31,642.07
1806	$ 66,580.73	$ 55,700.87	$ 51,393.80	$ 46,517.51
1901	$ 23,437.68	$ 16,738.81	$ 16,206.69	$ 15,559.61
1902	$ 33,160.58	$ 23,680.57	$ 22,929.65	$ 22,015.58
1903	$ 46,397.00	$ 33,134.62	$ 32,081.49	$ 30,802.16
1904	$ 78,717.67	$ 56,214.46	$ 54,428.96	$ 52,261.52
2001	$ 22,073.06	$ 17,719.63	$ 16,521.89	$ 14,984.84
2002	$ 27,379.49	$ 21,980.36	$ 20,495.22	$ 18,587.35
2003	$ 32,509.79	$ 26,096.46	$ 24,333.21	$ 22,069.35
2004	$ 38,721.02	$ 31,083.99	$ 28,983.29	$ 26,285.58
2005	$ 41,520.72	$ 33,333.01	$ 31,080.28	$ 28,187.88
2101	$ 28,130.41	$ 23,704.67	$ 21,108.93	$ 18,867.32
2102	$ 45,521.86	$ 38,361.33	$ 34,161.79	$ 30,533.32
5001	$ -	$ -	$ -	$ 3,207.59
5101	$ -	$ -	$ -	$ 14,450.86
5102	$ -	$ -	$ -	$ 34,845.96
5103	$ -	$ -	$ -	$ 16,349.45
5104	$ -	$ -	$ -	$ 43,662.20

H. Example of the Methodology for Adjusting the Prospective Payment Rates

Table 16 illustrates the methodology for adjusting the prospective payments (as described in section VI. of this final rule). The following examples are based on two hypothetical Medicare beneficiaries, both classified into CMG 0104 (without comorbidities). The unadjusted prospective payment rate for CMG 0104 (without comorbidities) appears in Table 16.

Example: One beneficiary is in Facility A, an IRF located in rural Spencer County, Indiana, and another beneficiary is in Facility B, an IRF located in urban Harrison County, Indiana. Facility A, a rural non-teaching hospital has a Disproportionate Share Hospital (DSH) percentage of 5 percent (which would result in a LIP adjustment of 1.0156), a wage index of 0.8347, and a rural adjustment of 14.9 percent. Facility B, an urban teaching hospital, has a DSH percentage of 15 percent (which would result in a LIP adjustment of 1.0454 percent), a wage index of 0.8793, and a teaching status adjustment of 0.0784.

To calculate each IRF's labor and non-labor portion of the prospective

payment, we begin by taking the unadjusted prospective payment rate for CMG 0104 (without comorbidities) from Table 16. Then, we multiply the labor-related share for FY 2024 (74.1 percent) described in section VI.E. of this final rule by the unadjusted prospective payment rate. To determine the non-labor portion of the prospective payment rate, we subtract the labor portion of the Federal payment from the unadjusted prospective payment.

To compute the wage-adjusted prospective payment, we multiply the labor portion of the Federal payment by the appropriate wage index located in the applicable wage index table. This table is available on the CMS website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/IRF-Rules-and-Related-Files.html.*

The resulting figure is the wage-adjusted labor amount. Next, we compute the wage-adjusted Federal payment by adding the wage-adjusted labor amount to the non-labor portion of the Federal payment.

Adjusting the wage-adjusted Federal payment by the facility-level adjustments involves several steps. First, we take the wage-adjusted prospective payment and multiply it by the appropriate rural and LIP adjustments (if applicable). Second, to determine the appropriate amount of additional payment for the teaching status adjustment (if applicable), we multiply the teaching status adjustment (0.0784, in this example) by the wage-adjusted and rural-adjusted amount (if applicable). Finally, we add the additional teaching status payments (if applicable) to the wage, rural, and LIP-adjusted prospective payment rates. Table 16 illustrates the components of the adjusted payment calculation.

TABLE 16: Example of Computing the FY 2024 IRF Prospective Payment

Steps		Rural Facility A (Spencer Co., IN)		Urban Facility B (Harrison Co., IN)	
1	Unadjusted Payment		$ 28,875.75		$ 28,875.75
2	Labor-Related Share	X	0.741	X	0.741
3	Labor Portion of Payment	=	$ 21,396.93	=	$21,396.93
4	CBSA-Based Wage Index	X	0.8347	X	0.8793
5	Wage-Adjusted Amount	=	$ 17,860.02	=	$18,814.32
6	Non-Labor Amount	+	$ 7,478.82	+	$7,478.82
7	Wage-Adjusted Payment	=	$25,338.84	=	$26,293.14
8	Rural Adjustment	X	1.149	X	1.000
9	Wage- and Rural-Adjusted Payment	=	$29,114.32	=	$26,293.14
10	LIP Adjustment	X	1.0156	X	1.0454
11	Wage-, Rural- and LIP-Adjusted Payment	=	$29,568.51	=	$27,486.85
12	Wage- and Rural-Adjusted Payment		$29,114.32		$26,293.14
13	Teaching Status Adjustment	X	0	X	0.0784
14	Teaching Status Adjustment Amount	=	$0.00	=	$2,061.38
15	Wage-, Rural-, and LIP-Adjusted Payment	+	$ 29,568.51	+	$27,486.85
16	Total Adjusted Payment	=	$ 29,568.51	=	$29,548.23

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Thus, the adjusted payment for Facility A would be $29,568.51, and the adjusted payment for Facility B would be $29,548.23.

VII. Update to Payments for High-Cost Outliers Under the IRF PPS for FY 2024

A. Update to the Outlier Threshold Amount for FY 2024

Section 1886(j)(4) of the Act provides the Secretary with the authority to make payments in addition to the basic IRF prospective payments for cases incurring extraordinarily high costs. A case qualifies for an outlier payment if the estimated cost of the case exceeds the adjusted outlier threshold. We calculate the adjusted outlier threshold by adding the IRF PPS payment for the case (that is, the CMG payment adjusted by all of the relevant facility-level adjustments) and the adjusted threshold amount (also adjusted by all of the relevant facility-level adjustments). Then, we calculate the estimated cost of a case by multiplying the IRF's overall CCR by the Medicare allowable covered charge. If the estimated cost of the case is higher than the adjusted outlier threshold, we make an outlier payment for the case equal to 80 percent of the difference between the estimated cost of the case and the outlier threshold.

In the FY 2002 IRF PPS final rule (66 FR 41362 through 41363), we discussed our rationale for setting the outlier threshold amount for the IRF PPS so that estimated outlier payments would equal 3 percent of total estimated payments. For the FY 2002 IRF PPS final rule, we analyzed various outlier policies using 3, 4, and 5 percent of the total estimated payments, and we concluded that an outlier policy set at 3 percent of total estimated payments would optimize the extent to which we could reduce the financial risk to IRFs of caring for high-cost patients, while still providing for adequate payments for all other (non-high cost outlier) cases.

Subsequently, we updated the IRF outlier threshold amount in the FYs 2006 through 2023 IRF PPS final rules and the FY 2011 and FY 2013 notices (70 FR 47880, 71 FR 48354, 72 FR 44284, 73 FR 46370, 74 FR 39762, 75 FR 42836, 76 FR 47836, 76 FR 59256, 77 FR 44618, 78 FR 47860, 79 FR 45872, 80 FR 47036, 81 FR 52056, 82 FR 36238, 83 FR 38514, 84 FR 39054, 85 FR 48444, 86 FR 42362, and 87 FR 47038, respectively) to maintain estimated outlier payments at 3 percent of total estimated payments. We also stated in the FY 2009 final rule (73 FR 46370 at 46385) that we would continue to analyze the estimated outlier payments for subsequent years and adjust the outlier threshold amount as appropriate to maintain the 3 percent target.

To update the IRF outlier threshold amount for FY 2024, we proposed to use FY 2022 claims data and the same methodology that we used to set the initial outlier threshold amount in the FY 2002 IRF PPS final rule (66 FR 41362 through 41363), which is also the same methodology that we used to update the outlier threshold amounts for FYs 2006 through 2023. The outlier threshold is calculated by simulating aggregate payments and using an iterative process to determine a threshold that results in outlier payments being equal to 3 percent of total payments under the simulation. To determine the outlier threshold for FY 2024, we estimated the amount of FY 2024 IRF PPS aggregate and outlier payments using the most recent claims available (FY 2022) and the proposed FY 2024 standard payment conversion factor, labor-related share, and wage indexes, incorporating any applicable budget-neutrality adjustment factors. The outlier threshold is adjusted either up or down in this simulation until the estimated outlier payments equal 3 percent of the estimated aggregate payments. Based on an analysis of the preliminary data used for the proposed rule, we estimated that IRF outlier payments as a percentage of total estimated payments would be approximately 2.3 percent in FY 2023. Therefore, we proposed to update the outlier threshold amount from $12,526 for FY 2023 to $9,690 for FY 2024 to maintain estimated outlier payments at approximately 3 percent of total estimated aggregate IRF payments for FY 2024.

We note that, as we typically do, we updated our data between the FY 2024 IRF PPS proposed and final rules to ensure that we use the most recent available data in calculating IRF PPS payments. This updated data includes a more complete set of claims for FY 2022. Based on our analysis using this updated data, we estimate that IRF outlier payments as a percentage of total estimated payments are approximately 2.5 percent in FY 2023. Therefore, we will update the outlier threshold amount from $12,526 for FY 2023 to $10,423 for FY 2024 to account for the increases in IRF PPS payments and estimated costs and to maintain estimated outlier payments at approximately 3 percent of total estimated aggregate IRF payments for FY 2024.

The following is a summary of the public comments received on the proposed update to the FY 2024 outlier threshold amount and our responses.

Comment: Commenters were supportive of the update to the outlier threshold for FY 2024; however, some commenters recommended that CMS implement a new methodology to set the outlier fixed loss amount using a 3-year average approach to promote stability in the outlier threshold value. One commenter suggested that changes in the outlier threshold should be limited to no more than plus or minus the market basket amount in any given year.

Response: We thank the commenters for their suggestions regarding the outlier threshold. We appreciate the suggestion to modify the outlier threshold methodology to use a 3-year average; however, it has been our long-standing practice to utilize the most recent full fiscal year of data to update the prospective payment rates and determine the outlier threshold amount, as this data is generally considered to be the best overall predictor of experience in the upcoming fiscal year. Additionally, we do not believe it would be appropriate to limit changes in the outlier threshold to changes in the market basket as constraining adjustments to the outlier threshold may result in a threshold that generates outlier payments above or below the 3 percent target. We appreciate the commenters' suggestions and will take them into consideration as we continue to consider revisions to our outlier threshold methodology in future rulemaking.

Comment: Commenters suggested that CMS should consider policies to better target outlier payments, such as placing a cap on the amount of outlier payments any IRF could receive, lowering the 3 percent outlier pool, and including historical outlier reconciliation dollars in the outlier projections. Additionally, commenters encouraged CMS to monitor the increasing concentration of outlier payments and provide additional information on outlier payments for the public.

Response: We appreciate the various suggestions regarding the outlier threshold methodology. As most recently discussed in the FY 2023 IRF PPS Final Rule (87 FR 47038) our outlier policy is intended to reimburse IRFs for treating extraordinarily costly cases. Any future consideration given to imposing a limit on outlier payments or adjusting the outlier threshold to account for historical outlier reconciliation dollars would need to be carefully assessed and take into consideration the effect on access to IRF care for certain high-cost populations. We continue to believe that maintaining the outlier pool at 3 percent of aggregate IRF payments optimizes the extent to which we can reduce financial risk to IRFs of caring for highest-cost patients, while still providing for adequate payments for all other non-outlier cases. We appreciate the commenters' suggestions for refinements to the outlier methodology as well as the suggested areas of analysis and will take them into consideration as we continue to assess our outlier threshold methodology. We will continue to monitor our outlier policy to ensure it continues to compensate IRFs appropriately.

After consideration of the comments received and considering the most recent available data, we are finalizing the outlier threshold amount of $10,423 to maintain estimated outlier payments at approximately 3 percent of total estimated aggregate IRF payments for FY 2024.

B. Update to the IRF Cost-to-Charge Ratio Ceiling and Urban/Rural Averages for FY 2024

CCRs are used to adjust charges from Medicare claims to costs and are computed annually from facility-specific data obtained from MCRs. IRF specific CCRs are used in the development of the CMG relative weights and the calculation of outlier payments under the IRF PPS. In accordance with the methodology stated in the FY 2004 IRF PPS final rule (68 FR45692 through 45694), we proposed to apply a ceiling to IRFs' CCRs. Using the methodology described in that final rule, we proposed to update the national urban and rural CCRs for IRFs, as well as the national CCR ceiling for FY 2024, based on analysis of the most recent data available. We apply the national urban and rural CCRs in the following situations:

- New IRFs that have not yet submitted their first MCR.
- IRFs whose overall CCR is in excess of the national CCR ceiling for FY 2024, as discussed below in this section.
- Other IRFs for which accurate data to calculate an overall CCR are not available.

Specifically, for FY 2024, we proposed to estimate a national average CCR of 0.487 for rural IRFs, which we calculated by taking an average of the CCRs for all rural IRFs using their most recently submitted cost report data. Similarly, we proposed to estimate a national average CCR of 0.398 for urban IRFs, which we calculated by taking an average of the CCRs for all urban IRFs using their most recently submitted cost report data. We apply weights to both of these averages using the IRFs' estimated costs, meaning that the CCRs of IRFs with higher total costs factor more heavily into the averages than the CCRs of IRFs with lower total costs. For this

final rule, we have used the most recent available cost report data (FY 2021). This includes all IRFs whose cost reporting periods begin on or after October 1, 2020, and before October 1, 2021. If, for any IRF, the FY 2021 cost report was missing or had an ''as submitted'' status, we used data from a previous FY's (that is, FY 2004 through FY 2020) settled cost report for that IRF. We do not use cost report data from before FY 2004 for any IRF because changes in IRF utilization since FY 2004 resulting from the 60 percent rule and IRF medical review activities suggest that these older data do not adequately reflect the current cost of care. Using updated FY 2021 cost report data for this final rule, we estimate a national average CCR of 0.491 for rural IRFs, and a national average CCR of 0.402 for urban IRFs.

In accordance with past practice, we proposed to set the national CCR ceiling at 3 standard deviations above the mean CCR. Using this method, we proposed a national CCR ceiling of 1.45 for FY 2024. This means that, if an individual IRF's CCR were to exceed this ceiling of 1.45 for FY 2024, we will replace the IRF's CCR with the appropriate proposed national average CCR (either rural or urban, depending on the geographic location of the IRF). We calculated the proposed national CCR ceiling by:

Step 1. Taking the national average CCR (weighted by each IRF's total costs, as previously discussed) of all IRFs for which we have sufficient cost report data (both rural and urban IRFs combined).

Step 2. Estimating the standard deviation of the national average CCR computed in step 1.

Step 3. Multiplying the standard deviation of the national average CCR computed in step 2 by a factor of 3 to compute a statistically significant reliable ceiling.

Step 4. Adding the result from step 3 to the national average CCR of all IRFs for which we have sufficient cost report data, from step 1.

We also proposed that if more recent data become available after the publication of this proposed rule and before the publication of the final rule, we would use such data to determine the FY 2024 national average rural and urban CCRs and the national CCR ceiling in the final rule. Using the updated FY 2021 cost report data for this final rule, we estimate a national average CCR ceiling of 1.48, using the same methodology.

We invited public comment on the proposed update to the IRF CCR ceiling and the urban/rural averages for FY 2024.

We did not receive any comments on the proposed revisions to the IRF CCR ceiling and the urban/rural averages for FY 2024. Consistent with the methodology outlined in the proposed rule, and using the most recent cost report data, we are finalizing a national average urban CCR at 0.402, the national average rural CCR at 0.491, and the national average CCR ceiling at 1.48 for FY 2024.

VIII. Modification to the Regulation for Excluded Inpatient Rehabilitation Facility Units Paid Under the IRF PPS

A. Background

Under current regulation, to be excluded from the IPPS, and to be paid under the IRF PPS or the IPF PPS, an IRF or IPF unit of a hospital must meet a number of requirements under § 412.25. Both this regulation and the policies applying to excluded units (which include excluded IRF units and excluded IPF units) have been in effect since before both the IRF PPS and IPF PPS were established, as discussed in the following paragraphs of this section. Before the IRF PPS and the IPF PPS were established, excluded units were paid based on their costs, as reported on their Medicare cost reports, subject to certain facility-specific cost limits. These cost-based payments were determined separately for operating and capital costs. Thus, under cost-based payments, the process of allocating costs to an IRF or IPF unit for reimbursement created significant administrative complexity. This administrative complexity necessitated strict regulations that allowed hospitals to open a new IPPS-excluded unit only at the start of a cost reporting period.

In the January 3, 1984, final rule (49 FR 235), CMS (then known as the Health Care Financing Administration) established policies and regulations for hospitals and units subject to and excluded from the IPPS. In that rule, we explained that section 1886(d) of the Act requires that the prospective payment system apply to inpatient hospital services furnished by all hospitals participating in the Medicare program except those hospitals or units specifically excluded by the law. We further explained our expectation that a hospital's status (that is, whether it is subject to, or excluded from, the prospective payment system) would generally be determined at the beginning of each cost reporting period. We also stated that this status would continue throughout the period, which is normally 1 year. Accordingly, we stated that changes in a hospital's (or unit's) status that result from meeting or failing to meet the criteria for exclusion would be implemented only at the start of a cost reporting period. However, we also acknowledged that under some circumstances involving factors external to the hospital, status changes could be made at times other than the beginning of the cost reporting period. For example, a change in status could occur if a hospital is first included under the prospective payment system and, after the start of its cost reporting period, is excluded because of its participation in an approved demonstration project or State reimbursement control program that begins after the hospital's cost reporting period has begun.

In the FY 1993 IPPS final rule (57 FR 39798 through 39799), we codified our longstanding policies regarding when a hospital unit can change its status from not excluded to excluded. We explained in that final rule that since the inception of the prospective payment system for operating costs of hospital inpatient services in October 1983, certain types of specialty-care hospitals and hospital units have been excluded from that system under section 1888(d)(1)(B) of the Act. We noted that these currently include psychiatric and rehabilitation hospitals and distinct part units, children's hospitals, and long-term care hospitals. We further explained that section 6004(a)(1) of the Omnibus Budget Reconciliation Act of 1989, (Pub. L. 101–239, enacted December 19, 1989) amended section 1886(d)(1)(B) of the Act to provide that certain cancer hospitals are also excluded. We noted that the preamble to the January 3,1984 final rule implementing the prospective payment system for operating costs (49 FR 235) stated that the status of a hospital or unit (that is, whether it is subject to, or excluded from, the prospective payment system) will be determined at the beginning of each cost reporting period. We noted that that same 1984 final rule also provided that changes in a hospital's or unit's status that result from meeting or failing to meet the criteria for exclusion will be implemented prospectively only at the start of a cost reporting period, that is, starting with the beginning date of the next cost reporting period (49 FR 243). However, we noted that this policy was not set forth in the regulations. In the FY 1993 final rule, we stated that we proposed revising §§ 412.22 and 412.25 to specify that changes in the status of each hospital or hospital unit would be recognized only at the start of a cost reporting period. We stated that except in the case of retroactive payment

adjustments for excluded rehabilitation units described in § 412.30(c), any change in a hospital's or unit's compliance with the exclusion criteria that occurs after the start of a cost reporting period would not be considered until the start of the following period. We noted that this policy would also apply to any unit that is added to a hospital during the hospital's cost reporting period. We also stated that we proposed revising § 412.25(a) to specify that as a requirement for exclusion, a hospital unit must be fully equipped and staffed, and be capable of providing inpatient psychiatric or rehabilitation care, as of the first day of the first cost reporting period for which all other exclusion requirements are met. We explained that a unit that meets this requirement would be considered open regardless of whether there are any inpatients in the unit.

In the same FY 1993 IPPS final rule, we responded to commenters who objected to this policy, stating that it unnecessarily penalizes hospitals for factors beyond their control, such as construction delays, that it discourages hospitals from making changes in their programs to meet community needs, or that it can place undue workload demands on regulatory agencies during certain time periods. In response, we explained that we believed that regulatory agencies, hospitals, and the public generally would benefit from policies that are clearly stated, can be easily understood by both hospitals and intermediaries, and can be simply administered. We stated that recognizing changes in status only at the beginning of cost reporting periods is consistent with these goals, while recognizing changes in the middle of cost reporting periods would introduce added complexity to the administration of the exclusion provisions. Therefore, we did not revise the proposed changes based on these comments.

In the FY 2000 IPPS final rule (64 FR 41531 through 41532), we amended the regulations at § 412.25(c) to allow a hospital unit to change from excluded to not excluded at any time during the cost reporting period. We explained the statutory basis and rationale for this change in the FY 2000 IPPS proposed rule (64 FR 24740), and noted that a number of hospitals suggested that we consider a change in our policy to recognize, for purposes of exclusion from the IPPS, reductions in number of beds in, or entire closure of, units at any time during a cost reporting period. In that FY 2000 IPPS proposed rule, we explained that hospitals indicated that the bed capacity made available as a result of these changes could be used, as they need them, to provide additional services to meet patient needs in the acute care part of the hospital that is paid under the IPPS. We further explained that we evaluated the concerns of the hospitals and the effect on the administration of the Medicare program and the health care of beneficiaries of making these payment changes. As a result of that evaluation, we stated that we believed it was reasonable to adopt a more flexible policy in recognition of hospitals' changes in the use of their facilities. However, we noted that whenever a hospital establishes an excluded unit within the hospital, our Medicare fiscal intermediary would need to be able to determine costs of the unit separately from costs of the part of the hospital paid under the prospective payment system. At that time, we stated that the proper determination of costs ensured that the hospital was paid the correct amount for services in each part of the facility, and that payments under the IPPS did not duplicate payments made under the rules that were applicable to excluded hospitals and units, or vice versa. For this reason, we stated that we did not believe it would be appropriate to recognize, for purposes of exclusion from the IPPS, changes in the bed size or status of an excluded unit that are so frequent that they interfere with the ability of the intermediary to accurately determine costs. Moreover, we explained that section 1886(d)(1)(B) of the Act authorizes exclusion from the IPPS of specific types of hospitals and units, but not of specific admissions or stays, such as admissions for rehabilitation or psychiatric care, in a hospital paid under the IPPS. We stated that without limits on the frequency of changes in excluded units for purposes of proper Medicare payment, there was the potential for some hospitals to adjust the status or size of their excluded units so frequently that the units would no longer be distinct entities and the exclusion would effectively apply only to certain types of care.

In the FY 2012 IRF PPS final rule (76 FR 47870), we began further efforts to increase flexibilities for excluded IPF and IRF units. In that rule, we explained that cost-based reimbursement methodologies that were in place before the IPF PPS and IRF PPS meant that the facilities' capital costs were determined, in part, by their bed size and square footage. Changes in the bed size and square footage would complicate the facilities' capital cost allocation. Thus, the regulations at § 412.25 limited the situations under which an IRF or IPF could change its bed size and square footage. In the FY 2012 IRF PPS final rule, we revised § 412.25(b) to enable IRFs and IPFs to more easily adjust to beneficiary changes in demand for IRF or IPF services and improve beneficiary access to these services. We believed that the first requirement (that beds can only be added at the start of a cost reporting period) was difficult, and potentially costly, for IRFs and IPFs that were expanding through new construction because the exact timing of the end of a construction project is often difficult to predict.

In that same FY 2012 IRF PPS final rule, commenters suggested that CMS allow new IRF units or new IPF units to open and begin being paid under their respective IRF PPS or IPF PPS at any time during a cost reporting period, rather than requiring that they could only begin being paid under the IRF PPS or the IPF PPS at the start of a cost reporting period. In response, we stated that we believed that this suggestion was outside the scope of the FY 2012 IRF PPS proposed rule (76 FR 24214) because we did not propose any changes to the regulations in § 412.25(c). However, we stated that we would consider this suggestion for possible inclusion in future rulemaking. Within the FY 2018 IRF PPS proposed rule (82 FR 20690, 20742 through 20743), CMS published a request for information (RFI) on ways to reduce burden for hospitals, physicians, and patients; improve the quality of care; decrease costs; and ensure that patients and their providers and physicians are making the best health care choices possible. In response to the RFI, we received comments from IRF industry associations, State and national hospital associations, industry groups representing hospitals, and individual IRF providers. One of the comments we received in response to the RFI suggested allowing new IRF units to become excluded and be paid under the IRF PPS at any time during the cost reporting period, rather than only at the start of a cost reporting period, which the commenter believed would increase flexibility and eliminate a policy that may impose higher costs for providers while harmonizing an IRF payment system versus the IPPS payment system across all new IRF units.

B. Current Challenges Related to Excluded Hospital Units (§ 412.25(c)(1) and (c)(2))

Currently, under § 412.25(c)(1), a hospital can only start being paid under the IRF PPS or the IPF PPS for services provided in an excluded unit at the start

of a cost reporting period. Specifically, § 412.25(c) limits when the status of hospital units may change for purposes of exclusion from the IPPS, as specified in § 412.25(c)(1) and § 412.25(c)(2). Section 412.25(c)(1) states that the status of a hospital unit may be changed from not excluded to excluded only at the start of the cost reporting period. If a unit is added to a hospital after the start of a cost reporting period, it cannot be excluded from the IPPS before the start of a hospital's next cost reporting period. Under § 412.25(c)(2), the status of a hospital unit may be changed from excluded to not excluded at any time during a cost reporting period, but only if the hospital notifies the fiscal intermediary and the CMS Regional Office in writing of the change at least 30 days before the date of the change, and maintains the information needed to accurately determine costs that are or are not attributable to the excluded unit. A change in the status of a unit from excluded to not excluded that is made during a cost reporting period must remain in effect for the rest of that cost reporting period.

In recent years, interested parties, such as hospitals, have written to CMS to express concerns about what they see as the unnecessary restrictiveness of the requirements of § 412.25(c). Based on this feedback, we continued to explore opportunities to reduce burden for providers and clinicians, while keeping patient-centered care a priority. For instance, we considered whether this regulation might create unnecessary burden for hospitals and could potentially delay necessary rehabilitation beds from opening and being paid under the IRF PPS. As we continued to review and reconsider regulations to identify ways to improve policy, we recognized that the requirement at § 412.25(c)(1) that hospital units can only be excluded at the start of a cost reporting period, may be challenging to meet and potentially costly for facilities under some circumstances, for example, those that are expanding through new construction. Hospitals have indicated it is often difficult to predict the exact timing of the end of a construction project and construction delays may hamper a hospital's ability to have the construction of an excluded unit completed exactly at the start of a cost reporting period, which hospitals stated can lead to significant revenue loss if they are unable to be paid under the IRF PPS or IPF PPS until the start of the next cost reporting period.

As discussed, the requirements of § 412.25(c) were established to manage the administrative complexity associated with cost-based reimbursement for excluded IRF and IPF units. Today, however, because IRF units are paid under the IRF PPS, and IPF units are paid under the IPF PPS, cost allocation is not used for payment purposes. Because advancements in technology since the inception of the IRF PPS and IPF PPS have simplified the cost reporting process and enhanced communication between providers, CMS, and Medicare contractors, we are reconsidering whether it is necessary to continue to allow hospital units to become excluded only at the start of a cost reporting period.

C. Changes to Excluded Hospital Units (§ 412.25(c)(1) and (c)(2))

We are committed to continuing to transform the health care delivery system—and the Medicare program—by putting additional focus on patient-centered care and working with providers, physicians, and patients to improve outcomes, while meeting relevant health care priorities and reducing burden.

In response to the need for availability of inpatient rehabilitation beds we are finalizing changes to § 412.25(c) to allow greater flexibility for hospitals to open excluded units, while minimizing the amount of effort Medicare contractors would need to spend administering the regulatory requirements. Although we are cognizant that there is a need for rehabilitative health services and support for providers along a continuum of care, including a robust investment in community-based rehabilitative services, this rule is focused on inpatient rehabilitation facility settings.

We note that § 412.25(c) applies to both IRFs and IPFs; therefore, revisions to § 412.25(c) will also affect IPFs in similar ways. Readers should refer to the FY 2024 IPF PPS final rule for discussion of revisions to § 412.25(c) and unique considerations applicable to IPF units.

As discussed, the current requirements of § 412.25(c)(1) were originally established to manage the administrative complexity associated with cost-based reimbursement for excluded IPF and IRF units. Because IPF and IRF units are no longer paid under cost-based reimbursement, but rather under the IPF PPS and IRF PPS respectively, we believe that the restriction that limits an IPF or IRF unit to being excluded only at the start of a cost reporting period is no longer necessary.

We amended our regulations in the FY 2012 IRF PPS final rule to address a regulation that similarly was previously necessary for cost-based reimbursement, but was not material to payment under the IRF PPS and IPF PPS. In that final rule, we explained that under cost-based payments, the facilities' capital costs were determined, in part, by their bed size and square footage. Changes in the bed size and square footage would complicate the facilities' capital cost allocation. We explained that under the IRF PPS and IPF PPS, however, a facility's bed size and square footage were not relevant for determining the individual facility's Medicare payment. Therefore, we believed it was appropriate to modify some of the restrictions on a facility's ability to change its bed size and square footage. Accordingly, we relaxed the restrictions on a facility's ability to increase its bed size and square footage. Under the revised requirements that we adopted in the FY 2012 IRF PPS final rule in § 412.25(b), an IRF or IPF can change (either increase or decrease) its bed size or square footage one time at any point in a given cost reporting period as long as it notifies the CMS Regional Office at least 30 days before the date of the proposed change, and maintains the information needed to accurately determine costs that are attributable to the excluded units.

Similarly, in the case of the establishment of a new excluded IPF and IRF units, we do not believe that the timing of the establishment of the new unit is material for determining the individual facility's level of Medicare payment under the IRF PPS or IPF PPS. We believe it would be appropriate to allow a unit to become excluded at any time in the cost reporting year. However, we also believe it is important to minimize the potential administrative complexity associated with units changing their excluded status.

Accordingly, we amend the requirements currently in regulation at § 412.25(c)(1) to allow a hospital to open a new IRF unit anytime within the cost reporting year, as long as the hospital notifies the CMS Regional Office and Medicare Administrative Contractor (MAC) in writing of the change at least 30 days before the date of the change. Additionally, if a unit becomes excluded during a cost reporting year, this change would remain in effect for the rest of that cost reporting year. We maintain the current requirements of § 412.25(c)(2), which specify that, if an excluded unit becomes not excluded during a cost reporting year, the hospital must notify the MAC and the CMS Regional Office in writing of the change at least 30 days before the change, and this change would remain in effect for the rest of that cost reporting year.

Finally, we consolidate the requirements for § 412.25(c)(1) and § 412.25(c)(2) into a new § 412.25(c)(1) that would apply to IRF units and specify the requirements for an IRF unit to become excluded or not excluded.

We believe this will provide IRFs greater flexibility when establishing an excluded unit at a time other than the start of a cost reporting period.

As noted, we proposed an identical policy for inpatient psychiatric units of hospitals in § 412.25(c)(2) in the FY 2024 IPF PPS proposed rule.

We proposed discrete regulation text for each of the hospital unit types (that is, IRF units and IPF units) to solicit comment on issues that might affect one hospital unit type and not the other. However, we stated that we may consider adopting one consolidated regulation text for both IRF and IPF units in either the IRF or IPF final rules for both unit types if we finalize both of our proposals. We requested public comments on finalizing a consolidated provision that would pertain to both IRF and IPF units.

The following is a summary of the public comments received on finalizing a consolidated provision that would pertain to both IRF and IPF units and our responses.

Comment: Commenters expressed broad support for the revision to the excluded hospital unit regulation at § 412.25(c). Many commenters stated that amending the excluded unit regulation improves access to critical rehabilitative services. One commenter appreciated CMS' recognition that the prior policy at § 412.25(c) created burden and complexity when attempting to open a new IRF unit amid construction, State agencies and certificate of need constraints, sometimes resulting in missing the start of the new cost reporting period.

Response: We appreciate the commenters' support of the modification to the excluded unit regulation allowing the opening of a new IRF unit to occur at any time during the cost reporting period. We agree with the commenters that the proposed amendments to § 412.25(c) will reduce burden and complexity and make it easier to open a new IRF unit.

After consideration of the comments we received, we are finalizing the consolidated provision that pertains to both IRF and IPF units. The amendments to § 412.25(c) for this consolidated provision will be finalized in the IPF final rule published elsewhere in this issue of the **Federal Register**.

IX. Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP)

A. Background and Statutory Authority

The Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP) is authorized by section 1886(j)(7) of the Act, and it applies to freestanding IRFs, as well as inpatient rehabilitation units of hospitals or Critical Access Hospitals (CAHs) paid by Medicare under the IRF PPS. Section 1886(j)(7)(A)(i) of the Act requires the Secretary to reduce by 2 percentage points the annual increase factor for discharges occurring during a fiscal year (FY) for any IRF that does not submit data in accordance with the IRF QRP requirements set forth in subparagraphs (C) and (F) of section 1886(j)(7) of the Act. Section 1890A of the Act requires that the Secretary establish and follow a pre-rulemaking process, in coordination with the consensus-based entity (CBE) with a contract under section 1890 of the Act, to solicit input from certain groups regarding he selection of quality and efficiency measures for the IRF QRP. We have codified our program requirements in our regulations at § 412.634.

In the FY 2024 IRF PPS proposed rule, we proposed to adopt two new measures, remove three existing measures, and modify one existing measure. Second, we sought information on principles we could use to select and prioritize IRF QRP quality measures in future years. Third, we provided an update on our efforts to close the health equity gap. Finally, we proposed to begin public reporting of four measures.

B. General Considerations Used for the Selection of Measures for the IRF QRP

For a detailed discussion of the considerations we use for the selection of IRF QRP quality, resource use, or other measures, we refer readers to the FY 2016 IRF PPS final rule (80 FR 47083 through 47084).

1. Quality Measures Currently Adopted for the FY 2024 IRF QRP

The IRF QRP currently has 18 measures for the FY 2024 IRF QRP, which are listed in Table 17. For a discussion of the factors used to evaluate whether a measure should be removed from the IRF QRP, we refer readers to § 412.634(b)(2).

Short Name	Measure Name & Data Source
Inpatient Rehabilitation Facility – Patient Assessment Instrument (IRF-PAI) Assessment-Based Measures	
Pressure Ulcer/Injury	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury
Application of Falls	Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)
Application of Functional Assessment	Application of Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function
Change in Mobility	IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients
Discharge Mobility Score	IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients
Change in Self-Care	IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients
Discharge Self-Care Score	IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients
DRR	Drug Regimen Review Conducted With Follow-Up for Identified Issues–Post Acute Care (PAC) Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP)
TOH-Provider	Transfer of Health Information to the Provider–Post-Acute Care (PAC)
TOH-Patient	Transfer of Health Information to the Patient–Post-Acute Care (PAC)
NHSN	
CAUTI	National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection Outcome Measure
CDI	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset *Clostridium difficile* Infection (CDI) Outcome Measure
HCP Influenza Vaccine	Influenza Vaccination Coverage among Healthcare Personnel
HCP COVID-19 Vaccine	COVID-19 Vaccination Coverage among Healthcare Personnel (HCP)
Claims-Based	
MSPB IRF	Medicare Spending Per Beneficiary (MSPB)–Post Acute Care (PAC) IRF QRP
DTC	Discharge to Community–PAC IRF QRP
PPR 30 day	Potentially Preventable 30-Day Post-Discharge Readmission Measure for IRF QRP
PPR Within Stay	Potentially Preventable Within Stay Readmission Measure for IRFs

C. Overview of IRF QRP Quality Measure Proposals

In the FY 2024 IRF PPS proposed rule, we proposed to adopt two new measures, remove three existing measures, and modify one existing measure for the FY 2025 IRF QRP and the FY 2026 IRF QRP. Beginning with the FY 2025 IRF QRP we proposed to (1) modify the COVID–19 Vaccination Coverage among Healthcare Personnel (HCP) measure, (2) adopt the Discharge Function Score measure,[18] which we specified under sections 1886(j)(7)(F) and 1899B(c)(1) of the Act, and (3) remove three current measures: (i) the Application of Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function measure, (ii) the IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients measure, and (iii) the IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients measure.

We proposed to add one new measure beginning with the FY 2026 IRF QRP, the COVID–19 Vaccine: Percent of Patients/Residents Who Are Up to Date measure, which we are specifying under sections 1886(j)(7)(F) and 1899B(d)(1) of the Act.

1. IRF QRP Quality Measures Beginning With the FY 2025 IRF QRP

a. Modification of the COVID–19 Vaccination Coverage Among Healthcare Personnel (HCP) Measure Beginning With the FY 2025 IRF QRP

(1) Background

On January 31, 2020, the Secretary declared a public health emergency (PHE) for the United States in response to the global outbreak of SARS-CoV–2, a novel (new) coronavirus that causes ''coronavirus disease 2019'' (COVID–19).[19] Subsequently, in the FY 2022 IRF PPS final rule (86 FR 42385 through 42396), we adopted the COVID–19 Vaccination Coverage among Healthcare Personnel (HCP COVID–19 Vaccine)

[18] This measure was submitted to the Measures Under Consideration (MUC) List as the Cross-Setting Discharge Function Score. Subsequent to the MAP Workgroup meetings, the measure developer modified the name. Discharge Function Score for Inpatient Rehabilitation Facilities (IRFs) Technical Report. *https://www.cms.gov/files/document/irf-discharge-function-score-technical-report-february-2023.pdf.*

[19] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Preparedness and Response. Determination that a Public Health Emergency Exists. January 31, 2020. *https://aspr.hhs.gov/legal/PHE/Pages/2019-nCoV.aspx.*

measure for the IRF QRP. The HCP COVID–19 Vaccine measure requires each IRF to submit data on the number of healthcare personnel (HCP) eligible to work in the IRF for at least one day during the reporting period, excluding persons with contraindications to the COVID–19 vaccine, who have received a complete vaccination course against SARS-CoV–2 (86 FR 42389 through 42396).

Since that time, COVID–19 has continued to spread domestically and around the world with more than 103.8 million cases and 1.1 million deaths in the United States as of March 21, 2023.[20] In recognition of the ongoing significance and complexity of COVID–19, the Secretary has renewed the PHE on April 21, 2020, July 23, 2020, October 2, 2020, January 7, 2021, April 15, 2021, July 19, 2021, October 15, 2021, January 14, 2022, April 12, 2022, July 15, 2022, October 13, 2022, January 11, 2023, and February 9, 2023.[21] The Department of Health and Human Services (HHS) let the PHE expire on May 11, 2023. However, HHS stated that the public health response to COVID–19 remains a public health priority with a whole-of-government approach to combatting the virus, including through vaccination efforts.[22]

In the FY 2022 IRF PPS final rule (86 FR 42386 through 42396) and in the Revised Guidance for Staff Vaccination Requirements,[23] we stated that vaccination is a critical part of the nation's strategy to effectively counter the spread of COVID–19. We continue to believe it is important to incentivize and track HCP vaccination in IRFs through quality measurement in order to protect healthcare workers, patients, and caregivers, and to help sustain the ability of IRFs to continue serving their communities after the PHE. At the time we issued the FY 2022 IRF PPS final rule where we adopted the HCP COVID–19 Vaccine measure, the Food and Drug Administration (FDA) had issued emergency use authorizations (EUAs) for COVID–19 vaccines manufactured by Pfizer-BioNTech,[24] Moderna,[25] and Janssen.[26] The populations for which all three vaccines were authorized at that time included individuals 18 years of age and older. Shortly following the publication of the FY 2022 IRF PPS final rule on August 23, 2021, the FDA issued an approval for the Pfizer-BioNTech vaccine, marketed as Comirnaty.[27] The FDA issued approval for the Moderna vaccine, marketed as Spikevax, on January 31, 2022 [28] and an EUA for the Novavax vaccine, on July 13, 2022.[29] The FDA also issued EUAs for single booster doses of the then authorized COVID–19 vaccines. As of November 19, 2021,[30] [31] [32] a single booster dose of each COVID–19 vaccine was authorized for all eligible individuals 18 years of age and older. EUAs were subsequently issued for a second booster dose of the Pfizer-BioNTech and Moderna vaccines in certain populations in March 2022.[33] The FDA first authorized the use of a booster dose of bivalent or ''updated'' COVID–19 vaccines from Pfizer-BioNTech and Moderna in August 2022.[34]

(a) Measure Importance

In the FY 2022 IRF PPS final rule (86 FR 42401), we acknowledged that we were still learning how effective the vaccines were against new variants of the virus that cause COVID–19. While the impact of COVID–19 vaccines on asymptomatic infection and transmission is not yet fully known, there are now robust data available across multiple populations on COVID–19 vaccine effectiveness against severe illness, hospitalization, and death. Two-dose COVID–19 vaccines from Pfizer-BioNTech and Moderna were found to be 88 percent and 93 percent effective against hospitalization for COVID–19, respectively, over 6 months for adults over age 18 without immunocompromising conditions.[35] During a SARS-CoV–2 surge in the spring and summer of 2021, 92 percent of COVID–19 hospitalizations and 91 percent of COVID–19-associated deaths were reported among persons not fully vaccinated.[36] Real-world studies of population-level vaccine effectiveness indicated similarly high rates of efficacy

[20] Centers for Disease Control and Prevention. COVID Data Tracker. March 21, 2023. *https://covid.cdc.gov/covid-data-tracker/#datatracker-home.*

[21] U.S. Department of Health and Human Services. Office of the Assistant Secretary for Preparedness and Response. Renewal of Determination that a Public Health Emergency Exists. February 9, 2023. *https://aspr.hhs.gov/legal/PHE/Pages/COVID19-9Feb2023.aspx.*

[22] U.S. Department of Health and Human Services. Fact Sheet: COVID–19 Public Health Emergency Transition Roadmap. February 9, 2023. *https://www.hhs.gov/about/news/2023/02/09/fact-sheet-covid-19-public-health-emergency-transition-roadmap.html.*

[23] Centers for Medicare & Medicaid Services. Revised Guidance for Staff Vaccination Requirements QSO–23–02–ALL. October 26, 2022. *https://www.cms.gov/files/document/qs0-23-02-all.pdf.*

[24] Food and Drug Administration. FDA Takes Key Action in Fight Against COVID–19 By Issuing Emergency Use Authorization for First COVID–19 Vaccine. December 11, 2020. *https://www.fda.gov/news-events/press-announcements/fda-takes-key-action-fight-against-covid-19-issuing-emergency-use-authorization-first-covid-19.*

[25] Food and Drug Administration. FDA Takes Additional Action in Fight Against COVID–19 By Issuing Emergency Use Authorization for Second COVID–19 Vaccine. December 18, 2020. *https://www.fda.gov/news-events/press-announcements/fda-takes-additional-action-fight-against-covid-19-issuing-emergency-use-authorization-second-covid.*

[26] Food and Drug Administration. FDA Issues Emergency Use Authorization for Third COVID–19 Vaccine. February 27, 2021. *https://www.fda.gov/news-events/press-announcements/fda-issues-emergency-use-authorization-third-covid-19-vaccine.*

[27] Food and Drug Administration. FDA Approves First COVID–19 Vaccine. August 23, 2021. *https://www.fda.gov/news-events/press-announcements/fda-approves-first-covid-19-vaccine.*

[28] Food and Drug Administration. Coronavirus (COVID–19) Update: FDA Takes Key Action by Approving Second COVID–19 Vaccine. January 21, 2022. *https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-takes-key-action-approving-second-covid-19-vaccine.*

[29] Food and Drug Administration. Coronavirus (COVID–19) Update: FDA Authorizes Emergency Use of Novavax COVID–19 Vaccine, Adjuvanted. July 13, 2022. *https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-authorizes-emergency-use-novavax-covid-19-vaccine-adjuvanted.*

[30] Food and Drug Administration. FDA Authorizes Booster Dose of Pfizer-BioNTech COVID–19 Vaccine for Certain Populations. September 22, 2021. *https://www.fda.gov/news-events/press-announcements/fda-authorizes-booster-dose-pfizer-biontech-covid-19-vaccine-certain-populations.*

[31] Food and Drug Administration. Coronavirus (COVID–19) Update: FDA Takes Additional Actions on the Use of a Booster Dose for COVID–19 Vaccines. October 20, 2021. *https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-takes-additional-actions-use-booster-dose-covid-19-vaccines.*

[32] Food and Drug Administration. Coronavirus (COVID–19) Update: FDA Expands Eligibility for COVID–19 Vaccine Boosters. November 19, 2021. *https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-expands-eligibility-covid-19-vaccine-boosters.*

[33] Food and Drug Administration. Coronavirus (COVID–19) Update: FDA Authorizes Second Booster Dose of Two COVID–19 Vaccines for Older and Immunocompromised Individuals. March 29, 2022. *https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-authorizes-second-booster-dose-two-covid-19-vaccines-older-and.*

[34] Food and Drug Administration. (August 2022). Coronavirus (COVID–19) Update: FDA Authorizes Moderna, Pfizer-BioNTech Bivalent COVID–19 Vaccines for Use as a Booster Dose. *https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-authorizes-moderna-pfizer-biontech-bivalent-covid-19-vaccines-use.*

[35] Self WH, Tenforde MW, Rhoads JP, et al. Comparative Effectiveness of Moderna, Pfizer-BioNTech, and Janssen (Johnson & Johnson) Vaccines in Preventing COVID–19 Hospitalizations Among Adults Without Immunocompromising Conditions—United States, March-August 2021. MMWR Morb Mortal Wkly Rep 2021;70:1337–1343. doi: 10.15585/mmwr.mm7038e1. *https://cdc.gov/mmwr/volumes/70/wr/mm7038e1.htm?s_cid=mm7038e1_w.*

[36] Scobie HM, Johnson AG, Suthar AB, et al. Monitoring Incidence of COVID–19 Cases, Hospitalizations, and Deaths, by Vaccination Status—13 U.S. Jurisdictions, April 4-July 17, 2021. MMWR Morb Mortal Wkly Rep 2021;70:1284–1290. doi: 10.15585/mmwr.mm7037e1. *https://www.cdc.gov/mmwr/volumes/70/wr/mm7037e1.htm.*

in preventing SARS-CoV–2 infection among frontline workers in multiple industries, with a 90 percent effectiveness in preventing symptomatic and asymptomatic infection from December 2020 through August 2021.[37] Vaccines have also been highly effective in real-world conditions at preventing COVID–19 in HCP with up to 96 percent efficacy for fully vaccinated HCP, including those at risk for severe infection and those in racial and ethnic groups disproportionately affected by COVID–19.[38] Overall, data demonstrate that COVID–19 vaccines are effective and prevent severe disease, hospitalization, and death.

As SARS-CoV–2 persists and evolves, our COVID–19 vaccination strategy must remain responsive. When we adopted the HCP COVID–19 Vaccine measure in the FY 2022 IRF PPS final rule, we stated that the need for additional/booster doses of COVID–19 vaccines had not been established and no additional doses had been recommended (86 FR 42390). We also stated that we believed the numerator was sufficiently broad to include potential future additional/booster doses as part of a ''complete vaccination course'' and that the measure was sufficiently specified to address boosters (86 FR 42390). Since we adopted the HCP COVID–19 Vaccine measure in the FY 2022 IRF PPS final rule, new variants of SARS-CoV–2 have emerged around the world and within the United States. Specifically, the Omicron variant (and its related subvariants) is listed as a variant of concern by the Centers for Disease Control and Prevention (CDC) because it spreads more easily than earlier variants.[39] Vaccine manufacturers have responded to the Omicron variant by developing bivalent COVID–19 vaccines, which include a component of the original virus strain, to provide broad protection against COVID–19 and a component of the Omicron variant, to provide better protection against COVID–19 caused by the Omicron variant.[40] These booster doses of the bivalent COVID–19 vaccines have been shown to increase immune response to SARS-CoV–2 variants, including Omicron, particularly in individuals that are more than 6 months removed from receipt of their primary series.[41] The FDA issued EUAs for booster doses of two bivalent COVID–19 vaccines, one from Pfizer-BioNTech [42] and one from Moderna [43] and strongly encourages anyone who is eligible to consider receiving a booster dose with a bivalent COVID–19 vaccine to provide better protection against currently circulating variants.[44] COVID–19 booster doses are associated with a greater reduction in infections among HCP relative to those who only received primary series vaccination, with a rate of breakthrough infections among HCP who received only a two-dose regimen of 21.4 percent compared to a rate of 0.7 percent among HCP who received booster doses of the COVID–19 vaccine.[45] [46]

We believe that vaccination remains the most effective means to prevent the severe consequences of COVID–19, including severe illness, hospitalization, and death. Given the availability of vaccine efficacy data, EUAs issued by the FDA for bivalent boosters, the continued presence of SARS-CoV–2 in the United States, and variance among rates of booster dose vaccination, it is important to update the specifications of the HCP COVID–19 Vaccine measure to refer to HCP who receive primary series and additional/booster doses in a timely manner. Given the persistent spread of COVID–19, we continue to believe that monitoring and surveillance of vaccination rates among HCP is important and provides patients, beneficiaries, and their caregivers with information to support informed decision making. We proposed to modify the HCP COVID–19 Vaccine measure to replace the term ''complete vaccination course'' with the term ''up to date'' in the HCP vaccination definition. We also proposed to update the numerator to specify the time frames within which an HCP is considered up to date with recommended COVID–19 vaccines, including additional/booster doses, beginning with the FY 2025 IRF QRP.

(b) Measure Testing

The CDC conducted beta testing of the proposed modified HCP COVID–19 Vaccine measure by assessing if the collection of information on additional/booster doses received by HCP was feasible, as information on receipt of additional/booster doses is required for determining if HCP are up to date with the current COVID–19 vaccination recommendations. Feasibility was assessed by calculating the proportion of facilities that reported additional/booster doses of the COVID–19 vaccine. The assessment was conducted in various facility types, including IRFs, using vaccine coverage data for the first quarter of calendar year (CY) 2022 (January–March), which was reported through the CDC's National Healthcare Safety Network (NHSN). Feasibility of reporting additional/booster doses is evident by the fact that 63.9 percent of IRFs reported vaccination additional/booster dose coverage data to the NHSN for the first quarter of 2022.[47] Additionally, HCP COVID–19 Vaccine measure scores calculated using January 1–March 31, 2022 data had a median of 20.3 percent and an interquartile range of 8.9 to 37.7 percent, indicating a measure performance gap as there are clinically significant differences in

[37] Fowlkes A, Gaglani M, Groover K, et al. Effectiveness of COVID–19 Vaccines in Preventing SARS-CoV–2 Infection Among Frontline Workers Before and During B.1.617.2 (Delta) Variant Predominance—Eight U.S. Locations, December 2020-August 2021. MMWR Morb Mortal Wkly Rep 2021;70:1167–1169. doi: 10.15585/mmwr.mm7034e4. *https://www.cdc.gov/mmwr/volumes/70/wr/mm7034e4.htm.*

[38] Pilishvili T, Gierke R, Fleming-Dutra KE, et al. Effectiveness of mRNA Covid–19 Vaccine among U.S. Health Care Personnel. N Engl J Med. 2021 Dec 16;385(25):e90. doi: 10.1056/NEJMoa2106599. PMID: 34551224; PMCID: PMC8482809. *https://pubmed.ncbi.nlm.nih.gov/34551224/.*

[39] Centers for Disease Control and Prevention. COVID–19: Variants. *https://www.cdc.gov/coronavirus/2019-ncov/variants/index.html.*

[40] Food and Drug Administration. COVID–19 Bivalent Vaccines. *https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/covid-19-bivalent-vaccines.*

[41] Chalkias S, Harper C, Vrbicky K, et al. A Bivalent Omicron-Containing Booster Vaccine Against COVID–19. N Engl J Med. 2022 Oct 6;387(14):1279–1291. doi: 10.1056/NEJMoa2208343. PMID: 36112399; PMCID: PMC9511634.

[42] Food and Drug Administration. Pfizer-BioNTech COVID–19 Vaccines. *https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/pfizer-biontech-covid-19-vaccines.*

[43] Food and Drug Administration. Moderna COVID–19 Vaccines. *https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/moderna-covid-19-vaccines.*

[44] Food and Drug Administration. Coronavirus (COVID–19) Update: FDA Authorizes Moderna, Pfizer-BioNTech Bivalent COVID–19 Vaccines for Use as a Booster Dose. August 31, 2022. *https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-authorizes-moderna-pfizer-biontech-bivalent-covid-19-vaccines-use.*

[45] Oster Y, Benenson S, Nir-Paz R, Buda I, Cohen MJ. The effect of a third BNT162b2 vaccine on breakthrough infections in health care workers: a cohort analysis. Clin Microbiol Infect. 2022 May;28(5):735.e1–735.e3. *https://pubmed.ncbi.nlm.nih.gov/35143997/.*

[46] Prasad N, Derado G, Acharya Nanduri S, et al. Effectiveness of a COVID–19 Additional Primary or Booster Vaccine Dose in Preventing SARS-CoV–2 Infection Among Nursing Home Residents During Widespread Circulation of the Omicron Variant—United States, February 14–March 27, 2022. MMWR Morb Mortal Wkly Rep. 2022 May 6;71(18):633–637. doi: 10.1016/j.cmi.2022.01.019. PMID: 35143997; PMCID: PMC8820100.

[47] National Quality Forum. Measure Applications Partnership (MAP) Post-Acute Care/Long-Term Care: 2022–2023 Measures Under Consideration (MUC) Cycle Measure Specifications. December 1, 2022. *https://mmshub.cms.gov/sites/default/files/map-pac-muc-measure-specifications-2022-2023.pdf.*

additional/booster dose vaccination coverage rates among IRFs.[48]

(2) Competing and Related Measures

Section 1886(j)(7)(D)(i) of the Act and section 1899B(e)(2)(A) of the Act require that, absent an exception under section 1886(j)(7)(D)(i) and section 1899B(e)(2)(B) of the Act, measures specified under section 1899B of the Act must be endorsed by a CBE with a contract under section 1890(a) of the Act. In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed, section 1886(j)(7)(D)(i) of the Act and section 1899B(e)(2)(B) of the Act permit the Secretary to specify a measure that is not so endorsed, as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

The current version of the HCP COVID–19 Vaccine measure recently received endorsement by the CBE on July 26, 2022 under the name ''Quarterly Reporting of COVID–19 Vaccination Coverage Among Healthcare Personnel.'' [49] However, this measure received endorsement based on its specifications depicted in the FY 2022 IRF PPS final rule (86 FR 42386 through 42396) and does not capture information about whether HCP are up to date with their COVID–19 vaccinations. The proposed modification of this measure utilizes the term up to date in the HCP vaccination definition and updates the numerator to specify the time frames within which an HCP is considered up to date with recommended COVID–19 vaccines. We were unable to identify any measures endorsed or adopted by a consensus organization for IRFs that captured information on whether HCP are up to date with their COVID–19 vaccinations, and we found no other feasible and practical measure on this topic.

Therefore, after consideration of other available measures, we found that the exception under sections 1886(j)(7)(D)(ii) and 1899B(e)(2)(B) of the Act applies and proposed the modified measure, HCP COVID–19 Vaccine beginning with the FY 2025 IRF QRP. The CDC, the measure developer, is pursuing CBE endorsement for the modified version of the measure and is considering an expedited review process as the current version of the measure has already received endorsement.

(3) Measure Applications Partnership (MAP) Review

We refer readers to the FY 2022 IRF PPS final rule (86 FR 42387 through 42388) for more information on the initial review of the HCP COVID–19 Vaccine measure by the Measure Applications Partnership (MAP).

The pre-rulemaking process includes making publicly available a list of quality and efficiency measures, called the Measures Under Consideration (MUC) List, that the Secretary is considering adopting for use in the Medicare program, including our quality reporting programs. This allows interested parties to provide recommendations to the Secretary on the measures included on the list. We included an updated version of the HCP COVID–19 Vaccine measure on the MUC List, entitled ''List of Measures under Consideration for December 1, 2022'' [50] for the 2022–2023 pre-rulemaking cycle for consideration by the MAP. Interested parties submitted three comments during the pre-rulemaking process on the proposed modifications of the HCP COVID–19 Vaccine measure, and support was mixed. One commenter noted the importance for HCP to be vaccinated against COVID–19 and supported measurement and reporting as an important strategy to help healthcare organizations assess their performance in achieving high rates of up to date vaccination of their HCP, while also noting that the measure would provide valuable information to the government as part of its ongoing response to the pandemic. This commenter also recommended the measure be used for internal quality improvement purposes rather than being publicly reported on Care Compare. Finally, this commenter also suggested that the measure should be stratified by social risk factors. However, two commenters supported less specific criteria for denominator and numerator inclusion. Specifically, one such commenter did not support the inclusion of unpaid volunteers in the measure denominator and found the measure's denominator to be unclear. Two commenters expressed concerns regarding burden of data collection, data lag, staffing challenges, and reportedly ''high rates of providers contesting penalties tied to the existing HCP COVID–19 Vaccine measure adopted in the FY 2022 IRF PPS final rule.'' One commenter recommended that the measure be recharacterized as a surveillance measure given what they referred to as a tenuous relationship between collected data and quality of care provided by IRFs. Finally, all three commenters raised concern about the difficulty of defining up to date for purposes of the measure.

Shortly after publication of the MUC List, several MAP workgroups met to provide input on the modification we proposed for the current HCP COVID–19 Vaccine measure. First, the MAP Health Equity Advisory Group convened on December 6–7, 2022. The MAP Health Equity Advisory Group questioned whether the measure excludes patients with contraindications to FDA authorized or approved COVID–19 vaccines, and whether the measure will be stratified by demographic factors. The measure developer (that is, the CDC) confirmed that HCP with contraindications to the vaccines are excluded from the measure denominator and responded that the measure will not be stratified by demographic factors since the data are submitted at an aggregate rather than an individual level.

The MAP Rural Health Advisory Group met on December 8–9, 2022, during which a few members expressed concerns about data collection burden, given that small rural hospitals may not have employee health software. The measure developer acknowledged the challenge of getting adequate documentation and emphasized their goal is to ensure the measures do not present a burden on the provider. The measure developer also noted that the model used for the HCP COVID–19 Vaccine measure is based on the Influenza Vaccination Coverage among HCP measure (CBE #0431), and it intends to utilize a similar approach to the modified HCP COVID–19 Vaccine measure if vaccination strategy becomes seasonal. The measure developer acknowledged that if COVID–19 becomes seasonal, the measure model could evolve to capture seasonal vaccination.

Next, the MAP Post-Acute Care/Long-Term Care (PAC/LTC) workgroup met on December 12, 2022, and provided input on the modification we proposed for the HCP COVID–19 Vaccine measure. The MAP PAC/LTC workgroup noted that the previous version of the measure received endorsement from the CBE (CBE

[48] National Quality Forum. Measure Applications Partnership (MAP) Post-Acute Care/Long-Term Care: 2022–2023 Measures Under Consideration (MUC) Cycle Measure Specifications. December 1, 2022. *https://mmshub.cms.gov/sites/default/files/map-pac-muc-measure-specifications-2022-2023.pdf.*

[49] Partnership for Quality Measurement. Quarterly Reporting of COVID–19 Vaccination Coverage among Healthcare Personnel. July 26, 2022. *https://p4qm.org/measures/3636.*

[50] Centers for Medicare & Medicaid Services. Overview of the List of Measures Under Consideration for December 1, 2022. *CMS.gov. https://mmshub.cms.gov/sites/default/files/2022-MUC-List-Overview.pdf.*

#3636),[51] and that the CDC intends to submit the updated measure for endorsement. The PAC/LTC workgroup voted to support the staff recommendation of conditional support for rulemaking pending testing indicating the measure is reliable and valid, and endorsement by the CBE.

Following the PAC/LTC workgroup meeting, a public comment period was held in which interested parties commented on the PAC/LTC workgroup's preliminary recommendations, and the MAP received three comments. Two supported the proposed modification of the HCP COVID–19 Vaccine measure, one of which strongly supported the vaccination of HCP against COVID–19. Although these commenters supported the measure, one commenter recommended seeking CBE[52] endorsement for the updated measure and encouraged CMS to monitor any unintended consequences from the measure. Two commenters raised concerns with the measure's specifications. Specifically, one noted the denominator included a broad number of HCP, and another recommended a vaccination exclusion or exception for sincerely held religious beliefs. Finally, one commenter raised issues related to the time lag between data collection and public reporting on Care Compare and encouraged CMS to provide information as to whether the measure is reflecting vaccination rates accurately and encouraging HCP vaccination.

The MAP Coordinating Committee convened on January 24–25, 2023, during which the proposed measure was placed on the consent calendar and received a final recommendation of conditional support for rulemaking pending testing indicating the measure is reliable and valid, and endorsement by the CBE. We refer readers to the final MAP recommendations, titled *2022–2023 MAP Final Recommendations.*[53]

(4) Quality Measure Calculation

The HCP COVID–19 Vaccine measure is a process measure developed by the CDC to track COVID–19 vaccination coverage among HCP in facilities such as IRFs. The HCP COVID–19 Vaccine measure is a process measure and is not risk-adjusted.

The denominator would be the number of HCP eligible to work in the facility for at least one day during the reporting period, excluding persons with contraindications to COVID–19 vaccination that are described by the CDC.[54] We believe it is necessary to allow IRFs to include all HCP within the facility in the reporting because all HCP would have access to and may interact with IRF patients. IRFs report the following four categories of HCP to NHSN; the first three are included in the measure denominator:

- *Employees:* Includes all persons who receive a direct paycheck from the reporting facility (that is, on the facility's payroll), regardless of clinical responsibility or patient contact.
- *Licensed independent practitioners (LIPs):* This includes physicians (MD, DO), advanced practice nurses, and physician assistants only who are affiliated with the reporting facility but are not directly employed by it (that is, they do not receive a direct paycheck from the facility), regardless of clinical responsibility or patient contact. Post-residency fellows are also included in this category if they are not on the facility's payroll.
- *Adult students/trainees and volunteers:* This includes all medical, nursing, or other health professional, students, interns, medical residents and volunteers aged 18 or over who are affiliated with the healthcare facility, but are not directly employed by it (that is, they do not receive a direct paycheck from the facility) regardless of clinical responsibility or patient contact.
- *Other contract personnel:* Contract personnel are defined as persons providing care, treatment, or services at the facility through a contract who do not fall into any of the above-mentioned denominator categories. This also includes vendors providing care, treatment, or services at the facility who may or may not be paid through a contract. Facilities are required to enter data on other contract personnel for submission in the NHSN application, but data for this category are not included in the HCP COVID–19 Vaccine measure.

The denominator excludes denominator-eligible individuals with contraindications as defined by the CDC.[55] We did not propose any changes to the denominator exclusions.

The numerator would be the cumulative number of HCP in the denominator population who are considered up to date with CDC-recommended COVID–19 vaccines. Providers would refer to the definition of up to date as of the first day of the quarter, which can be found at *https://www.cdc.gov/nhsn/pdfs/hps/covidvax/UpToDateGuidance-508.pdf.* For the purposes of NHSN surveillance, individuals would have been considered up to date during the Quarter 4 CY 2022 reporting period (surveillance period September 26, 2022—December 25, 2022) for the IRF QRP if they meet one of the following criteria in place at the time:

1. Individuals who received an updated bivalent[56] booster dose, or

2a. Individuals who received their last booster dose less than 2 months ago, or

2b. Individuals who completed their primary series[57] less than 2 months ago.

We refer readers to *https://www.cdc.gov/nhsn/pdfs/nqf/covid-vax-hcpcoverage-rev-2023-508.pdf* for more details on the measure specifications.[58]

While we did not propose any changes to the data submission or reporting process for the HCP COVID–19 Vaccine measure, we proposed that for purposes of meeting FY 2025 IRF QRP compliance, IRFs would report HCP who are up to date beginning in quarter four of CY 2023. Under the data submission and reporting process, IRFs would collect the numerator and denominator for the modified HCP COVID–19 Vaccine measure for at least one self-selected week during each month of the reporting quarter. IRFs would submit the data to the NHSN Healthcare Personnel Safety (HPS) Component before the quarterly deadline. If an IRF submits more than 1 week of data in a month, the CDC would use the most recent week's data to

[51] Partnership for Quality Measurement. Quarterly Reporting of COVID–19 Vaccination Coverage among Healthcare Personnel. July 26, 2022. *https://p4qm.org/measures/3636.*

[52] We emphasize that any references to NQF in the proposed rule were intended to refer to the CBE contracted by CMS at that time.

[53] 1 Measure Applications Partnership. 2022–2023 MAP Final Recommendations. *https://mmshub.cms.gov/sites/default/files/2022-2023-MAP-Final-Recommendations-508.xlsx.*

[54] Centers for Disease Control and Prevention. Contraindications and precautions. *https://www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us.html#contraindications.*

[55] Centers for Disease Control and Prevention. Contraindications and precautions. *https://www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us.html#contraindications.*

[56] The updated (bivalent) Moderna and Pfizer-BioNTech boosters target the most recent Omicron subvariants. The updated (bivalent) boosters were recommended by the CDC on September 2, 2022. As of this date, the original, monovalent mRNA vaccines are no longer authorized as a booster dose for people ages 12 years and older.

[57] Completing a primary series means receiving a two-dose series of a COVID–19 vaccine or a single dose of Janssen/J&J COVID–19 vaccine.

[58] We highlight that the hyperlink included in the FY 2024 IRF PPS proposed rule has been retired as the CDC has uploaded a new measure specification document to the NHSN. Therefore, the hyperlink has been updated in this FY 2024 IRF PPS final rule.

calculate the measure. Each quarter, the CDC would calculate a single quarterly COVID–19 HCP vaccination coverage rate for each IRF, which would be calculated by taking the average of the data from the three weekly rates submitted by the IRF for that quarter. Beginning with the FY 2026 IRF QRP, we proposed that IRFs would be required to submit data for the entire calendar year.

We also proposed that public reporting of the modified version of the HCP COVID–19 Vaccine measure would begin by the September 2024 Care Compare refresh or as soon as technically feasible.

We invited public comment on our proposal to modify the HCP COVID–19 Vaccine measure beginning with the FY 2025 IRF QRP. The following is a summary of the comments we received on our proposal to modify the HCP COVID–19 Vaccine measure beginning with the FY 2025 IRF QRP and our responses.

Comment: Several commenters supported our proposal to modify the numerator definition for the HCP COVID–19 Vaccine measure and to update the numerator to specify the time frames within which an HCP is considered up to date with recommended COVID–19 vaccines. One of these commenters said they continue to believe COVID–19 vaccination among HCP in all healthcare settings is the most effective infection prevention tool to protect staff, patients, and visitors against severe illness, hospitalization, and death. Another one of these commenters stated they recognized that vaccinations play a critical role in the nation's strategy to counter the spread of COVID–19, but still encouraged CMS to continue to monitor the measure.

Response: We thank the commenters for their support. We agree that vaccination is a critical part of the nation's strategy to effectively counter the spread of COVID–19. We continue to believe it is important to incentivize and track HCP vaccination through quality measurement across care settings, including IRFs, in order to protect HCP, patients, and caregivers, and to help sustain the ability of HCP in each of these care settings to continue serving their communities. We will continue to monitor all measures to identify any concerning trends as part of our routine monitoring activities to regularly assess measure performance, reliability, and reportability for all data submitted for the IRF QRP.

Comment: Several commenters were concerned that the measure has not undergone full reliability and validity testing, and they believe the CBE endorsement process will allow a full evaluation of a range of issues affecting measure reliability, accuracy, and feasibility. Two of these commenters, however, stated that the current version of the HCP COVID–19 Vaccine measure has not had a holistic evaluation to determine whether it is working as intended since it never went through a CBE endorsement process and is relatively new to the CMS quality reporting programs.

Response: We refer commenters to section IX.C.1.a.2. of this final rule where we point out that the current version of the HCP COVID–19 Vaccine measure received endorsement by the CBE on July 26, 2022, under the name ''Quarterly Reporting of COVID–19 Vaccination Coverage among Healthcare Personnel.'' [59] However, this measure received endorsement based on its specifications in the FY 2022 IRF PPS final rule (86 FR 42386 through 42396). Even though the current, endorsed version does not capture information about whether HCP are up to date with their COVID–19 vaccinations, we believe its endorsement speaks to the quality of the measure design as we proposed that many components of the measure remain intact in this modified version. Since we were unable to identify any CBE-endorsed measures for IRFs that captured information on whether HCP are up to date with their COVID–19 vaccinations, and we found no other feasible and practical measure on this topic, we find the modification to the HCP COVID–19 Vaccine measure reasonable for IRF QRP adoption and implementation. The CDC, the measure developer, is pursuing CBE endorsement for the modified version of the measure.

In terms of measure testing, as mentioned in section IX.C.1.a.1.b. of this final rule, we reiterate that the CDC conducted beta testing of the modified HCP COVID–19 Vaccine measure and concluded that the collection of information on additional/booster doses received by HCP was feasible with 63.9 percent of IRFs reported vaccination additional/booster dose coverage data to the NHSN for the first quarter of 2022. Additionally, the measure score displayed a performance gap indicating clinically significant differences in additional/booster dose vaccination coverage rates among IRFs. We will continue to monitor all our measures to identify any concerning trends as part of our routine monitoring activities to regularly assess measure performance, reliability, and reportability for all data submitted for the IRF QRP.

Comment: Several commenters opposed the proposed modifications to the HCP COVID–19 Vaccine measure. The most frequently cited reasons were that the COVID–19 PHE ended on May 11, 2023, and subsequently CMS removed the staff vaccination requirement under the Hospital Conditions of Participation (CoP) at § 482.42(g) established by the Omnibus COVID–19 Health Care Staff Vaccination Interim Final Rule (86 FR 61555). Two of these commenters questioned why the HCP COVID–19 Vaccine measure would still be used as a metric for quality of care in the IRF QRP at the same time CMS is removing the requirement that covered providers and suppliers establish policies and procedures for staff vaccination for COVID–19 and removing the COVID–19 vaccination requirements from the hospital conditions of participation. One of these commenters suggested that if CMS plans to require providers report staff vaccination status, it would be more appropriate to implement the requirement through the CoPs rather than the IRF QRP. One of these commenters highlighted that facilities will no longer have any Federal authority to require staff to receive any COVID–19 vaccines and demand vaccination status from staff. One commenter suggested the proposed revision to the measure would be inconsistent with Federal and State mandates which require only a primary vaccination series, and since the PHE is ending, many (if not all) of these mandates are being lifted. They point out that the Federal and State mandates did not extend the HCP vaccination requirement to include the bivalent booster or any other booster. Given the Administration's announcement that the COVID–19 PHE has ended, they believe the need for HCP to be up to date with vaccinations will be diminished, and the benefit of this measure may be compromised.

Response: We appreciate the commenters' feedback, but disagree. We continue to believe that it is important to measure vaccination status regardless of whether the COVID–19 PHE is in effect. We also believe this measure continues to align with our goals to promote wellness and disease prevention. Under CMS' Meaningful Measures Framework 2.0, the HCP COVID–19 Vaccine measure addresses the quality priorities of ''Immunizations'' and ''Public Health'' through the Meaningful Measures Area

[59] Partnership for Quality Measurement. Quarterly Reporting of COVID–19 Vaccination Coverage among Healthcare Personnel. July 26, 2022. *https://p4qm.org/measures/3636.*

of ''Wellness and Prevention.'' [60] Under the National Quality Strategy, the measure addresses the goal of Safety under the priority area Safety and Resiliency.[61] While we removed vaccination requirements from the Hospital CoP at the end of the PHE as discussed previously, we note that the reporting requirements of the IRF QRP for the proposed modified version of the HCP COVID–19 Vaccine measure are distinct from those cited by the commenter. Specifically, the IRF QRP is a pay-for-reporting program, and therefore the inclusion of this measure does not require that HCP actually receive these additional/booster vaccine doses. The Administration's continued response to COVID–19 is not fully dependent on the emergency declaration for the COVID–19 PHE, and even beyond the end of the COVID–19 PHE, we will continue to work to protect individuals and communities from the virus and its worst impacts by supporting access to COVID–19 vaccines, treatments, and tests.[62]

Comment: One commenter requested that CMS clarify whether the elimination of vaccine ''mandates'' will impact the adoption or use of the proposed HCP COVID–19 Vaccine measure.

Response: We clarify that the vaccination requirements under § 482.42(g) (which have now been lifted), are separate from IRF QRP requirements to report HCP COVID–19 vaccination data. Even though the PHE has ended and vaccination requirements have been lifted, CMS intends to encourage ongoing COVID–19 vaccination through use of its quality reporting programs (88 FR 36487). One way to encourage patient safety and COVID–19 vaccination is through adoption of the modified up to date numerator definition of the HCP COVID–19 Vaccine measure. Despite the White House's announcement,[63] the IRF QRP still requires data submission of the HCP COVID–19 Vaccine measure to the NHSN for IRFs to remain in compliance with the IRF QRP. However, since the IRF QRP is a pay-for-reporting program, HCP COVID–19 vaccination is not mandated by this measure.

Comment: A number of commenters expressed concerns with the evolving nature of the measure's up to date numerator definition, and believe that the reliability and validity of the measure may be negatively impacted if the up to date definition were to change frequently. Several of these commenters raised concerns with the potential inaccuracy of the measure since the term up to date could be revised between reporting periods or in the middle of a reporting period. One of these commenters suggested the definition will quickly and frequently become outdated, and another commenter believes the science is still emerging and it is too soon to adopt a revised definition for the HCP COVID–19 vaccine. Finally, several commenters believed that the current specifications are flawed given the lack of a stable definition of the up to date numerator definition.

Response: We recognize that the up to date COVID–19 vaccination definition may evolve due to the changing nature of the virus. Since the adoption of the current version of the measure, the public health response to COVID–19 has necessarily adapted to respond to the changing nature of the virus's transmission and community spread. As mentioned in the FY 2022 IRF PPS final rule (86 FR 42362), we received several public comments during the current measure's pre-rulemaking process encouraging us to continue to update the measure as new evidence on COVID–19 continues to arise and we stated our intention to continue to work with partners including FDA and CDC to consider any updates to the measure in future rulemaking as appropriate. We believe that the proposed modification to this measure aligns with our responsive approach to COVID–19 and will continue to support vaccination as the most effective means to prevent the worst consequences of COVID–19, including severe illness, hospitalization, and death.

In response to the commenter's concerns that the up to date numerator definition may evolve, we refer commenters to section IX.C.1.a.4. of this final rule where we explained that providers would refer to the definition of up to date as the first day of the quarter, which can be found at the following CDC NHSN web page: *https://www.cdc.gov/nhsn/pdfs/hps/covidvax/UpToDateGuidance-508.pdf.* The CDC notes that this aforementioned document will be updated quarterly to reflect any changes as COVID–19 guidance evolves, and notes that providers should use the definitions for the reporting period associated with the reporting weeks included in data submission. At the beginning of each reporting period and before collecting or submitting data on this modified measure, IRFs must refer to the aforementioned document to determine the then-applicable definition of up to date to apply when collecting data on the vaccination status of HCP for that quarterly reporting period. As such, the up to date vaccination definition during a particular reporting period would not change, and each provider will be measured against the same criteria within the same quarter. If the requirements do change from one quarter to the next, IRFs would have the up to date definition at the beginning of the quarter (using the aforementioned CDC NHSN web page) and have a minimum of 3 weeks to assess whether their HCP meet the definition of up to date before submitting HCP COVID–19 Vaccine measure data during the self-selected week of a corresponding month. We will continue to monitor all measures to identify any concerning trends as part of our routine monitoring activities to regularly assess measures performance, reliability, and reportability for all data submitted for the IRF QRP.

Comment: Several commenters also suggested that the proposed modification to the measure numerator would be administratively burdensome due to the time it will take to (1) stay abreast of the current definition of up to date and (2) track whether their HCP met that definition at a time when IRFs are dealing with workforce issues. One commenter stated that given the current workforce shortage, adding more requirements on the healthcare workforce and health care systems will only exacerbate the situation. Another commenter said that healthcare facilities that are currently voluntarily reporting data to the CDC using the new up to date definition find the collection process quite administratively burdensome. Many commenters were concerned that frequent changes to the

[60] Centers for Medicare & Medicaid Services. June 17, 2022. Meaningful Measures 2.0: Moving from Measure Reduction to Modernization. *https://www.cms.gov/medicare/meaningful-measures-framework/meaningful-measures-20-moving-measure-reduction-modernization.*

[61] Centers for Medicare & Medicaid Services. May 1, 2023. CMS National Quality Strategy. *https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/value-based-programs/cms-quality-strategy.*

[62] U.S. Department of Health and Human Services. May 9, 2023. Fact Sheet: End of the COVID–19 Public Health Emergency. *https://www.hhs.gov/about/news/2023/05/09/fact-sheet-end-of-the-covid-19-public-health-emergency.html#:~:text=That%20means%20with%20the%20COVID,the%20expiration%20of%20the%20PHE.*

[63] The White House. May 1, 2023. The Biden-Harris Administration Will End COVID-19 Vaccination Requirements for Federal Employees, Contractors, International Travelers, Head Start Educators, and CMS-Certified Facilities. *https://www.whitehouse.gov/briefing-room/statements-releases/2023/05/01/the-biden-administration-will-end-covid-19-vaccination-requirements-for-federal-employees-contractors-international-travelers-head-start-educators-and-cms-certified-facilities/.*

definition of up to date would increase administrative burden for IRFs because they would have to alter their data collection processes to ensure that they report the proper data on HCP vaccination.

Response: We appreciate commenters' concerns regarding the reporting of the measure, but disagree that the proposed up to date numerator definition for the HCP COVID–19 Vaccine measure may exacerbate workforce shortages. We believe that the risks associated with COVID–19 warrant direct attention, especially because HCP are working directly with, and in close proximity to, patients. IRFs have been reporting the current version of the measure since the measure's initial data submission period (October 1, 2021 through December 31, 2021), and we believe that there has been sufficient time to allocate the necessary resources required to report this measure. We note that for purposes of NHSN surveillance, the CDC used the up to date numerator definition during the Quarter 4 2022 surveillance period (September 26, 2022 through December 25, 2022) (88 FR 20905) and IRFs have been successfully reporting the measure in alignment with the proposed modifications.

The CDC provides frequent communications and education to support IRFs' understanding of the latest guidelines. CDC posts an updated document approximately 2 weeks before the start of a new reporting quarter. If there are any changes to the definition, forms, etc., CDC will host a webinar in the 1–2 weeks before the beginning of a new reporting quarter. If IRFs have any concerns they would like to address with CMS regarding the data submission of this measure, they can voice their concerns during CMS' Hospitals Open Door Forums (ODFs). For more information on ODFs and to sign up for email notifications, we refer readers to the following CMS web page: *https://www.cms.gov/outreach-and-education/outreach/opendoorforums/odf_hospitals.*

Comment: One commenter questioned whether HCP without booster(s) would be mandated to get booster(s) if the proposed measure were adopted. Two commenters were concerned that because the proposed reporting requirements are inconsistent with internal, State, and Federal policies for vaccination, it will lead to inaccurate reporting.

Response: The current HCP COVID–19 Vaccine measure in the IRF QRP does not require HCP to receive a COVID–19 vaccine and the proposed modification to the measure numerator definition would not mandate HCP to receive an additional/booster dose under the up to date definition for this measure. It is an IRF's responsibility to determine its own personnel policies. The HCP COVID–19 Vaccine measure only requires reporting of vaccination rates for an IRF to successfully participate in the IRF QRP. As we have described previously, the CDC posts an updated document approximately 2 weeks before the start of a new reporting quarter. If there are any changes to the definition, forms, etc., CDC will host a webinar in the 1–2 weeks before the beginning of a new reporting quarter. It is the IRF's responsibility to accurately report vaccination status of HCP in accordance with this measure's specifications.

Comment: One commenter noted that the CDC's vaccination guidance suggests that some individuals with certain risk factors should consider receiving an additional booster dose within four months of receiving their first bivalent dose. Yet, the commenter noted that IRFs usually do not have routine access to data to know which of their HCP may need an additional booster. The commenter was concerned that, in order to collect accurate data, IRFs would have to obtain permission to inquire and attain information on each individual HCP's underlying health risk factors and a mechanism to keep the data fully secure. As a result, they express concern that the resource intensiveness of collecting data under the CDC's current definitions for the HCP COVID–19 Vaccine measure may outweigh its value.

Response: IRFs have been engaging with their staff since October 1, 2022 when the data collection for the HCP COVID–19 Vaccine measure began. This proposed modification to the HCP COVID–19 Vaccine measure should not require any changes to how IRFs currently engage with their staff and administer a comprehensive vaccine administration strategy. Specifically, we note that considerations for individuals with certain risk factors, such as those who are immunocompromised, are not impacted by the modification proposed to this measure as these considerations are present with the primary vaccination series for the current HCP COVID–19 Vaccine measure. As emphasized in the CDC NHSN ''COVID–19 Vaccination Modules: Understanding Key Terms and Up to Date Vaccination'' web page *https://www.cdc.gov/nhsn/pdfs/hps/covidvax/UpToDateGuidance-508.pdf* referred to in section IX.C.1.a.4. of this final rule, the NHSN surveillance definition for up to date is currently the same for all HCP regardless of immunocompromised status.

Comment: One commenter acknowledged that even though the proposed modification to this measure does not mandate HCP become up to date with their COVID–19 vaccine, it may affect how providers approach vaccination requirements for their workforce. They are concerned that entry-level workers will choose to work in other areas of commerce without similar COVID–19 vaccination requirements.

Response: We clarify that the HCP COVID–19 Vaccine measure does not require providers to adopt mandatory vaccination policies, and note that it is an IRFs' responsibility to determine its own personnel policies. The proposed modified HCP COVID–19 Vaccine measure would only require reporting of HCP vaccination rates, which would then be publicly reported on CMS' Care Compare website. We believe that the risks associated with COVID–19 warrant direct attention, especially because HCP are working directly with, and in close proximity to, patients. To support a comprehensive vaccine administration strategy, we encourage IRFs to voluntarily engage in the provision of appropriate and accessible education and vaccine-offering activities. Many IRFs across the country are educating staff, patients, and patients' representatives, participating in vaccine distribution programs, and voluntarily reporting up to date vaccine administration.

Comment: One commenter questioned whether the measure would be a comparison of the number of HCP with a primary series only and the number of HCP with a primary series and booster doses.

Response: We interpret the commenter's response as asking whether the measure would compare an IRF's HCP's primary series vaccination rate to an IRF's performance on the modified version of the HCP COVID–19 Vaccine measure. The modification to the HCP COVID–19 Vaccine measure does not make a comparison between the two HCP groups. Rather, the measure assesses the ratio between the number of HCP who are considered up to date on their COVID–19 vaccinations with the total number of HCP eligible to work in the facility for at least one day during the reporting period.

Comment: Several commenters did not support the HCP COVID–19 quality measure since it does not exclude HCP who choose not to receive up to date vaccinations due to personal or religious beliefs. Four of these commenters suggested we align the measure's exclusion criteria with the Hospital Conditions of Participation (CoPs)

requirement from the interim final rule ''Medicare and Medicaid Programs; Omnibus COVID–19 Health Care Staff Vaccination'' (86 FR 61555), which allowed exclusions for religious exemptions.[64] One of these commenters recommended that CMS develop an additional exclusion for this measure to account for sincerely held religious beliefs in order to align with Office of Civil Rights guidance.

Additionally, one commenter noted that even though the current version of the HCP COVID–19 Vaccine measure excludes persons with medical contraindications from the measure's denominator, they believe that the exclusion may be inconsistently applied among IRFs and other healthcare settings.

Response: We acknowledge that individual HCP may have sincerely held religious beliefs, observances, or practices that would prevent them from receiving a vaccine. However, we want to reiterate that neither the current version nor the proposed modified version of the measure mandate that HCP be up to date on their COVID–19 vaccination. The HCP COVID–19 Vaccine measure only requires reporting of vaccination rates for successful IRF QRP participation.

With respect to the comment about exclusions being inconsistently applied, CMS has multiple processes in place to ensure reported patient data are accurate. State agencies conduct standard certification surveys for IRFs, and accuracy and completeness of the IRF–PAI are among the regulatory requirements that surveyors evaluate during surveys.[65] Additionally, the IRF–PAI process has multiple regulatory requirements. Our regulations at § 412.606(b) require that (1) the assessment accurately reflects the patient's status, (2) a clinician appropriately trained to perform a patient assessment using the IRF–PAI conducts or coordinates each assessment with the appropriate participation of health professionals, and (3) the assessment process includes direct observation, as well as communication with the patient.[66] We take the accuracy of IRF–PAI assessment data very seriously, and routinely monitor the IRF QRP measures' performance, and will take appropriate steps to address any such issues, if identified, in future rulemaking.

Comment: One commenter suggested the measure needs to be restructured given the variation among States as to what information can be requested of staff and can be conditions of employment. These variations would make the ability to create any national average invalid. Another commenter suggested that without a regular cadence of boosters or a defined COVID–19 ''season,'' similar to influenza, modifying the definition of up to date is premature.

Response: We acknowledge the commenter's concern regarding how State laws may impact an IRF's ability to collect data regarding HCP COVID–19 vaccination status in order to report on this measure, and note that these Federal requirements would remain regardless of fluctuating State requirements. We believe, however, that IRFs obtaining information on HCP COVID–19 vaccination status is important for determining reasonable measures to protect the health and safety of not only the patients whom the IRF serves, but other staff working within the facility. We clarify that the HCP COVID–19 Vaccine measure does not require providers to adopt mandatory vaccination policies. In addition, we recognize that the up to date COVID–19 vaccination definition may evolve due to the changing nature of the virus. Since the adoption of the current version of the measure, the public health response to COVID–19 has necessarily adapted to respond to the changing nature of the virus's transmission and community spread. As mentioned in the FY 2022 IRF PPS final rule (86 FR 42362), we received several public comments during the measure's pre-rulemaking process encouraging us to continue to update the measure as new evidence on COVID–19 continues to arise and we stated our intention to continue to work with partners including FDA and CDC to consider any updates to the measure in future rulemaking as appropriate. We believe that the proposed measure modification aligns with the Administration's responsive approach to COVID–19 and will continue to support vaccination as the most effective means to prevent the worst consequences of COVID–19, including severe illness, hospitalization, and death.

Comment: One commenter suggested CMS would be able to obtain the same information by examining community levels of COVID–19 vaccination.

Response: This measure reports the vaccination rate among the HCPs eligible to work in the facility for at least one day during the reporting period, excluding persons with contraindications to COVID–19 vaccination that are described by the CDC. We disagree that facility-level HCP vaccination information can be obtained by examining community levels of COVID–19 vaccinations since facility-level rates could vary within the same community.

Comment: A number of commenters raised concerns about the frequency and manner of data submission. Commenters noted that if the CDC revises the up to date definition in the middle of a reporting period, the data reported by providers will no longer be an accurate reflection of the facility. One commenter recommended CMS should adopt a ''fixed definition of vaccine coverage'' for calculating measure performance. Commenters noted that, without a single consistent resource for reporting instructions when the definition of up to date is revised, the risk of inaccurate reporting increases.

Response: In response to the commenters' concerns that the up to date numerator definition may change during the reporting period, we refer commenters to section IX.C.1.a.4. of this final rule where we discuss how providers should refer to the definition of up to date as of the first day of the quarterly reporting period, which can be found at the following CDC NHSN web page: *https://www.cdc.gov/nhsn/pdfs/hps/covidvax/UpToDateGuidance-508.pdf.* The CDC notes that this aforementioned document will be updated quarterly to reflect any changes as COVID–19 guidance evolves, and notes that providers should use the definitions for the reporting period associated with the reporting weeks included in data submission. As such, the up to date vaccination definition that would be applicable during a particular reporting period should not change, which addresses the commenter's concern that there be a single consistent resource for reporting instructions when the definition of up to date is revised. If the requirements do change from one quarter to the next,

[64] Conditions of Participation requirements from the interim final rule ''Medicare and Medicaid Programs; Omnibus COVID–19 Health Care Staff Vaccination'' (86 FR 61555) are no longer in effect due to the ''Medicare and Medicaid Programs; Policy and Regulatory Changes to the Omnibus COVID–19 Health Care Staff Vaccination Requirements; Additional Policy and Regulatory Changes to the Requirements for Long-Term Care (LTC) Facilities and Intermediate Care Facilities for Individuals With Intellectual Disabilities (ICFs–IID) To Provide COVID–19 Vaccine Education and Offer Vaccinations to Residents, Clients, and Staff; Policy and Regulatory Changes to the Long Term Care Facility COVID–19 Testing Requirements'' final rule (88 FR 36485).

[65] Center for Medicare and Medicaid Services. September 6, 2022. Hospitals. *https:/www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcomplianc/hospitals.*

[66] 42 CFR 412.606 *https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-P/section-412.606.*

IRFs would have the up to date definition at the beginning of the quarter (using the aforementioned CDC NHSN web page), and have a minimum of 3 weeks to assess whether their HCP meet the definition of up to date before submitting HCP COVID–19 Vaccine measure data during the self-selected week of a corresponding month. IRFs would determine the up to date definition at the beginning of the quarter (using the aforementioned CDC NHSN web page) and would have a minimum of 3 weeks to determine whether their staff are up to date on vaccinations before submitting HCP COVID–19 Vaccine measure data during the self-selected week of a corresponding month.

We interpret the commenter's recommendation to adopt a ''fixed definition of vaccine coverage'' as maintaining only one version of an up to date definition indefinitely. We thank the commenter for the suggestion. However, we note that in section IX.C.1.a.1.a of this final rule that as SARS-CoV–2 evolves, our COVID–19 vaccination strategy must remain responsive. When we adopted the HCP COVID–19 Vaccine measure in the FY 2022 IRF PPS final rule, we stated that the need for additional/booster doses of COVID–19 vaccines had not been established and no additional doses had been recommended (86 FR 42390). To address the new variants of COVID–19, vaccine manufacturers have developed bivalent vaccines, which have been shown to increase immune responses to SARS-CoV–2 variants. We continue to believe that vaccination remains the most effective means to prevent severe consequences of COVID–19 and feel it is important to update the specifications of the HCP COVID–19 Vaccine measure to reflect most recent guidance that explicitly specifies for HCP to receive primary series and additional/booster doses in a timely manner.

Comment: One commenter questioned if retroactive assessment of data will be required if the up to date definition were to change during the reporting period.

Response: If the definition of up to date changes from one quarter to the next, IRFs would not have to submit data retroactively.

Comment: One commenter suggested that if the measure continues to be included in the IRF QRP, CMS should reduce the burden of gathering data from all personnel captured within the measure's denominator population.

Response: We did not propose changes to the measure denominator and disagree that the denominator criteria should be loosened. We emphasize that any HCP working in the facility for at least one working day during the reporting period, meeting denominator eligibility criteria, may come into contact with IRF patients, increasing the risk for HCP to patient transmission of infection. Therefore, we believe the measure as proposed has the potential to generate actionable data on up to date HCP COVID–19 vaccination rates that can be used to target quality improvement among IRF providers, including increasing up to date HCP COVID–19 vaccination coverage in IRFs, while also promoting patient safety and increasing the transparency of quality of care in the IRF setting.

Comment: Two commenters recommended that the HCP COVID–19 Vaccine measure's reporting requirements should align more closely to those of the HCP Influenza Vaccine measure. One commenter notes that the HCP Influenza Vaccine measure does not require providers to track and report whether HCP receive up to date vaccinations. A few commenters suggested CMS consider limiting the reporting requirement to at least one week for each quarter and to work with the CDC to move toward a version of the measure that may be reported annually. One of the commenters who suggested annual reporting was generally supportive of the modification to the measure. Another commenter questioned if HCP without booster vaccinations will be mandated to receive boosters, and if booster vaccinations will be required annually or seasonally like the influenza vaccine.

Response: As we stated in the FY 2024 IRF PPS proposed rule (88 FR 20950), the measure developer (the CDC) noted that the model used for this measure is based on the Influenza Vaccination Coverage among HCP measure (CBE #0431), and it intends to utilize a similar approach for the HCP COVID–19 Vaccine measure if vaccination strategy becomes seasonal. Neither the current nor proposed modified versions of the HCP COVID–19 Vaccine measure mandate that HCPs receive an up to date COVID–19 vaccine.

Comment: Six commenters expressed concerns with the delay between data submission via the NHSN and public reporting on Care Compare, emphasizing that the up to date numerator definition may change between the time when data are submitted and when data are publicly reported. One commenter points out that it may mean that HCP who counted as up to date in a given quarter may no longer be up to date in the next quarter and CMS needs to clearly communicate what publicly reported data reflect.

Response: We thank the commenters for expressing their concerns about the data lag between data submission and public reporting. We clarify that, as mentioned in the FY 2022 IRF PPS final rule (86 FR 42496 through 42497), we revised our public reporting policy for this measure to use quarterly reporting, which allows the most recent quarter of data to be displayed, as opposed to an average of four rolling quarters. Additionally, the public display schedule of the HCP COVID–19 Vaccine measure aligns with IRF QRP public display policies finalized in the FY 2017 IRF PPS final rule (81 FR 52055), which allows IRFs to submit their IRF QRP data up to 4.5 months after the end of the reporting quarter. A number of administrative tasks must then occur in sequential order between the time IRF QRP data are submitted and reported in Care Compare to ensure the validity of data and to allow IRFs sufficient time to appeal any determinations of non-compliance with our requirements for the IRF QRP. We believe this reporting schedule, outlined in section IX.C.1.a.4. of this final rule is reasonable, and expediting this schedule may establish undue burden on providers and jeopardize the integrity of the data.

Additionally, CMS does communicate the time periods that publicly reported data reflect. This information can be retrieved through the Care Compare site (*https://www.medicare.gov/care-compare/*) through ''View Quality Measures,'' and then clicking on ''Get current data collection period.''

Comment: One commenter believed the delay between when the information is collected and when it is actually publicly reported could cause confusion and damage the public's trust and confidence in the quality of care delivered in their community if the rate of up to date healthcare personnel vaccination is ''low'' due to the data lag. Another commenter noted that changing CDC definitions is challenging for health care professionals, and they do not believe that this information can be articulated in a manner for patients to fully digest in order to make meaningful health care decisions.

Response: While we acknowledge that an IRF's percentage of HCP who are up to date with their COVID–19 vaccination could change if the CDC modifies it guidance, each provider will be measured against the same criteria within the same quarter, and the guideline for each quarter will be shared through the CDC website ahead of each quarter at the following NHSN web page: *https://www.cdc.gov/nhsn/pdfs/hps/covidvax/UpToDateGuidance-508.pdf.* If the requirements do change from one quarter to the next, IRFs would have the up to date definition at the beginning of the quarter and have a minimum of 3 weeks to assess whether their HCP meet the definition of up to date before submitting HCP COVID–19 Vaccine measure data during the self-selected week of a corresponding month.

We also believe patients will be able to understand what changes to the up to date definition mean on Care Compare. We note that the public has been using the information displayed on Care Compare for the current HCP COVID–19 Vaccine measure since it was first publicly reported in 2022. CMS works closely with its Office of Communications and consumer groups when onboarding measures to the Care Compare websites, and we will do the same with the modified HCP COVID–19 Vaccine measure to ensure that the measure description on Care Compare is clear and understandable for the general public.

Comment: One commenter requested that CMS account for how CMS will publicly report the HCP COVID–19 Vaccine measure when the up to date definition in the numerator changes. They provide as example using CDC data where in the population greater than or equal to 65 years old, 94.3 percent have completed the primary series (the current measure numerator definition), while only 42.6 percent have received a booster dose (the proposed measure numerator definition). This commenter does not believe that the two numbers should be trended and compared over time given that they are different definitions of vaccination.

Response: We thank the commenter for the question, and we clarify that only one FY quarter of data is publicly reported at a time and the provider's performance is compared with its peers using data collected from the same FY quarter, and thus subject to the same definitions as set forth in the measure's guidelines. While the measure is only publicly reported one FY quarter at a time, we review measure trends as part of our routine monitoring activities and will exercise caution when monitoring measure trends especially during time periods when the CDC guidelines may change.

Comment: One commenter inquired about if and where the HCP COVID–19 Vaccine measure will be reported. This commenter also inquired about if facilities with more up to date vaccinations will get higher star-ratings. Additionally, this commenter questioned if there will be additional reimbursement for collecting up to date vaccination rates of HCP. Lastly, the commenter inquired about how information about HCP vaccine percentages will be aggregated.

Response: We thank the commenter for their questions. As mentioned in section IX.C.1.a.4. of this final rule, the HCP COVID–19 Vaccine measure will be publicly reported on Care Compare beginning with the September 2024 Care Compare refresh. Additionally, we will make available to IRFs a preview of their performance on the HCP COVID–19 Vaccine measure on the IRF Provider Preview Report, which will be issued approximately 3 months prior to displaying the measure on Care Compare. In terms of star-ratings, the IRF QRP is not a part of the Hospital Quality Star Rating program. Furthermore, we reiterate that the IRF QRP is a pay-for-reporting program. Therefore, IRFs will only be financially penalized under the IRF QRP if they fail to comply with measure data submission requirements. There will not be additional reimbursement for collecting up to date vaccination rates of HCP or reimbursement based on HCP COVID–19 Vaccine measure performance. In response to the commenter's question about how percentages of HCP who are up to date with their COVID–19 vaccination will be aggregated, each quarter the CDC will calculate a single quarterly HCP COVID–19 vaccination coverage rate for each facility, by taking the average of the data from the three weekly rates submitted by the facility for that quarter. If more than 1 week of data are submitted for the month, the most recent submitted week of the month will be used. We refer readers to the following CDC NHSN web page for additional information: *https://www.cdc.gov/nhsn/pdfs/hps/covidvax/protocol-hcp-508.pdf.*

After careful consideration of the public comments we received, we are finalizing our proposal to modify the HCP COVID–19 Vaccine measure beginning with the FY 2025 IRF QRP as proposed.

b. Discharge Function Score Measure Beginning With the FY 2025 IRF QRP

(1) Background

IRFs provide rehabilitation therapy in a resource-intensive inpatient hospital environment to patients with complex nursing, medical management, and rehabilitation needs, who require and can reasonably be expected to benefit from the multidisciplinary care provided in an IRF. Patients tend to have neurological conditions such as stroke, spinal cord injury, and brain injury; degenerative conditions including multiple sclerosis; congenital deformities; amputations; burns; active inflammatory conditions; severe or advanced osteoarthritis; or knee and hip joint replacements.[67] In 2019, the most common condition treated by IRFs was stroke, which accounted for about one-fifth of IRF cases.[68] For stroke patients, rehabilitation has been shown to be the most effective way to reduce stroke-associated motor impairments. Addressing these impairments is crucial as functional deficits affect patients' mobility, their capabilities in daily life activities, and their participation in society, which can lead to a lower quality of life.[69]

Section 1886(j)(7)(F)(ii) of the Act, cross-referencing subsections (b), (c), and (d) of section 1899B of the Act, requires CMS to develop and implement standardized quality measures from five quality measure domains, including the domain of functional status, cognitive function, and changes in function and cognitive function, across post-acute care (PAC) settings, including IRFs. To satisfy this requirement, we adopted the Application of Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (Application of Functional Assessment/Care Plan) measure for the IRF QRP in the FY 2016 IRF PPS final rule (80 FR 47100 through 47111). While this process measure allowed for the standardization of functional assessments across assessment instruments and facilitated cross-setting data collection, quality

[67] 42 CFR 412.29.

[68] Medicare Payment Advisory Commission. Report to the Congress: Medicare and the Health Care Delivery System. June 2021. *https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun21_medpac_report_to_congress_sec.pdf.*

[69] Hatem SM, Saussez G, Della Faille M, Prist V, Zhang X, Dispa D, Bleyenheuft Y. Rehabilitation of Motor Function After Stroke: A Multiple Systematic Review Focused on Techniques to Stimulate Upper Extremity Recovery. Front Hum Neurosci. 2016 Sep 13;10:442. doi: 10.3389/fnhum.2016.00442. PMID: 27679565; PMCID: PMC5020059.

measurement, and interoperable data exchange, we believe it is now topped out [70] and proposed to remove it in section VIII.C.1.c. of the proposed rule. While there are other outcome measures addressing functional status [71] that can reliably distinguish performance among providers in the IRF QRP, these outcome measures are not cross-setting in nature because they rely on functional status items not collected in all PAC settings. In contrast, a cross-setting functional outcome measure would align measure specifications across settings, including the use of a common set of standardized functional assessment data elements.

(a) Measure Importance

Maintenance or improvement of physical function among older adults is increasingly an important focus of health care. Adults age 65 years and older constitute the most rapidly growing population in the United States, and functional capacity in physical (non-psychological) domains has been shown to decline with age.[72] Moreover, impaired functional capacity is associated with poorer quality of life and an increased risk of all-cause mortality, postoperative complications, and cognitive impairment, the latter of which can complicate the return of a patient to the community from post-acute care.[73 74 75] Nonetheless, evidence suggests that physical functional abilities, including mobility and self-care, are modifiable predictors of patient outcomes across PAC settings, including functional recovery or decline after post-acute care,[76 77 78 79] rehospitalization rates,[80 81 82] discharge to community,[83 84] and falls.[85]

The implementation of interventions that improve patients' functional outcomes and reduce the risks of associated undesirable outcomes as a part of a patient-centered care plan is essential to maximizing functional improvement. For many people, the overall goals of IRF care may include optimizing functional improvement, returning to a previous level of independence, or avoiding institutionalization. Several studies have reported that IRF care can improve patients' motor function at discharge for patients with various diagnoses, including traumatic brain injury and stroke.[86 87 88 89] While patients generally improve in all functional domains at IRF discharge, evidence has shown that a significant number of patients continue to exhibit deficits in the domains of fall risk, gait speed, and cognition, suggesting the need for ongoing treatment. Assessing functional status as a health outcome in IRFs can provide valuable information in determining treatment decisions throughout the care continuum, such as the need for rehabilitation services and discharge planning,[90 91 92 93] as well as

[70] Centers for Medicare & Medicaid Services. 2022 Annual Call for Quality Measures Fact Sheet, p. 10. *https://www.cms.gov/files/document/mips-call-quality-measures-overview-fact-sheet-2022.pdf.*

[71] The measures include: Change in Self-Care Score for Medical Rehabilitation Patients (Change in Mobility for Medical Rehabilitation Patients, Discharge Self-Care Score for Medical Rehabilitation Patients), Discharge Mobility Score for Medical Rehabilitation Patients.

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provide information to consumers about the effectiveness of rehabilitation and other IRF services delivered. Because evidence shows that older adults experience aging heterogeneously and require individualized and comprehensive health care, functional status can serve as a vital component in informing the provision of health care and thus indicate an IRF's quality of care.[94] [95]

We proposed to adopt the Discharge Function Score (DC Function) measure [96] in the IRF QRP beginning with the FY 2025 IRF QRP. This assessment-based outcome measure evaluates functional status by calculating the percentage of IRF patients who meet or exceed an expected discharge function score. We also proposed that this measure would replace the topped-out Application of Functional Assessment/Care Plan cross-setting process measure. Like the Application of Functional Assessment/Care Plan cross-setting process measure, the proposed DC Function measure is calculated using standardized patient assessment data from the IRF Patient Assessment Instrument (IRF–PAI).

The DC Function measure supports our current priorities. Specifically, the measure aligns with the Streamline Quality Measurement domain in CMS's Meaningful Measures 2.0 Framework in two ways. First, the proposed outcome measure could further CMS's objective to prioritize outcome measures by replacing the current cross-setting process measure (see section VIII.C.1.c. of the proposed rule). This proposed DC Function measure uses a set of cross-setting assessment items which would facilitate data collection, quality measurement, outcome comparison, and interoperable data exchange among PAC settings; existing functional outcome measures do not use a set of cross-setting assessment items. Second, this measure would add no additional provider burden since it would be calculated using data from the IRF–PAI that IRFs are already required to collect.

The proposed DC Function measure would also follow a calculation approach similar to the existing functional outcome measures, which are endorsed by the CBE, with some modifications.[97] Specifically, the measure (1) considers two dimensions of function [98] (self-care and mobility activities) and (2) accounts for missing data by using statistical imputation to improve the validity of measure performance. The statistical imputation approach recodes missing functional status data to *the most likely value* had the status been assessed, whereas the current imputation approach implemented in existing functional outcome measures recodes missing data to the *lowest* functional status. A benefit of statistical imputation is that it uses patient characteristics to produce an unbiased estimate of the score on each item with a missing value. In contrast, the current approach treats patients with missing values and patients who were coded to the lowest functional status similarly, despite evidence suggesting varying measure performance between the two groups, which can lead to less accurate measure performances.

(b) Measure Testing

The measure development contractor used FY 2019 data to conduct testing on the DC Function measure to assess validity, reliability, and reportability, all of which informed interested parties' feedback and Technical Expert Panel (TEP) input (see section VIII.C.1.b.(3) of the proposed rule). Validity was assessed for the measure performance, the risk adjustment model, face validity, and statistical imputation models. Validity testing of measure performance entailed determining Spearman's rank correlations between the proposed measure's performance for providers with 20 or more stays and the performance of other publicly reported IRF quality measures. Results indicated that the proposed DC Function measure captures the intended outcome based on the directionalities and strengths of correlation coefficients and are further detailed below in Table 18.

Mobility Inpatient Short Form and National Institutes of Health Stroke Scale to Predict Hospital Discharge Disposition After Stroke. Phys Ther. 2020 Aug 31;100(9):1423–1433. doi: 10.1093/ptj/pzaa102. PMID: 32494809.

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[96] Discharge Function Score for Inpatient Rehabilitation Facilities (IRFs) Technical Report. *https://www.cms.gov/files/document/irf-discharge-function-score-technical-report-february-2023.pdf.*

[97] The existing measures are the IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients measure (Discharge Self-Care Score), and the Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients measures (Discharge Mobility Score).

[98] Post-Acute Care Payment Reform Demonstration Report to Congress Supplement—Interim Report. May 2011. *https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/Downloads/GAGE_PACPRD_RTC_Supp_Materials_May_2011.pdf.*

TABLE 18: Spearman's Rank Correlation Results of DC Function Measure with Publicly Reported IRF Quality Measures

Measure – Long Name	Measure – Short Name	ρ
Discharge to Community–PAC IRF QRP	Discharge to Community	0.25
IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients	Change in Self-Care Score	0.82
IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients	Change in Mobility Score	0.86
IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients	Discharge Self-Care Score	0.85
IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients	Discharge Mobility Score	0.88

Validity testing of the risk adjustment model showed good model discrimination as the measure model has the predictive ability to distinguish patients with low expected functional capabilities from those with high expected functional capabilities.[99] The ratios of observed-to-predicted discharge function score across eligible stays, by deciles of expected functional capabilities, ranged from 0.99 to 1.01. Both the Cross-Setting Discharge Function TEPs and patient-family feedback showed strong support for the face validity and importance of the proposed measure as an indicator of quality of care (see section VIII.C.1.b.(3) of the proposed rule). Lastly, validity testing of the measure's statistical imputation models indicated that the models demonstrate good discrimination and produce more precise and accurate estimates of function scores for items with missing scores when compared to the current imputation approach implemented in IRF QRP functional outcome measures, specifically the IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients measure (Change in Self-Care Score), the IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients measure (Change in Mobility Score), the IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients measure (Discharge Self-Care Score), and the IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients measure (Discharge Mobility Score).

Reliability and reportability testing also yielded results that support the proposed DC Function measure's scientific acceptability. Split-half testing revealed the proposed measure's excellent reliability, indicated by an intraclass correlation coefficient value of 0.95. Reportability testing indicated high reportability (98 percent) of IRFs meeting the public reporting threshold of 20 eligible stays. For additional measure testing details, we refer readers to the document titled *Discharge Function Score for Inpatient Rehabilitation Facilities (IRFs) Technical Report.*[100]

(2) Competing and Related Measures

Section 1886(j)(7)(D)(i) of the Act and section 1899B(e)(2)(A) of the Act require that, absent an exception under section 1886(j)(7)(D)(i) and 1899B(e)(2)(B) of the Act, measures specified under section 1886(j)(7)(D)(ii) of the Act and section 1899B of the Act must be endorsed by the CBE with a contract under section 1890(a). In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed, section 1886(j)(7)(D)(ii) of the Act and section 1899B(e)(2)(B) of the Act permit the Secretary to specify a measure that is not so endorsed, as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

The proposed DC Function measure is not CBE endorsed, so we considered whether there are other available measures that: (1) assess both functional domains of self-care and mobility in IRFs and (2) satisfy the requirement of the Act to develop and implement standardized quality measures from the quality measure domain of functional status, cognitive function, and changes in function and cognitive function across the PAC settings. While the Application of Functional Assessment/Care Plan measure assesses both functional domains and satisfies the Act's requirement, this current cross-setting process measure is not endorsed by a consensus organization and the performance on the Application of Functional Assessment/Care Plan measure among IRFs is so high and unvarying that this current measure does not offer meaningful distinctions in performance. Additionally, after review of other measures, we were unable to identify any measures endorsed or adopted by a consensus organization for IRFs that meet the aforementioned requirements. While the IRF QRP includes CBE endorsed outcome measures addressing functional status,[101] they each assess a single domain of function, and are not cross-setting in nature because they rely

[99] ''Expected functional capabilities'' is defined as the predicted discharge function score.

[100] *Discharge Function Score for Inpatient Rehabilitation Facilities* (IRFs) *Technical Report. https://www.cms.gov/files/document/irf-discharge-function-score-technical-report-february-2023.pdf.*

[101] The measures include: Change in Self-Care Score for Medical Rehabilitation Patients Change in Mobility Score for Medical Rehabilitation Patients, Discharge Self-Care Score for Medical Rehabilitation Patients, and Discharge Mobility Score for Medical Rehabilitation Patients.

on functional status items not collected in all PAC settings.

Therefore, after consideration of other available measures, we found that the exceptions under sections 1886(j)(7)(D)(ii) and 1899B(e)(2)(B) of the Act apply and proposed to adopt the DC Function measure beginning with the FY 2025 IRF QRP. We intend to submit the proposed measure to the CBE for consideration of endorsement when feasible.

(3) Interested Parties and Technical Expert Panel (TEP) Input

In our development and specification of this measure, we employed a transparent process in which we sought input from interested parties and national experts and engaged in a process that allowed for pre-rulemaking input in accordance with section 1890A of the Act. To meet this requirement, we provided the following opportunities for input from interested parties: a patient and family/caregiver advocates (PFA) focus group, two TEPs, and public comments through a request for information (RFI).

First, the measure development contractor convened a PFA focus group, during which patients and caregivers provided support for the proposed measure concept. Participants emphasized the importance of measuring functional outcomes and found self-care and mobility to be critical aspects of care. Additionally, they expressed a strong interest in metrics assessing the number of patients discharged from particular facilities with improvements in self-care and mobility, and their views of self-care and mobility aligned with the functional domains captured by the proposed measure. All feedback was used to inform measure development efforts.

The measure development contractor for the DC Function measure subsequently convened TEPs on July 14–15, 2021 and January 26–27, 2022 to obtain expert input on the development of a cross-setting function measure for use in the IRF QRP. The TEPs consisted of interested parties with a diverse range of expertise, including IRF and PAC subject matter knowledge, clinical expertise, patient and family perspectives, and measure development experience. The TEPs supported the proposed measure concept and provided substantive feedback regarding the measure's specifications and measure testing data.

First, the TEP was asked whether they prefer a cross-setting measure that is modeled after the currently adopted Discharge Mobility Score and Discharge Self-Care Score measures, or one that is modeled after the currently adopted Change in Mobility Score and Change in Self-Care Score measures. With the Discharge Mobility Score and Change in Mobility Score measures and the Discharge Self-Care Score and Change in Self-Care Score measures being both highly correlated and not appearing to measure unique concepts, the TEP favored the Discharge Mobility Score and Discharge Self-Care Score measures over the Change in Mobility Score and Change in Self-Care Score measures and recommended moving forward with utilizing the Discharge Mobility Score and Discharge Self-Care Score measures' concepts for the development of the cross-setting measure.

Second, in deciding the standardized functional assessment data elements to include in the cross-setting measure, the TEP recommended removing redundant data elements. Strong correlations between scores of functional items within the same functional domain suggested that certain items may be redundant in eliciting information about patient function and inclusion of these items could lead to overrepresentation of a particular functional area. Subsequently, our measure development contractor focused on the Discharge Mobility Score measure as a starting point for cross-setting development due to the greater number of cross-setting standardized functional assessment data elements for mobility while also identifying redundant functional items that could be removed from a cross-setting functional measure.

Third, the TEP supported including the cross-setting self-care items such that the cross-setting function measure would capture both self-care and mobility. Panelists agreed that self-care items added value to the measure and are clinically important to function. Lastly, the TEP provided refinements to imputation strategies to more accurately represent function performance across all PAC settings, including the support of using statistical imputation over the current imputation approach implemented in existing functional outcome measures in the PAC QRPs. We considered all the TEP's recommendations for developing a cross-setting function measure, and we applied their recommendations where technically feasible and appropriate. Summaries of the TEP proceedings titled *Technical Expert Panel (TEP) for the Refinement of Long-Term Care Hospital (LTCH), Inpatient Rehabilitation Facility (IRF), Skilled Nursing Facility (SNF)/Nursing Facility (NF), and Home Health (HH) Function Measures Summary Report* (July 2021 TEP) [102] and *Technical Expert Panel (TEP) for Cross-Setting Function Measure Development Summary Report* (January 2022 TEP) [103] are available on the CMS Measures Management System (MMS) Hub.

Finally, we solicited feedback from interested parties on the importance, relevance, and applicability of a cross-setting functional outcome measure for IRFs through an RFI in the FY 2023 IRF PPS proposed rule (87 FR 20244). Commenters were supportive of a cross-setting functional outcome measure that is inclusive of both self-care and mobility items, but also provided information related to potential risk adjustment methodologies as well as other measures that could be used to capture functional outcomes across PAC settings (87 FR 47070).

(4) Measure Applications Partnership (MAP) Review

Our pre-rulemaking process includes making publicly available a list of quality and efficiency measures, called the MUC List, that the Secretary is considering adopting for use in the Medicare program, including our quality reporting programs. This allows multi-interested parties to provide recommendations to the Secretary on the measures included on the list.

We included the DC Function measure under the IRF QRP in the publicly available MUC List for December 1, 2022.[104] After the MUC List was published, the CBE convened MAP received four comments from interested parties in the industry on the 2022 MUC List. Two commenters were supportive of the measure and two were not. Among the commenters in support of the measure, one commenter stated that function scores are the most meaningful outcome measure in the IRF setting, as they not only assess patient outcomes but also can be used for clinical improvement processes. Additionally, this commenter noted the measure's good reliability and validity and that the measure is feasible to

[102] *Technical Expert Panel (TEP) for the Refinement of Long-Term Care Hospital (LTCH), Inpatient Rehabilitation Facility (IRF), Skilled Nursing Facility (SNF)/Nursing Facility (NF), and Home Health (HH) Function Measures Summary Report* (July 2021 TEP) is available at *https://mmshub.cms.gov/sites/default/files/TEP-Summary-Report-PAC-Function.pdf.*

[103] Technical Expert Panel (TEP) for Cross-Setting Function Measure Development Summary Report (January 2022 TEP) is available at *https://mmshub.cms.gov/sites/default/files/PAC-Function-TEP-Summary-Report-Jan2022-508.pdf.*

[104] Centers for Medicare & Medicaid Services. Overview of the List of Measures Under Consideration for December 1, 2022. *https://mmshub.cms.gov/sites/default/files/2022-MUC-List-Overview.pdf.*

implement. The second commenter supported including the measure in the IRF QRP measures we propose through rulemaking.

Commenters not in support of the measure raised the following concerns: the need for more detailed measure specifications, the complexity of calculating the expected discharge score, the measure's validity and usability, and the differences in denominator populations across PAC settings. We were able to address these concerns during the MAP PAC/LTC workgroup meeting held on December 12, 2022. Specifically, we clarified that the technical reports include detailed measure specifications, and that expected discharge scores are calculated by risk-adjusting the observed discharge scores (see section VIII.C.1.b.(5) of the proposed rule). We also noted that the measure exhibits good validity (see section VIII.C.1.b(1)(b) of the proposed rule) and clarified that the wide range of expected scores does not indicate poor validity and is consistent with the range of observed scores. We also pointed out that the measure is highly usable since it is similar in design and complexity to existing function measures and its data elements are already in use. Lastly, we explained that the denominator population in each measure setting represents the assessed population within the setting and the measure satisfies the requirement of the Act for a cross-setting measure in the functional status domain.

Shortly after, several CBE convened MAP workgroups met to provide input on the proposed DC Function measure. First, the MAP Health Equity Advisory Group convened on December 6–7, 2022. The MAP Health Equity Advisory Group did not share any health equity concerns related to the implementation of the DC Function measure, and only requested clarification regarding measure specifications from the measure steward. The MAP Rural Health Advisory Group met on December 8–9, 2022, during which two of its members provided support for the DC Function measure and other MAP Rural Health Advisory Group members did not express rural health concerns regarding the measure.

The MAP PAC/LTC workgroup met on December 12, 2022 and provided input on the proposed DC Function measure. During this meeting, we were able to address several concerns raised by interested parties after the publication of the MUC List. Specifically, we clarified that the expected discharge scores are not calculated using self-reported functional goals and are simply calculated by risk-adjusting the observed discharge scores (see section VIII.C.1.b.(5) of the proposed rule). Therefore, we believe that these scores cannot be ''gamed'' by reporting less-ambitious functional goals. We also pointed out that the measure is highly usable as it is similar in design and complexity to existing function measures and that the data elements used in this measure are already in use on the IRF–PAI submitted by IRFs. Lastly, we clarified that the DC Function measure is intended to supplement, rather than replace, existing IRF QRP measures for self-care and mobility and implements improvements on the existing Discharge Self-Care Score and Discharge Mobility Score measures that make the proposed measure more valid and harder to game.

The MAP PAC/LTC workgroup went on to discuss several concerns with the DC Function measure, including (1) whether the measure is cross-setting due to denominator populations that differ among settings, (2) whether the measure would adequately represent the full picture of function, especially for patients who may have a limited potential for functional gain, and (3) that the range of expected scores was too large to offer a valid facility-level score. We clarified that the denominator population in each measure-setting represents the assessed population within the setting and that the measure satisfies the requirement of section 1886(j)(7) of the Act for a cross-setting measure in the functional status domain specified under section 1899B(c)(1) of the Act. Additionally, we noted that the TEP had reviewed the item set and determined that all the self-care and mobility items were suitable for all settings. Further, we clarified that, because the DC Function measure would assess whether a patient met *or* exceeded their expected discharge score, it accounts for patients who are not expected to improve. Lastly, we noted that the DC Function measure has a high degree of correlation with the existing function measures and that the measure exhibits good validity and clarified that the wide range of expected scores does not indicate poor validity and is consistent with the range of observed scores. The PAC/LTC workgroup voted to support the staff recommendation of conditional support for rulemaking, with the condition that we seek CBE endorsement.

In response to the MAP PAC/LTC workgroup's preliminary recommendation, the CBE received two comments in support of the MAP PAC/LTC workgroup's preliminary recommendation of conditional support for rulemaking. One commenter recommended the DC Function measure under the condition that the measure be reviewed and refined such that its implementation supports patient autonomy and results in care that aligns with patients' personal functional goals. The second commenter provided support for the DC Function measure under the condition that it produces statistically meaningful information that can inform improvements in care processes, while also expressing concern that the measure is not truly cross-setting because: (1) the measure utilizes different patient populations in each setting-specific denominator, (2) the risk-adjustment models use setting-specific covariates, and (3) using a single set of cross-setting Section GG self-care and mobility function items in our standardized patient assessment instruments is not appropriate since the items may not be relevant given the differences in each PAC resident/patient population.

Finally, the MAP Coordinating Committee workgroup convened on January 24–25, 2023. At this meeting, one interested party indicated their lack of support for the PAC/LTC workgroup's preliminary recommendation. The commenter expressed concern that the proposed DC Function measure competes with existing self-care and mobility measures in the IRF QRP. We noted that we monitor measures to determine whether they meet any measure removal factors, set forth in 42 CFR 413.360(b)(2), and when identified, we may remove such measures through the rulemaking process. We noted again that the TEP had reviewed the item set and determined that all the self-care and mobility items were suitable for all settings. The MAP Coordinating Committee members expressed support for our review of existing measures for potential removal, as well as for the proposed DC Function measure, favoring the implementation of a single, standardized function measure across PAC settings. The Coordinating Committee unanimously upheld the workgroup recommendation of conditional support for rulemaking. We refer readers to the final MAP recommendations titled *2022–2023 MAP Final Recommendations.*[105]

(5) Quality Measure Calculation

The proposed DC Function measure is an outcome measure that estimates the percentage of IRF patients who meet or exceed an expected discharge score during the reporting period. The

[105] 2022–2023 MAP Final Recommendations. *https://mmshub.cms.gov/sites/default/files/2022-2023-MAP-Final-Recommendations-508.xlsx.*

proposed measure's numerator is the number of IRF stays with an observed discharge function score that is equal to or greater than the calculated expected discharge function score. The observed discharge function score is the sum of individual function item values at discharge. The expected discharge function score is computed by risk-adjusting the observed discharge function score for each IRF stay. Risk adjustment controls for patient characteristics such as admission function score, age, and clinical conditions. The denominator is the total number of IRF stays with an IRF–PAI record in the measure target period (four rolling quarters) that do not meet the measure exclusion criteria. For additional details regarding the numerator, denominator, risk adjustment, and exclusion criteria, refer to the *Discharge Function Score for Inpatient Rehabilitation Facilities (IRFs) Technical Report.*[106]

The proposed DC Function measure implements a statistical imputation approach for handling ''missing'' standardized functional assessment data elements. The coding guidance for standardized functional assessment data elements allows for using ''Activity Not Attempted'' (ANA) codes, resulting in ''missing'' information about a patient's functional ability on at least some items, at admission and/or discharge, for a substantive portion of IRF patients. Currently, functional outcome measures in the IRF QRP use a simple imputation method whereby all ANA codes or otherwise missing scores, on both admission and discharge records, are recoded to ''1'' or ''most dependent.'' Statistical imputation, on the other hand, replaces these missing values with a variable based on the values of other, non-missing variables in the assessment and on the values of other assessments which are otherwise similar to the assessment with a missing value. Specifically, this proposed DC Function measure's statistical imputation allows missing values (that is, the ANA codes) to be replaced with any value from 1 to 6, based on a patient's clinical characteristics and codes assigned on other standardized functional assessment data elements. The measure implements separate imputation models for each standardized functional assessment data element used in the construction of the discharge score and the admission score. Relative to the current simple imputation method, this statistical imputation approach increases precision and accuracy and reduces the bias in estimates of missing item values. We refer readers to the *Discharge Function Score for Inpatient Rehabilitation Facilities (IRFs) Technical Report*[107] for measure specifications and additional details.

We invited public comment on our proposal to adopt the DC Function measure, beginning with the FY 2025 IRF QRP. The following is a summary of the public comments received on our proposal to adopt the DC Function measure, beginning with the FY 2025 IRF QRP, and our responses:

Comment: Two commenters supported the addition of the DC Function measure to the IRF QRP. One of these commenters agreed that the measure is a significant improvement upon existing function measures and notes the measure's potential to demonstrate the value of maintenance therapy. While supportive of the measure, one commenter believes the data sources for certain risk adjustment covariates, such as the Brief Interview of Mental Status (BIMS) to assess cognitive function, can be improved upon and urges CMS to closely monitor the appropriateness of the risk model used to estimate expected discharge scores. Another commenter noted that the measure does not impose additional provider burden, is an outcome measure rather than a process measure, and implements an imputation approach that improves upon the method used in the currently adopted Discharge Self-Care Score, Discharge Mobility Score, Change in Self-Care Score, and Change in Mobility Score measures. Both commenters encouraged continual evaluation of the imputation methodology for validity and any unintended negative consequences.

Response: We thank the commenters for their support of the proposed measure and agree that the measure improves upon existing function measures implemented in the IRF QRP. We reevaluate measures implemented in the IRF QRP on an ongoing basis to ensure they have strong scientific acceptability and appropriately capture the care provided by IRFs. This monitoring includes the appropriateness and performance of both the risk models and imputation models used to calculate the measure. We also agree that the accuracy of the expected discharge function score is vital to the measure's performance but disagree that the data sources for cognitive function are flawed. As described in the FY 2019 IRF PPS final rule (83 FR 38544) and the FY 2020 proposed rule (84 FR 17294–17295), the cognitive items including the expression of ideas and wants, understanding verbal and non-verbal content, and the Brief Interview of Mental Status (BIMS) items have been thoroughly tested and have been shown to be valid. The reliability of these cognitive items was tested in the IRF setting through kappa statistics. Results indicated that most kappa values were above 0.60, which indicates strong reliability.[108]

Comment: One commenter who supported the measure requested a simplified overview of the risk adjustment methodology, as this would enable clinicians to provide more meaningful feedback in future years and also serve to alleviate clinician fear associated with an unknown measurement of the quality of care they provide.

Response: We agree that it is important for clinicians to understand the proposed quality measure, and thus provided detailed specifications to ensure transparency with respect to the measure's calculation, including the risk adjustment methodology. At a high level, the 'expected' discharge score is calculated by risk-adjusting the observed discharge score (that is, the sum of individual function item values at discharge) for admission functional status, age, and clinical characteristics using an ordinary least squares linear regression model. The model intercept and risk adjustor coefficients are determined by running the risk adjustment model on all eligible IRF stays. For more detailed measure specifications, we direct readers to the document titled *Discharge Function Score for Inpatient Rehabilitation Facilities (IRFs) Technical Report.*[109]

Comment: One commenter supported the proposed adoption of the DC Function measure, noting its importance as a patient-centered measure. However, this commenter strongly encouraged CMS to submit the measure for CBE endorsement.

Response: We thank the commenter for their support and agree it is an important patient-centered measure. We

[106] Discharge Function Score for Inpatient Rehabilitation Facilities (IRFs) Technical Report. *https://www.cms.gov/files/document/irf-discharge-function-score-technical-report-february-2023.pdf.*

[107] *Discharge Function Score for Inpatient Rehabilitation Facilities* (IRFs) *Technical Report. https://www.cms.gov/files/document/irf-discharge-function-score-technical-report-february-2023.pdf.*

[108] *The Development and Testing of the Continuity Assessment Record and Evaluation (CARE) Item Set: Final Report on Reliability Testing Volume 2 of 3 https://www.cms.gov/files/document/development-and-testing-continuity-assessment-record-and-evaluation-care-item-set-final-report.pdf.*

[109] *Discharge Function Score for Inpatient Rehabilitation Facilities* (IRFs) *Technical Report. https://www.cms.gov/files/document/irf-discharge-function-score-technical-report-february-2023.pdf.*

intend to submit the proposed measure to the CBE for consideration of endorsement when feasible.

Comment: One commenter supported the proposed measure as it captures both self-care and mobility items and encouraged the review and refinement of the measure as needed. However, this commenter preferred separate quality measures for self-care and mobility to ensure each setting is able to capture the items most relevant to its patient population needs and goals and use the measures to determine meaningful quality improvement activities.

Response: We thank the commenter for their support and agree with the importance of capturing both self-care and mobility items in the proposed measure, and for this reason, the Discharge Self-Care Score and Discharge Mobility Score measures are not proposed for removal. As with all other measures, we will routinely monitor this measure to ensure the measure maintains strong scientific acceptability and utility to PAC settings.

Comment: Several commenters did not support the adoption of this proposed measure because it lacks CBE endorsement or has not undergone the CBE endorsement process. Three of these commenters noted that the CBE endorsement process provides information on whether or not the measure provides valuable information that can be used to inform improvements in care. Two other commenters pointed out that the measure received a MAP recommendation of ''conditional support for rulemaking pending endorsement by a consensus-based entity'' and believe there should be a discussion about competing measures, since the Discharge Self-Care Score and Discharge Mobility Score measures in the IRF QRP are CBE endorsed.

Response: We direct readers to section IX.C.1.b.(2) of this final rule, where we discuss this topic in detail. Despite the current absence of CBE endorsement for this measure, we still believe it is important to adopt the DC Function measure into the IRF QRP because, unlike the Discharge Self-Care Score and Discharge Mobility Score measures, the DC Function measure relies on functional status items collected on the IRF–PAI and in all PAC settings, satisfies requirement of a cross-setting quality measure set forth in sections 1886(j)(7)(F)(ii) and 1899B(c)(1)(A) of the Act, and assesses both domains of function. We also direct readers to section IX.C.1.b.(2) of this final rule, where we discuss measurement gaps that the DC Function measure fills in relation to competing and related measures. We also acknowledge the importance of the CBE endorsement process and plan to submit the proposed measure for CBE endorsement in the future. We direct readers to section IX.C.1.b.(1)(b) of this final rule, and the technical report for detailed measure testing results demonstrating that the measure provides meaningful information which can be used to improve quality of care, and to the TEP report summaries [110] [111] which detail TEP support for the proposed measure concept.

Comment: A few commenters oppose the adoption of this proposed measure, claiming that it is duplicative of the Discharge Self-Care Score and Discharge Mobility Score currently in the IRF QRP. They believe the adoption of the proposed measure will create confusion among clinicians, patients, and payers who review publicly displayed quality measure information. Two of these commenters added that if the DC Function Score measure is adopted, then the Discharge Self-Care Score and Discharge Mobility Score measures should be removed.

Response: We disagree that the proposed measure is duplicative of the Discharge Self-Care Score and Discharge Mobility Score measures and believe all three measures add value to the IRF QRP measure set. As discussed in section IX.C.1.b.(2) of this final rule, the Discharge Self-Care Score and Discharge Mobility Score measures are not cross-setting because they rely on functional status items not collected in all PAC settings and thus do not satisfy requirement of a cross-setting quality measure set forth in sections 1886(j)(7)(F)(ii) and 1899B(c)(1)(A) of the Act. In contrast, the DC Function measure does include functional status items collected in each of the four PAC settings. Moreover, the DC Function measure captures information that is distinct from the Discharge Self-Care Score and Discharge Mobility Score measures. Specifically, the DC Function measure considers both dimensions of function (utilizing a subset of self-care and mobility GG items in the IRF–PAI), while the Discharge Self-Care Score and Discharge Mobility Score measures each consider one dimension of function (utilizing all self-care or mobility GG items, respectively). We intend for IRFs to use information from the DC Function measure and the Discharge Self-Care Score and Discharge Mobility Score measures when assessing functional areas that may be opportunities for improvement.

Comment: Several commenters opposed the proposed DC Function measure because it combines self-care and mobility items collected on the IRF–PAI. Five of these commenters expressed a preference toward the Discharge Self-Care Score and Discharge Mobility Score measures currently adopted in the IRF QRP because they reflect the two dimensions of function separately. These five commenters believe a composite measure may disadvantage certain patient populations. The same commenters suggested that patients with limited function in their lower extremities may have more difficulty improving mobility while a patient with limited function in their upper extremities may have more difficulty improving self-care.

Response: The DC Function measure is intended to summarize several cross-setting functional assessment items while meeting the requirements of sections 1886(j)(7)(F) and 1899B(c)(1)(A) of the Act. We agree with the commenters that the individual Discharge Self-Care Score and Discharge Mobility Score measures will continue to be useful to assess care quality in these dimensions, and for this reason, these two measures are not proposed for removal. Providers will be able to use information from both the DC Function measure and the Discharge Self-Care Score and Discharge Mobility Score measures when determining which functional areas may be opportunities for improvement. Moreover, we disagree that patients with lower functional performance on either self-care or mobility items will be disadvantaged in the proposed measure calculations. For each stay included in measure calculations, the observed function score is compared to the expected discharge score, which is adjusted to account for clinical characteristics, admission functional status, and demographic characteristics of the patient. Risk adjustment creates an individualized expectation for discharge function score for each stay that controls for these factors and ensures that each stay is measured against an expectation that is calibrated to the patient's individual circumstances when determining the numerator for each IRF.

Comment: Several commenters stated that the DC Function measure has not

[110] Technical Expert Panel (TEP) for the Refinement of Long-Term Care Hospital (LTCH), Inpatient Rehabilitation Facility (IRF), Skilled Nursing Facility (SNF)/Nursing Facility (NF), and Home Health (HH) Function Measures Summary Report (July 2021 TEP). *https://mms-test.battelle.org/sites/default/files/TEP-Summary-Report-PAC-Function.pdf.*

[111] Technical Expert Panel (TEP) for Cross-Setting Function Measure Development Summary Report (January 2022 TEP). *https://mmshub.cms.gov/sites/default/files/PAC-Function-TEP-Summary-Report-Jan2022-508.pdf.*

been tested, such as testing for reliability, validity, or feasibility.

Response: We direct readers to section IX.C.1.b.(1)(b) of this final rule, where we discuss extensively the testing of the proposed DC Function measure. Testing demonstrated good validity for the measure performance, the risk adjustment model, face validity, and statistical imputation models; excellent reliability; and high reportability. The proposed measure would be calculated using data from the IRF–PAI that are already reported to the Medicare program for payment and quality reporting purposes and are therefore feasible to implement and require no additional provider burden. Additionally, we direct readers to section IX.C.1.b.(1)(b) of this final rule and to the Discharge Function Score for IRFs Technical Report [112] for detailed measures testing results that support that the measure provides meaningful information which can be used to improve quality of care, as well as the TEP report summaries [113] [114] which detail TEP support for the proposed measure concept.

Comment: Several commenters oppose the adoption of the DC Function measure because they do not believe it is appropriate or accurate for CMS to override the clinical judgement of the clinicians who are treating the patient by using statistical imputation to impute a value to a data element when an ANA code is used. Two of these commenters noted that the ANA codes allow clinicians to use their professional judgement when certain activities should not or could not be safely attempted by the patient, which may be due to medical reasons. Additionally, two of these commenters stated that among some patients not able to attempt certain self-care and mobility tasks at the time of admission, the use of ANA codes decreases significantly at the time of discharge, which they believe reflect the functional outcomes achieved during their IRF stay. One of these commenters additionally noted that a patient who cannot attempt an activity due to medical or safety concerns is considered dependent for that activity at that time.

Response: We acknowledge that the ANA codes allow clinicians to use their professional judgement when certain activities should not or could not be attempted safely by the patient and that there may be medical reasons that a patient cannot safely attempt a task. We note that we did not propose any changes to the coding guidance for using ANA codes, and we would not expect IRF coding practices to change. However, we want to clarify that utilizing statistical imputation to calculate a quality measure does not override the clinical judgement of clinicians who are expected to continue determining whether certain activities can be safely attempted by patients at the time of admission and discharge and utilize that information to determine appropriate goals and treatment interventions for their IRF patients. Rather, statistical imputation is a component in measure calculation of reported data and improves upon the imputation approach currently implemented in the Change in Mobility Score, Change in Self-Care Score, Discharge in Mobility Score, and Discharge in Self-Care Score measures. In these currently adopted measures, ANA codes are always imputed to 1 (dependent) when calculating the measure scores, regardless of a patient's own clinical and functional information. However, the imputation approach implemented in the proposed DC Function measure uses each patient's available functional and clinical information to estimate each ANA value had the item been completed. Testing demonstrates that, relative to the current simple imputation method, the statistical imputation approach used in this DC Function measure increases precision and accuracy and reduces bias in estimates of missing item values.

Comment: Two commenters stated that clinicians do not have the autonomy to choose whether walk items or wheelchair items are the most appropriate choice for the patient at discharge. To illustrate this point, these commenters provided an example to show how the measure logic may not be equitable for walk patients versus wheelchair patients. The example states that if a patient walks 10 feet dependently because a second helper assists with a wheelchair due to poor balance and will use a wheelchair full time after discharge, then the patient's risk-adjusted expected outcomes would be based on their ability to walk, since a score was coded for Walk 10 feet on admission or discharge.

Response: We disagree that clinicians do not have the autonomy to choose whether walk or wheelchair items should be assessed for a patient at discharge. Clinicians are expected to use their clinical judgement when determining whether certain activities can be safely attempted by the patients when completing the IRF–PAI, reporting ANA codes in measure data, and utilizing the assessment data to determine appropriate goals for their IRF patients. With respect to the example provided, we would like to point out that the use of walk and wheelchair items in the calculation of measure outcomes is similar to that of the existing Discharge Mobility measure: namely, wheelchair items are used only if walk items were coded as ANA at both admission and discharge, in order to maximize the use of walk item scores whenever they are available, including for patients who are scored on both walk and wheelchair items. Both the DC Function and Discharge Mobility Score measures would use the information about the patient's dependent walking at admission. The Discharge Mobility measure would then impute the lowest score (''dependent'') to the ANA walking items at discharge, while the DC Function measure may impute a higher score to those items, based on the clinical and functional covariates for that patient.

Comment: Some commenters expressed concerns regarding the bootstrapping samples used during the development of the DC Function measure imputation model because they believe these samples are not representative of the full IRF population. These commenters believe the validity testing of the proposed DC Function imputation model is not accurate because the models are built using only the functional abilities of patients who had no Section GG items on the IRF–PAI coded ANA, and they believe this comprises a small percentage of the IRF population and exhibits clinical, demographic, and functional characteristics that likely differ from those of the entire IRF population. As such, two of these commenters stated that these imputation models should not be imposed on patients who had ANA assessments, as doing so could lead to unfair penalization of IRF providers treating certain patient populations and performance scores that are not representative of true functional gains achieved by patients during an IRF stay. Another one of four commenters further suggested that the current model of

[112] Discharge Function Score for Inpatient Rehabilitation Facilities (IRFs) Technical Report. *https://www.cms.gov/files/document/irf-discharge-function-score-technical-report-february-2023.pdf.*

[113] Technical Expert Panel (TEP) for the Refinement of Long-Term Care Hospital (LTCH), Inpatient Rehabilitation Facility (IRF), Skilled Nursing Facility (SNF)/Nursing Facility (NF), and Home Health (HH) Function Measures Summary Report (July 2021 TEP) is available at *https://mms-test.battelle.org/sites/default/files/TEP-Summary-Report-PAC-Function.pdf.*

[114] Technical Expert Panel (TEP) for Cross-Setting Function Measure Development Summary Report (January 2022 TEP) is available *at https://mmshub.cms.gov/sites/default/files/PAC-Function-TEP-Summary-Report-Jan2022-508.pdf.*

imputing ANA patients as dependent on that functional item is likely more representative of a patient's functional capabilities than the statistical imputation approach, as a patient who is unable to complete an activity would be viewed as ''dependent'' for purposes of that activity's assessment at that time. This same commenter recommended for CMS to release more demographic data of the patient population that the bootstrapping model utilizes to understand if this population is truly representative of IRF patients.

Response: We would like to clarify that bootstrapping samples were used only to determine validity of the imputation models; to develop the imputation models themselves, all stays without ANAs for each single item were used. As an example, when estimating the imputation model for GG0130A admission scores, all stays without ANAs for GG0130A at admission (≤95 percent of eligible stays) were used. In other words, rather than using the relatively small subset of stays without any ANAs across all GG items, we used much larger subsets without ANAs on a given item. In fact, measure calculations using FY 2021 data utilized 89–100 percent of stays in each of the discharge imputation models and in each of the non-walk/wheelchair admission imputation models. The percentage of stays in the walk/wheelchair admission imputation models ranges from around 45 percent to 73 percent, which is expected as these items have higher rates of skips based on the CMS guidance for coding the IRF–PAI. Given that 89–100 percent of samples are utilized in almost all the imputation models, the imputation models are, in fact, built upon samples that are representative of the IRF population. Furthermore, the imputation methodology builds upon the risk-adjustment methodology which has been in place for multiple years for existing measures. Risk adjustment creates an individualized expectation for the discharge function score for each stay that controls for clinical, demographic, and function characteristics to ensure that each stay is measured against an expectation that is calibrated to the patient's individual circumstances. Similarly, imputation creates an individualized prediction for each GG item value for each stay based on clinical, demographic, and function characteristics to ensure that each imputed value is calibrated to the patient's individual circumstances. Lastly, testing has indicated that discharge functional abilities of patients with ANA codes at admission tended to be higher than those coded as dependent at admission. Treating ANAs and dependent scores equivalently, as is done in the Discharge Self-Care Score and Discharge Mobility Score measures, may disadvantage patients who were truly scored as dependent at admission. Statistical imputation allows the DC Function measure to address this bias.

Comment: Two commenters advocated for the release of more data and methodology pertaining to the statistical imputation approach. One commenter stated that this is the first time CMS is implementing a quality measure score with imputed data and that the report is unclear in how walk versus wheelchair patients are accounted for in this measure when there is an ANA code. This commenter shared results of an analysis they conducted on their own data which indicated that the sample of patients without an ANA can range from over 60 percent to over 90 percent depending on how the model handles dashes and ANA codes for walk and wheel patients, and this wide discrepancy shows the complexity of developing this measure and in verifying its results. The other commenter noted that the statistical imputation approach may falsely elevate overall discharge scores, and thus encouraged oversight and reporting related to the frequency of use of ANA codes on discharge.

Response: We remind commenters that the four functional outcome measures currently used in the IRF QRP are calculated using imputed data. The current imputation approach in these four measures is to recode all ANA codes to 1 (dependent) for purposes of calculating the measure scores, regardless of a patient's reason for receiving IRF care, their demographics, or their clinical and functional characteristics. In contrast, the imputation approach of the proposed DC Function measure uses each patient's available primary reason for IRF care, their demographics, and their functional and clinical information to estimate each ANA value had the item been completed. Testing demonstrates that, relative to the current simple imputation method, the statistical imputation approach increases precision and accuracy and reduces bias in estimates of missing item values. Additionally, we are unsure which report is being referenced and direct readers to the document titled *Discharge Function Score for Inpatient Rehabilitation Facilities (IRFs) Technical Report* for more detailed measure specifications.[115]

We cannot respond to the findings of the analyses performed by the commenter since we do not have sufficient information. However, our analyses of FY 2021 data have indicated that around 89–100 percent of stays are used in each of the discharge imputation models and in each of the non-walk/wheelchair admission imputation models. The percentage of stays in the walk/wheelchair admission imputation models range from around 45 percent to 73 percent, which is expected as these items have higher rates of skips based on the CMS guidance in the IRF–PAI.

Lastly, we disagree that the statistical imputation approach may falsely elevate overall discharge scores. The statistical imputation approach will in fact reflect more accurate performance scores, as indicated by testing results presented pertaining to statistical imputation, compared to the current simple imputation method.

Comment: A few commenters stated that under the statistical imputation methodology, a patient's functional status could be recoded at a higher level based on ''the most likely score'' of other, completely unrelated functional items (for example, oral hygiene and the ability to go up and down steps) and reliance on completely unrelated functional items to impute function scores is not clinically or statistically appropriate.

Response: We disagree that using a full set of clinical characteristics and functional items is not appropriate. The imputation models for the proposed DC Function measure use a similar set of covariates as the risk adjustment model for the Discharge Self-Care Score and Discharge Mobility Score measures which IRFs have been reporting since FY 2016. In addition to these covariates, the proposed DC Function measure's model adds the available information from all available Section GG functional items on the IRF–PAI. While less-related functional variables are generally less correlated with a given item's score, and thus carry less weight in terms of how much they influence the imputed value, they still contribute to the overall model performance by improving overall model fit and reducing estimation error.

Comment: A few commenters suggested that CMS be more involved with clinicians in discussions surrounding the assessment and coding

[115] *Discharge Function Score for Inpatient Rehabilitation Facilities* (IRFs) *Technical Report. https://www.cms.gov/files/document/irf-discharge-function-score-technical-report-february-2023.pdf.*

of patients rather than using an imputation approach if there is concern that ANA codes are not truly reflective of patients' functional abilities. One of these commenters also urged CMS to provide additional coding guidance for ANA use for the GG items in order to better standardize and reduce the use of ANA codes.

Response: We engaged with PAC providers on more than one occasion. As described in section IX.C.1.b.(3) of this final rule, our measure development contractor convened two TEPs to obtain expert clinician input on the development of the measure. The TEPs consisted of interested parties with a diverse range of expertise, including IRF and other PAC subject matter knowledge, clinical expertise, and measure development experience in PAC settings. As described in the PAC QRP Functions TEP Summary Report—March 2022,[116] panelists agreed that the recode approach used in the currently implemented Discharge Self-Care Score, Discharge Mobility Score, Change in Self-Care Score, and Change in Mobility Score measures could be improved upon and reiterated that not all ANAs reflect dependence on a function activity. Based on the extensive testing results presented to the TEP, a majority of panelists favored the statistical imputation over alternative methodologies and an imputation method that is more accurate over one that is simpler.

Additionally, CMS continually provides training resources to providers to give guidance about how to code functional items,[117] including the use of ANA codes.

Comment: One commenter believed self-care and mobility items in the IRF–PAI can be reported as a zero, resulting in the proposed imputation approach producing errors or needing to be recoded to a different measure; while another commenter sought clarification on measure calculations and stated that the DC Function measure calculates a risk adjusted ratio of observed to expected scores at discharge for all patients over 18 years old that do not meet exclusion criteria. While they supported the risk adjustment method, this commenter warned that it may give different results than the ''alternative standardization risk-adjustment model.''

Response: The DC Function measure's items are neither recoded to 0 nor recoded in another measure but are recoded to a value between 1 and 6. The imputation approach is similar in complexity to the DC Function measure's risk adjustment approach, which is modeled after the approach in the currently adopted Discharge Self-Care Score, Discharge Mobility Score, Change in Self-Care Score, and Change in Mobility Score measures. Please reference section IX.C.1.b.(5) of this final rule for more information on the proposed imputation approach.

We agree that it is important for clinicians to understand the proposed quality measure, and thus provided detailed specifications to ensure transparency with respect to the measure's calculation, including the risk-adjustment methodology. To clarify, the DC Function measure score is not a ratio. The measure is constructed by calculating the number of IRF stays where the expected score is higher than the observed score out of total stays. At a high level, the ''expected'' discharge score is calculated by risk-adjusting the observed discharge score (that is, the sum of individual function item values at discharge) for admission functional status, age, and clinical characteristics using an ordinary least squares linear regression model. The model intercept and risk adjustor coefficients are determined by running the risk adjustment model on all eligible IRF stays. For more detailed measure specifications, we direct readers to the document titled Discharge Function Score for Inpatient Rehabilitation Facilities (IRFs) Technical Report.[118]

Also, we are unsure of the ''alternative standardization risk-adjustment model'' this commenter references and would like to clarify that the proposed risk adjustment model has undergone validity testing, showing good model discrimination as the measure model has the predictive ability to distinguish patients with low expected functional capabilities from those with high expected functional capabilities.[119]

Comment: One commenter stated that there is no minimum number of eligible stays from which to base the imputation method, potentially invalidating results.

Response: We would like to clarify that imputation models are estimated using the entire population of eligible stays, and thus sample size is not a concern. For additional measure testing details, we refer readers to the document titled *Discharge Function Score for Inpatient Rehabilitation Facilities (IRFs) Technical Report.*[120]

Comment: One commenter expressed concern with the proposed statistical imputation approach utilized in the DC Function measure and suggested it might lead to this measure score varying significantly from the Discharge Self-Care Score and Discharge Mobility Score measures' scores.

Response: The DC Function measure captures information that is distinct from the Discharge Self-Care Score and Discharge Mobility Score measures. Specifically, the DC Function measure considers both dimensions of function (utilizing a subset of self-care and mobility GG items), while the Discharge Self-Care Score and Discharge Mobility Score measures each consider one dimension of function (utilizing all self-care and mobility GG items, respectively). For these same reasons, we expect to see differences in outcome percentages among these three measures for reasons unrelated to the imputation approach used.

Comment: Two commenters believe the measure's imputed and risk-adjusted expected values will complicate clinicians' ability to review and validate information used for public reporting. Another commenter stated that the statistical imputation approach is a very complex calculation and understanding how performance is impacted may be difficult for both IRFs and the public. This commenter urges CMS to continuously evaluate this method and its impact impacts across the PAC settings.

Response: The proposed measure uses methods that are similar in complexity to CBE-endorsed functional outcome measures that have been adopted in the PAC QRP for several years and will be similarly specified. As such, understanding performance should be no more difficult than understanding the currently adopted Discharge Self-Care Score, Discharge Mobility Score, Change in Self-Care Score, and Change in Mobility Score measures. As with all other measures, we will routinely monitor this measure's performance, including the statistical imputation

[116] Technical Expert Panel (TEP) for Cross-Setting Function Measure Development, January 26–27, 2022 Summary Report. *https://mmshub.cms.gov/sites/default/files/PAC-Function-TEP-Summary-Report-Jan2022-508.pdf.* Page 20.

[117] Centers for Medicare & Medicaid Services. Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP) Training. *https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/irf-quality-reporting/irf-quality-reporting-training.*

[118] *Discharge Function Score for Inpatient Rehabilitation Facilities* (IRFs) *Technical Report. https://www.cms.gov/files/document/irf-discharge-function-score-technical-report-february-2023.pdf.*

[119] ''Expected functional capabilities'' is defined as the predicted discharge function score.

[120] *Discharge Function Score for Inpatient Rehabilitation Facilities* (IRFs) *Technical Report. https://www.cms.gov/files/document/irf-discharge-function-score-technical-report-february-2023.pdf.*

approach, to ensure the measure remains valid and reliable.

Comment: One commenter requested that CMS provide more clarity on its imputation approach to recoding, specifically contrasting it with a Rasch analysis used in the PAC PPS prototype, to ensure transparency and clinical meaningfulness.

Response: The Rasch analysis in the PAC PPS prototype produces a single value to which every single ANA is recoded for a given item across all patients and settings. By contrast, under the imputation approach for the DC Function measure, we estimate a different recode value for each patient, based on their clinical comorbidities, codes on all other GG items, and setting. We believe our approach accounts for several likely effects: setting-specific coding guidance and practice differences; function scores being correlated with clinical comorbidities; and functional scores for a given GG item being correlated with functional codes on other GG items, particularly on ''adjacent'' (similar) items. Therefore, we believe recoding ANAs based on patients' specific clinical risk and using all available GG item scores (codes) is a more valid approach. For more detailed measure specifications, we direct readers to the document titled *Discharge Function Score for Inpatient Rehabilitation Facilities (IRFs) Technical Report.*[121]

Comment: Two commenters expressed concern that the proposed measure numerator is not wholly attributed to a facility's quality of care and that the calculation of the ''expected'' discharge score is opaque, resulting in difficulty for providers to determine the score for which they are striving. These commenters further noted that functional goals are not based on statistical regression and are identified via individual-specific goals related to function, independence, and overall health.

Response: We agree with the commenter that functional goals are identified for each patient as a result of an individual assessment and clinical decisions, rather than statistics. However, we want to remind commenters that the DC Function measure is not calculated using the goals identified in clinical process. The ''expected'' discharge score is calculated by risk-adjusting the observed discharge score (that is, the sum of individual function item values at discharge) for admission functional status, age, and clinical characteristics using an ordinary least squares linear regression model. The model intercept and risk adjustor coefficients are determined by running the risk adjustment model on all eligible IRF stays. For more detailed measure specifications, we direct readers to the document titled *Discharge Function Score for Inpatient Rehabilitation Facilities (IRFs) Technical Report.*[122] The risk-adjustment model for this measure controls for clinical, demographic, and function characteristics to ensure that the score fully reflects a facility's quality of care.

Comment: One commenter opposed the adoption of the proposed measure because this commenter has significant concern with the current calculations of the ''expected'' discharge score for the proposed measure. This commenter stated that there are identified discrepancies in the way that CMS calculates an ''expected'' discharge score for the existing Discharge Self-Care Score and Discharge Mobility Score measures, calculations are complex, and calculations of the ''expected'' discharge value for multiple separate function items is unclear. As a result, this commenter believed it is premature to implement an expanded discharge function score measure and doing so will result in serious implementation burdens and technical challenges.

Response: This commenter noted discrepancies in the way ''expected'' discharge scores for current functional outcome measures are calculated but did not provide additional information regarding the discrepancies to which they were referring. CMS is unaware of any discrepancies and would require further details in order to respond to these concerns. Nonetheless, we believe the proposed measure's calculations of the ''expected'' discharge score has strong scientific acceptability based on measure testing results, as previously discussed. As with all other measures, we will routinely monitor this measure's performance, including the issue raised about the calculation of ''expected'' discharge scores, to ensure the measure remains valid and reliable.

We would also like to clarify that the ''expected'' discharge score is not calculated for each function item separately. Instead, the ''expected'' discharge score is calculated by risk-adjusting the observed discharge score, which is the sum of individual function item (observed) values at discharge. For more detailed measure specifications, we direct readers to the document titled *Discharge Function Score for Inpatient Rehabilitation Facilities (IRFs) Technical Report.*[123]

Comment: Several commenters disagreed with language in the proposed rule that characterized items coded with an ANA code (codes 07, 09, 10, and 88), a dash (-), and a skip (^) as ''missing'' data since CMS provides distinct guidance and specifications for each code's use. Specifically, these commenters stated that ANA codes represent clinical information that the patient was incapable of performing a task for reasons specified by CMS in the IRF–PAI manual and thus are not considered ''missing data''; because these ANA codes represent clinical information, three of these commenters stated that imputation of these ANA codes based on other function activities would not improve the precision of the score.

Response: We agree that ANA codes, a dash, and a skip have different meanings when used on the IRF–PAI. To clarify, the use of the term ''missing'' data refers to codes that are not coded 01, 02, 03, 04, 05, or 06 which represent the amount of (or lack of) helper assistance a patient needs to complete a functional activity. ANA codes, a dash, and a skip are considered ''missing'' in the context of the measure calculations since the observed discharge score is the sum of 01–06 values from functional assessment items included in the observed discharge score. Utilizing statistical imputation to calculate the observed discharge score does not disregard the clinical information represented by ANA codes. Rather, statistical imputation is a component in measure calculation of reported data and improves upon the imputation approach currently implemented in the Change in Mobility Score, Change in Self-Care Score, Discharge in Mobility Score, and Discharge in Self-Care Score measures. In these measures, ANA codes are always imputed to 1 (dependent) when calculating the measure scores, regardless of a patient's own clinical and functional information. The imputation approach implemented in the proposed DC Function measure uses each patient's available functional and clinical information, including ANA codes on other functional assessment items, to

[121] *Discharge Function Score for Inpatient Rehabilitation Facilities* (IRFs) *Technical Report. https://www.cms.gov/files/document/irf-discharge-function-score-technical-report-february-2023.pdf.*

[122] *Discharge Function Score for Inpatient Rehabilitation Facilities* (IRFs) *Technical Report. https://www.cms.gov/files/document/irf-discharge-function-score-technical-report-february-2023.pdf.*

[123] *Discharge Function Score for Inpatient Rehabilitation Facilities* (IRFs) *Technical Report. https://www.cms.gov/files/document/irf-discharge-function-score-technical-report-february-2023.pdf.*

estimate each ANA value had the item been completed. Testing demonstrates that, relative to the current simple imputation method, the statistical imputation approach in used this DC Function measure increases precision and accuracy, while reducing bias in estimates of missing item values.

Comment: Several commenters raised concerns about the extent to which the measure can be considered a cross-setting measure, and its utility for comparing performance across settings. Some of these commenters believe that calculating a cross-setting function measure with different populations across PAC settings will not be meaningful in characterizing patients or comparing their outcomes across the different PAC settings, and may lead to inaccurate comparisons for patients, caregivers, Medicare Advantage plans, Medicaid managed care plans, and other interested parties. The same commenters also stated that CMS should work with interested parties to standardize data so that interested parties can differentiate patients' abilities and disabilities in a wide range of functional levels across the PAC spectrum.

Response: We acknowledge that the measure denominators differ across PAC settings. However, as clarified during the MAP PAC/LTC workgroup discussed in section IX.C.1.b.(4) of this final rule, the denominator population in each measure setting is the population included in the respective setting's quality reporting program, as stated in the FY 2023 IRF PPS final rule (87 FR 47082 and 87 FR 47074) and the FY 2018 SNF PPS final rule (82 FR 36598). Moreover, we would like to clarify that cross-setting measures do not necessarily suggest that facilities can be compared across settings. Instead, these measures are intended to compare providers within a specific setting while standardizing measurement of function across settings. The proposed measure does just this, by aligning measure specifications across settings and including the use of a common set of standardized functional assessment data elements. This alignment satisfies the requirements of section 1886(j)(7)(F)(i) of the Act for a cross-setting measure in the functional status domain specified under section 1899B(c)(1) of the Act.

Comment: One commenter requested the rationale as to why confidence intervals were not calculated and reported for the expected function scores and utilized in determining meaningful differences between the observed and expected function score. This commenter also stated that the minimum clinical difference in discharge function scores that indicates a change is meaningful to patient progress has not been identified.

Response: The proposed DC Function measure uses the same approach in determining whether an observed discharge score is different than its associated expected discharge score as the currently adopted Discharge Self-Care Score and Discharge Mobility Score measures that are CBE endorsed. Specifically, the DC Function measure reports the proportion of a given provider's stays where observed discharge function score matches or exceeds expected discharge function score. The measure score is a continuous variable with values between 0 and 100, allowing for intuitive interpretation and comparisons. Our TEP supported that patients and families are more likely to understand a measure that expresses functional outcome as a simple proportion of patients who meet expectation for their discharge functional status, rather than units of change in a scoring system that is unfamiliar to most Care Compare website users (the primary audience for this measure). Measure scores based on statistical significance of differences between observed and expected values (based on confidence intervals) place providers in broad categories, such as 'No different than national average,' which do not allow more granular provider comparisons for the public reviewing the measure's data on Care Compare. Given the excellent reliability of the DC Function measure, we believe that reporting provider scores as broad categories is not warranted.

Comment: One commenter noted the variability in median scores and believed this range suggests the measure may not be valid, and that the variability may be problematic when making comparisons among providers.

Response: First, we would like to clarify that median scores are not used in the calculation of this measure. While we would require additional information regarding the median scores referenced in this comment to provide a more complete response, we acknowledge that the measure has a large range of average expected discharge scores, as calculated for each provider. This range is consistent with the range of observed discharge scores, indicating that the measure is capturing the range of patient's functional abilities, and thus, in fact, supports the validity of the measure.

Comment: One commenter noted that intrinsic to the discharge scores are the associated admission scores, and suggested an analysis of this measure to assess the variability in initial admission function scores between hospitals for similar types of patients as differences may account for the gaps in the observed discharge function scores.

Response: We acknowledge that the observed gap in discharge function scores may be due to variability in the initial admission function scores; nevertheless, the admission function scores are included as covariates in the risk adjustment model and thus are accounted for in the calculations of the expected discharge function scores.

Comment: One commenter questioned CMS' characterization of the adjusted R-squared value of 0.65 for the proposed DC Function measure's risk adjustment model. This commenter believed a value of 0.65 suggests moderate, rather than ''good'' model discrimination. This commenter suggested CMS should address the ability of the risk adjustment model to make predictions by comparing R-squared values of the ''training'' and ''validation'' sets and reporting ''predicted R-squared'' values.

Response: We want to clarify that the adjusted R-squared for the DC Function measure, as reported in the Discharge Function Score for Inpatient Rehabilitation Facilities (IRFs) Technical Report,[124] was 0.51. We believe that this value indicates ''good'' model discrimination, and it is comparable to those of the Discharge Self-Care Score and Discharge Mobility Score measures (0.48–0.50). Additionally, because the measure model uses all available data, the concepts of ''training'' and ''validation'' sets (and any related ''predicted R-squared'') are not applicable. Rather, adjusted R-squared values capture model fit for the risk-adjustment model.

Comment: Two commenters expressed concern that the measure performance may not adequately demonstrate the advancement in functional ability a patient has gained across the mobility and selfcare domains during their IRF stay. One of these commenters believed that upper body dressing and lower body dressing are better indicators of patient functional success at discharge than items currently included in the DC Function measure, and the rationale for selecting certain function items to be captured in this measure seem to be based solely on ensuring cross-setting applicability and less on the accuracy of an ''expected'' function score.

Response: We acknowledge that the cross-setting applicability was a

[124] *Discharge Function Score for Inpatient Rehabilitation Facilities* (IRFs) *Technical Report. https://www.cms.gov/files/document/irf-discharge-function-score-technical-report-february-2023.pdf.*

motivating factor in determining function items captured in the proposed DC Function measure, and upper body dressing and lower body dressing function items were not available across settings. Nonetheless, the proposed DC Function measure does reflect the progress of patients across both the mobility and selfcare domains. As stated in section IX.C.1.b.(3) of this final rule, the TEP supported the inclusion of both functional domains as self-care items impact mobility items and are clinically relevant to function. Additionally, the proposed measure is meant to supplement, rather than replace, the Discharge Self-Care Score and Discharge Mobility Score measures which implement the remaining self-care and mobility function items not captured in the DC Function measure. High correlations between the proposed measure and the Discharge Self-Care Score and Discharge Mobility Score measures (0.85 and 0.88, respectively) demonstrate that these three measures capture related but distinct aspects of provider care in relation to patients' function. The TEP understood these aforementioned considerations and supported the inclusion of the function items included in the proposed measure.

Comment: Two commenters (one in support of this proposed measure, and one opposed) raised concerns that the measure does not account for cognition and communication. One commenter urged CMS to consider alternative assessments that better incorporate cognition and communication into the measure calculation. The other commenter similarly raised concerns that Section GG items in the IRF–PAI insufficiently capture all elements of function and do not adequately capture the outcomes required for safety and independence.

Response: We agree that cognition and communication are critically important and related to the safety and independence of patients. Although not directly assessed for the purpose of measure calculation, this measure does indirectly capture a facility's ability to impact a patient's cognition and communication to the extent that these factors are correlated to improvements in self-care and mobility. That said, we agree that communication and cognition are important to assess directly, and facilities currently do so through completion of the BIMS, CAM©, and items BB0700–BB0800 in the IRF–PAI. Additionally, CMS regularly assesses the measures in the IRF QRP for measurement gaps, and as described in section IX.D of this final rule, specifically identified cognitive improvement as a possible gap and sought feedback about how to best assess this clinical dimension. CMS will use this feedback as well as discussion with technical experts and empirical analyses to determine how to measure communication and cognition.

Comment: Two commenters expressed concern regarding the validity or completeness of reported functional assessment data. One of these commenters recommended that CMS improve providers' reporting of functional assessment data before adopting this measure, as the inconsistency of PAC providers' recording of this information raises concerns about publicly reporting this measure and using this measure for payment. This commenter provided the example that some providers code patient function in response to payment incentives. Although there are currently no payment implications for this measure, this commenter noted that differential coding practices and profitability by case type across IRFs may contribute to differential profitability. Additionally, this commenter stated that the current imputation approach used in existing measures in the IRF QRP recodes any ANA code to the most or second most dependent level which would lead to a lower motor score and raise Medicare payment for the stay.

Response: We acknowledge that the coding of GG items may be affected by payment and quality reporting considerations and are actively monitoring IRF coding practices. The imputation approach implemented in the currently adopted Discharge Self-Care Score and Discharge Mobility Score measures, which recodes any ANA code to the most dependent level, can exacerbate these incentives, particularly with respect to function at admission. We would like to point out that statistical imputation used in the proposed DC Function measure reduces these incentives by using all available relevant information to assign the most likely score, ranging from most to least dependent, to each GG item. We acknowledge the importance of utilizing valid assessment data and will continue to monitor this potential data validity concern and will reconsider the measure's implementation in the quality reporting program, if needed.

CMS has multiple processes in place to ensure reported patient data are accurate. State agencies conduct standard certification surveys for IRFs, and accuracy and completeness of the IRF–PAI are among the regulatory requirements that surveyors evaluate during surveys.[125] Additionally, the IRF–PAI process has multiple regulatory requirements. Our regulations at § 412.606(b) require that (1) the assessment accurately reflects the patient's status, (2) a clinician appropriately trained to perform a patient assessment using the IRF–PAI conducts or coordinates each assessment with the appropriate participation of health professionals, and (3) the assessment process includes direct observation, as well as communication with the patient.[126] We take the accuracy of IRF–PAI assessment data very seriously, and routinely monitor the IRF QRP measures' performance, and will take appropriate steps to address any such issues, if identified, in future rulemaking.

We note that the potential consequences of submitting false data and information in the IRF–PAI, including the potential for civil liability under the False Claims Act (31 U.S.C. 3729 to 3733) for knowingly presenting a false or fraudulent claim to the government for payment, provide strong incentives for providers to ensure that the data submitted in the IRF–PAI are accurate.

Comment: One commenter raised concerns about the measure, noting that IRFs are allowed to have 5 percent of the IRF–PAI data incomplete.

Response: We interpret the comment as referring to the 95 percent completion threshold for the Annual Increase Factor (AIF) update. IRFs must submit 95 percent of their assessments with 100 percent of the required data elements to avoid the 2 percent penalty.[127] As with all our IRF QRP measures, we will continue to monitor this measure to identify any concerning trends as part of our routine monitoring activities to regularly assess measure performance, reliability, and reportability for all data submitted for the IRF QRP.

Comment: One commenter believes that self-care and mobility items are not tracked across PAC settings, creating inconsistent reporting and undue burden on IRFs, and stating that IRFs are held to different standards compared to other settings.

Response: In addition to the IRF, the items in the DC Function measure are

[125] Center for Medicare and Medicaid Services. September 6, 2022. Hospitals. *https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcomplianc/hospitals.*

[126] 42 CFR 412.606 *https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-P/section-412.606.*

[127] § 412.634(f) Requirements under the Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP). *https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-P/section-412.634.*

collected and tracked across the SNF, LTCH and Home Health setting. Therefore, we do not believe IRFs are held to a higher standard as it relates to collecting this information.

After careful consideration of the public comments we received, we are finalizing our proposal to adopt the DC Function measure as an assessment-based outcome measure beginning with the FY 2025 IRF QRP.

c. Removal of the Application of Percent of Long-Term Care Hospital Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function Beginning With the FY 2025 IRF QRP

We proposed to remove the Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (Application of Functional Assessment/Care Plan) measure from the IRF QRP beginning with the FY 2025 IRF QRP. Section 412.634(b)(2) of our regulations specifies eight factors we consider for measure removal from the IRF QRP, and we believe this measure should be removed because it satisfies two of these factors.

First, the Application of Functional Assessment/Care Plan measure meets the conditions for measure removal factor one: measure performance among IRFs is so high and unvarying that meaningful distinctions in improvements in performance can no longer be made.[128] Second, this measure meets the conditions for measure removal factor six: there is an available measure that is more strongly associated with desired patient functional outcomes. We believe the proposed DC Function measure discussed in section IX.C.1.b. of the proposed rule better measures functional outcomes than the current Application of Functional Assessment/Care Plan measure. We discuss each of these reasons in more detail below.

In regard to removal factor one, the Application of Functional Assessment/Care Plan measure has become topped out, with average performance rates reaching nearly 100 percent over the past 3 years (ranging from 99.8 percent to 99.9 percent during CYs 2019–2021).[129] [130] [131] For the 12-month period of third quarter of CY 2020 through second quarter of CY 2021 (July 1, 2020 through June 30, 2021), IRFs had an average score for this measure of 99.8 percent, with nearly 80 percent of IRFs scoring 100 percent,[132] and for CY 2021, IRFs had an average score of 99.9 percent, with nearly 78 percent of IRFs scoring 100 percent.[133] The proximity of these mean rates to the maximum score of 100 percent suggests a ceiling effect and a lack of variation that restricts distinction among IRFs.

In regard to measure removal factor six, the proposed DC Function measure is more strongly associated with desired patient functional outcomes than this current process measure, the Application of Functional Assessment/Care Plan measure. As described in section VIII.C.b.(1)(b) of the proposed rule, the DC Function measure has the predictive ability to distinguish patients with low expected functional capabilities from those with high expected functional capabilities.[134] We have been collecting standardized functional assessment elements across PAC settings since 2016, which has allowed for the development of the proposed DC Function measure and meets the statutory requirements to submit standardized patient assessment data and other necessary data with respect to the domain of functional status, cognitive function, and changes in function and cognitive function. In light of this development, this process measure, the Application of Functional Assessment/Care Plan measure which measures only whether a functional assessment is completed, and a functional goal is included in the care plan, is no longer necessary, and can be replaced with a measure that evaluates the IRF's outcome of care on a patient's function.

Because the Application of Functional Assessment/Care Plan measure meets measure removal factors one and six under § 412.634(b)(2), we proposed to remove it from the IRF QRP beginning with the FY 2025 IRF QRP. We also proposed that public reporting of the Application of Functional Assessment/Care Plan measure would end by the September 2024 Care Compare refresh or as soon as technically feasible when public reporting of the proposed DC Function measure would begin (see section VIII.G.3. of the proposed rule).

Under our proposal, IRFs would no longer be required to report a Self-Care Discharge Goal (that is, GG0130, Column 2) or a Mobility Discharge Goal (that is, GG0170, Column 2) on the IRF–PAI beginning with patients admitted on October 1, 2023. We would remove the items for Self-Care Discharge Goals (that is, GG0130, Column 2) and Mobility Discharge Goals (that is, GG0170, Column 2) with the next release of the IRF–PAI. Under our proposal, these items would not be required to meet IRF QRP requirements beginning with the FY 2025 IRF QRP.

We invited public comment on our proposal to remove the Application of Functional Assessment/Care Plan measure from the IRF QRP beginning with the FY 2025 IRF QRP. The following is a summary of the public comments received on our proposal and our responses:

Comment: Several commenters supported the removal of the Application of Functional Assessment/Care Plan measure, along with the requirement to submit the associated goal items (that is, the Self-Care Discharge Goals and Mobility Discharge Goals), stating that the measure lacks variation in performance and is no longer meaningful, and noted its removal will reduce burden. Three of these commenters noted that the measure's removal should not be tied to the adoption of the DC Function measure because the measure is topped out and is no longer representative of meaningful distinctions in improvements and performance.

Response: We thank the commenters for their support to remove the Application of Functional Assessment/Care Plan measure and the removal of the GG items from the IRF–PAI and agree that the measure provides limited value given the lack of variation. With respect to the commenters' request that we not tie this measure removal proposal to the adoption of the DC Function measure, we would like to

[128] For more information on the factors CMS uses to base decisions for measure removal, we refer readers to § 412.634(b)(2) Subpart P—Requirements under the Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP). *https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-P/section-412.634.*

[129] Centers for Medicare & Medicaid Services. Inpatient Rehabilitation Facilities Data Archive, 2021, Annual Files National Data 07–21. *https://data.cms.gov/provider-data/archived-data/inpatient-rehabilitation-facilities.*

[130] Centers for Medicare & Medicaid Services. Inpatient Rehabilitation Facilities Data Archive, 2022, Annual Files National Data 04–22. *https://data.cms.gov/provider-data/archived-data/inpatient-rehabilitation-facilities.*

[131] Centers for Medicare & Medicaid Services. Inpatient Rehabilitation Facilities Data Archive, 2022, Annual Files National Data 09–22. *https://data.cms.gov/provider-data/archived-data/inpatient-rehabilitation-facilities.*

[132] Centers for Medicare & Medicaid Services. Inpatient Rehabilitation Facilities Data Archive, 2022, Annual Files Provider Data 04–22. *https://data.cms.gov/provider-data/archived-data/inpatient-rehabilitation-facilities.*

[133] Centers for Medicare & Medicaid Services. Inpatient Rehabilitation Facilities Data Archive, 2022, Annual Files Provider Data 09–22. *https://data.cms.gov/provider-data/archived-data/inpatient-rehabilitation-facilities.*

[134] ''Expected functional capabilities'' is defined as the predicted discharge function score.

clarify that a cross-setting measure of function is required to meet the requirements set forth in sections 1886(j)(7)(F)(i) and 1899B(c)(1)(A) of the Act. Thus, the removal of this measure is inherently dependent on the adoption of a new measure that would also meet the requirements of sections 1886(j)(7)(F)(i) and 1899B(c)(1)(A) of the Act.

Comment: One commenter supported the removal of the Application of Functional Assessment/Care Plan measure, but also noted that it is important and integral to set and track individual patient functional goals for a patient's care plan.

Response: We thank the commenter for their support to remove the Application of Functional Assessment/Care Plan measure from the IRF QRP. Additionally, we agree that it is critically important that facilities continue to set and track patient functional goals, even after the measure is removed. While CMS will not require the assessment or reporting of, items associated with this measure, IRFs have the option to continue collection within their own health records to meet patient needs.

After consideration of the public comments we received, we are finalizing our proposal to remove the Application of Functional Assessment/Care Plan measure from the IRF QRP beginning with the FY 2025 IRF QRP as proposed.

d. Removal of the IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients and Removal of the IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients Beginning With the FY 2025 IRF QRP

We proposed to remove the IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (Change in Self-Care Score) and the IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (Change in Mobility Score) measures from the IRF QRP beginning with the FY 2025 IRF QRP. Section 412.634(b)(2) of our regulations specifies eight factors we consider for measure removal from the IRF QRP. We proposed removal of these measures because they satisfy measure removal factor eight: the costs associated with a measure outweigh the benefits of its use in the IRF QRP.

Measure costs are multifaceted and include costs associated with implementing and maintaining the measures. On this basis, we proposed to remove these measures for two reasons. First, the costs to IRFs associated with tracking similar or duplicative measures in the IRF QRP outweigh any benefit that might be associated with the measures. Second, the costs to CMS associated with program oversight of the measures, including measure maintenance and public display, outweigh the benefit of information obtained from the measures. We discuss each of these in more detail below.

We adopted the Change in Self-Care Score and Change in Mobility Score measures in the FY 2016 IRF PPS final rule (80 FR 47112 through 47118) under section 1886(j)(7)(D)(ii) of the Act because the measures meet the functional status, cognitive function, and changes in function and cognitive function domain under section 1899B(c)(1) of the Act. Two additional measures addressing the functional status, cognitive function, and changes in function and cognitive function domain were adopted in the same program year: the IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (Discharge Self-Care Score) and the IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (Discharge Mobility Score) measures. Given that the primary goal of rehabilitation is improvement in functional status, IRF clinicians have traditionally assessed and documented individual patients' functional status at admission and discharge to evaluate the effectiveness of the rehabilitation care provided.

We proposed to remove the Change in Self-Care Score and Change in Mobility Score measures because we believe the IRF costs associated with tracking duplicative measures outweigh any benefit that might be associated with the measures. Since the adoption of these measures in 2016, we have been monitoring the data and found that the scores for the two self-care functional outcome measures, Change in Self-Care Score and Discharge Self-Care Score, are very highly correlated in IRF settings (0.97).[135] Similarly, in the monitoring data, we have found that, the scores for the two mobility score measures, Change in Mobility Score and Discharge Mobility Score, are very highly correlated in IRF settings (0.98).[136] The high correlation between these measures suggests that the Change in Self-Care Score and Discharge Self-Care Score and the Change in Mobility Score and the Discharge Mobility Score measures provide almost identical information about this dimension of quality to IRFs and are therefore duplicative.

Our proposal to remove the Change in Self-Care Score and the Change in Mobility Score measures is supported by feedback received from the TEP convened for the Refinement of LTCH, IRF, SNF/NF, and HH Function Measures. As described in section VIII.C.1.b(3) of the proposed rule, the TEP panelists were presented with analyses that demonstrated the ''Change in Score'' and ''Discharge Score'' measure sets are highly correlated and do not appear to measure unique concepts, and they subsequently articulated that it would be sensible to retire either the ''Change in Score'' or ''Discharge Score'' measure sets for both self-care and mobility. Based on responses to the post-TEP survey, the majority of panelists (nine out of 12 respondents) suggested that only one measure is necessary. Of those nine respondents, six preferred retaining the ''Discharge Score'' measures over the ''Change in Score'' measures.[137]

Additionally, we proposed to remove the Change in Self-Care Score and Change in Mobility Score measures because the program oversight costs outweigh the benefit of information that CMS, IRFs, and the public obtain from the measures. We must engage in various activities when administering the QRPs, such as monitoring measure results, producing provider preview reports, and ensuring the accuracy of the publicly reported data. Because these measures essentially provide the same information to IRFs and consumers as the Discharge Self-Care Score and Discharge Mobility Score measures, the costs to CMS associated with measure maintenance and public display outweigh the benefit of

[135] Acumen, LLC and Abt Associates. Technical Expert Panel (TEP) for the Refinement of Long-Term Care Hospital (LTCH), Inpatient Rehabilitation Facility (IRF), Skilled Nursing Facility (SNF)/Nursing Facility (NF), and Home Health (HH) Function Measures, July 14–15, 2021: Summary Report. February 2022. *https://mmshub.cms.gov/sites/default/files/TEP-Summary-Report-PAC-Function.pdf.*

[136] Acumen, LLC and Abt Associates. Technical Expert Panel (TEP) for the Refinement of Long-Term Care Hospital (LTCH), Inpatient Rehabilitation Facility (IRF), Skilled Nursing Facility (SNF)/Nursing Facility (NF), and Home Health (HH) Function Measures: July 14–15, 2021: Summary Report. February 2022. *https://mmshub.cms.gov/sites/default/files/TEP-Summary-Report-PAC-Function.pdf.*

[137] Acumen, LLC and Abt Associates. Technical Expert Panel (TEP) for the Refinement of Long-Term Care Hospital (LTCH), Inpatient Rehabilitation Facility (IRF), Skilled Nursing Facility (SNF)/Nursing Facility (NF), and Home Health (HH) Function Measures, July 14–15, 2021: Summary Report. February 2022. *https://mmshub.cms.gov/sites/default/files/TEP-Summary-Report-PAC-Function.pdf.*

information obtained from the measures.

Because these measures meet the criteria for measure removal factor eight, we proposed to remove the Change in Self-Care Score and Change in Mobility Score measures from the IRF QRP beginning with the FY 2025 IRF QRP. We also proposed that public reporting of the Change in Self-Care Score and the Change in Mobility Score measure would end by the September 2024 Care Compare refresh or as soon as technically feasible.

We invited public comment on our proposal to remove the Change in Self-Care Score and Change in Mobility Score measures from the IRF QRP beginning with the FY 2025 IRF QRP.

The following is a summary of the public comments received on our proposal to remove the Change in Self-Care Score and Change in Mobility Score measures from the IRF QRP beginning with the FY 2025 IRF QRP and our responses.

Comment: Several commenters expressed their support for the removal of the Change in Self-Care Score and the Change in Mobility Score measures, noting that these measures are duplicative of other measures and that their removal will reduce costs to IRFs and to CMS.

Response: We thank the commenters for their support of the removal of the measures and agree, based on the testing we presented in the proposed rule, that the Change in Self-Care Score and Change in Mobility Score measures are duplicative of the Discharge Self-Care Score and Discharge Mobility Score measures.

Comment: Several commenters did not agree with the removal of the Change in Self-Care Score and Change in Mobility Score measures because they believe these measures provide more information than the Discharge Self-Care Score and the Discharge Mobility Score measures. Specifically, some commenters stated that capturing the amount of change patients experience is more valuable than capturing whether patients meet or exceed an expected amount of change during their stay. One commenter noted that the greater variability in performance of the Change in Self-Care Score and Change in Mobility Score measures offers significantly greater opportunity to differentiate IRF performance, compared to the analogous Discharge Self-Care Score and Discharge Mobility Score measures.

Response: We appreciate the perspective of the commenters and understand that there are advantages and disadvantages to retiring the Change in Self-Care Score and Change in Mobility Score versus the Discharge Self-Care Score and Discharge in Mobility Score measures. We weighed the tradeoffs of these measures in consultation with a TEP, comprised of 15 panelists with diverse perspectives and areas of expertise, including IRF representation.[138] The majority of the TEP favored the retirement of the Change in Self-Care Score and Change in Mobility Score measures because they believed the Discharge Self-Care Score and Discharge in Mobility Score measures better capture a patient's relevant functional abilities. We agree that it is important for facilities to track the amount of change that occurs over the course of a stay for is patients and would like to point out that the removal of the Change in Self-Care Score and Change in Mobility Score measures does not preclude IRFs' abilities in this regard. However, we also believe that the Change in Self-Care Score and Change in Mobility Score measures are not intuitive to interpret for the primary audience of Care Compare, as the unit of change, and what constitutes a meaningful change, are unfamiliar to the vast majority of users, particularly prospective or current patients and their caregivers. This is in contrast to the Discharge Self-Care Score and Discharge Mobility Score measures, which are presented as a simple proportion. Additionally, as noted in section VII.C.1.b.1.b of this final rule, the correlations between the Change in Self-Care Score and Discharge Self-Care Score measures and Change in Mobility Score and Discharge Mobility Score measures are very high (Spearman correlation: 0.97–0.98), indicating the measures capture almost identical concepts and lead to very similar rankings.[139] As such, the testing does not support the claim that the Change in Self-Care Score and Change in Mobility Score measures provide significantly more information on which to compare facilities, as the relative rankings of facilities are very similar between the Change in Self-Care Score and Discharge Self-Care Score measures and the Change in Mobility Score and Discharge Mobility Score measures. Given the TEP's recommendation, the more intuitive interpretation, and the very high correlations, we believe there is more value in retiring the Change in Self-Care Score and Change in Mobility Score measures and retaining the Discharge Self-Care Score and Discharge Mobility Score measures.

Comment: Two commenters raised concerns that the methodology used to calculate the Discharge Self-Care Score and Discharge Mobility Score measures does not account for functional abilities at admission in the way that the Change in Self-Care Score and Change in Mobility Score measures being proposed for removal do. One of these commenters requested that CMS clarify the extent to which these remaining Discharge Self-Care Score and Discharge Mobility Score measures would account for change in patients' function over time, as well as patient heterogeneity. Relatedly, another commenter noted that patients with higher discharge scores at the end of their IRF stay may include many patients who were admitted with high scores initially, and therefore, the quality and value of the IRF's care can be potentially misunderstood. These commenters also raised concerns about unintended consequences that could be introduced through the removal of the Change in Self-Care Score and Change in Mobility Score measures, such as the cherry-picking of patients or creating limited access to services for those with lower functional status. One of these commenters urged CMS to carefully evaluate whether the removal of the Change in Self-Care Score and Change in Mobility Score measures could lead to such unintended consequences.

Response: We appreciate that measures of functional outcomes must account for patient case-mix to ensure fair and meaningful comparisons across facilities. Accordingly, the Discharge Self-Care Score and Discharge Mobility Score measures that would remain in the IRF QRP do in fact account for functional abilities at admission, as well as other relevant demographic and clinical characteristics (see, for example, *Inpatient Rehabilitation Facility Quality Reporting Program Measure Calculations and Reporting User's Manual v4.0*).[140] Specifically, the

[138] Acumen, LLC and Abt Associates. Technical Expert Panel (TEP) for the Refinement of Long-Term Care Hospital (LTCH), Inpatient Rehabilitation Facility (IRF), Skilled Nursing Facility (SNF)/Nursing Facility (NF), and Home Health (HH) Function Measures, July 14–15, 2021: Summary Report. February 2022. *https://mmshub.cms.gov/sites/default/files/TEP-Summary-Report-PAC-Function.pdf.*

[139] Acumen, LLC and Abt Associates. Technical Expert Panel (TEP) for the Refinement of Long-Term Care Hospital (LTCH), Inpatient Rehabilitation Facility (IRF), Skilled Nursing Facility (SNF)/Nursing Facility (NF), and Home Health (HH) Function Measures: July 14–15, 2021: Summary Report. February 2022. *https://mmshub.cms.gov/sites/default/files/TEP-Summary-Report-PAC-Function.pdf.*

[140] Centers for Medicare & Medicaid Services. Inpatient Rehabilitation Facility Quality Reporting Program Measure Calculations and Reporting User's Manual Version 4.0. October 2022. *https://*

Continued

expected discharge scores, which patients must meet or exceed to meet for the measures' numerators are predicted using the patients' observed admission function scores plus the same clinical comorbidities and demographic characteristics as the corresponding Change in Self-Care Score and Change in Mobility Score measures. Given that the Discharge Self-Care Score and Discharge Mobility Score measures do account for functional abilities at admission, among other relevant clinical characteristics that can impact functional improvement, we do not anticipate that the removal of the Change in Self-Care Score and Change in Mobility Score measures will increase any incentive to cherry-pick patients or block access to care. We take the appropriate access to care in IRFs very seriously, and routinely monitor the performance of measures in the IRF QRP, including performance gaps across IRFs. We will continue to monitor closely whether any proposed changes to the IRF QRP have unintended consequences on access to care for high-risk patients. Should we find any unintended consequences, we will take appropriate steps to address these issues in future rulemaking.

Comment: One commenter stated that they do not support the removal of the Change in Self-Care Score and Change in Mobility Score measures, stating that these measures assess patients who meet or exceed a specific risk-adjusted goal, and as such are representative of IRF care as a whole.

Response: We agree that there is value in assessing the extent to which patients meet or exceed an expected level of function, where the expected level of function accounts for a patient's own case mix. However, we would like to point out that this is exactly what the Discharge Self-Care Score and Discharge Mobility Score measures assess (which would be retained in the IRF QRP), as opposed to the Change in Self-Care and Change in Mobility Measure, which measure the risk-adjusted change in function between admission and discharge.

After consideration of the public comments we received, we are finalizing our proposal to remove the Change in Self-Care Score and Change in Mobility Score measures from the IRF QRP beginning with the FY 2025 IRF QRP as proposed.

www.cms.gov/files/document/irf-quality-measure-calculations-and-reporting-users-manual-v40.pdf.

2. IRF QRP Quality Measure Beginning With the FY 2026 IRF QRP

a. COVID–19 Vaccine: Percent of Patients/Residents Who Are Up to Date Measure Beginning With the FY 2026 IRF QRP

(1) Background

COVID–19 has been and continues to be a major challenge for PAC facilities, including IRFs. The Secretary first declared COVID–19 a PHE on January 31, 2020. As of March 23, 2023, the U.S. has reported 103,957,053 cumulative cases of COVID–19, and 1,123,613 total deaths due to COVID–19.[141] Although all age groups are at risk of contracting COVID–19, older persons are at a significantly higher risk of mortality and severe disease following infection, with those over age 80 dying at five times the average rate.[142] Older adults, in general, are prone to both acute and chronic infections owing to reduced immunity, and are a high-risk population.[143] Adults age 65 and older comprise over 75 percent of total COVID–19 deaths despite representing 13.4 percent of reported cases.[144] COVID–19 has impacted older adults' access to care, leading to poorer clinical outcomes, as well as taking a serious toll on their mental health and well-being due to social distancing.[145]

Since the development of the vaccines to combat COVID–19, studies have shown they continue to provide strong protection against severe disease, hospitalization, and death in adults, including during the predominance of Omicron BA.4 and BA.5 variants.[146] Initial studies showed the efficacy of FDA-approved or authorized COVID–19 vaccines in preventing COVID–19. Prior to the emergence of the Delta variant of the virus, vaccine effectiveness against COVID–19-associated hospitalization among adults aged 65 and older was 91 percent for those who were fully vaccinated with an mRNA vaccine (Pfizer-BioNTech or Moderna), and 84 percent for those receiving a viral vector vaccine (Janssen). Adults aged 65 and older who were fully vaccinated with an mRNA COVID–19 vaccine had a 94 percent reduction in risk of COVID–19 hospitalization while those who were partially vaccinated had a 64 percent reduction in risk.[147] Further, after the emergence of the Delta variant, vaccine effectiveness against COVID–19-associated hospitalization for adults who were fully vaccinated was 76 percent among adults age 75 and older.[148]

More recently, since the emergence of the Omicron variants and availability of booster doses, multiple studies have shown that while vaccine effectiveness has waned, protection is higher among those receiving booster doses than among those only receiving the primary series.[149] [150] [151] CDC data show that, among people age 50 and older, those who have received both a primary vaccination series and booster doses have a lower risk of hospitalization and dying from COVID–19 than their non-

[141] Centers for Disease Control and Prevention. COVID Data Tracker. *https://covid.cdc.gov/covid-data-tracker/#cases_totalcases.*

[142] United Nations. Policy Brief: The impact of COVID–19 on older persons. May 2020. *https://unsdg.un.org/sites/default/files/2020-05/Policy-Brief-The-Impact-of-COVID-19-on-Older-Persons.pdf.*

[143] Lekamwasam R, Lekamwasam S. Effects of COVID–19 pandemic on health and wellbeing of older people: a comprehensive review. *Ann Geriatr Med Res.* 2020 Sep;24(3):166–172.doi: 10.4235/agmr.20.0027. PMID: 32752587; PMCID: PMC7533189.

[144] Centers for Disease Control and Prevention. Demographic trends of COVID–19 cases and deaths in the US reported to CDC. COVID Data Tracker. *https://covid.cdc.gov/covid-data-tracker/#demographics.*

[145] United Nations. Policy Brief: The impact of COVID–19 on older persons. May 2020. *https://unsdg.un.org/sites/default/files/2020-05/Policy-Brief-The-Impact-of-COVID-19-on-Older-Persons.pdf.*

[146] Chalkias S, Harper C, Vrbicky K, et al. A Bivalent Omicron-Containing Booster Vaccine Against COVID–19. *N Engl J Med.* 2022 Oct 6;387(14):1279–1291. doi: 10.1056/NEJMoa2208343. PMID: 36112399; PMCID: PMC9511634.

[147] Centers for Disease Control and Prevention. Fully Vaccinated Adults 65 and Older Are 94% Less Likely to Be Hospitalized with COVID–19. April 28, 2021. *https://www.cdc.gov/media/releases/2021/p0428-vaccinated-adults-less-hospitalized.html.*

[148] Grannis SJ, Rowley EA, Ong TC, et al. Interim Estimates of COVID–19 Vaccine Effectiveness Against COVID–19-Associated Emergency Department or Urgent Care Clinic Encounters and Hospitalizations Among Adults During SARS-CoV–2 B.1.617.2 (Delta) Variant Predominance—Nine States, June–August 2021. (Grannis SJ, et al. *MMWR Morb Mortal Wkly Rep.* 2021;70(37):1291–1293. *doi.org/10.15585/mmwr.mm7037e2.*

[149] Surie D, Bonnell L, Adams K, et al. Effectiveness of monovalent mRNA vaccines against COVID–19–associated hospitalization among immunocompetent adults during BA.1/BA.2 and BA.4/BA.5 predominant periods of SARS CoV–2 Omicron variant in the United States—IVY Network, 18 States, December 26, 2021–August 31, 2022. *MMWR Morb Mortal Wkly Rep. 2022;71(42):1327–1334. doi: 10.15585/mmwr.mm7142a3.*

[150] Andrews N, Stowe J, Kirsebom F, et al. Covid-19 vaccine effectiveness against the Omicron (B.1.1.529) variant. *N Engl J Med.* 2022 Apr 21;386(16):1532–1546. doi 10.1056/NEJMoa2119451. PMID: 35249272; PMCID: PMC8908811.

[151] Buchan SA, Chung H, Brown KA, et al. Estimated effectiveness of COVID–19 vaccines against Omicron or Delta symptomatic infection and severe outcomes. *JAMA Netw Open.* 2022 Sep 1;5(9):e2232760.doi: 10.1001/jamanetworkopen.2022.32760. *https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2796615.* PMID: 36136332; PMCID: PMC9500552.

vaccinated counterparts.[152] Additionally, a second vaccine booster dose has been shown to reduce risk of severe outcomes related to COVID–19, such as hospitalization or death.[153] Early evidence also demonstrates that the bivalent boosters, specifically aimed to provide better protection against disease caused by Omicron subvariants, have been quite effective, and underscores the role of up to date vaccination protocols in effectively countering the spread of COVID–19.[154] [155]

(a) Measure Importance

Despite the availability and demonstrated effectiveness of COVID–19 vaccinations, significant gaps continue to exist in vaccination rates.[156] As of March 22, 2023, vaccination rates among people age 65 and older are generally high for the primary vaccination series (94.3 percent) but lower for the first booster (73.6 percent among those who received a primary series) and even lower for the second booster (59.9 percent among those who received a first booster).[157] Additionally, though the uptake in boosters among people age 65 and older has been much higher than among people of other ages, booster uptake still remains relatively low compared to primary vaccination among older adults.[158] Variations are also present when examining vaccination rates by race, gender, and geographic location.[159] For example, 66.2 percent of the Asian, non-Hispanic population have completed the primary series and 21.2 percent have received a bivalent booster dose, whereas 44.9 percent of the Black, non-Hispanic population have completed the primary series and only 8.9 percent have received a bivalent booster dose. Among Hispanic populations, 57.1 percent of the population have completed the primary series, and 8.5 percent have received a bivalent booster dose, while in White, non-Hispanic populations, 51.9 percent have completed the primary series and 16.2 percent have received a bivalent booster dose.[160] Disparities have been found in vaccination rates between rural and urban areas, with lower vaccination rates found in rural areas.[161] [162] Data show that 55.2 percent of the eligible population in rural areas have completed the primary vaccination series, as compared to 66.5 percent of the eligible population in urban areas.[163] Receipt of bivalent booster doses among those eligible has been lower, with 18 percent of urban population having received a booster dose, and 11.5 percent of the rural population having received a booster dose.[164]

We proposed to adopt the COVID–19 Vaccine: Percent of Patients/Residents Who Are Up to Date (Patient/Resident COVID–19 Vaccine) measure for the IRF QRP beginning with the FY 2026 IRF QRP. The proposed measure has the potential to increase COVID–19 vaccination coverage of patients in IRFs, as well as prevent the spread of COVID–19 within the IRF patient population. The proposed Patient/Resident COVID–19 Vaccine measure would also support the goal of CMS's Meaningful Measure Initiative 2.0 to ''Empower consumers to make good health care choices through patient-directed quality measures and public transparency objectives.'' The proposed Patient/Resident COVID–19 Vaccine measure would be publicly reported on Care Compare and would provide patients, including those who are at high risk for developing serious complications from COVID–19, and their caregivers, with valuable information they can consider when choosing an IRF. The proposed Patient/Resident COVID–19 Vaccine measure would also facilitate patient care and care coordination during the hospital discharge planning process. For example, a discharging hospital, in collaboration with the patient and family, could use this proposed measure's publicly reported information on Care Compare to coordinate care and ensure patient preferences are considered in the discharge plan. Additionally, the proposed Patient/Resident COVID–19 Vaccine measure would be an indirect measure of IRF action. Since the patient's COVID–19 vaccination status would be reported at discharge from the IRF, if a patient is not up to date with their COVID–19 vaccination per applicable CDC guidance at the time they are admitted, the IRF has the opportunity to educate the patient and provide information on why they should become up to date with their COVID–19 vaccination. IRFs may also choose to administer the vaccine to the patient prior to their discharge from the IRF or coordinate a follow-up visit for the patient to obtain the vaccine at their physician's office or local pharmacy.

(b) Item Testing

The measure development contractor conducted testing of the proposed standardized patient/resident COVID–19 vaccination coverage assessment item for the proposed Patient/Resident COVID–19 Vaccine measure using patient scenarios, draft guidance manual coding instructions, and cognitive interviews to assess IRFs' comprehension of the item and the associated guidance. A team of clinical experts assembled by our measure development contractor developed these patient scenarios to represent the most common scenarios that IRFs would encounter. The results of the item testing demonstrated that IRFs that used the draft guidance manual coding

[152] Centers for Disease Control and Prevention. Rates of laboratory-confirmed COVID–19 hospitalizations by vaccination status. COVID Data Tracker. February 9, 2023. *https://covid.cdc.gov/covid-data-tracker/#covidnet-hospitalizations-vaccination.*

[153] Centers for Disease Control and Prevention. COVID–19 vaccine effectiveness monthly update. COVID Data Tracker. November 10, 2022. *https://covid.cdc.gov/covid-data-tracker/#vaccine-effectiveness.*

[154] Chalkias S, Harper C, Vrbicky K, et al. A bivalent omicron-containing booster vaccine against COVID–19. *N Engl J Med.* 2022 Oct 6;387(14):1279–1291. doi: 10.1056/NEJMoa2208343. PMID: 36112399; PMCID: PMC9511634.

[155] Tan, S.T., Kwan, A.T., Rodríguez-Barraquer, I. et al. Infectiousness of SARS-CoV–2 breakthrough infections and reinfections during the Omicron wave. Nat Med 29, 358–365 (2023). *https://doi.org/10.1038/s41591-022-02138-x.*

[156] Centers for Disease Control and Prevention. COVID Data Tracker: COVID–19 vaccinations in the United States. *https://covid.cdc.gov/covid-data-tracker/#vaccinations_vacc-people-booster-percent-pop5.*

[157] Centers for Disease Control and Prevention. COVID–19 vaccination age and sex trends in the United States, national and jurisdictional. *https://data.cdc.gov/Vaccinations/COVID-19-Vaccination-Age-and-Sex-Trends-in-the-Uni/5i5k-6cmh.*

[158] Freed M, Neuman T, Kates J, Cubanski J. Deaths among older adults due to COVID–19 jumped during the summer of 2022 before falling somewhat in September. Kaiser Family Foundation. October 6, 2022. *https://www.kff.org/coronavirus-covid-19/issue-brief/deaths-among-older-adults-due-to-covid-19-jumped-during-the-summer-of-2022-before-falling-somewhat-in-september/.*

[159] Saelee R, Zell E, Murthy BP, et al. Disparities in COVID–19 Vaccination Coverage Between Urban and Rural Counties—United States, December 14, 2020–January 31, 2022. *MMWR Morb Mortal Wkly Rep.* 2022 Mar 4;71:335–340. doi: 10.15585/mmwr.mm7109a2. PMID: 35239636; PMCID: PMC8893338.

[160] Centers for Disease Control and Prevention. COVID Data Tracker: Trends in demographic characteristics of people receiving COVID–19 vaccinations in the United States. *https://covid.cdc.gov/covid-data-tracker/#vaccination-demographics-trends.*

[161] Saelee R, Zell E, Murthy BP, et al. Disparities in COVID–19 Vaccination Coverage Between Urban and Rural Counties—United States, December 14, 2020–January 31, 2022. *MMWR Morb Mortal Wkly Rep.* 2022 Mar 4;71:335–340. doi: 10.15585/mmwr.mm7109a2. PMID: 35239636; PMCID: PMC8893338.

[162] Sun Y, Monnat SM. Rural-urban and within-rural differences in COVID–19 vaccination rates. *J Rural Health.* 2022 Sep;38(4):916–922. doi: 10.1111/jrh.12625. PMID: 34555222; PMCID: PMC8661570

[163] Centers for Disease Control and Prevention. COVID Data Tracker. COVID–19 Vaccination Equity. *https://covid.cdc.gov/covid-data-tracker/#vaccination-equity.*

[164] Centers for Disease Control and Prevention. COVID–19 Vaccination Equity. COVID Data Tracker. *https://covid.cdc.gov/covid-data-tracker/#vaccination-equity.*

instructions had strong agreement (that is, 84 percent) with the correct responses, supporting its reliability. The testing also provided information to improve both the item itself and the accompanying guidance.

(2) Competing and Related Measures

Sections 1886(j)(7)(D)(i) and 1899B(e)(2)(A) of the Act require that, absent an exception under sections 1886(j)(7)(D)(ii) and 1899B(e)(2)(B) of the Act, measures specified under section 1886(j)(7)(D)(i) of the Act and section 1899B of the Act must be endorsed by a CBE with a contract under section 1890(a) of the Act. In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed, sections 1886(j)(7)(D)(ii) and 1899B(e)(2)(B) of the Act permit the Secretary to specify a measure that is not so endorsed, as long as due consideration is given to the measures that have been endorsed or adopted by a consensus organization identified by the Secretary. The proposed Patient/Resident COVID–19 Vaccine measure is not CBE endorsed, and after review of other endorsed and adopted measures, we were unable to identify any measures endorsed or adopted by a consensus organization for IRFs focused on capturing COVID–19 vaccination coverage of IRF patients. We found only one related measure addressing COVID–19 vaccination, the COVID–19 Vaccination Coverage among Healthcare Personnel measure, adopted for the FY 2023 IRF QRP (86 FR 42385 through 42396), which captures the percentage of HCP who receive a complete COVID–19 primary vaccination course.

Therefore, after consideration of other available measures that assess COVID–19 vaccination rates among IRF patients, we believe the exceptions under sections 1886(j)(7)(D)(ii) and 1899B(e)(2)(B) of the Act apply. We intend to submit the proposed measure for consideration of endorsement by the CBE when feasible.

(3) Interested Parties and Technical Expert Panel (TEP) Input

First, the measure development contractor convened a focus group of patient and family/caregiver advocates (PFAs) to solicit input. The PFAs felt a measure capturing raw vaccination rate, irrespective of IRF action, would be most helpful in patient and family/caregiver decision-making. Next, TEP meetings were held on November 19, 2021 and December 15, 2021 to solicit feedback on the development of patient/resident COVID–19 vaccination measures and assessment items for the PAC settings. The TEP panelists voiced their support for PAC patient/resident COVID–19 vaccination measures and agreed that developing a measure to report the rate of vaccination in an IRF setting without denominator exclusions was an important goal. We considered the TEP's recommendations, and we applied the recommendations where technically feasible and appropriate. A summary of the TEP proceedings titled *Technical Expert Panel (TEP) for the Development of Long-Term Care Hospital (LTCH), Inpatient Rehabilitation Facility (IRF), Skilled Nursing Facility (SNF)/Nursing Facility (NF), and Home Health (HH) COVID–19 Vaccination-Related Items and Measures Summary Report* is available on the CMS MMS Hub.[165]

To seek input on the importance, relevance, and applicability of a patient/resident COVID–19 vaccination coverage measure, we also solicited public comments in an RFI for publication in the FY 2023 IRF PPS proposed rule (87 FR 47038).[166] Comments were generally positive on the concept of a measure addressing COVID–19 vaccination coverage among IRF patients. Some commenters included caveats with their support and requested further details regarding measure specifications and CBE endorsement. In addition, commenters voiced concerns regarding the evolving recommendations related to boosters and the definition of ''up to date,'' as well as whether an IRF length of stay would allow for meaningful distinctions among IRFs (87 FR 47071).

(4) Measure Applications Partnership (MAP) Review

The pre-rulemaking process includes making publicly available a list of quality and efficiency measures, called the Measures Under Consideration (MUC) List, that the Secretary is considering adopting for use in Medicare programs. This allows interested parties to provide recommendations to the Secretary on the measures included on the list. The Patient/Resident COVID–19 Vaccine measure was included on the publicly available 2022 MUC List for the IRF QRP.[167]

After the MUC List was published, the MAP received five comments from interested parties. Commenters were mostly supportive of the measure and recognized the importance of patients' COVID–19 vaccination, and that measurement and reporting is one important method to help healthcare organizations assess their performance in achieving high rates of up to date vaccination. One commenter noted that patient engagement is critical at this stage of the pandemic, while another noted the criteria for inclusion in the numerator and denominator provide flexibility for the measure to remain relevant to current circumstances. Another commenter anticipated minimal implementation challenges since healthcare providers are already asking for patients' COVID–19 vaccination status at intake. Commenters who were not supportive of the measure raised several issues, including that the measure does not capture quality of care, concern about the evolving definition of the term ''up to date,'' that data collection would be burdensome, that administering the vaccine could impact the IRF treatment plan, and that a measure only covering one quarter may not be meaningful.

Subsequently, several MAP workgroups met to provide input on the proposed measure. First, the MAP Health Equity Advisory Group convened on December 6, 2022. One MAP Health Equity Advisory Group member noted that the percentage of true contraindications for the COVID–19 vaccine is low, and the lack of exclusions on the measure is reasonable in order to minimize variation in what constitutes a contraindication.[168] Similarly, the MAP Rural Health Advisory Group met on December 8, 2022, and requested clarification of the term ''up to date'' and noted concerns with the perceived level of burden for collection of data .[169]

Next, the MAP PAC/LTC workgroup met on December 12, 2022. The MAP PAC/LTC workgroup's voting members

[165] *Technical Expert Panel (TEP) for the Development of Long-Term Care Hospital (LTCH), Inpatient Rehabilitation Facility (IRF), Skilled Nursing Facility (SNF)/Nursing Facility (NF), and Home Health (HH) COVID–19 Vaccination-Related Items and Measures Summary Report. https://mmshub.cms.gov/sites/default/files/COVID19-Patient-Level-Vaccination-TEP-Summary-Report-NovDec2021.pdf.*

[166] 87 FR 20218.

[167] Centers for Medicare & Medicaid Services. (2022). Overview of the List of Measures Under Consideration for December 1, 2022. *https://mmshub.cms.gov/sites/default/files/2022-MUC-List-Overview.pdf.*

[168] CMS Measures Management System (MMS). Measure Implementation: Pre-rulemaking MUC Lists and MAP reports. *https://mmshub.cms.gov/measure-lifecycle/measure-implementation/pre-rulemaking/lists-and-reports.*

[169] CMS Measures Management System (MMS). Measure Implementation: Pre-rulemaking MUC Lists and MAP reports. *https://mmshub.cms.gov/measure-lifecycle/measure-implementation/pre-rulemaking/lists-and-reports.*

raised concerns brought up in public comments, such as provider actionability, lack of denominator exclusions, requirements for assessing patient vaccination status, evolving COVID–19 vaccination recommendations, and data reporting frequency for this measure. Additionally, MAP PAC/LTC workgroup members noted the potential inability of IRFs to administer the vaccine due to the shorter average length of stay as compared to other PAC settings. In response to workgroup member feedback, we noted that the intent of the Patient/Resident COVID–19 Vaccine measure would be to promote transparency of data for patients to make informed decisions regarding care and is not intended to be a measure of IRF action. We also explained that this measure does not have exclusions for patient refusal since this measure was intended to report raw rates of vaccination, and this information is important for consumer choice. Additionally, we believe that PAC providers, including IRFs, are in a unique position to leverage their care processes to increase vaccination coverage in their settings to protect patients and prevent negative outcomes. We also noted that collection of these data will not require additional documentation or proof of vaccination. We clarified that the Patient/Resident COVID–19 Vaccine measure would include the definition of up to date, so the measure would consider future changes in the CDC guidance regarding COVID–19 vaccination. We also clarified that the measure would continue to be a quarterly measure similar to the existing HCP COVID–19 Vaccine measure, as CDC has not determined whether COVID–19 is, or will be, a seasonal disease like influenza. Finally, we noted that the average 12-day length of stay at IRFs is generally longer than patient stays at acute care hospitals. Given that health care is a continuum and every contact along the continuum provides an opportunity to encourage vaccination, IRFs have sufficient time to act on the patient's vaccination status. However, the MAP PAC/LTC workgroup reached a 60 percent consensus on the vote of ''Do not support for rulemaking'' for this measure.[170]

The MAP received four comments from industry commenters in response to the MAP PAC/LTC workgroup's recommendations. Interested parties generally understood the importance of COVID–19 vaccinations in preventing the spread of COVID–19, although a majority of commenters did not recommend the inclusion of the proposed Patient/Resident COVID–19 Vaccine measure for the IRF QRP and raised several concerns. Specifically, commenters were concerned about vaccine hesitancy and providers' inability to influence results based on factors outside of their control. Commenters also noted that the measure has not been fully tested and encouraged CMS to monitor the measure for unintended consequences and ensure that the measure has meaningful results. One commenter raised concerns on whether patients' vaccination information would be easily available to IRFs as well as potential limitations with patients recounting vaccination status. One commenter was in support of the measure and provided recommendations for CMS to consider adding an exclusion for medical contraindications and submitting the measure for CBE endorsement.

Finally, the MAP Coordinating Committee convened on January 24, 2023, and noted concerns which were previously discussed in the MAP PAC/LTC workgroup, such as potential disruption to patient therapy due to vaccination and acuity of patients in the IRF setting. However, a MAP Coordinating Committee member noted that a patient's potential inability to complete rehabilitation was not a valid reason to withhold support of this measure, and that, because these patients have a high acuity, they are more vulnerable to COVID–19, further emphasizing the need to vaccinate them. MAP Coordinating Committee members also raised concerns discussed previously during the MAP PAC/LTC workgroup, including the shorter IRF length of stay and excluding medical contraindications from the denominator.

The MAP Coordinating Committee recommended three mitigation strategies for the Patient/Resident COVID–19 Vaccine measure: (i) reconsider exclusions for medical contraindications, (ii) complete reliability and validity measure testing, and (iii) seek CBE endorsement. The MAP Coordinating Committee ultimately reached 81 percent consensus on its voted recommendation of ''Do not support with potential for mitigation.'' Despite the MAP Coordinating Committee's vote, we believe it is still important to propose the Patient/Resident COVID–19 Vaccine measure for the IRF QRP. As we stated in section VIII.C.2.a.(3) of the proposed rule, we did not include exclusions for medical contraindications because the PFAs we met with told us that a measure capturing raw vaccination rate, irrespective of any medical contraindications, would be most helpful in patient and family/caregiver decision-making. We do plan to conduct reliability and validity measure testing once we have collected enough data, and we intend to submit the proposed measure to the CBE for consideration of endorsement when feasible. We refer readers to the final MAP recommendations, titled *2022–2023 MAP Final Recommendations.*[171]

(5) Quality Measure Calculation

The proposed Patient/Resident COVID–19 Vaccine measure is an assessment-based process measure that reports the percent of stays in which patients in an IRF are up to date on their COVID–19 vaccinations per the CDC's latest guidance.[172] This measure has no exclusions and is not risk adjusted.

The numerator for the proposed measure would be the total number of IRF stays in the denominator in which patients are up to date with their COVID–19 vaccination per CDC's latest guidance. The denominator for the proposed measure would be the total number of IRF stays discharged during the reporting period.

The data source for the proposed Patient/Resident COVID–19 Vaccine measure is the IRF–PAI for IRF patients. For more information about the proposed data submission requirements, we refer readers to section VIII.F.3. of the proposed rule. For additional technical information about this proposed measure, we refer readers to the draft measure specifications document titled *COVID–19 Vaccine: Percent of Patients/Residents Who Are Up to Date Draft Measure Specifications.*[173] available on the IRF QRP Measures and Technical Information web page.

We invited public comments on the proposal to adopt the Patient/Resident COVID–19 Vaccine measure beginning with the FY 2026 IRF QRP. The following is a summary of the public

[170] CMS Measures Management System (MMS). Measure Implementation: Pre-rulemaking MUC Lists and MAP reports. *https://mmshub.cms.gov/measure-lifecycle/measure-implementation/pre-rulemaking/lists-and-reports.*

[171] 2022–2023 MAP Final Recommendations. *https://mmshub.cms.gov/sites/default/files/2022-2023-MAP-Final-Recommendations-508.xlsx*

[172] The definition of ''up to date'' may change based on CDC's latest guidelines and is available on the CDC web page, ''Stay Up to Date with COVID–19 Vaccines Including Boosters,'' at *https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html* (updated March 2, 2023).

[173] COVID–19 Vaccine: Percent of Patients/Residents Who Are Up to Date Draft Measure Specifications. *https://www.cms.gov/files/document/patient-resident-covid-vaccine-draft-specs.pdf.*

comments received on our proposal and our responses.

Comment: One commenter supported the measure noting it does not add significant burden.

Response: We thank the commenter for their support.

A number of commenters did not support the proposal to adopt the Patient/Resident COVID–19 Vaccine measure to the IRF QRP for various reasons. The following is a summary of these public comments received on our proposal and our responses.

Comment: One commenter agreed with CMS's proposed justification that the measure has the potential to drive COVID–19 vaccination uptake among IRF patients and prevent the spread of COVID–19 in the IRF population and agreed that the measure could help empower consumers in making decisions about their care. Despite this, they still urged CMS to ensure that measures are appropriately specified and adequately tested and validated prior to implementation. This commenter also noted that, unlike the proposed HCP COVID–19 Vaccine measure, the specifications for this Patient/Resident COVID–19 Vaccine measure solely reference the definition of up to date as described on CDC's ''Stay Up to Date'' website. Even though this definition more accurately reflects the most current Advisory Committee on Immunization Practices (ACIP) recommendation, the commenter urged CMS to ensure that this approach to specifying measures is valid and will not serve to cause confusion or reporting challenges in the future.

However, several commenters did not support the proposal due to the measure not being fully tested for reliability and validity, and one commenter noted that even CMS stated that the measure would need to be tested for reliability and validity once enough data were collected. One commenter said it was unclear whether it is feasible for PAC facilities to collect and report information for the proposed measure. Another one of these commenters suggested CMS ''rushed through'' the validation process to add the measure to the IRF QRP as soon as possible because there is no support showing the measure is practical or feasible. Some commenters also encouraged CMS to delay implementation of the measure in the IRF QRP until the measure had been fully tested.

Response: We are pleased that the commenter agrees with CMS's proposed rationale that the measure has the potential to drive COVID–19 vaccination uptake among IRF patients, prevent the spread of COVID–19 in the IRF population, and empower consumers in making decisions about their care.

We also acknowledge the concerns brought up regarding the measure not being tested yet and commenters' reasons for not supporting the measure. However, we have tested the item proposed for the IRF–PAI to capture data for this measure and its feasibility and appropriateness. Since a COVID–19 vaccination item does not yet exist within the IRF–PAI, we developed clinical vignettes to test item-level reliability of a draft Patient/Resident COVID–19 Vaccine item for the IRF–PAI. The clinical vignettes were a proxy for patient records with the most common and challenging cases providers would encounter, similar to the approach that CMS uses to train providers on all new assessment items, and the results demonstrated strong agreement (that is, 84 percent).

Validity testing has not yet been completed, since the COVID–19 vaccination item does not yet exist on the IRF–PAI. However, the Patient/Resident COVID–19 Vaccine measure was constructed based on prior use of similar items, such as the Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) for the IRF QRP and LTCH QRP.[174] We have used these types of patient/resident vaccination assessment items in the calculation of vaccination quality measures in our PAC QRPs and intend to conduct reliability and validity testing for this specific Patient/Resident COVID–19 Vaccine measure once the COVID–19 vaccination item has been added to the IRF–PAI and we have collected sufficient data.

Additionally, we solicited feedback from our TEP on the proposed assessment item and its feasibility. No concerns were raised by the TEP regarding obtaining information required to complete the new COVID–19 vaccination item.[175]

Comment: Several commenters did not support the measure and cited the CBE's MAP 2022–2023 review cycle where the MAP failed to reach consensus, and ultimately did not recommend the measure for rulemaking. One commenter said they were deeply concerned about the proposal to add the Patient/Resident COVID–19 Vaccine measure because it appeared as though CMS disregarded the recommendations of the MAP. Several of the commenters noted that the MAP is a multi-stakeholder panel of experts representing providers, patients, and payers, and encouraged CMS to address the MAP's concerns about the measure, including adding exclusions in the measure, conducting measure testing, and submitting the measure for CBE endorsement prior to adopting it in the IRF QRP.

Response: As part of the pre-rulemaking process, HHS takes into consideration the recommendations of the MAP in selecting candidate quality and efficiency measures. HHS selects candidate measures and publishes proposed rules in the **Federal Register**, which allows for public comment and further consideration before a final rule is issued. If the CBE under contract with CMS has not endorsed a candidate measure, then HHS must publish a rationale for the use of the measure described in section 1890(b)(7)(B) of the Act in the notice. The MAP Coordinating Committee recommended three mitigation strategies for the Patient/Resident COVID–19 Vaccine measure: (i) reconsider exclusions for medical contraindications, (ii) complete reliability and validity measure testing, and (iii) seek CBE endorsement. We would like to reiterate that this measure is intended to promote transparency of data for patients/caregivers to make informed decisions for selecting facilities, providing potential patients and their caregivers with an important piece of information regarding vaccination rates as part of their process of identifying providers they would want to seek care from. As we stated in section IX.C.2.a.(3) of this final rule, we did not include exclusions for medical contraindications because the PFAs we met with told us that a measure capturing raw vaccination rate, irrespective of any medical contraindications, would be most helpful in patient and family/caregiver decision-making. We intend to add a new item to the IRF–PAI assessment tool to collect this information. We will then conduct measure testing once sufficient data on the COVID–19 vaccination item are collected through the IRF–PAI and plan to submit the measure for CBE endorsement when it is technically feasible to do so.

Comment: A few commenters believe the adoption of a patient-level measure of COVID–19 vaccination status might quickly become topped out due to lack of meaningful improvement in the

[174] 78 FR 47859 and 77 FR 53257.

[175] Technical Expert Panel (TEP) for the Development of Long-Term Care Hospital (LTCH), Inpatient Rehabilitation Facility (IRF), Skilled Nursing Facility (SNF)/Nursing Facility (NF), and Home Health (HH) COVID–19 Vaccination-Related Items and Measures Summary Report. *https://mmshub.cms.gov/sites/default/files/COVID19-Patient-Level-Vaccination-TEP-Summary-Report-NovDec2021.pdf.*

vaccination rate, comparing it to the Percent of Residents of Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (CBE #0680) that was removed from the IRF QRP measure set in the FY 2019 IRF PPS final rule (83 FR 38514). One of these commenters also stated that IRF performance on this proposed measure will fail to show meaningful distinctions in improvements since 94.3 percent of the United States population at least 65 years of age had completed their primary series as of May 2023.

Response: We do not believe this measure is at risk of being retired early. The Patient/Resident COVID–19 Vaccine measure reports the percentage of patients in an IRF who are up to date on their COVID–19 vaccinations per the CDC's latest guidance, rather than capturing the rates of primary vaccination series only. Because the measure reflects an up to date vaccination status, it minimizes the potential for topping out. We believe that continued monitoring of up to date vaccination among patients will remain an important tool to minimize severe illness, hospitalization, and death in PAC facilities. Additionally, we believe there is substantial room for improvement in measure performance. As of May 2023, while the vaccination rates among people 65 and older were high for the primary vaccination series (94.3 percent), the vaccination rates were lower for the first booster dose (73.9 percent among those who received a primary series) and even lower for the second booster dose (60.4 percent among those who received a first booster).[176]

Comment: A few commenters were concerned that the Yes/No response options for the COVID–19 vaccination item in the IRF–PAI may be unreliable and lead to inaccurate and inconsistent reporting of data. One of these commenters noted that they are also concerned that a self-reported up to date answer might not be accurate, which could lead to incorrect timing for the next dosage or inaccurate reporting overall. Two of these commenters said that it is unlikely most patients would have an understanding of the CDC's specific definition of up to date when answering a yes/no question for the patient assessment, which could also lead to potentially inaccurate data.

Response: We disagree with the commenters. The results of the item testing conducted to test the COVID–19 vaccination item supported the use of a Patient-level COVID–19 Vaccination Coverage measure item. When the item was tested as drafted in the measure specifications with Yes/No response options, overall agreement for IRFs was 84 percent. Across all provider types, those who used the CDC website, or the guidance manual and the CDC website had the highest percent agreement (100 percent and 88 percent, respectively). We also believe the provision of two response options helps alleviate provider burden of providing additional details and information regarding the patient's vaccination status. Our TEP panelists indicated that they generally prefer items with less information in order to reduce IRFs' burden and that the nuance provided by the ''more information'' options could add additional burden and potential confusion.[177] Additionally, coding guidance for this item would allow providers to use all sources of information available to obtain the vaccination data, such as patient interviews, medical records, proxy response, and vaccination cards provided by the patient or their caregivers.[178] As with any other assessment item on the IRF–PAI, we expect IRF providers to work closely with the patient to obtain the most accurate response to the assessment question.

Comment: A few commenters were concerned that the measure does not provide response options for patients who refuse to answer, refuse the vaccination, or are excluded due to medical contraindications or closely held religious beliefs. Another commenter urged CMS to consider adding an exclusion for medical contraindications, while still another noted that CMS has failed to address the recommendations of the CBE to explore adding medical exemptions to the measure.

Response: We understand and thank the commenters for their recommendations about adding exclusions to the measure. Our measure development contractor convened a focus group of PFAs as well as a TEP that included interested parties from every PAC setting, to solicit input on patient/resident COVID–19 vaccination measures and assessment items. The PFAs told us that a measure capturing raw vaccination rates would be most helpful in patient and family/caregiver decision-making. Our TEP agreed that developing a measure to report the rate of vaccination without denominator exclusions was an important goal.[179] Based on this feedback, we believe excluding patients/residents with contraindications from the measure would distort the intent of the measure of providing raw COVID–19 patient vaccination rates, while making the information more difficult for patients/caregivers to interpret, and therefore we did not include any exclusions.

Comment: Several commenters were concerned regarding the lack of a well-defined definition of up to date, and the burden it poses on providers to collect this data. One commenter said the ''moving target definition'' contributes to concerns about the reliability of the data collected. One commenter believed that the current specifications are flawed since the current numerator specifications refers the end user to a website outlining when primary and additional/booster dose(s) are recommended and stated that this lack of a well-defined set of specifications could negatively impact the reliability and validity of the measure.

Response: The up to date concept is not new to providers and is currently in use by Nursing Home facilities for the short-stay and long-stay Percent of Residents Assessed and Appropriately Given the Pneumococcal Vaccine and Percent of Residents Who Received the Pneumococcal Vaccine measures. Beyond the historical use of this concept, ensuring that standards of care are up to date according to the relevant authorities remains a widespread goal for all providers. We believe that IRF providers should be staying current on the latest care guidelines for COVID–19 vaccination as part of best practice. Further, the IRF–PAI Guidance Manual will indicate how to code the item and providers could access the CDC website at any time to find the definition of up to date. The CDC has published FAQs that clearly state the definition of up to

[176] Centers for Disease Control and Prevention. COVID–19 vaccination age and sex trends in the United States, national and jurisdictional. May 11, 2023. *https://data.cdc.gov/Vaccinations/COVID-19-Vaccination-Age-and-Sex-Trends-in-the-Uni/5i5k-6cmh.*

[177] Technical Expert Panel (TEP) for the Development of Long-Term Care Hospital (LTCH), Inpatient Rehabilitation Facility (IRF), Skilled Nursing Facility (SNF)/Nursing Facility (NF), and Home Health (HH) COVID–19 Vaccination-Related Items and Measures Summary Report. *https://mmshub.cms.gov/sites/default/files/COVID19-Patient-Level-Vaccination-TEP-Summary-Report-NovDec2021.pdf.*

[178] COVID–19 Vaccine: Percent of Patients/Residents Who Are Up to Date Draft Measure Specifications. *https://www.cms.gov/files/document/patient-resident-covid-vaccine-draft-specs.pdf.*

[179] Technical Expert Panel (TEP) for the Development of Long-Term Care Hospital (LTCH), Inpatient Rehabilitation Facility (IRF), Skilled Nursing Facility (SNF)/Nursing Facility (NF), and Home Health (HH) COVID–19 Vaccination-Related Items and Measures Summary Report. *https://mmshub.cms.gov/sites/default/files/COVID19-Patient-Level-Vaccination-TEP-Summary-Report-NovDec2021.pdf.*

date.[180] In fact, when we tested the COVID–19 vaccination item, there was strong agreement with the correct responses when facilities used the available guidance, and rates of correct responses increased when facilities accessed the CDC website. Across all provider types, those who used the CDC website, or the guidance manual and the CDC website, had the highest percent agreement (100 percent and 88 percent respectively).

Comment: One commenter noted that some patient stays may overlap between the period when new additional/booster dose(s) become available and/or the definition of up to date changes and requested clarification on how providers should account for such ''bridge'' cases.

Response: Given this assessment item is completed at discharge, providers would code the item using guidance in place at the time of the patient's discharge. As previously discussed, this measure does not mandate or require patients to be up to date with their COVID–19 vaccination. IRFs are successfully able to report the measure, and comply with the IRF QRP requirements, irrespective of the number of patients who have been vaccinated.

Comment: Another commenter was concerned regarding the uncertainty about the seasonality of COVID–19, future vaccination schedules, and how often new versions of a COVID–19 vaccine will be available.

Response: Beyond the historical use of the concept of up to date, ensuring that standards of care are up to date according to the relevant authorities remains a widespread goal for all providers. As the SARS-CoV–2 virus mutates, this vaccination measure takes a forward-thinking approach to ensure that PAC patients are protected in the event of COVID–19 infection. Given that CDC guidelines may change over time in response to the virus, we believe the use of up to date will actually be simpler for facilities since it ensures that the measure specifications, item responses, and accompanying item guidance would not have to continually change. Additionally, CMS regularly reviews its measures as part of the measure maintenance process, and will re-specify the measure in the future, if needed, based on any changes to guidelines.

A number of commenters were concerned about the burden this measure places on providers and listed several types of burden including difficulty with data collection and keeping up with the definition of up to date. The following is a summary of those comments and our responses.

Comment: Two commenters believe the proposed measure will pose unique challenges due to patients' different comorbidities and preexisting conditions that may impact which vaccine recommendation applies to them, and they believe that complying with the CDC guidelines may be challenging and time consuming for IRFs, especially if CDC revises its guidance. One of the commenters also noted that given the potential that there could be audits related to the COVID–19 vaccine measures, that increased time, personnel and financial resources would be required to collect and report the required data for these measures, and they believe those resources would be better utilized for direct patient care and other quality improvement activities that more closely align with the primary mission of IRFs.

Response: We disagree that this measure, if finalized, would take time away from patient care. We believe PAC providers should be assessing whether patients are up to date with COVID–19 vaccination as a part of their care, and even if they do not administer the vaccine, they can coordinate follow-up care for the patient to obtain the vaccine elsewhere. During our item testing, we heard from providers that they are routinely inquiring about COVID–19 vaccination status when admitting patients. CMS is committed to providing Medicare beneficiaries with high quality health care and therefore, routinely performs audits and reviews to ensure the standard of IRF care is maintained. We believe providers need to exercise due diligence as they stay abreast of standards of care and new evidence, as it becomes available. We believe IRFs consider vaccination essential to patient safety and quality care.

Gathering information about a patient's vaccination status is an important part of developing and administering a comprehensive plan of care. Rather than taking time away from patient care, providers will be documenting information they are likely already collecting through the course of providing care to the patients. We would remind providers that IRFs are currently required to meet the IRF QRP requirements as authorized by section 1886(j)(7) of the Act, and it applies to freestanding IRFs, as well as inpatient rehabilitation units of hospitals or Critical Access Hospitals (CAHs) paid by Medicare under the IRF PPS.

Comment: Two commenters believe that, as the CDC updates eligibility requirements for the latest versions of the COVID–19 vaccine, keeping track of eligibility and what is considered up to date will be difficult for IRFs. One of these commenters stated that data infrastructure would be needed to capture the non-static definition of up to date to reassess vaccine status with each new revision of the reporting definition, and this would result in a heavy burden on data collection, analysis, and reporting programs.

Response: We recognize that the up to date COVID–19 vaccination definition may evolve due to the changing nature of the virus, but we are also confident in IRFs' ability to understand these changes as they have been at the front lines of managing COVID–19 since the beginning of the pandemic. The public health response to COVID–19 has necessarily adapted to respond to the changing nature of the virus's transmission and community spread. As mentioned in the FY 2022 IRF PPS final rule (86 FR 42386), we received several public comments during the HCP COVID–19 Vaccine measure's pre-rulemaking process encouraging us to continue to evaluate the new evidence on COVID–19 as it continues to arise and we stated our intention to continue to work with partners, including FDA and CDC. We believe that the proposed measure aligns with the Administration's responsive approach to COVID–19 and will continue to support vaccination as the most effective means to prevent the worst consequences of COVID–19, including severe illness, hospitalization, and death. However, IRFs can choose how they want to manage tracking CDC information.

Comment: A few commenters noted that collecting this information would be especially burdensome in cases where patients are unable or unwilling to provide the necessary information. One of these commenters also stated that patients will have cognitive, communication, and memory deficits that will cause barriers to appropriate communication and understanding of their vaccination status.

Response: As noted in the COVID–19 Vaccine: Percent of Patients/Residents Who Are Up to Date Draft Measure Specifications,[181] providers will be able to use multiple sources of information available to obtain the vaccination data, such as patient interviews, medical

[180] Centers for Disease Control and Prevention. Frequently Asked Questions. May 15, 2023. *https://www.cdc.gov/coronavirus/2019-ncov/vaccines/faq.html.*

[181] COVID–19 Vaccine: Percent of Patients/Residents Who Are Up to Date Draft Measure Specifications. *https://www.cms.gov/files/document/patient-resident-covid-vaccine-draft-specs.pdf.*

records, proxy response, and vaccination cards provided by the patient or their caregivers. Therefore, coding of this item in the IRF–PAI would not be limited to a patient's oral response. As with any assessment item, we will also publish coding guidance and instructions to further assist providers in collection of these data.

Comment: Commenters did not support the measure stating that IRFs do not typically administer vaccines and it would be an undue burden for rehabilitation units to store, provide, and report the administration of the COVID–19 vaccine.

Response: This measure does not require IRF providers to administer the vaccine to the patients. While we know of no current indications of shortages or delays for the COVID–19 vaccines in IRF facilities and believe that facilities should be able to administer the vaccine if a patient is agreeable to receiving the vaccination, IRFs do not have to administer the vaccine themselves. They can arrange for the patient to obtain the vaccine outside of their facility or can work with community pharmacies to obtain vaccines.

Several commenters did not support the measure as they do not think it is a measure of quality of care due to a lack of correlation between the vaccine uptake of patients and the quality of care a patient can expect when being admitted for a stay at an IRF and the inability of IRFs to affect the results. Commenters disagreed with CMS's statement in the proposed rule (86 FR 21000) that ''PAC providers, including IRFs, are in a unique position to leverage their care processes to increase vaccination coverage in their setting to protect patients and prevent negative outcomes.'' One commenter expressed significant logistical and clinician concerns with the proposal and its ability to quantify quality of care. They gave several reasons, which we address below.

Comment: Two commenters noted that IRFs do not have immediate or ongoing access to COVID–19 vaccines and/or booster dose(s)s and will have difficulty reporting and demonstrating improvement on this measure.

Response: While we believe facilities should be able to administer the vaccine if a patient is agreeable to receiving the vaccination, this measure does not require IRFs to administer the vaccine themselves. There are no current indications that there are vaccine shortages or delays for the COVID–19 vaccines in PAC facilities. However, IRFs can arrange for the patient to obtain the vaccine outside of their facility or can work with community pharmacies to obtain vaccines. We would also like to point out that the number of patients who have been vaccinated by an IRF does not impact an IRF's ability to successfully report the measure to comply with the requirements of the IRF QRP.

Comment: Several commenters believe it is often infeasible or inappropriate to offer vaccination for patients due to length of stay, ability to manage side effects and medical contraindications, or other logistical challenges to gathering information from a patient who may have received care from multiple proximal providers. One commenter said that administering the vaccine could cause a readmission back to acute care or delay the patient's course of rehabilitation and extend their length of stay beyond the average time frame for which they receive payment. Therefore, these things would make it difficult for IRFs to manage and potentially improve their performance on this measure.

Response: We understand concerns about PAC length of stay or effect of the vaccine on patient care. We believe providers should use clinical judgement to determine if a patient is eligible to receive the vaccination and avoid harm to the patient. It is the responsibility of the IRFs to determine when a patient is ready for discharge, keeping in mind patient's health and safety, which may necessitate a longer length of stay.

However, we also believe that vaccination for high-risk populations, such as those in IRFs, is of paramount importance, and regardless of length of stay, a provider has the opportunity to educate the patient and provide information on why they should become up to date with COVID–19 vaccination, if they are not up to date at the time they are admitted. We believe vaccines can be scheduled at times that prevent or minimize disruptions with the patient treatment plan. For example, the vaccine could be given on a weekend or prior to discharge if the patient chooses to receive it. We would also like to point out that this measure does not mandate patients to be up to date with their COVID–19 vaccine. The number of patients who have been vaccinated in an IRF does not impact an IRF's ability to successfully report the measure to comply with the requirements of the IRF QRP.

Comment: Other commenters said that most patients who are interested in receiving a vaccine have already received it from the referring hospital, long-term care hospital, skilled nursing facility or other setting where the patient received care prior to admission to the IRF, and therefore they did not think this measure would have an impact on the vaccination rates.

Response: This measure is intended to provide the percent of patients who are up to date with their COVID–19 vaccination in an IRF at the time of discharge. This measure promotes transparency of raw data regarding COVID–19 vaccination rates for patients/caregivers to make informed decisions for selecting facilities. Irrespective of the patient's vaccination status, this measure will provide potential patients and their caregivers with an important piece of information regarding vaccination rates as part of their process of identifying providers they would want to seek care from, alongside other measures available on Care Compare, to make an informed, comprehensive decision. Additionally, we believe IRF providers would benefit in such situations where patients have already been vaccinated prior to admission, given this would mean the patient is up to date and reduce IRF burden to educate or vaccinate the patient.

Comment: Several commenters list other factors affecting patient vaccination status outside of the IRF's control such as patient refusals and other cultural or religious reasons for a patient not receiving vaccination. One commenter believes COVID–19 vaccinations are still highly influenced by the political environment and political beliefs of patients/residents and their families. Therefore, they believe the percentage of patients who are vaccinated within an IRF will reflect the political leanings of the region in which the facility is located, and IRFs will not be able to influence this. Commenters noted that patients/residents may choose to forgo vaccination despite a provider's best efforts to encourage vaccination among their patients/residents. One commenter stated that patients retain their right to decline a vaccine when they are admitted to an IRF and they believe patient acceptance of a vaccine does not measure an IRF's quality of care.

Response: We appreciate providers' commitment to ensuring that patients are educated and encouraged to receive vaccinations, and we acknowledge that individual patients have a choice regarding whether to receive a COVID–19 vaccine or additional/booster dose(s), despite provider efforts. However, it is also true that patients and family/caregivers have choices about selecting PAC providers, and it is our intention to empower them with the information they need to make an informed decision by publicly reporting the data we receive from IRFs on this measure. We

understand that despite provider efforts, there may be instances where a patient chooses not to be vaccinated, and we want to remind IRFs that this measure does not mandate that patients be up to date with their COVID–19 vaccine. The number of patients who have been vaccinated in an IRF does not impact an IRF's ability to successfully report the measure to comply with the requirements of the IRF QRP.

Comment: One commenter said that even if the measure is intended to give patients and families information to make decisions about care, the lack of IRF access in many areas may reduce the impact of having IRFs collect this information. Several commenters believe the IRF's rate of vaccination will generally mirror the current COVID–19 vaccination rate in an IRF's local community, which they do not believe is a reflection of an IRF's quality as a provider nor would it provide relevant or useful information through public reporting.

Response: As described in section IX.C.2.a.(3) of this final rule, the measure development contractor convened TEP meetings to solicit feedback on the development of patient/resident COVID–19 vaccination measures. Analyses showed considerable variation in COVID–19 vaccination rates among nursing homes by State and within State. Further, States with the lowest complete vaccination rates also show wider within-State variations in vaccination rates among nursing homes.[182] The TEP panelists indicated that the presence of disparities in vaccination rates makes the patient-level vaccination measure meaningful to develop, and they broadly agreed that the vaccination gaps identified for nursing homes were also likely present within other PAC settings, including IRFs.[183] Therefore, we believe that the information this measure will provide will still be valuable to potential IRF patients and their caregivers who have geographic limitations while seeking care. Additionally, this measure will provide potential patients and their caregivers with an important piece of information regarding vaccination rates as part of their process of identifying IRF providers they would want to seek care from, alongside other measures available on Care Compare to make a comprehensive decision.

Comment: Several commenters raised concerns about unintended consequences of receiving the vaccine during an IRF stay and believe they would interfere with a patient's therapy. They believe that scheduling a COVID–19 vaccine during a patient's relatively short length of stay, 12–13 days on average, could mean they have to forego several days of therapy they would otherwise need and be entitled to. One commenter noted that providers may have concerns that the side effects of a vaccine can interfere with or cause confusion while a patient is being diagnosed or treated during their hospitalization, and that the side effects of a vaccine like COVID–19 could delay needed intense therapy treatment. One commenter noted that the known side-effects of the COVID–19 vaccine per the CDC, ''pain, redness, swelling at the injection site, tiredness, headache, muscle pain, chills, fever, and nausea,'' are contradictory to participating in intensive therapy, at least 3 hours a day, 5 days a week.

Response: We understand and acknowledge commenters' concerns about potential side effects of COVID–19 vaccination on patient participation in IRF care and activities. However, vaccines can be scheduled at times that prevent or minimize disruptions to the patient treatment plan. For example, if an IRF is concerned about a patient's ability to perform in 3 hours of therapy a day, the vaccine could be given on a weekend or prior to discharge. We support an IRF's use of clinical judgement to determine if a patient is eligible to receive the vaccination and if a patient chooses to receive one, to work with the patient to schedule the appropriate time to administer the vaccine. We also want to remind IRFs that they do not have to administer the COVID–19 vaccine. The number of patients who have been vaccinated in an IRF does not impact an IRF's ability to successfully report the measure to comply with the requirements of the IRF QRP

Comment: One commenter pointed to the concerns raised by the MAP and other interested parties and believes CMS should consider the potential impacts of its approach on vaccination efforts. They caution that as providers are endeavoring to follow the vaccine guidelines and gain patient trust, this measure—as constructed—has the potential to adversely impact patient-provider relationships, trust, and provider performance.

Response: We disagree with the commenter. We believe the proposed measure will support the goal of the CMS Meaningful Measure Initiative 2.0 to ''Empower consumers to make good health care choices through patient-directed quality measures and public transparency objectives,'' and the PFAs we met with agreed that a measure capturing raw vaccination rates would be most helpful in patient and family/caregiver decision-making. Additionally, we take the appropriate access to care in IRFs very seriously, and routinely monitor the QRP measures' performance, including performance gaps across IRFs. We intend to monitor closely whether any proposed change to the IRF QRP has unintended consequences on access to care for high risk patients. Should we find any unintended consequences, we will take appropriate steps to address these issues in future rulemaking.

Comment: Several commenters did not support adoption of this measure in light of the Administration's announcement of the end of the COVID–19 PHE on May 11. 2023. One of these commenters commended CMS for recognizing the burden of such a requirement included in the Hospital Conditions of Participation and working to remove it, but now questions the ''juxtaposition'' of proposing a vaccine uptake measure as a metric for quality of care. Another one of these commenters said that the end of the PHE will make it more challenging for patients to stay informed on the most recent guidance from the CDC. Finally, one of these commenters also brought up concerns about CDC's recent recommendations that individuals aged 65 and over ''may'' receive an additional dose of the updated vaccines.

Response: Despite the announcement of the end of the COVID–19 PHE, many people continue to be affected by COVID–19, particularly seniors, people who are immunocompromised, and people with disabilities. As mentioned in the End of COVID–19 Public Health Emergency Fact Sheet,[184] our response to the spread of SARS-CoV–2, the virus that causes COVID–19, remains a public health priority. Even beyond the end of the COVID–19 PHE, we will continue to work to protect Americans from the

[182] Technical Expert Panel (TEP) for the Development of Long-Term Care Hospital (LTCH), Inpatient Rehabilitation Facility (IRF), Skilled Nursing Facility (SNF)/Nursing Facility (NF), and Home Health (HH) COVID–19 Vaccination-Related Items and Measures Summary Report. *https://mmshub.cms.gov/sites/default/files/COVID19-Patient-Level-Vaccination-TEP-Summary-Report-NovDec2021.pdf.*

[183] Technical Expert Panel (TEP) for the Development of Long-Term Care Hospital (LTCH), Inpatient Rehabilitation Facility (IRF), Skilled Nursing Facility (SNF)/Nursing Facility (NF), and Home Health (HH) COVID–19 Vaccination-Related Items and Measures Summary Report. *https://mmshub.cms.gov/sites/default/files/COVID19-Patient-Level-Vaccination-TEP-Summary-Report-NovDec2021.pdf.*

[184] U.S. Department of Health and Human Services. Fact Sheet: End of the COVID–19 Public Health Emergency. May 9, 2023. *https://www.hhs.gov/about/news/2023/05/09/fact-sheet-end-of-the-covid-19-public-health-emergency.html.*

virus and its worst impacts by supporting access to COVID–19 vaccines, treatments, and tests, including for people without health insurance. Given the continued impacts of COVID–19, we believe it is important to promote patient vaccination and education, which this measure aims to achieve. Accordingly, we are aligning our approach with those for other infectious diseases, such as influenza by encouraging ongoing COVID–19 vaccination.[185] Further, published coding guidance will indicate how to code the item taking into account CDC guidelines, and providers could access the CDC website at any time to find the definition of up to date. Lastly, this measure as proposed for the IRF QRP is not associated with the PHE declaration, or the Conditions of Participation. This measure is being proposed to address CMS's priority to empower consumers to make informed health care choices through patient-directed quality measures and public transparency, as with previous vaccination measures.

Comment: Two commenters noted that the draft item does not provide response options for patients who refuse to answer, refuse the vaccination, or are excluded due to medical contraindications or closely held religious beliefs. One commenter said that if CMS does add the measure to the IRF QRP, they must allow IRFs to report that they could not determine the patient's vaccination status. This commenter also noted that the CBE's MAP Health Equity Advisory Group ''expressed concerns about vaccine hesitancy due to cultural norms,'' and that if CMS adopts the proposed Patient/Resident COVID–19 Vaccine measure, IRFs should be able to report that they were unable to determine if a patient was vaccinated. Another commenter suggested that having a single yes or no item on the IRF–PAI without any requirements for documentation or validation of vaccination status would amount to a mere checkmark in a box with no evidence that it leads to improved quality of care.

Response: We thank commenters for their recommendations about adding additional response options to the item for exclusions. However, as we have stated previously, the PFAs convened for our TEP told us that a measure capturing raw vaccination rates would be most helpful in patient and family/caregiver decision-making. The TEP agreed that developing a measure to report the rate of vaccination without denominator exclusions was an important goal. Based on this feedback, we believe excluding patients/residents with contraindications from the measure would distort the intent of the measure of providing raw COVID–19 patient vaccination rates, while making the information more difficult for patients/caregivers to interpret, and hence did not include any exclusions.

CMS has multiple processes in place to ensure reported patient data are accurate. State agencies conduct standard certification surveys for IRFs, and accuracy and completeness of the IRF–PAI are among the regulatory requirements that surveyors evaluate during surveys.[186] Additionally, the IRF–PAI process has multiple regulatory requirements. Our regulations at § 412.606(b) require that (1) the assessment accurately reflects the patient's status, (2) a clinician appropriately trained to perform a patient assessment using the IRF–PAI conducts or coordinates each assessment with the appropriate participation of health professionals, and (3) the assessment process includes direct observation, as well as communication with the patient.[187] We take the accuracy of IRF–PAI assessment data very seriously, and routinely monitor the IRF QRP measures' performance, and will take appropriate steps to address any such issues, if identified, in future rulemaking.

We note that the potential consequences of submitting false data and information in the IRF–PAI, including the potential for civil liability under the False Claims Act (31 U.S.C. 3729 to 3733) for knowingly presenting a false or fraudulent claim to the government for payment, provide strong incentives for providers to ensure that the data submitted in the IRF–PAI are accurate.

Comment: One commenter noted that the intent of the measure as proposed was unclear. This commenter referred to CMS' comment in the FY 2024 IRF PPS proposed rule that the ''intent of the Patient/Resident COVID–19 Vaccine measures would be to promote transparency of data for patients to make informed decisions regarding care and is not intended to be a measure of IRF action.'' However, the commenter disagreed with this rationale, referencing the RFI in section VIII.D. of the proposed rule, *Principles for Selecting and Prioritizing IRF QRP Quality Measures and Concepts under Consideration for Future Years.* The commenter believes the proposed measure fails to qualify for the first proposed principle for selecting and prioritizing IRF QRP quality measure concepts under consideration for future years, ''actionability.''

Response: As stated in section VIII.D.2. of the proposed rule, to address actionability, IRF QRP measures should focus on structural elements, healthcare processes, and outcomes of care that have been demonstrated, such as through clinical evidence or other best practices, to be amenable to improvement and feasible for IRFs to implement. As stated previously, we believe this Patient/Resident COVID–19 Vaccine measure is an indirect measure of provider action. Providers have the opportunity to engage and educate patients on the benefits and importance of COVID–19 vaccination, especially in the IRF setting where patients are at higher risk of contracting COVID–19. Additionally, once collected these data will be available on the patient-level reports for IRF providers, which will further help providers decide on actions such as patient education and steps they can take to increase vaccination in their facility.

After consideration of the public comments we received, we are finalizing our proposal to adopt the Patient/Resident COVID–19 Vaccine measure as an assessment-based measure beginning with the FY 2026 IRF QRP as proposed.

D. Principles for Selecting and Prioritizing IRF QRP Quality Measures and Concepts Under Consideration for Future Years—Request for Information (RFI)

1. Solicitation of Comments

In the proposed rule, we invited general comments on the principles for identifying IRF QRP measures, as well as additional comments about measurement gaps, and suitable measures for filling these gaps. Specifically, we solicited comment on the following questions:

- Principles for Selecting and Prioritizing QRP Measures

[185] Medicare and Medicaid Programs; Policy and Regulatory Changes to the Omnibus COVID–19 Health Care Staff Vaccination Requirements; Additional Policy and Regulatory Changes to the Requirements for Long-Term Care (LTC) Facilities and Intermediate Care Facilities for Individuals With Intellectual Disabilities (ICFs-IID) To Provide COVID–19 Vaccine Education and Offer Vaccinations to Residents, Clients, and Staff; Policy and Regulatory Changes to the Long Term Care Facility COVID–19 Testing Requirements. (88 FR 36487).

[186] Centers for Medicare & Medicaid Services. Hospitals. September 6, 2022. *https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcomplianc/hospitals.*

[187] 42 CFR 412.606 *https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-P/section-412.606.*

++ To what extent do you agree with the principles for selecting and prioritizing measures?

++ Are there principles that you believe CMS should eliminate from the measure selection criteria?

++ Are there principles that you believe CMS should add to the measure selection criteria?

• IRF QRP Measurement Gaps

++ CMS requests input on the identified measurement gaps, including in the areas of cognitive function, behavioral and mental health, patient experience and patient satisfaction, and chronic conditions and pain management.

++ Are there gaps in the IRF QRP measures that have not been identified in this RFI?

• Measures and Measure Concepts Recommended for Use in the IRF QRP

++ Are there measures that you believe are either currently available for use, or that could be adapted or developed for use in the IRF QRP program to assess performance in the areas of (1) cognitive functioning, (2) behavioral and mental health, (3) patient experience and patient satisfaction, (4) chronic conditions, (5) pain management, or (6) other areas not mentioned in this RFI?

CMS also sought input on data available to develop measures, approaches for data collection, perceived challenges or barriers, and approaches for addressing challenges. We received several comments in response to this RFI, which are summarized below.

Comments on Principles for Selecting and Prioritizing QRP Measure

A few commenters expressed support for the measure selection and prioritization criteria identified by CMS in the RFI in the proposed rule, as well as those espoused through the National Quality Strategy and the ''Universal Foundation'' of quality measures. One commenter indicated that principles for measure selection and prioritization identified by CMS in the RFI are consistent with the principles inherent in the CMS Measure Management System and recommended that MMS measure development principles be integrated into the IRF QRP principles. The same commenter suggested that clearly delineated processes are required in order to guide the application of these principles.

One commenter recommended that CMS consider the extent to which measures offer a well-rounded assessment of performance, are complementary, and demonstrate the patient's journey.

Several commenters expressed concern about the addition of measures to the QRP and specifically requested that CMS consider the administrative burden associated with measure reporting. To reduce administrative burden, commenters suggested that CMS consider opportunity costs, and remove measures that are not tied to strategic quality improvement aims.

In addition to administrative burden, other criteria that commenters suggested be considered as part of CMS' guiding principles, included: whether the measure is endorsed by a CBE; the extent to which the measure focuses on a salient healthcare issue; the measure's technical specifications, reliability and validity, implementation feasibility, and electronic availability of data.

One commenter requested that CMS clearly explain how measures selected for development meet the set criteria used.

Comments on Principles for Selecting and Prioritizing QRP Measures and Measures and Measure Concepts Recommended for Use in the IRF QRP

Although several commenters agreed with CMS on the presence of measurement gaps in the IRF QRP, particularly in the domain of cognitive functioning, one commenter stated that even if intended to fill a gap, additional measures to the IRF QRP could not be justified given the present administrative burden on IRFs. The commenter recommended that CMS continually evaluate whether measures are necessary and remove those that are deemed unnecessary. Another commenter indicated that CMS should neither add quality measures to the IRF QRP nor attempt to fill gaps until IRFs receive financial assistance for EHR systems.

Comments on Cognitive Function

Several commenters supported the introduction of cognitive measures for future QRP measure sets, with one commenter indicating that cognitive function measures would provide additional context concerning IRF efficacy.

Multiple commenters did not support the use of the CAM or BIMS as a source of data for use in measuring cognitive function. One commenter stated that neither the CAM nor BIMS provide clinical value to inform rehabilitation care planning or outcomes, including the change in cognitive functioning from admission to discharge. Commenters indicated that the BIMS was not developed as a tool to screen for the presence or absence of cognitive impairment and that it only captures selected elements of cognition, such as attention, short-term memory and verbal interaction, rather than executive functioning, judgement, reasoning, and higher-level cognitive functions. Commenters further stated that the BIMS scale shows low sensitivity identifying cognitive deficits that affect community placement.

Other concerns about the BIMS for use in development of measures of cognitive functioning included the lack of physician buy-in for the BIMS, variation in the reliability of scoring, and limited utility of the BIMS for measuring and risk-adjusting patient cognition and communication.

Although one commenter indicated that the proprietary nature of cognitive functioning instruments and administrative burden posed a challenge to adopting a cognitive assessment instrument, several commenters encouraged CMS to pursue alternative data sources and measures of cognitive functioning. Suggestions of ways to assess cognition included the Functional Independence Measure™ (FIM™) and patient-reported outcome measures. Another commenter encouraged CMS to select measures that are reliable, feasible, valid, and that are, or could be, endorsed by a consensus organization.

Comments on Behavioral and Mental Health

Commenters voiced appreciation for CMS interest in addressing behavioral and mental health issues through the development of quality measures for the IRF QRP. Other commenters cited potential challenges to the adoption of behavioral and mental health measures. One commenter indicated that it would be difficult for IRFs to offer psychological services given the 3-hour therapy per day requirement.[188] Another commenter indicated that such measures would not be relevant for the IRF setting, since patients with a severe behavioral or mental health impairment would be unlikely to participate in therapy, and inpatient rehabilitation would not be an appropriate setting. Should CMS still seek to develop behavioral and mental health quality measures, the commenter suggested consideration of the Patient Health Questionnaire (PHQ)-2 through PHQ–9, which are required for completion of the IRF–PAI.

One commenter suggested that CMS consider adoption of measures that evaluate psychosocial functioning. One

[188] § 412.622(a)(3)(ii) Subpart P—Prospective Payment for Inpatient Rehabilitation Hospitals and Rehabilitation Units; Basis of payment.

commenter recommended that behavioral and mental health measures capture rehabilitative services, such as therapeutic recreation, that support activities that the patient is expected to enjoy post-hospitalization.

Comments on Patient Experience and Patient Satisfaction

A few commenters expressed support for the adoption of measures derived from patient experience surveys, including the IRF Experience of Care (EOC) survey. One commenter expressed preference for the use of the IRF EOC survey over the CoreQ Short Stay Discharge Survey (CoreQ survey) to measure patient experience, indicating that the IRF EOC survey addresses essential assessment areas (for example, goal setting, communications with staff, respect and privacy received, ability to obtain assistance when needed, cleanliness of the facility), whereas the CoreQ survey provides a more limited assessment and lacks the depth to drive quality improvement. Should CMS decide to use the CoreQ survey, the commenter recommended that CMS allow the fielding of supplemental questions, such as items from the IRF EOC survey. Regardless of which tool is used, the commenter urged CMS to ensure the reliability and validity of the measure and composites, subject the measure for review by a CBE, and to pursue the Consumer Assessment of Healthcare Providers and Services (CAHPS) trademark.

One commenter, who did not support the inclusion of a patient experience or satisfaction measure in the IRF QRP, indicated that the administrative and financial costs associated with data collection, particularly for smaller, hospital-based IRFs, would be too high. The commenter further indicated that information gathered from these items would not be meaningful.

Comments on Chronic Condition and Pain Management

One commenter indicated that, because pain is an inherent part of intensive rehabilitation therapy, rather than measuring whether pain exists or whether level of pain was assessed, a more meaningful pain measure would assess the extent to which IRF staff are responsive to and help manage patients' pain. The commenter suggested that the use of a patient-reported outcome measure would provide more meaningful information than a process measure of pain and would not increase burden to the IRF. Another commenter expressed concern about unintended consequences associated with measures related to pain management.

Comments on Other Measurement Gaps

Some commenters believe measurement gaps to exist in areas not identified in the RFI. Other measures and measurement concepts identified by commenters included health equity; care for degenerative cognitive conditions; IRF workforce safety culture, engagement, and burnout; and measures of quality of life, such as the World Health Organization Quality of Life (WHOQOL) assessment and the Comprehensive Evaluation in Recreational Therapy for Physical Disabilities (CERT-Phys Dis).

Response: We appreciate the input provided by commenters. While we will not be responding to specific comments submitted in response to this RFI in this final rule, we intend to use this input to inform our future measure development efforts.

E. Health Equity Update

1. Background

In the FY 2023 IRF PPS proposed rule (87 FR 20247through 20254), we included an RFI entitled ''*Overarching Principles for Measuring Equity and Healthcare Quality Disparities Across CMS Quality Programs.*'' We define health equity as ''the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.'' [189] We are working to advance health equity by designing, implementing, and operationalizing policies and programs that support health for all the people served by our programs and models, eliminating avoidable differences in health outcomes experienced by people who are disadvantaged or underserved, and providing the care and support that our enrollees need to thrive. Our goals outlined in the *CMS Framework for Health Equity 2022–2023* [190] are in line with Executive Order 13985, ''Advancing Racial Equity and Support for Underserved Communities Through the Federal Government.'' [191] The goals included in the CMS Framework for Health Equity serve to further advance health equity, expand coverage, and improve health outcomes for the more than 170 million individuals supported by our programs, and set a foundation and priorities for our work, including: strengthening our infrastructure for assessment, creating synergies across the health care system to drive structural change, and identifying and working to eliminate barriers to CMS-supported benefits, services, and coverage. The CMS Framework for Health Equity outlines the approach CMS will use to promote health equity for enrollees, mitigate health disparities, and prioritize CMS's commitment to expanding the collection, reporting, and analysis of standardized data.[192]

In addition to the CMS Framework for Health Equity, we seek to advance health equity and whole-person care as one of eight goals comprising the CMS National Quality Strategy (NQS).[193] The NQS identifies a wide range of potential quality levers that can support our advancement of equity, including: (1) establishing a standardized approach for patient-reported data and stratification; (2) employing quality and value-based programs to address closing equity gaps; and (3) developing equity-focused data collections, regulations, oversight strategies, and quality improvement initiatives.

A goal of the NQS is to address persistent disparities that underlie our healthcare system. Racial disparities, in particular, are estimated to cost the U.S. $93 billion in excess medical costs and $42 billion in lost productivity per year, in addition to economic losses due to premature deaths.[194] At the same time, racial and ethnic diversity has increased in recent years with an increase in the percentage of people who identify as two or more races accounting for most of the change, rising from 2.9 percent to 10.2 percent between 2010 and 2020.[195]

[189] Centers for Medicare & Medicaid Services. Health Equity. October 3, 2022. *https://www.cms.gov/pillar/health-equity.*

[190] Centers for Medicare & Medicaid Services. CMS Framework for Health Equity 2022–2032. April 2022. *https://www.cms.gov/files/document/cms-framework-health-equity-2022.pdf.*

[191] The White House. Executive Order on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government. Executive Order 13985, January 20, 2021. *https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/.*

[192] Centers for Medicare and Medicaid Services. The Path Forward: Improving Data to Advance Health Equity Solutions. *https://www.cms.gov/files/document/path-forwardhe-data-paper.pdf.* July 11, 2023.

[193] Centers for Medicare & Medicaid Services. CMS National Quality Strategy? *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/CMS-Quality-Strategy.*

[194] Turner A. The Business Case for Racial Equity: A Strategy for Growth. April 24, 2018. W.K. Kellogg Foundation and Altarum. *https://altarum.org/RacialEquity2018.*

[195] Agency for Healthcare Research and Quality. 2022 National Healthcare Quality and Disparities

Continued

Therefore, we need to consider ways to reduce disparities, achieve equity, and support our diverse beneficiary population through the way we measure quality and display the data.

We solicited public comments via the aforementioned RFI on changes that we should consider in order to advance health equity. We refer readers to the FY 2023 IRF PPS final rule (87 FR 47072 through 47073) for a summary of the public comments and suggestions CMS received in response to the health equity RFI. In the proposed rule, we said we would take these comments into account as we continue to work to develop policies, quality measures, and measurement strategies on this important topic.

2. Anticipated Future State

We are committed to developing approaches to meaningfully incorporate the advancement of health equity into the IRF QRP. One option we are considering is including social determinants of health (SDOH) as part of new quality measures.

Social determinants of health are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. They may have a stronger influence on the population's health and well-being than services delivered by practitioners and healthcare delivery organizations.[196] Measure stratification by CMS is important for better understanding the differences in health outcomes from across different patient population groups according to specific demographic and SDOH variables. For example, when pediatric measures over the past two decades are stratified by race, ethnicity, and income, they show that outcomes for children in the lowest income households and for Black and Hispanic children have improved faster than outcomes for children in the highest income households or for White children, thus narrowing an important health disparity.[197] This analysis and comparison of the SDOH items in the assessment instruments support our desire to understand the benefits of measure stratification. Hospital providers receive such information in their confidential feedback reports (CFRs) and we think this learning opportunity would benefit PAC providers. The goals of the CFR are to provide IRFs with their results so they can compare certain quality measures stratified by dual eligible status and race and ethnicity. The process is meant to increase providers' awareness of their data. We will solicit feedback from IRFs for future enhancements to the CFRs.

In the proposed rule, we said that we are considering whether health equity measures we have adopted for other settings, such as hospitals,[198] could be adopted in PAC settings. We said we were exploring ways to incorporate SDOH elements into the measure specifications. For example, we could consider a future health equity measure like screening for social needs and interventions using our current SDOH data items of preferred language, interpreter services, health literacy, transportation, and social isolation. With 30 percent to 55 percent of health outcomes attributed to SDOH,[199] a measure capturing and addressing SDOH could encourage IRFs to identify patients' specific needs and connect them with the community resources necessary to overcome social barriers to their wellness. We could specify a health equity measure using the same SDOH data items that we currently collect as standardized patient assessment data elements under the IRF. These SDOH data items assess health literacy, social isolation, transportation problems, and preferred language (including need for or want of an interpreter). We also see value in aligning SDOH data items according to existing health information technology (IT) vocabulary and codes sets where applicable and appropriate such as those included in the Office of the National Coordinator for Health Information (ONC) United States Core Data for Interoperability (USCDI) [200] across all care settings as we develop future health equity quality measures under our IRF QRP statutory authority. This would further the NQS' goal of aligning quality measures across our programs as part of the Universal Foundation.[201]

Although we did not directly solicit feedback to our update, we did receive some public comments, which we summarize.

Comment: Several commenters responded to our update on the continuing efforts to advance health equity. One commenter encouraged CMS to consider data collection reports as a starting point, and also a structural measure that is based on health equity priorities, similar to what has been adopted in other Medicare quality reporting programs.

Two commenters supported the idea of measure stratification by certain SDOH, and one requested this information on all claims-based measures. Both commenters emphasized that any additional stratification of quality measures, including social risk factors and SDOH, would be of value to PAC providers, including IRFs.

One commenter also noted that receiving patient-level data for claims-based measures on a more frequent basis would enable them to make better informed decisions. This commenter referenced the Hospital Inpatient Quality Reporting (IQR) Program which provides reports with patient-level data to hospitals and urged CMS to provide IRFs with the same level of detail in their quality data. They also noted that while having the measures stratified by SDOH would be helpful, they believe having it in a timely manner could have a more meaningful impact on equity and quality of care.

We received some comments on other data points that may be useful in identifying and addressing health disparities. One commenter suggested focusing efforts on social risk factors that are of sufficient granularity to drive appropriate interventions at the individual level. Another commenter noted that while it is important to still try to understand differences by race and ethnicity to identify and address disparities that might stem from racism and social and economic inequities, they recommended against making generalizations about differences in health and health care simply based on race and ethnicity and to instead conduct more in-depth evaluations of underlying social and economic drivers of health. This commenter suggested

Report. November 2022. *https://www.ahrq.gov/research/findings/nhqrdr/nhqdr22/index.html.*

[196] Agency for Healthcare Research and Quality. 2022 National Healthcare Quality and Disparities Report. November 2022. *https://www.ahrq.gov/research/findings/nhqrdr/nhqdr22/index.html.*

[197] Agency for Healthcare Research and Quality. 2022 National Healthcare Quality and Disparities Report. November 2022. *https://www.ahrq.gov/research/findings/nhqrdr/nhqdr22/index.html.*

[198] Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2023 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Costs Incurred for Qualified and Non-Qualified Deferred Compensation Plans; and Changes to Hospital and Critical Access Hospital Conditions of Participation. 87 FR 49202 through 49215.

[199] World Health Organization. Social Determinants of Health. *https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1.*

[200] United States Core Data for Interoperability (USCDI), *https://www.healthit.gov/isa/united-states-core-data-interoperability-uscdi.*

[201] Jacobs DB, Schreiber M, Seshamani M, Tsai D, Fowler E, Fleisher LA. Aligning Quality Measures across CMS—The Universal Foundation. N Engl J Med. 2023 Mar 2;338:776–779. doi: 10.1056/NEJMp2215539. PMID: 36724323.

that CMS incentivize the collection and analysis of data on factors such as, but not limited to, disability status, veteran status, primary or preferred language, health literacy, food security, transportation access, housing stability, social support after discharge from an IRF, and a person's access to care. This same commenter, however, pointed out that any program must account for the fact that there are many contributors to health inequities, including personal factors, many of which are outside the control of IRFs. They encouraged CMS to have ongoing engagement with interested parties to best understand structural and socioeconomic barriers to health and to monitor for any unintended consequences. Finally, this commenter urged CMS to focus on improving care coordination as patients move between settings. However, another commenter requested CMS consider what is already being collected by providers prior to adding additional data collection requirements.

One commenter encouraged CMS to thoughtfully consider the appropriate data collection of SDOH factors before attempting to report the data, given the resources required to implement new items in the electronic medical record. They pointed to the current work underway by the Office of Management and Budget (OMB) seeking feedback about combining race and ethnicity questions (88 FR 5375).

One commenter recommended CMS consider including SDOH in new quality measures and in IRF payment and suggested it could be accomplished through the use of ICD–10 Z-codes as indicators of the additional resources required to care for patients.

Response: We thank all the commenters for responding to our update on this important CMS priority. We will take your recommendations into consideration in our future work on health equity.

F. Form, Manner, and Timing of Data Submission Under the IRF QRP

1. Background

We refer readers to the regulatory text at § 412.634(b)(1) for information regarding the current policies for reporting IRF QRP data.

2. Reporting Schedule for the IRF–PAI Assessment Data for the Discharge Function Score Measure Beginning With the FY 2025 IRF.

As discussed in section VIII.C.1.b. of the proposed rule, we proposed to adopt the Discharge Function Score (DC Function) measure beginning with the FY 2025 IRF QRP. We proposed that IRFs would be required to report these IRF–PAI assessment data related to the DC Function measure beginning with patients discharged on October 1, 2023, for purposes of the FY 2025 IRF QRP. Starting in CY 2024, IRFs would be required to submit data for the entire calendar year beginning with the FY 2026 IRF QRP. Because the DC Function measure is calculated based on data that are currently submitted to the Medicare program in the IRF–PAI, there would be no new burden associated with data collection for this measure.

We invited public comments on our proposal.

We did not receive any comments on this proposed revision, and therefore, we are finalizing the revisions as proposed.

3. Reporting Schedule for the Data Submission of IRF–PAI Assessment Data for the COVID–19 Vaccine: Percent of Patients/Residents Who Are Up to Date Quality Measure Beginning With the FY 2026 IRF QRP

As discussed in section VIII.C.2.a. of the proposed rule, we proposed to adopt the COVID–19 Vaccine: Percent of Patients/Residents Who Are Up to Date (Patient/Resident COVID–19 Vaccine) measure beginning with the FY 2026 IRF QRP. We proposed that IRFs would be required to report the IRF–PAI assessment data related to the Patient/Resident COVID–19 Vaccine measure beginning with patients discharged on October 1, 2024, for purposes of the FY 2026 IRF QRP. Starting in CY 2025, IRFs would be required to submit data for the entire CY beginning with the FY 2027 IRF QRP.

We also proposed to add a new item to the IRF–PAI in order for IRFs to report this measure. Specifically, a new item would be added to the IRF–PAI discharge assessment to collect information on whether a patient is up to date with their COVID–19 vaccine at the time of discharge from the IRF. A draft of the new item is available in the *COVID–19 Vaccine: Percent of Patients/Residents Who Are Up to Date* Draft Measure Specifications.[202]

We invited public comments on our proposal. The following is a summary of the public comments received on our proposal to require IRFs to report a new IRF–PAI assessment data item for the Patient/Resident COVID–19 Vaccine measure beginning with patients discharged on October 1, 2024, and our responses.

Comment: One commenter stated that this proposed measure has the potential to increase COVID–19 vaccination coverage of patients in IRFs, as well as prevent the spread of COVID–19 within the IRF patient population. However, given that the patient's COVID–19 vaccination status was proposed to be collected at discharge from the IRF rather than upon admission, they believe the opportunity is lost.

Response: We believe that during a patient stay, IRFs have the opportunity to educate the patient and provide information on why they should become up to date, if a patient is not up to date with their vaccine at the time they are admitted. This is particularly important for patients in IRFs, who tend to be at higher risk for serious complications from COVID–19. If the patient is agreeable, the patient may receive the necessary vaccine to become up to date any time during their IRF stay prior to discharge.

Comment: One commenter noted that IRFs have been reporting COVID–19 vaccination and infection data to both State departments of health and the CDC's National Healthcare Safety Network (NHSN) and introducing a new IRF–PAI item would create the potential for duplicative reporting.

Response: Currently, as part of the IRF QRP, we do not collect COVID–19 vaccination data for patients. CMS only collects COVID–19 vaccination data for healthcare personnel via the NHSN. Therefore, addition of an IRF–PAI item for the purposes of collecting patient COVID–19 vaccination data would not lead to duplicative reporting at the Federal level.

Comment: One commenter noted that the draft specifications for this measure do not specify what the preferred source would be, or how facilities should deal with conflicting information from different sources (for example, the patient responding that they are vaccinated, but the medical record suggesting they are not).

Response: As described in the Draft Technical Specifications,[203] providers will be able to use all sources of information available to obtain the vaccination data, such as patient interviews, medical records, proxy response, and vaccination cards provided by the patient or their caregivers. As with any assessment item in the IRF–PAI, we will also publish coding guidance and instructions to further aid providers in collection of

[202] *COVID–19 Vaccine: Percent of Patients/Residents Who Are Up to Date.* Draft Measure Specifications. *https://www.cms.gov/files/document/patient-resident-covid-vaccine-draft-specs.pdf.*

[203] COVID–19 Vaccine: Percent of Patients/Residents Who Are Up to Date Draft Measure Specifications. *https://www.cms.gov/files/document/patient-resident-covid-vaccine-draft-specs.pdf.*

this data, including coding in situations with conflicting information.

After consideration of the public comments we received, we are finalizing our proposal to require IRFs to report a new IRF–PAI assessment data item for the Patient/Resident COVID–19 Vaccine measure beginning with patients discharged on October 1, 2024 for the FY 2026 IRF QRP as proposed.

G. Policies Regarding Public Display of Measure Data for the IRF QRP

1. Background

Section 1886(j)(7)(E) of the Act requires the Secretary to establish procedures for making the IRF QRP data available to the public after ensuring that IRFs have the opportunity to review their data prior to public display. For a more detailed discussion about our policies regarding public display of IRF QRP measure data and procedures for the IRF's opportunity to review and correct data and information, we refer readers to the FY 2017 IRF PPS final rule (81 FR 52045 through 52048).

2. Public Reporting of the Transfer of Health (TOH) Information to the Provider—Post-Acute Care (PAC) Measure and TOH Information to the Patient—PAC Measure Beginning With the FY 2025 IRF QRP

We proposed to begin publicly displaying data for the measures, TOH Information to the Provider—PAC Measure (TOH—Provider) and TOH Information to the—Patient PAC Measure (TOH—Patient) beginning with the September 2024 Care Compare refresh or as soon as technically feasible.

We adopted these measures in the FY 2020 IRF PPS final rule (84 FR 39099 through 39107). In response to the COVID–19 PHE, we issued an interim final rule (85 FR 27595 through 27596), which delayed the compliance date for the collection and reporting of the TOH—Provider and TOH—Patient measures to October 1st of the year that is at least one full FY after the end of the COVID–19 PHE. Subsequently, the CY 2022 Home Health PPS Rate Update final rule (86 FR 62381 through 62386) revised the compliance date for the collection and reporting of the TOH—Provider and TOH—Patient measures under the IRF QRP to October 1, 2022. Data collection for these two assessment-based measures in the IRF QRP began with patients discharged on or after October 1, 2022.

We proposed to publicly display four rolling quarters of the data we receive for these two assessment-based measures, initially using data on discharges from January 1, 2023, through December 31, 2023 (Quarter 1 2023 through Quarter 4 2023); and to begin publicly reporting data on these measures with the September 2024 refresh of Care Compare, or as soon as technically feasible. To ensure the statistical reliability of the data, we proposed that we would not publicly report an IRF's performance on a measure if the IRF had fewer than 20 eligible cases in any four consecutive rolling quarters for that measure. IRFs that have fewer than 20 eligible cases would be distinguished with a footnote that states, ''The number of cases/patient stays is too small to publicly report.''

We invited public comment on our proposal for the public display of the TOH—Provider and TOH—Patient assessment-based measures. The following is a summary of the public comments received on the proposal to publicly report these measures and our responses.

Comment: Several commenters supported the proposal to publicly report the Transfer of Health Information to the Provider-PAC Measure and the Transfer of Health Information to the Patient-PAC Measure beginning with the September 2024 Care Compare refresh or as soon as technically feasible. One commenter believes the additional attention and focus on the transfer of health information would improve internal and external processes for patients and caregivers. Another commenter suggested stratification of the data would add value to consumers and providers.

Response: We thank the commenters for their support and agree that the information will provide helpful information to consumers about an IRFs internal and external processes related to transfer of important health information. We also appreciate the suggestion for stratifying the data, and we will use this input to inform our future public reporting refinements.

Comment: One commenter was not supportive of the proposal, saying that the reporting requirement would be duplicative of information IRFs are already required to collect and the measures would be redundant.

Response: We want to clarify that the proposal would add no additional reporting requirements to the IRF QRP. IRFs began collecting the Transfer of Health information data elements for all patients discharged beginning October 1, 2022. In section IX.G.2 of this final rule, we proposed using data collected from January 1, 2023 through December 31, 2023 for the inaugural display of the measures on Care Compare beginning September 2024 or as soon as technically feasible.

Comment: One commenter said they valued the public reporting of metrics that reflect the quality of care a patient received in an IRF but encouraged CMS to delay reporting of the TOH-Patient and TOH-Provider measures until 2025, using discharges from January 1, 2024 through December 31, 2024 (Quarter 1, 2024 through Quarter 4, 2024), given their recent adoption into the IRF QRP.

Response: We disagree with the commenter. While the TOH-Patient and TOH-Provider measures original data collection start date was October 1, 2020, we delayed the collection of the measures due to the COVID–19 PHE. As the commenter noted, CMS revised the data collection to begin October 1, 2022, and while we have received some questions about the new data items on the IRF–PAI through our IRF QRP helpdesk, the number of questions have been minimal. Neither have there been any reported problems with the implementation of these items. The inaugural reporting period we proposed, January 1, 2023 through December 31, 2023 (Quarter 1, 2023 through Quarter 4, 2023) is consistent with our public reporting proposals for other new IRF QRP measures. We do not agree that IRFs need more time to adjust for these measures.

As a result of the public comments, we are finalizing our proposal to begin publicly displaying data for the measures: (1) Transfer of Health (TOH) Information to the Provider—Post-Acute Care (PAC) Measure (TOH-Provider); and (2) TOH Information to the Patient—PAC Measure (TOH-Patient) beginning with the September 2025 Care Compare refresh or as soon as technically feasible.

3. Public Reporting of the Discharge Function Score Measure Beginning With the FY 2025 IRF QRP

We proposed to begin publicly displaying data for the Discharge Function Score (DC Function) measure beginning with the September 2024 refresh of Care Compare, or as soon as technically feasible, using data collected from January 1, 2023 through December 31, 2023 (Quarter 1 2023 through Quarter 4 2023). We proposed that an IRF's DC Function measure score would be displayed based on four quarters of data. Provider preview reports would be distributed to IRFs in June 2024, or as soon as technically feasible. Thereafter, an IRF's DC Function measure score would be publicly displayed based on four quarters of data and updated

quarterly. To ensure the statistical reliability of the data, we proposed that we would not publicly report an IRF's performance on the measure if the IRF had fewer than 20 eligible cases in any quarter. IRFs that have fewer than 20 eligible cases would be distinguished with a footnote that states: ''The number of cases/patient stays is too small to report.''

We invited public comment on the proposal for the public display of the DC Function assessment-based measure beginning with the September 2024 refresh of Care Compare, or as soon as technically feasible. The following is a summary of the public comments received on our proposal and our responses.

Comment: One commenter provided support to publicly report the DC Function measure.

Response: We thank the commenter for their support to publicly report the proposed measure.

Comment: One commenter recommended that CMS specify when results will be provided to IRFs for their review, that CMS provide more patient-specific data, and clarify whether CMS uses results for ''judgement or quality improvement or both.'' This commenter suggests CMS report ''comparative stratified functional status based on key risk factors at discharge'' to assist IRF improvements.

Response: CMS plans to publicly display the DC Function measure score quarterly, based on four quarters of data. We refer readers to section IX.F.2 of this final rule for information about when the proposed DC Function measure will be publicly reported. Specifically, we proposed to begin publicly displaying data for the DC Function measure beginning with the September 2024 refresh of Care Compare, or as soon as technically feasible, using data collected from January 1, 2023, through December 31, 2023 (Quarter 1 2023 through Quarter 4 2023). Provider preview reports would be distributed to IRFs in June 2024, or as soon as technically feasible. Thereafter, an IRF's DC Function measure score would be publicly displayed based on four quarters of data and updated quarterly.

In regards to patient-specific data, IRFs can review key aspects of this measure, such as who did and did not meet the numerator criteria, in their own patent-level quality measure reports. In terms of the intended use of this measure, as with all QRPs, this measure will help inform Medicare beneficiaries and their caregivers when selecting IRF care and can be used by IRFs to monitor their own performance and improve care quality. Finally, we thank the commenter for their suggestion that CMS provide performance results stratified by key risk factors and will consider the feasibility of adding stratified performance scores to the provider preview report at a later date.

Comment: One commenter expressed concern that IRFs with eligible stays requiring imputation during the first quarter of the measure period will not know the imputed values for their patients until the entire 12-month measure target period ends. Additionally, this commenter believes that after the first 12-month period ends and a new quarter begins, changes in imputed values from the first year will not be reflected in measure scores. The same commenter expressed concern for the inclusion of new IRFs in the proposed measure calculations, believing these IRFs will be excluded from the measure until they have a full 12 months of data.

Response: New IRFs will not need 12 full months of data to receive scores but will receive scores with the following quarterly update. We propose to use data collected from January 1, 2023, through December 31, 2023 (Quarter 1 2023 through Quarter 4 2023) for the first scores published. Therefore, IRFs will not need to wait 12 months for results. Also, because scores will be updated quarterly, results will consider new information provided that will impact scores from previous quarters.

After consideration of the public comments we received, we are finalizing our proposal to begin publicly displaying data for the DC Function measure beginning with the September 2024 Care Compare refresh or as soon as technically feasible.

4. Public Reporting of the COVID–19 Vaccine: Percent of Patients/Residents Who Are Up to Date Measure Beginning With the FY 2026 IRF QRP

We proposed to begin publicly displaying data for the COVID–19 Vaccine: Percent of Patients/Residents Who are Up to Date (Patient/Resident COVID–19 Vaccine) measure beginning with the September 2025 refresh of Care Compare, or as soon as technically feasible, using data collected for Q4 2024 (October 1, 2024 through December 31, 2024). We proposed that an IRF's percent of patients who are up to date, as reported under the Patient/Resident COVID–19 Vaccine measure, would be displayed based on one quarter of data. Provider preview reports would be distributed to IRFs in June 2025 for data collected in Q4 2024, or as soon as technically feasible. Thereafter, the percent of IRF patients who are up to date with their COVID–19 vaccinations would be publicly displayed based on one quarter of data updated quarterly. To ensure the statistical reliability of the data, we proposed that we would not publicly report an IRF's performance on the measure if the IRF had fewer than 20 eligible cases in any quarter. IRFs that have fewer than 20 eligible cases would be distinguished with a footnote that states: ''The number of cases/patient stays is too small to report.''

We invited public comment on the proposal for the public display of the Patient/Resident COVID–19 Vaccine measure beginning with the September 2025 refresh of Care Compare, or as soon as technically feasible. The following is a summary of the public comments received and our responses.

Comment: Several commenters questioned the value of reporting only one quarter of data, since community vaccination rates vary over time and as definitions update.

Response: We believe it is important to make the most up to date data available to patients and their caregivers, which will support them in making essential decisions about their health care. We proposed the measure to be publicly reported on a rolling quarterly basis in order to align with the existing HCP COVID–19 Vaccine measure. This means the information would be updated quarterly with only the most recent data, such that the measure would be consumed as the most recent quarter of data refreshed. We believe averaging over 12 months would result in the dilution of the most recent and potentially more meaningful information, as opposed to the proposed method of reporting, which would result in publishing information that is more up to date and would not affect the data collection schedule established for submitting assessment data.

Comment: We received comments on whether the public reporting of the measure would be meaningful or useful to consumers. One commenter said that as with most publicly reported data, there is a generous lag time from when the vaccine is administered, the data gathered and submitted, and their eventual display online.

Response: The data will be posted on Care Compare as soon as technically feasible, and therefore having a one quarter reporting period reduces the lag following the data submission deadline. We believe this mitigates concerns that the data would not reflect 'recent' information to consumers.

Comment: Another commenter expressed concern about the impact of publicly reporting the data due to the

fact that potential patients may infer that a lower vaccination rate implies the facility has a certain political viewpoint on vaccinations, and that could influence their decision to choose the facility.

Response: It is true that individual patients can make their own inference regarding the rates displayed publicly, and a provider may or may not be able to influence that. However, per 1899B(g) of the Act, CMS is statutorily obligated to publicly report IRF performance on the IRF QRP quality measures. This measure will provide potential patients and their caregivers with an important piece of information regarding vaccination rates as part of their process of identifying providers they would want to seek care from, alongside other measures available on Care Compare to make a comprehensive decision.

After consideration of the public comments we received, we are finalizing our proposal to begin publicly displaying data for the Patient/Resident COVID–19 measure beginning with the September 2025 Care Compare refresh or as soon as technically feasible.

X. Provisions of the Final Regulations

In the final rule, we are adopting the provisions set forth in the FY 2024 IRF PPS proposed rule (88 FR 20950), specifically:

- We will update the CMG relative weights and average length of stay values for FY 2024, in a budget neutral manner, as discussed in section V. of this final rule.
- We will update the IRF PPS payment rates for FY 2024 by the market basket increase factor, based upon the most current data available, with a productivity adjustment required by section 1886(j)(3)(C)(ii)(I) of the Act, as described in section VI. of this final rule.
- We will rebase and revise the IRF market basket to reflect a 2021 base year, as discussed in section VI. of this final rule.
- We will update the FY 2024 IRF PPS payment rates by the FY 2024 wage index and the labor-related share in a budget-neutral manner, as discussed in section VI. of this final rule.
- We will calculate the IRF standard payment conversion factor for FY 2024, as discussed in section VI. of final rule.
- We will update the outlier threshold amount for FY 2024, as discussed in section VII. of this final rule.
- We will update the cost-to-charge ratio (CCR) ceiling and urban/rural average CCRs for FY 2024, as discussed in section VII. of this final rule.
- We will modify the regulation for IRF units to become excluded and paid under the IRF PPS as discussed in section VIII. of this final rule.
- We are also adopting updates to the IRF QRP in section IX. of this final rule as follows:

++ We are adopting the COVID–19 Vaccine: Percent of Patients/Residents Who Are Up to Date (Patient/Resident COVID–19 Vaccine) measure.

++ We are adopting the Discharge Function Score (DC Function) measure.

++ We are modifying the COVID–19 Vaccination Coverage among Healthcare Personnel (HCP) (HCP COVID–19 Vaccine) measure.

++ We are removing the Application of Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (Application of Functional Assessment/Care Plan) measure.

++ We are removing the IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (Change in Self-Score) measure.

++ We are removing the IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (Change in Mobility Score) measure.

XI. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

This final rule refers to associated information collections that are not discussed in the regulation text contained in this document.

A. Requirements for Updates Related to the IRF QRP Beginning With the FY 2025 IRF QRP

An IRF that does not meet the requirements of the IRF QRP for a fiscal year will receive a 2-percentage point reduction to its otherwise applicable annual increase factor for that fiscal year.

We believe that the burden associated with the IRF QRP is the time and effort associated with complying with the requirements of the IRF QRP. In section VIII.C. of the proposed rule, we proposed to modify one measure, adopt three new measures, and remove three measures from the IRF QRP.

As stated in section VIII.C.1.a. of the proposed rule, we proposed that IRFs submit data on one modified quality measure, the COVID–19 Vaccination Coverage among Healthcare Personnel (HCP) (HCP COVID–19 Vaccine) measure beginning with the FY 2025 IRF QRP. The data is collected through the Centers for Disease Control and Prevention (CDC's) National Health Safety Network (NHSN). IRFs currently utilize the NHSN for purposes of meeting other IRF QRP requirements, including the current HCP COVID–19 Vaccine measure. IRFs will continue to submit the HCP COVID–19 Vaccine measure data to CMS through the NHSN. The burden associated with the HCP COVID–19 Vaccine measure is accounted for under the CDC's information collection request currently approved under OMB control number 0920–1317 (expiration date: January 31, 2024). Because we did not propose any updates to the form, manner, and timing of data submission for this HCP COVID–19 Vaccine measure, there will be no increase in burden associated with the proposal and refer readers to the FY 2022 IRF PPS final rule (86 FR 42399 through 42400) for these policies.

In section VIII.C.1.b. of the proposed rule, we proposed to adopt the Discharge Function Score (DC Function) measure beginning with the FY 2025 IRF QRP. This assessment-based quality measure will be calculated using data from the IRF Patient Assessment Instrument (IRF–PAI) that are already reported to CMS for payment and quality reporting purposes, and the burden is accounted for in the information collection request currently approved under OMB control number 0938–0842 (expiration date: August 31, 2025). There will be no additional burden for IRFs associated with the DC Function measure since it does not require collection of new data elements.

In section VIII.C.1.c. of the proposed rule, we also proposed to remove the

Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (Application of Functional Assessment/Care Plan) measure beginning with the FY 2025 IRF QRP. We believe that the removal of the Application of Functional Assessment/Care Plan measure will result in a decrease of 18 seconds (0.3 minutes or 0.005 hours) of clinical staff time at admission beginning with the FY 2025 IRF QRP. We believe the IRF–PAI item affected by the Application of Functional Assessment/Care Plan measure is completed by Occupational Therapists (OT), Physical Therapists (PT), Registered Nurses (RN), Licensed Practical and Licensed Vocational Nurses (LVN), and/or Speech-Language Pathologists (SLP) depending on the functional goal selected. We identified the staff type per item based on past IRF burden calculations in conjunction with expert opinion. Our assumptions for staff type were based on the categories generally necessary to perform an assessment. Individual providers determine the staffing resources necessary. Therefore, we averaged the national average for these labor types and established a composite cost estimate. This composite estimate was calculated by weighting each salary based on the following breakdown regarding provider types most likely to collect this data: OT 45 percent; PT 45 percent; RN 5 percent; LVN 2.5 percent; SLP 2.5 percent. For the purposes of calculating the costs associated with the collection of information requirements, we obtained mean hourly wages for these staff from the U.S. Bureau of Labor Statistics' (BLS) May 2021 National Occupational Employment and Wage Estimates.[204] To account for overhead and fringe benefits, we doubled the hourly wage. These amounts are detailed in Table 19.

TABLE 19: U.S. Bureau of Labor and Statistics' May 2021 National Occupational Employment and Wage Estimates

Occupation Title	Occupation Code	Mean Hourly Wage ($/hr)	Overhead and Fringe Benefit ($/hr)	Adjusted Hourly Wage ($/hr)
Registered Nurse (RN)	29-1141	$39.78	$39.78	$79.56
Licensed Vocational Nurse (LVN)	29-2061	$24.93	$24.93	$49.86
Speech Language Pathologist (SLP)	29-1127	$41.26	$41.26	$82.52
Physical Therapist (PT)	29-1123	$44.67	$44.67	$89.34
Occupational Therapist (OT)	29-1122	$43.02	$43.02	$86.04

We estimated that the burden and cost for IRFs for complying with requirements of the FY 2025 IRF QRP would decrease under our proposal. Specifically, we believe that there will be a 0.005 hour decrease in clinical staff time to report data for each IRF–PAI completed at admission. Using data from calendar year 2021, we estimated 511,938 admission assessments from 1,133 IRFs annually. This equates to a decrease of 2,560 hours in burden at admission for all IRFs (0.005 hour × 511,938 admissions). Given 0.135 minutes of occupational therapist time at $86.04 per hour, 0.135 minutes of physical therapist time at $89.34 per hour, 0.015 minutes registered nurse time at $79.56 per hour, 0.0075 minutes of licensed vocational nurse time at $49.86 per hour, and 0.0075 minutes of speech language pathologist time at $82.52 per hour to complete an average of 454 IRF–PAI admission assessments per IRF per year, we estimate the total cost will be decreased by $194.79 ($220,697.60 total reduction/1,133 IRFs) per IRF annually, or $220,697.60 for all IRFs annually based on the proposed removal of the Application of Functional Assessment/Care Plan measure.

In section VIII.C.1.d. of the proposed rule, we proposed to remove the IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (Change in Self-Care Score) and the IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (Change in Mobility Score) measures beginning with the FY 2025 IRF QRP. While these assessment-based quality measures were proposed for removal, the data elements used to calculate the measures will still be collected by IRFs for payment and quality reporting purposes, specifically for other quality measures under the IRF QRP. Therefore, we believe that the proposal to remove the Change in Self-Care Score and Change in Mobility Score measures will not decrease burden for IRFs.

In section VIII.C.2.a. of the proposed rule, we proposed to adopt the COVID–19 Vaccine: Percent of Patients/Residents Who Are Up to Date (Patient/Resident COVID–19 Vaccine) measure beginning with the FY 2026 IRF QRP. The proposed measure will be collected using the IRF–PAI. One data element will be added to the IRF–PAI at discharge in order to allow for collection of the Patient/Resident COVID–19 Vaccine measure, and we believe will result in an increase of 0.3 minutes of clinical staff time at discharge. We believe that the additional Patient/Resident COVID–19 Vaccine measure's data element will be completed equally by registered nurses and licensed vocational nurses. Mean hourly wages for these staff are detailed in Table 19. However, individual IRFs determine the staffing resources necessary. Using data from CY 2021, we estimated a total of 779,274 discharges

[204] U.S. Bureau of Labor Statistics' (BLS) May 2021 National Occupational Employment and Wage Estimates. *https://www.bls.gov/oes/current/oes_nat.htm.*

on all patients regardless of payer from 1,133 IRFs annually. This equates to an increase of 3,896 hours in burden for all IRFs (0.005 hour × 779,274 admissions). Given 0.15 minutes of registered nurse time at $79.56 per hour and 0.15 minutes of licensed vocational nurse time at $49.86 per hour to complete an average of 691 IRF–PAI discharge assessments per IRF per year, we estimate that the total cost of complying with the IRF QRP requirements will be increased by $222.52 [($64.71/hr × 3,896 hours)/1,133 IRFs) per IRF annually, or $252,110.16 ($64.71/hr × 3,896 hours) for all IRFs annually based on the adoption of the Patient/Resident COVID–19 Vaccine measure. The information collection request approved under OMB control number 0938–0842 (expiration date: August 31, 2025) will be revised and sent to OMB for approval.

In summary, under OMB control number 0938–0842, the changes to the IRF QRP will result in a burden addition of $27.73 per IRF ($31,412.56/1,133 IRFs). The total cost increase related to this information collection is approximately $31,412.56 and is summarized in Table 20.

TABLE 20: Change in Burden Associated with OMB Control Number 0938-0842

Quality Measure	Per IRF		All IRFs	
	Change in annual burden hours	Change in annual cost	Change in annual burden hours	Change in annual cost
Change in Burden associated with removal of the Application of Functional Assessment/Care Plan measure beginning with the FY 2025 IRF QRP	-2.26	-$ 194.79	-2,560	-$ 220,697.60
Change in Burden associated with adoption of the Patient/Resident COVID-19 Vaccine measure beginning with the FY 2026 IRF QRP	+3.44	+$ 222.52	+3,896	+$ 252,110.16
Total Change in burden for the IRF QRP associated with 0938-0842	**1.18**	**$ 27.73**	**1,336**	**$ 31,412.56**

We invited public comments on the proposed information collection requirements.

The following is a summary of the public comments received on the proposed revisions and our responses:

Comment: One commenter noted their disappointment that CMS continues to add and modify IRF QRP requirements while IRFs are still facing operational challenges related to the COVID–19 pandemic. They said the proposed modification to the HCP COVID–19 Vaccine measure beginning with the FY 2025 IRF QRP will add to their administrative burden and compliance costs. They also stated that the net effect of the removal of three current measures, the addition of two new measures, and the modification of one measure did not reduce any administrative burden associated with the IRF QRP.

Response: We acknowledge that the net effect of our policies finalized in this final rule is an increase of $27.73 per IRF per year. However, despite the operational challenges imposed by the COVID–19 pandemic, we must maintain our commitment to quality of care for all patients. In this final rule, we have sought to strike an appropriate balance between maintaining our commitment to quality of care with the impact on IRFs. The result is a reduction of the IRF QRP measure set from 18 to 17. We will continue to assess the IRF QRP measure set and use our Meaningful Measures Framework and measure removal criteria to guide decisions about future changes.

Comment: Two commenters stated the estimate of 18 seconds or 0.3 minutes of clinical staff time at discharge underestimates the burden of clinical staff to collect the Patient/Resident COVID–19 Vaccine measure. One of these commenters estimated the time required by a clinician to document a single item in the electronic medical record is around 7 seconds. This commenter also suggested the collection of the information from the patient to complete the data element will likely take far more than the remaining estimated 11 seconds, particularly due to the confusing nature and ongoing changes to the definition of ''up to date,'' as well as the time necessary to conduct a patient interview, reconcile information provided by the patient, review the medical records, or contact a proxy for the information. The commenter stated that CMS' estimate does not account for the time needed to modify their electronic medical record system or to train staff for this measure. The other commenter suggested that the clinician type included in the burden estimate for the Patient/Resident COVID–19 Vaccine measure was not inclusive of the range of staff type that would need to receive an estimated hour of training. The commenter stated the training costs should be considered as a part of the burden estimate for completing the item.

Response: The 18 seconds (0.3 minutes) estimated for this item is based on past IRF burden calculations and represents the time it takes to encode the IRF–PAI. As the commenter pointed out in their example, the patient must be assessed, and information gathered. After the patient assessment is completed, the IRF–PAI is coded with the information and submitted to the internet Quality Improvement and Evaluation System (iQIES), and it is these steps (after the patient assessment) that the estimated burden and cost captures. Finally, as we stated in section X.A. of this final rule, our assumptions

for staff type were based on the categories generally necessary to perform an assessment, and subsequently encode it, which is consistent with past collection of information estimates.[205] While we acknowledge that some IRFs may train and utilize other personnel, our estimates are based on the categories of personnel necessary to complete the IRF–PAI.

Comment: We received comments about the burden estimate for the DC Function Score measure. One commenter opposed the adoption of this measure given the growing burden of administering the IRF QRP, workforce shortages, and financial pressures. Two other commenters suggested that the measure's adoption will require software updates to implement and monitor the measure's complex calculations prior to CMS publishing results, as well as additional training and education for clinical and administrative personnel. One of these commenters recommended CMS should consider these costs because they impact the values presented in the FY 2024 IRF PPS proposed rule. Another commenter observed IRFs will still need to educate and train their clinicians on the new measure, incorporate discussion of this measure into their interdisciplinary team meetings, and create a solution that will calculate imputation values and the risk-adjusted expected discharge function score values in order to manage performance.

Response: CMS continually looks for opportunities to minimize burden associated with collection of the IRF–PAI for information users through strategies that simplify collection and submission requirements. As discussed in sections IX.C.1.b. and X.A. of this final rule, this measure is modeled after the currently adopted Discharge Mobility Score and Discharge Self-Care Score measures, and we are not proposing changes to the number of items required or the reporting frequency of the items reported in the IRF–PAI for this DC Function measure. IRFs have been collecting the data elements used in the calculation of the DC Function measure since FY 2017. At that time, we standardized the collection instructions across all IRFs, ensuring that all instructions and notices are written in plain language, and by providing step-by-step examples for completing the IRF–PAI. CMS provides a dedicated help desk to support users and respond to questions about the data collection. Additionally, a dedicated IRF QRP web page houses multiple modes of tools, such as instructional videos, case studies, user manuals, and frequently asked questions which support understanding of the items collected for the DC Function measure and the IRF–PAI generally, and these can be used by current users and assist new users of the IRF–PAI. CMS utilizes a listserv to facilitate outreach to users, such as communicating timely and important new material(s), and we will use those outreach resources when providing training and information about the new DC Function measure. CMS creates data collection specifications for IRF electronic health record (EHR) software with 'skip' patterns associated with the Quality Indicator items used for the DC Function measure to ensure the IRF–PAI is limited to the minimum data required to meet quality reporting requirements. These specifications are available free of charge to all IRFs and their technology partners. Further, these minimum requirements are standardized for all users of the IRF–PAI assessment forms. Finally, CMS calculates this measure for IRFs, and provides IRFs with various resources to review and monitor their own performance on this measure, including a free internet-based system through which users can access on-demand reports for feedback on the collection of the IRF–PAI associated with their facility.

After considering the public comments received, and for the reasons outlined in this section of the final rule and our comment responses, we are finalizing the revisions as proposed.

[205] FY 2016 IRF PPS proposed rule (80 FR 23390).

XII. Regulatory Impact Analysis

A. Statement of Need

This final rule updates the IRF prospective payment rates for FY 2024 as required under section 1886(j)(3)(C) of the Act and in accordance with section 1886(j)(5) of the Act, which requires the Secretary to publish in the **Federal Register** on or before August 1 before each FY, the classification and weighting factors for CMGs used under the IRF PPS for such FY and a description of the methodology and data used in computing the prospective payment rates under the IRF PPS for that FY. This final rule also implements section 1886(j)(3)(C) of the Act, which requires the Secretary to apply a productivity adjustment to the market basket increase factor for FY 2012 and subsequent years.

Furthermore, this final rule adopts policy changes to the IRF QRP under the statutory discretion afforded to the Secretary under section 1886(j)(7) of the Act. We are finalizing updates to the IRF QRP requirements beginning with the FY 2025 IRF QRP and FY 2026 IRF QRP. We are finalizing a modification to a current measure in the IRF QRP which we believe will encourage healthcare personnel to remain up to date with the COVID–19 vaccine, resulting in fewer cases, less hospitalizations, and lower mortality associated with the virus. We are finalizing the adoption of two new measures: one measure to maintain compliance with the requirements of section 1899B of the Act and replace the current cross-setting process measure with a measure that is more strongly associated with desired patient functional outcomes; and a second measure that supports the goals of CMS Meaningful Measures Initiative 2.0 to empower consumers with tools and information as they make healthcare choices as well as assist IRFs to leverage their care processes to increase vaccination coverage in their settings to protect residents and prevent negative outcomes. We are finalizing the removal of three measures from the IRF QRP as they meet the criteria specified at § 412.634(b)(2) for measure removal.

B. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), Executive Order 14094 entitled ''Modernizing Regulatory Review'' (April 6, 2023), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999) and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). The Executive Order 14094 entitled ''Modernizing Regulatory Review'' (hereinafter, the Modernizing E.O.) amends section 3(f)(1) of Executive Order 12866 (Regulatory Planning and Review). The amended section 3(f) of Executive Order 12866 defines a ''significant regulatory action'' as an action that is likely to result in a rule: (1) having an annual effect on the economy of $200 million or more in any 1 year (adjusted every 3 years by the

Administrator of OIRA for changes in gross domestic product), 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, territorial, or tribal governments or communities; (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raise legal or policy issues for which centralized review would meaningfully further the President's priorities or the principles set forth in this Executive order, as specifically authorized in a timely manner by the Administrator of OIRA in each case.

A regulatory impact analysis (RIA) must be prepared for major rules with significant regulatory action/s and/or with significant effects as per section 3(f)(1) ($200 million or more in any 1 year). We estimate the total impact of the policy updates described in this final rule by comparing the estimated payments in FY 2024 with those in FY 2023. This analysis results in an estimated $355 million increase for FY 2024 IRF PPS payments. Additionally, we estimate that costs associated with updating the reporting requirements under the IRF QRP result in an estimated $31,783,532.15 additional cost in FY 2026 for IRFs. Based on our estimates, OMB's Office of Information and Regulatory Affairs has determined this rulemaking is significant per section 3(f)(1) as measured by the $200 million or more in any 1 year, and hence also a major rule under Subtitle E of the Small Business Regulatory Enforcement Fairness Act of 1996 (also known as the Congressional Review Act). Accordingly, we have prepared an RIA that, to the best of our ability, presents the costs and benefits of the rulemaking.

C. Anticipated Effects

1. Effects on IRFs

The RFA requires agencies to analyze options for regulatory relief of small entities, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most IRFs and most other providers and suppliers are small entities, either by having revenues of $8.0 million to $41.5 million or less in any 1 year depending on industry classification, or by being nonprofit organizations that are not dominant in their markets. (For details, see the Small Business Administration's final rule that set forth size standards for health care industries, at 65 FR 69432 at *https://www.sba.gov/sites/default/files/2019-08/SBA%20Table%20of%20Size%20Standards_Effective%20Aug%2019%2C%202019_Rev.pdf,* effective January 1, 2017 and updated on August 19, 2019.) Because we lack data on individual hospital receipts, we cannot determine the number of small proprietary IRFs or the proportion of IRFs' revenue that is derived from Medicare payments. Therefore, we assume that all IRFs (an approximate total of 1,133 IRFs, of which approximately 50 percent are nonprofit facilities) are considered small entities and that Medicare payment constitutes the majority of their revenues. HHS generally uses a revenue impact of 3 to 5 percent as a significance threshold under the RFA. As shown in Table 21, we estimate that the net revenue impact of the final rule on all IRFs is to increase estimated payments by approximately 4.0 percent. The rates and policies set forth in this final rule will not have a significant impact (not greater than 4 percent) on a substantial number of small entities. The estimated impact on small entities is shown in Table 21. MACs are not considered to be small entities. Individuals and States are not included in the definition of a small entity.

In addition, section 1102(b) of the Act requires us to prepare an RIA if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. As shown in Table 21, we estimate that the net revenue impact of this final rule on rural IRFs is to increase estimated payments by approximately 3.6 percent based on the data of the 135 rural units and 12 rural hospitals in our database of 1,133 IRFs for which data were available. We estimate an overall impact for rural IRFs in all areas between 2.0 percent and 6.2 percent. As a result, we anticipate that this final rule will not have a significant impact on a substantial number of small entities.

Section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–04, enacted March 22, 1995) (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2023, that threshold is approximately $177 million. This final rule does not mandate any requirements for State, local, or tribal governments, or for the private sector.

Executive Order 13132 establishes certain requirements that an agency must meet when it issues a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has federalism implications. As stated, this final rule will not have a substantial effect on State and local governments, preempt State law, or otherwise have a federalism implication.

2. Detailed Economic Analysis

This final rule will update the IRF PPS rates contained in the FY 2023 IRF PPS final rule (87 FR 47038). Specifically, this final rule will update the CMG relative weights and ALOS values, the wage index, and the outlier threshold for high-cost cases. This final rule will apply a productivity adjustment to the FY 2024 IRF market basket increase factor in accordance with section 1886(j)(3)(C)(ii)(I) of the Act. Further, this final rule rebases and revises the IRF market basket to reflect a 2021 base year. We are also modifying the regulation governing when IRF units can be excluded and paid under the IRF PPS.

We estimate that the impact of the changes and updates described in this final rule would be a net estimated increase of $355 million in payments to IRFs. The impact analysis in Table 21 of this final rule represents the projected effects of the updates to IRF PPS payments for FY 2024 compared with the estimated IRF PPS payments in FY 2023. We determine the effects by estimating payments while holding all other payment variables constant. We use the best data available, but we do not attempt to predict behavioral responses to these changes, and we do not make adjustments for future changes in such variables as number of discharges or case-mix.

We note that certain events may combine to limit the scope or accuracy of our impact analysis, because such an analysis is future-oriented and, thus, susceptible to forecasting errors because of other changes in the forecasted impact time period. Some examples could be legislative changes made by the Congress to the Medicare program that would impact program funding, or changes specifically related to IRFs. Although some of these changes may not necessarily be specific to the IRF PPS, the nature of the Medicare program

is such that the changes may interact, and the complexity of the interaction of these changes could make it difficult to predict accurately the full scope of the impact upon IRFs.

In updating the rates for FY 2024, we are implementing the standard annual revisions described in this final rule (for example, the update to the wage index and market basket increase factor used to adjust the Federal rates). We are also reducing the FY 2024 IRF market basket increase factor by a productivity adjustment in accordance with section 1886(j)(3)(C)(ii)(I) of the Act. We estimate the total increase in payments to IRFs in FY 2024, relative to FY 2023, would be approximately $355 million.

This estimate is derived from the application of the FY 2024 IRF market basket increase factor, as reduced by a productivity adjustment in accordance with section 1886(j)(3)(C)(ii)(I) of the Act, which yields an estimated increase in aggregate payments to IRFs of $305 million. However, there is an estimated $50 million increase in aggregate payments to IRFs due to the update to the outlier threshold amount. Therefore, we estimate that these updates would result in a net increase in estimated payments of $355 million from FY 2023 to FY 2024.

The effects of the updates that impact IRF PPS payment rates are shown in Table 21. The following updates that affect the IRF PPS payment rates are discussed separately below:

- The effects of the update to the outlier threshold amount, from approximately 2.5 percent to 3.0 percent of total estimated payments for FY 2024, consistent with section 1886(j)(4) of the Act.
- The effects of the annual market basket update (using the 2021-based IRF market basket) to IRF PPS payment rates, as required by sections 1886(j)(3)(A)(i) and (j)(3)(C) of the Act, including a productivity adjustment in accordance with section 1886(j)(3)(C)(ii)(I) of the Act.
- The effects of applying the budget-neutral labor-related share and wage index adjustment, as required under section 1886(j)(6) of the Act, accounting for the permanent cap on wage index decreases when applicable.
- The effects of the budget-neutral changes to the CMG relative weights and ALOS values under the authority of section 1886(j)(2)(C)(i) of the Act.
- The total change in estimated payments based on the FY 2024 payment changes relative to the estimated FY 2023 payments.

3. Description of Table 21

Table 21 shows the overall impact on the 1,133 IRFs included in the analysis.

The next 12 rows of Table 21 contain IRFs categorized according to their geographic location, designation as either a freestanding hospital or a unit of a hospital, and by type of ownership; all urban, which is further divided into urban units of a hospital, urban freestanding hospitals, and by type of ownership; and all rural, which is further divided into rural units of a hospital, rural freestanding hospitals, and by type of ownership. There are 986 IRFs located in urban areas included in our analysis. Among these, there are 648 IRF units of hospitals located in urban areas and 338 freestanding IRF hospitals located in urban areas. There are 147 IRFs located in rural areas included in our analysis. Among these, there are 135 IRF units of hospitals located in rural areas and 12 freestanding IRF hospitals located in rural areas. There are 459 for-profit IRFs. Among these, there are 424 IRFs in urban areas and 35 IRFs in rural areas. There are 571 non-profit IRFs. Among these, there are 480 urban IRFs and 91 rural IRFs. There are 103 government-owned IRFs. Among these, there are 82 urban IRFs and 21 rural IRFs.

The remaining four parts of Table 21 show IRFs grouped by their geographic location within a region, by teaching status, and by DSH patient percentage (PP). First, IRFs located in urban areas are categorized for their location within a particular one of the nine Census geographic regions. Second, IRFs located in rural areas are categorized for their location within a particular one of the nine Census geographic regions. In some cases, especially for rural IRFs located in the New England, Mountain, and Pacific regions, the number of IRFs represented is small. IRFs are then grouped by teaching status, including non-teaching IRFs, IRFs with an intern and resident to average daily census (ADC) ratio less than 10 percent, IRFs with an intern and resident to ADC ratio greater than or equal to 10 percent and less than or equal to 19 percent, and IRFs with an intern and resident to ADC ratio greater than 19 percent. Finally, IRFs are grouped by DSH PP, including IRFs with zero DSH PP, IRFs with a DSH PP less than 5 percent, IRFs with a DSH PP between 5 and less than 10 percent, IRFs with a DSH PP between 10 and 20 percent, and IRFs with a DSH PP greater than 20 percent.

The estimated impacts of each policy described in this rule to the facility categories listed are shown in the columns of Table 21. The description of each column is as follows:

- Column (1) shows the facility classification categories.
- Column (2) shows the number of IRFs in each category in our FY 2024 analysis file.
- Column (3) shows the number of cases in each category in our FY 2024 analysis file.
- Column (4) shows the estimated effect of the adjustment to the outlier threshold amount.
- Column (5) shows the estimated effect of the update to the IRF labor-related share and wage index, in a budget-neutral manner.
- Column (6) shows the estimated effect of the update to the CMG relative weights and ALOS values, in a budget-neutral manner.
- Column (7) compares our estimates of the payments per discharge, incorporating all of the policies reflected in this final rule for FY 2024 to our estimates of payments per discharge in FY 2023.

The average estimated increase for all IRFs is approximately 4.0 percent. This estimated net increase includes the effects of the IRF market basket update for FY 2024 of 3.4 percent, which is based on a IRF market basket increase factor of 3.6 percent, less a 0.2 percentage point productivity adjustment, as required by section 1886(j)(3)(C)(ii)(I) of the Act. It also includes the approximate 0.6 percent overall increase in estimated IRF outlier payments from the update to the outlier threshold amount. Since we are making the updates to the IRF wage index, labor-related share and the CMG relative weights in a budget-neutral manner, they will not be expected to affect total estimated IRF payments in the aggregate. However, as described in more detail in each section, they will be expected to affect the estimated distribution of payments among providers.

TABLE 21: IRF Impact for FY 2024 (Columns 4 through 7 in percentage)

Facility Classification	Number of IRFs	Number of Cases	Outlier	FY 2024 Wage Index and Labor-Related Share	CMG Weights	Total Percent Change [1]
(1)	(2)	(3)	(4)	(5)	(6)	(7)
Total	1,133	385,653	0.6	0.0	0.0	4.0
Urban unit	648	137,080	1.0	0.0	0.0	4.5
Rural unit	135	16,844	0.9	-0.4	0.0	3.9
Urban hospital	338	226,579	0.2	0.0	0.0	3.7
Rural hospital	12	5,150	0.2	-0.8	0.1	2.8
Urban For-Profit	424	221,988	0.3	0.0	0.0	3.7
Rural For-Profit	35	8,209	0.4	-0.7	0.0	3.1
Urban Non-Profit	480	123,128	0.9	0.1	0.0	4.4
Rural Non-Profit	91	11,642	1.0	-0.3	0.0	4.0
Urban Government	82	18,543	1.0	0.0	0.0	4.5
Rural Government	21	2,143	0.6	-0.5	0.0	3.4
Urban	986	363,659	0.5	0.0	0.0	4.0
Rural	147	21,994	0.7	-0.5	0.0	3.6
Urban by region						
Urban New England	29	13,450	0.4	-0.2	0.0	3.6
Urban Middle Atlantic	118	40,542	0.7	0.5	0.0	4.7
Urban South Atlantic	170	81,632	0.5	0.1	0.0	4.0
Urban East North Central	164	43,093	0.6	-0.5	0.0	3.5
Urban East South Central	55	25,607	0.2	-0.1	0.0	3.5
Urban West North Central	77	21,080	0.6	0.1	0.0	4.1
Urban West South Central	201	87,094	0.3	0.3	0.0	4.0
Urban Mountain	77	27,560	0.5	-1.0	0.0	2.8
Urban Pacific	95	23,601	1.2	0.3	0.0	5.0
Rural by region						
Rural New England	5	1,054	0.8	-2.3	0.2	2.0
Rural Middle Atlantic	10	1,048	1.1	-0.5	0.0	4.1
Rural South Atlantic	15	3,957	0.3	0.2	0.0	3.9
Rural East North Central	24	2,939	0.6	-0.6	0.0	3.4
Rural East South Central	21	3,453	0.3	-0.6	0.0	3.0
Rural West North Central	20	2,374	1.2	-0.5	-0.1	4.0
Rural West South Central	43	6,423	0.8	-0.5	0.0	3.7
Rural Mountain	6	461	1.7	-0.1	0.0	4.9
Rural Pacific	3	285	3.1	-0.3	0.0	6.2
Teaching status						
Non-teaching	1,030	341,160	0.5	-0.1	0.0	3.9
Resident to ADC less than 10%	58	32,410	0.7	0.3	0.0	4.4
Resident to ADC 10%-19%	33	10,675	1.1	0.6	0.0	5.2
Resident to ADC greater than 19%	12	1,408	1.4	0.7	-0.1	5.5
Disproportionate share patient percentage (DSH PP)						
DSH PP = 0%	49	6,136	0.7	0.5	0.0	4.6
DSH PP <5%	137	60,402	0.4	0.4	0.0	4.1
DSH PP 5%-10%	233	92,942	0.4	0.0	0.0	3.9

Facility Classification	Number of IRFs	Number of Cases	Outlier	FY 2024 Wage Index and Labor-Related Share	CMG Weights	Total Percent Change [1]
DSH PP 10%-20%	415	150,180	0.6	-0.1	0.0	3.8
DSH PP greater than 20%	299	75,993	0.8	-0.1	0.0	4.2

[1]This column includes the impact of the updates in columns (4), (5), and (6) above, and of the IRF market basket update for FY 2024 of 3.6 percent, reduced by 0.2 percentage point for the productivity adjustment as required by section 1886(j)(3)(C)(ii)(I) of the Act. Note, the products of these impacts may be different from the percentage changes shown here due to rounding effects.

4. Impact of the Update to the Outlier Threshold Amount

The estimated effects of the update to the outlier threshold adjustment are presented in column 4 of Table 21.

For the FY 2024 proposed rule, we used preliminary FY 2022 IRF claims data and based on that preliminary analysis, we estimated that IRF outlier payments as a percentage of total estimated IRF payments would be 2.3 percent in FY 2023. As we typically do between the proposed and final rules each year, we updated our FY 2022 IRF claims data to ensure that we are using the most recent available data in setting IRF payments. Therefore, based on an updated analysis of the most recent IRF claims data for this final rule, we estimate that IRF outlier payments as a percentage of total estimated IRF payments are 2.5 percent in FY 2023. Thus, we are adjusting the outlier threshold amount in this final rule to maintain total estimated outlier payments equal to 3 percent of total estimated payments in FY 2024.

The impact of this update to the outlier threshold amount (as shown in column 4 of Table 21) is to increase estimated overall payments to IRFs by 0.6 percentage point. We do not estimate that any group of IRFs would experience a decrease in payments from this proposed update.

5. Impact of the Wage Index, Labor-Related Share, and Wage Index Cap

In column 5 of Table 21, we present the effects of the budget-neutral update of the wage index and labor-related share, taking into account the permanent 5 percent cap on wage index decreases, when applicable. The changes to the wage index and the labor-related share are discussed together because the wage index is applied to the labor-related share portion of payments, so the changes in the two have a combined effect on payments to providers. As discussed in section VI.E. of this final rule, we update the FY 2024 labor-related share from 72.9 percent in FY 2023 to 74.1 percent in FY 2024. In aggregate, we do not estimate that these updates will affect overall estimated payments to IRFs. However, we do expect these updates to have small distributional effects. We estimate the largest decrease in payment from the update to the CBSA wage index and labor-related share to be a 2.3 percent decrease for IRFs in the Rural New England region and the largest increase in payment to be a 0.5 percent increase for IRFs in the Urban Middle Atlantic Region.

6. Impact of the Update to the CMG Relative Weights and ALOS Values

In column 6 of Table 21, we present the effects of the budget-neutral update of the CMG relative weights and ALOS values. In the aggregate, we do not estimate that these updates will affect overall estimated payments of IRFs. However, we do expect these updates to have small distributional effects, with the largest effect being an increase in payments of 0.2 percent to IRFs in the Rural New England region.

7. Effects of Modification of the Regulation for Excluded IRF Units Paid Under the IRF PPS

As discussed in section VIII. of this final rule, we are amending the regulation text at § 412.25(c)(1) in this final rule.

We do not anticipate a financial impact associated with the modification of the regulation for excluded IRF units paid under the IRF PPS because an IRF unit would simply be opening on a different date (in the middle of a cost reporting period) than they otherwise would have (at the start of a cost reporting period). Although this modification to the regulatory requirements significantly reduces the burden of opening new IRF units and reduces IRF's construction costs, we do not believe that it will significantly affect IRF payments.

In response to the need for availability of inpatient rehabilitation beds we are implementing changes to § 412.25(c) to allow greater flexibility for hospitals to open excluded units, while minimizing the amount of effort that Medicare contractors would need to spend administering the regulatory requirements. We believe this change will provide IRFs greater flexibility when establishing an excluded unit at a time other than the start of a cost reporting period.

8. Effects of Requirements for the IRF QRP Beginning With FY 2025

In accordance with section 1886(j)(7)(A) of the Act, the Secretary must reduce by 2 percentage points the annual market basket increase factor otherwise applicable to an IRF for a fiscal year if the IRF does not comply with the requirements of the IRF QRP for that fiscal year. In section IX.A. of the proposed rule, we discussed the method for applying the 2 percentage point reduction to IRFs that fail to meet the IRF QRP requirements.

As discussed in section IX.C.1.a. of this final rule, we are finalizing the proposal to modify one measure in the IRF QRP beginning with the FY 2025 IRF QRP, the HCP COVID–19 Vaccine measure. We believe that the burden associated with the IRF QRP is the time and effort associated with complying with the non-claims-based measures requirements of the IRF QRP. The burden associated with the HCP COVID–19 Vaccine measure is accounted for under the CDC PRA package currently approved under OMB control number 0920–1317 (expiration January 31, 2024).

As discussed in section IX.C.1.b. of this final rule, we are finalizing the proposal for IRFs to collect data on one new quality measure, the DC Function measure, beginning with assessments

completed on October 1, 2023. However, the measure utilizes data items that IRFs already report to CMS for payment and quality reporting purposes, and therefore the burden is accounted for in the PRA package approved under OMB control number 0938–0842 (expiration August 31, 2025).

As discussed in section IX.C.1.c. of this final rule, we are finalizing the proposal to remove the Application of Functional Assessment/Care Plan measure, from the IRF QRP, and this proposal would result in a decrease of 0.3 minutes of clinical staff time beginning with admission assessments completed on October 1, 2023. The proposed decrease in burden will be accounted for in a revised information collection request under OMB control number (0938–0842), and we provided impact information. We believe the data element for this quality measure is completed by occupational therapists (45 percent of the time or 0.135 minutes), physical therapists (45 percent of the time or 0.135 minutes), registered nurses (5 percent of the time or 0.015 minutes), licensed practical and vocational nurses (2.5 percent of the time or 0.0075 minutes), or by speech-language pathologists (2.5 percent of the time or 0.0075 minutes). For the purposes of calculating the costs associated with the collection of information requirements, we obtained mean hourly wages for these staff from the U.S. Bureau of Labor Statistics' (BLS) May 2021 National Occupational Employment and Wage Estimates.[206] To account for overhead and fringe benefits, we doubled the hourly wage. These amounts are detailed in Table 22.

TABLE 22: U.S. Bureau of Labor and Statistics' May 2021 National Occupational Employment and Wage Estimates

Occupation title	Occupation code	Mean Hourly Wage ($/hr)	Overhead and Fringe Benefit ($/hr)	Adjusted Hourly Wage ($/hr)
Registered Nurse (RN)	29-1141	$39.78	$39.78	$79.56
Licensed Vocational Nurse (LVN)	29-2061	$24.93	$24.93	$49.86
Speech Language Pathologist (SLP)	29-1127	$41.26	$41.26	$82.52
Physical Therapist (PT)	29-1123	$44.67	$44.67	$89.34
Occupational Therapist (OT)	29-1122	$43.02	$43.02	$86.04

With 511,938 admissions from 1,133 IRFs annually, we estimated an annual burden decrease of 2,560 fewer hours (511,938 admissions × .005 hours) and a decrease of $220,697.60 [2,560 hours × $86.21/hr)]. For each IRF we estimated an annual burden decrease of 2.26 hours (2,560 hours/1,133 IRFs) at a savings of $194.79 ($220,697.60/1,133 IRFs).

As discussed in section IX.C.1.d. of this final rule, we are finalizing the removal of two additional measures from the IRF QRP, the Change in Self-Care Score and Change in Mobility Score measures, beginning with assessments completed on October 1, 2023. However, the data items used in the calculation of this measure are used for other payment and quality reporting purposes, and therefore there is no change in burden associated with this proposal.

9. Effects of Requirements for the IRF QRP Beginning With FY 2026

As discussed in section IX.C.2.a. of this final rule, we are finalizing the adoption of the Patient/Resident COVID–19 Vaccine measure, beginning with the FY 2026 IRF QRP. We estimated this measure would result in an increase of 0.3 minutes of clinical staff time beginning with discharge assessments completed on October 1, 2024. Although the increase in burden will be accounted for in a revised information collection request under OMB control number 0938–0842, we provided impact information. We estimated the data element for this quality measure would be completed by registered nurses (50 percent of the time or 0.15 minutes) or by licensed practical and vocational nurses (50 percent of the time or 0.15 minutes). For the purposes of calculating the costs associated with the collection of information requirements, we obtained mean hourly wages for these staff from the U.S. Bureau of Labor Statistics' (BLS) May 2021 National Occupational Employment and Wage Estimates.[207] To account for overhead and fringe benefits, we doubled the hourly wage. These amounts are detailed in Table 22. With 779,274 discharges on all patients regardless of payer from 1,133 IRFs annually, we estimated an annual burden increase of 3,896 hours (779,274 discharges × 0.005 hours) and an increase of $252,110.16 ($64.71/hr × 3,896 hours). For each IRF, we estimated an annual burden increase of 3.44 hours (3,896 hours/1,133 IRFs) at an additional cost of $222.52 ($252,110.16/1,133 IRFs).

In summary, under OMB control number 0938–0842, the changes to the IRF QRP will result in an estimated increase in programmatic burden for 1,133 IRFs. The total burden increase is approximately $31,412.56 for all IRFs and $27.73 per IRF and is summarized in Table 23.

[206] U.S. Bureau of Labor Statistics' (BLS) May 2021 National Occupational Employment and Wage Estimates. *https://www.bls.gov/oes/current/oes_nat.htm.*

[207] U.S. Bureau of Labor Statistics' (BLS) May 2021 National Occupational Employment and Wage Estimates. *https://www.bls.gov/oes/current/oes_nat.htm.*

TABLE 23: Estimated IRF QRP Program Impacts for FY 2025 and FY 2026

Quality Measure	Per IRF		All IRFs	
	Change in annual burden hours	Change in annual cost	Change in annual burden hours	Change in annual cost
Change in Burden associated with removal of the Application of Functional Assessment/Care Plan measure beginning with the FY 2025 IRF QRP	-2.26	-$ 194.79	-2,560	-$ 220,697.60
Change in Burden associated with the adoption of the Patient/Resident COVID-19 Vaccine measure beginning with the FY 2026 IRF QRP	+3.44	+$ 222.52	+3,896	+$ 252,110.16
Total increase in burden for the IRF QRP finalized in this rule	**1.18**	**$ 27.73**	**1,336**	**$ 31,412.56**

We invited public comments on the overall impact of the IRF QRP proposals for FY 2025 and FY 2026.

We did not receive any comments on the proposed revisions and therefore, we are finalizing the revisions as proposed.

D. Alternatives Considered

The following is a discussion of the alternatives considered for the IRF PPS updates contained in this final rule.

Section 1886(j)(3)(C) of the Act requires the Secretary to update the IRF PPS payment rates by an increase factor that reflects changes over time in the prices of an appropriate mix of goods and services included in the covered IRF services.

We proposed to adopt a market basket increase factor for FY 2024 that is based on a rebased and revised market basket reflecting a 2021 base year. We considered the alternative of continuing to use the 2016-based IRF market basket without rebasing to determine the market basket increase factor for FY 2024. However, we typically rebase and revise the market baskets for the various PPS every 4 to 5 years so that the cost weights and price proxies reflect more recent data. Therefore, we believe it is more technically appropriate to use a 2021-based IRF market basket since it allows for the FY 2024 market basket increase factor to reflect a more up-to-date cost structure experienced by IRFs.

As noted previously in this final rule, section 1886(j)(3)(C) of the Act requires the Secretary to update the IRF PPS payment rates by an increase factor that reflects changes over time in the prices of an appropriate mix of goods and services included in the covered IRF services and section 1886(j)(3)(C)(ii)(I) of the Act requires the Secretary to apply a productivity adjustment to the market basket increase factor for FY 2024. Thus, in accordance with section 1886(j)(3)(C) of the Act, we are updating the IRF prospective payments in this final rule by 3.4 percent (which equals the 3.6 percent estimated IRF market basket increase factor for FY 2024 reduced by a 0.2 percentage point productivity adjustment as determined under section 1886(b)(3)(B)(xi)(II) of the Act (as required by section 1886(j)(3)(C)(ii)(I) of the Act)).

We considered maintaining the existing CMG relative weights and average length of stay values for FY 2024. However, in light of recently available data and our desire to ensure that the CMG relative weights and average length of stay values are as reflective as possible of recent changes in IRF utilization and case mix, we believe that it is appropriate to update the CMG relative weights and average length of stay values at this time to ensure that IRF PPS payments continue to reflect as accurately as possible the current costs of care in IRFs.

We considered maintaining the existing outlier threshold amount for FY 2024. However, analysis of updated FY 2023 data indicates that estimated outlier payments would be less than 3 percent of total estimated payments for FY 2024, unless we updated the outlier threshold amount. Consequently, we are adjusting the outlier threshold amount in this final rule to maintain estimated outlier payments at 3 percent of estimated aggregate payments in FY 2024.

We considered not modifying the regulation governing when IRF units can be excluded and paid under the IRF PPS. However, we believe that amending the regulation would provide hospitals greater flexibility when establishing an IRF.

With regard to the proposal to modify the HCP COVID–19 Vaccine measure and to add the Patient/Resident COVID–19 Vaccine measure to the IRF QRP Program, the COVID–19 pandemic has exposed the importance of implementing infection prevention strategies, including the promotion of COVID–19 vaccination for HCP and patients/residents. We believe these measures would encourage healthcare personnel to get up to date with the COVID–19 vaccine and increase vaccine uptake in patients/residents resulting in fewer cases, less hospitalizations, and lower mortality associated with the SARS-CoV–2 virus, but we were unable to identify any alternative methods for collecting the data. An overwhelming public need exists to target quality improvement among IRFs as well as provide data to patients and caregivers through transparency of data. Therefore, these measures have the potential to generate actionable data on COVID–19 vaccination rates.

The proposal to replace the topped-out Application of Functional Assessment/Care Plan process measure with the proposed DC Function measure, which has strong scientific acceptability, satisfies the requirement that there be at least one cross-setting function measure in the PAC QRPs, including the IRF QRP, that uses standardized functional assessment data elements from standardized patient

assessment instruments. We considered the alternative of delaying the proposal of adopting the DC Function measure. However, given the proposed DC Function measure's strong scientific acceptability, the fact that it provides an opportunity to replace the current cross-setting process measure (that is, the Application of Functional Assessment/Care Plan measure) with an outcome measure, and uses standardized functional assessment data elements that are already collected, we believe further delay of the DC Function measure is unwarranted. Further, the removal of the Application of Functional Assessment/Care Plan measure meets measure removal factors one and six, and no longer provides meaningful distinctions in improvements in performance. Finally, the removal of the Change in Self-Care Score and Change in Mobility Score measures meets measure removal factor eight, and the costs associated with these measures outweigh the benefits of their use in the program. Therefore, no alternatives were considered.

E. Regulatory Review Costs

If regulations impose administrative costs on private entities, such as the time needed to read and interpret this final rule, we should estimate the cost associated with regulatory review. Due to the uncertainty involved with accurately quantifying the number of entities that will review the rule, we assume that the total number of unique commenters on the FY 2024 IRF PPS proposed rule will be the number of reviewers of this year's final rule. We acknowledge that this assumption may understate or overstate the costs of reviewing this final rule. It is possible that not all commenters reviewed the FY 2024 IRF PPS proposed rule in detail, and it is also possible that some reviewers chose not to comment on the FY 2024 proposed rule. For these reasons, we thought that the number of commenters would be a fair estimate of the number of reviewers of this final rule.

We also recognize that different types of entities are in many cases affected by mutually exclusive sections of this final rule, and therefore, for the purposes of our estimate we assume that each reviewer reads approximately 50 percent of the rule.

Using the national mean hourly wage data from the May 2022 BLS for Occupational Employment Statistics (OES) for medical and health service managers (SOC 11–9111), we estimate that the cost of reviewing this rule is $123.06 per hour, including overhead and fringe benefits (*https://www.bls.gov/oes/current/oes_nat.htm*). Assuming an average reading speed, we estimate that it would take approximately 3 hours for the staff to review half of this final rule. For each reviewer of the rule, the estimated cost is $369.18 (3 hours × $123.06). Therefore, we estimate that the total cost of reviewing this regulation is $16,613.10 ($369.18 × 45 reviewers).

F. Accounting Statement and Table

As required by OMB Circular A–4 (available at *https://www.whitehouse.gov/wp-content/uploads/legacy_drupal_files/omb/circulars/A4/a-4.pdf*), in Table 24 we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this final rule. Table 24 provides our best estimate of the increase in Medicare payments under the IRF PPS as a result of the updates presented in this final rule based on the data for 1,133 IRFs in our database.

TABLE 24: Accounting Statement: Classification of Estimated Expenditure

	Category	Transfers
Change in Estimated Transfers from FY 2023 IRF PPS to FY 2024 IRF PPS	Annualized Monetized Transfers	$355 million
	From Whom to Whom?	Federal Government to IRF Medicare Providers
Estimated Costs Associated with the FY 2025 and FY 2026 IRF QRP	Annualized monetized cost in FY 2025 and FY 2026 for IRFs due to new quality reporting program requirements	$31,412.56
Estimated Costs Associated with Review Cost for FY 2024 IRF PPS	Cost associated with regulatory review cost	$16,613.10

G. Conclusion

Overall, the estimated payments per discharge for IRFs in FY 2024 are projected to increase by 4.0 percent, compared with the estimated payments in FY 2023, as reflected in column 7 of Table 21.

IRF payments per discharge are estimated to increase by 4.0 percent in urban areas and 3.6 percent in rural areas, compared with estimated FY 2023 payments. Payments per discharge to rehabilitation units are estimated to increase 4.5 percent in urban areas and 3.9 percent in rural areas. Payments per discharge to freestanding rehabilitation hospitals are estimated to increase 3.7 percent in urban areas and 2.8 percent in rural areas.

Overall, IRFs are estimated to experience a net increase in payments as a result of the policies in this final rule. The largest payment increase is estimated to be a 6.2 percent increase for IRFs located in the Rural Pacific region. The analysis above, together with the remainder of this preamble, provides an RIA.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by OMB.

Chiquita Brooks-LaSure, Administrator of the Centers for Medicare & Medicaid Services, approved this document on July 24, 2023.

Xavier Becerra,

Secretary, Department of Health and Human Services.

[FR Doc. 2023–16050 Filed 7–27–23; 4:15 pm]

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Part III

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Part 412

Medicare Program; FY2024 Inpatient Psychiatric Facilities Prospective Payment System—Rate Update; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 412

[CMS–1783–F]

RIN 0938–AV06

Medicare Program; FY 2024 Inpatient Psychiatric Facilities Prospective Payment System—Rate Update

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Final rule.

SUMMARY: This final rule updates the prospective payment rates, the outlier threshold, and the wage index for Medicare inpatient hospital services provided by Inpatient Psychiatric Facilities (IPF), which include psychiatric hospitals and excluded psychiatric units of an acute care hospital or critical access hospital. Additionally, this final rule rebases and revises the IPF market basket to reflect a 2021 base year. These changes will be effective for IPF discharges occurring during the Fiscal Year (FY) beginning October 1, 2023 through September 30, 2024 (FY 2024). In addition, this final rule discusses quality measures and reporting requirements under the Inpatient Psychiatric Facilities Quality Reporting (IPFQR) Program with changes beginning with the FY 2025 payment determination through changes beginning with the FY 2028 payment determination.

DATES: These regulations are effective on October 1, 2023.

FOR FURTHER INFORMATION CONTACT: Mollie Knight (410) 786–7948 or Bridget Dickensheets (410) 786–8670, for information regarding the market basket update or the labor-related share.

Nick Brock (410) 786–5148 or Theresa Bean (410) 786–2287, for information regarding the regulatory impact analysis.

Lauren Lowenstein-Turner, (410) 786–4507, for information regarding the inpatient psychiatric facilities quality reporting program.

SUPPLEMENTARY INFORMATION:

Availability of Certain Tables Exclusively Through the Internet on the CMS Website

Addendum A to this final rule summarizes the fiscal year (FY) 2024 IPF PPS payment rates, outlier threshold, cost of living adjustment factors (COLA) for Alaska and Hawaii, national and upper limit cost-to-charge ratios, and adjustment factors. In addition, Addenda B to this final rule show the complete listing of ICD–10 Clinical Modification (CM) and Procedure Coding System (PCS) codes, the FY 2024 IPF PPS comorbidity adjustment, and electroconvulsive therapy (ECT) procedure codes. Addenda A and B to this final rule are available online at: *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/tools.html.*

Tables setting forth the FY 2024 Wage Index for Urban Areas Based on Core Based Statistical Area (CBSA) Labor Market Areas and the FY 2024 Wage Index Based on CBSA Labor Market Areas for Rural Areas are available exclusively through the internet, on the CMS website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/IPFPPS/WageIndex.html.*

I. Executive Summary

A. Purpose

This final rule rebases and revises the market basket for the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) to reflect a 2021 base year, revises the labor-related share, and updates the prospective payment rates, the outlier threshold, and the wage index for Medicare inpatient hospital services provided by Inpatient Psychiatric Facilities (IPFs) for discharges occurring during FY 2024, (beginning October 1, 2023 through September 30, 2024). This rule also modifies our regulations to make it easier for hospitals to open new excluded psychiatric units paid under the IPF PPS. In addition, this final rule includes a summary of the public comments received to inform revisions to IPF PPS payments for FY 2025, as required by the Consolidated Appropriations Act, 2023 (hereafter referred to as CAA, 2023) (Pub. L. 117-328). Lastly, this final rule discusses quality measures and reporting requirements under the Inpatient Psychiatric Facilities Quality Reporting (IPFQR) Program.

B. Summary of the Major Provisions

1. Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS)

For the IPF PPS, we are finalizing our proposal to—

- Modify the regulations to allow the status of a hospital psychiatric unit to be changed from not excluded to excluded, and therefore paid under the IPF PPS, at any time during a cost reporting period if certain requirements are met.
- Rebase and revise the IPF market basket to reflect a 2021 base year.
- Adjust the 2021-based IPF market basket update (3.5 percent) for economy-wide productivity (0.2 percentage point) as required by section 1886(s)(2)(A)(i) of the Social Security Act (the Act), resulting in a final IPF payment rate update of 3.3 percent for FY 2024.
- Make technical rate setting updates: The IPF PPS payment rates will be adjusted annually for inflation, as well as statutory and other policy factors.

This rule updates:

++ The IPF PPS Federal per diem base rate from $865.63 to $895.63.

++ The IPF PPS Federal per diem base rate for providers who failed to report quality data to $878.29.

++ The electroconvulsive therapy (ECT) payment per treatment from $372.67 to $385.58 .

++ The ECT payment per treatment for providers who failed to report quality data to $378.12.

++ The labor-related share from 77.4 percent to 78.7 percent.

++ The wage index budget-neutrality factor to 1.0016.

++ The fixed dollar loss threshold amount from $24,630 to $33,470 to maintain estimated outlier payments at 2 percent of total estimated aggregate IPF PPS payments.

2. Inpatient Psychiatric Facilities Quality Reporting (IPFQR) Program

For the IPFQR Program, we are finalizing our proposals to—

- Adopt the Facility Commitment to Health Equity measure beginning with the FY 2026 payment determination;
- Adopt the Screening for Social Drivers of Health measure beginning with voluntary reporting of calendar year (CY) 2024 data followed by mandatory reporting of CY 2025 data for the FY 2027 payment determination;
- Adopt the Screen Positive Rate for Social Drivers of Health measure beginning with voluntary reporting of CY 2024 data followed by mandatory reporting of CY 2025 data for the FY 2027 payment determination;
- Adopt the Psychiatric Inpatient Experience (PIX) survey to measure patient experience of care in the IPF setting beginning with voluntary reporting of CY 2025 data followed by mandatory reporting of CY 2026 data for the FY 2028 payment determination;
- Modify the Coronavirus disease 2019 (COVID–19) Vaccination Coverage Among Health Care Personnel (HCP) measure to align the measure with updated measure specifications developed by the Centers for Disease Control and Prevention (CDC), which

address refinements reflecting the availability, and FDA authorization, of Moderna and Pfizer-BioNTech COVID–19 vaccines for use as booster doses, beginning with fourth quarter CY 2023 data for the FY 2025 payment determination and, following this first single-quarter reporting period, reporting for the full calendar year beginning with CY 2024 data for the FY 2026 payment determination;

- Remove the following two measures beginning with the FY 2025 payment determination and subsequent years:

++ Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification (HBIPS–5); and

++ Tobacco Use Brief Intervention Provided or Offered and Tobacco Use Brief Intervention Provided (TOB–2/2a) measure;

- Adopt a data validation pilot program starting with data submitted in CY 2025 and continuing until a full data validation program is proposed and adopted in future rulemaking; and
- Codify the IPFQR Program's procedural requirements related to statutory authority, participation and withdrawal, data submission, quality measure retention and removal, extraordinary circumstances exceptions, and public reporting at 42 CFR 412.433 Procedural requirements under the IPFQR Program.

C. Summary of Impacts

Provision Description	Total Transfers & Cost Reductions
FY 2024 IPF PPS payment update	The overall economic impact of this final rule is an estimated $70 million in increased payments to IPFs during FY 2024.
FY 2024 IPFQR Program update.	The overall economic impact of the IPFQR Program updates in this final rule is an estimated decrease of 380,897 hours in information collection burden resulting in a savings of $8,150,478.

II. Background

A. Overview of the Legislative Requirements of the IPF PPS

Section 124 of the Medicare, Medicaid, and State Children's Health Insurance Program Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106–113) required the establishment and implementation of an IPF PPS. Specifically, section 124 of the BBRA mandated that the Secretary of the Department of Health and Human Services (the Secretary) develop a per diem payment perspective system (PPS) for inpatient hospital services furnished in psychiatric hospitals and excluded psychiatric units including an adequate patient classification system that reflects the differences in patient resource use and costs among psychiatric hospitals and excluded psychiatric units. ''Excluded psychiatric unit'' means a psychiatric unit of an acute care hospital or of a Critical Access Hospital (CAH), which is excluded from payment under the Inpatient Prospective Payment System (IPPS) or CAH payment system, respectively. These excluded psychiatric units will be paid under the IPF PPS.

Section 405(g)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108–173) extended the IPF PPS to psychiatric distinct part units of CAHs.

Sections 3401(f) and 10322 of the Patient Protection and Affordable Care Act (Pub. L. 111–148) as amended by section 10319(e) of that Act and by section 1105(d) of the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152) (hereafter referred to jointly as ''the Affordable Care Act'') added subsection (s) to section 1886 of the Social Security Act (the Act).

Section 1886(s)(1) of the Act titled, ''Reference to Establishment and Implementation of System,'' refers to section 124 of the BBRA, which relates to the establishment of the IPF PPS.

Section 1886(s)(2)(A)(i) of the Act requires the application of the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act to the IPF PPS for the rate year (RY) beginning in 2012 (that is, a RY that coincides with a FY) and each subsequent RY.

Section 1886(s)(2)(A)(ii) of the Act required the application of an ''other adjustment'' that reduced any update to an IPF PPS base rate by a percentage point amount specified in section 1886(s)(3) of the Act for the RY beginning in 2010 through the RY beginning in 2019. As noted in the FY 2020 IPF PPS final rule, for the RY beginning in 2019, section 1886(s)(3)(E) of the Act required that the other adjustment reduction be equal to 0.75 percentage point; that was the final year the statute required the application of this adjustment. Because FY 2021 was a RY beginning in 2020, FY 2021 was the first-year section 1886(s)(2)(A)(ii) of the Act did not apply since its enactment.

Sections 1886(s)(4)(A) through (D) of the Act require that for RY 2014 and each subsequent RY, IPFs that fail to report required quality data with respect to such a RY will have their annual update to a standard Federal rate for discharges reduced by 2.0 percentage points. This may result in an annual update being less than 0.0 for a RY, and may result in payment rates for the upcoming RY being less than such payment rates for the preceding RY. Any reduction for failure to report required quality data will apply only to the RY involved, and the Secretary will not consider such reduction in computing the payment amount for a subsequent RY. Section 4125 of division FF, title IV, subtitle C, the CAA, 2023 requires that not later than FY 2028 each IPF will submit data through the use of a standardized assessment instrument which includes data on functional status; cognitive function; special services treatments, and interventions for psychiatric conditions; impairments; and other categories deemed appropriate. In addition, section 4125 of the CAA, 2023 requires that a patients' perspective of care quality measure be added to the IPFQR Program not later than for FY 2031. Information regarding the newly

adopted Psychiatric Inpatient Experience (PIX) survey measure is provided in section VI.D.5 of this final rule.

Section 4125 of the CAA, 2023 also requires revisions to the Medicare prospective payment system (PPS) for psychiatric hospitals and psychiatric units. Specifically, section 4125(a) of the CAA, 2023 amends section 1886(s) of the Act by adding a new paragraph (5) that requires the Secretary to collect data and information beginning no later than October 1, 2023, as the Secretary determines appropriate, to inform revisions to IPF PPS payments. In addition, the Secretary is required to implement revisions to the methodology for determining the payment rates under the IPF PPS for FY 2025 as the Secretary determines appropriate.

To implement and periodically update the IPF PPS, we have published various proposed and final rules and notices in the **Federal Register**. For more information regarding these documents, see the CMS website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/index.html?redirect=/InpatientPsychFacilPPS/.*

B. Overview of the IPF PPS

On November 15, 2004, we published the IPF PPS final rule in the **Federal Register** (69 FR 66922). The November 2004 IPF PPS final rule established the IPF PPS, as required by section 124 of the BBRA and codified at 42 CFR part 412, subpart N. The November 2004 IPF PPS final rule set forth the Federal per diem base rate for the implementation year (the 18-month period from January 1, 2005 through June 30, 2006), and provided payment for the inpatient operating and capital costs to IPFs for covered psychiatric services they furnish (that is, routine, ancillary, and capital costs, but not costs of approved educational activities, bad debts, and other services or items that are outside the scope of the IPF PPS). Covered psychiatric services include services for which benefits are provided under the fee-for-service Part A (Hospital Insurance Program) of the Medicare program.

The IPF PPS established the Federal per diem base rate for each patient day in an IPF derived from the national average daily routine operating, ancillary, and capital costs in IPFs in FY 2002. The average per diem cost was updated to the midpoint of the first year under the IPF PPS, standardized to account for the overall positive effects of the IPF PPS payment adjustments, and adjusted for budget-neutrality.

The Federal per diem payment under the IPF PPS is comprised of the Federal per diem base rate described previously and certain patient- and facility-level payment adjustments for characteristics that were found in the regression analysis to be associated with statistically significant per diem cost differences; with statistical significance defined as p less than 0.05. A complete discussion of the regression analysis that established the IPF PPS adjustment factors can be found in the November 2004 IPF PPS final rule (69 FR 66933 through 66936).

The patient-level adjustments include age, Diagnosis-Related Group (DRG) assignment, and comorbidities, as well as adjustments to reflect higher per diem costs at the beginning of a patient's IPF stay and lower costs for later days of the stay. Facility-level adjustments include adjustments for the IPF's wage index, rural location, teaching status, a cost-of-living adjustment for IPFs located in Alaska and Hawaii, and an adjustment for the presence of a qualifying emergency department (ED).

The IPF PPS has additional payment policies for outlier cases, interrupted stays, and a per treatment payment for patients who undergo ECT. During the IPF PPS mandatory 3-year transition period, stop-loss payments were also provided; however, since the transition ended as of January 1, 2008, these payments are no longer available.

C. Annual Requirements for Updating the IPF PPS

Section 124 of the BBRA did not specify an annual rate update strategy for the IPF PPS and was broadly written to give the Secretary discretion in establishing an update methodology. In the November 2004 IPF PPS final rule (69 FR 66922), we implemented the IPF PPS using the following update strategy:

- Calculate the final Federal per diem base rate to be budget-neutral for the 18-month period of January 1, 2005 through June 30, 2006.
- Use a July 1 through June 30 annual update cycle.
- Allow the IPF PPS first update to be effective for discharges on or after July 1, 2006 through June 30, 2007.

In developing the IPF PPS, and to ensure that the IPF PPS can account adequately for each IPF's case-mix, we performed an extensive regression analysis of the relationship between the per diem costs and certain patient and facility characteristics to determine those characteristics associated with statistically significant cost differences on a per diem basis. That regression analysis is described in detail in our November 28, 2003 IPF PPS proposed rule (68 FR 66923; 66928 through 66933) and our November 15, 2004 IPF PPS final rule (69 FR 66933 through 66960). For characteristics with statistically significant cost differences, we used the regression coefficients of those variables to determine the size of the corresponding payment adjustments.

In the November 2004 IPF PPS final rule, we explained the reasons for delaying an update to the adjustment factors, derived from the regression analysis, including waiting until we have IPF PPS data that yields as much information as possible regarding the patient-level characteristics of the population that each IPF serves. We indicated that we did not intend to update the regression analysis and the patient-level and facility-level adjustments until we complete that analysis. Until that analysis is complete, we stated our intention to publish a notice in the **Federal Register** each spring to update the IPF PPS (69 FR 66966).

On May 6, 2011, we published a final rule in the **Federal Register** titled, ''Inpatient Psychiatric Facilities Prospective Payment System—Update for Rate Year Beginning July 1, 2011 (RY 2012)'' (76 FR 26432), which changed the payment rate update period to a RY that coincides with a FY update. Therefore, final rules are now published in the **Federal Register** in the summer to be effective on October 1st. When proposing changes in IPF payment policy, a proposed rule would be issued in the spring and the final rule in the summer to be effective on October 1st. For a detailed list of updates to the IPF PPS, we refer readers to our regulations at 42 CFR 412.428.

The most recent IPF PPS annual update was published in a final rule on July 29, 2022 in the **Federal Register** titled, ''Medicare Program; FY 2023 Inpatient Psychiatric Facilities Prospective Payment System—Rate Update and Quality Reporting—Request for Information'' (87 FR 46846), which updated the IPF PPS payment rates for FY 2023. That final rule updated the IPF PPS Federal per diem base rates that were published in the FY 2022 IPF PPS Rate Update final rule (86 FR 42608) in accordance with our established policies.

III. Analysis of and Responses to Public Comments

We received 2,506 public comments that pertain to proposed IPF PPS payment policies, requests for information, and the proposed updates to the IPFQR Program. Comments were

from Inpatient Psychiatric Facilities, health systems, national and state level provider and patient advocacy organizations, the Medicare Payment Advisory Commission (MedPAC), and individuals. We reviewed each comment and grouped related comments, after which we placed them in categories based on subject matter or section(s) of the regulation affected. Summaries of the public comments received and our responses to those comments are provided in the appropriate sections in the preamble of this final rule.

IV. Provisions of the FY 2024 IPF PPS Final Rule and Responses to Comments

A. Rebasing and Revising of the Market Basket for the IPF PPS

1. Background

Originally, the input price index used to develop the IPF PPS was the Excluded Hospital with Capital market basket. This market basket was based on 1997 Medicare cost reports for Medicare-participating inpatient rehabilitation facilities (IRFs), IPFs, long-term care hospitals (LTCHs), cancer hospitals, and children's hospitals. Although ''market basket'' technically describes the mix of goods and services used in providing health care at a given point in time, this term is also commonly used to denote the input price index (that is, cost category weights and price proxies) derived from that market basket. Accordingly, the term ''market basket,'' as used in this document, refers to an input price index.

Since the IPF PPS inception, the market basket used to update IPF PPS payments has been rebased and revised to reflect more recent data on IPF cost structures. We last rebased and revised the market basket applicable to the IPF PPS in the FY 2020 IPF PPS final rule (84 FR 38426 through 38447), where we adopted a 2016-based IPF market basket. The 2016-based IPF market basket used Medicare cost report data for both Medicare-participating freestanding psychiatric hospitals and hospital-based psychiatric units. References to the historical market baskets used to update IPF PPS payments are listed in the FY 2016 IPF PPS final rule (80 FR 46656). For the FY 2024 IPF PPS proposed rule, we proposed to rebase and revise the IPF market basket to reflect a 2021 base year.

2. Overview of the 2021-Based IPF Market Basket

The 2021-based IPF market basket is a fixed-weight, Laspeyres-type price index. A Laspeyres price index measures the change in price, over time, of the same mix of goods and services purchased in the base period. Any changes in the quantity or mix of goods and services (that is, intensity) purchased over time relative to a base period are not measured.

The index itself is constructed in three steps. First, a base period is selected (in the proposed rule, we proposed to use 2021 as the base period) and total base period costs are estimated for a set of mutually exclusive and exhaustive cost categories. Each category is calculated as a proportion of total costs. These proportions are called cost weights. Second, each cost category is matched to an appropriate price or wage variable, referred to as a price proxy. In nearly every instance, these price proxies are derived from publicly available statistical series that are published on a consistent schedule (preferably at least on a quarterly basis). Finally, the cost weight for each cost category is multiplied by the level of its respective price proxy. The sum of these products (that is, the cost weights multiplied by their price index levels) for all cost categories yields the composite index level of the market basket in a given period. Repeating this step for other periods produces a series of market basket levels over time. Dividing an index level for a given period by an index level for an earlier period produces a rate of growth in the input price index over that timeframe.

As noted, the market basket is described as a fixed-weight index because it represents the change in price over time of a constant mix (quantity and intensity) of goods and services needed to provide IPF services. The effects on total costs resulting from changes in the mix of goods and services purchased subsequent to the base period are not measured. For example, an IPF hiring more nurses after the base period to accommodate the needs of patients will increase the volume of goods and services purchased by the IPF but will not be factored into the price change measured by a fixed-weight IPF market basket. Only when the index is rebased will changes in the quantity and intensity be captured, with those changes being reflected in the cost weights. Therefore, we rebase the market basket periodically so that the cost weights reflect recent changes in the mix of goods and services that IPFs purchase to furnish inpatient care between base periods.

3. Rebasing and Revising of the IPF Market Basket

As discussed in the FY 2020 IPF PPS final rule (84 FR 38426 through 38447), the 2016-based IPF market basket reflects the Medicare cost reports for both freestanding and hospital-based IPFs. Beginning with FY 2024, we proposed to rebase and revise the IPF market basket to a 2021 base year reflecting the 2021 Medicare cost report data submitted by both freestanding and hospital-based IPFs. We provide a detailed description of our proposed methodology used to develop the 2021-based IPF market basket below. This proposed methodology is generally similar to the methodology used to develop the 2016-based IPF market basket. We solicited public comment on our proposed methodology for developing the 2021-based IPF market basket.

Comment: Several commenters supported CMS's proposal to rebase and revise the market basket to reflect more recent data, noting that the changes in the cost weights were consistent with their expectations or experience. One commenter, however, proposed that CMS wait to rebase the IPF market basket until FY 2022 data is available. The commenter stated that, due to the increased demand for hospital care during the initial year following the outbreak of COVID–19 in the United States, they assume that a base year of FY 2021 would not necessarily reflect costs in FY 2024. Though inflation was particularly high during FY 2021, the commenter noted that FY 2022 would be further removed from the initial outbreak of COVID–19 in the United States and the massive changes in healthcare that occurred during that time. Similarly, one commenter supported the proposal to rebase but recommended CMS plan to rebase and revise the market basket and labor-related share to reflect a 2023 base year to fully incorporate the cost structures from the Public Health Emergency (PHE) as well as the evolving hospital workforce shortage.

Response: We appreciate the commenters' support regarding the proposed IPF market basket. For the proposed rebasing and revising, we used the most current and complete set of Medicare cost report data (2021) at the time of rulemaking to determine the major base year cost weights (Wages and Salaries, Employee Benefits, Contract Labor, Professional Liability Insurance, Pharmaceuticals, Home Office/Related Organization Contract Labor, and Capital).

As stated in the FY 2024 IPF PPS proposed rule (88 FR 21241), many commenters expressed concern in response to the FY 2023 IPF PPS proposed rule, in which we did not propose to rebase the IPF market basket.

The commenters stated at that time that the 2016-based IPF market basket did not reflect the current costs of IPFs, particularly the use of contract labor. Therefore, based on the typical timeframe for rebasing the market baskets and in response to commenters' concerns expressed in FY 2023 IPF rulemaking, we proposed to rebase and revise the IPF market basket for FY 2024. We understand the commenters' concerns that the impact of the PHE may have resulted in increased costs compared to 2016. However, we believe it is appropriate to rebase the market basket regularly and to reflect more recent IPF cost structures. It has been our longstanding practice to rebase the IPF market basket (as well as other CMS market baskets) on a regular basis to ensure it reflects a more up-to-date input cost structure of IPFs so that the price change in the market basket best reflects input prices faced by IPFs. Because complete 2022 IPF Medicare cost report data is currently unavailable, we believe it is more appropriate to update the base year cost weights to 2021 to reflect changes over this period rather than to delay the rebasing for another year or two in order to use 2022 or 2023 Medicare cost report data as suggested by the commenter. We regularly rebase every 4 to 5 years because more recent data is typically more reflective of IPF cost structures. Therefore, we are using the most recent cost report data we have, which is 2021 cost report data, as it is more reflective of IPF cost structures than 2016 data. For example, the 2021-based IPF market basket reflects the higher compensation cost weight (as compared to the 2016-based IPF market basket) as a result of an increase in the contract labor cost weight (calculated using the 2021 Medicare cost report data) as noted by the commenters in response to the FY 2023 IPF proposed rule (87 FR 46849). Additionally, we will continue to monitor the Medicare cost report data to assess whether a more frequent rebasing of the IPF market basket is appropriate through future notice and comment rulemaking.

Final Decision: We are finalizing our proposal to rebase the IPF market basket to reflect a 2021 base year for FY 2024.

We provide a summary of the more detailed public comments received on our proposed methodology for developing the 2021-based IPF market basket and our responses in the following sections.

a. Development of Cost Categories and Weights for the 2021-Based IPF Market Basket

(1) Use of Medicare Cost Report Data

We proposed a 2021-based IPF market basket that consists of seven major cost categories and a residual derived from the 2021 Medicare cost reports (CMS Form 2552–10, OMB No. 0938–0050) for freestanding and hospital-based IPFs. The seven major cost categories are Wages and Salaries, Employee Benefits, Contract Labor, Pharmaceuticals, Professional Liability Insurance (PLI), Home Office/Related Organization Contract Labor, and Capital. The cost reports include providers whose cost reporting period began on or after October 1, 2020 and before October 1, 2021. As noted previously, the current IPF market basket is based on 2016 Medicare cost reports and therefore, reflects the 2016 cost structure for IPFs. As described in the FY 2023 IPF PPS final rule (87 FR 46849), we received comments on the FY 2023 IPF PPS proposed rule (87 FR 19418 through 19419) where stakeholders expressed concern that the proposed market basket update inadequately reflected the input price inflation experienced by IPFs, particularly as a result of the COVID–19 PHE. These commenters stated that the PHE, along with inflation, has significantly driven up operating costs. Specifically, some commenters noted changes to labor markets that led to the use of more contract labor, a trend that we verified in analyzing the Medicare cost report data through 2021. Therefore, we believe it is appropriate to incorporate more recent data to reflect updated cost structures for IPFs, and so we proposed to use 2021 as the base year, because we believe that the Medicare cost reports for this year represent the most recent complete set of Medicare cost report data available for developing the proposed IPF market basket at the time of this rulemaking. Given the potential impact of the PHE on the Medicare cost report data, we will continue to monitor these data going forward, and any changes to the IPF market basket will be proposed in future rulemaking.

Similar to the Medicare cost report data used to develop the 2016-based IPF market basket, the Medicare cost report data for 2021 show large differences between some providers' Medicare length of stay (LOS) and total facility LOS. Our goal has always been to measure cost weights that are reflective of case mix and practice patterns associated with providing services to Medicare beneficiaries. Therefore, we proposed to limit our selection of Medicare cost reports used in the 2021-based IPF market basket to those facilities that had a Medicare LOS within a comparable range of their total facility average LOS. The Medicare average LOS for freestanding IPFs is calculated from data reported on line 14 of Worksheet S–3, part I. The Medicare average LOS for hospital-based IPFs is calculated from data reported on line 16 of Worksheet S–3, part I. To derive the 2021-based IPF market basket, for those IPFs with an average facility LOS of greater than or equal to 15 days, we proposed to include IPFs where the Medicare LOS is within 50 percent (higher or lower) of the average facility LOS. For those IPFs whose average facility LOS is less than 15 days, we proposed to include IPFs where the Medicare LOS is within 95 percent (higher or lower) of the facility LOS. We proposed to apply this LOS edit to the data for IPFs to exclude providers that serve a population whose LOS will indicate that the patients served are not consistent with a LOS of a typical Medicare patient. This is the same LOS edit applied to the 2016-based IPF market basket.

Applying these trims to the approximate 1,370 total cost reports (freestanding and hospital-based) resulted in roughly 1,250 IPF Medicare cost reports with an average Medicare LOS of 13 days, average facility LOS of 10 days, and Medicare utilization (as measured by Medicare inpatient IPF days as a percentage of total facility days) of 16 percent. Providers excluded from the 2021-based IPF market basket (about 120 Medicare cost reports) had an average Medicare LOS of 21 days, average facility LOS of 41 days, and a Medicare utilization of 3 percent. Of those excluded, about 62 percent of these were freestanding providers; on the other hand, freestanding providers represent about 38 percent of all IPFs. We note that 70 percent of those excluded from the 2016-based IPF market basket using this LOS edit were freestanding providers.

We then proposed to use the cost reports for IPFs that met this requirement to calculate the costs for the seven major cost categories (Wages and Salaries, Employee Benefits, Contract Labor, Professional Liability Insurance, Pharmaceuticals, Home Office/Related Organization Contract Labor, and Capital) for the market basket. These are the same categories used for the 2016-based IPF market basket. Also, as described in section IV.A.3.a.(4) of this final rule, and as done for the 2016-based IPF market basket, we proposed to use the Medicare cost report data to calculate the detailed

capital cost weights for the Depreciation, Interest, Lease, and Other Capital-related cost categories. We also proposed to rename the Home Office Contract Labor cost category to the Home Office/Related Organization Contract Labor cost category to be more consistent with the Medicare cost report instructions.

Similar to the 2016-based IPF market basket major cost weights, for the majority of the 2021-based IPF market basket cost weights, we proposed to divide the costs for each cost category by total Medicare allowable costs (routine, ancillary and capital)—costs that are eligible for payment through the IPF PPS (we noted that we use total facility medical care costs as the denominator to derive both the PLI and Home Office/Related Organization Contract Labor cost weights). We next describe our proposed methodology for deriving the cost levels used to derive the 2021-based IPF market basket.

(a) Total Medicare Allowable Costs

For freestanding IPFs, we proposed that total Medicare allowable costs would be equal to the sum of total costs for the Medicare allowable cost centers as reported on Worksheet B, part I, column 26, lines 30 through 35, 50 through 76 (excluding 52 and 75), 90 through 91, and 93.

For hospital-based IPFs, we proposed that total Medicare allowable costs would be equal to the total costs for the IPF inpatient unit after the allocation of overhead costs (Worksheet B, part I, column 26, line 40) and a proportion of total ancillary costs reported on Worksheet B, part I, column 26, lines 50 through 76 (excluding 52 and 75), 90 through 91, and 93.

We proposed to calculate total ancillary costs attributable to the hospital-based IPF by first deriving an ''IPF ancillary ratio'' for each ancillary cost center. The IPF ancillary ratio is defined as the ratio of IPF Medicare ancillary costs for the cost center (as reported on Worksheet D–3, column 3 for hospital-based IPFs) to total Medicare ancillary costs for the cost center (equal to the sum of Worksheet D–3, column 3 for all relevant PPSs [that is, IPPS, IRF, IPF and skilled nursing facility (SNF)]). For example, if hospital-based IPF Medicare laboratory costs represent about 2 percent of the total Medicare laboratory costs for the entire facility, then the IPF ancillary ratio for laboratory costs would be 2 percent. We believe it is appropriate to use only a portion of the ancillary costs in the market basket cost weight calculations since the hospital-based IPF only utilizes a portion of the facility's ancillary services. We believe the ratio of reported IPF Medicare costs to reported total Medicare costs provides a reasonable estimate of the ancillary services utilized, and costs incurred, by the hospital-based IPF. We proposed that this IPF ancillary ratio for each cost center is also used to calculate Wages and Salaries and Capital costs as described below.

Then, for each ancillary cost center, we proposed to multiply the IPF ancillary ratio for the given cost center by the total facility ancillary costs for that specific cost center (as reported on Worksheet B, part I, column 26) to derive IPF ancillary costs. For example, the 2 percent IPF ancillary ratio for laboratory cost center would be multiplied by the total ancillary costs for laboratory (Worksheet B, part I, column 26, line 60). The IPF ancillary costs for each cost center are then added to total costs for the IPF inpatient unit after the allocation of overhead costs (Worksheet B, part I, column 26, line 40) to derive total Medicare allowable costs.

We proposed to use these methods to derive levels of total Medicare allowable costs for IPF providers. This is the same methodology used for the 2016-based IPF market basket. We proposed that these total Medicare allowable costs for the IPF will be the denominator for the cost weight calculations for the Wages and Salaries, Employee Benefits, Contract Labor, Pharmaceuticals, and Capital cost weights. With this work complete, we then set about deriving cost levels for the seven major cost categories and then derive a residual cost weight reflecting all other costs not classified.

(b) Wages and Salaries Costs

For freestanding IPFs, we proposed to derive Wages and Salaries costs as the sum of routine inpatient salaries (Worksheet A, column 1, lines 30 through 35), ancillary salaries (Worksheet A, column 1, lines 50 through 76 (excluding 52 and 75), 90 through 91, and 93), and a proportion of overhead (or general service cost centers in the Medicare cost reports) salaries. Since overhead salary costs are attributable to the entire IPF, we only include the proportion attributable to the Medicare allowable cost centers. We proposed to estimate the proportion of overhead salaries that are attributed to Medicare allowable costs centers by multiplying the ratio of Medicare allowable area salaries (Worksheet A, column 1, lines 30 through 35, 50 through 76 (excluding 52 and 75), 90 through 91, and 93) to total non-overhead salaries (Worksheet A, column 1, line 200 less Worksheet A, column 1, lines 4 through 18) times total overhead salaries (Worksheet A, column 1, lines 4 through 18). This is a similar methodology as used in the 2016-based IPF market basket.

For hospital-based IPFs, we proposed to derive Wages and Salaries costs as the sum of the following salaries attributable to the hospital-based IPF: Inpatient routine salary costs (Worksheet A, column 1, line 40); overhead salary costs; ancillary salary costs; and a portion of overhead salary costs attributable to the ancillary departments.

(i) Overhead Salary Costs

We proposed to calculate the portion of overhead salary cost attributable to hospital-based IPFs by first calculating an IPF overhead salary ratio, which is equal to the ratio of total facility overhead salaries (as reported on Worksheet A, column 1, lines 4–18) to total facility noncapital overhead costs (as reported on Worksheet A, column 1 and 2, lines 4–18). We then proposed to multiply this IPF overhead salary ratio by total noncapital overhead costs (sum of Worksheet B, part I, columns 4 through 18, line 40, less Worksheet B, part II, columns 4 through 18, line 40). This methodology assumes the proportion of total costs related to salaries for the overhead cost center is similar for all inpatient units (that is, acute inpatient or inpatient psychiatric).

(ii) Ancillary Salary Costs

We proposed to calculate hospital-based IPF ancillary salary costs for a specific cost center (Worksheet A, column 1, lines 50 through 76 (excluding 52 and 75), 90 through 91, and 93) as salary costs from Worksheet A, column 1, multiplied by the IPF ancillary ratio for each cost center as described in section IV.A.3.a.(1)(a) of this final rule. The sum of these costs represents hospital-based IPF ancillary salary costs.

(iii) Overhead Salary Costs for Ancillary Cost Centers

We proposed to calculate the portion of overhead salaries attributable to each ancillary department (lines 50 through 76 (excluding 52 and 75), 90 through 91, and 93) by first calculating total noncapital overhead cost attributable to each specific ancillary department (sum of Worksheet B, part I, columns 4–18, less Worksheet B, part II, column 26). We then identify the portion of these total noncapital overhead cost for each ancillary department that is attributable to the hospital-based IPF by multiplying these costs by the IPF ancillary ratio as described in section IV.A.3.a.(1)(a) of

this final rule. We then sum these estimated IPF Medicare allowable noncapital overhead costs for all ancillary departments (cost centers 50 through 76, 90 through 91, and 93). Finally, we then identify the portion of these IPF Medicare allowable noncapital overhead cost that are attributable to Wages and Salaries by multiplying these costs by the IPF overhead salary ratio as described in section IV.A.3.a.(1)(b)(i) of this final rule. This is the same methodology used to derive the 2016-based IPF market basket.

(c) Employee Benefits Costs

Effective with the implementation of CMS Form 2552–10, we began collecting Employee Benefits and Contract Labor data on Worksheet S–3, part V.

For the 2021 Medicare cost report data, the majority of IPF providers did not report data on Worksheet S–3, part V. Two percent of freestanding IPFs and roughly 48 percent of hospital-based IPFs reported Employee Benefits data on Worksheet S–3, part V. Two percent of freestanding IPFs and roughly 13 percent of hospital-based IPFs reported Contract Labor data on Worksheet S–3, part V. We continue to encourage all providers to report these data on the Medicare cost report.

For freestanding IPFs, we proposed that Employee Benefits cost would be equal to the data reported on Worksheet S–3, part V, column 2, line 2. We note that while not required to do so, freestanding IPFs also may report Employee Benefits data on Worksheet S–3, part II, which is applicable to only IPPS providers. Similar to the method for the 2016-based IPF market basket, for those freestanding IPFs that report Worksheet S–3, part II, data, but not Worksheet S–3, part V, we proposed to use the sum of Worksheet S–3, part II, lines 17, 18, 20, and 22, to derive Employee Benefits costs.

For hospital-based IPFs, we proposed to calculate total benefit cost as the sum of inpatient unit benefit cost, a portion of ancillary departments benefit costs, and a portion of overhead benefits attributable to both the routine inpatient unit and the ancillary departments. For those hospital-based IPFs that report Worksheet S–3, part V data, we proposed inpatient unit benefit costs be equal to Worksheet S–3, part V, column 2, line 3. Given the limited reporting on Worksheet S–3, part V, we proposed that for those hospital-based IPFs that do not report these data, we calculate inpatient unit benefits cost using a portion of benefits cost reported for Excluded areas on Worksheet S–3, part II. We proposed to calculate the ratio of inpatient unit salaries (Worksheet A, column 1, line 40) to total excluded area salaries (sum of Worksheet A, column 1, lines 20, 23, 40 through 42, 44, 45, 46, 94, 95, 98 through 101, 105 through 112, 114, 115 through 117, 190 through 194). We then proposed to apply this ratio to Excluded area benefits (Worksheet S–3, part II, column 4, line 19) to derive inpatient unit benefits cost for those providers that do not report benefit costs on Worksheet S–3, part V.

We proposed the ancillary departments benefits and overhead benefits (attributable to both the inpatient unit and ancillary departments) costs are derived by first calculating the sum of hospital-based IPF overhead salaries as described in section IV.A.3.a.(1)(b)(i) of this final rule, hospital-based IPF ancillary salaries as described in section IV.A.3.a.(1)(b)(ii) of this final rule and hospital-based IPF overhead salaries for ancillary cost centers as described in section IV.A.3.a.(1)(b)(iii) of this final rule. This sum is then multiplied by the ratio of total facility benefits to total facility salaries, where total facility benefits is equal to the sum of Worksheet S- 3, part II, column 4, lines 17–25, and total facility salaries is equal to Worksheet S–3, part II, column 4, line 1.

(d) Contract Labor Costs

Contract Labor costs are primarily associated with direct patient care services. Contract labor costs for other services such as accounting, billing, and legal are calculated separately using other government data sources as described in section IV.A.3.a.(3) of this final rule. To derive contract labor costs using Worksheet S–3, part V, data for freestanding IPFs, we proposed Contract Labor costs be equal to Worksheet S–3, part V, column 1, line 2. As we noted for Employee Benefits, freestanding IPFs also may report Contract Labor data on Worksheet S–3, part II, which is applicable to only IPPS providers. For those freestanding IPFs that report Worksheet S–3, part II data, but not Worksheet S–3, part V, we proposed to use the sum of Worksheet S–3, part II, column 4, lines 11 and 13, to derive Contract Labor costs.

For hospital-based IPFs, we proposed that Contract Labor costs be equal to Worksheet S- 3, part V, column 1, line 3. Reporting of this data continues to be somewhat limited; therefore, we continue to encourage all providers to report these data on the Medicare cost report. Given the limited reporting on Worksheet S–3, part V, we proposed that for those hospital-based IPFs that do not report these data, we calculate Contract Labor costs using a portion of contract labor costs reported on Worksheet S–3, part II. We proposed to calculate the ratio of contract labor costs (Worksheet S–3, part II, column 4, lines 11 and 13) to PPS salaries (Worksheet S–3, part II, column 4, line 1 less the sum of Worksheet S–3, part II, column 4, lines 3, 401, 5, 6, 7, 701, 8, 9, 10 less Worksheet A, column 1, line 20 and 23). We then proposed to apply this ratio to total inpatient routine salary costs (Worksheet A, column 1, line 40) to derive contract labor costs for those providers that do not report contract labor costs on Worksheet S–3, part V.

(e) Pharmaceuticals Costs

For freestanding IPFs, we proposed to calculate pharmaceuticals costs using non-salary costs reported on Worksheet A, column 7, less Worksheet A, column 1, for the pharmacy cost center (line 15) and drugs charged to patients cost center (line 73).

For hospital-based IPFs, we proposed to calculate pharmaceuticals costs as the sum of a portion of the non-salary pharmacy costs and a portion of the non-salary drugs charged to patient costs reported for the total facility. We proposed that non-salary pharmacy costs attributable to the hospital-based IPF would be calculated by multiplying total pharmacy costs attributable to the hospital-based IPF (as reported on Worksheet B, part I, column 15, line 40) by the ratio of total non-salary pharmacy costs (Worksheet A, column 2, line 15) to total pharmacy costs (sum of Worksheet A, columns 1 and 2 for line 15) for the total facility. We proposed that non-salary drugs charged to patient costs attributable to the hospital-based IPF would be calculated by multiplying total non-salary drugs charged to patient costs (Worksheet B, part I, column 0, line 73 plus Worksheet B, part I, column 15, line 73 less Worksheet A, column 1, line 73) for the total facility by the ratio of Medicare drugs charged to patient ancillary costs for the IPF unit (as reported on Worksheet D–3 for hospital-based IPFs, column 3, line 73) to total Medicare drugs charged to patient ancillary costs for the total facility (equal to the sum of Worksheet D–3, column 3, line 73 for all relevant PPS [that is, IPPS, IRF, IPF and SNF]).

(f) Professional Liability Insurance Costs

For freestanding and hospital-based IPFs, we proposed that Professional Liability Insurance (PLI) costs (often referred to as malpractice costs) would be equal to premiums, paid losses and self-insurance costs reported on Worksheet S–2, columns 1 through 3, line 118—the same data used for the

2016-based IPF market basket. For hospital-based IPFs, we proposed to assume that the PLI weight for the total facility is similar to the hospital-based IPF unit since the only data reported on this worksheet is for the entire facility, as we currently have no means to identify the proportion of total PLI costs that are only attributable to the hospital-based IPF. However, when we derive the cost weight for PLI for both hospital-based and freestanding IPFs, we use the total facility medical care costs as the denominator as opposed to total Medicare allowable costs. For freestanding IPFs and hospital-based IPFs, we proposed to derive total facility medical care costs as the sum of total costs (Worksheet B, part I, column 26, line 202) less non-reimbursable costs (Worksheet B, part I, column 26, lines 190 through 201). Our assumption is that the same proportion of expenses are used among each unit of the hospital.

(g) Home Office/Related Organization Contract Labor Costs

For hospital-based IPFs, we proposed to calculate the Home Office/Related Organization Contract Labor costs using data reported on Worksheet S–3, part II, column 4, lines 1401, 1402, 2550, and 2551. Similar to the PLI costs, these costs are for the entire facility. Therefore, when we derive the cost weight for home office/related organization contract labor costs, we use the total facility medical care costs as the denominator (reflecting the total facility costs (Worksheet B, part I, column 26, line 202) less the nonreimbursable costs reported on lines 190 through 201).

(h) Capital Costs

For freestanding IPFs, we proposed that capital costs would be equal to Medicare allowable capital costs as reported on Worksheet B, part II, column 26, lines 30 through 35, 50 through 76 (excluding 52 and 75), 90 through 91, and 93.

For hospital-based IPFs, we proposed that capital costs would be equal to IPF inpatient capital costs (as reported on Worksheet B, part II, column 26, line 40) and a portion of IPF ancillary capital costs. We calculate the portion of ancillary capital costs attributable to the hospital-based IPF for a given cost center by multiplying total facility ancillary capital costs for the specific ancillary cost center (as reported on Worksheet B, part II, column 26) by the IPF ancillary ratio as described in section IV.A.3.a.(1)(a) of this final rule.

(2) Final Major Cost Category Computation

After we derive costs for each of the major cost categories and total Medicare allowable costs for each provider using the Medicare cost report data as previously described, we proposed to address data outliers using the following steps. First, for the Wages and Salaries, Employee Benefits, Contract Labor, Pharmaceuticals, and Capital cost weights, we first divide the costs for each of these five categories by total Medicare allowable costs calculated for the provider to obtain cost weights for the universe of IPF providers. We then proposed to trim the data to remove outliers (a standard statistical process) by: (1) requiring that major expenses (such as Wages and Salaries costs) and total Medicare allowable operating costs be greater than zero; and (2) excluding the top and bottom 5 percent of the major cost weight (for example, Wages and Salaries costs as a percent of total Medicare allowable operating costs). We note that missing values are assumed to be zero consistent with the methodology for how missing values were treated in the 2016-based IPF market basket. After these outliers have been excluded, we sum the costs for each category across all remaining providers. We then divide this by the sum of total Medicare allowable costs across all remaining providers to obtain a cost weight for the 2021-based IPF market basket for the given category.

The proposed trimming methodology for the Home Office/Related Organization Contract Labor and PLI cost weights are slightly different than the proposed trimming methodology for the other five cost categories as described above. For these cost weights, since we are using total facility medical care costs rather than Medicare allowable costs associated with IPF services, we proposed to trim the freestanding and hospital-based IPF cost weights separately.

For the PLI cost weight, for each of the providers, we first divide the PLI costs by total facility medical care costs to obtain a PLI cost weight for the universe of IPF providers. We then proposed to trim the data to remove outliers by: (1) requiring that PLI costs are greater than zero and are less than total facility medical care costs; and (2) excluding the top and bottom 5 percent of the major cost weight trimming freestanding and hospital-based providers separately. After removing these outliers, we are left with a trimmed data set for both freestanding and hospital-based providers. We proposed to separately sum the costs for each category (freestanding and hospital-based) across all remaining providers. We next divide this by the sum of total facility medical care costs across all remaining providers to obtain both a freestanding cost weight and hospital-based cost weight. Lastly, we proposed to weight these two cost weights together using the Medicare allowable costs from the sample of freestanding and hospital-based IPFs that passed the PLI trim (63 percent for hospital-based and 37 percent for freestanding IPFs) to derive a PLI cost weight for the 2021-based IPF market basket.

For the Home Office/Related Organization Contract Labor cost weight, for each of the providers, we first divide the home office/related organization contract labor costs by total facility medical care costs to obtain a Home Office/Related Organization Contract Labor cost weight for the universe of IPF providers. Similar to the other market basket costs weights, we proposed to trim the Home Office/Related Organization Contract Labor cost weight to remove outliers. Since not all hospital-based IPFs will have home office/related organization contract labor costs (approximately 80 percent of hospital-based IPFs report having a home office), we proposed to trim the top one percent of the Home Office/Related Organization Contract Labor cost weight. Using this proposed methodology, we calculate a Home Office/Related Organization Contract Labor cost weight for hospital-based IPFs of 5.1 percent.

Freestanding IPFs are not required to complete Worksheet S–3, part II. Therefore, to estimate the Home Office/Related Organization Contract Labor cost weight for freestanding IPFs, we proposed the following methodology:

Step 1: Using hospital-based IPFs with a home office and also passing the 1 percent trim as described, we calculate the ratio of the Home Office/Related Organization Contract Labor cost weight to the Medicare allowable non-salary, non-capital cost weight (Medicare allowable non-salary, non-capital costs as a percent of total Medicare allowable costs).

Step 2: We identify freestanding IPFs that report a home office on Worksheet S–2, line 140—roughly 87 percent of freestanding IPFs. We proposed to calculate a Home Office/Related Organization Contract Labor cost weight for these freestanding IPFs by multiplying the ratio calculated in Step 1 by the Medicare allowable non-salary, noncapital cost weight for those freestanding IPFs with a home office.

Step 3: We then calculate the freestanding IPF cost weight by multiplying the Home Office/Related Organization Contract Labor cost weight in Step 2 by the total Medicare allowable costs for freestanding IPFs with a home office as a percent of total Medicare allowable costs for all freestanding IPFs (87 percent), which derives a freestanding Home Office/Related Organization Contract Labor cost weight of 4.2 percent.

To calculate the overall Home Office/Related Organization Contract Labor cost weight for the 2021-based IPF market basket, we proposed to weight together the freestanding Home Office/Related Organization Contract Labor cost weight (4.2 percent) and the hospital-based Home Office Contract Labor/Related Organization cost weight (5.1 percent) using total Medicare allowable costs from the sample of hospital-based IPFs that passed the one percent trim and the universe of freestanding IPFs. The resulting overall cost weight for Home Office/Related Organization Contract Labor is 4.7 percent (4.2 percent × 44 percent + 5.1 percent × 56 percent). This is the same methodology used to calculate the Home Office/Related Organization Contract Labor cost weight in the 2016-based IPF market basket.

Finally, we proposed to calculate the residual ''All Other'' cost weight that reflects all remaining costs that are not captured in the seven cost categories listed. See Table 1 for the resulting cost weights for these major cost categories that we obtain from the Medicare cost reports.

TABLE 1: Major Cost Categories as Derived from Medicare Cost Reports

Major Cost Categories	2021-Based IPF Market Basket (Percent)	2016-Based IPF Market Basket (Percent)
Wages and Salaries	50.4	51.2
Employee Benefits	13.7	13.5
Contract Labor	2.8	1.3
Professional Liability Insurance (Malpractice)	1.0	0.9
Pharmaceuticals	3.6	4.7
Home Office/Related Organization Contract Labor	4.7	3.5
Capital	7.2	7.1
All Other	16.7	17.9

As we did for the 2016-based IPF market basket, we proposed to allocate the Contract Labor cost weight to the Wages and Salaries and Employee Benefits cost weights based on their relative proportions under the assumption that contract labor costs are comprised of both wages and salaries, and employee benefits. The Contract Labor allocation proportion for Wages and Salaries is equal to the Wages and Salaries cost weight as a percent of the sum of the Wages and Salaries cost weight and the Employee Benefits cost weight. For the proposed rule, the rounded percentage is 79 percent; therefore, we proposed to allocate 79 percent of the Contract Labor cost weight to the Wages and Salaries cost weight and 21 percent to the Employee Benefits cost weight. This allocation was 81/19 in the 2016-based IPF market basket (84 FR 38430). Table 2 shows the Wages and Salaries and Employee Benefit cost weights after Contract Labor cost weight allocation for both the 2021-based IPF market basket and 2016-based IPF market basket.

TABLE 2: Wages and Salaries and Employee Benefits Cost Weights After Contract Labor Allocation

Major Cost Categories	2021-Based IPF Market Basket	2016-Based IPF Market Basket
Wages and Salaries	52.6	52.2
Employee Benefits	14.3	13.8

We did not receive any comments on our proposed methodology for developing the major cost weights of the 2021-based IPF market basket. We are finalizing these major cost weights as proposed.

(3) Derivation of the Detailed Operating Cost Weights

To further divide the ''All Other'' residual cost weight estimated from the 2021 Medicare cost report data into more detailed cost categories, we proposed to use the 2012 Benchmark Input-Output (I–O) ''Use Tables/Before Redefinitions/Purchaser Value'' for North American Industry Classification System (NAICS) 622000, Hospitals, published by the Bureau of Economic Analysis (BEA). This data is publicly available at *http://www.bea.gov/industry/io_annual.htm.* For the 2016-based IPF market basket, we also used the 2012 Benchmark I–O data, the most recent data available at the time (84 FR 38431).

The BEA Benchmark I–O data are scheduled for publication every 5 years with the most recent data available for 2012. The 2012 Benchmark I–O data are derived from the 2012 Economic Census and are the building blocks for BEA's economic accounts. Thus, they represent the most comprehensive and complete set of data on the economic processes or mechanisms by which

output is produced and distributed.[1] BEA also produces Annual I–O estimates; however, while based on a similar methodology, these estimates reflect less comprehensive and less detailed data sources and are subject to revision when benchmark data becomes available. Instead of using the less detailed Annual I–O data, we proposed to inflate the 2012 Benchmark I–O data forward to 2021 by applying the annual price changes from the respective price proxies to the appropriate market basket cost categories that are obtained from the 2012 Benchmark I–O data. We repeat this practice for each year. We then proposed to calculate the cost shares that each cost category represents of the inflated 2012 data. These resulting 2021 cost shares are applied to the ''All Other'' residual cost weight to obtain the detailed cost weights for the 2021-based IPF market basket. For example, the cost for Food: Direct Purchases represents 5.0 percent of the sum of the ''All Other'' 2012 Benchmark I–O Hospital Expenditures inflated to 2021; therefore, the Food: Direct Purchases cost weight represents 5.0 percent of the proposed 2021-based IPF market basket's ''All Other'' cost category (16.7 percent), yielding a ''final'' Food: Direct Purchases cost weight of 0.8 percent in the 2021-based IPF market basket (0.05 * 16.7 percent = 0.8 percent).

Using this methodology, we proposed to derive seventeen detailed IPF market basket cost category weights from the 2021-based IPF market basket residual cost weight (16.7 percent). These categories are: (1) Electricity and Other Non-Fuel Utilities; (2) Fuel: Oil and Gas; (3) Food: Direct Purchases; (4) Food: Contract Services; (5) Chemicals; (6) Medical Instruments; (7) Rubber and Plastics; (8) Paper and Printing Products; (9) Miscellaneous Products; (10) Professional Fees: Labor-Related; (11) Administrative and Facilities Support Services; (12) Installation, Maintenance, and Repair Services; (13) All Other Labor-Related Services; (14) Professional Fees: Nonlabor-Related; (15) Financial Services; (16) Telephone Services; and (17) All Other Nonlabor-Related Services.

We did not receive any comments on our methodology to use the BEA I–O data to derive the detailed operating cost weights. We are finalizing this methodology as we proposed. We note that we did receive one comment on the derivation of the Professional Fees: Labor-Related cost weight, which we discuss in section IV.A.5 of this final rule.

(4) Derivation of the Detailed Capital Cost Weights

As described in section IV.A.3.a.(2) of this final rule, we proposed a Capital-Related cost weight of 7.2 percent as obtained from the 2021 Medicare cost reports for freestanding and hospital-based IPF providers. We proposed to then separate this total Capital-Related cost weight into more detailed cost categories.

Using 2021 Medicare cost reports, we are able to group Capital-Related costs into the following categories: Depreciation, Interest, Lease, and Other Capital-Related costs. For each of these categories, we proposed to determine separately for hospital-based IPFs and freestanding IPFs what proportion of total capital-related costs the category represents.

For freestanding IPFs, using Medicare Cost Report data on Worksheet A–7 part III, we proposed to derive the proportions for Depreciation (column 9), Interest (column 11), Lease (column 10), and Other Capital-related costs (column 12 through 14), which is similar to the methodology used for the 2016-based IPF market basket.

For hospital-based IPFs, data for these four categories are not reported separately for the hospital-based IPF; therefore, we proposed to derive these proportions using data reported on Worksheet A–7 for the total facility. We are assuming the cost shares for the overall hospital are representative for the hospital-based IPF unit. For example, if depreciation costs make up 60 percent of total capital costs for the entire facility, we believe it is reasonable to assume that the hospital-based IPF would also have a 60 percent proportion because it is a unit contained within the total facility. This is the same methodology used for the 2016-based IPF market basket (84 FR 38431).

To combine each detailed capital cost weight for freestanding and hospital-based IPFs into a single capital cost weight for the 2021-based IPF market basket, we proposed to weight together the shares for each of the categories (Depreciation, Interest, Lease, and Other Capital-Related costs) based on the share of total capital costs each provider type represents of the total capital costs for all IPFs for 2021. Applying this methodology results in proportions of total capital-related costs for Depreciation, Interest, Lease and Other Capital-Related costs that are representative of the universe of IPF providers. This is the same methodology used for the 2016-based IPF market basket (84 FR 38432).

Lease costs are unique in that they are not broken out as a separate cost category in the 2021-based IPF market basket. Rather, we proposed to proportionally distribute these costs among the cost categories of Depreciation, Interest, and Other Capital-Related costs, reflecting the assumption that the underlying cost structure of leases is similar to that of Capital-Related costs in general. As was done for the 2016-based IPF market basket, we proposed to assume that 10 percent of the lease costs as a proportion of total Capital-Related costs represent overhead and assign those costs to the Other Capital-Related cost category accordingly. We proposed to distribute the remaining lease costs proportionally across the three cost categories (Depreciation, Interest, and Other Capital-Related) based on the proportion that these categories comprise of the sum of the Depreciation, Interest, and Other Capital-Related cost categories (excluding lease expenses). This would result in three primary Capital-Related cost categories in the 2021-based IPF market basket: Depreciation, Interest, and Other Capital-Related costs. This is the same methodology used for the 2016-based IPF market basket (84 FR 38432). The allocation of these lease expenses is shown in Table 3.

Finally, we proposed to further divide the Depreciation and Interest cost categories. We proposed to separate Depreciation into the following two categories: (1) Building and Fixed Equipment; and (2) Movable Equipment. We proposed to separate Interest into the following two categories: (1) Government/Nonprofit; and (2) For-profit.

To disaggregate the Depreciation cost weight, we need to determine the percent of total Depreciation costs for IPFs that is attributable to Building and Fixed Equipment, which we hereafter refer to as the ''fixed percentage.'' For the 2021-based IPF market basket, we proposed to use slightly different methods to obtain the fixed percentages for hospital-based IPFs compared to freestanding IPFs.

For freestanding IPFs, we proposed to use depreciation data from Worksheet A–7 of the 2021 Medicare cost reports. However, for hospital-based IPFs, we determined that the fixed percentage for the entire facility may not be representative of the hospital-based IPF unit due to the entire facility likely employing more sophisticated movable assets that are not utilized by the hospital-based IPF. Therefore, for hospital-based IPFs, we proposed to

[1] *http://www.bea.gov/papers/pdf/IOmanual_092906.pdf.*

calculate a fixed percentage using: (1) building and fixture capital costs allocated to the hospital-based IPF unit as reported on Worksheet B, part I, column 1, line 40; and (2) building and fixture capital costs for the top five ancillary cost centers utilized by hospital-based IPFs accounting for 82 percent of hospital-based IPF ancillary total costs: Clinic (Worksheet B, part I, column 1, line 90), Drugs Charged to Patients (Worksheet B, part I, column 1, line 73), Emergency (Worksheet B, part I, column 1, line 91), Laboratory (Worksheet B, part I, column 1, line 60) and Radiology—Diagnostic (Worksheet B, part I, column 1, line 54). We proposed to weight these two fixed percentages (inpatient and ancillary) using the proportion that each capital cost type represents of total capital costs in the 2021-based IPF market basket. We proposed to then weight the fixed percentages for hospital-based and freestanding IPFs together using the proportion of total capital costs each provider type represents. For both freestanding and hospital-based IPFs, this is the same methodology used for the 2016-based IPF market basket (84 FR 38432).

To disaggregate the Interest cost weight, we determined the percent of total interest costs for IPFs that are attributable to government and nonprofit facilities, which is hereafter referred to as the ''nonprofit percentage,'' as price pressures associated with these types of interest costs tend to differ from those for for-profit facilities. For the 2021-based IPF market basket, we proposed to use interest costs data from Worksheet A–7 of the 2021 Medicare cost reports for both freestanding and hospital-based IPFs. We proposed to determine the percent of total interest costs that are attributed to government and nonprofit IPFs separately for hospital-based and freestanding IPFs. We then proposed to weight the nonprofit percentages for hospital-based and freestanding IPFs together using the proportion of total capital costs that each provider type represents.

Table 3 provides the proposed detailed capital cost share composition estimated from the 2021 IPF Medicare cost reports. These detailed capital cost share composition percentages are applied to the total Capital-Related cost weight of 7.2 percent explained in detail in sections IV.A.3.a.(1)(h) and IV.A.3.a.(2) of this final rule.

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TABLE 3: Capital Cost Share Composition for the 2021-based IPF Market Basket

	Capital Cost Share Composition before Lease Expense Allocation	Capital Cost Share Composition after Lease Expense Allocation
Depreciation	**55%**	**68%**
Building and Fixed Equipment	40%	48%
Movable Equipment	16%	19%
Interest	**17%**	**21%**
Government/Nonprofit	11%	13%
For Profit	6%	7%
Lease	20%	-
Other Capital-Related	**8%**	**12%**

*Detail may not add to total due to rounding.

We did not receive any comments on our proposed methodology for developing the detailed capital cost weights of the 2021-based IPF market basket. We are finalizing these detailed capital cost weights as proposed.

(5) 2021-Based IPF Market Basket Cost Categories and Weights

Table 4 compares the cost categories and weights for the finalized 2021-based IPF market basket compared to the 2016-based IPF market basket.

TABLE 4: 2021-based IPF Market Basket Cost Weights Compared to 2016-based IPF Market Basket Cost Weights

Cost Category	2021-based IPF Market Basket Cost Weight	2016-based IPF Market Basket Cost Weight
Total	**100.0**	**100.0**
Compensation	**66.9**	**66.0**
Wages and Salaries	52.6	52.2
Employee Benefits	14.3	13.8
Utilities	**1.2**	**1.1**
Electricity and Other Non-Fuel Utilities	0.7	0.8
Fuel: Oil and Gas	0.4	0.3
Professional Liability Insurance	**1.0**	**0.9**
All Other Products and Services	**23.8**	**24.9**
All Other Products	**9.1**	**10.7**
Pharmaceuticals	3.6	4.7
Food: Direct Purchases	0.8	0.9
Food: Contract Services	1.0	1.0
Chemicals	0.3	0.3
Medical Instruments	2.0	2.3
Rubber and Plastics	0.3	0.3
Paper and Printing Products	0.5	0.5
Miscellaneous Products	0.6	0.7
All Other Services	**14.7**	**14.2**
Labor-Related Services	**7.9**	**7.7**
Professional Fees: Labor-Related	4.7	4.4
Administrative and Facilities Support Services	0.6	0.6
Installation, Maintenance, and Repair Services	1.2	1.3
All Other: Labor-related Services	1.4	1.4
Nonlabor-Related Services	**6.8**	**6.5**
Professional Fees: Nonlabor-Related	4.9	4.5
Financial Services	0.7	0.8
Telephone Services	0.2	0.3
All Other: Nonlabor-Related Services	0.9	1.0
Capital-Related Costs	**7.2**	**7.1**
Depreciation	**4.9**	**5.3**
Building and Fixed Equipment	3.5	3.7
Movable Equipment	1.4	1.5
Interest Costs	**1.5**	**1.2**
Government/Nonprofit	1.0	0.9
For Profit	0.5	0.3
Other Capital-Related Costs	**0.8**	**0.7**

*Detail may not add to total due to rounding.

b. Selection of Price Proxies

After developing the cost weights for the 2021-based IPF market basket, we proposed to select the most appropriate wage and price proxies currently available to represent the rate of price change for each expenditure category. For the majority of the cost weights, we base the price proxies on Bureau of Labor Statistics (BLS) data and grouped them into one of the following BLS categories:

- *Employment Cost Indexes (ECIs):* measure the rate of change in employment wage rates and employer costs for employee benefits per hour worked. These indexes are fixed-weight indexes and strictly measure the change in wage rates and employee benefits per hour. ECIs are superior to Average Hourly Earnings (AHE) as price proxies for input price indexes because they are not affected by shifts in occupation or industry mix, and because they measure pure price change and are available by both occupational group and by industry. The industry ECIs are based on the NAICS and the occupational ECIs are based on the Standard Occupational Classification System (SOC).
- *Producer Price Indexes (PPI):* measure the average change over time in

the selling prices received by domestic producers for their output. The prices included in the PPI are from the first commercial transaction for many products and some services (*https://www.bls.gov/ppi/*).

- *Consumer Price Indexes (CPIs):* measure the average change over time in the prices paid by urban consumers for a market basket of consumer goods and services (*https://www.bls.gov/cpi/*). CPIs are only used when the purchases are similar to those of retail consumers rather than purchases at the wholesale level, or if no appropriate PPIs are available.

We evaluated the price proxies using the criteria of reliability, timeliness, availability, and relevance:

- *Reliability:* indicates that the index is based on valid statistical methods and has low sampling variability. Widely accepted statistical methods ensure that the data were collected and aggregated in a way that can be replicated. Low sampling variability is desirable because it indicates that the sample reflects the typical members of the population. (Sampling variability is variation that occurs by chance because only a sample was surveyed rather than the entire population.)
- *Timeliness:* implies that the proxy is published regularly, preferably at least once a quarter. The market baskets are updated quarterly and, therefore, it is important for the underlying price proxies to be up-to-date, reflecting the most recent data available. We believe that using proxies that are published regularly (at least quarterly, whenever possible) helps to ensure that we are using the most recent data available to update the market basket. We strive to use publications that are disseminated frequently, because we believe that this is an optimal way to stay abreast of the most current data available.
- *Availability:* means that the proxy is publicly available. We prefer that our proxies are publicly available because this will help ensure that our market basket updates are as transparent to the public as possible. In addition, this enables the public to be able to obtain the price proxy data on a regular basis.
- *Relevance:* means that the proxy is applicable and representative of the cost category weight to which it is applied. The CPIs, PPIs, and ECIs that we proposed in this regulation meet these criteria. Therefore, we believe that they continue to be the best measure of price changes for the cost categories to which they would be applied.

Table 13 lists all price proxies that we proposed to use for the 2021-based IPF market basket. A detailed explanation of the price proxies we proposed for each cost category weight is provided below.

(1) Price Proxies for the Operating Portion of the 2021-Based IPF Market Basket

(a) Wages and Salaries

There is not a published wage proxy that we believe represents the occupational distribution of workers in IPFs. To measure wage price growth in the 2021-based IPF market basket, we proposed to apply a proxy blend based on six occupational subcategories within the Wages and Salaries category, which would reflect the IPF occupational mix, as was done for the 2016-based IPF market basket.

We proposed to use the National Industry-Specific Occupational Employment and Wage estimates for NAICS 622200, Psychiatric & Substance Abuse Hospitals, published by the BLS Occupational Employment and Wage Statistics (OEWS) program, as the data source for the wage cost shares in the wage proxy blend. We note that in the spring of 2021, the Occupational Employment Statistics (OES) program began using the name Occupational Employment and Wage Statistics (OEWS) to better reflect the range of data available from the program. Data released on or after March 31, 2021 reflect the new program name. We proposed to use May 2021 OEWS data. Detailed information on the methodology for the national industry-specific occupational employment and wage estimates survey can be found at *http://www.bls.gov/oes/current/oes_tec.htm.* For the 2016-based IPF market basket, we used May 2016 OES data.

Based on the OEWS data, there are six wage subcategories: Management; NonHealth Professional and Technical; Health Professional and Technical; Health Service; NonHealth Service; and Clerical. Table 5 lists the 2021 occupational assignments for the six wage subcategories; these are the same occupational groups used in the 2016-based IPF market basket.

TABLE 5: 2021 Occupational Assignments for IPF Wage Blend

2021 Occupational Groupings	
Group 1	**Management**
11-0000	Management Occupations
Group 2	**NonHealth Professional & Technical**
13-0000	Business and Financial Operations Occupations
15-0000	Computer and Mathematical Occupations
19-0000	Life, Physical, and Social Science Occupations
23-0000	Legal Occupations
25-0000	Educational Instruction and Library Occupations
27-0000	Arts, Design, Entertainment, Sports, and Media Occupations
Group 3	**Health Professional & Technical**
29-1021	Dentists, General
29-1031	Dietitians and Nutritionists
29-1051	Pharmacists
29-1071	Physician Assistants
29-1122	Occupational Therapists
29-1123	Physical Therapists
29-1125	Recreational Therapists
29-1126	Respiratory Therapists
29-1127	Speech-Language Pathologists
29-1129	Therapists, All Other
29-1141	Registered Nurses
29-1171	Nurse Practitioners
29-1215	Family Medicine Physicians
29-1216	General Internal Medicine Physicians
29-1223	Psychiatrists
29-1229	Physicians, All Other
29-1292	Dental Hygienists
29-1299	Healthcare Diagnosing or Treating Practitioners, All Other
Group 4	**Health Service**
21-0000	Community and Social Service Occupations
29-2010	Clinical Laboratory Technologists and Technicians
29-2034	Radiologic Technologists and Technicians
29-2042	Emergency Medical Technicians
29-2051	Dietetic Technicians
29-2052	Pharmacy Technicians
29-2053	Psychiatric Technicians
29-2061	Licensed Practical and Licensed Vocational Nurses

2021 Occupational Groupings	
29-2072	Medical Records Specialists
29-2099	Health Technologists and Technicians, All Other
29-9021	Health Information Technologists and Medical Registrars
29-9099	Healthcare Practitioners and Technical Workers, All Other
31-0000	Healthcare Support Occupations
Group 5	**NonHealth Service**
33-0000	Protective Service Occupations
35-0000	Food Preparation and Serving Related Occupations
37-0000	Building and Grounds Cleaning and Maintenance Occupations
39-0000	Personal Care and Service Occupations
41-0000	Sales and Related Occupations
47-0000	Construction and Extraction Occupations
49-0000	Installation, Maintenance, and Repair Occupations
51-0000	Production Occupations
53-0000	Transportation and Material Moving Occupations
Group 6	**Clerical**
43-0000	Office and Administrative Support Occupations

Total expenditures by occupation (that is, occupational assignment) were calculated by taking the OEWS number of employees multiplied by the OEWS annual average salary. These expenditures were aggregated based on the six groups in Table 5. We next calculated the proportion of each group's expenditures relative to the total expenditures of all six groups. These proportions, listed in Table 6, represent the weights used in the wage proxy blend. We then proposed to use the published wage proxies in Table 6 for each of the six groups (that is, wage subcategories) as we believe these six price proxies are the most technically appropriate indices available to measure the price growth of the Wages and Salaries cost category. These are the same price proxies used in the 2016-based IPF market basket (84 FR 38437).

TABLE 6: 2021-Based IPF Market Basket Wage Proxy Blend

Wage Subcategory	2021-based Wage Blend Weights	2016-based Wage Blend Weights	Price Proxy	BLS Series ID
Healthcare Professional and Technical	36.9%	34.9%	ECI for Wages and Salaries for All Civilian workers in Hospitals	CIU10262200000000I
Healthcare Service	34.4%	36.3%	ECI for Wages and Salaries for All Civilian workers in Healthcare and Social Assistance	CIU10262000000000I
NonHealthcare Service	7.5%	8.9%	ECI for Wages and Salaries for Private Industry workers in Service Occupations	CIU20200003000000I
NonHealthcare Professional and Technical	7.3%	7.0%	ECI for Wages and Salaries for Private Industry workers in Professional, Scientific, and Technical Services	CIU20254000000000I
Management	7.8%	6.8%	ECI for Wages and Salaries for Private industry workers in Management, Business, and Financial	CIU20200001100000I
Administrative Support and Clerical	6.1%	6.1%	ECI for Wages and Salaries for Private Industry workers in Office and Administrative Support	CIU20200002200000I
Total	100.0	100.0		

A comparison of the yearly changes from FY 2021 to FY 2024 for the 2021-based IPF wage blend and the 2016-based IPF wage blend is shown in Table 7. The average annual growth rate is the same for both price proxies over 2021–2024.

TABLE 7: Fiscal Year Growth in the 2021-based IPF Wage Proxy Blend and 2016-based IPF Wage Proxy Blend

	2021	2022	2023	2024	Average 2021 - 2024
2021-based IPF Wage Proxy Blend	3.0	5.5	5.4	4.1	4.5
2016-based IPF Wage Proxy Blend	3.1	5.6	5.4	4.1	4.6

**Source: IHS Global Inc., 2nd Quarter 2023 forecast with historical data through 1st Quarter 2023.

(b) Employee Benefits

To measure benefits price growth in the 2021-based IPF market basket, we proposed to apply a benefits proxy blend based on the same six subcategories and the same six blend weights for the wage proxy blend. These subcategories and blend weights are listed in Table 8.

The benefit ECIs, listed in Table 8, are not publicly available. Therefore, an ''ECIs for Total Benefits'' is calculated using publicly available ''ECIs for Total Compensation'' for each subcategory and the relative importance of wages within that subcategory's total compensation. This is the same benefits ECI methodology that we implemented in our 2016-based IPF market basket as well as used in the IPPS, SNF, Home Health Agency (HHA), IRF, LTCH, and End-Stage Renal Disease (ESRD) market baskets. We believe that the six price proxies listed in Table 8 are the most technically appropriate indices to measure the price growth of the Employee Benefits cost category in the 2021-based IPF market basket.

TABLE 8: 2021-Based IPF Market Basket Benefits Proxy Blend and 2016-based IPF Benefit Proxy Blend

Wage Subcategory	2021-based Benefit Blend Weight	2016-based Benefit Blend Weight	Price Proxy
Healthcare Professional and Technical	36.9%	34.9%	ECI for Total Benefits for All Civilian workers in Hospitals
Healthcare Service	34.4%	36.3%	ECI for Total Benefits for All Civilian workers in Healthcare and Social Assistance
NonHealthcare Service	7.5%	8.9%	ECI for Total Benefits for Private Industry workers in Service Occupations
NonHealthcare Professional and Technical	7.3%	7.0%	ECI for Total Benefits for Private Industry workers in Professional, Scientific, and Technical Services
Management	7.8%	6.8%	ECI for Total Benefits for Private industry workers in Management, Business, and Financial
Administrative Support and Clerical	6.1%	6.1%	ECI for Total Benefits for Private Industry workers in Office and Administrative Support
Total	100.0	100.0	

A comparison of the yearly changes from FY 2021 to FY 2024 for the 2021-based IPF benefit proxy blend and the 2016-based IPF benefit proxy is shown in Table 9. The average annual growth rate is the same for both price proxies over 2021 through 2024.

TABLE 9: Fiscal Year Growth in the 2021-based IPF Benefit Proxy Blend and 2016-based IPF Benefit Proxy Blend

	2021	2022	2023	2024	Average 2021- 2024
2021-based IPF Benefit Proxy Blend	2.4	4.4	4.5	3.7	3.8
2016-based IPF Benefit Proxy Blend	2.4	4.4	4.5	3.7	3.8

Source: IHS Global Inc., 2nd Quarter 2023 forecast with historical data through 1st Quarter 2023.

(c) Electricity and Other Non-Fuel Utilities

We proposed to use the PPI Commodity Index for Commercial Electric Power (BLS series code WPU0542) to measure the price growth of this cost category (which we proposed to rename from Electricity to Electricity and Other Non-Fuel Utilities). This is the same price proxy used in the 2016-based IPF market basket (84 FR 38438).

(d) Fuel: Oil and Gas

Similar to the 2016-based IPF market basket, for the 2021-based IPF market basket, we proposed to use a blend of the PPI for Petroleum Refineries and the PPI Commodity for Natural Gas. Our analysis of the Bureau of Economic Analysis' 2012 Benchmark Input-Output data (use table before redefinitions, purchaser's value for NAICS 622000 [Hospitals]), shows that Petroleum Refineries expenses account for approximately 90 percent and Natural Gas expenses account for approximately 10 percent of Hospitals' (NAICS 622000) total Fuel: Oil and Gas expenses. Therefore, we proposed to use a blend of 90 percent of the PPI for Petroleum Refineries (BLS series code PCU324110324110) and 10 percent of the PPI Commodity Index for Natural Gas (BLS series code WPU0531) as the price proxy for this cost category. This is the same blend that was used for the 2016-based IPF market basket (84 FR 38438).

(e) Professional Liability Insurance

We proposed to use the CMS Hospital Professional Liability Index to measure changes in PLI premiums. To generate this index, we collect commercial insurance premiums for a fixed level of coverage while holding non-price factors constant (such as a change in the level of coverage). This is the same proxy used in the 2016-based IPF market basket (84 FR 38438).

(f) Pharmaceuticals

We proposed to use the PPI for Pharmaceuticals for Human Use, Prescription (BLS series code WPUSI07003) to measure the price growth of this cost category. This is the same proxy used in the 2016-based IPF market basket (84 FR 38438).

(g) Food: Direct Purchases

We proposed to use the PPI for Processed Foods and Feeds (BLS series code WPU02) to measure the price growth of this cost category. This is the same proxy used in the 2016-based IPF market basket (84 FR 38438).

(h) Food: Contract Purchases

We proposed to use the CPI for Food Away From Home (BLS series code CUUR0000SEFV) to measure the price growth of this cost category. This is the same proxy used in the 2016-based IPF market basket (84 FR 38438).

(i) Chemicals

Similar to the 2016-based IPF market basket, we proposed to use a four-part blended PPI as the proxy for the chemical cost category in the 2021-based IPF market basket. The proposed blend is composed of the PPI for Industrial Gas Manufacturing, Primary Products (BLS series code PCU325120325120P), the PPI for Other Basic Inorganic Chemical Manufacturing (BLS series code PCU32518–32518-), the PPI for Other Basic Organic Chemical Manufacturing (BLS series code PCU32519–32519-), and the PPI for Other Miscellaneous Chemical Product Manufacturing (BLS series code PCU325998325998). For the 2021-based IPF market basket, we proposed to derive the weights for the PPIs using the 2012 Benchmark I–O data.

Table 10 shows the weights for each of the four PPIs used to create the blended Chemical proxy for the 2021-based IPF market basket. This is the same blend that was used for the 2016-based IPF market basket (84 FR 38439).

TABLE 10: Blended Chemical PPI Weights

Name	2021-based IPF Weights	NAICS
PPI for Industrial Gas Manufacturing	19%	325120
PPI for Other Basic Inorganic Chemical Manufacturing	13%	325180
PPI for Other Basic Organic Chemical Manufacturing	60%	325190
PPI for Other Miscellaneous Chemical Product Manufacturing	8%	325998

(j) Medical Instruments

We proposed to use a blended price proxy for the Medical Instruments category, as shown in Table 11. The 2012 Benchmark I–O data shows the majority of medical instruments and supply costs are for NAICS 339112—Surgical and medical instrument manufacturing costs (approximately 56 percent) and NAICS 339113—Surgical appliance and supplies manufacturing costs (approximately 43 percent). Therefore, we proposed to use a blend of these two price proxies. To proxy the price changes associated with NAICS 339112, we proposed to use the PPI for Surgical and medical instruments (BLS series code WPU1562). This is the same price proxy we used in the 2016-based IPF market basket. To proxy the price changes associated with NAICS 339113, we proposed to use a 50/50 blend of the PPI for Medical and surgical appliances and supplies (BLS series code WPU1563) and the PPI for Miscellaneous products, Personal safety equipment and clothing (BLS series code WPU1571). We proposed to include the latter price proxy as it will reflect personal protective equipment including but not limited to face shields and protective clothing. The 2012 Benchmark I–O data does not provide specific expenses for these products; however, we recognize that this category reflects costs faced by IPFs.

TABLE 11: Blended Medical Instruments PPI Weights

Name	2021-based IPF Weights	NAICS
PPI - Commodity - Surgical and medical instruments	56%	339112
PPI - Commodity - Medical and surgical appliances and supplies	22%	339113
PPI - Commodity - Miscellaneous products-Personal safety equipment and clothing	22%	

(k) Rubber and Plastics

We proposed to use the PPI for Rubber and Plastic Products (BLS series code WPU07) to measure price growth of this cost category. This is the same proxy used in the 2016-based IPF market basket (84 FR 38439).

(l) Paper and Printing Products

We proposed to use the PPI for Converted Paper and Paperboard Products (BLS series code WPU0915) to measure the price growth of this cost category. This is the same proxy used in the 2016-based IPF market basket (84 FR 38439).

(m) Miscellaneous Products

We proposed to use the PPI for Finished Goods Less Food and Energy (BLS series code WPUFD4131) to measure the price growth of this cost category. This is the same proxy used in the 2016-based IPF market basket (84 FR 38439).

(n) Professional Fees: Labor-Related

We proposed to use the ECI for Total Compensation for Private Industry workers in Professional and Related (BLS series code CIU2010000120000I) to measure the price growth of this category. This is the same proxy used in the 2016-based IPF market basket (84 FR 38439).

(o) Administrative and Facilities Support Services

We proposed to use the ECI for Total Compensation for Private Industry workers in Office and Administrative Support (BLS series code CIU2010000220000I) to measure the price growth of this category. This is the same proxy used in the 2016-based IPF market basket (84 FR 38439).

(p) Installation, Maintenance, and Repair Services

We proposed to use the ECI for Total Compensation for Civilian workers in Installation, Maintenance, and Repair (BLS series code CIU1010000430000I) to measure the price growth of this cost category. This is the same proxy used in the 2016-based IPF market basket (84 FR 38439).

(q) All Other: Labor-Related Services

We proposed to use the ECI for Total Compensation for Private Industry workers in Service Occupations (BLS series code CIU2010000300000I) to measure the price growth of this cost category. This is the same proxy used in the 2016-based IPF market basket (84 FR 38439).

(r) Professional Fees: Nonlabor-Related

We proposed to use the ECI for Total Compensation for Private Industry workers in Professional and Related (BLS series code CIU2010000120000I) to measure the price growth of this category. This is the same proxy used in the 2016-based IPF market basket (84 FR 38439).

(s) Financial Services

We proposed to use the ECI for Total Compensation for Private Industry workers in Financial Activities (BLS series code CIU201520A000000I) to measure the price growth of this cost category. This is the same proxy used in the 2016-based IPF market basket (84 FR 38439).

(t) Telephone Services

We proposed to use the CPI for Telephone Services (BLS series code CUUR0000SEED) to measure the price growth of this cost category. This is the same proxy used in the 2016-based IPF market basket (84 FR 38439).

(u) All Other: Nonlabor-Related Services

We proposed to use the CPI for All Items Less Food and Energy (BLS series code CUUR0000SA0L1E) to measure the price growth of this cost category. This is the same proxy used in the 2016-based IPF market basket (84 FR 38439).

We did not receive any comments on our proposed price proxies for the operating portion of the 2021-based IPF market basket. We are finalizing these price proxies as proposed.

Table 13 lists all price proxies that we are finalizing for the 2021-based IPF market basket.

(2) Price Proxies for the Capital Portion of the 2021-Based IPF Market Basket

(a) Capital Price Proxies Prior to Vintage Weighting

We proposed to use the same price proxies for the capital-related cost categories in the 2021-based IPF market basket as were used in the 2016-based IPF market basket, which are provided in Table 13 and described below. Specifically, we proposed to proxy:

- Depreciation: Building and Fixed Equipment cost category by BEA's Chained Price Index for Nonresidential Construction for Hospitals and Special Care Facilities (BEA Table 5.4.4. Price Indexes for Private Fixed Investment in Structures by Type).
- Depreciation: Movable Equipment cost category by the PPI for Machinery and Equipment (BLS series code WPU11).
- Nonprofit Interest cost category by the average yield on domestic municipal bonds (Bond Buyer 20-bond index).
- For-profit Interest cost category by the iBoxx AAA Corporate Bond Yield index
- Other Capital-Related cost category by the CPI–U for Rent of Primary Residence (BLS series code CUUS0000SEHA).

We believe these are the most appropriate proxies for IPF capital-related costs that meet our selection criteria of relevance, timeliness, availability, and reliability. We also proposed to vintage weight the capital price proxies for Depreciation and Interest to capture the long-term consumption of capital. This vintage weighting method is similar to the method used for the 2016-based IPF market basket (84 FR 38440) and is described below.

(b) Vintage Weights for Price Proxies

Because capital is acquired and paid for over time, capital-related expenses in any given year are determined by both past and present purchases of physical and financial capital. The vintage-weighted capital-related portion of the 2021-based IPF market basket is intended to capture the long-term consumption of capital, using vintage weights for depreciation (physical capital) and interest (financial capital). These vintage weights reflect the proportion of capital-related purchases attributable to each year of the expected life of building and fixed equipment, movable equipment, and interest. We proposed to use vintage weights to compute vintage-weighted price changes associated with depreciation and interest expenses.

Capital-related costs are inherently complicated and are determined by complex capital-related purchasing decisions, over time, based on such factors as interest rates and debt financing. In addition, capital is depreciated over time instead of being consumed in the same period it is purchased. By accounting for the vintage nature of capital, we are able to provide an accurate and stable annual measure of price changes. Annual non-vintage price changes for capital are unstable due to the volatility of interest rate changes, and therefore, do not reflect the actual annual price changes for IPF capital-related costs. The capital-related component of the 2021-based IPF market basket reflects the underlying stability of the capital-related acquisition process.

The methodology used to calculate the vintage weights for the 2021-based IPF market basket is the same as that used for the 2016-based IPF market basket (84 FR 38439 through 38441) with the only difference being the inclusion of more recent data. To calculate the vintage weights for depreciation and interest expenses, we first need a time series of capital-related purchases for building and fixed equipment and movable equipment. We found no single source that provides an appropriate time series of capital-related purchases by hospitals for all of the above components of capital purchases. The early Medicare cost reports did not have sufficient capital-related data to meet this need. Data we obtained from the American Hospital Association (AHA) do not include annual capital-related purchases. However, we are able to obtain data on total expenses back to 1963 from the AHA. Consequently, we proposed to use data from the AHA Panel Survey and the AHA Annual Survey to obtain a time series of total expenses for hospitals. We then proposed to use data from the AHA Panel Survey supplemented with the ratio of depreciation to total hospital expenses obtained from the Medicare cost reports to derive a trend of annual depreciation expenses for 1963 through 2020, which is the latest year of AHA data available. We proposed to separate these depreciation expenses into annual amounts of building and fixed equipment depreciation and movable equipment depreciation as determined earlier. From these annual depreciation amounts, we derive annual end-of-year

book values for building and fixed equipment and movable equipment using the expected life for each type of asset category. While data is not available that is specific to IPFs, we believe this information for all hospitals serves as a reasonable alternative for the pattern of depreciation for IPFs.

To continue to calculate the vintage weights for depreciation and interest expenses, we also need to account for the expected lives for Building and Fixed Equipment, Movable Equipment, and Interest for the 2021-based IPF market basket. We proposed to calculate the expected lives using Medicare cost report data from freestanding and hospital-based IPFs. The expected life of any asset can be determined by dividing the value of the asset (excluding fully depreciated assets) by its current year depreciation amount. This calculation yields the estimated expected life of an asset if the rates of depreciation were to continue at current year levels, assuming straight-line depreciation. We proposed to determine the expected life of building and fixed equipment separately for hospital-based IPFs and freestanding IPFs, and then weight these expected lives using the percent of total capital costs each provider type represents. We proposed to apply a similar method for movable equipment. Using these proposed methods, we determined the average expected life of building and fixed equipment to be equal to 25 years, and the average expected life of movable equipment to be equal to 12 years. For the expected life of interest, we believe vintage weights for interest should represent the average expected life of building and fixed equipment because, based on previous research described in the FY 1997 IPPS final rule (61 FR 46198), the expected life of hospital debt instruments and the expected life of buildings and fixed equipment are similar. We note that for the 2016-based IPF market basket, the expected life of building and fixed equipment is 22 years, and the expected life of movable equipment is 11 years (84 FR 38441).

Multiplying these expected lives by the annual depreciation amounts results in annual year-end asset costs for building and fixed equipment and movable equipment. We then calculate a time series, beginning in 1964, of annual capital purchases by subtracting the previous year's asset costs from the current year's asset costs.

For the building and fixed equipment and movable equipment vintage weights, we proposed to use the real annual capital-related purchase amounts for each asset type to capture the actual amount of the physical acquisition, net of the effect of price inflation. These real annual capital-related purchase amounts are produced by deflating the nominal annual purchase amount by the associated price proxy as provided earlier in this final rule. For the interest vintage weights, we proposed to use the total nominal annual capital-related purchase amounts to capture the value of the debt instrument (including, but not limited to, mortgages and bonds). Using these capital-related purchase time series specific to each asset type, we proposed to calculate the vintage weights for building and fixed equipment, for movable equipment, and for interest.

The vintage weights for each asset type are deemed to represent the average purchase pattern of the asset over its expected life (in the case of building and fixed equipment and interest, 25 years, and in the case of movable equipment, 12 years). For each asset type, we used the time series of annual capital-related purchase amounts available from 2020 back to 1964. These data allow us to derive thirty-three 25-year periods of capital-related purchases for building and fixed equipment and interest, and forty-six 12-year periods of capital-related purchases for movable equipment. For each 25-year period for building and fixed equipment and interest, or 12-year period for movable equipment, we calculate annual vintage weights by dividing the capital-related purchase amount in any given year by the total amount of purchases over the entire 25-year or 12-year period. This calculation is done for each year in the 25-year or 12-year period and for each of the periods for which we have data. We then calculate the average vintage weight for a given year of the expected life by taking the average of these vintage weights across the multiple periods of data. The vintage weights for the capital-related portion of the 2021-based IPF market basket and the 2016-based IPF market basket are presented in Table 12.

TABLE 12: 2021-Based IPF Market Basket and 2016-based IPF Market Basket Vintage Weights for Capital-Related Price Proxies

Year*	Building and Fixed Equipment		Movable Equipment		Interest	
	2021-based 25 years	2016-based 22 years	2021 based 12 years	2016-based 11 years	2021 based 25 years	2016 based 22 years
1	0.031	0.035	0.066	0.071	0.018	0.021
2	0.032	0.036	0.068	0.075	0.019	0.023
3	0.033	0.038	0.071	0.080	0.021	0.025
4	0.034	0.038	0.076	0.085	0.023	0.026
5	0.035	0.040	0.080	0.087	0.024	0.029
6	0.036	0.042	0.082	0.091	0.026	0.031
7	0.035	0.042	0.084	0.095	0.026	0.033
8	0.036	0.041	0.088	0.099	0.028	0.033
9	0.036	0.042	0.091	0.102	0.029	0.036
10	0.039	0.043	0.094	0.105	0.033	0.038
11	0.040	0.046	0.098	0.110	0.035	0.042
12	0.040	0.047	0.101	--	0.037	0.045
13	0.042	0.048	--	--	0.040	0.048
14	0.042	0.049	--	--	0.042	0.052
15	0.042	0.050	--	--	0.044	0.055
16	0.043	0.050	--	--	0.046	0.057
17	0.044	0.051	--	--	0.049	0.060
18	0.045	0.053	--	--	0.052	0.065
19	0.045	0.053	--	--	0.054	0.068
20	0.045	0.053	--	--	0.055	0.069
21	0.045	0.052	--	--	0.057	0.070
22	0.045	0.052	--	--	0.058	0.072
23	0.045	--	--	--	0.060	
24	0.045	--	--	--	0.061	
25	0.044	--	--	--	0.062	
Total	1.000	1.000	1.000	1.000	1.000	1.000

Note: Numbers may not add to total due to rounding.

The process of creating vintage-weighted price proxies requires applying the vintage weights to the price proxy index where the last applied vintage weight in Table 12 is applied to the most recent data point. We have provided on the CMS website an example of how the vintage weighting price proxies are calculated, using example vintage weights and example price indices. The example can be found at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketResearch.html* in the zip file titled ''Weight Calculations as described in the IPPS FY 2010 Proposed Rule.''

We did not receive any comments on our proposed price proxies for the capital portion of the 2021-based IPF market basket. We are finalizing these price proxies as proposed.

(3) Summary of Price Proxies of the 2021-Based IPF Market Basket

Table 13 shows both the operating and capital price proxies that we are finalizing for the 2021-based IPF market basket.

TABLE 13: Price Proxies for the 2021-based IPF Market Basket

Cost Description	Price Proxies	Weight
Total		**100.0**
Compensation		**66.9**
Wages and Salaries	Blended Wages and Salaries Price Proxy	52.6
Employee Benefits	Blended Employee Benefits Price Proxy	14.3
Utilities		**1.2**
Electricity and Other Non-Fuel Utilities	PPI for Commercial Electric Power	0.7
Fuel: Oil and Gas	Blend of PPIs*	0.4
Professional Liability Insurance		**1.0**
Malpractice	CMS Hospital Professional Liability Insurance Premium Index	1.0
All Other Products and Services		**23.8**
All Other Products		**9.1**
Pharmaceuticals	PPI for Pharmaceuticals for Human Use, Prescription	3.6
Food: Direct Purchases	PPI for Processed Foods and Feeds	0.8
Food: Contract Services	CPI-U for Food Away From Home	1.0
Chemicals	Blend of PPIs*	0.3
Medical Instruments	Blend of PPIs*	2.0
Rubber and Plastics	PPI for Rubber and Plastic Products	0.3
Paper and Printing Products	PPI for Converted Paper and Paperboard Products	0.5
Miscellaneous Products	PPI for Finished Goods Less Food and Energy	0.6
All Other Services		**14.7**
Labor-Related Services		**7.9**
Professional Fees: Labor-Related	ECI for Total compensation for Private industry workers in Professional and related	4.7
Administrative and Facilities Support Services	ECI for Total compensation for Private industry workers in Office and administrative support	0.6
Installation, Maintenance & Repair Services	ECI for Total compensation for Civilian workers in Installation, maintenance, and repair	1.2
All Other: Labor-related Services	ECI for Total compensation for Private industry workers in Service occupations	1.4
Nonlabor-Related Services		**6.8**
Professional Fees: Nonlabor-Related	ECI for Total compensation for Private industry workers in Professional and related	4.9
Financial Services	ECI for Total compensation for Private industry workers in Financial activities	0.7
Telephone Services	CPI-U for Telephone Services	0.2
All Other: Nonlabor-Related Services	CPI-U for All Items Less Food and Energy	0.9
Capital-Related Costs		**7.2**
Depreciation		**4.9**
Building and Fixed Equipment	BEA chained price index for nonresidential construction for hospitals and special care facilities - vintage weighted (25 years)	3.5
Movable Equipment	PPI for machinery and equipment - vintage weighted (12 years)	1.4
Interest Costs		**1.5**
Government/Nonprofit	Average yield on domestic municipal bonds (Bond Buyer 20 bonds) - vintage weighted (25 years)	1.0
For Profit	Average Yield on iBoxx AAA Corporate Bonds – vintage weighted (25 years)	0.5
Other Capital-Related Costs	CPI-U for Rent of primary residence	**0.8**

Note: Totals may not sum to 100.0 percent due to rounding.

*Details on the series and weight for each price proxy used in the PPI blends is provided in section IV.A.3.b.

After consideration of public comments, we are finalizing the 2021-based IPF market basket as proposed.

4. FY 2024 Market Basket Update and Productivity Adjustment

a. FY 2024 Market Basket Update

For FY 2024 (that is, beginning October 1, 2023 and ending September 30, 2024), we proposed to use an estimate of the proposed 2021-based IPF market basket increase factor to update the IPF PPS base payment rate. Consistent with historical practice, we estimate the market basket update for the IPF PPS based on IHS Global Inc.'s (IGI) forecast. IGI is a nationally recognized economic and financial forecasting firm with which CMS contracts to forecast the components of the market baskets.

Using IGI's fourth quarter 2022 forecast with historical data through the third quarter of 2022, the projected proposed 2021-based IPF market basket increase factor for FY 2024 was 3.2 percent. We also proposed that if more recent data were subsequently available (for example, a more recent estimate of the market basket increase factor) we would use such data, to determine the FY 2024 update in the final rule.

Based on IGI's second quarter 2023 forecast with historical data through the first quarter of 2023, the 2021-based IPF market basket increase percentage for FY 2024 is 3.5 percent. For comparison, the current 2016-based IPF market basket is also projected to increase by 3.5 percent in FY 2024 based on IGI's second quarter 2023 forecast. Table 14 compares the 2021-based IPF market basket and the 2016-based IPF market basket percent changes. On average, the two indexes produce similar updates to one another, with the 4-year average historical growth rates (for FY 2019–FY 2022) of the 2021-based IPF market basket being equal to 3.2 percent compared to the 2016-based IPF market basket with 3.2 percent.

TABLE 14: 2021-Based IPF Market basket and 2016-Based IPF Market Basket Percent Changes, FY 2019 through FY 2026

Fiscal Year (FY)	2021-Based IPF Market Basket Index Percent Change	2016-Based IPF Market Basket Index Percent Change
Historical data:		
FY 2019	2.4	2.5
FY 2020	2.1	2.2
FY 2021	2.8	2.9
FY 2022	5.3	5.3
Average 2019-2022	**3.2**	**3.2**
Forecast:		
FY 2023	4.8	4.8
FY 2024	3.5	3.5
FY 2025	3.0	3.0
FY 2026	2.9	2.9
Average 2023-2026	**3.6**	**3.6**

Note: These market basket percent changes do not include any further adjustments as may be statutorily required. Source: IHS Global Inc. 2nd quarter 2023 forecast.

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b. Productivity Adjustment

Section 1886(s)(2)(A)(i) of the Act requires the application of the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act to the IPF PPS for the RY beginning in 2012 (that is, a RY that coincides with a FY) and each subsequent RY. The statute defines the productivity adjustment to be equal to the 10-year moving average of changes in annual economy-wide, private nonfarm business multifactor productivity (as projected by the Secretary for the 10-year period ending with the applicable FY, year, cost reporting period, or other annual period) (the ''productivity adjustment''). The United States Department of Labor's Bureau of Labor Statistics (BLS) publishes the official measures of productivity for the United States economy. We note that previously the productivity measure referenced in section 1886(b)(3)(B)(xi)(II) of the Act, was published by BLS as private nonfarm business multifactor productivity. Beginning with the November 18, 2021 release of productivity data, BLS replaced the term multifactor productivity (MFP) with total factor productivity (TFP). BLS noted that this is a change in terminology only and will not affect the data or methodology. As a result of the BLS name change, the productivity measure referenced in section 1886(b)(3)(B)(xi)(II) of the Act is now published by BLS as private nonfarm business total factor productivity. However, as mentioned above, the data and methods are unchanged. We refer readers to *www.bls.gov* for the BLS historical published TFP data. A complete description of IGI's TFP projection methodology is available on the CMS website at *https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/*

medicareprogramratesstats/marketbasketresearch. In addition, in the FY 2022 IPF PPS final rule (86 FR 42611), we noted that effective with FY 2022 and forward, CMS changed the name of this adjustment to refer to it as the productivity adjustment rather than the MFP adjustment.

Using IGI's fourth quarter 2022 forecast, the 10-year moving average growth of TFP for FY 2024 was projected to be 0.2 percent. Thus, in accordance with section 1886(s)(2)(A)(i) of the Act, we proposed to calculate the FY 2024 market basket update, which is used to determine the applicable percentage increase for the IPF payments, using IGI's fourth quarter 2022 forecast of the proposed 2021-based IPF market basket. We proposed to then reduce this percentage increase by the estimated productivity adjustment for FY 2024 of 0.2 percentage point (the 10-year moving average growth of TFP for the period ending FY 2024 based on IGI's fourth quarter 2022 forecast). Therefore, the proposed FY 2024 IPF update was equal to 3.0 percent (3.2 percent market basket update reduced by the 0.2 percentage point productivity adjustment). Furthermore, we proposed that if more recent data became available after the publication of the proposed rule and before the publication of the final rule (for example, a more recent estimate of the productivity adjustment), we would use such data, if appropriate, to determine the FY 2024 productivity adjustment in the final rule.

Using IGI's second quarter 2023 forecast, the 10-year moving average growth of TFP for FY 2024 is projected to be 0.2 percent. Thus, in accordance with section 1886(s)(2)(A)(i) of the Act, we calculate the FY 2024 market basket update, which is used to determine the applicable percentage increase for the IPF payments, using IGI's second quarter 2023 forecast of the 2021-based IPF market basket. We then reduce this percentage increase by the estimated productivity adjustment for FY 2024 of 0.2 percentage point (the 10-year moving average growth of TFP for the period ending FY 2024 based on IGI's second quarter 2023 forecast). Therefore, the FY 2024 IPF update is equal to 3.3 percent (3.5 percent market basket update reduced by the 0.2 percentage point productivity adjustment).

We invited public comment on our proposals for the FY 2024 market basket update and productivity adjustment. The following is a summary of the public comments received on the proposed FY 2024 market basket update and productivity adjustment.

Comment: Several commenters expressed concern about the proposed 2021-based IPF market basket increase factor for FY 2024 of 3.2 percent. They stated that hospitals throughout the country face enormous cost pressures, with labor costs (due to increased demand and workforce shortages) leading to this dramatic increase in overall cost pressure. They also noted the significant cost increases for drugs, medical supplies, and personal protective equipment since before the PHE. The commenters stated that the cumulative effect of this inflationary pressure coupled with the proposed low Medicare payment increases for FY 2024 will continue to have negative effects on IPF operating margins. They cited that the Medicare Payment Advisory Commission determined that Medicare has failed to cover the cost of caring for patients in hospital-based and freestanding nonprofit IPFs since at least 2016.

The commenters also noted that CMS proposed that if more recent data became available after the publication of the proposed rule and before the publication of the final rule that CMS would use such data to determine the FY 2024 update in the final rule. They recommended CMS use more recent data and implement a payment rate for FY 2024 that more accurately reflects current costs, rather than relying on data that preceded the extraordinary inflation they are experiencing. Some commenters suggested CMS use other methods to determine the market basket update, such as the average growth rate in allowable Medicare costs per risk-adjusted discharge for IPFs between FY 2019 and FY 2021 to calculate the FY 2024 final rule market basket update. They stated that if CMS fails to provide an adequate market basket update, they are deeply concerned inadequate payments will result in reduced access to inpatient psychiatric services for Medicare beneficiaries.

Response: We appreciate the commenters' concerns regarding inflationary pressure facing IPFs and the proposed FY 2024 market basket update. As stated in Section IV.A.2 in this final rule, the IPF market basket (including the proposed 2021-based and other CMS market baskets) is a fixed-weight, Laspeyres-type index that measures price changes over time. Since the inception of the IPF PPS, the IPF payment rates (with the exception of statutorily mandated updates) have been updated by a projection of a market basket percentage increase, which is designed to measure price inflation for IPF providers and does not reflect increases in costs associated with changes in the volume or intensity of input goods and services (such as the quantity of labor used). In this way, the IPF market basket is consistent in concept and methodology with market baskets used for other CMS PPS updates, including IPPS, SNF, and HHA. The longstanding IPF market basket methodology establishes a market basket that appropriately reflects expectations, based on the latest available data, of price inflation for IPF providers for FY 2024. It would be inappropriate for the IPF market basket to reflect the method proposed by the commenter where the update would be based on increases in Medicare allowable costs per risk-adjusted discharge from a past period, since that measure would incorporate changes in costs that are not solely reflective of price inflation that is intended to be captured by the market basket update in the IPF PPS.

The projection of the 2021-based IPF market basket is based on the most recent forecast from IHS Global Inc.—a nationally recognized economic and financial forecasting firm with which CMS contracts to forecast the price proxies of the market baskets. For this final rule, based on the more recent IGI second quarter 2023 forecast with historical data through the first quarter of 2023, the projected 2021-based IPF market basket increase factor for FY 2024 is 3.5 percent, which is 0.3 percentage point higher than the projected FY 2024 market basket increase factor in the proposed rule, and reflects an increase in compensation prices of 4.0 percent. We note that the 10-year historical average (2013–2022) growth rate of the 2021-based IPF market basket is 2.4 percent with an average growth rate in compensation prices of 2.5 percent.

Therefore, consistent with our historical practice of estimating market basket increases based on the best available data, we are finalizing a market basket increase percentage of 3.5 percent for FY 2024.

Comment: Several commenters expressed concern about the application of the productivity adjustment, stating that the PHE has had unimaginable impacts on hospital productivity. They state that even before the PHE, OACT indicated that hospital productivity will be less than the general economy-wide productivity, which is the measure that is required by law to be used to derive the productivity adjustment. Given that CMS is required by statute to implement a productivity adjustment to the market basket update, commenters asked the agency to work with the Congress to permanently eliminate this unjustified

reduction to hospital payments. Further, they asked CMS to use its authority under section 1886(s) of the Act to remove the productivity adjustment for any fiscal year that was covered under PHE determination (that is, 2020 (0.4 percent), 2021 (0.0 percent), 2022 (0.7 percent), and 2023 (0.3 percent)) from the calculation of the market basket update for FY 2024 and any year thereafter.

Response: Section 1886(s)(2)(A)(i) of the Act requires the application of the productivity adjustment described in section 1886(b)(3)(xi)(II) of the Act. As required by statute, the FY 2024 productivity adjustment is derived based on the 10-year moving average growth in economy-wide productivity for the period ending FY 2024. We recognize the concerns of the commenters regarding the appropriateness of the productivity adjustment; however, we are required pursuant to section 1886(s)(2)(A)(i) of the Act to apply the specific productivity adjustment described here. Because that provision specifically requires application of the productivity adjustment, we do not believe section 1886(s) of the Act permits the Secretary discretion to remove it from the calculation of the market basket update.

Comment: Commenters noted that CMS has underestimated the IPF market basket increase over the last several years. They encouraged CMS to utilize its exceptions and adjustments authority to apply a one-time adjustment to course correct for its significantly lower estimates of costs for FYs 2021 through 2023. They stated that failing to correct CMS's gross underestimation of the payment updates during the pandemic will further perpetuate inaccuracies in the payment rate moving forward, resulting in a permanent cut to IPF payments.

Response: The IPF market basket updates are set prospectively, which means that the update relies on a mix of both historical data for part of the period for which the update is calculated and forecasted data for the remainder. For instance, the FY 2024 market basket update in this final rule reflects historical data through the first quarter of CY 2023 and forecasted data through the third quarter of CY 2024. While there is no precedent to adjust for market basket forecast error in the IPF payment update, a forecast error can be calculated by comparing the actual market basket increase for a given year less the forecasted market basket increase. Due to the uncertainty regarding future price trends, forecast errors can be both positive and negative. Regarding the comment that the IPF market basket increase over the last several years has been underestimated, we disagree with this assertion, as from 2012 through 2020, the forecasted market basket updates for each payment year for IPFs were higher than the actual market basket updates. For this final rule, we have incorporated more recent historical data and forecasts to capture the price and wage pressures facing IPFs. We believe IGI's second quarter 2023 forecast of the FY 2024 percentage increase in the 2021-based IPF market basket is the best available projection of inflation to determine the applicable percentage increase for the IPF payments in FY 2024.

Final Decision: After consideration of public comments, we are finalizing a FY 2024 IPF payment rate update of 3.3 percent (3.5 percent IPF market basket percentage increase reduced by the 0.2 percentage point productivity adjustment).

5. Labor-Related Share for FY 2024

Due to variations in geographic wage levels and other labor-related costs, we believe that payment rates under the IPF PPS should continue to be adjusted by a geographic wage index, which applies to the labor-related portion of the Federal per diem base rate (hereafter referred to as the labor-related share). The labor-related share is determined by identifying the national average proportion of total costs that are related to, influenced by, or vary with the local labor market. We proposed to continue to classify a cost category as labor-related if the costs are labor-intensive and vary with the local labor market.

We proposed to include in the labor-related share the sum of the relative importance of the following cost categories: Wages and Salaries, Employee Benefits, Professional Fees: Labor-Related, Administrative and Facilities Support Services, Installation, Maintenance, and Repair Services, All Other: Labor-Related Services, and a portion of the Capital-Related cost weight from the 2021-based IPF market basket. These are the same categories as the 2016-based IPF market basket.

Similar to the 2016-based IPF market basket, the 2021-based IPF market basket includes two cost categories for nonmedical Professional fees (including but not limited to, expenses for legal, accounting, and engineering services). These are Professional Fees: Labor-Related and Professional Fees: Nonlabor-Related. For the 2021-based IPF market basket, we proposed to estimate the labor-related percentage of non-medical professional fees (and assign these expenses to the Professional Fees: Labor-Related services cost category) based on the same method that was used to determine the labor-related percentage of professional fees in the 2016-based IPF market basket.

As was done in the 2016-based IPF market basket, we proposed to determine the proportion of legal, accounting and auditing, engineering, and management consulting services that meet our definition of labor-related services based on a survey of hospitals conducted by CMS in 2008. We notified the public of our intent to conduct this survey on December 9, 2005, (70 FR 73250) and did not receive any public comments in response to the notice (71 FR 8588). A discussion of the composition of the survey and post-stratification can be found in the FY 2010 IPPS/LTCH PPS final rule (74 FR 43850 through 43856). Based on the weighted results of the survey, we determined that hospitals purchase, on average, the following portions of contracted professional services outside of their local labor market:

- 34 percent of accounting and auditing services.
- 30 percent of engineering services.
- 33 percent of legal services.
- 42 percent of management consulting services.

We proposed to apply each of these percentages to the respective 2012 Benchmark I–O cost category underlying the professional fees cost category to determine the Professional Fees: Nonlabor-Related costs. The Professional Fees: Labor-Related costs were determined to be the difference between the total costs for each Benchmark I–O category and the Professional Fees: Nonlabor-Related costs. This is the same methodology that we used to separate the 2016-based IPF market basket professional fees category into Professional Fees: Labor-Related and Professional Fees: Nonlabor-Related cost categories (84 FR 38445).

Effective for transmittal 18, (*https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Transmittals/r18p240i*) the hospital Medicare cost report (CMS Form 2552–10, OMB No. 0938–0050) is collecting information on whether a hospital purchased professional services (for example, legal, accounting, tax preparation, bookkeeping, payroll, advertising, and/or management/consulting services) from an unrelated organization and if the majority of these expenses were purchased from unrelated organizations located outside of the main hospital's local area labor market. We encourage all providers to provide this information so we can potentially use these data in future

rulemaking to determine the labor-related share.

In the 2021-based IPF market basket, nonmedical professional fees that were subject to allocation based on these survey results represent 3.3 percent of total costs (and are limited to those fees related to Accounting & Auditing, Legal, Engineering, and Management Consulting services). Based on our survey results, we proposed to apportion 2.1 percentage points of the 3.3 percentage point figure into the Professional Fees: Labor-Related share cost category and designate the remaining 1.2 percentage point into the Professional Fees: Nonlabor-Related cost category.

In addition to the professional services listed, for the 2021-based IPF market basket, we proposed to allocate a proportion of the Home Office/Related Organization Contract Labor cost weight, calculated using the Medicare cost reports, into the Professional Fees: Labor-Related and Professional Fees: Nonlabor-Related cost categories. We proposed to classify these expenses as labor-related and nonlabor-related, as many facilities are not located in the same geographic area as their home office and, therefore, do not meet our definition for the labor-related share, which requires the services to be purchased in the local labor market.

Similar to the 2016-based IPF market basket, we proposed for the 2021-based IPF market basket to use the Medicare cost reports for both freestanding IPF providers and hospital-based IPF providers to determine the home office labor-related percentages. The Medicare cost report requires a hospital to report information regarding its home office provider. Using information on the Medicare cost report, we then compare the location of the IPF with the location of the IPF's home office. We proposed to classify an IPF with a home office located in its respective labor market if the IPF and its home office are located in the same metropolitan statistical area (MSA). We then determine the proportion of the Home Office/Related Organization Contract Labor cost weight that should be allocated to the labor-related share based on the percent of total Medicare allowable costs for those IPFs that had home offices located in their respective local labor markets of total Medicare allowable costs for IPFs with a home office. We determined an IPF's and its home office's MSA using their zip code information from the Medicare cost report. Using this methodology, we determined that 46 percent of IPFs' Medicare allowable costs were for home offices located in their respective local labor markets. Therefore, we are allocating 46 percent of the Home Office/Related Organization Contract Labor cost weight (2.1 percentage points = 4.7 percent times 46 percent) to the Professional Fees: Labor-Related cost weight and 54 percent of the Home Office/Related Organization Contract Labor cost weight to the Professional Fees: Nonlabor-Related cost weight (2.5 percentage points = 4.7 percent times 54 percent). The same methodology was used for the 2016-based IPF market basket (84 FR 38445).

In summary, we apportioned 2.1 percentage points of the non-medical professional fees and 2.1 percentage points of the Home Office/Related Organization Contract Labor cost weight into the Professional Fees: Labor-Related cost category. This amount was added to the portion of professional fees that we already identified as labor-related using the I–O data such as contracted advertising and marketing costs (approximately 0.5 percentage point of total costs), resulting in a Professional Fees: Labor-Related cost weight of 4.7 percent.

Comment: One commenter appreciated CMS's proposal to increase the labor-related share based on data that better reflects increased labor costs as a percentage of an IPF's overall cost structure. However, they disagreed with CMS's proposal to exclude from the labor-related share the proportion of non-medical professional services fees presumed to have been purchased outside of the hospital's labor market. The commenter disagreed with CMS's assertion/assumption that services purchased from national firms are not affected by the local labor market. The commenter stated that when hospitals seek professional services, the services they are seeking (such as, accounting, engineering, or management consulting) typically are not so unique that they could only be provided by regional or national firms. The commenter stated that CMS's own survey data support this conclusion, as approximately 64 percent of these services are sourced from firms in the local market. The commenter stated that costs of services purchased from firms outside the hospital's labor market should be included with the labor-related share of costs.

The commenter requested that CMS provide evidence that pricing for professional services provided by regional and national firms to hospitals is offered in a national market that is not subject to geographic cost variation. The commenter urged that, unless the agency can produce strong evidence that prices for professional services provided by firms outside of a hospital's local labor market are homogenous, CMS restore the 1.2 percentage points it proposed to reclassify to Professional Services: Nonlabor-Related to the Professional Services: Labor-Related category.

Response: We respectfully disagree with the commenter and continue to believe it is appropriate that a proportion of Accounting & Auditing, Legal, Engineering, and Management Consulting services costs purchased by hospitals should be excluded from the labor-related share.

As discussed in the RY 2007 IPF PPS final rule (71 FR 27061), RY 2009 IPF PPS (73 FR 25719) and the RY 2010 IPF PPS notices (74 FR 20373), to provide an adjustment for geographic wage levels, the labor-related portion of an IPF's payment is adjusted using an appropriate wage index. The purpose of the labor-related share is to reflect the proportion of the national PPS base payment rate that is adjusted by the hospital's wage index (representing the relative costs of their local labor market to the national average). Therefore, we include a cost category in the labor-related share if the costs are labor-intensive and vary with the local labor market.

As acknowledged by the commenter and confirmed by the survey of hospitals conducted by CMS in 2008 (as stated above), professional services can be purchased from local firms as well as national and regional professional services firms. It is not necessarily the case, as asserted by the commenter, that these national and regional firms have fees that match those in the local labor market even though providers have the option to utilize those firms. That is, fees for services purchased from firms outside the local labor market may differ from those that would be purchased in the local labor market for any number of reasons (including but not limited to, the skill level of the contracted personnel, higher capital costs, etc.). As noted earlier in this section of this final rule, the definition for the labor-related share requires the services to be purchased in the local labor market; therefore, CMS's allocation of approximately 64 percent of the Professional Fees cost weight allocated to the Professional Fees: Labor-Related cost weight based on the 2008 survey results [2] is consistent with the commenter's assertion that not all Professional Fees services are purchased

[2] The 64 percent value is based on a survey conducted by CMS in 2008 as detailed in the FY 2010 IPPS/LTCH PPS final rule (74 FR 43850 through 43856). This was also used to determine the Professional Fees: Labor-Related cost weight in the 2016-based IPF market basket.

in the local labor market. We believe it is reasonable to conclude that costs of those professional services purchased directly within the local labor market are directly related to local labor market conditions (which are reflected in the IPF's respective wage index) and, thus, should be included in the labor-related share. The remaining approximately 36 percent of Professional Fees costs which are purchased outside the local labor market reflects different and additional factors outside the local labor market and, thus, should be excluded from the labor-related share. In addition, we note the compensation costs of professional services provided by hospital employees (which would reflect the local labor market) are included in the labor-related share, as they are included in the Wages and Salaries and Benefit cost weights.

Therefore, for the reasons discussed, we believe our proposed methodology of allocating only a portion of Professional Fees to the Professional Fees: Labor-Related cost category is appropriate. As stated previously, effective for transmittal 18 (*https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Transmittals/r18p240i*), the hospital Medicare Cost Report (CMS Form 2552–10, OMB No. 0938–0050) is collecting information on whether a hospital purchased professional services (for example, legal, accounting, tax preparation, bookkeeping, payroll, advertising, and/or management/consulting services) from an unrelated organization and if the majority of these expenses were purchased from unrelated organizations located outside of the main hospital's local area labor market. We encourage all providers to provide this information for potential use in future rulemaking to determine the labor-related share.

Comment: One commenter did not support the proposed increase to the labor-related share. This commenter stated that any increase to the labor-related share percentage penalizes any facility that has a wage index less than 1.0. The commenter further stated that across the country, there is a growing disparity between high-wage and low-wage states that harms hospitals in many rural and underserved communities. The commenter stated that limiting the increase in the labor-related share would help mitigate that growing disparity and recommended that CMS consider excluding the labor portion of capital-related costs for FY 2024 and going forward.

Response: As discussed in section IV.D.1.a, the IPF PPS wage index is applied to the labor-related portion of an IPF's payment to provide an adjustment for geographic wage levels. The methodology to use the relative importance values for the labor-related cost categories from the most recent IPF market basket is consistent with the determination of the labor-related share since the implementation of the IPF PPS in 2007. The labor-related cost categories reflect IPF costs that are related to, influenced by, or vary with the local labor market, which would include a portion of the capital-related costs since the construction costs for capital infrastructure would be influenced by the local labor market. Therefore, we disagree with the commenter that we should exclude the labor portion of capital-related costs for FY 2024 and going forward.

Comment: One commenter disagreed with the assumption that home office compensation costs that occur outside of a hospital's labor market are not subject to geographic wage variation and stated that they do not believe that the proposed reclassification to the Professional Fees: Non-Labor-Related cost category is justified. The commenters stated that the proposed methodology fails to consider that the home office is essentially a part of the hospital, and thus the hospital, along with its home office, is operating in multiple labor markets. The commenters stated that the home office's portion of the hospital's labor costs should not be excluded from the labor-related share simply because they are not in the same labor market as the hospital.

The commenter conducted their own analysis of the Medicare cost report data showing that providers with a home office outside of their local labor market had wage indexes both below 1 as well as greater than 1. The commenter stated that those hospitals in a labor market with a wage index greater than 1 had mean home office average hourly wage costs that were greater than the mean home office average hourly wage costs of those hospitals in a labor market with a wage index less than 1. The commenter claimed that these data indicate that, contrary to CMS' assertion, home office salary, wage, and benefit costs for hospitals with home offices outside of their labor market are subject to geographic wage variation. The commenter requested that CMS allocate the full 4.7 percentage points of the Home Office/Related Organization cost weight to the labor-related share.

Response: As discussed in the RY 2007 IPF PPS final rule (71 FR 27061), RY 2009 IPF PPS (73 FR 25719) and the RY 2010 IPF PPS notices (74 FR 20373), to provide an adjustment for geographic wage levels, the labor-related portion of an IPF's payment is adjusted using an appropriate wage index. Due to the variation in costs and because of the differences in geographic wage levels, in the November 15, 2004 IPF PPS final rule, we required that payment rates under the IPF PPS be adjusted by a geographic wage index. We proposed and finalized a policy to use the unadjusted, pre-floor, pre-reclassified IPPS hospital wage index (representing the wage level in the geographic area of the hospital compared to the national average hospital wage level as specified under Section 1886(d)(3)(E)) to account for geographic differences in IPF labor costs. Therefore, consistent with the definition of labor-related share used for IPPS hospitals, we have included a cost category in the labor-related share for IPFs if the costs are labor-intensive and vary with the local labor market (that is, the geographic area of the hospital).

As the commenter stated, and as validated with the Medicare cost report data, a hospital's home office can be located outside the hospital's local labor market. For other types of professional services, we only include the costs for services purchased directly within the geographic area of the hospital in the labor-related share because they reflect the local labor market conditions that are consistent with the intent of the geographic adjustment. We believe it is reasonable to conclude that costs of those home office services purchased directly within the geographic area of the hospital should also be included in the labor-related share because they are impacted by local labor market conditions. As we have previously discussed in the RY 2007 final rule (71 FR 27066), we believe that the actual location of an IPF (as opposed to the location of affiliated providers) is most appropriate for determining the wage adjustment, because the prevailing wages in the area in which the IPF is located influence the cost of a case. And as we do for professional services, we believe home office costs that are not in the same geographic area as the hospital should be excluded from the labor-related share because they are influenced by factors outside of the hospital's local labor market. To implement this approach, we proposed a methodology that relies on the Medicare cost report data for hospitals reporting home office information to determine whether their home office is in the same geographic area of the hospital (which we define as the hospital's Metropolitan Statistical Area). Our methodology determined that 46 percent of the Home Office/Related Organization cost weight (reflecting compensation costs) are associated with

the geographic area of the hospital, whereas the remaining 54 percent of home office costs are purchased outside the geographic area of the hospital. Therefore, we believe our proposed methodology of only allocating the portion of the Home Office/Related Organization cost weight (46 percent) into the Professional Fees: Labor-Related cost weight that are purchased in the same geographic area as the hospital is appropriate as it is consistent with the intent of the geographic adjustment. In addition, we note that the compensation costs for hospital employees, which would reflect the local labor market performing the same tasks as home office personnel are included in the labor-related share as they are included in the Wages and Salaries and Employee Benefits cost weights.

As stated, we proposed to include in the labor-related share the sum of the relative importance of Wages and Salaries, Employee Benefits, Professional Fees: Labor-Related, Administrative and Facilities Support Services, Installation, Maintenance, and Repair Services, All Other: Labor-Related Services, and a portion of the Capital-Related cost weight from the 2021-based IPF market basket, as this meets our definition of the labor-related share with costs that are labor intensive and vary with the local labor market.

Final Decision: After consideration of public comments, we are finalizing the 2021-based IPF market basket proposed labor-related cost categories and base year cost weights as proposed.

We also proposed that if more recent data were subsequently available, we would use such data to determine the FY 2024 labor-related share in the final rule. Based on IGI's second quarter 2023 forecast for the 2021-based IPF market basket, the sum of the FY 2024 relative importance for Wages and Salaries, Employee Benefits, Professional Fees: Labor-Related, Administrative and Facilities Support Services, Installation Maintenance & Repair Services, and All Other: Labor-Related Services is 75.6 percent. The portion of Capital-Related costs that is influenced by the local labor market is estimated to be 46 percent, which is the same percentage applied to the 2016-based IPF market basket (84 FR 38446 through 38447). Since the relative importance for Capital-Related costs is 6.8 percent of the 2021-based IPF market basket in FY 2024, we took 46 percent of 6.8 percent to determine the labor-related share of Capital-Related costs for FY 2024 of 3.1 percent. Therefore, the total labor-related share for FY 2024 based on more recent data is 78.7 percent (the sum of 75.6 percent for the operating costs and 3.1 percent for the labor-related share of Capital-Related costs). Table 15 shows the FY 2024 labor-related share using the 2021-based IPF market basket relative importance and the FY 2023 labor-related share using the 2016-based IPF market basket.

TABLE 15: FY 2024 IPF Labor-Related Share and FY 2023 IPF Labor-Related Share

	FY 2024 Labor-related Share based on 2021-based IPF Market Basket[1]	FY 2023 Labor-related Share based on 2016-based IPF Market Basket[2]
Wages and Salaries	53.4	53.2
Employee Benefits	14.2	13.5
Professional Fees: Labor-Related[3]	4.7	4.3
Administrative and Facilities Support Services	0.6	0.6
Installation, Maintenance and Repair Services	1.2	1.3
All Other: Labor-Related Services	1.5	1.5
Subtotal	**75.6**	**74.4**
Labor-related portion of Capital-Related (46%)	3.1	3.0
Total Labor-Related Share (LRS)	**78.7**	**77.4**

1. IHS Global Inc. 2nd quarter 2023 forecast.
2. Based on IHS Global Inc. 2nd quarter 2022 forecast as published in the **Federal Register** (87 FR 46851).
3. Includes all contract advertising and marketing costs and a portion of accounting, architectural, engineering, legal, management consulting, and home office/related organization contract labor costs.

The FY 2024 labor-related share using the 2021-based IPF market basket is about 1.0 percentage point higher than the FY 2023 labor-related share using the 2016-based IPF market basket. This higher labor-related share is primarily due to the incorporation of the 2021 Medicare cost report data, which increased the Compensation cost weight by 0.9 percentage point compared to the 2016-based IPF market basket, as shown in Table 1 and Table 2 in section IV.A.3.a.(2) of this final rule.

B. Updates to the IPF PPS Rates for FY Beginning October 1, 2023

The IPF PPS is based on a standardized Federal per diem base rate calculated from the IPF average per diem costs and adjusted for budget neutrality in the implementation year. The Federal per diem base rate is used as the standard payment per day under the IPF PPS and is adjusted by the patient-level and facility-level adjustments that are applicable to the IPF stay. A detailed explanation of how we calculated the average per diem cost appears in the November 2004 IPF PPS final rule (69 FR 66926).

1. Determining the Standardized Budget-Neutral Federal Per Diem Base Rate

Section 124(a)(1) of the BBRA required that we implement the IPF PPS in a budget-neutral manner. In other words, the amount of total payments under the IPF PPS, including any payment adjustments, must be projected to be equal to the amount of total payments that would have been made if the IPF PPS were not implemented. Therefore, we calculated the budget neutrality factor by setting the total estimated IPF PPS payments to be equal to the total estimated payments that would have been made under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) (Pub. L. 97–248) methodology had the IPF PPS not been implemented. A step-by-step description of the methodology used to estimate payments under the Tax Equity and Fiscal Responsibility Act (TEFRA) payment system appears in the November 2004 IPF PPS final rule (69 FR 66926).

Under the IPF PPS methodology, we calculated the final Federal per diem base rate to be budget-neutral during the IPF PPS implementation period (that is, the 18-month period from January 1, 2005, through June 30, 2006) using a July 1 update cycle. We updated the average cost per day to the midpoint of the IPF PPS implementation period (October 1, 2005), and this amount was used in the payment model to establish the budget-neutrality adjustment.

Next, we standardized the IPF PPS Federal per diem base rate to account for the overall positive effects of the IPF PPS payment adjustment factors by dividing total estimated payments under the TEFRA payment system by estimated payments under the IPF PPS. The information concerning this standardization can be found in the November 2004 IPF PPS final rule (69 FR 66932) and the RY 2006 IPF PPS final rule (71 FR 27045). We then reduced the standardized Federal per diem base rate to account for the outlier policy, the stop loss provision, and anticipated behavioral changes. A complete discussion of how we calculated each component of the budget neutrality adjustment appears in the November 2004 IPF PPS final rule (69 FR 66932 through 66933) and in the RY 2007 IPF PPS final rule (71 FR 27044 through 27046). The final standardized budget-neutral Federal per diem base rate established for cost reporting periods beginning on or after January 1, 2005, was calculated to be $575.95.

The Federal per diem base rate has been updated in accordance with applicable statutory requirements and § 412.428 through publication of annual notices or proposed and final rules. A detailed discussion on the standardized budget-neutral Federal per diem base rate and the ECT payment per treatment appears in the FY 2014 IPF PPS update notice (78 FR 46738 through 46740). These documents are available on the CMS website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/index.html.*

IPFs must include a valid procedure code for ECT services provided to IPF beneficiaries in order to bill for ECT services, as described in our Medicare Claims Processing Manual, Chapter 3, Section 190.7.3 (available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf.*) There were no changes to the ECT procedure codes used on IPF claims as a result of the final update to the ICD–10–PCS code set for FY 2024. Addendum B to this final rule shows the ECT procedure codes for FY 2024 and is available on our website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/tools.html.*

2. Update of the Federal Per Diem Base Rate and Electroconvulsive Therapy Payment Per Treatment

The current (FY 2023) Federal per diem base rate is $865.63, and the ECT payment per treatment is $372.67. For the final FY 2024 Federal per diem base rate, we applied the payment rate update of 3.3 percent—that is, the 2021-based IPF market basket increase for FY 2024 of 3.5 percent less the productivity adjustment of 0.2 percentage point—and the wage index budget-neutrality factor of 1.0016 (as discussed in section IV.D.1 of this final rule) to the FY 2023 Federal per diem base rate of $865.63, yielding a final Federal per diem base rate of $895.63 for FY 2024. Similarly, we applied the 3.3 percent payment rate update and the 1.0016 wage index budget-neutrality factor to the FY 2023 ECT payment per treatment of $372.67, yielding a final ECT payment per treatment of $385.58 for FY 2024.

Section 1886(s)(4)(A)(i) of the Act requires that for RY 2014 and each subsequent RY, in the case of an IPF that fails to report required data under the IPFQR Program with respect to such RY, the Secretary will reduce any annual update to a standard federal rate for discharges during the RY by 2.0 percentage points. Therefore, we are applying a 2.0 percentage points reduction to the Federal per diem base rate and the ECT payment per treatment as follows:

- For IPFs that fail requirements under the IPFQR Program, we applied a 1.3 percent payment rate update—that is, the IPF market basket increase for FY 2024 of 3.5 percent less the productivity adjustment of 0.2 percentage point for an update of 3.3 percent, and further reduced by 2.0 percentage points in accordance with section 1886(s)(4)(A)(i) of the Act—and the wage index budget-neutrality factor of 1.0016 to the FY 2023 Federal per diem base rate of $865.63, yielding a Federal per diem base rate of $878.29 for FY 2024.

- For IPFs that fail to meet requirements under the IPFQR Program, we applied a 1.3 percent annual payment rate update and a 1.0016 wage index budget-neutrality factor to the FY 2023 ECT payment per treatment of $372.67 yielding an ECT payment per treatment of $378.12 for FY 2024. Lastly, we proposed that if more recent data became available, we would use such data, if appropriate, to determine the FY 2024 Federal per diem base rate and ECT payment per treatment for the final rule.

Finally, we note that in the April 10, 2023 IPF PPS proposed rule (88 FR 21259), there were two technical errors in describing the calculation of the FY 2024 proposed base rate and electroconvulsive therapy (ECT) payment per treatment for IPFs that fail to meet requirements under the Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program. In describing the calculation of the FY 2024 Federal per diem base rate for IPFs that fail to meet requirements under the IPFQR Program, we inadvertently stated that we applied the market basket update, reduced by 2.0 percentage points to the FY 2024 Federal per diem base rate and FY 2024 ECT payment per treatment. In accordance with our longstanding methodology, and with the actual calculation of these proposed payment updates, the description of these calculations should have used the FY 2023 Federal per diem rate and FY 2023 ECT payment per treatment rather than the FY 2024 Federal per diem rate and ECT payment per treatment. To be clear, these errors only affected the description of the starting values from which the rates were calculated, and the calculations themselves, as well as the rates indicated in the proposed rule, were correct and consistent with our longstanding methodology for updating the IPF Federal per diem base rate and ECT payment per treatment.

C. Updates to the IPF PPS Patient-Level Adjustment Factors

1. Overview of the IPF PPS Adjustment Factors

The IPF PPS payment adjustments were derived from a regression analysis of 100 percent of the FY 2002 Medicare Provider and Analysis Review (MedPAR) data file, which contained 483,038 cases. For a more detailed description of the data file used for the regression analysis, see the November 2004 IPF PPS final rule (69 FR 66935 through 66936). We proposed to use the existing regression-derived adjustment factors established in 2005 for FY 2024. However, we have used more recent claims data to simulate payments to finalize the outlier fixed dollar loss threshold amount and to assess the impact of the IPF PPS updates.

2. IPF PPS Patient-Level Adjustments

The IPF PPS includes payment adjustments for the following patient-level characteristics: Medicare Severity Diagnosis Related Groups (MS–DRGs) assignment of the patient's principal diagnosis, selected comorbidities, patient age, and the variable per diem adjustments.

a. Update to MS–DRG Assignment

We believe it is important to maintain for IPFs the same diagnostic coding and Diagnosis Related Group (DRG) classification used under the IPPS for providing psychiatric care. For this reason, when the IPF PPS was implemented for cost reporting periods beginning on or after January 1, 2005, we adopted the same diagnostic code set (ICD–9–CM) and DRG patient classification system (MS–DRGs) that were utilized at the time under the IPPS. In the RY 2009 IPF PPS notice (73 FR 25709), we discussed CMS's effort to better recognize resource use and the severity of illness among patients. CMS adopted the new MS–DRGs for the IPPS in the FY 2008 IPPS final rule with comment period (72 FR 47130). In the RY 2009 IPF PPS notice (73 FR 25716), we provided a crosswalk to reflect changes that were made under the IPF PPS to adopt the new MS–DRGs. For a detailed description of the mapping changes from the original DRG adjustment categories to the current MS–DRG adjustment categories, we refer readers to the RY 2009 IPF PPS notice (73 FR 25714).

The IPF PPS includes payment adjustments for designated psychiatric DRGs assigned to the claim based on the patient's principal diagnosis. The DRG adjustment factors were expressed relative to the most frequently reported psychiatric DRG in FY 2002, that is, DRG 430 (psychoses). The coefficient values and adjustment factors were derived from the regression analysis discussed in detail in the November 28, 2003 IPF PPS proposed rule (68 FR 66923; 66928 through 66933) and the November 15, 2004 IPF PPS final rule (69 FR 66933 through 66960). Mapping the DRGs to the MS–DRGs resulted in the current 17 IPF MS–DRGs, instead of the original 15 DRGs, for which the IPF PPS provides an adjustment. For FY 2024, we did not propose any changes to the IPF MS–DRG adjustment factors. Therefore, we are retaining the existing IPF MS–DRG adjustment factors.

In the FY 2015 IPF PPS final rule published August 6, 2014, in the **Federal Register** titled, ''Inpatient Psychiatric Facilities Prospective Payment System—Update for FY Beginning October 1, 2014 (FY 2015)'' (79 FR 45945 through 45947), we finalized conversions of the ICD–9–CM-based MS–DRGs to ICD–10–CM/PCS-based MS–DRGs, which were implemented on October 1, 2015. As discussed in the FY 2015 IPF PPS proposed rule (79 FR 26047) in more detail, every year, changes to the ICD–10–CM and the ICD–10–PCS coding system are addressed in the IPPS proposed and final rules. The changes to the codes are effective October 1 of each year and must be used by acute care hospitals as well as other providers to report diagnostic and procedure information. In accordance with § 412.428(e), the IPF PPS has always incorporated ICD–10–CM and ICD–10–PCS coding changes made in the annual IPPS update and will continue to do so. We will continue to publish coding changes in a Transmittal/Change Request, similar to how coding changes are announced by the IPPS and LTCH PPS. The coding changes relevant to the IPF PPS are also published in the IPF PPS proposed and final rules, or in IPF PPS update notices. Further information on the ICD–10–CM/PCS MS–DRG conversion project can be found on the CMS ICD–10–CM website at *https://www.cms.gov/Medicare/Coding/ICD10/ICD-10-MS-DRG-Conversion-Project.html.*

For FY 2024, we proposed to continue making the existing payment adjustment for psychiatric diagnoses that group to one of the existing 17 IPF MS–DRGs listed in Addendum A. Addendum A is available on our website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/tools.html.*. Psychiatric principal diagnoses that do not group to one of the 17 designated MS–DRGs will still receive the Federal per diem base rate and all other applicable adjustments, but the payment will not include an MS–DRG adjustment.

As we did not propose any changes to the IPF MS–DRG adjustment factors, we are retaining the existing IPF MS–DRG adjustment factors for FY 2024.

The diagnoses for each IPF MS–DRG will be updated as of October 1, 2023, using the final FY 2024 IPPS ICD–10–CM/PCS code sets. The FY 2024 IPPS/LTCH PPS final rule will include tables of the changes to the ICD–10–CM/PCS code sets, which underlie the FY 2024 IPF MS–DRGs. Both the FY 2024 IPPS final rule and the tables of final changes to the ICD–10–CM/PCS code sets, which underlie the FY 2024 MS–DRGs, will be available on the CMS IPPS website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html.*

Code First

As discussed in the ICD–10–CM Official Guidelines for Coding and Reporting, certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology. For such conditions, the ICD–10–CM has a coding convention that requires the underlying condition be sequenced first followed by the manifestation. Wherever such a combination exists, there is a ''use additional code'' note at the etiology code, and a ''code first'' note at the manifestation code. These instructional notes indicate the proper sequencing order of the codes (etiology followed by manifestation). In accordance with the ICD–10–CM Official Guidelines for Coding and Reporting, when a primary (psychiatric) diagnosis code has a ''code first'' note, the provider will follow the instructions in the ICD–10–CM Tabular List. The submitted claim goes through the CMS processing system, which will identify the principal diagnosis code as non-psychiatric and search the secondary codes for a psychiatric code to assign a DRG code for adjustment. The system will continue to search the secondary codes for those that are appropriate for comorbidity adjustment.

For more information on the code first policy, we refer our readers to the November 2004 IPF PPS final rule (69 FR 66945), and see sections I.A.13 and I.B.7 of the FY 2020 ICD–10–CM Coding Guidelines, available at *https://www.cdc.gov/nchs/data/icd/10cmguidelines-FY2020_final.pdf.* In the FY 2015 IPF PPS final rule, we provided a code first table for reference that highlights the same or similar manifestation codes where the code first

instructions apply in ICD–10–CM that were present in ICD–10–CM (79 FR 46009). In FY 2018, FY 2019 and FY 2020, there were no changes to the final ICD–10–CM codes in the IPF Code First table. For FY 2021 and FY 2022, there were 18 ICD–10–CM codes deleted from the final IPF Code First table. For FY 2023, there were 2 ICD–10–CM codes deleted and 48 ICD–10–CM codes added to the IPF Code First table.

For FY 2024, there were no proposed changes to the Code First Table. For this final rule, we are finalizing the deletion of 1 ICD–10–CM code and the addition of 5 ICD–10–CM codes as ''code first'' codes. There are 26 codes whose ''code first'' codes are being updated in the IPF Code First Table to reflect these changes In accordance with our longstanding practice for the IPF PPS and with § 412.428(e), we are adopting these latest ICD–10–CM changes for October, 2023 and describing these changes in this FY 2024 IPF PPS final rule. The FY 2024 Code First table is shown in Addendum B on the CMS website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/tools.html.*

b. Payment for Comorbid Conditions

The intent of the comorbidity adjustments is to recognize the increased costs associated with comorbid conditions by providing additional payments for certain existing medical or psychiatric conditions that are expensive to treat. In our RY 2012 IPF PPS final rule (76 FR 26451 through 26452), we explained that the IPF PPS includes 17 comorbidity categories and identified the new, revised, and deleted ICD–9–CM diagnosis codes that generate a comorbid condition payment adjustment under the IPF PPS for RY 2012 (76 FR 26451).

Comorbidities are specific patient conditions that are secondary to the patient's principal diagnosis and that require treatment during the stay. Diagnoses that relate to an earlier episode of care and have no bearing on the current hospital stay are excluded and must not be reported on IPF claims. Comorbid conditions must exist at the time of admission or develop subsequently, and affect the treatment received, LOS, or both treatment and LOS.

For each claim, an IPF may receive only one comorbidity adjustment within a comorbidity category, but it may receive an adjustment for more than one comorbidity category. Current billing instructions for discharge claims, on or after October 1, 2015, require IPFs to enter the complete ICD–10–CM codes for up to 24 additional diagnoses if they co-exist at the time of admission, or develop subsequently and impact the treatment provided.

The comorbidity adjustments were determined based on the regression analysis using the diagnoses reported by IPFs in FY 2002. The principal diagnoses were used to establish the DRG adjustments and were not accounted for in establishing the comorbidity category adjustments, except where ICD–9–CM code first instructions applied. In a code first situation, the submitted claim goes through the CMS processing system, which will identify the principal diagnosis code as non-psychiatric and search the secondary codes for a psychiatric code to assign an MS–DRG code for adjustment. The system will continue to search the secondary codes for those that are appropriate for comorbidity adjustment.

As noted previously, it is our policy to maintain the same diagnostic coding set for IPFs that is used under the IPPS for providing the same psychiatric care. The 17 comorbidity categories formerly defined using ICD–9–CM codes were converted to ICD–10–CM/PCS in our FY 2015 IPF PPS final rule (79 FR 45947 through 45955). The goal for converting the comorbidity categories is referred to as replication, meaning that the payment adjustment for a given patient encounter is the same after ICD–10–CM implementation as it would be if the same record had been coded in ICD–9–CM and submitted prior to ICD–10–CM/PCS implementation on October 1, 2015. All conversion efforts were made with the intent of achieving this goal. For FY 2024, we proposed to use the same comorbidity adjustment factors in effect in FY 2023. The FY 2024 comorbidity adjustment factors are found in Addendum A, available on the CMS website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/tools.html.*

For FY 2024, we proposed to add 2 ICD–10–CM codes and remove 1 ICD–10–CM code from the Chronic Renal Failure category. We did not receive any comments on this proposal, and we are finalizing these changes as proposed. In addition, we are adding 2 ICD–10–CM codes to the Chronic Obstructive Pulmonary Disease category, 1 ICD–10–CM code to the Infectious Disease category, 4 ICD–10–CM codes to the Poisoning category, 6 ICD–10–PCS codes for the Oncology Treatment Procedure category. For the Oncology Treatment Diagnosis Category, we are adding 12 ICD–10–CM codes and deleting 2 ICD–10–CM codes. Finally, for the Acute Renal Failure Category, we are adding 1 ICD–10–CM code and deleting 1 ICD–10_CM code. In accordance with our longstanding practice for the IPF PPS and with § 412.428(e), we are adopting these latest ICD–10–CM changes for October, 2023 and describing these changes in this FY 2024 IPF PPS final rule.

The FY 2024 comorbidity codes are shown in Addenda B, available on the CMS website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/tools.html.*

In accordance with the policy established in the FY 2015 IPF PPS final rule (79 FR 45949 through 45952), we reviewed all new FY 2024 ICD–10–CM codes to remove codes that were site ''unspecified'' in terms of laterality from the FY 2024 ICD–10–CM/PCS codes in instances where more specific codes are available. As we stated in the FY 2015 IPF PPS final rule, we believe that specific diagnosis codes that narrowly identify anatomical sites where disease, injury, or a condition exists should be used when coding patients' diagnoses whenever these codes are available. We finalized in the FY 2015 IPF PPS rule, that we will remove site ''unspecified'' codes from the IPF PPS ICD–10–CM/PCS codes in instances when laterality codes (site specified codes) are available, as the clinician should be able to identify a more specific diagnosis based on clinical assessment at the medical encounter. None of the finalized additions to the FY 2024 ICD–10–CM/PCS codes were site ''unspecified'' by laterality; therefore, we are not removing any of the new codes.

c. Patient Age Adjustments

As explained in the November 2004 IPF PPS final rule (69 FR 66922), we analyzed the impact of age on per diem cost by examining the age variable (range of ages) for payment adjustments. In general, we found that the cost per day increases with age. The older age groups are costlier than the under 45 age group, the differences in per diem cost increase for each successive age group, and the differences are statistically significant. For FY 2024, we proposed continuing to use the patient age adjustments currently in effect for FY 2023, as shown in Addendum A of this final rule (see *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/tools.html*).

As we did not propose any changes to the patient age adjustment factors, we are retaining the existing patient age adjustment factors for FY 2024.

d. Variable Per Diem Adjustments

We explained in the November 2004 IPF PPS final rule (69 FR 66946) that the regression analysis indicated that per diem cost declines as the LOS increases. The variable per diem adjustments to the Federal per diem base rate account for ancillary and administrative costs that occur disproportionately in the first days after admission to an IPF. As discussed in the November 2004 IPF PPS final rule, we used a regression analysis to estimate the average differences in per diem cost among stays of different lengths (69 FR 66947 through 66950). As a result of this analysis, we established variable per diem adjustments that begin on day 1 and decline gradually until day 21 of a patient's stay. For day 22 and thereafter, the variable per diem adjustment remains the same each day for the remainder of the stay. However, the adjustment applied to day 1 depends upon whether the IPF has a qualifying ED. If an IPF has a qualifying ED, it receives a 1.31 adjustment factor for day 1 of each stay. If an IPF does not have a qualifying ED, it receives a 1.19 adjustment factor for day 1 of the stay. The ED adjustment is explained in more detail in section IV.D.4 of this final rule.

For FY 2024, we proposed to use the variable per diem adjustment factors currently in effect in FY 2023, as shown in Addendum A to this final rule (available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/tools.html*). A complete discussion of the variable per diem adjustments appears in the November 2004 IPF PPS final rule (69 FR 66946).

As we did not propose any changes to the variable per diem adjustment factors, we are retaining the existing variable per diem adjustment factors for FY 2024.

D. Updates to the IPF PPS Facility-Level Adjustments

The IPF PPS includes facility-level adjustments for the wage index, IPFs located in rural areas, teaching IPFs, cost of living adjustments for IPFs located in Alaska and Hawaii, and IPFs with a qualifying ED.

1. Wage Index Adjustment

a. Background

As discussed in the RY 2007 IPF PPS final rule (71 FR 27061), RY 2009 IPF PPS (73 FR 25719) and the RY 2010 IPF PPS notices (74 FR 20373), to provide an adjustment for geographic wage levels, the labor-related portion of an IPF's payment is adjusted using an appropriate wage index. Currently, an IPF's geographic wage index value is determined based on the actual location of the IPF in an urban or rural area, as defined in 42 CFR 412.64(b)(1)(ii)(A) and (C).

Due to the variation in costs and because of the differences in geographic wage levels, in the November 15, 2004 IPF PPS final rule, we required that payment rates under the IPF PPS be adjusted by a geographic wage index. We proposed and finalized a policy to use the unadjusted, pre-floor, pre-reclassified IPPS hospital wage index to account for geographic differences in IPF labor costs. We implemented use of the pre-floor, pre-reclassified IPPS hospital wage data to compute the IPF wage index since there was not an IPF-specific wage index available. We believe that IPFs generally compete in the same labor market as IPPS hospitals, so the pre-floor, pre-reclassified IPPS hospital wage data should be reflective of labor costs of IPFs. We believe this pre-floor, pre-reclassified IPPS hospital wage index to be the best available data to use as proxy for an IPF specific wage index. As discussed in the RY 2007 IPF PPS final rule (71 FR 27061 through 27067), under the IPF PPS, the wage index is calculated using the IPPS wage index for the labor market area in which the IPF is located, without considering geographic reclassifications, floors, and other adjustments made to the wage index under the IPPS. For a complete description of these IPPS wage index adjustments, we refer readers to the FY 2019 IPPS/LTCH PPS final rule (83 FR 41362 through 41390). Our wage index policy at § 412.424(a)(2), requires that we use the best Medicare data available to estimate costs per day, including an appropriate wage index to adjust for wage differences.

When the IPF PPS was implemented in the November 15, 2004 IPF PPS final rule, with an effective date of January 1, 2005, the pre-floor, pre-reclassified IPPS hospital wage index that was available at the time was the FY 2005 pre-floor, pre-reclassified IPPS hospital wage index. Historically, the IPF wage index for a given RY has used the pre-floor, pre-reclassified IPPS hospital wage index from the prior FY as its basis. This has been due in part to the pre-floor, pre-reclassified IPPS hospital wage index data that were available during the IPF rulemaking cycle, where an annual IPF notice or IPF PPS final rule was usually published in early May. This publication timeframe was relatively early compared to other Medicare payment rules, because the IPF PPS follows a RY, which was defined in the implementation of the IPF PPS as the 12-month period from July 1 to June 30 (69 FR 66927). Therefore, the best available data at the time the IPF PPS was implemented was the pre-floor, pre-reclassified IPPS hospital wage index from the prior FY (for example, the RY 2006 IPF wage index was based on the FY 2005 pre-floor, pre-reclassified IPPS hospital wage index).

In the RY 2012 IPF PPS final rule, we changed the reporting year timeframe for IPFs from a RY to the FY, which begins October 1 and ends September 30 (76 FR 26434 through 26435). In that RY 2012 IPF PPS final rule, we continued our established policy of using the pre-floor, pre-reclassified IPPS hospital wage index from the prior year (that is, from FY 2011) as the basis for the FY 2012 IPF wage index. This policy of basing a wage index on the prior year's pre-floor, pre-reclassified IPPS hospital wage index has been followed by other Medicare payment systems, such as hospice and inpatient rehabilitation facilities. By continuing with our established policy, we remained consistent with other Medicare payment systems.

In FY 2020, we finalized the IPF wage index methodology to align the IPF PPS wage index with the same wage data timeframe used by the IPPS for FY 2020 and subsequent years. Specifically, we finalized to use the pre-floor, pre-reclassified IPPS hospital wage index from the FY concurrent with the IPF FY as the basis for the IPF wage index. For example, the FY 2020 IPF wage index was based on the FY 2020 pre-floor, pre-reclassified IPPS hospital wage index rather than on the FY 2019 pre-floor, pre-reclassified IPPS hospital wage index.

We explained in the FY 2020 proposed rule (84 FR 16973), that using the concurrent pre-floor, pre-reclassified IPPS hospital wage index will result in the most up-to-date wage data being the basis for the IPF wage index. It will also result in more consistency and parity in the wage index methodology used by other Medicare payment systems. The Medicare SNF PPS already used the concurrent IPPS hospital wage index data as the basis for the SNF PPS wage index. Thus, the wage adjusted Medicare payments of various provider types will be based upon wage index data from the same timeframe. CMS proposed similar policies to use the concurrent pre-floor, pre-reclassified IPPS hospital wage index data in other Medicare payment systems, such as hospice and inpatient rehabilitation facilities. For FY 2024, we proposed to continue using the concurrent pre-floor, pre-reclassified IPPS hospital wage

index as the basis for the IPF wage index.

We proposed to apply the IPF wage index adjustment to the labor-related share of the national base rate and ECT payment per treatment. The labor-related share of the national rate and ECT payment per treatment would change from 77.4 percent in FY 2023 to 78.7 percent in FY 2024. This percentage reflects the labor-related share of the 2021-based IPF market basket for FY 2024 (see section IV.A of this final rule).

Comment: Several commenters urged CMS to revise the IPF wage index methodology. Specifically, a few commenters suggested CMS revise the policy so that the post-reclassification and post-floor hospital IPPS wage index is used to calculate the wage index for IPFs. The commenter believes that the continued use of the pre-reclassification and pre-floor hospital inpatient wage index is unreasonable because it places IPFs at a disadvantage in the labor markets in which they operate relative to hospitals in the same markets.

Other commenters suggested CMS exercise its authority to refine the IPF PPS by applying the pre-floor, pre-reclassified IPPS hospital wage index for the CBSA in which the nearest IPPS hospital is located where the pre-floor, pre-classified IPPS hospital wage index for the CBSA in which the IPF is located only includes data from a closed IPPS hospital. Commenters stated they believe the closed hospital data is more likely to be unreliable such that the application of the pre-floor, pre-reclassified IPPS hospital wage index would result in an inappropriately deflated wage index value. Commenters further asserted that the closure of the only IPPS hospital in the CBSA would suggest that the community is currently underserved, and would make it particularly appropriate to ensure that aberrant wage index data does not serve as an impediment to new IPF services in a community.

Response: We appreciate the commenters' recommendations. We did not propose the specific policies suggested by commenters, but we will take them into consideration to potentially inform future rulemaking. We do not believe that the continued use of the pre-reclassification and pre-floor hospital inpatient wage index for FY 2024 is unreasonable or that this policy puts IPFs at a disadvantage relative to hospitals in the labor markets in which they operate. As we have previously discussed in the RY 2007 final rule (71 FR 27066), we believe that the actual location of an IPF (as opposed to the location of affiliated providers) is most appropriate for determining the wage adjustment, because the prevailing wages in the area in which the IPF is located influence the cost of a case. In that same RY 2007 final rule (71 FR 27066), we also stated that we believe the ''rural floor'' is required only for the acute care hospital payment system, because section 4410 of the Balanced Budget Act of 1997 (Pub. L. 105–33) applies specifically to acute care hospitals and not excluded hospitals and excluded units. As we have previously discussed, the IPF wage index is intended to be a relative measure of the value of labor in prescribed labor market areas (87 FR 46857). There is a variety of reasons why our longstanding IPF wage index policy has not applied floors or reclassifications, which as we previously noted, are not applied to the IPF wage index by statute. For example, applying floors and reclassifications to the IPF wage index would significantly increase administrative burden, both for IPFs and for CMS, that would be associated with IPFs reclassifying from one CBSA to another, and it would significantly increase the complexity of the methodology. Furthermore, because floors and reclassifications would be applied budget-neutrally under the wage index, these policies would increase the wage index for some IPFs while reducing IPF PPS payments for all other IPFs, which would upset the long-settled expectations with which IPFs across the country have been operating. For these reasons, we believe using the pre-floor, pre-reclassified IPPS hospital wage index is the most appropriate data to use as a proxy for an IPF wage index.

Regarding the suggestion to apply the wage index for the CBSA of the nearest IPPS hospital in cases when an IPF's CBSA includes only a closed IPPS hospital, we disagree with the commenter that wage data from a hospital that has subsequently closed is more likely to be unreliable and that such data would inappropriately deflate the wage index for that CBSA. Rather, following the longstanding methodology for calculating the wage index, wage data from the period during which the hospital was open would be comparable to wage data from the same period for hospitals located in other geographical areas, and would provide an appropriate relative measure of the value of labor in that CBSA's labor market area compared to others. We do not believe that such wage data or the wage index of a CBSA in this situation would serve as an impediment for either new or existing IPF services in a community. In addition, we recognize that in some cases, the closure of the only IPPS hospital in the CBSA could suggest that the community is underserved; however, in other cases, the lack of an IPPS hospital could be due to other factors, such as when an area's only IPPS hospital converts to another hospital type such as a CAH. We note that at this time, there is only one urban CBSA with no IPPS hospitals; however, there are also no IPFs located in this CBSA.

Lastly, as discussed in the FY 2024 IPPS proposed rule (88 FR 26966) in constructing the proposed FY 2024 wage index, wage data was included for facilities that were IPPS hospitals in FY 2020, inclusive of those facilities that have since terminated their participation in the program as hospitals, as long as those data did not fail any of our edits for reasonableness. We believe that including the wage data for these hospitals is, in general, appropriate to reflect the economic conditions in the various labor market areas during the relevant past period and to ensure that the current wage index represents the labor market area's current wages as compared to the national average of wages.

Final Decision: After consideration of the comments received, we are finalizing our proposal for FY 2024 to continue to use the concurrent pre-floor, pre-reclassified IPPS hospital wage index as the basis for the IPF wage index.

We will apply the IPF wage index adjustment to the labor-related share of the national base rate and ECT payment per treatment. The labor-related share of the national rate and ECT payment per treatment will change from 77.4 percent in FY 2023 to 78.7 percent in FY 2024. This percentage reflects the labor-related share of the 2021-based IPF market basket for FY 2024 (see section IV.A.5 of this final rule).

b. Office of Management and Budget (OMB) Bulletins

i. Background

The wage index used for the IPF PPS is calculated using the unadjusted, pre-reclassified and pre-floor IPPS wage index data and is assigned to the IPF on the basis of the labor market area in which the IPF is geographically located. IPF labor market areas are delineated based on the CBSAs established by the OMB.

Generally, OMB issues major revisions to statistical areas every 10 years, based on the results of the decennial census. However, OMB occasionally issues minor updates and revisions to statistical areas in the years

between the decennial censuses through OMB Bulletins. These bulletins contain information regarding CBSA changes, including changes to CBSA numbers and titles. OMB bulletins may be accessed online at *https://www.whitehouse.gov/wp-content/uploads/2020/03/Bulletin-20-01.pdf.* In accordance with our established methodology, the IPF PPS has historically adopted any CBSA changes that are published in the OMB bulletin that corresponds with the IPPS hospital wage index used to determine the IPF wage index and, when necessary and appropriate, has proposed and finalized transition policies for these changes.

In the RY 2007 IPF PPS final rule (71 FR 27061 through 27067), we adopted the changes discussed in the OMB Bulletin No. 03–04 (June 6, 2003), which announced revised definitions for Micropolitan Statistical Areas and the creation of Micropolitan Statistical Areas and Combined Statistical Areas. In adopting the OMB CBSA geographic designations in RY 2007, we did not provide a separate transition for the CBSA-based wage index since the IPF PPS was already in a transition period from TEFRA payments to PPS payments.

In the RY 2009 IPF PPS notice, we incorporated the CBSA nomenclature changes published in the most recent OMB bulletin that applied to the IPPS hospital wage index used to determine the current IPF wage index and stated that we expected to continue to do the same for all the OMB CBSA nomenclature changes in future IPF PPS rules and notices, as necessary (73 FR 25721).

Subsequently, CMS adopted the changes that were published in past OMB bulletins in the FY 2016 IPF PPS final rule (80 FR 46682 through 46689), the FY 2018 IPF PPS rate update (82 FR 36778 through 36779), the FY 2020 IPF PPS final rule (84 FR 38453 through 38454), and the FY 2021 IPF PPS final rule (85 FR 47051 through 47059). We direct readers to each of these rules for more information about the changes that were adopted and any associated transition policies.

In part due to the scope of changes involved in adopting the CBSA delineations for FY 2021, we finalized a 2-year transition policy consistent with our past practice of using transition policies to help mitigate negative impacts on hospitals of certain wage index policy changes. We applied a 5-percent cap on wage index decreases to all IPF providers that had any decrease in their wage indexes, regardless of the circumstance causing the decline, so that an IPF's final wage index for FY 2021 will not be less than 95 percent of its final wage index for FY 2020, regardless of whether the IPF was part of an updated CBSA. We refer readers to the FY 2021 IPF PPS final rule (85 FR 47058 through 47059) for a more detailed discussion about the wage index transition policy for FY 2021.

On March 6, 2020 OMB issued OMB Bulletin 20–01 (available on the web at *https://www.whitehouse.gov/wp-content/uploads/2020/03/Bulletin-20-01.pdf*). In considering whether to adopt this bulletin, we analyzed whether the changes in this bulletin would have a material impact on the IPF PPS wage index. This bulletin creates only one Micropolitan statistical area. As discussed in further detail in section IV.D.1.b.ii of this final rule, since Micropolitan areas are considered rural for the IPF PPS wage index, this bulletin has no material impact on the IPF PPS wage index. That is, the constituent county of the new Micropolitan area was considered rural effective as of FY 2021 and would continue to be considered rural if we adopted OMB Bulletin 20–01. Therefore, we did not propose to adopt OMB Bulletin 20–01 in the FY 2022 IPF PPS proposed rule.

In the FY 2023 IPF PPS final rule (87 FR 46856 through 46859), we finalized a permanent 5-percent cap on any decrease to a provider's wage index from its wage index in the prior year, and we stated that we would apply this cap in a budget-neutral manner. Additionally, we finalized a policy that a new IPF would be paid the wage index for the area in which it is geographically located for its first full or partial FY with no cap applied because a new IPF would not have a wage index in the prior FY. We amended the IPF PPS regulations at § 412.424(d)(1)(i) to reflect this permanent cap on wage index decreases. We refer readers to the FY 2023 IPF PPS final rule for a more detailed discussion about this policy.

ii. Micropolitan Statistical Areas (MSA)

OMB defines a ''Micropolitan Statistical Area'' as a CBSA associated with at least one urban cluster that has a population of at least 10,000, but less than 50,000 (75 FR 37252). We refer to these as Micropolitan Areas. After extensive impact analysis, consistent with the treatment of these areas under the IPPS as discussed in the FY 2005 IPPS final rule (69 FR 49029 through 49032), we determined the best course of action would be to treat Micropolitan Areas as ''rural'' and include them in the calculation of each state's IPF PPS rural wage index. We refer the reader to the FY 2007 IPF PPS final rule (71 FR 27064 through 27065) for a complete discussion regarding treating Micropolitan Areas as rural.

c. Adjustment for Rural Location

In the November 2004 IPF PPS final rule, (69 FR 66954), we provided a 17 percent payment adjustment for IPFs located in a rural area. This adjustment was based on the regression analysis, which indicated that the per diem cost of rural facilities was 17 percent higher than that of urban facilities after accounting for the influence of the other variables included in the regression. This 17 percent adjustment has been part of the IPF PPS each year since the inception of the IPF PPS. For FY 2024, we proposed to apply a 17 percent payment adjustment for IPFs located in a rural area as defined at § 412.64(b)(1)(ii)(C) (see 69 FR 66954 for a complete discussion of the adjustment for rural locations).

d. Budget Neutrality Adjustment

Changes to the wage index are made in a budget-neutral manner so that updates do not increase expenditures. Therefore, for FY 2024, we proposed to apply a budget-neutrality adjustment in accordance with our existing budget-neutrality policy. This policy requires us to update the wage index in such a way that total estimated payments to IPFs for FY 2024 are the same with or without the changes (that is, in a budget-neutral manner) by applying a budget-neutrality factor to the IPF PPS rates. We use the following steps to ensure that the rates reflect the FY 2024 update to the wage indexes (based on the FY 2020 hospital cost report data) and the labor-related share in a budget-neutral manner:

Step 1: Simulate estimated IPF PPS payments, using the FY 2023 IPF wage index values (available on the CMS website) and labor-related share (as published in the FY 2023 IPF PPS final rule (87 FR 46846).

Step 2: Simulate estimated IPF PPS payments using the FY 2024 IPF wage index values (available on the CMS website) and FY 2024 labor-related share (based on the latest available data as discussed previously).

Step 3: Divide the amount calculated in step 1 by the amount calculated in step 2. The resulting quotient is the FY 2024 budget-neutral wage adjustment factor of 1.0016.

Step 4: Apply the FY 2024 budget-neutral wage adjustment factor from step 3 to the FY 2023 IPF PPS Federal per diem base rate after the application of the market basket update described in section IV.A of this final rule, to determine the FY 2024 IPF PPS Federal per diem base rate.

2. Teaching Adjustment

a. Background

In the November 2004 IPF PPS final rule, we implemented regulations at § 412.424(d)(1)(iii) to establish a facility-level adjustment for IPFs that are, or are part of, teaching hospitals. The teaching adjustment accounts for the higher indirect operating costs experienced by hospitals that participate in graduate medical education (GME) programs. The payment adjustments are made based on the ratio of the number of fulltime equivalent (FTE) interns and residents training in the IPF and the IPF's average daily census.

Medicare makes direct GME payments (for direct costs such as resident and teaching physician salaries, and other direct teaching costs) to all teaching hospitals including those paid under a PPS, and those paid under the TEFRA rate-of-increase limits. These direct GME payments are made separately from payments for hospital operating costs and are not part of the IPF PPS. The direct GME payments do not address the estimated higher indirect operating costs teaching hospitals may face.

The results of the regression analysis of FY 2002 IPF data established the basis for the payment adjustments included in the November 2004 IPF PPS final rule. The results showed that the indirect teaching cost variable is significant in explaining the higher costs of IPFs that have teaching programs. We calculated the teaching adjustment based on the IPF's ''teaching variable'', which is (1 + [the number of FTE residents training in the IPF's average daily census]). The teaching variable is then raised to the 0.5150 power to result in the teaching adjustment. This formula is subject to the limitations on the number of FTE residents, which are described in this section of this final rule.

We established the teaching adjustment in a manner that limited the incentives for IPFs to add FTE residents for the purpose of increasing their teaching adjustment. We imposed a cap on the number of FTE residents that may be counted for purposes of calculating the teaching adjustment. The cap limits the number of FTE residents that teaching IPFs may count for the purpose of calculating the IPF PPS teaching adjustment, not the number of residents teaching institutions can hire or train. We calculated the number of FTE residents that trained in the IPF during a ''base year'' and used that FTE resident number as the cap. An IPF's FTE resident cap is ultimately determined based on the final settlement of the IPF's most recent cost report filed before November 15, 2004 (69 FR 66955). A complete discussion of the temporary adjustment to the FTE cap to reflect residents due to hospital closure or residency program closure appears in the RY 2012 IPF PPS proposed rule (76 FR 5018 through 5020) and the RY 2012 IPF PPS final rule (76 FR 26453 through 26456).

In the regression analysis, the logarithm of the teaching variable had a coefficient value of 0.5150. We converted this cost effect to a teaching payment adjustment by treating the regression coefficient as an exponent and raising the teaching variable to a power equal to the coefficient value. We note that the coefficient value of 0.5150 was based on the regression analysis holding all other components of the payment system constant. A complete discussion of how the teaching adjustment was calculated appears in the November 2004 IPF PPS final rule (69 FR 66954 through 66957) and the RY 2009 IPF PPS notice (73 FR 25721). As with other adjustment factors derived through the regression analysis, we do not plan to propose updates to the teaching adjustment factors until we more fully analyze IPF PPS data. Therefore, in this FY 2024 final rule, we are retaining the coefficient value of 0.5150 for the teaching adjustment to the Federal per diem base rate.

Comment: One commenter recommended CMS update its methodology for calculating the IPF teaching adjustment, particularly in recognition of the Congress authorizing the awarding of new Medicare-reimbursable residency positions under the CAA, 2023 and the Consolidated Appropriations Act, 2021 (hereafter referred to as CAA, 2021) (Pub. L. 116–260). This commenter suggested CMS collect information on awards of new Medicare residency positions under section 126 of division CC, CAA, 2021 and section 4122 of CAA, 2023 from those hospitals subject to the IPF so that it can provide resident FTE cap increases under the IPF for those hospitals that receive awards for psychiatry programs.

One commenter requested that CMS permit IPFs to aggregate and adjust their FTE caps through affiliation agreements. The commenter noted training residents often indirectly increases the hospital's operational costs, but freestanding IPFs that take over this role are unable to receive any corresponding payment increase that was previously available to the host-hospital distinct part unit (DPU).

Response: We appreciate the commenter's suggestion regarding potential changes to the IPF teaching adjustment to recognize new Medicare-reimbursable residency positions under the CAA, 2023 and the CAA, 2021. The CAA, 2021 and CAA, 2023 established resident slots for direct medical education and indirect medical education, which are paid under the IPPS. We will take this comment into consideration to potentially inform future rulemaking for the IPF PPS.

Regarding the commenter's suggestion to recognize affiliation agreements, we did not propose to recognize affiliation agreements for the IPF PPS teaching adjustment and are not making a change to this policy. As we previously stated in the RY 2005 IPF PPS final rule (69 FR 66956), our intent is not to affect affiliation agreements and rotational arrangements for hospitals that have residents that train in more than one hospital. We have not implemented a provision concerning affiliation agreements specifically pertaining to the FTE caps used in the teaching adjustment under the IPF PPS.

Final Decision: We are finalizing as proposed to calculate the IPF teaching adjustment according to our established methodology.

3. Cost of Living Adjustment (COLA) for IPFs Located in Alaska and Hawaii

The IPF PPS includes a payment adjustment for IPFs located in Alaska and Hawaii based upon the area in which the IPF is located. As we explained in the November 2004 IPF PPS final rule, the FY 2002 data demonstrated that IPFs in Alaska and Hawaii had per diem costs that were disproportionately higher than other IPFs. Other Medicare prospective payment systems (for example, the IPPS and LTCH PPS) adopted a COLA to account for the cost differential of care furnished in Alaska and Hawaii.

We analyzed the effect of applying a COLA to payments for IPFs located in Alaska and Hawaii. The results of our analysis demonstrated that a COLA for IPFs located in Alaska and Hawaii will improve payment equity for these facilities. As a result of this analysis, we provided a COLA in the November 2004 IPF PPS final rule.

A COLA for IPFs located in Alaska and Hawaii is made by multiplying the non-labor-related portion of the Federal per diem base rate by the applicable COLA factor based on the COLA area in which the IPF is located.

The COLA factors through 2009 were published by the Office of Personnel Management (OPM), and the OPM memo showing the 2009 COLA factors is available at *https://www.chcoc.gov/*

content/nonforeign-area-retirement-equity-assurance-act.

We note that the COLA areas for Alaska are not defined by county as are the COLA areas for Hawaii. In 5 CFR 591.207, the OPM established the following COLA areas:

- City of Anchorage, and 80-kilometer (50-mile) radius by road, as measured from the Federal courthouse.
- City of Fairbanks, and 80-kilometer (50-mile) radius by road, as measured from the Federal courthouse.
- City of Juneau, and 80-kilometer (50-mile) radius by road, as measured from the Federal courthouse.
- Rest of the state of Alaska.

As stated in the November 2004 IPF PPS final rule, we update the COLA factors according to updates established by the OPM. However, sections 1911 through 1919 of the Non-foreign Area Retirement Equity Assurance Act, as contained in subtitle B of title XIX of the National Defense Authorization Act (NDAA) (Pub. L. 111–84, October 28, 2009), for FY 2010 transitions the Alaska and Hawaii COLAs to locality pay. Under section 1914 of NDAA, locality pay was phased in over a 3-year period beginning in January 2010, with COLA rates frozen as of the date of enactment, October 28, 2009, and then proportionately reduced to reflect the phase-in of locality pay.

When we published the proposed COLA factors in the RY 2012 IPF PPS proposed rule (76 FR 4998), we inadvertently selected the FY 2010 COLA rates, which had been reduced to account for the phase-in of locality pay. We did not intend to propose the reduced COLA rates because that would have understated the adjustment. Since the 2009 COLA rates did not reflect the phase-in of locality pay, we finalized the FY 2009 COLA rates for RY 2010 through RY 2014.

In the FY 2013 IPPS/LTCH final rule (77 FR 53700 through 53701), we established a new methodology to update the COLA factors for Alaska and Hawaii and adopted this methodology for the IPF PPS in the FY 2015 IPF PPS final rule (79 FR 45958 through 45960). We adopted this new COLA methodology for the IPF PPS because IPFs are hospitals with a similar mix of commodities and services. We believe it is appropriate to have a consistent policy approach with that of other hospitals in Alaska and Hawaii. Therefore, the IPF COLAs for FY 2015 through FY 2017 were the same as those applied under the IPPS in those years. As finalized in the FY 2013 IPPS/LTCH PPS final rule (77 FR 53700 and 53701), the COLA updates are determined every 4 years, when the IPPS market basket labor-related share is updated. Because the labor-related share of the IPPS market basket was updated for FY 2022, the COLA factors were updated in FY 2022 IPPS/LTCH rulemaking (86 FR 45547). As such, we also updated the IPF PPS COLA factors for FY 2022 (86 FR 42621 through 42622) to reflect the updated COLA factors finalized in the FY 2022 IPPS/LTCH rulemaking. Table 16 shows the IPF PPS COLA factors effective for FY 2022 through FY 2025.

TABLE 16: IPF PPS Cost-of-Living- Adjustment Factors: IPFs Located in Alaska and Hawaii

Area	FY 2022 through FY 2025
Alaska:	
City of Anchorage and 80-kilometer (50-mile) radius by road	1.22
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.22
City of Juneau and 80-kilometer (50-mile) radius by road	1.22
Rest of Alaska	1.24
Hawaii:	
City and County of Honolulu	1.25
County of Hawaii	1.22
County of Kauai	1.25
County of Maui and County of Kalawao	1.25

The IPF PPS COLA factors for FY 2024 are also shown in Addendum A to this final rule, which is available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/tools.html.*

4. Adjustment for IPFs With a Qualifying Emergency Department (ED)

The IPF PPS includes a facility-level adjustment for IPFs with qualifying EDs. We provide an adjustment to the Federal per diem base rate to account for the costs associated with maintaining a full-service ED. The adjustment is intended to account for ED costs incurred by a psychiatric hospital with a qualifying ED or an excluded psychiatric unit of an IPPS hospital or a CAH, for preadmission services otherwise payable under the Medicare Hospital Outpatient Prospective Payment System (OPPS), furnished to a beneficiary on the date of the beneficiary's admission to the hospital and during the day immediately preceding the date of admission to the IPF (see § 413.40(c)(2)), and the overhead cost of maintaining the ED. This payment is a facility-level adjustment that applies to all IPF admissions (with one exception, which we described), regardless of whether a particular patient receives preadmission services in the hospital's ED.

The ED adjustment is incorporated into the variable per diem adjustment for the first day of each stay for IPFs with a qualifying ED. Those IPFs with a qualifying ED receive an adjustment factor of 1.31 as the variable per diem adjustment for day 1 of each patient stay. If an IPF does not have a qualifying ED, it receives an adjustment factor of 1.19 as the variable per diem adjustment for day 1 of each patient stay.

The ED adjustment is made on every qualifying claim except as described in

this section of this final rule. As specified in § 412.424(d)(1)(v)(B), the ED adjustment is not made when a patient is discharged from an IPPS hospital or CAH and admitted to the same IPPS hospital's or CAH's excluded psychiatric unit. We clarified in the November 2004 IPF PPS final rule (69 FR 66960) that an ED adjustment is not made in this case because the costs associated with ED services are reflected in the DRG payment to the IPPS hospital or through the reasonable cost payment made to the CAH.

Therefore, when patients are discharged from an IPPS hospital or CAH and admitted to the same hospital's or CAH's excluded psychiatric unit, the IPF receives the 1.19 adjustment factor as the variable per diem adjustment for the first day of the patient's stay in the IPF. For FY 2024, we proposed to retain the 1.31 adjustment factor for IPFs with qualifying EDs. A complete discussion of the steps involved in the calculation of the ED adjustment factors are in the November 2004 IPF PPS final rule (69 FR 66959 through 66960) and the RY 2007 IPF PPS final rule (71 FR 27070 through 27072).

As we did not propose any changes to the ED adjustment, we are retaining the existing ED adjustment for FY 2024.

E. Other Proposed Payment Adjustments and Policies

1. Outlier Payment Overview

The IPF PPS includes an outlier adjustment to promote access to IPF care for those patients who require expensive care and to limit the financial risk of IPFs treating unusually costly patients. In the November 2004 IPF PPS final rule, we implemented regulations at § 412.424(d)(3)(i) to provide a per case payment for IPF stays that are extraordinarily costly. Providing additional payments to IPFs for extremely costly cases strongly improves the accuracy of the IPF PPS in determining resource costs at the patient and facility level. These additional payments reduce the financial losses that would otherwise be incurred in treating patients who require costlier care, and therefore, reduce the incentives for IPFs to under-serve these patients. We make outlier payments for discharges in which an IPF's estimated total cost for a case exceeds a fixed dollar loss threshold amount (multiplied by the IPF's facility-level adjustments) plus the Federal per diem payment amount for the case.

In instances when the case qualifies for an outlier payment, we pay 80 percent of the difference between the estimated cost for the case and the adjusted threshold amount for days 1 through 9 of the stay (consistent with the median LOS for IPFs in FY 2002), and 60 percent of the difference for day 10 and thereafter. The adjusted threshold amount is equal to the outlier threshold amount adjusted for wage area, teaching status, rural area, and the COLA adjustment (if applicable), plus the amount of the Medicare IPF payment for the case. We established the 80 percent and 60 percent loss sharing ratios because we were concerned that a single ratio established at 80 percent (like other Medicare PPSs) might provide an incentive under the IPF per diem payment system to increase LOS in order to receive additional payments.

After establishing the loss sharing ratios, we determined the current fixed dollar loss threshold amount through payment simulations designed to compute a dollar loss beyond which payments are estimated to meet the 2 percent outlier spending target. Each year when we update the IPF PPS, we simulate payments using the latest available data to compute the fixed dollar loss threshold so that outlier payments represent 2 percent of total estimated IPF PPS payments.

2. Update to the Outlier Fixed Dollar Loss Threshold Amount

In accordance with the update methodology described in § 412.428(d), we proposed to update the fixed dollar loss threshold amount used under the IPF PPS outlier policy. Based on the regression analysis and payment simulations used to develop the IPF PPS, we established a 2 percent outlier policy, which strikes an appropriate balance between protecting IPFs from extraordinarily costly cases while ensuring the adequacy of the Federal per diem base rate for all other cases that are not outlier cases.

Our longstanding methodology for updating the outlier fixed dollar loss threshold involves using the best available data, which is typically the most recent available data. For the FY 2022 IPF PPS final rule, we finalized the use of FY 2019 claims rather than the more recent FY 2020 claims for updating the outlier fixed dollar loss threshold (86 FR 42623). We noted that our use of the FY 2019 claims to set the final outlier fixed dollar loss threshold for FY 2022 deviated from our longstanding practice of using the most recent available year of claims but remained otherwise consistent with the established outlier update methodology. We explained that we finalized our proposal to deviate from our longstanding practice of using the most recent available year of claims only because, and to the extent that, the ''coronavirus disease 2019'' (abbreviated ''COVID–19'') Public Health Emergency (PHE) appeared to have significantly impacted the FY 2020 IPF claims. We further stated that we intended to continue to analyze further data in order to better understand both the short-term and long-term effects of the COVID–19 PHE on IPFs (86 FR 42624).

In the FY 2023 IPF PPS final rule (87 FR 46862 through 46864) we noted that we observed an overall increase in average cost per day and an overall decrease in the number of covered days. However, we identified that some providers had significant increases in their charges, resulting in higher-than-normal estimated cost per day that would skew our estimate of outlier payments for FY 2022 and FY 2023. We finalized our proposal for FY 2023 to use the latest available FY 2021 claims, in accordance with our longstanding practice, to simulate payments for determining the final FY 2023 IPF PPS outlier fixed dollar loss threshold amount. In addition, we finalized a methodology for FY 2023 to exclude providers from our impact simulations whose change in simulated cost per day is outside 3 standard deviations from the mean.

For the FY 2024 IPF PPS proposed rule, consistent with our longstanding practice, we analyzed the most recent available data for simulating IPF PPS payments in FY 2023. Based on an analysis of these updated data, we estimated that IPF outlier payments as a percentage of total estimated payments were approximately 3.0 percent in FY 2023. We analyzed the change in providers' charges from the FY 2021 claims that were used to simulate payments for determining the final FY 2023 IPF PPS outlier threshold, and the latest available FY 2022 claims. In contrast to our analysis of FY 2021 claims for the FY 2023 IPF PPS proposed and final rules, we did not find the same level of significant increases in charges in the FY 2022 claims that we believe would skew our estimate of outlier payments for FY 2023 and FY 2024. Therefore, we proposed to update the outlier threshold amount to $34,750. This would allow us to maintain estimated outlier payments at 2 percent of total estimated aggregate IPF payments for FY 2024. This proposed update was an increase from the FY 2023 threshold of $24,630. We solicited comments on this proposed increase to the outlier threshold for FY 2024, and whether we should consider alternative methodologies for FY 2024.

Specifically, we were interested in understanding whether commenters believe it would be appropriate to exclude providers from our FY 2024 impact simulations whose change in simulated cost per day is outside 3 standard deviations from the mean, following the same methodology we applied in FY 2023. We noted that our analysis for the FY 2024 proposed rule showed that the FY 2024 outlier fixed dollar loss threshold amount would be closer to $30,000 if we were to exclude providers based on the same methodology finalized for FY 2023. We were also interested in other methodologies that commenters believe might be appropriate to consider, including why commenters believe applying such a methodology would be appropriate for establishing the outlier threshold for FY 2024.

Comment: We received five comments in response to the FY 2024 IPF PPS pertaining to an alternative IPF PPS outlier policy. Commenters included state-level and national provider associations. One commenter stated the increase in the outlier threshold amount should be limited to no more than the market basket update for the year but did not provide a rationale for this suggestion. Two commenters recommended CMS mitigate the financial impact that imperfect outlier threshold estimates have on IPFs. Four commenters requested that CMS explain in greater detail the factors driving the increase and that CMS examine its methodology and consider making changes to mitigate increases to the outlier threshold. Commenters also requested information on how the proposed increase would affect the IPF field and its patients.

Response: We appreciate the suggestions from commenters regarding mitigating the financial impact of the outlier threshold on IPFs and the use of alternative methodologies for estimating the outlier threshold. We are not finalizing any of the alternative methodologies that commenters suggested, but we are providing additional information about the drivers and impact of the increase to the outlier threshold, as commenters requested.

As we previously noted in the FY 2023 final rule (87 FR 46863), we observed two main trends in the claims data for FY 2020 and FY 2021. In summary, these were an increase in average cost per day and a decrease in total IPF PPS payments corresponding with a decrease in covered IPF PPS days. Both of these trends continued in the FY 2022 claims data used for this FY 2024 IPF PPS final rule. First, we observed that average cost per day increased approximately 8 percent when comparing the simulated FY 2022 IPF PPS payments from the FY 2023 IPF PPS final rule to the simulated FY 2023 IPF PPS payments that we used to estimate the outlier percentage for this FY 2024 IPF PPS final rule. In the FY 2022 IPF PPS proposed rule (86 FR 19526), we explained that we estimate the costs per case based on the covered charges on each IPF claim and the IPF's most recent CCR. The second continued trend that we observed was that the number of covered days continued to decrease in the FY 2022 claims. The number of covered days in the FY 2022 claims were approximately 12 percent lower than the number of covered days in the FY 2021 claims used for FY 2023 final rulemaking, before applying the statistical trim for the FY 2023 IPF PPS final rule (87 FR 46862). This decrease in covered days corresponds with a decrease of approximately 10 percent in the total simulated FY 2023 IPF PPS payments compared to total simulated FY 2022 IPF PPS payments used for FY 2023 final rulemaking. In addition, when comparing the data used for this FY 2024 IPF PPS final rule with the statistically trimmed data used for the FY 2023 IPF PPS final rule, the covered days for FY 2024 were approximately 8 percent lower than FY 2023, and total simulated FY 2023 IPF PPS payments that we used to estimate the outlier percentage for this FY 2024 IPF PPS final rule were approximately 4 percent lower than total simulated FY 2022 IPF PPS payments. Because we calculate the outlier fixed dollar loss threshold amount so that outlier payments represent 2 percent of total estimated IPF PPS payments, the decrease to the number of days and total estimated IPF PPS payments increases the percentage of outlier payments relative to total payments, which contributes to the upward trend in the outlier fixed dollar loss threshold amount. In our simulated FY 2023 outlier payments using the FY 2023 IPF PPS outlier fixed dollar loss threshold of $24,630, we estimated that 5,817 cases will receive outlier payments, with a mean outlier payment amount per outlier case of $13,807.28. We observed that the distribution of simulated FY 2023 outlier payments is skewed right, which means that a large number of outlier cases receive relatively small amounts of outlier payments, and a smaller number of outlier cases receive relatively large outlier payments. Consequently, half of all simulated outlier cases receive outlier payments of $7,543.65 or less, and 559 cases receive outlier payments of $1,000 or less. We also observed that outlier payments are concentrated among certain types of IPFs. As shown in Table 40, in section VIII.C.2 of this final rule, urban government-owned IPF units are projected to experience the largest decreases in estimated payments as a result of the increase to the outlier fixed dollar loss threshold amount, because these providers had a larger share of outlier cases than other provider types. We did not observe that changes in case mix appear to be driving the increase in the outlier percentage. In the simulated FY 2023 IPF PPS payments, we observed that approximately 79 percent of outlier cases are for DRG 885 (Psychoses), which aligns with the proportion of IPF PPS cases that typically receive that DRG. We estimate that the average outlier payment for cases with DRG 885 is $14,485.21, which is comparable to the average outlier payment for all cases.

Regarding the suggestion to limit increases to the outlier threshold to no more than the market basket update, we are concerned that this methodology would not be technically appropriate for the IPF PPS outlier policy. As discussed earlier in this section, the longstanding IPF PPS 2-percent outlier policy was established based on the regression analysis and payment simulations used to develop the IPF PPS. We have previously explained that the 2-percent outlier policy strikes an appropriate balance between protecting IPFs from extraordinarily costly cases while ensuring the adequacy of the Federal per diem base rate for all other cases that are not outlier cases. Each year when we update the IPF PPS, we simulate payments using the latest available data to compute the fixed dollar loss threshold so that outlier payments represent 2 percent of total estimated IPF PPS payments. For this FY 2024 IPF PPS final rule, we have simulated payments using the latest available data, and these payment simulations indicate that an increase to the outlier fixed dollar loss threshold is necessary in order to maintain outlier payments at 2 percent of total payments. We are concerned that limiting increases to the outlier fixed dollar loss threshold to no more than the market basket update percentage would not appropriately target outlier payments such that they remain at 2 percent of total IPF PPS payments and that such a policy would increase outlier payments above the 2 percent target for FY 2024. As we noted in the prior paragraph, we observe that the increase in the outlier fixed dollar loss threshold is driven in part by a continual downward trend in

covered days over the past several years. We are concerned that it would not be appropriate to increase outlier payments to offset the fact that IPFs are providing fewer days of care for Medicare beneficiaries.

Final Decision: After consideration of the comments received, we are finalizing our proposal to update the fixed dollar loss threshold amount used under the IPF PPS outlier policy. Based on the latest available data, we are finalizing an outlier fixed dollar loss threshold amount of $33,470 for FY 2024.

3. Update to IPF Cost-To-Charge Ratio Ceilings

Under the IPF PPS, an outlier payment is made if an IPF's cost for a stay exceeds a fixed dollar loss threshold amount plus the IPF PPS amount. In order to establish an IPF's cost for a particular case, we multiply the IPF's reported charges on the discharge bill by its overall cost-to-charge ratio (CCR). This approach to determining an IPF's cost is consistent with the approach used under the IPPS and other PPSs. In the FY 2004 IPPS final rule (68 FR 34494), we implemented changes to the IPPS policy used to determine CCRs for IPPS hospitals, because we became aware that payment vulnerabilities resulted in inappropriate outlier payments. Under the IPPS, we established a statistical measure of accuracy for CCRs to ensure that aberrant CCR data did not result in inappropriate outlier payments.

As indicated in the November 2004 IPF PPS final rule (69 FR 66961), we believe that the IPF outlier policy is susceptible to the same payment vulnerabilities as the IPPS; therefore, we adopted a method to ensure the statistical accuracy of CCRs under the IPF PPS. Specifically, we adopted the following procedure in the November 2004 IPF PPS final rule:

- Calculated two national ceilings, one for IPFs located in rural areas and one for IPFs located in urban areas.
- Computed the ceilings by first calculating the national average and the standard deviation of the CCR for both urban and rural IPFs using the most recent CCRs entered in the most recent Provider Specific File (PSF) available.

For FY 2024, we proposed to continue to follow this methodology.

To determine the rural and urban ceilings, we multiplied each of the standard deviations by 3 and added the result to the appropriate national CCR average (either rural or urban). The upper threshold CCR for IPFs in FY 2024 is 2.1419 for rural IPFs, and 1.8026 for urban IPFs, based on CBSA-based geographic designations. If an IPF's CCR is above the applicable ceiling, the ratio is considered statistically inaccurate, and we assign the appropriate national (either rural or urban) median CCR to the IPF.

We apply the national median CCRs to the following situations:

- New IPFs that have not yet submitted their first Medicare cost report. We continue to use these national median CCRs until the facility's actual CCR can be computed using the first tentatively or final settled cost report.
- IPFs whose overall CCR is in excess of three standard deviations above the corresponding national geometric mean (that is, above the ceiling).
- Other IPFs for which the Medicare Administrative Contractor (MAC) obtains inaccurate or incomplete data with which to calculate a CCR.

We proposed to update the FY 2024 national median and ceiling CCRs for urban and rural IPFs based on the CCRs entered in the latest available IPF PPS PSF.

Specifically, for FY 2024, to be used in each of the three situations listed previously, using the most recent CCRs entered in the CY 2022 PSF, we provided an estimated national median CCR of 0.5720 for rural IPFs and a national median CCR of 0.4200 for urban IPFs. These calculations are based on the IPF's location (either urban or rural) using the CBSA-based geographic designations. A complete discussion regarding the national median CCRs appears in the November 2004 IPF PPS final rule (69 FR 66961 through 66964).

4. Modification to the Regulation for Excluded Psychiatric Units Paid Under the IPF PPS

a. Background

Under current regulation, in order to be excluded from the IPPS and paid under the IPF PPS or the IRF PPS, an IPF or IRF unit of a hospital must meet a number of requirements under 42 CFR 412.25. As discussed in the following paragraphs, both this regulation and the policies applying to excluded units (which include excluded IRF units and excluded IPF units) have been in effect since before both the IPF PPS and IRF PPS were established. Before the IRF PPS and the IPF PPS were established, excluded units were paid based on their costs, as reported on their Medicare cost reports, subject to certain facility-specific cost limits. These cost-based payments were determined separately for operating and capital costs. Thus, under cost-based payments, the process of allocating costs to an IPF unit for reimbursement created significant administrative complexity. This administrative complexity necessitated strict regulations that allowed hospitals to open a new IPPS-excluded unit only at the start of a cost reporting period.

In the January 3, 1984 final rule (49 FR 235), CMS (then known as the Health Care Financing Administration) established policies and regulations for hospitals and units subject to and excluded from the IPPS. In that rule, we explained that section 1886(d) of the Act requires that the prospective payment system apply to inpatient hospital services furnished by all hospitals participating in the Medicare program except those hospitals or units specifically excluded by the law. We further explained our expectation that a hospital's status (that is, whether it is subject to, or excluded from, the prospective payment system) would generally be determined at the beginning of each cost reporting period. We also stated that this status would continue throughout the period, which is normally 1 year. Accordingly, we stated that changes in a hospital's (or unit's) status that result from meeting or failing to meet the criteria for exclusion would be implemented only at the start of a cost reporting period. However, we also acknowledged that under some circumstances involving factors external to the hospital, status changes could be made at times other than the beginning of the cost reporting period. For example, a change in status could occur if a hospital is first included under the prospective payment system and, after the start of its cost reporting period, is excluded because of its participation in an approved demonstration project or State reimbursement control program that begins after the hospital's cost reporting period has begun.

In the 1993 IPPS final rule (57 FR 39798 through 39799), we codified our longstanding policies regarding when a hospital unit can change its status from not excluded to excluded. We explained in that final rule that since the inception of the PPS for operating costs of hospital inpatient services in October 1983, certain types of specialty-care hospitals and hospital units have been excluded from that system under section 1888(d)(1)(B) of the Act. We noted that these currently include psychiatric and rehabilitation hospitals and distinct part units, children's hospitals, and long-term care hospitals. We further explained that section 6004(a)(1) of Public Law 101–239 amended section 1886(d)(1)(B) of the Act to provide that certain cancer hospitals are also excluded. We noted that the preamble to the January 3, 1984 final rule

implementing the PPS for operating costs (49 FR 235) stated that the status of a hospital or unit (that is, whether it is subject to, or excluded from, the PPS) will be determined at the beginning of each cost reporting period. We noted that that same 1984 final rule also provided that changes in a hospital's or unit's status that result from meeting or failing to meet the criteria for exclusion will be implemented prospectively only at the start of a cost reporting period, that is, starting with the beginning date of the next cost reporting period (49 FR 243). However, we noted that this policy was not set forth in the regulations. In that 1993 IPPS final rule, we stated that we proposed revising §§ 412.22 and 412.25 to specify that changes in the status of each hospital or hospital unit would be recognized only at the start of a cost reporting period. We stated that, except in the case of retroactive payment adjustments for excluded rehabilitation units described in § 412.30(c), any change in a hospital's or unit's compliance with the exclusion criteria that occurs after the start of a cost reporting period would not be taken into consideration until the start of the following period. We noted that this policy would also apply to any unit that is added to a hospital during the hospital's cost reporting period. We also stated that we proposed revising § 412.25(a) to specify that as a requirement for exclusion, a hospital unit must be fully equipped and staffed, and be capable of providing inpatient psychiatric or rehabilitation care as of the first day of the first cost reporting period for which all other exclusion requirements are met. We explained that a unit that meets this requirement would be considered open regardless of whether there are any inpatients in the unit.

In the same 1993 IPPS final rule, we responded to commenters who objected to this policy, stating that it unnecessarily penalizes hospitals for factors beyond their control, such as construction delays, that it discourages hospitals from making changes in their programs to meet community needs, or that it can place undue workload demands on regulatory agencies during certain time periods. In response, we explained that we believed that regulatory agencies, hospitals, and the public generally would benefit from policies that are clearly stated, can be easily understood by both hospitals and intermediaries, and can be simply administered. We stated that recognizing changes in status only at the beginning of cost reporting periods is consistent with these goals, while recognizing changes in the middle of cost reporting periods would introduce added complexity to the administration of the exclusion provisions. Therefore, we did not revise the proposed changes based on these comments.

In the FY 2000 IPPS final rule (64 FR 41531 through 41532), we amended the regulations at § 412.25(c) to allow a hospital unit to change from excluded to not excluded at any time during the cost reporting period. We explained the statutory basis and rationale for this change in the FY 2000 IPPS proposed rule (64 FR 24740) and noted that a number of hospitals suggested that we consider a change in our policy to recognize, for purposes of exclusion from the IPPS, reductions in number of beds in, or entire closure of, units at any time during a cost reporting period. In that FY 2000 IPPS proposed rule, we explained that hospitals indicated that the bed capacity made available as a result of these changes could be used as needed to provide additional services to meet patient needs in the acute care part of the hospital that is paid under the IPPS. We further explained that we evaluated the concerns of the hospitals and the effects on the administration of the Medicare program and the health care of beneficiaries of making these payment changes. As a result of that evaluation, we stated that we believed it was reasonable to adopt a more flexible policy in recognition of hospitals' changes in the use of their facilities. However, we noted that whenever a hospital establishes an excluded unit within the hospital, our Medicare fiscal intermediary would need to be able to determine costs of the unit separately from costs of the part of the hospital paid under the prospective payment system. At that time, we stated that the proper determination of costs ensured that the hospital was paid the correct amount for services in each part of the facility, and that payments under the IPPS did not duplicate payments made under the rules that were applicable to excluded hospitals and units, or vice versa. For this reason, we did not believe it would be appropriate to recognize, for purposes of exclusion from the IPPS, changes in the bed size or status of an excluded unit that are so frequent that they interfere with the ability of the intermediary to accurately determine costs. Moreover, we explained that section 1886(d)(1)(B) of the Act authorizes exclusion from the IPPS of specific types of hospitals and units, but not of specific admissions or stays, such as admissions for rehabilitation or psychiatric care, in a hospital paid under the IPPS. We stated that without limits on the frequency of changes in excluded units for purposes of proper Medicare payment, there was the potential for some hospitals to adjust the status or size of their excluded units so frequently that the units would no longer be distinct entities and the exclusion would effectively apply only to certain types of care.

In the FY 2012 IRF PPS final rule (76 FR 47870), we began further efforts to increase flexibilities for excluded IPF and IRF units. In that rule, we explained that cost-based reimbursement methodologies that were in place before the IPF PPS and IRF PPS meant that the facilities' capital costs were determined, in part, by their bed size and square footage. Changes in the bed size and square footage would complicate the facilities' capital cost allocation. Thus, regulations at § 412.25 limited the situations under which an IRF or IPF could change its bed size and square footage. In the FY 2012 IRF PPS final rule, we revised § 412.25(b) to enable IRFs and IPFs to more easily adjust to beneficiary changes in demand for IRF or IPF services and improve beneficiary access to these services. We believed that the first requirement (that beds can only be added at the start of a cost reporting period) was difficult, and potentially costly, for IRFs and IPFs that were expanding through new construction because the exact timing of the end of a construction project is often difficult to predict. In that same FY 2012 IRF PPS final rule, commenters suggested that CMS allow new IRF units or new IPF units to open and begin being paid under their respective IRF PPS or IPF PPS at any time during a cost reporting period, rather than requiring that they could only begin being paid under the IRF PPS or the IPF PPS at the start of a cost reporting period. We believed that this suggestion was outside the scope of the FY 2012 IRF PPS proposed rule (76 FR 24214), because we did not propose any changes to the § 412.25(c). However, we stated that we would consider this suggestion for possible inclusion in future rulemaking.

b. Current Challenges Related to Excluded Hospital Units (§§ 412.25(c)(1) and (c)(2))

Currently, under § 412.25(c)(1), a hospital can only start being paid under the IPF PPS or the IRF PPS for services provided in an excluded hospital unit at the start of a cost reporting period. Specifically, § 412.25(c) limits when the status of hospital units may change for purposes of exclusion from the IPPS, as specified in §§ 412.25(c)(1) and

412.25(c)(2). Section 412.25(c)(1) states that the status of a hospital unit may be changed from not excluded to excluded only at the start of the cost reporting period. If a unit is added to a hospital after the start of a cost reporting period, it cannot be excluded from the IPPS before the start of a hospital's next cost reporting period. Section 412.25(c)(2) states the status of a hospital unit may be changed from excluded to not excluded at any time during a cost reporting period, but only if the hospital notifies the fiscal intermediary and the CMS Regional Office in writing of the change at least 30 days before the date of the change, and maintains the information needed to accurately determine costs that are or are not attributable to the excluded unit. A change in the status of a unit from excluded to not excluded that is made during a cost reporting period must remain in effect for the rest of that cost reporting period.

In recent years, interested parties, such as hospitals, have written CMS to express concerns about what they see as the unnecessary restrictiveness of the requirements at § 412.25(c). Based on this feedback, we continued to explore opportunities to reduce burden for providers and clinicians, while keeping patient-centered care a priority. For instance, we considered whether this regulation might create unnecessary burden for hospitals and potentially delay necessary psychiatric beds from opening and being paid under the IPF PPS. As we continued to review and reconsider regulations to identify ways to improve policy, we recognized that the requirement at § 412.25(c)(1), that hospital units can only be excluded at the start of a cost reporting period, may be challenging and potentially costly for facilities under some circumstances, for example, those that are expanding through new construction. Hospitals have indicated it is often difficult to predict the exact timing of the end of a construction project and construction delays may hamper a hospital's ability to have the construction of an excluded unit completed exactly at the start of a cost reporting period, which hospitals have said can lead to significant revenue loss if they are unable to be paid under the IPF PPS or IRF PPS until the start of the next cost reporting period.

As previously stated, the requirements at § 412.25(c) were established to manage the administrative complexity associated with cost-based reimbursement for excluded IPF and IRF units. Today, however, because IPF units are paid under the IPF PPS and IRF units are paid under the IRF PPS, cost allocation is not used for payment purposes. Because advancements in technology since the inception of the IPF PPS and IRF PPS have simplified the cost reporting process and enhanced communication between providers, Medicare contractors, and CMS, we are reconsidering whether it is necessary to continue to allow hospital units to become excluded only at the start of a cost reporting period.

c. Changes to Excluded Hospital Units (§§ 412.25(c)(1) and (c)(2))

We are committed to continuing to transform the health care delivery system and the Medicare program by putting additional focus on patient-centered care and working with providers, physicians, and patients to improve outcomes, while meeting relevant health care priorities and exploring burden reduction.

In response to increased mental health needs, including the need for availability of inpatient psychiatric beds, we proposed changes to § 412.25(c) to allow greater flexibility for hospitals to open excluded units, while minimizing the amount of effort Medicare contractors would need to spend administering the regulatory requirements. Although we are cognizant that there is need for mental health services and support for providers along a continuum of care, including a robust investment in community-based mental health services, this proposal was focused on inpatient psychiatric facility settings.

We proposed that changes to § 412.25(c) would apply to both IPFs and IRFs; therefore, revisions to § 412.25(c) would also affect IRFs in similar ways. Readers should refer to the FY 2024 IRF PPS proposed rule (88 FR 20981 through 20984) for discussion of proposed revisions to § 412.25(c) and unique considerations applicable to IRF units. As previously stated, the current requirements at § 412.25(c)(1) were originally established to manage the administrative complexity associated with cost-based reimbursement for excluded IPF and IRF units. Because IPF and IRF units are no longer paid under cost-based reimbursement, but rather under the IPF PPS and IRF PPS respectively, we believe that the restriction that limits an IPF or IRF unit to being excluded only at the start of a cost reporting period is no longer necessary. We amended our regulations in the FY 2012 IRF PPS final rule to address a regulation that, similarly, was previously necessary for cost-based reimbursement, but was not material to payment under the IRF PPS and IPF PPS. In that final rule, we explained that under cost-based payments, the facilities' capital costs were determined, in part, by their bed size and square footage. Changes in the bed size and square footage would complicate the facilities' capital cost allocation. We explained that under the IRF PPS and IPF PPS, a facility's bed size and square footage were not relevant for determining the individual facility's Medicare payment. Therefore, we believed it was appropriate to modify some of the restrictions on a facility's ability to change its bed size and square footage. Accordingly, we relaxed the restrictions on a facility's ability to increase its bed size and square footage. Under the revised requirements that we adopted in the FY 2012 IRF PPS final rule at § 412.25(b), an IRF or IPF can change (either increase or decrease) its bed size or square footage one time at any point in a given cost reporting period as long as it notifies the CMS Regional Office (RO) at least 30 days before the date of the proposed change, and maintains the information needed to accurately determine costs that are attributable to the excluded units.

Similarly, in the case of the establishment of new excluded IPF and IRF units, we do not believe that the timing of the establishment of the new unit is material for determining the individual facility's Medicare payment under the IPF PPS or IRF PPS. We believe it would be appropriate to allow a unit to become excluded at any time in the cost reporting year. However, we also believe it is important to minimize the potential administrative complexity associated with units changing their excluded status.

Accordingly, we proposed to modify the requirements currently in regulation at § 412.25(c)(1) to allow a hospital to change the status of an IPF unit any time within the cost reporting year, as long as the hospital notifies the CMS Regional Office and Medicare Administrative Contractor (MAC) in writing of the change at least 30 days before the date of the change, and that this change would remain in effect for the rest of that cost reporting year. We also proposed to maintain the current requirements of § 412.25(c)(2) which specify that, if an excluded unit becomes not excluded during a cost reporting year, the hospital must notify the MAC and CMS Regional Office in writing of the change at least 30 days before the change, and this change would remain in effect for the rest of that cost reporting year. Finally, we proposed to consolidate the requirements for § 412.25(c)(1) and § 412.25(c)(2) into a new § 412.25(c)(2) that would apply to IPF units and

specify the requirements for an IPF unit to become excluded or not excluded. We stated that we believed this proposal would provide greater flexibility to hospitals to establish an excluded unit at a time other than the start of a cost reporting period. We solicited comments on the proposed changes.

Comment: We received unanimous commenter support on the proposal to modify the requirements to allow a hospital to open a new IPF unit any time within the cost reporting year, as long as the hospital notifies the CMS Regional Office and MAC in writing of the change at least 30 days before the date of the change. Commenters were appreciative of how this change would allow greater flexibility in how and when a unit could be designated to be excluded or not from the IPPS. Commenters also stated this change could alleviate the problem of limited bed availability by allowing hospitals to be more responsive to the need for inpatient psychiatric beds in their communities.

Response: We thank commenters for their support and agree this modification will allow greater flexibility in how and when a unit could be designated to be excluded from the IPPS. We also agree this change will allow hospitals to be more responsive to the need for inpatient psychiatric beds.

Comment: One commenter requested that CMS allow certain units that have changed their status to change their status back at least one time during the same cost reporting period. Specifically, they believe that units that experience a status change on the first day of the cost reporting period should have the opportunity to revert to their original designation one time throughout the cost reporting period. They further clarified that, if an IPF unit specifies and communicates with the appropriate parties before the beginning of the next cost reporting year that it would want to reclassify, and then when the cost reporting period begins decides to revert, it should be allowed the opportunity to make the necessary changes.

Response: We do not fully understand the commenter's concern, but we believe the commenter is seeking clarification about whether a hospital unit would be permitted to change its status during the cost reporting year to revert to the status it held during the prior year. Under the proposed policy, a hospital unit would be permitted to change its status to either excluded or not excluded only one time during the cost reporting year, and would be required to maintain that status until the end of the cost reporting year. We are clarifying that changes made at the beginning of a cost reporting year would not limit the ability of the hospital unit to make a one-time status change during the same cost reporting year. Therefore, if the hospital unit starts the cost reporting year as excluded, it could become not excluded at any time during the cost reporting year; if the hospital unit starts the cost reporting year as not excluded, it could become excluded at any time during the cost reporting year.

Final Decision: After consideration of the comments received, we are finalizing our proposal to modify the requirements currently in regulation at § 412.25(c)(1) to allow a hospital to change the status of an IPF unit from not excluded to excluded any time within the cost reporting year. We are also finalizing as proposed that a hospital will be required to notify the CMS Regional Office and MAC in writing of the change at least 30 days before the date of the change, and that this change would remain in effect for the rest of that cost reporting year. In addition, we are finalizing our proposal to maintain the current requirements of § 412.25(c)(2), which specify that, if an excluded unit becomes not excluded during a cost reporting year, the hospital must notify the MAC and CMS Regional Office in writing of the change at least 30 days before the change, and this change would remain in effect for the rest of that cost reporting year.

Lastly, we proposed an identical policy for rehabilitation units of hospitals in the FY 2024 IRF PPS proposed rule, specifying that the regulatory provision that would pertain to IRF units would appear in § 412.25(c)(1). We proposed discrete regulation text for each of the hospital unit types (that is, IRF units and IPF units) in order to solicit comments on issues that might impact one hospital unit type and not the other. We also stated that we may consider adopting one consolidated regulations text for both IRF and IPF units in the final rules if we finalize both of our proposals. We did not receive any comments regarding a consolidated regulation for both IRF and IPF units; nor did commenters raise any issues that would impact one hospital unit type and not the other. We are finalizing a consolidated regulation at § 412.25(c) that applies to both IPF hospital units and IRF hospital units.

V. Existing Data Collection and Request for Information (RFI) To Inform Revisions to the IPF PPS as Required by the CAA, 2023

A. Changes to IPF PPS in the CAA, 2023

As discussed in section IV.C.1 of this final rule, we proposed to continue using the existing regression-derived IPF PPS adjustment factors for FY 2024. In the FY 2023 IPF PPS proposed rule (87 FR 19428 through 19429), we discussed the background of these current IPF PPS patient-level and facility-level adjustment factors, which are the regression-derived adjustment factors from the November 15, 2004 IPF PPS final rule and briefly discussed past analyses and areas of concern for future refinement, about which we previously solicited comments. Finally, in the FY 2023 proposed rule, we described the results of the latest analysis of the IPF PPS, which were summarized in a technical report posted to the CMS website [3] accompanying the rule and solicited comments on certain topics from the report.

Section 4125 of the CAA, 2023 amended section 1886(s) of the Act to add new paragraph 1886(s)(5), which requires revisions to the methodology for determining the payment rates under the IPF PPS for FY 2025 and future years as the Secretary determines appropriate. Specifically, new section 1886(s)(5)(A) of the Act requires the Secretary to collect data and information as the Secretary as determines appropriate to revise payments under the IPF PPS. This data collection is required to begin no later than October 1, 2023, which is the start of FY 2024. In addition, new section 1886(s)(5)(D) of the Act requires that the Secretary implement by regulation revisions to the methodology for determining the payment rates for psychiatric hospitals and psychiatric units (that is, under the IPF PPS), for rate year 2025 (FY 2025) and for subsequent years if the Secretary determines it appropriate. The revisions may be based on a review of the data and information collection.

As noted above, section 1886(s)(5)(A) of the Act requires the Secretary to begin collecting, by not later than October 1, 2023, data and information as appropriate to inform revisions to the IPF PPS. New section 1886(s)(5)(B) of the Act, as added by the CAA, 2023 lists the following types of data and information as a non-exhaustive list of

[3] *https://www.cms.gov/files/document/technical-report-medicare-program-inpatient-psychiatric-facilities-prospective-payment-system.pdf.*

examples of what may be collected under this authority:

- Charges, including those related to ancillary services;
- The required intensity of behavioral monitoring, such as cognitive deficit, suicidal ideations, violent behavior, and need for physical restraint; and
- Interventions, such as detoxification services for substance abuse, dependence on respirator, total parenteral nutritional support, dependence on renal dialysis, and burn care.

We note that our extensive years-long and ongoing data collection efforts are consistent with the types of data the CAA, 2023 suggests we might collect as well as the purpose for which the CAA, 2023 requires the data collection, as described in the following paragraphs.

B. Current Data and Information Collection Requirements

1. Charges, Including Those Related to Ancillary Services

As specified at 42 CFR 413.20, hospitals are required to file cost reports on an annual basis and maintain sufficient financial records and statistical data for proper determination of costs payable under the Medicare program. Currently, IPFs and psychiatric units are required to report ancillary charges on cost reports.

In general, most providers allocate their Medicare costs using costs and charges as described at 42 CFR 413.53(a)(1)(i) and referred to as the Departmental Method. For cost reporting periods beginning on or after October 1, 1982, the Departmental Method, which is the ratio of beneficiary charges to total patient charges for the services of each ancillary department, is applied to apportion the cost of the department. Added to this amount is the cost of routine services for program beneficiaries, determined on the basis of a separate average cost per diem for all patients for general routine patient care areas as required at § 413.53(a)(1)(i) and (e).

The Departmental Method for apportioning allowable cost between Medicare and non-Medicare patients under the program is not readily adaptable to those hospitals that do not have a charge structure. Current cost reporting rules allow hospitals that do not have a charge structure to file an all-inclusive cost report using an alternative cost allocation method. These alternative methods as described in the CMS Pub. 15–1, chapter 22 of the Provider Reimbursement Manual (PRM), Methods A, B and E, in order of preference, must be approved by the MAC after considering the data available and ascertaining which method can be applied to achieve equity, not merely greater reimbursement, in the allocation of costs for services rendered to Medicare beneficiaries.

Method A (Departmental Statistical Method) is used in the absence of charge data and where adequate departmental statistics are available. Where Method A was not used, the MAC may have granted specific permission for a hospital to continue to use on a temporary basis a less sophisticated Method B (Sliding Scale) or E (Percentage of Per Diem). A provider that elects and is approved under Method A, may not change to a Method B or E in a subsequent year. These alternative methods of apportionment are limited and available only to those hospitals that do not and never have had a charge structure for individual services rendered. Historically, most hospitals that were approved to file all-inclusive cost reports were Indian Health Services hospitals, government-owned psychiatric and acute care hospitals, and nominal charge hospitals.

In the FY 2016 IPF PPS final rule (80 FR 46693 through 46694), we discussed analysis conducted to better understand IPF industry practices for future IPF PPS refinements. This analysis revealed that in 2012 to 2013, over 20 percent of IPF stays show no reported ancillary costs, such as laboratory and drug costs, on cost reports or charges on claims. In the FY 2016 IPF PPS final rule (80 FR 46694), FY 2017 IPF PPS final rule (81 FR 50513), FY 2018 IPF PPS final rule (82 FR 36784), FY 2019 IPF PPS final rule (83 FR 38588) and FY 2020 IPF PPS final rule (84 FR 38458), we reminded providers that we pay only the IPF for services furnished to a Medicare beneficiary who is an inpatient of that IPF, except for certain professional services, and payments are considered to be payments in full for all inpatient hospital services provided directly or under arrangement (see 42 CFR 412.404(d)), as specified in 42 CFR 409.10.

On November 17, 2017, we issued Transmittal 12, which made changes to the hospital cost report form CMS–2552–10 (OMB No. 0938–0050), and included cost report Level I edit 10710S, effective for cost reporting periods ending on or after August 31, 2017. Edit 10710S required that cost reports from psychiatric hospitals include certain ancillary costs, or the cost report will be rejected. On January 30, 2018, we issued Transmittal 13, which changed the implementation date for Transmittal 12 to be for cost reporting periods ending on or after September 30, 2017. CMS suspended edit 10710S effective April 27, 2018, pending evaluation of the application of the edit to all-inclusive-rate providers. CMS issued Transmittal 15 on October 19, 2018, reinstating the requirement that cost reports from psychiatric hospitals, except all-inclusive rate providers, include certain ancillary costs. For details, we refer readers to see these Transmittals, which are available on the CMS website at *https://www.cms.gov/regulations-and-guidance/guidance/transmittals.*

2. Required Intensity of Behavioral Monitoring and Interventions

As discussed in the November 2004 IPF PPS final rule (69 FR 66946), we encourage IPFs to code all diagnoses requiring active treatment during the IPF stay. These include ICD–10–CM codes that indicate the required intensity of behavioral monitoring, such as cognitive deficit, suicidal ideations, violent behavior, and need for physical restraint. The IPF PPS includes comorbidity and MS–DRG adjustment factors that increase IPF PPS payment for stays that include these codes. For example, ICD–10–CM codes X71 through X83 indicate self-harm. ICD–10–CM codes under R45 indicate emotional state including violent behavior. These and other ICD–10–CM codes indicate the required intensity of behavioral monitoring and should be reported on the IPF claims, if applicable.

The presence of certain ICD–10–CM codes as a principal or comorbid condition is used to adjust IPF PPS payments to reflect the resource intensity associated with these conditions. For example, codes that group to MS–DRG 884 Organic Disturbances & Intellectual Disabilities, and codes that are included in the IPF comorbidity category for Developmental Disabilities, result in increased payment for IPF stays for patients with cognitive deficit.

As we further discussed in the November 2004 IPF PPS final rule (69 FR 66938 through 66944), we developed comorbidity categories based on the clinical expertise of physicians to identify conditions that would require comparatively more costly treatment during an IPF stay than other comorbid conditions. We used a regression analysis of administrative claims and cost report data to determine the adjustment factors associated with each comorbidity category. In addition, we used the same regression analysis to determine the adjustment factors associated with the 17 MS–DRGs that are included for payment adjustments

under the IPF PPS (as identified in Addendum A). As discussed in section IV.C.2.b of this final rule, we routinely update the ICD–10–CM codes that are included in the MS–DRGs and comorbidity categories.

We also collect relevant demographic information such as patient age, and we collect information and adjust payment based on the length of IPF stays. Each of these adjustments reflects the difference in service intensity, as measured by increased or decreased costs, for different patients over the course of an IPF stay.

In addition, IPFs and psychiatric units report on claims the ICD–10–PCS codes for interventions including oncology treatment procedures, which is used for adjusting payment under the oncology comorbidity category, and ECT, which is paid for using a per treatment amount as discussed in section IV.B.2 of this final rule. Other ICD–10–CM diagnosis codes indicate the need for certain interventions, such as detoxification services or substance abuse (for example, F10.121, which is included in the drug and alcohol abuse comorbidity category), dependence on respirator (for example, Z99.11 included in the COPD category), and dependence on renal dialysis (for example, Z99.2 included in the chronic renal failure category). We note that the IPS PPF does not currently adjust for burn care but recognize there are ICD–10–CM/PCS codes that denote conditions and procedures related to burn care. As discussed in the previous paragraph, the IPF PPS includes comorbidity adjustments that reflect the higher relative costs for active treatment of these conditions. IPF patients with these conditions are costlier to treat primarily because of the costs associated with interventions and longer lengths of stay.

3. Request for Information on Data and Information Collection

As noted in section V.A of this final rule, our extensive years-long and ongoing data collection efforts are consistent with the types of data that the CAA, 2023 suggests we might collect, as well as aligns with the purpose for which the CAA, 2023 requires the data collection. In this final rule, we are requesting information from the public to inform revisions to the IPF PPS required by section 4125(a) of the CAA, 2023. We are seeking information about specific additional data and information psychiatric hospitals and psychiatric units might report that could be appropriate and useful to help inform possible revisions to the methodology for payment rates under the IPF PPS for FY 2025 and future years if determined appropriate by the Secretary.

Section 1886(s)(5)(C) of the Act provides that the Secretary may collect additional data and information on cost reports, claims, or otherwise. Therefore, we also sought information about potential available data and information sources, including using additional elements of the current cost reports, claims, or other sources, taking into consideration factors such as the timing and availability of data, the quality of the potential data and information to be collected, and the potential administrative burden on providers, MACs, and CMS.

We solicited comment on the following topics:

- What other data and information would be beneficial for informing revisions to the IPF PPS payment methodologies that are currently obtainable through claims or cost report information? What codes, conditions, or other indicators should we examine in order to potentially identify this data from existing sources?
- What other data and information would be beneficial for informing revisions to the IPF PPS payment methodologies that are not routinely coded on claims or identifiable through cost report information? What are some potential alternative sources we could consider for collecting these data and information?
- What data and information that is currently reported on claims data could be used to inform revisions to the IPF PPS payment methodologies?
- As we discussed in the FY 2024 IPF PPS proposed rule, the current IPF PPS payment adjustments were derived from a regression analysis based on the FY 2002 MedPAR data file. The adjustment factors included for payment were found in the regression analysis to be associated with statistically significant per diem cost differences; with statistical significance defined as p less than 0.05. Are there alternative methodological approaches or considerations that we should consider for future analysis?
- What if any additional data or information should we consider collecting that could address access to care in rural and isolated communities?

4. Request for Information About Charges for Ancillary Services

In conjunction with the FY 2023 IPF PPS proposed rule (87 FR 19428 through 19429), we posted a report on the CMS website that summarizes the results of the latest analysis of more recent IPF cost and claim information for potential IPF PPS adjustments and requested comments about the results summarized in the report. That report showed that approximately 23 percent of IPF stays were trimmed from the data set used in that analysis because they were stays at facilities where fewer than 5 percent of their stays had ancillary charges. This report is available online at *https://www.cms.gov/medicare/inpatient-psychiatric-facility-pps/ipf-reports-and-educational-resources.*

In response to the comment solicitation, we received a comment from MedPAC regarding facilities that do not report ancillary charges on most or any of their claims. Ancillary services are the services for which charges are customarily made in addition to routine services. These include services such as labs, drugs, radiology, physical and occupational therapy services, and other types of services that typically vary between stays. Generally, based on the nature of IPF services and the conditions of participation [4] applicable to IPFs, we expect to see ancillary services and correlating charges, such as labs and drugs, on most IPF claims. Our ongoing analysis has found that certain providers, especially for-profit freestanding IPFs, are consistently reporting no ancillary charges or very minimal ancillary charges. MedPAC stated that it is not known: whether IPFs fail to report ancillary charges separately because they were appropriately bundled with all other charges into an all-inclusive per diem rate; if no ancillary charges were incurred because the IPF cares for a patient mix with lower care needs or inappropriately stints on care; or if ancillary charges for services furnished during the IPF stay are inappropriately billed outside of the IPF base rate (unbundling). MedPAC recommended CMS conduct further investigation into the lack of certain ancillary costs and charges and whether IPFs are providing necessary care and appropriately billing for inpatient psychiatric services under the IPF PPS.

As discussed in the previous section of this FY 2024 IPF PPS final rule, we requested information related to the specific types of data and information specified in the CAA, 2023, including the reporting of charges for ancillary services, such as labs and drugs, on IPF claims. We are interested in better understanding IPF industry practices

[4] IPFs are subject to all hospital conditions of participation, including 42 CFR 482.25, which specifies that ''The hospital must have pharmaceutical services that meet the needs of the patients,'' and 482.27, which specifies that ''The hospital must maintain, or have available, adequate laboratory services to meet the needs of its patients.''

pertaining to the billing and provision of ancillary services to inform future IPF PPS refinements. We are considering whether to require charges for ancillary services to be reported on claims and potentially reject claims if no ancillary services are reported, and whether to consider payment for such claims to be inappropriate or erroneous and subject to recoupment. Accordingly, we solicited comments on the following questions:

- What would be the appropriate level of ancillary charges CMS should expect to be reported on claims? Are there specific reasons that an IPF stay would include no ancillary services?
- What are the reasons that some providers are not reporting ancillary charges on their claims?
- Would it be appropriate for CMS to require and reject claims if there are no ancillary charges reported? Or should CMS consider adjusting payment to providers that do not report ancillary charges on their claims? For example, does the lack of ancillary charges on claims suggest a lack of reasonable and necessary treatment during the IPF stay, and would it be appropriate for CMS to only apply the IPF PPS patient-level adjustment factors for claims that include ancillary charges?

C. Social Drivers of Health

Social drivers of health (SDOH), also known as social determinants of health, are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.[5] Studies have shown that there is a correlation between the effects of low income and education and overall health status. One study derived that the lowest income and least educated individuals were consistently least healthy.[6] We have previously demonstrated our commitment to advancing health equity and reducing health disparities. In the past, and in our ongoing efforts, we have strived to identify and implement policies, procedures, reporting protocols, and other initiatives in a number of our programs that address the impact of SDOH on an individual's health.

For the IPF Quality Reporting Program, as discussed in section VI.D below of this final rule, we are adopting the Facility Commitment to Health Equity measure for the FY 2026 payment determination and subsequent years, the Screening for Social Drivers of Health measure beginning with voluntary reporting of data reflecting care provided in 2024 beginning in CY 2025 with required reporting for the FY 2027 payment determination and subsequent years, and the Screen Positive Rate for Social Drivers of Health measure beginning with voluntary reporting of data beginning in CY 2024 with required reporting for the FY 2027 payment determination and subsequent years.

Additionally, in the technical report[7] accompanying the FY 2023 IPF PPS proposed rule, we explained that we analyzed the costs associated with SDOH but found that our analysis was confounded by a low frequency of IPF claims reporting the applicable ICD–10 diagnosis codes. In response to the FY 2023 IPF PPS proposed rule we received 10 comments pertaining to the report on the analysis of patient-level and facility-level adjustment factors, and areas of interest for further research, including additional SDOH analysis.

Working in collaboration with a contractor, subsequent analysis has shown that other SDOH codes, such as Z59.9 Problem related to housing and economic circumstances, unspecified, are associated with statistically significant, higher costs. In general, our analysis found that claims that included SDOH codes had lower costs than claims that did not include such codes. This finding is counterintuitive; however, we note that studies have found that there are disparities in the reporting of SDOH codes, such as homelessness.[8] Additionally, our analysis found that certain codes were associated with increased cost for IPF treatment. Specifically, the below SDOH codes in the analysis were found to be statistically significant and had a stay count of greater than 100. These codes had an adjustment factor above 1, suggesting that these conditions may increase relative costliness of IPF stays:

- Z559 Problems related to education and literacy, unspecified.
- Z599 Problems related to housing and economic circumstances, unspecified.
- Z600 Problems of adjustment to life-cycle transitions.
- Z634 Disappearance and death of family member.
- Z653 Problems related to other legal circumstances.
- Z659 Problems related to unspecified psychosocial circumstances.

We solicited comments on these findings and information about whether it would be appropriate to consider incorporating these codes into the IPF PPS in the future, for example as a patient-level adjustment. Specifically, for codes that are ''unspecified,'' we sought information about what types of conditions or circumstances these codes might represent. We sought any information that commenters could provide about the reasons for including these codes on claims. We also requested information on what factors commenters believe we should consider in order to better understand the cost regression results presented above.

D. Public Comments Received in Response to CY 2024 IPF PPS Proposed Rule

We received 15 comments in response to the FY 2024 IPF PPS proposed rule pertaining to existing and future data collection to inform revisions to the IPF PPS as required by the CAA, 2023. Commenters offered various suggestions of patient characteristics and factors we could consider for analysis. Commenters included MedPAC, state-level and national provider and patient advocacy organizations, and health systems.

We thank commenters for their detailed responses to this comment solicitation. We will take these comments into consideration to potentially inform future rulemaking.

VI. Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program

A. Background and Statutory Authority

The Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program is authorized by section 1886(s)(4) of the Act, and it applies to psychiatric hospitals and psychiatric units paid by Medicare under the IPF PPS (see section VI.B. of this final rule). Section 1886(s)(4)(A)(i) of the Act requires the Secretary to reduce by 2 percentage points the annual update to the standard federal rate for discharges for the IPF occurring during such fiscal year[9] for

[5] *https://health.gov/healthypeople/priority-areas/social-determinants-health.*

[6] Paula A. Braveman, Catherine Cubbin, Susan Egerter, David R. Williams, and Elsie Pamuk, 2010: Socioeconomic Disparities in Health in the United States: What the Patterns Tell Us American Journal of Public Health 100, S186_S196, *https://doi.org/10.2105/AJPH.2009.166082.*

[7] *https://www.cms.gov/files/document/technical-report-medicare-program-inpatient-psychiatric-facilities-prospective-payment-system.pdf.*

[8] *https://aspe.hhs.gov/reports/health-conditions-among-individuals-history-homelessness-research-brief-0.*

[9] We note that the statute uses the term ''rate year'' (RY). However, beginning with the annual update of the inpatient psychiatric facility prospective payment system (IPF PPS) that took effect on July 1, 2011 (RY 2012), we aligned the IPF PPS update with the annual update of the ICD codes, effective on October 1 of each year. This change allowed for annual payment updates and the ICD coding update to occur on the same schedule and appear in the same **Federal Register**

any IPF that does not comply with quality data submission requirements under the IPFQR Program, set forth in accordance with section 1886(s)(4)(C) of the Act, with respect to an applicable fiscal year.

Section 1886(s)(4)(C) of the Act requires IPFs to submit to the Secretary data on quality measures specified by the Secretary under section 1886(s)(4)(D) of the Act. Except as provided in section 1886(s)(4)(D)(ii) of the Act, section 1886(s)(4)(D)(i) of the Act requires that any measure specified by the Secretary must have been endorsed by the consensus-based entity (CBE) with a contract under section 1890(a) of the Act. Section 1886(s)(4)(D)(ii) of the Act provides that, in the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the CBE with a contract under section 1890(a) of the Act, the Secretary may specify a measure that is not endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

We refer readers to the FY 2019 IPF PPS final rule (83 FR 38589) for a more detailed discussion of the background and statutory authority of the IPFQR Program.

For the IPFQR Program, we refer to the year in which an IPF would receive the 2-percentage point reduction to the annual update to the standard federal rate as the *payment determination* year. An IPF generally meets IPFQR Program requirements by submitting data on specified quality measures in a specified time and manner during a *data submission period* that occurs prior to the payment determination year. These data reflect a period prior to the data submission period during which the IPF furnished care to patients; this period is known as the *performance period.* For example, for a measure affecting FY 2026 payment determination, for which CY 2024 is the performance period and for which data are required to be submitted in CY 2025, if an IPF did not submit the data for this measure as specified during CY 2025 (even if the IPF meets all other IPFQR Program requirements for the FY 2026 payment determination) we would reduce by 2-percentage points that IPF's update for the FY 2026 payment determination year.

In the FY 2024 IPF PPS proposed rule (88 FR 21273), we proposed to codify the IPFQR Program requirements governing IPF reporting on quality measures in a new regulation at § 412.433, which is the section preceding our existing regulation governing reconsideration and appeals procedures for IPFQR Program decisions in our regulations at § 412.434. Specifically, we proposed to codify a general statement of the IPFQR Program authority and structure at § 412.433(a). Paragraph (a) will cite section 1886(s)(4) of the Act, which requires the Secretary to implement a quality reporting program for inpatient psychiatric hospitals and psychiatric units. Paragraph (a) will also state that IPFs paid under the IPF PPS as provided in section 1886(s)(1) of the Act that do not report data required for the quality measures selected by the Secretary in a form and manner, and at a time specified by the Secretary will incur a 2.0 percentage point reduction to the annual update to the standard federal rate with respect to the applicable fiscal year.

We solicited comments on this proposal.

Comment: One commenter requested clarification regarding whether there are penalties for facilities that do not meet all the reporting requirements for a specific year.

Response: The IPFQR Program is a pay-for-reporting program. IPFs are not, and will not be, penalized based on their performance on measures reported to CMS as part of the IPFQR Program. However, if an IPF does not comply with quality data submission requirements under the IPFQR Program for a given fiscal year, section 1886(s)(4)(A)(i) of the Act requires the Secretary to reduce by 2 percentage points the annual update to the standard federal rate for discharges for the IPF occurring during such fiscal year.

We specifically proposed to codify established IPFQR Program requirements, particularly those set forth in the statute at section 1886(s)(4) of the Act and our prior rulemaking, in a new regulation at § 412.433. Our proposal to codify penalties for an IPF's failure to submit data as required by the IPFQR Program at § 412.433(a) merely reiterates the penalty already required by the statute set forth at section 1886(s)(4) of the Act.

Final Decision: After consideration of the public comments we received, we are finalizing codification of the IPFQR Program requirements governing IPF reporting on quality measures at a new regulation at § 412.433. We are finalizing the regulation text as proposed except that we are correcting one typographical error in which the ''Act'' was inadvertently referred to as the ''act.''

B. Covered Entities

In the FY 2013 IPPS/LTCH PPS final rule (77 FR 53645), we established that the IPFQR Program's quality reporting requirements cover those psychiatric hospitals and psychiatric units paid by Medicare under IPF PPS in accordance with § 412.404(b). Generally, psychiatric hospitals and psychiatric units within acute care and critical access hospitals (CAHs) that treat Medicare patients are paid under the IPF PPS. Consistent with previous regulations, we continue to use the terms ''facility'' or ''IPF'' to refer to both inpatient psychiatric hospitals and psychiatric units. This usage follows the terminology in our IPF PPS regulations at § 412.402. For more information on covered entities, we refer readers to the FY 2013 IPPS/LTCH PPS final rule (77 FR 53645).

C. Previously Finalized Measures

The current IPFQR Program includes 14 measures for the FY 2024 payment determination. For more information on these measures, we refer readers to Table 20 of this final rule (see section VI.G of this final rule).

D. Measure Adoption

We strive to put patients and caregivers first, ensuring they are empowered to partner with their clinicians in their healthcare decision-making using information from data-driven insights that are increasingly aligned with meaningful quality measures. We support technology that reduces burden and allows clinicians to focus on providing high-quality healthcare for their patients. We also support innovative approaches to improve quality, accessibility, and affordability of care while paying particular attention to improving clinicians' and beneficiaries' experiences when interacting with our programs. In combination with other efforts across HHS, we believe the IPFQR Program helps to incentivize IPFs to improve healthcare quality and value while giving patients and providers the tools and information needed to make the best individualized decisions. Consistent with these goals, our objective in selecting quality

document, promoting administrative efficiency. To reflect the change to the annual payment rate update cycle, we revised the regulations at 42 CFR 412.402 to specify that, beginning October 1, 2012, the IPF PPS RY means the 12-month period from October 1 through September 30, which we refer to as a ''fiscal year'' (FY) (76 FR 26435). Therefore, with respect to the IPFQR Program, the terms ''rate year,'' as used in the statute, and ''fiscal year'' as used in the regulation, both refer to the period from October 1 through September 30. For more information regarding this terminology change, we refer readers to section III of the RY 2012 IPF PPS final rule (76 FR 26434 through 26435).

measures for the IPFQR Program is to balance the need for information on the full spectrum of care delivery and the need to minimize the burden of data collection and reporting. We have primarily focused on measures that evaluate critical processes of care that have significant impact on patient outcomes and support CMS and HHS priorities for improved quality and efficiency of care provided by IPFs. When possible, we also propose to incorporate measures that directly evaluate patient outcomes and experience.

We refer readers to the CMS National Quality Strategy,[10] the Behavioral Health Strategy,[11] the Framework for Health Equity,[12] and the Meaningful Measures Framework [13] for information related to our priorities in selecting quality measures.

1. Measure Selection Process

Section 1890A of the Act requires that the Secretary establish and follow a pre-rulemaking process, in coordination with the consensus-based entity (CBE) with a contract under section 1890 of the Act, to solicit input from certain groups regarding the selection of quality and efficiency measures for the IPFQR Program. Before being proposed for inclusion in the IPFQR Program, measures are placed on a list of Measures Under Consideration (MUC) list, which is published annually on behalf of CMS by the consensus-based entity (CBE),[14] with which the Secretary must contract as required by section 1890(a) of the Act. Following publication on the MUC list, a multi-stakeholder group convened by the CBE reviews the measures under consideration for the IPFQR Program, among other federal programs, and provides input on those measures to the Secretary. We consider the input and recommendations provided by this multi-stakeholder group in selecting all measures for the IPFQR Program.

Information about the multi-stakeholder group's input on each of our newly adopted measures is described in the following subsections. In our evaluation of the IPFQR Program measure set, we identified four measures that we believe are appropriate for adoption for the IPFQR Program:

- Facility Commitment to Health Equity;
- Screening for Social Drivers of Health;
- Screen Positive Rate for Social Drivers of Health; and
- Psychiatric Inpatient Experience (PIX) Survey.

These four measures are described in the following subsections.

2. Adoption of the Facility Commitment to Health Equity Measure Beginning With the CY 2024 Reporting Period (Data Submitted in CY 2025)/FY 2026 Payment Determination

a. Background

Significant and persistent disparities in healthcare outcomes exist in the United States. For example, belonging to a racial or ethnic minority group, living with a disability, being a member of the lesbian, gay, bisexual, transgender, and queer (LGBTQ+) community, being a member of a religious minority, living in a rural area, or being near or below the poverty level, is often associated with worse health outcomes.[15] [16] [17] [18] [19] [20] [21] [22] [23] [24] Numerous studies have shown that among Medicare beneficiaries, racial and ethnic minority individuals often receive clinical care of lower quality, report having worse care experiences, and experience more frequent hospital readmissions and procedural complications.[25] [26] [27] [28] [29] [30] Readmission rates in the Hospital Readmissions Reduction Program have been shown to be higher among Black and Hispanic Medicare beneficiaries with common

[10] Schreiber, M, Richards, A, et al. (2022). The CMS National Quality Strategy: A Person-Centered Approach to Improving Quality. Available at: *https://www.cms.gov/blog/cms-national-quality-strategy-person-centered-approach-improving-quality*. Accessed on February 20, 2023.

[11] CMS. (2022). CMS Behavioral Health Strategy. Available at *https://www.cms.gov/cms-behavioral-health-strategy*. Accessed on February 20, 2023.

[12] CMS. (2022). CMS Framework for Health Equity 2022–2032. Available at *https://www.cms.gov/files/document/cms-framework-health-equity-2022.pdf*. Accessed on February 20, 2023.

[13] CMS. (2022). Meaningful Measures 2.0: Moving from Measure Reduction to Modernization. Available at *https://www.cms.gov/medicare/meaningful-measures-framework/meaningful-measures-20-moving-measure-reduction-modernization*. Accessed on February 20, 2023.

[14] In previous years, we referred to the consensus-based entity by corporate name. We have updated this language to refer to the consensus-based entity more generally.

[15] Joynt KE, Orav E, Jha AK. (2011). Thirty-Day Readmission Rates for Medicare Beneficiaries by Race and Site of Care. JAMA, 305(7), 675–681. Available at: *https://jamanetwork.com/journals/jama/fullarticle/645647*. Accessed on February 13, 2023.

[16] Lindenauer PK, Lagu T, Rothberg MB, et al. (2013). Income Inequality and Thirty-Day Outcomes After Acute Myocardial Infarction, Heart Failure, and Pneumonia: Retrospective Cohort Study. BMJ, 346. Available at: *https://doi.org/10.1136/bmj.f521*. Accessed on February 13, 2023.

[17] Trivedi AN, Nsa W, Hausmann LRM, et al. (2014). Quality and Equity of Care in U.S. Hospitals. N Engl J Med, 371(24), 2298–2308. Available at: *https://www.nejm.org/doi/10.1056/NEJMsa1405003*. Accessed on February 13, 2023.

[18] Polyakova, M, Udalova V, et al. (2021). Racial Disparities In Excess All-Cause Mortality During The Early COVID–19 Pandemic Varied Substantially Across States. Health Affairs, 40(2), 307–316. Available at: *https://doi.org/10.1377/hlthaff.2020.02142*. Accessed on February 14, 2023.

[19] Rural Health Research Gateway. (2018). Rural Communities: Age, Income, and Health Status. Rural Health Research Recap. Available at: *https://www.ruralhealthresearch.org/assets/2200–8536/rural-communities-age-income-health-status-recap.pdf*. Accessed on February 14, 2023.

[20] HHS Office of Minority Health. (2020). Progress Report to Congress, 2020 Update on the Action Plan to Reduce Racial and Ethnic Health Disparities. Department of Health and Human Services. Available at: *https://www.minorityhealth.hhs.gov/assets/PDF/Update_HHS_Disparities_Dept-FY2020.pdf* . Accessed on February 14, 2023.

[21] Heslin KC, Hall JE. (2021). Sexual Orientation Disparities in Risk Factors for Adverse COVID–19 Related Outcomes, by Race/Ethnicity—Behavioral Risk Factor Surveillance System, United States, 2017–2019. MMWR Morb Mortal Wkly Rep, 70(5), 149. Available at: *https://www.cdc.gov/mmwr/volumes/70/wr/mm7005a1.htm*. Accessed on February 14, 2023.

[22] Poteat TC, Reisner SL, Miller M, Wirtz AL. (2020). COVID–19 Vulnerability of Transgender Women With and Without HIV Infection in the Eastern and Southern U.S. medRxiv. Available at: *https://www.medrxiv.org/content/10.1101/2020.07.21.20159327v1.full.pdf*. Accessed on February 14, 2023.

[23] Vu M, Azmat A, Radejko T, Padela AI. (2016). Predictors of Delayed Healthcare Seeking Among American Muslim Women. Journal of Women's Health, 25(6), 586–593. Available at: *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5912720/*. Accessed on February 14, 2023.

[24] Nadimpalli SB, Cleland CM, Hutchinson MK, Islam N, Barnes LL, Van Devanter N. (2016). The Association Between Discrimination and the Health of Sikh Asian Indians. Health Psychology, 35(4), 351–355. Available at: *https://doi.org/10.1037/hea0000268*. Accessed o n February 14, 2023.

[25] CMS Office of Minority Health. (2020). Racial, Ethnic, and Gender Disparities in Healthcare in Medicare Advantage. Baltimore, MD: Centers for Medicare & Medicaid Services. Available at: *https://www.cms.gov/files/document/2020-national-level-results-race-ethnicity-and-gender-pdf.pdf* Accessed on February 14, 2023.

[26] CMS Office of Minority Health. (2018). Guide to Reducing Disparities in Readmissions. Available at: *https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/OMH_Readmissions_Guide.pdf*. Accessed on February 14, 2023.

[27] Singh JA, Lu X, et al. (2014). Racial Disparities in Knee and Hip Total Joint Arthroplasty: An 18-year analysis of national Medicare data. Ann Rheum Dis., 73(12), 2107–15. Available at: *https://ard.bmj.com/content/73/12/2107.full*. Accessed on February 14, 2023.

[28] Rivera-Hernandez M, Rahman M, Mor V, Trivedi AN. (2019). Racial Disparities in Readmission Rates among Patients Discharged to Skilled Nursing Facilities. J Am Geriatr Soc., 67(8), 1672–1679. Available at: *https://doi.org/10.1111/jgs.15960*. Accessed on February 14, 2023.

[29] Joynt KE, Orav E, Jha AK. (2011). Thirty-Day Readmission Rates for Medicare Beneficiaries by Race and Site of Care. JAMA, 305(7), 675–681. Available at: *https://jamanetwork.com/journals/jama/fullarticle/645647*. Accessed on February 13, 2023.

[30] Tsai TC, Orav EJ, Joynt KE. (2014). Disparities in Surgical 30-day Readmission Rates for Medicare Beneficiaries by Race and Site of Care. Ann Surg., 259(6), 1086–1090. Available at: *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4107654/*. Accessed on February 14, 2023.

conditions, including congestive heart failure and acute myocardial infarction.[31 32 33 34 35] Data indicate that, even after accounting for factors such as socioeconomic conditions, members of racial and ethnic minority groups reported experiencing lower quality of healthcare.[36] Evidence of differences in quality of care received among people from racial and ethnic minority groups shows worse health outcomes, including a higher incidence of diabetes complications such as retinopathy.[37] Additionally, inequities in the social drivers of health (SDOH) affecting these groups, such as poverty and healthcare access, are interrelated and influence a wide range of health and quality-of-life outcomes and risks.[38]

Because we are working toward the goal of all patients receiving high-quality healthcare, regardless of individual characteristics, we are committed to supporting healthcare organizations in building a culture of safety and equity that focuses on educating and empowering their workforce to recognize and eliminate health disparities. This includes patients receiving the right care, at the right time, in the right setting for their condition(s), regardless of those characteristics.

In the FY 2022 IPF PPS final rule (86 FR 42625 through 42632), we summarized the comments we received in response to our Request for Information (RFI) on closing health equity gaps in our quality programs, specifically the IPFQR Program. In response to this RFI, several commenters recommended that we consider a measure of organizational commitment to health equity. These commenters further described how infrastructure supports delivery of equitable care. In the FY 2023 IPF PPS final rule (87 FR 46865 through 46873), we described our RFI on overarching principles for measuring equity and healthcare quality across our quality programs and summarized the comments we received in response to that RFI. Because we had specifically solicited comments on the potential for a structural measure assessing an IPF's commitment to health equity, many commenters provided input on a structural measure. While many commenters supported the concept, one commenter expressed concern with this measure concept and stated that there is no evidence that performance on this measure will lead to improved patient outcomes (87 FR 46872 through 46873). However, we believe that strong and committed leadership from IPF executives and board members is essential and can play a role in shifting organizational culture and advancing equity goals.

Additionally, studies demonstrate that facility leadership can positively influence culture for better quality, patient outcomes, and experience of care.[39 40 41] A systematic review of 122 published studies showed that strong leadership that prioritized safety, quality, and the setting of clear guidance with measurable goals for improvement resulted in high-performing facilities with better patient outcomes.[42] Therefore, we believe leadership commitment to health equity will have a parallel effect in contributing to a reduction in health disparities.

Further, we note that the Agency for Healthcare Research and Quality (AHRQ) and The Joint Commission (TJC) identified that facility leadership plays an important role in promoting a culture of quality and safety.[43 44 45] For instance, AHRQ research shows that a facility's board can influence quality and safety in a variety of ways, not only through strategic initiatives, but also through more direct interactions with frontline workers.[46]

In addition, the Institute of Healthcare Improvement's (IHI's) research of 23 health systems throughout the United States and Canada shows that health equity must be a priority championed by leadership teams to improve both patient access to needed healthcare services and outcomes among populations that have been disadvantaged by the healthcare system.[47] This IHI study specifically identified concrete actions to make advancing health equity a core strategy,

[31] Rodriguez F, Joynt KE, Lopez L, Saldana F, Jha AK. (2011). Readmission Rates for Hispanic Medicare Beneficiaries with Heart Failure and Acute Myocardial Infarction. Am Heart J., 162(2), 254–261 e253. Available at: *https://www.sciencedirect.com/science/article/pii/S0002870311003966?viewFullText=true.* Accessed on February 14, 2023.

[32] Centers for Medicare & Medicaid Services. (2014). Medicare Hospital Quality Chartbook: Performance Report on Outcome Measures. Available at: *https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/YNH_Chartbook_2014_508Compliant_FINAL.pdf.* Accessed on February 14, 2023.

[33] CMS Office of Minority Health. (2018). Guide to Reducing Disparities in Readmissions. Available at: *https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/OMH_Readmissions_Guide.pdf.* Accessed on February 14, 2023.

[34] Prieto-Centurion V, Gussin HA, Rolle AJ, Krishnan JA. (2013). Chronic Obstructive Pulmonary Disease Readmissions at Minority Serving Institutions. Ann Am Thorac Soc., 10(6), 680–684. Available at: *https://doi.org/10.1513/AnnalsATS.201307-223OT.* Accessed on February 14, 2023.

[35] Joynt KE, Orav E, Jha AK. (2011). Thirty-Day Readmission Rates for Medicare Beneficiaries by Race and Site of Care. JAMA, 305(7), 675–681. Available at: *https://jamanetwork.com/journals/jama/fullarticle/645647.* Accessed on February 13, 2023.

[36] Nelson AR. (2003). Unequal Treatment: Report of the Institute of Medicine on Racial and Ethnic Disparities in Healthcare. The Annals of Thoracic Surgery, 76(4), S1377–S1381. *https://www.annalsthoracicsurgery.org/action/showPdf?pii=S0003-4975%2803%2901205-0.* Accessed on February 14, 2023.

[37] Peek, ME, Odoms-Young, A, et al. (2010). Race and Shared Decision-Making: Perspectives of African-Americans with diabetes. Social Science & Medicine, 71(1), 1–9. Available at: *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2885527/.* Accessed on February 14, 2023.

[38] Department of Health and Human Services. (2023). Healthy People 2030: Social Determinants of Health. Available at: *https://health.gov/healthypeople/priority-areas/social-determinants-health.* Accessed on February 20, 2023.

[39] Bradley EH, Brewster AL, et al. (2018). How Guiding Coalitions Promote Positive Culture Change in Hospitals: A Longitudinal Mixed Methods Interventional Study. BMJ Qual Saf., 27(3), 218–225. Available at: *https://qualitysafety.bmj.com/content/qhc/27/3/218.full.pdf.* Accessed on February 14, 2023.

[40] Smith SA, Yount N, Sorra J. (2017). Exploring Relationships Between Hospital Patient Safety Culture and Consumer Reports Safety Scores. BMC Health Services Research, 17(1), 143. Available at: *https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-017-2078-6.* Accessed on February 14, 2023.

[41] Keroack MA, Youngberg BJ, et al. (2007). Organizational Factors Associated with High Performance in Quality and Safety in Academic Medical Centers. Acad Med., 82(12), 1178–86. Available at: *https://journals.lww.com/academicmedicine/Fulltext/2007/12000/Organizational_Factors_Associated_with_High.14.aspx.* Accessed on February 14, 2023.

[42] Millar R, Mannion R, Freeman T, et al. (2013). Hospital Board Oversight of Quality and Patient Safety: A Narrative Review and Synthesis of Recent Empirical Research. The Milbank Quarterly, 91(4), 738–70. Available at: *https://onlinelibrary.wiley.com/doi/10.1111/1468-0009.12032.* Accessed February 14, 2023.

[43] Agency for Healthcare Research and Quality. Leadership Role in Improving Patient Safety. Patient Safety Primer, September 2019. Available at: *https://psnet.ahrq.gov/primer/leadership-role-improving-safety.* Accessed on February 14, 2023.

[44] Joint Commission on Accreditation of Healthcare Organizations, USA. The essential role of leadership in developing a safety culture. Sentinel Event Alert. 2017 (Revised June 2021). Available at: *https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/sentinel-event/sea-57-safety-culture-and-leadership-final2.pdf.* Accessed on February 15, 2023.

[45] See information on launch of new ''Health Care Equity Certification'' in July 2023 from Joint Commission on Accreditation of Healthcare Organizations, USA, available at: *https://www.jointcommission.org/our-priorities/health-care-equity/health-care-equity-prepublication/.* Accessed on February 15, 2023.

[46] Agency for Healthcare Research and Quality. Leadership Role in Improving Patient Safety. Patient Safety Primer. (2019). Available at: *https://psnet.ahrq.gov/primer/leadership-role-improving-safety.* Accessed on February 14, 2023.

[47] Mate KS and Wyatt R. (2017). Health Equity Must Be a Strategic Priority. NEJM Catalyst. Available at: *https://catalyst.nejm.org/doi/full/10.1056/CAT.17.0556.* Accessed on February 15, 2023.

including establishing this goal as a leader-driven priority alongside organizational development structures and processes.[48]

Based upon these findings, we believe that IPF leadership can be instrumental in setting specific, measurable, attainable, realistic, and time-based (SMART) goals to assess progress towards achieving equity goals and ensuring high-quality care is accessible to all. Therefore, consistent with the Hospital Inpatient Quality Reporting (IQR) Program's adoption of an attestation-based structural measure in the FY 2023 IPPS/LTCH PPS final rule (87 FR 49191 through 49201), we proposed to adopt an attestation-based structural measure, Facility Commitment to Health Equity, to address health equity beginning with the CY 2024 reporting period/FY 2026 payment determination.

The first pillar of our strategic priorities [49] reflects our deep commitment to improvements in health equity by addressing the health disparities that underly our health system. In line with this strategic pillar, we developed this structural measure to assess facility commitment to health equity across five domains (described in Table 17 in section VI.D.2.b of this final rule) using a suite of organizational competencies aimed at achieving health equity for racial and ethnic minority groups, people with disabilities, members of the LGBTQ+ community, individuals with limited English proficiency, rural populations, religious minorities, and people facing socioeconomic challenges. We believe these elements are actionable focus areas, and assessment of IPFs' leadership commitment to them is foundational.

We also believe adoption of the Facility Commitment to Health Equity measure will incentivize IPFs to collect and utilize data to identify critical equity gaps, implement plans to address these gaps, and ensure that resources are dedicated toward addressing health equity initiatives. While many factors contribute to health equity, we believe this measure is an important step toward assessing IPFs' leadership commitment, and a fundamental step toward closing the gap in equitable care for all populations. We note that this measure is not intended to encourage IPFs to act on any one data element or domain, but instead encourages IPFs to analyze their own findings to understand if there are any demographic factors (for example, race, national origin, primary language, and ethnicity) as well as SDOHs (for example, housing status and food security) associated with underlying inequities and, in turn, develop solutions to deliver more equitable care. Thus, the Facility Commitment to Health Equity measure aims to support IPFs in leveraging available data, pursuing focused quality improvement activities, and promoting efficient and effective use of resources.

The Facility Commitment to Health Equity measure aligns with the measure previously adopted in the Hospital IQR Program, and we refer readers to the FY 2023 IPPS/LTCH PPS final rule (87 FR 49191 through 49201) for more information regarding the measure's adoption in the Hospital IQR Program. The five domains of the Facility Commitment to Health Equity measure are adapted from the CMS Office of Minority Health's Building an Organizational Response to Health Disparities framework, which focuses on data collection, data analysis, culture of equity, and quality improvement.[50]

The Facility Commitment to Health Equity measure also aligns with our efforts under the Meaningful Measures Framework, which identifies high-priority areas for quality measurement and improvement to assess core issues most critical to high-quality healthcare and improving patient outcomes.[51] In 2021, we launched Meaningful Measures 2.0 to promote innovation and modernization of all aspects of quality, and to address a wide variety of settings, stakeholders, and measure requirements.[52] We are addressing healthcare priorities and gaps with Meaningful Measures 2.0 by leveraging quality measures to promote equity and close gaps in care. The Facility Commitment to Health Equity measure supports these efforts and is aligned with the Meaningful Measures Area of ''Equity of Care'' and the Meaningful Measures 2.0 goal to ''Leverage Quality Measures to Promote Equity and Close Gaps in Care.'' This measure also supports the Meaningful Measures 2.0 objective to commit to a patient-centered approach in quality measure and value-based incentives programs to ensure that quality and safety measures address health equity.

b. Overview of Measure

The Facility Commitment to Health Equity measure will assess IPFs' commitment to health equity using a suite of equity-focused organizational competencies aimed at achieving health equity for populations that have been disadvantaged, marginalized, and underserved by the healthcare system. As previously noted, these populations include, but are not limited to, racial and ethnic minority groups, people with disabilities, members of the LGBTQ+ community, individuals with limited English proficiency, rural populations, religious minorities, and people facing socioeconomic challenges. Table 17 sets forth the five attestation domains, and the elements within each of those domains, to which an IPF will affirmatively attest for the IPF to receive credit for that domain within the Facility Commitment to Health Equity measure.

[48] Mate KS and Wyatt R. (2017). Health Equity Must Be a Strategic Priority. NEJM Catalyst. Available at: *https://catalyst.nejm.org/doi/full/10.1056/CAT.17.0556.* Accessed on February 15, 2023.

[49] Brooks-LaSure, C. (2021). My First 100 Days and Where We Go From Here: A Strategic Vision for CMS. Centers for Medicare & Medicaid. Available at: *https://www.cms.gov/blog/my-first-100-days-and-where-we-go-here-strategic-vision-cms.* Accessed on February 15, 2023. Also see *https://www.cms.gov/cms-strategic-plan.*

[50] CMS. (2021). Building an Organizational Response to Health Disparities [Fact Sheet]. Available at: *https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Health-Disparities-Guide.pdf.* Accessed on February 15, 2023.

[51] Centers for Medicare & Medicaid Services. Meaningful Measures Framework. Available at: *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/CMS-Quality-Strategy.* Accessed on February 15, 2023.

[52] CMS. (2022). Meaningful Measures 2.0: Moving from Measure Reduction to Modernization. Available at *https://www.cms.gov/medicare/meaningful-measures-framework/meaningful-measures-20-moving-measure-reduction-modernization.* Accessed on February 20, 2023.

TABLE 17: THE FACILITY COMMITMENT TO HEALTH EQUITY MEASURE FIVE ATTESTATIONS

Attestation	**Elements**: Select all that apply (Note: Affirmative attestation of all elements within a domain will be required for the facility to receive a point for the domain in the numerator).
Domain 1: Equity is a Strategic Priority	
Facility commitment to reducing healthcare disparities is strengthened when equity is a key organizational priority. Please attest that your facility has a strategic plan for advancing health equity* and that it includes all the following elements.	(A) Our facility strategic plan identifies priority populations who currently experience health disparities. (B) Our facility strategic plan identifies health equity goals and discrete action steps to achieving these goals.* (C) Our facility strategic plan outlines specific resources which have been dedicated to achieving our equity goals. (D) Our facility strategic plan describes our approach for engaging key stakeholders, such as community-based organizations.
Domain 2: Data Collection	
Collecting valid and reliable demographic and SDOH data on patients served in a facility is an important step in identifying and eliminating health disparities. Please attest that your facility engages in the following activities.	(A) Our facility collects demographic information (such as self-reported race, national origin, primary language, and ethnicity data) and/or social determinant of health information on the majority of our patients.** (B) Our facility has training for staff in culturally sensitive collection of demographic and/or SDOH information. (C) Our facility inputs demographic and/or SDOH information collected from patients into structured, interoperable data elements using a certified electronic health record (EHR) technology.
Domain 3: Data Analysis	
Effective data analysis can provide insights into which factors contribute to health disparities and how to respond. Please attest that your facility engages in the following activities.	(A) Our facility stratifies key performance indicators by demographic and/or SDOH variables to identify equity gaps and includes this information on facility performance dashboards.
Domain 4: Quality Improvement	
Health disparities are evidence that high-quality care has not been delivered equitably*** to all patients. Engagement in quality improvement activities can improve quality of care for all patients.	(A) Our facility participates in local, regional, or national quality improvement activities focused on reducing health disparities.
Domain 5: Leadership Engagement	
Leaders and staff can improve their capacity to address disparities by demonstrating routine and thorough attention to equity and setting an organizational culture of equity. Please attest that your facility engages in the following activities.	(A) Our facility senior leadership, including chief executives and the entire facility**** board of trustees, annually reviews our strategic plan for achieving health equity. (B) Our facility senior leadership, including chief executives and the entire facility board of trustees, annually reviews key performance indicators stratified by demographic and/or social factors.

* After publication of the 2022 MUC List, we clarified the language in Domain 1 to refer to "health equity" instead of "healthcare equity."

** After publication of the 2022 MUC List, we clarified the language in Domain 2 to refer to example demographic information.

*** After publication of the 2022 MUC List, we clarified the language in Domain 4: "Health disparities are evidence that high quality care has not been delivered *equitably* to all patients."

**** After publication of the 2022 MUC List, we identified that Domain 5 incorrectly referred to the "hospital board of trustees" instead of the "facility board of trustees."

(1) Measure Calculation

The Facility Commitment to Health Equity measure consists of five attestation-based questions, each representing a separate domain of the IPF's commitment to addressing health equity. Some of these domains have multiple elements to which an IPF will be required to attest. For an IPF to affirmatively attest ''yes'' to a domain, and receive credit for that domain, the IPF would evaluate and determine whether it engages in each of the elements that comprise that domain. Each of the domains will be represented in the denominator as a point, for a total of five points (that is, one point per domain).

The numerator of the Facility Commitment to Health Equity measure will capture the total number of domain attestations that the IPF is able to affirm. An IPF that affirmatively attests to each element within the five domains will receive the maximum five points.

An IPF will only receive a point for a domain if it attests ''yes'' to all related elements within that domain. There is no ''partial credit'' for elements. For example, for Domain 1 (''Facility commitment to reducing healthcare disparities is strengthened when equity is a key organizational priority''), an IPF will evaluate and determine whether its strategic plan meets each of the elements described in (A) through (D) (see Table 17 in section VI.D.2.b of this final rule). If the IPF's strategic plan meets all four of these elements, the IPF would affirmatively attest ''yes'' to Domain 1 and would receive one (1) point for that attestation. An IPF will not be able to receive partial credit for a domain. For example, if the IPF's strategic plan meets elements (A) and (B), but not (C) and (D), of Domain 1, then the IPF would not be able to affirmatively attest ''yes'' to Domain 1 and would not receive a point for that attestation, and instead would receive zero points for Domain 1.

In response to our RFI on the potential for a structural measure assessing an IPF's commitment to health equity, several commenters expressed concern that such a measure would be difficult for IPFs to report because of the requirement to use certified electronic health record (EHR) technology for Domain 2 (87 FR 46972 through 46873). We believe that use of certified EHR technology is an important element of collecting valid and reliable demographic and social drivers of health data on patients served in an IPF and that use of this technology facilitates data analytics to ensure consistent, high-quality, equitable care. However, we recognize that some IPFs may face challenges to adopting certified EHR technology. We note that the IPFQR Program is a pay-for-reporting program, not a pay-for-performance program, and therefore IPFs that do not have certified EHR technology can attest that they satisfy the other domains, as applicable, and receive a score of 0–4 out of 5 without any penalties.

(2) Review by the Measure Applications Partnership (MAP) [53]

We included the Facility Commitment to Health Equity measure on the publicly available MUC List, a list of measures under consideration for use in various Medicare programs.[54] The specifications for the Facility Commitment to Health Equity measure, which were available during the review of the MUC List, are available on the CMS website at: *https://mmshub.cms.gov/sites/default/files/map-hospital-measure-specifications-manual-2022.pdf.*

The CBE-convened MAP Health Equity Advisory Group reviewed the MUC List and the Facility Commitment to Health Equity measure (MUC 2022–027) in detail on December 6 through 7, 2022.[55] The MAP Health Equity Advisory Group raised concerns that this measure does not evaluate outcomes and may not directly address health inequities at a systemic level, but generally agreed that a structural measure such as this one represents progress toward improving equitable care.[56]

In addition, on December 8 through 9, 2022, the MAP Rural Health Advisory Group reviewed the 2022 MUC List and expressed support for this measure as a step towards advancing access to and quality of care with the caveat that resource challenges exist in rural communities.[57]

The MAP Hospital Workgroup reviewed the 2022 MUC List on December 13 through 14, 2022.[58] The MAP Hospital Workgroup recognized that reducing health care disparities would represent a substantial benefit to overall quality of care but expressed reservations about the measure's link to clinical outcomes. As stated in the MAP recommendations document, the MAP Hospital Workgroup members voted to conditionally support the Facility Commitment to Health Equity measure for rulemaking pending: (1) endorsement by the CBE; (2) commitment to consideration of equity related outcome measures in the future; (3) provision of more clarity on the Facility Commitment to Health Equity measure and supplementing interpretation with results; and (4) verification of accurate attestation by IPFs.[59] Thereafter, the MAP Coordinating Committee deliberated on January 24 through 25, 2023 and ultimately voted to uphold the MAP Hospital Workgroup's recommendation to conditionally support the measure for rulemaking.[60]

We believe that the Facility Commitment to Health Equity measure establishes an important foundation for prioritizing the achievement of health equity among IPFs participating in the IPFQR Program. Our approach to developing health equity measures has been incremental to date, but we see inclusion of such measures in the IPFQR Program as informing efforts to advance and achieve health equity not only among IPFs, but also other acute care settings. We believe this measure to be a building block that lays the groundwork for a future meaningful suite of measures that would assess IPF progress in providing high-quality healthcare for all patients regardless of social risk factors or demographic characteristics.

(3) CBE Endorsement

We have not submitted this measure for CBE endorsement at this time.

[53] Interested parties convened by the consensus-based entity provide input and recommendations on the Measures under Consideration (MUC) list as part of the pre-rulemaking process required by section 1890A of the Act. We refer readers to *https://p4qm.org/PRMR-MSR* for more information.

[54] Centers for Medicare & Medicaid Services. List of Measures Under Consideration for December 1, 2022. Available at: *https://mmshub.cms.gov/measure-lifecycle/measure-implementation/pre-rulemaking/lists-and-reports.*

[55] Centers for Medicare & Medicaid Services. 2022–2023 MAP Final Recommendations. Available at: *https://mmshub.cms.gov/measure-lifecycle/measure-implementation/pre-rulemaking/lists-and-reports.*

[56] Centers for Medicare & Medicaid Services. 2022–2023 MAP Final Recommendations. Available at: *https://mmshub.cms.gov/measure-lifecycle/measure-implementation/pre-rulemaking/lists-and-reports.*

[57] Centers for Medicare & Medicaid Services. 2022–2023 MAP Final Recommendations. Available at: *https://mmshub.cms.gov/measure-lifecycle/measure-implementation/pre-rulemaking/lists-and-reports.*

[58] Centers for Medicare & Medicaid Services. 2022–2023 MAP Final Recommendations. Available at: *https://mmshub.cms.gov/measure-lifecycle/measure-implementation/pre-rulemaking/lists-and-reports.*

[59] Centers for Medicare & Medicaid Services. 2022–2023 MAP Final Recommendations. Available at: *https://mmshub.cms.gov/measure-lifecycle/measure-implementation/pre-rulemaking/lists-and-reports.*

[60] Centers for Medicare & Medicaid Services. 2022–2023 MAP Final Recommendations. Available at: *https://mmshub.cms.gov/measure-lifecycle/measure-implementation/pre-rulemaking/lists-and-reports.*

Although section 1886(s)(4)(D)(i) of the Act generally requires that measures specified by the Secretary must be endorsed by the entity with a contract under section 1890(a) of the Act, section 1886(s)(4)(D)(ii) of the Act states that, in the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a) of the Act, the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary. We reviewed measures endorsed by consensus organizations and were unable to identify any other measures on this topic endorsed by a consensus organization, and therefore, we believe the exception in section 1886(s)(4)(D)(ii) of the Act applies.

c. Data Collection, Submission, and Reporting

IPFs are required to submit information for structural measures once annually using a CMS-approved web-based data collection tool available within the Hospital Quality Reporting (HQR) System. For more information about our previously finalized policies related to reporting of structural measures, we refer readers to the FY 2014 IPPS/LTCH PPS final rule (78 FR 50890 through 50901) and the FY 2015 IPF PPS final rule (79 FR 45963 through 45964 and 45976). Given the role of committed leadership in improving health outcomes for all patients, we proposed to adopt this measure beginning with attestations submitted to CMS in CY 2025 reflecting the CY 2024 reporting period and affecting the FY 2026 payment determination.

We invited comments on our proposed adoption of the Facility Commitment to Health Equity Measure beginning with the FY 2026 payment determination.

Comment: Many commenters supported adoption of the Facility Commitment to Health Equity measure. One commenter stated that alignment with other programs will support consistent measurement across the continuum of patient care. Several commenters stated that facilities' commitment to health equity is particularly important for IPFs because of health disparities experienced by patients with mental health conditions. Several commenters stated that the Facility Commitment to Health Equity measure is consistent with new standards from The Joint Commission. One commenter stated that facilities attesting to their commitment to health equity will help empower the healthcare workforce to recognize and eliminate health disparities.

Response: We thank commenters for their support of our proposal to adopt the Facility Commitment to Health Equity measure and agree that this measure addresses a topic that is important for IPF patients and this setting.

Comment: Other commenters recommended additional testing, specifically in the IPF setting, to ensure that this measure addresses unique challenges associated with treating the psychiatric patient population prior to adoption of this measure. Some of these commenters also recommended engaging IPFs to voluntarily test the measure to ensure usability, acceptability, and face validity are met for this setting.

Response: We acknowledge that this measure was initially developed for the general acute care setting. While we recognize the value of measures undergoing testing and evaluation of validity and feasibility in the setting for which they are being adopted, given the urgency of achieving health equity and, as there are currently no other existing measures that address facility commitment to health equity, we believe it is important to implement this measure as soon as feasible. Strong and consistent facility leadership can be instrumental in establishing specific, measurable, and attainable goals to advance equity priorities and improve care for all patients in any care setting, including patients who receive care in inpatient psychiatric facilities. We believe that this measure is equally applicable to freestanding IPFs and psychiatric units within acute care facilities as it is to general acute care settings. Leaders of health services organizations across the health care system, including both IPFs and acute care hospitals, are likely to encounter the same challenges and use the same types of strategies to achieve organizational goals related to improving health equity within their respective organizations. We note that health equity is a critical topic for patients treated in IPFs and that there are high levels of health disparities experienced by this patient population. CMS will monitor measure implementation and data reporting as part of standard program and measure review and will consider updates to the measure if improvements are identified through this process.

Comment: Many commenters expressed concern that this measure has not received endorsement by the CBE.

Response: While we recognize the value of measures undergoing review for potential CBE endorsement, given the urgency of achieving health equity, we believe it is important to implement this measure beginning with the CY 2024 reporting period. We note that, in accordance with section 1886(s)(4)(D)(ii) of the Act, the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary. We reviewed measures endorsed by consensus organizations and were unable to identify any other measures on this topic endorsed by a consensus organization, and therefore, we believe the exception in section 1886(s)(4)(D)(ii) of the Act applies.

Comment: Some commenters recommended that CMS defer adoption of this measure until CMS and IPFs have reviewed the Hospital IQR Program's implementation of this measure to identify potential improvements to data collection processes that would reduce burden for IPFs. These commenters stated that IPFs often have fewer resources available for data collection relative to acute care hospitals.

Response: We acknowledge commenters' desire to be able to learn from the experiences of acute care hospitals reporting this measure. We note that hospitals participating in the Hospital IQR Program will have already reported data on the similar Hospital Commitment to Health Equity measure for the FY 2025 payment determination (that is, data submitted in CY 2024 representing the CY 2023 performance period) (87 FR 49201) before the reporting of the Facility Commitment to Health Equity Measure for the IPFQR Program begins with the FY 2026 payment determination. Given the timing of this similar measure in the Hospital IQR Program, we believe IPFs will have had the opportunity to learn from the experiences of acute care hospitals, including best practices for minimally burdensome assessment of performance on the required domains.

Comment: Many commenters supported adoption of this measure on the condition that CMS commit to development and adoption of health equity related outcome measures in the future.

Response: We believe this measure to be a building block that lays the groundwork for a more comprehensive suite of measures that would assess progress in providing high-quality healthcare for all patients regardless of social risk factors or demographic

characteristics. This more comprehensive suite of measures could eventually include health equity related outcome measures.

Comment: Many commenters recommended that CMS establish a process to ensure that results are publicly reported in a way that helps patients interpret IPF scores on the Facility Commitment to Health Equity measure.

Response: We believe this measure will provide insightful information to healthcare providers and the public on the number of IPFs currently participating in health equity strategic planning, collecting data, using these data to identify equity gaps, establishing key performance indicators, and reviewing them with hospital senior leaders. We intend to provide educational materials as part of our outreach and public reporting of this measure to ensure understanding and interpretation of publicly reported data.

Comment: Many commenters recommended that prior to adoption of the Facility Commitment to Health Equity measure CMS identify a means to verify accurate attestation of commitment by IPFs.

Response: We understand commenters' concerns regarding the accuracy of provider self-reported data. While we do not have a specific means to validate IPFs' attestation to this measure, we do require all IPFs participating in the IPFQR Program to complete the Data Accuracy and Completeness Acknowledgement (DACA) each year, which requires attestation that all of the information reported to CMS for the IPFQR Program is accurate and complete. For more information on the IPFQR Program's DACA requirements, we refer readers to the FY 2013 IPPS/LTCH PPS final rule (77 FR 53658).

Comment: Several commenters recommended that CMS update the measure specifications so that IPFs without certified EHR technology are able to positively attest to all domains. These commenters expressed concern that public reporting of measure results for IPFs that do not positively attest to all domains because they are without access to certified EHR technology could lead the public to misinterpret the results as a lack of commitment to health equity when it is actually a resource limitation which, the commenters believed, is due to a lack of federal funding for EHR implementation.

Response: We acknowledge that some IPFs may face challenges to adopting certified EHR technology. We note that the IPFQR Program is a pay-for-reporting program, not a pay-for-performance program, and therefore IPFs that do not have certified EHR technology can attest that they satisfy the other domains, as applicable, and receive a score of 0–4 out of 5 without any penalties. We understand the commenters' concern that the public may misinterpret IPFs' reported results that are due to resource limitations as a lack of commitment to health equity. To reduce the likelihood of misinterpretation, we intend to provide educational materials as part of our outreach and public reporting of this measure to ensure understanding and appropriate interpretation of publicly reported data.

Comment: Some commenters recommended respecifying the measure so that IPFs are scored on a zero to eleven scale (one point for each element within a domain) as opposed to a zero to five scale (one point for each domain). Other commenters recommended only requiring attestation for 3 out of 5 domains. Some of these commenters stated that some domains are harder to achieve or have more required elements for attestation than others and expressed the belief that reducing the number of required domains would address this concern.

Response: We believe the five domains of this measure are actionable focus areas, and assessment of facility leadership commitment to them is foundational. We also believe this measure will incentivize providers to collect and utilize data to identify critical equity gaps, implement plans to address any identified gaps, and ensure that resources are dedicated toward addressing health equity initiatives. The five questions of the proposed structural measure are adapted from the CMS Office of Minority Health's Building an Organizational Response to Health Disparities framework, which focuses on data collection, data analysis, culture of equity, and quality improvement.[61] We believe that accomplishing each element within a domain is important together with the other elements to help hospitals identify, prioritize, and take action on health disparities. Additionally, as discussed previously, we note that the IPFQR Program is a pay-for-reporting program, and IPFs are not scored based on their performance on measures.

Comment: Several commenters expressed concern that IPFs may not report the measure consistently, and one commenter recommended that CMS provide clarification of key terms (such as ''strategic plan'') to mitigate the risk of inconsistent reporting.

Response: We note that Attestation Guidance for the similar measure adopted in the Hospital IQR Program (the Hospital Commitment to Health Equity measure), includes definitions of key terms including ''strategic plan,'' which we define as ''a written plan to address health equity that is shared across the hospital'' (or facility in the case of IPFs).[62] To help with consistent implementation, we will develop a similar Attestation Guidance document for IPFs as part of providing educational and training materials, and which will be conveyed through routine communication channels to IPFs, vendors, and QIOs, including, but not limited to, issuing memos, emails, and notices on a CMS website.

Comment: One commenter did not support adoption of the Facility Commitment to Health Equity measure and expressed their belief that there is insufficient evidence that this measure leads to improved patient outcomes.

Response: We believe this measure is an important foundational measure for improving health equity among those that have been disadvantaged or underserved by the healthcare system. Furthermore, as discussed in section VI.D.2.a of the proposed rule, there is substantial research showing differences in care and experiences among these populations (88 FR 21274 through 21275). We also believe adoption of the Facility Commitment to Health Equity measure will incentivize IPFs to collect and utilize data to identify critical equity gaps, implement plans to address these gaps, and ensure that resources are dedicated toward addressing health equity initiatives. This measure aims to support IPFs in leveraging available data, pursuing focused quality improvement activities, and promoting efficient and effective use of resources. Through this measure, providers are encouraged to analyze their own data to understand the many factors, including race, ethnicity, and various social drivers of health, such as housing stability and food security, in order to deliver more equitable care. We believe the delivery of more equitable care will, in turn, improve patient outcomes.

[61] Centers for Medicare & Medicaid Services. (2021). Building an Organizational Response to Health Disparities [Fact Sheet]. U.S. Department of Health and Human Services. Available at: *https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Health-Disparities-Guide.pdf.*

[62] Available at: *https://qualitynet.cms.gov/files/6481de126f7752001c37e34f?filename=AttstGdnceHCHEMeas_v1.1.pdf.*

Final Decision: After consideration of the public comments we received, we are finalizing adoption of the Facility Commitment to Health Equity measure as proposed.

3. Adoption of the Screening for Social Drivers of Health Measure Beginning With Voluntary Reporting of CY 2024 Data Followed by Mandatory Reporting Beginning With CY 2025 Data/FY 2027 Payment Determination

a. Background

Health-related social needs (HRSNs), which we define as individual-level, adverse social conditions that negatively impact an individual person's health or healthcare, are significant risk factors associated with worse health outcomes as well as increased healthcare utilization.[63] We believe that consistently pursuing identification of HRSNs would have two significant benefits. First, HRSNs disproportionately impact people who have historically been underserved by the healthcare system,[64] and screening helps identify individuals who may have HRSNs. Second, screening for HRSNs could support ongoing IPF quality improvement initiatives by providing data with which to stratify patient risk and organizational performance. Further, we believe that IPFs collecting patient-level HRSN data through screening is essential for the long-term in encouraging meaningful collaboration between healthcare providers and community-based organizations and in implementing and evaluating related innovations in health and social care delivery.

Health disparities manifest primarily as worse health outcomes in population groups where access to care is inequitable.[65] [66] [67] [68] [69] Such differences persist across geography and healthcare settings irrespective of improvements in quality of care over time.[70] [71] [72] Assessment of HRSNs is an essential mechanism for capturing the interaction between social, community, and environmental factors associated with health status and health outcomes.[73] [74] [75]

Growing evidence demonstrates that specific HRSNs are directly associated with patient health outcomes as well as healthcare utilization, costs, and performance in quality-based payment programs.[76] [77] While widespread interest in addressing HRSNs exists, action is inconsistent.[78]

While social risk factors account for 50 to 70 percent of health outcomes, the mechanisms by which this connection emerges are complex and multifaceted.[79] [80] [81] [82] The persistent interactions among individuals' HRSNs, medical providers' practices and behaviors, and community resources significantly impact healthcare access, quality, and ultimately costs, as described in the CMS Equity Plan for Improving Quality in Medicare.[83] [84] In their 2018 survey, to which more than 8,500 physicians responded, the

[63] Centers for Medicare & Medicaid Services. (2021). A Guide to Using the Accountable Health Communities Health-Related Social Needs Screening Tool: Promising Practices and Key Insights. June 2021. Available at: *https://innovation.cms.gov/media/document/ahcm-screeningtool-companion.* Accessed on February 20, 2023.

[64] American Hospital Association. (2020). Health Equity, Diversity & Inclusion Measures for Hospitals and Health System Dashboards. December 2020. Available at: *https://ifdhe.aha.org/system/files/media/file/2020/12/ifdhe_inclusion_dashboard.pdf.* Accessed on February 20, 2023.

[65] Seligman, H.K., & Berkowitz, S.A. (2019). Aligning Programs and Policies to Support Food Security and Public Health Goals in the United States. Annual Review of Public Health, 40(1), 319–337. Available at: *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6784838/.* Accessed on February 20, 2023.

[66] The Physicians Foundation. (2020). Survey of America's Patients, Part Three. Available at: *https://physiciansfoundation.org/wp-content/uploads/2020/10/2020-Physicians-Foundation-Survey-Part3.pdf.* Accessed on February 20, 2023.

[67] Office of the Assistant Secretary for Planning and Evaluation (ASPE) (2020). Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Program (Second of Two Reports). Available at: *https://aspe.hhs.gov/pdf-report/second-impact-report-to-congress.* Accessed on February 20, 2023.

[68] Trivedi AN, Nsa W, Hausmann LRM, et al. (2014). Quality and Equity of Care in U.S. Hospitals. N Engl J Med, 371(24), 2298–2308. Available at: *https://www.nejm.org/doi/10.1056/NEJMsa1405003.* Accessed on February 13, 2023.

[69] Billioux, A., Verlander, K., Anthony, S., & Alley, D. (2017). Standardized Screening for Health Related Social Needs in Clinical Settings: The Accountable Health Communities Screening Tool. NAM Perspectives, 7(5). Available at: *https://doi.org/10.31478/201705b.* Accessed on February 20, 2023.

[70] Office of the Assistant Secretary for Planning and Evaluation (ASPE) (2020). Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Program (Second of Two Reports). Available at: *https://aspe.hhs.gov/pdf-report/second-impact-report-to-congress.* Accessed on February 20, 2023.≤

[71] Hill-Briggs, F. (2021). Social Determinants of Health and Diabetes: A Scientific Review. Diabetes Care. Available at: *https://diabetesjournals.org/care/article/44/1/258/33180/Social-Determinants-of-Health-and-Diabetes-A.* Accessed on February 20, 2023.

[72] Khullar, D., MD. (2020). Association Between Patient Social Risk and Physician Performance American academy of Family Physicians. Addressing Social Determinants of Health in Primary Care team-based approach for advancing health equity. Available at: *https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/team-based-approach.pdf.* Accessed on February 20, 2023.

[73] Institute of Medicine. (2014). Capturing Social and Behavioral Domains and Measures in Electronic Health Records: Phase 2. Washington, DC: The National Academies Press. Available at: *https://doi.org/10.17226/18951.* Accessed on February 20, 2023.

[74] Alley, D.E., C.N. Asomugha, P.H. Conway, and D.M. Sanghavi. (2016). Accountable Health Communities—Addressing Social Needs through Medicare and Medicaid. The New England Journal of Medicine 374(1):8–11. Available at: *https://doi.org/10.1056/NEJMp1512532.* Accessed on February 20, 2023.

[75] Centers for Disease Control and Prevention. CDC COVID–19 Response Health Equity Strategy: Accelerating Progress Towards Reducing COVID–19 Disparities and Achieving Health Equity. July 2020. Available at: *https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/cdc-strategy.html.* Accessed on February 2, 2023.

[76] Zhang Y, Li J, Yu J, Braun RT, Casalino LP (2021). Social Determinants of Health and Geographic Variation in Medicare per Beneficiary Spending. JAMA Network Open. 2021;4(6):e2113212. *https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2780864.* Accessed on February 20, 2023.

[77] Khullar, D., Schpero, W.L., Bond, A.M., Qian, Y., & Casalino, L.P. (2020). Association Between Patient Social Risk and Physician Performance Scores in the First Year of the Merit-based Incentive Payment System. JAMA, 324(10), 975–983. *https://doi.org/10.1001/jama.2020.13129.* Accessed on February 20, 2023.

[78] TK Fraze, AL Brewster, VA Lewis, LB Beidler, GF Murray, CH Colla. Prevalence of screening for food insecurity, housing instability, utility needs, transportation needs, and interpersonal violence by US physician practices and hospitals. JAMA Network Open 2019; *https://jamanetwork.com/journals/jamanetworkopen/fullarticle/10.1001/jamanetworkopen.2019.11514.* Accessed on February 20, 2023.

[79] Kaiser Family Foundation. (2021). Racial and Ethnic Health Inequities and Medicare. Available at: *https://www.kff.org/medicare/report/racial-and-ethnic-health-inequities-and-medicare/.* Accessed February 20, 2023.

[80] Khullar, D., MD. (2020). Association Between Patient Social Risk and Physician Performance American academy of Family Physicians. Addressing Social Determinants of Health in Primary Care team-based approach for advancing health equity. Available at: *https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/team-based-approach.pdf.* Accessed on February 20, 2023.

[81] Hammond, G., Johnston, K., Huang, K., Joynt Maddox, K. (2020). Social Determinants of Health Improve Predictive Accuracy of Clinical Risk Models for Cardiovascular Hospitalization, Annual Cost, and Death. Circulation: Cardiovascular Quality and Outcomes, 13 (6) 290–299. Available at: *https://doi.org/10.1161/CIRCOUTCOMES.120.006752.* Accessed on February 20, 2023.

[82] The Physicians Foundation. (2021). Viewpoints: Social Determinants of Health. Available at: *https://physiciansfoundation.org/wp-content/uploads/2019/08/The-Physicians-Foundation-SDOH-Viewpoints.pdf.* Accessed on February 20, 2023.

[83] Centers for Medicare & Medicaid Services. (2021). Paving the Way to Equity: A Progress Report. Available at: *https://www.cms.gov/files/document/paving-way-equity-cms-omh-progress-report.pdf.* Accessed on February 20, 2023.

[84] Centers for Medicare & Medicaid Services Office of Minority Health. (2021). The CMS Equity Plan for Improving Quality in Medicare. 2015–2021. Available at: *https://www.cms.gov/About-CMS/Agency-Information/OMH/OMH_Dwnld-CMS_EquityPlanforMedicare_090615.pdf#:~:text=The%20Centers%20for%20Medicare%20%26%20Medicaid%20Services%20%28CMS%29,evidence%20base%2C%20identifying%20opportunities%2C%20and%20gathering%20stakeholder%20input.* Accessed on February 20, 2023.

Physicians Foundation found that almost 90 percent of these physician respondents reported their patients had a serious health problem linked to poverty or other social conditions.[85] Additionally, associations among disproportionate health risk, hospitalization, and adverse health outcomes have been highlighted and magnified by the COVID–19 pandemic.[86] [87]

In 2017, CMS' Center for Medicare and Medicaid Innovation (CMMI) launched the Accountable Health Communities (AHC) Model to test the impact of systematically identifying and addressing the HRSNs of Medicare and Medicaid beneficiaries (that is, through screening, referral, and community navigation) on their health outcomes and related healthcare utilization and costs.[88] [89] [90] [91] The AHC Model is one of the first federal pilots to systematically test whether identifying and addressing core HRSNs improves healthcare costs, utilization, and outcomes with over 600 clinical sites in 21 states.[92] The AHC Model had a 5-year period of performance that began in May 2017 and ended in April 2022, with beneficiary screening beginning in the summer of 2018.[93] [94] Evaluation of the AHC Model data is still underway.

Under the AHC Model, the following five core domains were selected to screen for HRSNs among Medicare and Medicaid beneficiaries: (1) food insecurity; (2) housing instability; (3) transportation needs; (4) utility difficulties; and (5) interpersonal safety. These domains were chosen based upon literature review and expert consensus utilizing the following criteria: (1) availability of high-quality scientific evidence linking a given HRSN to adverse health outcomes and increased healthcare utilization, including hospitalizations and associated costs; (2) ability for a given HRSN to be screened and identified in the inpatient setting prior to discharge, addressed by community-based services, and potentially improve healthcare outcomes, including reduced readmissions; and (3) evidence that a given HRSN is not systematically addressed by healthcare providers.[95] In addition to established evidence of their association with health status, risk, and outcomes, these five domains were selected because they can be assessed across the broadest spectrum of individuals in a variety of settings.[96] [97] [98]

These five evidence-based HRSN domains, which informed development of the two Social Drivers of Health measures adopted in the Hospital IQR Program and finalized here for the IPFQR Program, are described in Table 18. We note that while the measures were initially developed by The Health Initiative (THI), CMS has since assumed stewardship.

TABLE 18: THE FIVE CORE HRSN DOMAINS TO SCREEN FOR SOCIAL DRIVERS OF HEALTH

Domain	Description
Food Insecurity	Food insecurity is defined as limited or uncertain access to adequate quality and quantity of food at the household level. It is associated with diminished mental and physical health and increased risk for chronic conditions.[99] [100] Individuals experiencing food insecurity often have inadequate access to healthier food options which can impede self-management of chronic diseases like diabetes and heart disease, and require individuals to make personal trade-offs between food purchases and medical needs, including prescription medication refills and preventive health

[85] The Physicians Foundation. (2019). Viewpoints: Social Determinants of Health. Available at: *https://physiciansfoundation.org/wp-content/uploads/2019/08/The-Physicians-Foundation-SDOH-Viewpoints.pdf.* Accessed on February 20, 2023.

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[87] Kaiser Family Foundation. (2021). Racial and Ethnic Health Inequities and Medicare. Available at: *https://www.kff.org/medicare/report/racial-and-ethnic-health-inequities-and-medicare/.* Accessed on February 20, 2023.

[88] Centers for Medicare & Medicaid Services. (2021). A Guide to Using the Accountable Health Communities Health-Related Social Needs Screening Tool: Promising Practices and Key Insights. June 2021. Accessed: November 23, 2021. Available at: *https://innovation.cms.gov/media/document/ahcm-screeningtool-companion.* Accessed on February 20, 2023.

[89] Alley, D.E., Asomugha, C.N., et al. (2016). Accountable Health Communities—Addressing Social Needs through Medicare and Medicaid. The New England Journal of Medicine 374(1):8–11. Available at: *https://doi.org/10.1056/NEJMp1512532.* Accessed on February 20, 2023.

[90] Billioux, A., Verlander, K., Anthony, S., & Alley, D. (2017). Standardized Screening for Health-Related Social Needs in Clinical Settings: The Accountable Health Communities Screening Tool. NAM Perspectives, 7(5). Available at: *https://doi.org/10.31478/201705b.* Accessed on February 20, 2023.

[91] Centers for Medicare & Medicaid Services. (2021). Accountable Health Communities Model. Accountable Health Communities Model | CMS Innovation Center Available at: *https://innovation.cms.gov/innovation-models/ahcm.* Accessed on February 20, 2023.

[92] RTI International. (2020). Accountable Health Communities (AHC) Model Evaluation. Available at: *https://innovation.cms.gov/data-and-reports/2020/ahc-first-eval-rpt.* Accessed on February 20, 2023.

[93] RTI International. (2020). Accountable Health Communities (AHC) Model Evaluation. Available at: *https://innovation.cms.gov/data-and-reports/2020/ahc-first-eval-rpt.* Accessed on February 20, 2023.

[94] We note that the model officially concluded in April 2022, but many awardees have continued with no-cost extensions to continue utilizing unspent cooperative agreement funding and all awardees will conclude by April 2023.

[95] Billioux, A., Verlander, K., Anthony, S., & Alley, D. (2017). Standardized Screening for Health-Related Social Needs in Clinical Settings: The Accountable Health Communities Screening Tool. NAM Perspectives, 7(5). Available at: *https://doi.org/10.31478/201705b.* Accessed on February 20, 2023.

[96] Billioux, A., Verlander, K., Anthony, S., & Alley, D. (2017). Standardized Screening for Health-Related Social Needs in Clinical Settings: The Accountable Health Communities Screening Tool. NAM Perspectives, 7(5). Available at: *https://doi.org/10.31478/201705b.* Accessed on February 20, 2023.

[97] Centers for Medicare & Medicaid Services. (2021). Accountable Health Communities Model. Accountable Health Communities Model √ CMS Innovation Center. Available at: *https://innovation.cms.gov/innovation-models/ahcm.* Accessed on February 20, 2023.

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Domain	Description
	services.[101 102] Food insecurity is associated with high-cost healthcare utilization including emergency department (ED) visits and hospitalizations.[103 104 105] Evidence indicates that individuals with serious mental illness have a higher prevalence of food insecurity than the U.S. population as a whole (specifically 71% prevalence among patients with severe mental illness versus 14.9% in the population as a whole).[106]
Housing Instability	Housing instability encompasses multiple conditions ranging from inability to pay rent or mortgage, frequent changes in residence including temporary stays with friends and relatives, living in crowded conditions, and actual lack of sheltered housing in which an individual does not have a personal residence.[107 108] Population surveys consistently show that people from some racial and ethnic minority groups constitute the largest proportion of the U.S. population experiencing housing instability [109] Housing instability is associated with higher rates of chronic illnesses, injuries, and complications and more frequent utilization of high-cost healthcare services.[110 111] Additionally, housing instability can exacerbate psychiatric conditions and individuals with psychiatric

Domain	Description
	conditions are more likely to have housing instability.[112]
Transportation Needs	Unmet transportation needs include limitations that impede transportation to destinations required for all aspects of daily living.[113] Groups disproportionately affected include older adults (aged >65 years), people with lower incomes, people with impaired mobility, residents of rural areas, and people from some racial and ethnic minority groups. Transportation needs contribute to postponement of routine medical care and preventive services which ultimately lead to chronic illness exacerbation and more frequent utilization of high-cost healthcare services including emergency medical services, EDs, and hospitalizations.[114 115 116 117] Patients with serious mental illness often lack access to transportation with many Medicaid eligible patients relying on Medicaid's non-emergency medical transportation (NEMT) to access needed healthcare, though this does not provide access to transportation to other aspects of daily living.[118]
Utility Difficulties	Inconsistent availability of electricity, water, oil, and gas services is directly associated with housing instability and food insecurity.[119] Specifically, interventions that increase or maintain access to such services have been associated with individual and population-level health improvements.[120]
Interpersonal Safety	Interpersonal safety affects individuals across the lifespan, from birth to old age, and is directly linked to mental and physical health. Assessment for this domain includes screening for exposure to intimate

Domain	Description
	partner violence, child abuse, and elder abuse.[121] Exposure to violence and social isolation are reflective of individual-level social relations and living conditions that are directly associated with injury, psychological distress, and death in all age groups.[122] [123] Research indicates that adults with mental illness are at an increased risk of being victims of violence, noting that 30.9 percent were victims of violence within a six month period and recommending increased public health interventions to reduce violence in this vulnerable population.[124]

As a first step towards leveraging the opportunity to close equity gaps by identifying patients' HRSNs, we finalized the adoption of two evidence-based measures in the Hospital IQR Program—the Screening for Social Drivers of Health measure and the Screen Positive Rate for Social Drivers of Health measure (collectively, Social Drivers of Health measures)—and refer readers to the FY 2023 IPPS/LTCH PPS final rule (87 FR 49191 through 49220).

Through adoption in the IPFQR Program, these two Social Drivers of Health measures (that is, the Screening for Social Drivers of Health measure discussed in this section and the Screen Positive Rate for Social Drivers of Health measure discussed in section VI.D.4 of this final rule) will support identification of specific risk factors for inadequate healthcare access and adverse health outcomes among patients. We note that these measures will enable systematic collection of

[99] Berkowitz SA, Seligman HK, Meigs JB, Basu S. Food insecurity, healthcare utilization, and high cost: a longitudinal cohort study. Am J Managed Care. 2018 Sep;24(9):399–404. PMID: 30222918; PMCID: PMC6426124. Available at *https://pubmed.ncbi.nlm.nih.gov/30222918/.* Accessed on February 20, 2023.

[100] Hill-Briggs, F. (2021). Social Determinants of Health and Diabetes: A Scientific Review. Diabetes Care. Available at: *https://diabetesjournals.org/care/article/44/1/258/33180/Social-Determinants-of-Health-and-Diabetes-A.* Accessed on February 20, 2023.

[101] Seligman, H.K., & Berkowitz, S.A. (2019). Aligning Programs and Policies to Support Food Security and Public Health Goals in the United States. Annual Review of Public Health, 40(1), 319–337. Available at: *https://pubmed.ncbi.nlm.nih.gov/30444684/.* Accessed on February 20, 2023.

[102] National Academies of Sciences, Engineering, and Medicine 2006. Executive Summary: Cost-Benefit Analysis of Providing Non-Emergency Medical Transportation. Washington, DC: The National Academies Press. Available at: *https://doi.org/10.17226/23285.* Accessed on February 20, 2023.

[103] Hill-Briggs, F. (2021). Social Determinants of Health and Diabetes: A Scientific Review. Diabetes Care. Available at: *https://diabetesjournals.org/care/article/44/1/258/33180/Social-Determinants-of-Health-and-Diabetes-A.* Accessed on February 20, 2023.

[104] Berkowitz SA, Seligman HK, Meigs JB, Basu S. Food insecurity, healthcare utilization, and high cost: a longitudinal cohort study. Am J Managed Care. 2018 Sep;24(9):399–404. PMID: 30222918; PMCID: PMC6426124. Available at *https://pubmed.ncbi.nlm.nih.gov/30222918/.* Accessed on February 20, 2023.

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[106] *https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201300022?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%20%200pubmed.* Accessed on February 20, 2023.

[107] Larimer, M.E. (2009). Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons with Severe Alcohol Problems. JAMA, 301(13), 1349. Available at: *https://doi.org/10.1001/jama.2009.414.*

[108] Hill-Briggs, F. (2021, January 1). Social Determinants of Health and Diabetes: A Scientific Review. Diabetes Care. Available at: *https://pubmed.ncbi.nlm.nih.gov/33139407/.*

[109] Henry, M., de Sousa, T., Roddey, C., Gayen, S., Bednar, T.; Abt Associates. The 2020 Annual Homeless Assessment Report (AHAR) to Congress; Part 1: Point-in-Time Estimates of Homelessness, January 2021. U.S. Department of Housing and Urban Development. Accessed November 24, 2021. Available at: *https://www.huduser.gov/portal/sites/default/files/pdf/2020-AHAR-Part-1.pdf.*

[110] Larimer, M.E. (2009). Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons with Severe Alcohol Problems. JAMA, 301(13), 1349. Available at: *https://doi.org/10.1001/jama.2009.414.*

[111] Baxter, A., Tweed, E., Katikireddi, S., Thomson, H. (2019). Effects of Housing First approaches on health and well-being of adults who are homeless or at risk of homelessness: systematic review and meta-analysis of randomized controlled trials. Journal of Epidemiology and Community Health, 73; 379–387. Available at: *https://jech.bmj.com/content/jech/73/5/379.full.pdf.*

[112] Housing Instability and Mental Health. UNC Greensboro. May 7, 2021. Available at: *https://chcs.uncg.edu/housing-instability-mental-health/#:~:text=Mental%20health%20is%20correlated%20with%20housing%20in%20several,homeless%20population%20in%20America%20suffer%20a%20mental%20illness.* Accessed on December 7, 2022.

[113] National Academies of Sciences, Engineering, and Medicine 2006. Executive Summary: Cost-Benefit Analysis of Providing Non-Emergency Medical Transportation. Washington, DC: The National Academies Press. Available at: *https://doi.org/10.17226/23285.*

[114] National Academies of Sciences, Engineering, and Medicine 2006. Executive Summary: Cost-Benefit Analysis of Providing Non-Emergency Medical Transportation. Washington, DC: The National Academies Press. Available at: *https://doi.org/10.17226/23285.*

[115] Hill-Briggs, F. (2021, January 1). Social Determinants of Health and Diabetes: A Scientific Review. Diabetes Care. Available at: *https://pubmed.ncbi.nlm.nih.gov/33139407/.*

[116] Billioux, A., Verlander, K., Anthony, S., & Alley, D. (2017). Standardized Screening for Health-Related Social Needs in Clinical Settings: The Accountable Health Communities Screening Tool. NAM Perspectives, 7(5). Available at: *https://doi.org/10.31478/201705b.*

[117] Shier, G., Ginsburg, M., Howell, J., Volland, P., & Golden, R. (2013). Strong Social Support Services, Such as Transportation And Help For Caregivers, Can Lead To Lower Health Care Use And Costs. Health Affairs, 32(3), 544–551. Available at: *https://doi.org/10.1377/hlthaff.2012.0170.*

[118] *https://www.nami.org/Advocacy/Policy-Priorities/Supporting-Community-Inclusion-and-Non-Discrimination/Medicaid-Non-Emergency-Medical-Transportation.*

[119] Baxter, A., Tweed, E., Katikireddi, S., Thomson, H. (2019). Effects of Housing First approaches on health and well-being of adults who are homeless or at risk of homelessness: systematic review and meta-analysis of randomized controlled trials. Journal of Epidemiology and Community Health, 73; 379–387. Available at: *https://jech.bmj.com/content/jech/73/5/379.full.pdf.*

[120] Wright, B.J., Vartanian, K.B., Li, H.F., Royal, N., & Matson, J.K. (2016). Formerly Homeless People Had Lower Overall Health Care Expenditures After Moving into Supportive Housing. Health Affairs, 35(1), 20–27. Available at: *https://doi.org/10.1377/hlthaff.2015.0393.*

[121] Billioux, A., Verlander, K., Anthony, S., & Alley, D. (2017). Standardized Screening for Health-Related Social Needs in Clinical Settings: The Accountable Health Communities Screening Tool. NAM Perspectives, 7(5). Available at: *https://doi.org/10.31478/201705b.*

[122] Henry M., de Sousa, T., Roddey, C., Gayen, S., Bednar, T.; Abt Associates. The 2020 Annual Homeless Assessment Report (AHAR) to Congress; Part 1: Point-in-Time Estimates of Homelessness, January 2021. U.S. Department of Housing and Urban Development. Accessed November 24, 2021. Available at: *https://www.huduser.gov/portal/sites/default/files/pdf/2020-AHAR-Part-1.pdf.*

[123] Larimer, M.E. (2009). Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons with Severe Alcohol Problems. JAMA, 301(13), 1349. Available at: *https://doi.org/10.1001/jama.2009.414.*

[124] *https://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2013.301680.*

HRSNs data. This activity aligns with our other efforts beyond the acute care setting, including the CY 2023 Medicare Advantage and Part D final rule in which we finalized the policy requiring that all Special Needs Plans (SNPs) include one or more questions on housing stability, food security, and access to transportation in their health risk assessment using questions from a list of screening instruments specified in sub-regulatory guidance (87 FR 27726 through 27740) as well as the CY 2023 Physician Fee Schedule (PFS) final rule in which we adopted the Screening for Social Drivers of Health measure in the Merit-based Incentive Payment System (MIPS) (87 FR 70054 through 70055).

The Social Drivers of Health measures (as set forth in this section VI.D.3 and section VI.D.4. of this final rule) will encourage IPFs to identify patients with HRSNs, who are known to experience the greatest risk of poor health outcomes, thereby improving the accuracy of high-risk prediction calculations. Improvement in risk prediction has the potential to reduce healthcare access barriers, address the disproportionate expenditures attributed to people with greatest risk, and improve the IPF's quality of care.[125] [126] [127] [128] Further, these data could guide future public and private resource allocation to promote targeted collaboration among IPFs, health systems, community-based organizations, and others in support of improving patient outcomes. We believe that this screening is especially important for IPF patients because patients with psychiatric conditions have an increased risk of having HRSNs.[129]

In the FY 2023 IPF PPS final rule, we observed that the Hospital IQR Program had proposed two Social Drivers of Health measures and stated that we would consider these measures for the IPFQR Program in the future (87 FR 46873). The first of these two measures is the Screening for Social Drivers of Health measure, which assesses the percent of patients admitted to the hospital who are 18 years or older at time of admission and are screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety.

Utilization of screening tools to identify the burden of unmet HRSNs can be a helpful first step for IPFs in identifying necessary community partners and connecting individuals to resources in their communities. We believe collecting data across the same five HRSN domains that were screened under the AHC Model and adopted for acute care hospitals in the Hospital IQR Program will illuminate their impact on health outcomes and disparities and the healthcare cost burden for IPFs, particularly for IPFs that serve patients with disproportionately high levels of social risk, given that patients with serious mental illness are especially vulnerable to and affected by HRSNs. In addition, data collection in the IPF care setting could inform meaningful and sustainable solutions for provider-types participating in other quality reporting programs to close equity gaps among the communities they serve.[130] [131] [132] [133] [134]

For data collection of the Screening for Social Drivers of Health measure, IPFs could use a self-selected screening tool and collect these data in multiple ways, which can vary to accommodate the population they serve and their individual needs. One example of a potential screening tool for IPFs to collect data on the Screening for Social Drivers Health Measure is the AHC Model's standard 10-item AHC Health-Related Social Needs Screening Tool (AHC HRSN Screening Tool), which enables providers to identify HRSNs in the five core domains (described in Table 18) among community-dwelling Medicare, Medicaid, and dually eligible beneficiaries. The AHC Model, including its screening tool, was tested across many care delivery sites in diverse geographic locations across the United States. More than one million Medicare and Medicaid beneficiaries have been screened using the AHC HRSN Screening Tool, which was evaluated psychometrically and demonstrated evidence of both reliability and validity, including inter-rater reliability and concurrent and predictive validity. Moreover, the AHC HRSN Screening Tool can be implemented in a variety of places where patients seek healthcare, including inpatient psychiatric facilities.

The intent of the Screening for Social Drivers of Health measure is to promote adoption of HRSN screening by IPFs. We encourage IPFs to use the screening as a basis for developing their own individual action plans (for example, navigation services and subsequent referral), as well as an opportunity to initiate or improve partnerships with community-based service providers. We believe that this measure will yield actionable information to close equity gaps by encouraging IPFs to identify patients with HRSNs, with a reciprocal goal of strengthening linkages between IPFs and local community-based partners to promptly connect patients and families to the support they need.

Both the Screening for Social Drivers of Health measure and the Screen Positive Rate for Social Drivers of Health measure, discussed in VI.D.4. of this final rule, address our Meaningful Measures Framework's [135] quality priority of ''Work with Communities to Promote Best Practices of Healthy Living'' through the Meaningful Measures Area of ''Equity of Care.'' Additionally, pursuant to our Meaningful Measures 2.0, these Social Drivers of Health measures address the

[125] Baker, M.C., Alberti, P.M., et al. (2021). Social Determinants Matter for Hospital Readmission Policy: Insights From New York City. Health Affairs, 40(4), 645–654. Available at: *https://doi.org/10.1377/hlthaff.2020.01742.* Accessed on February 20, 2023.

[126] Hammond, G., Johnston, K., et al. (2020). Social Determinants of Health Improve Predictive Accuracy of Clinical Risk Models for Cardiovascular Hospitalization, Annual Cost, and Death. Circulation: Cardiovascular Quality and Outcomes, 13 (6) 290–299. Available at: *https://doi.org/10.1161/CIRCOUTCOMES.120.006752.* Accessed on February 20, 2023.

[127] Hill-Briggs, F. (2021). Social Determinants of Health and Diabetes: A Scientific Review. Diabetes Care. Available at: *https://diabetesjournals.org/care/article/44/1/258/33180/Social-Determinants-of-Health-and-Diabetes-A.* Accessed on February 20, 2023.

[128] Jaffrey, J.B., Safran, G.B., Addressing Social Risk Factors in Value-Based Payment: Adjusting Payment Not Performance to Optimize Outcomes and Fairness. Health Affairs Blog, April 19, 2021. Available at: *https://www.healthaffairs.org/do/10.1377/forefront.20210414.379479/full/.* Accessed on February 20, 2023.

[129] Adepoju, OE, Liaw, W, et al. (2022) Assessment of Unmet Health-Related Social Needs Among Patients with Mental Illness Enrolled in Medicare Advantage. Available at: *https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2798096.* Accessed on December 7, 2022.

[130] The Physicians Foundation: 2020 Survey of America's Patients, Part Three. Available at: *https://physiciansfoundation.org/wp-content/uploads/2020/10/2020-Physicians-Foundation-Survey-Part3.pdf.*

[131] Office of the Assistant Secretary for Planning and Evaluation (ASPE) (2020). Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Program (Second of Two Reports). Available at: *https://aspe.hhs.gov/pdf-report/second-impact-report-to-congress.*

[132] Billioux, A., Verlander, K., Anthony, S., & Alley, D. (2017). Standardized Screening for Health-Related Social Needs in Clinical Settings: The Accountable Health Communities Screening Tool. NAM Perspectives, 7(5). Available at: *https://doi.org/10.31478/201705b.*

[133] Baker, M.C., Alberti, P.M., Tsao, T.Y., Fluegge, K., Howland, R.E., & Haberman, M. (2021). Social Determinants Matter for Hospital Readmission Policy: Insights From New York City. Health Affairs, 40(4), 645–654. Available at: *https://doi.org/10.1377/hlthaff.2020.01742.*

[134] De Marchis, E., Knox, M., Hessler, D., WillardGrace, R., Oliyawola, JN, et al. (2019). Physician Burnout and Higher Clinic Capacity to Address Patients' Social Needs. The Journal of the American Board of Family Medicine, 32 (1), 69–78.

[135] Centers for Medicare & Medicaid Services. Meaningful Measures Framework. Available at: *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/CMS-Quality-Strategy.*

equity priority area and align with our commitment to introduce plans to close health equity gaps and promote equity through quality measures, including to ''develop and implement measures that reflect social and economic determinants.'' [136] Development, proposal, and adoption of these measures also aligns with our strategic pillar to advance health equity by addressing the health disparities that underlie our health system.[137] Further, inclusion of these measures in the IPFQR Program aligns with these measures' adoption in the Hospital IQR Program in the FY 2023 IPPS/LTCH final rule (87 FR 49202 through 49215).

The Screening for Social Drivers of Health measure (alongside the Screen Positive Rate for Social Drivers of Health measure described in section VI.D.4 of this final rule) will be the first measurement of social drivers of health in the IPFQR Program. We believe these measures are appropriate for measurement of the quality of care furnished by IPFs. Screening patients for HRSNs during inpatient hospitalization in an IPF will allow healthcare providers, including IPFs, to identify and potentially help address HRSNs for this medically underserved patient population as part of discharge planning and contribute to long-term improvements in patient outcomes. Identifying and addressing HRSNs for patients receiving care in IPFs could have a direct and positive impact on IPFs' quality performance because of improvements in patient outcomes that could occur when patients' HRSNs are reduced. Moreover, collecting aggregate data on the HRSNs of IPF patient populations via these measures is crucial in informing design of future measures that could enable us to set appropriate performance targets for IPFs with respect to closing the gap on health equity.

b. Overview of Measure

The Screening for Social Drivers of Health measure assesses whether an IPF implements screening for all patients who are 18 years or older at time of admission for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety. To report on this measure, IPFs will provide: (1) the number of inpatients admitted to the facility who are 18 years or older at time of admission and who are screened for all of the five HRSNs (food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety); and (2) the total number of patients who are admitted to the facility who are 18 years or older on the date they are admitted.

Measure specifications for the Screening for Social Drivers of Health measure, which were available during the review of the MUC List, are available at *https://mmshub.cms.gov/sites/default/files/map-hospital-measure-specifications-manual-2022.pdf.*

(1) Measure Calculation

(a) Cohort

The Screening for Social Drivers of Health measure assesses the total number of patients aged 18 years and older, screened for HRSNs (specifically, food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety) during an IPF stay.

(b) Numerator

The numerator of the Screening for Social Drivers of Health measure consists of the number of patients admitted to an IPF stay who are 18 years or older on the date of admission and are screened during their IPF stay for all of the following five HRSNs: food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety.

(c) Denominator

The denominator of the Screening for Social Drivers of Health measure consists of the number of patients who are admitted to an IPF stay and who are 18 years or older on the date of admission. The following patients are excluded from the denominator: (1) patients who opt-out of screening; and (2) patients who are themselves unable to complete the screening during their inpatient stay and have no legal guardian or caregiver able to do so on the patient's behalf during their IPF stay.

(d) Calculation

The Screening for Social Drivers of Health measure is calculated as the number of patients admitted to an IPF stay who are 18 years or older on the date of admission screened for all five HRSNs (food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety) divided by the number of patients 18 years or older on the date of admission admitted to the IPF.

(2) Review by the Measure Applications Partnership

We included the Screening for Social Drivers of Health measure on the publicly available ''List of Measures Under Consideration for December 1, 2022'' (MUC List), a list of measures under consideration for use in various Medicare programs.[138] The CBE-convened MAP Health Equity Advisory Group reviewed the MUC List including the Screening for Social Drivers of Health measure (MUC 2022–053) in detail on December 6 through 7, 2022.[139] The MAP Health Equity Advisory Group expressed support for the collection of data related to social drivers of health, but raised concerns regarding public reporting of these data and potential repetition of asking patients the same questions across settings.[140]

In addition, on December 8 through 9, 2022, the MAP Rural Health Advisory Group reviewed the 2022 MUC List and the MAP Hospital Workgroup did so on December 13 through 14, 2022.[141] The MAP Rural Health Advisory Group noted some potential reporting challenges including the potential masking of health disparities that are underrepresented in some areas and that sample size and populations served may be an issue, but expressed that the Screening for Social Drivers of Health measure serves as a starting point to determine where screening is occurring. The MAP Hospital Workgroup expressed strong support for the measure but noted that interoperability will be important and cautioned about survey fatigue. The MAP Hospital Workgroup members conditionally supported the measure pending: (1) testing of the measure's reliability and validity; (2) endorsement by the CBE; (3) additional details on how potential tools map to the individual HRSNs, as well as best practices; (4) identification of resources that may be available to assist patients with identified HRSNs; and (5)

[136] Centers for Medicare & Medicaid Services. Meaningful Measures 2.0: Moving from Measure Reduction to Modernization. Available at: *https://www.cms.gov/meaningful-measures-20-moving-measure-reduction-modernization.*

[137] Brooks-LaSure, C. (2021). My First 100 Days and Where We Go From Here: A Strategic Vision for CMS. Available at: *https://www.cms.gov/blog/my-first-100-days-and-where-we-go-here-strategic-vision-cms.*

[138] Centers for Medicare & Medicaid Services. List of Measures Under Consideration for December 1, 2022. Available at: *https://mmshub.cms.gov/measure-lifecycle/measure-implementation/pre-rulemaking/lists-and-reports.*

[139] Centers for Medicare & Medicaid Services. 2022–2023 MAP Final Recommendations. Available at: *https://mmshub.cms.gov/measure-lifecycle/measure-implementation/pre-rulemaking/lists-and-reports.*

[140] Centers for Medicare & Medicaid Services. 2022–2023 MAP Final Recommendations. Available at: *https://mmshub.cms.gov/measure-lifecycle/measure-implementation/pre-rulemaking/lists-and-reports.*

[141] Centers for Medicare & Medicaid Services. 2022–2023 MAP Final Recommendations. Available at: *https://mmshub.cms.gov/measure-lifecycle/measure-implementation/pre-rulemaking/lists-and-reports.*

the measure's alignment with data standards, particularly the GRAVITY project.[142] The GRAVITY project's mission statement is ''to serve as the open public collaborative advancing health and social data standardization for health equity.'' [143] Thereafter, the MAP Coordinating Committee deliberated on January 24 through 25, 2023, and ultimately voted to uphold the MAP Hospital Workgroup's recommendation to conditionally support for rulemaking with the same conditions.[144]

We believe this measure establishes an important foundation for prioritizing the achievement of health equity among IPFs. Our approach to developing health equity measures is incremental, and we believe that health care equity outcomes in the IPFQR Program will inform future efforts to advance and achieve health care equity by IPFs. We additionally believe this measure to be a building block that lays the groundwork for a future meaningful suite of measures that would assess IPF progress in providing high-quality healthcare for all patients, regardless of social risk factors or demographic characteristics.

(3) CBE Endorsement

We have not submitted this measure for CBE endorsement at this time. Although section 1886(s)(4)(D)(i) of the Act generally requires that measures specified by the Secretary must be endorsed by the entity with a contract under section 1890(a) of the Act, section 1886(s)(4)(D)(ii) of the Act, states that in the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a) of the Act, the Secretary may specify a measure that is not so endorsed as long as due consideration is given to a measure that has been endorsed or adopted by a consensus organization identified by the Secretary. We reviewed measures endorsed by consensus organizations and were unable to identify any other measures on this topic endorsed by a consensus organization and therefore, we believe the exception in section 1886(s)(4)(D)(ii) of the Act applies.

c. Data Collection, Submission and Reporting

We believe incremental implementation of the Screening for Social Drivers of Health measure, by permitting one year of voluntary reporting prior to mandatory reporting, will allow IPFs who are not yet screening patients for HRSNs to get experience with collecting data for this measure and equally allow IPFs who already undertake screening efforts to report data already being collected. Therefore, we proposed voluntary reporting of this measure beginning with the data collected in CY 2024, which would be reported to CMS in CY 2025, followed by mandatory reporting beginning with data collected in CY 2025, which would be reported to CMS in CY 2026 for the FY 2027 payment determination.

Due to variability across IPFs and the populations they serve, and in alignment with the Hospital IQR Program, we will allow IPFs flexibility with the selection of tools to screen patients for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety. Potential sources of these data could include, for example, administrative claims data, electronic clinical data, standardized patient assessments, or patient-reported data and surveys.

Multiple screening tools for health-related social needs (HRSNs) already exist. For additional information on resources, we refer readers to evidence-based resources like the Social Interventions Research and Evaluation Network (SIREN) website, for example, for comprehensive information about the most widely used HRSN screening tools.[145] [146] SIREN contains descriptions of the content and characteristics of various tools, including information about intended populations, completion time, and number of questions.

We encourage IPFs to consider digital standardized screening tools and refer readers to the FY 2023 IPPS/LTCH PPS final rule (87 FR 49207 through 49208) where we discuss how the use of certified health information technology (IT), including but not limited to certified EHR technology, can support capture of HRSN information in an interoperable fashion so that these data can be shared across the care continuum to support coordinated care. We also encourage readers to learn about the United States Core Data for Interoperability (USCDI) standard used in certified health IT and how this standard can support interoperable exchange of health and HRSN assessment data.[147]

We proposed that IPFs would report aggregate data on this measure, that is IPFs would report aggregated data for the numerator and the denominator to CMS (as described in section VI.D.3.b.(1). of this final rule) but would not be required to report patient-level data. IPFs are required to submit information for chart-abstracted measures once annually using a CMS-approved web-based data collection tool available within the HQR System (previously referred to as the QualityNet Secure Portal). We refer readers to section VI.I of this final rule (Form, Manner, and Timing of Quality Data Submission) for more details on our previously finalized data submission and deadline requirements across measure types.

We invited public comment on this proposal.

Comment: Many commenters supported adoption of the Screening for Social Drivers of Health measure. Some commenters stated that screening for these HRSNs will help IPFs better understand patients' needs, improve care coordination with outpatient and community resources, increase the dignity and respect with which patients are treated, and support development of patient-centered treatment plans. One commenter stated that the data collected through these screenings could help IPFs shape facility level goals associated with health equity and empower the workforce to recognize and eliminate health disparities. One commenter specifically supported the flexibility with respect to tool selection and stated that this will help IPFs select the standardized screening instruments most applicable for their individual patient populations. Another commenter stated that discharge will not lead to positive patient outcomes if the patient is discharged to unstable conditions or without the transportation necessary to access support services.

Response: We thank commenters for their support of the Screening for Social Drivers of Health measure. We agree that HRSNs are critical factors that

[142] Centers for Medicare & Medicaid Services. 2022–2023 MAP Final Recommendations. Available at: *https://mmshub.cms.gov/measure-lifecycle/measure-implementation/pre-rulemaking/lists-and-reports.*

[143] *https://thegravityproject.net/.*

[144] Centers for Medicare & Medicaid Services. 2022–2023 MAP Final Recommendations. Available at: *https://mmshub.cms.gov/measure-lifecycle/measure-implementation/pre-rulemaking/lists-and-reports.*

[145] Social Interventions Research & Evaluation Network. (2019). Social Needs Screening Tool Comparison Table. Available at: *https://sirenetwork.ucsf.edu/tools-resources/resources/screening-tools-comparison.* Accessed January 18, 2021.

[146] The Social Interventions Research and Evaluation Network (SIREN) at University of California San Francisco was launched in the spring of 2016 to synthesize, disseminate, and catalyze research on SDOH and healthcare delivery.

[147] Office of the National Coordinator for Health IT (ONC). United States Core Data for Interoperability. Accessed at: *https://www.healthit.gov/isa/united-states-core-data-interoperability-uscdi.*

impact patient outcomes, and increased knowledge about patients' HRSNs will help IPFs shape goals associated with health equity. Further, we agree that collecting these data will help IPFs improve coordination with outpatient and community resources to better deliver patient-centered care. Finally, we note that these activities would support IPFs' execution of responsibilities related to the required standard for social services under 42 CFR 482.62(f).

Comment: Several commenters recommended that CMS conduct additional testing, specifically in the IPF setting, to ensure that the measure addresses the specific needs of the IPF patient population.

Response: We acknowledge that this measure was initially developed for the general acute care setting. While we recognize the value of measures undergoing testing and evaluation of validity and feasibility in the setting for which they are being adopted, given the urgency of identifying and addressing HRSNs described in section VI.D.4.a of this final rule, and, as there are currently no other existing measures that address Screening for Social Drivers of Health, we believe it is important to implement this measure as soon as feasible. We believe that this measure is equally applicable to freestanding IPFs and psychiatric units within acute care facilities as to general acute care settings, because we believe that identifying the HRSNs of IPF patients will be equally valuable in understanding patients' needs, improving care coordination with outpatient and community resources, increasing the dignity and respect with which patients are treated, and supporting development of patient-centered treatment plans as identifying the HRSNs of acute care hospital patients. We note that identifying and addressing HRSNs is a critical topic for patients treated in IPFs and that there are high levels of health disparities experienced by this patient population. CMS will monitor measure implementation and data reporting as part of standard program and measure review and will consider updates to the measure if improvements are identified through this process.

Comment: Many commenters expressed concern that this measure has not received endorsement by the CBE.

Response: While we recognize the value of measures undergoing review for potential CBE endorsement, given the urgency of achieving health equity, we believe it is important to implement this measure with voluntary reporting beginning with the CY 2024 reporting period followed by mandatory reporting beginning with the CY 2025 reporting period/FY 2027 payment determination. We note that, under section 1886(s)(4)(D)(ii) of the Act, the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary. We reviewed measures endorsed by consensus organizations and were unable to identify any other measures on this topic endorsed by a consensus organization, and therefore, we believe the exception in section 1886(s)(4)(D)(ii) of the Act applies.

Comment: Many commenters recommended extending the voluntary reporting phase for this measure.

Response: Beginning to collect the data remains imperative as we continue to build on our strategic pillar to advance health equity by addressing the health disparities that underlie our health system. We therefore have determined that the proposed voluntary and mandatory reporting periods prioritize the urgency of capturing social drivers of health data and taking actionable steps towards closing the health equity gap.

Comment: Some commenters recommended that CMS defer adoption of this measure until the Hospital IQR Program's voluntary reporting period for its version of this measure concludes to allow CMS and IPFs to identify best practices for screening patients and collecting HRSNs data in a minimally burdensome way. Some of these commenters stated that IPFs often have fewer resources available for such data collection relative to acute care hospitals. Other commenters recommended engaging IPFs to voluntarily test the measure to ensure usability, acceptability, and face validity are met for this setting.

Response: We acknowledge commenters' desire to be able to learn from the experiences of acute care hospitals reporting this measure. Hospitals participating in the Hospital IQR Program that choose to voluntarily report this measure will have already reported data in CY 2024 (87 FR 49207). Furthermore, the Hospital IQR Program finalized mandatory reporting of this measure for the FY 2026 payment determination (that is data submitted in CY 2025 representing the CY 2024 performance period) (87 FR 49207). Given the timing of reporting this measure in the Hospital IQR Program, we believe that IPFs will have the opportunity to learn from the experiences of acute care hospitals, including best practices for collecting HRSNs data, prior to mandatory reporting for the IPFQR Program for the FY 2027 payment determination. Furthermore, we believe that the voluntary reporting of CY 2024 data submitted to CMS in CY 2025 for the IPFQR Program will provide additional opportunities to identify minimally burdensome screening instruments and data collection practices. Finally, we note that we will monitor measure implementation and data reporting as part of standard program and measure review and will consider updates to the measure if improvements are identified through this process. Therefore, we do not believe that the benefits of extending voluntary reporting of this measure in the IPFQR Program for more than one year outweigh the potential detriments associated with delay in measure adoption that extending the voluntary reporting period would require.

Comment: Several commenters had recommendations related to the specifications for the Screening for Social Drivers of Health measure regarding the frequency and timing of administering these screenings. One commenter recommended not requiring individual patients to be screened more frequently than once per quarter so that patients who are readmitted or admitted to other settings over a short duration are not repeatedly screened when their HRSNs are unlikely to have changed. Another commenter recommended that for patients who have long stays (sometimes greater than one year) the measure should be updated to require an annual screening and screening at discharge. This commenter stated that for these patients screening at discharge would provide data which would inform discharge planning.

Response: We understand the commenters' concerns, especially given the frequency of unmet HRSNs among psychiatric patients, regarding patients who may be screened frequently, or whose screening results may change significantly during their inpatient stay (such as those patients with long duration stays). We note that screening can occur any time during the hospital admission prior to discharge. Further, for patients frequently admitted to inpatient facilities, the IPF could confirm the current status of any previously reported HRSNs and inquire about other HRSNs not previously reported or that may have changed in the intervening period. For additional information on how to apply and report these screenings, we refer readers to the Hospital IQR Program's Frequently Asked Questions document regarding this measure in the Hospital IQR

Program, available at: We will develop a similar Frequently Asked Questions document for IPFs as part of providing educational and training materials; this document will be conveyed through routine communication channels to hospitals, vendors, and QIOs, including, but not limited to, issuing memos, emails, and notices on a CMS website.

Comment: Several commenters recommended additional changes to the measure specifications. Due to the sensitive nature of screening for risk of interpersonal violence, commenters recommended changes that included removing this domain from the measure specifications, and updating the measure to ensure patient privacy when responding to this screening question, either by excluding patients who could not respond to the question confidentially, or by ensuring responses remain hidden in all records and handouts accessible to patients. One commenter recommended removing the exclusion language ''and lack of a guardian or caregiver available to do so on the patient's behalf'' because such a guardian or caregiver may provide inaccurate information about the patient's risk of interpersonal violence. One commenter recommended excluding patients coming from or being discharged to long-term care settings because these patients would be at lower risk for these five HRSNs. Another commenter recommended expanding the measure to include screening for lack of financial resources.

Response: We have prioritized selection of the proposed five HRSN domains based on existing evidence from both the AHC Model, including recommendations from a technical expert panel (TEP) that informed the initial selection, and emerging evidence of correlations between given social drivers of health and worse health outcomes and social drivers of health for which interventions have shown marked improvements in health outcomes and healthcare utilization (88 FR 21280). Through this process we did not identify lack of financial resources as being one of the social drivers of health that met our criteria for selection (these criteria are set forth in section V.D.3.a. of the proposed rule and in section VI.D.3 of this final rule); therefore, we did not include it in the Screening for Social Drivers of Health measure. We note that while the Screening for Social Drivers of Health measure requires screening for the five identified HRSNs, IPFs may screen for additional HRSNs that they believe are relevant for their patient population and the community in which they serve, and that standardized screening instruments such as those available for screening for these five HRSNs may also include a screening for lack of financial resources. For example, the Accountable Health Communities screening tool includes questions for eight supplemental domains, including financial strain. Furthermore, we note that this measure is a first step towards development of a long-term strategy to integrate social drivers of health and HRSN data into quality performance measurement and is part of our broader commitment to health equity.

We believe it is imperative that IPFs screen for all five domains established in this measure. We understand commenters' concerns regarding the sensitive nature of screening for risk of interpersonal violence and agree that patient safety must remain the IPF's principal concern. We recommend that IPFs ensure that patients feel that they are safe answering questions and remind patients that they may opt out of the screening for any reason. We note that, because IPFs likely are covered entities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Rules (codified at 45 CFR parts 160 and 164),[148] information provided by patients in response to screening for this measure would be protected health information (PHI).[149] Therefore, IPFs are responsible for adopting reasonable safeguards to ensure that patients' PHI is not impermissibly disclosed contrary to applicable confidentiality, security, and privacy laws.

We do not believe it would be appropriate to remove the exclusion which would allow a caregiver or guardian to provide information on a patient's behalf if the patient is unable to do so. While we agree that the scenario presented by commenters (that is, a guardian or caregiver may provide inaccurate information about the patient's risk of interpersonal violence) is possible, we do not believe that the potential unintended consequence of capturing inaccurate data for this HRSN for a small portion of patients outweighs the potential benefit of capturing accurate data regarding all of these five HRSNs for as many patients as possible, including those who are unable to respond to the screening without the assistance of a caregiver or guardian.

Finally, we believe that it is appropriate to assess the HRSNs of all eligible patients (that is, patients who are over 18 years of age at admission and do not meet the measure's exclusion criteria) including patients being admitted from or discharged to long-term care settings. While these patients are at lower risk during their stay in the long-term care facility, we believe it is appropriate for the IPF to assess the patient's overall risk of unmet HRSNs. We note, for example, that the AHC screening instrument assesses the patient's HRSNs over the past 12 months for the majority of the HRSNs included in this tool. Therefore, screening patients admitted from or being discharged to long-term care settings could help identify unmet HRSNs among this patient population. We will continue to take all concerns, comments, and suggestions into account and will consider them as part of any potential future modifications to these measures or potential new measure development in future notice-and-comment rulemaking.

Comment: One commenter recommended that the Screening for Social Drivers of Health measure be completed by a peer support specialist to engender trust and create a safe environment.

Response: We agree with the commenter that it is important for the screening for HRSNs to be accomplished in a way that engenders trust and creates a safe environment. We recommend that IPFs evaluate the requirements for administration (such as whether the screening instrument can be administered by peer support specialists) as part of their instrument selection process. We note that the AHC instrument described in section VI.D.3 of this rule allows administration by clinicians and staff[150] and would allow administration by peer support specialists.

Comment: One commenter recommended aligning SDOH related measures, including this one, across programs including programs for the ambulatory setting (including MIPS).

Response: We agree with the commenter that addressing patients' HRSNs is important in all settings in which patients access care. We note that this measure was adopted into MIPS in the CY 2023 Physician Fee Schedule (PFS) final rule (87 FR 70055) as well as the Hospital IQR Program in the FY 2023 IPPS/LTCH PPS final rule (87 FR 49215). In addition, we have proposed to adopt this measure in the PPS-Exempt Cancer Hospital Quality Reporting Program in the FY 2024 IPPS/

[148] For more information on the three HIPAA rules, we refer readers to the HIPAA for Professionals site at: *https://www.hhs.gov/hipaa/for-professionals/index.html.*

[149] *https://www.hhs.gov/answers/hipaa/what-is-phi/index.html.*

[150] *https://nam.edu/standardized-screening-for-health-related-social-needs-in-clinical-settings-the-accountable-health-communities-screening-tool/.*

LTCH PPS proposed rule (88 FR 27128) and the End-Stage Renal Disease Quality Incentive Program in the CY 2024 ESRD PPS proposed rule (88 FR 42515). We note that only the IPFQR Program is the subject of this final rule, and the commenter's recommendation is therefore beyond the scope of this final rule.

Comment: One commenter recommended against public reporting until a standardized, validated instrument is adopted so the data are collected using a uniform tool. One commenter requested that CMS provide guidance on which available, standardized assessment instruments address each of the domains.

Response: We are sensitive to the concerns raised by commenters about the lack of clarity about which screening instrument IPFs should use in order to screen for HRSNs. We acknowledge the challenges that lack of standardization across screening instruments or data collection practices may introduce in the consistency of the information collected across IPFs. While we acknowledge the potential benefits of a single screening instrument or prescribed set of standards, we also recognize the benefits of providing IPFs with flexibility to customize screening and data collection to their local community contexts and patient populations, especially in the initial stages of implementing screening protocols. We encourage IPFs to prioritize screening tools that have undergone thorough testing to ensure they are accurate and reliable. We believe that this measure should promote high-quality screening practices which, among other things, ensure accurate identification of unmet social needs.

For selecting a screening tool, we suggest that IPFs refer to evidence-based resources for comprehensive information about the most widely used HRSN screening tools. For example, the Social Interventions Research and Evaluation Network (SIREN) website,[151] housed at the Center for Health and Community at the University of California, San Francisco, contains descriptions of the content and characteristics of various tools, including information about intended populations, completion time, and number of questions.

Comment: Several commenters stated that a measurement of whether a screening occurred does not indicate whether the needs have been met nor the impact of these specific HRSNs on the patient's health outcomes. Some of these commenters also stated that the lack of resources faced by IPFs may lead IPFs to screen for SDOH for which they are unable to assist patients. These commenters expressed concern that this may be frustrating for patients who would expect the IPF to address these needs after the screening.

Response: During the development of both Social Drivers of Health measures, we gave this topic significant consideration. The intent of the two measures is to promote adoption of screening patients for HRSNs by healthcare providers as well as taking action to connect patients who identify one or more HRSNs with available resources. Evaluation of the AHC Model concluded that universal screening may identify needs that would otherwise remain undetected.[152] While broad availability of community-based resources that address patients' health-related social needs would be ideal, we believe that one of the benefits of collecting data from screening for HRSNs will be identification of opportunities to enable meaningful action, including prioritizing and investing in such resources. Beginning to collect the data on patients' HRSNs remains imperative and a crucial step in developing resources for advancing health equity. Such data collection has already allowed some entities to reallocate resources to address particular HRSNs that disproportionately affect a given patient population or geographic region, as noted in the FY 2023 IPPS/LTCH PPS final rule, in which the Hospital IQR Program adopted these measures (87 FR 49213).

Comment: One commenter requested clarification of whether the measure will represent the ''total number'' of patients screened for SDOH or the proportion of patients screened for SDOH.

Response: IPFs will report the aggregate numerator for this measure (that is, the total number of patients admitted to an IPF stay who are 18 years or older on the date of admission and screened for all five HRSNs), and the aggregate denominator (that is, number of patients who are admitted to an IPF stay and who are 18 years or older on the date of admission). Using these data and the denominator exclusions (that is, patients who opt-out of screening and patients who are themselves unable to complete the screening during their inpatient stay and have no legal guardian or caregiver able to do so on their behalf during their IPF stay), we will calculate the screening rate (that is, the proportion of patients screened for all five SDOH) for this measure.

Comment: One commenter did not support this measure because of their concern that the specific HRSNs in the Screening for Social Drivers of Health measure are not completely aligned with the HL7 Gravity Project.

Response: We have prioritized the five HRSN domains in this measure based on existing evidence from the AHC Model including recommendations from a TEP that informed the initial selection. We commend additional initiatives currently underway to expand capabilities to capture additional social drivers of health data elements, including the Gravity Project. We note that the five domains covered by the Screening for Social Drivers of Health measure are included within the ''social risk domains'' of the Gravity Project. We support harmonization of data regarding HRSNs for interoperable electronic health information exchange that will meet information exchange standards.

Comment: One commenter did not support this measure stating their belief that there is a lack of evidence that screening impacts quality of care provided by IPFs.

Response: We note that the two Social Drivers of Health measures are derived from existing evidence from both the AHC Model and emerging evidence of correlations between the designated social drivers of health and higher healthcare utilization of emergency departments and hospitals, worse health outcomes and/or drivers of health for which interventions have shown marked improvements in health outcomes and health care utilization (88 FR 21280).

Comment: One commenter did not support required reporting of these data because, while the commenter agreed that screening for SDOH is important and should be occurring in the IPF setting, the commenter expressed concern that reporting these data is too burdensome and takes away from patient care. Another commenter did not support the Screening for Social Drivers of Health measure because IPF stays are typically only a few days, and the commenter stated their belief that there is therefore insufficient time to complete these screenings during the stay.

Response: While we understand implementation of HRSN screening processes and reporting of the SDOH measures is associated with some burden, as discussed in sections VII.B.

[151] *https://chc.ucsf.edu/siren.*

[152] RTI International. (2020). Accountable Health Communities (AHC) Model Evaluation. Available at: *https://innovation.cms.gov/data-and-reports/2020/ahc-first-eval-rpt.*

and VIII.A of this final rule, we believe the benefits outweigh the burden, as screening for and identifying patients' HRSNs is a critical step towards treating the whole patient, improving clinical outcomes, improving equitable care, and ultimately eliminating disparities in health outcomes among populations that have been historically underserved by the healthcare system.

We note that screening can occur any time during the IPF admission prior to discharge and that, for example, the AHC Screening Tool addresses these 5 HRSNs using a total of 10 questions. Therefore, we believe that IPFs will be able to find sufficient time during the patient's IPF stay to administer this or a similar screening tool for SDOH.

Final Decision: After consideration of the public comments we received, we are finalizing adoption of the Screening for Social Drivers of Health measure as proposed.

4. Adoption of the Screen Positive Rate for Social Drivers of Health Measure Beginning With Voluntary Reporting of CY 2024 Data and Followed by Mandatory Reporting Beginning With CY 2025 Data/FY 2027 Payment Determination

a. Background

The impact of social risk factors on health outcomes has been well-established in the literature.[153] [154] [155] [156] [157] The Physicians Foundation reported that 73 percent of the physician respondents to the 2021 iteration of their annual survey agreed that social risk factors like housing instability and food insecurity would drive health services demand.[158] Recognizing the need for a more comprehensive approach to eliminating the health equity gap, we have prioritized quality measures that would capture social risk factors and facilitate assessment of their impact on health outcomes and disparities and healthcare utilization and costs.[159] [160] [161] Specifically, in the inpatient setting, we aim to encourage systematic identification of patients' HRSNs (as defined in section VI.D.3.a. of this final rule) as part of discharge planning with the intention of promoting linkages with relevant community-based services that address those needs and support improvements in health outcomes following discharge from the IPF.

While the Screening for Social Drivers of Health measure (discussed previously in section VI.D.3. of this final rule) enables identification of individuals with HRSNs, use of the Screen Positive Rate for Social Drivers of Health measure would allow IPFs to capture the magnitude of these needs and even estimate the impact of individual-level HRSNs on healthcare utilization when evaluating quality of care.[162] [163] [164] The Screen Positive Rate for Social Drivers of Health measure will require IPFs to report the rates of patients who screened positive for each of the five core HRSNs. Reporting the screen positive rate for each of the five core HRSNs will inform actionable planning by IPFs towards closing health equity gaps unique to the populations they serve and enable the development of individual patient action plans (including navigation and referral services).

In the FY 2022 IPF PPS final rule (86 FR 42625 through 42632) and the FY 2023 IPF PPS final rule (87 FR 46865 through 46873), we discussed our ongoing consideration of potential approaches that could be implemented to address health equity through the IPFQR Program. As a result of the feedback we received, we identified the Screen Positive Rate for Social Drivers of Health measure to help inform efforts to address health equity.

This measure assesses the percent of patients admitted to the IPF who are 18 years or older at time of admission who were screened for HRSNs and who screen positive for one or more of the five HRSNs, including food insecurity, housing instability, transportation needs, utility difficulties, or interpersonal safety (reported as five separate rates).[165]

We refer readers to section VI.D.3 of this final rule where we previously discussed the screening and identification process resulting in the selection of these five domains associated with the Screen for Social Drivers of Health measure. The Screening for Social Drivers of Health measure forms the basis of this Screen Positive Rate for Social Drivers of Health measure. That is, the number of patients screened for all five HRSNs in the Screening for Social Drivers of Health measure is the denominator of the Screen Positive Rate for Social Drivers of Health measure described here.

The COVID–19 pandemic underscored the overwhelming impact that these five core domains of HRSNs have on disparities, health risk, healthcare access, and health outcomes, including premature mortality.[166] [167]

[153] Institute of Medicine 2014. Capturing Social and Behavioral Domains and Measures in Electronic Health Records: Phase 2. Washington, DC: The National Academies Press. Available at: *https://doi.org/10.17226/18951.*

[154] Centers for Medicare & Medicaid Services. (2021). Accountable Health Communities Model. Accountable Health Communities Model | CMS Innovation Center. Available at: *https://innovation.cms.gov/innovation-models/ahcm.* Accessed November 23, 2021.

[155] Kaiser Family Foundation. (2021). Racial and Ethnic Health Inequities and Medicare. Available at: *https://www.kff.org/medicare/report/racial-and-ethnic-health-inequities-and-medicare/.* Accessed November 23, 2021.

[156] Milkie Vu et al. Predictors of Delayed Healthcare Seeking Among American Muslim Women, Journal of Women's Health 26(6) (2016) at 58; Nadimpalli SB, Cleland CM, Hutchinson MK, Islam N, Barnes LL, Van Devanter N. (2016) The Association between Discrimination and the Health of Sikh Asian Indians. Health Psychology, 35(4), 351–355. *https://doi.org/10.1037/hea0000268.*

[157] Office of the Assistant Secretary for Planning and Evaluation (ASPE). (2020). Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Program (Second of Two Reports). Available at: *https://aspe.hhs.gov/pdf-report/second-impact-report-to-congress.*

[158] The Physicians Foundation. (2020) 2020 Survey of America's Patients, Part Three. Available at: *https://physiciansfoundation.org/wp-content/uploads/2020/10/2020-Physicians-Foundation-Survey-Part3.pdf.*

[159] Alley, D.E., C.N. Asomugha, P.H. Conway, and D.M. Sanghavi. 2016. Accountable Health Communities–Addressing Social Needs through Medicare and Medicaid. The New England Journal of Medicine 374(1):8–11. Available at: *https://doi.org/10.1056/NEJMp1512532.*

[160] Centers for Medicare & Medicaid Services. (2021). Accountable Health Communities Model. Accountable Health Communities Model | CMS Innovation Center. Available at: *https://innovation.cms.gov/innovation-models/ahcm.* Accessed November 23, 2021.

[161] Billioux, A., Verlander, K., Anthony, S., & Alley, D. (2017). Standardized Screening for Health-Related Social Needs in Clinical Settings: The Accountable Health Communities Screening Tool. NAM Perspectives, 7(5). Available at: *https://doi.org/10.31478/201705b.*

[162] Baker, M.C., Alberti, P.M., Tsao, T.Y., Fluegge, K., Howland, R.E., & Haberman, M. (2021). Social Determinants Matter for Hospital Readmission Policy: Insights From New York City. Health Affairs, 40(4), 645–654. Available at: *https://doi.org/10.1377/hlthaff.2020.01742.*

[163] CMS. Accountable Health Communities Model. Accountable Health Communities Model | CMS Innovation Center. Available at: *https://innovation.cms.gov/innovation-models/ahcm.* Accessed November 23, 2021.

[164] Hammond, G., Johnston, K., Huang, K., Joynt Maddox, K. (2020). Social Determinants of Health Improve Predictive Accuracy of Clinical Risk Models for Cardiovascular Hospitalization, Annual Cost, and Death. Circulation: Cardiovascular Quality and Outcomes, 13 (6) 290–299. Available at: *https://doi.org/10.1161/CIRCOUTCOMES.120.006752.*

[165] Billioux, A., Verlander, K., Anthony, S., & Alley, D. (2017). Standardized Screening for Health Related Social Needs in Clinical Settings: The Accountable Health Communities Screening Tool. NAM Perspectives, 7(5). Available at: *https://doi.org/10.31478/201705b.*

[166] Kaiser Family Foundation. (2021). Racial and Ethnic Health Inequities and Medicare. Available at: *https://www.kff.org/medicare/report/racial-and-ethnic-health-inequities-and-medicare/.* Accessed November 23, 2021.

[167] Centers for Disease Control and Prevention. (2019). CDC COVID–19 Response Health Equity Strategy: Accelerating Progress Towards Reducing COVID–19 Disparities and Achieving Health Equity. July 2020. Available at: *https://www.cdc.gov/*

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Adoption of the Screen Positive Rate for Social Drivers of Health measure will encourage IPFs to track prevalence of specific HRSNs among patients over time and use the data to stratify risk as part of quality performance improvement efforts. This measure may also prove useful for patients by providing data transparency and signifying IPFs' familiarity, expertise, and commitment regarding these health equity issues. This measure also has the potential to reduce healthcare provider burden and burnout, including among IPFs and their staff, by both acknowledging patients' non-clinical needs that nevertheless greatly contribute to adverse clinical outcomes and linking providers with community-based organizations to enhance patient-centered treatment and discharge planning.[168] [169] [170] Finally, we believe the Screen Positive Rate for Social Drivers of Health measure has the potential to facilitate data-informed collaboration with community-based services and focused community investments, including the development of pathways and infrastructure to connect patients to local community resources.

Ultimately, we are focused on supporting effective and sustainable collaboration between healthcare delivery and local community-based services organizations to meet the unmet needs of people they serve. Reporting data from both the Screening for Social Drivers of Health and the Screen Positive Rate for Social Drivers of Health measures will enable both identification and quantification of the levels of unmet HRSNs among communities served by IPFs. These two Social Drivers of Health measures harmonize, as it is important to know both whether screening occurred and the results from the screening in order to develop sustainable solutions. We believe that there are multiple benefits to increasing IPFs' understanding of their patients' HRSNs. First, we believe that this could lead to increased clinical-community collaborations and an associated increase in system capacity and community investments. Second, we believe this in turn could yield a net reduction in costly healthcare utilization by promoting more appropriate healthcare service consumption.[171]

Pursuant to our Meaningful Measures 2.0 Framework and in alignment with the measures previously adopted for hospitals participating in the Hospital IQR Program, the Screen Positive Rate for Social Drivers of Health measure will address the equity priority area and align with our commitment to introduce plans to close health equity gaps and promote equity through quality measures, including to ''develop and implement measures that reflect social and economic determinants.'' [172] Under our Meaningful Measures Framework, the Screen Positive Rate for Social Drivers of Health measure will address the quality priority of ''Work with Communities to Promote Best Practices of Healthy Living'' through the Meaningful Measures Area of ''Equity of Care.'' [173] Adoption of this measure will also align with our strategic pillar to advance health equity by addressing the health disparities that underlie our health system.[174]

b. Overview of Measure

The Screen Positive Rate for Social Drivers of Health measure is intended to enhance standardized data collection that can identify individuals who are at higher risk for poor health outcomes related to HRSNs who would benefit from connection via the IPF to targeted community-based services.[175] The measure identifies the proportion of patients admitted to an IPF stay who are 18 years or older on the date of admission to the IPF who screened positive for one or more of the following five HRSNs: food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety.

Consistent with the Hospital IQR Program, which adopted this measure in the FY 2023 IPPS/LTCH PPS final rule (87 FR 49215 through 49220), we will require IPFs to report this measure as five separate rates. Specifically, IPFs will report the number of patients who screened positive for food insecurity, the number of patients who screened positive for housing instability, the number of patients who screened positive for transportation needs, the number of patients who screened positive for utility difficulties, and the number of patients who screened positive for interpersonal safety. We note that this measure is intended to provide information to IPFs on the level of unmet HRSNs among patients served, and not for comparison between IPFs.

The specifications for the Screen Positive Rate for Social Drivers of Health measure, which were available during the review of the MUC List, are available at: *https://mmshub.cms.gov/sites/default/files/map-hospital-measure-specifications-manual-2022.pdf.*

(1) Measure Calculation

(a) Cohort

The Screen Positive Rate for Social Drivers of Health measure is a process measure that provides information on the percent of patients, 18 years or older on the date of admission for an IPF stay, who were screened for all five HRSNs,[176] and who screen positive for one or more of the following five HRSNs: food insecurity; housing instability; transportation needs; utility difficulties; or interpersonal safety.

(b) Numerator

The numerator consists of the number of patients admitted for an IPF stay who are 18 years or older on the date of admission, who were screened for an HRSN, and who screen positive for having an unmet need in one or more of the following five HRSNs (calculated separately): The number of patients who screened positive for food insecurity, the number of patients who screened positive for housing instability, the number of patients who screened positive for transportation needs, the

coronavirus/2019-ncov/community/health-equity/cdc-strategy.html. Accessed November 17, 2021.

[168] The Physicians Foundation. (2020). Survey of America's Patients, Part Three. Available at: *https://physiciansfoundation.org/wp-content/uploads/2020/10/2020-Physicians-Foundation-Survey-Part3.pdf.*

[169] De Marchis, E., Knox, M., Hessler, D., WillardGrace, R., Oliyawola, JN, et al. (2019). Physician Burnout and Higher Clinic Capacity to Address Patients' Social Needs. The Journal of the American Board of Family Medicine, 32 (1), 69–78.

[170] Kung, A., Cheung, T., Knox, M., Willard-Grace, R., Halpern, J., et.al, (2019). Capacity to Address Social Needs Affect Primary Care Clinician Burnout. Annals of Family Medicine. 17 (6), 487–494. Available at: *https://doi.org/10.1370/afm.2470.*

[171] Centers for Medicare & Medicaid Services. (2021). Accountable Health Communities Model. Accountable Health Communities Model | CMS Innovation Center. Available at: *https://innovation.cms.gov/innovation-models/ahcm.* Accessed November 23, 2021.

[172] Centers for Medicare & Medicaid Services. Meaningful Measures 2.0: Moving from Measure Reduction to Modernization. Available at: *https://www.cms.gov/meaningful-measures-20-moving-measure-reduction-modernization.*

[173] Centers for Medicare & Medicaid Services. (2021). CMS Measures Management System Blueprint (Blueprint v 17.0). Available at: *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/MMS-Blueprint.*

[174] Brooks-LaSure, C. (2021). My First 100 Days and Where We Go From Here: A Strategic Vision for CMS. Available at: *https://www.cms.gov/blog/my-first-100-days-and-where-we-go-here-strategic-vision-cms.*

[175] Centers for Medicare & Medicaid Services. (2021). A Guide to Using the Accountable Health Communities Health-Related Social Needs Screening Tool: Promising Practices and Key Insights (June 2021). Available at: *https://innovation.cms.gov/media/document/ahcm-screeningtool-companion.* Accessed November 23, 2021.

[176] We have updated this language to read ''all five HRSNs'' as opposed to ''an HRSN'' to update the language on the 2022 MUC List: *https://mmshub.cms.gov/sites/default/files/2022-MUC-List.xlsx.*

number of patients who screened positive for utility difficulties, and the number of patients who screened positive for interpersonal safety. IPFs will report the number of patients who screened positive for having unmet needs in each of the five HRSNs as a separate numerator. A patient who screened positive for more than one unmet HRSN will be included in the numerator for each of those HRSNs. For example, a patient who screened positive for food insecurity, housing instability, and transportation needs would be included in each of these numerators.

(c) Denominator

The denominator consists of the number of patients admitted for an IPF stay who are 18 years or older on the date of admission and are screened for all five HRSNs (food insecurity, housing instability, transportation needs, utility difficulties and interpersonal safety) [177] during their IPF stay. The following patients are excluded from the denominator: (1) patients who opt out of screening; and (2) patients who are themselves unable to complete the screening during their inpatient stay and have no caregiver able to do so on the patient's behalf during their inpatient stay.

(d) Calculation

The results of this measure are calculated as five separate rates. Each rate is derived from the number of patients admitted for an IPF stay and who are 18 years or older on the date of admission, screened for an HRSN, and who screen positive for each of the five HRSNs (that is, the number of patients who screened positive for food insecurity, the number of patients who screened positive for housing instability, the number of patients who screened positive for transportation needs, the number of patients who screened positive for utility difficulties, and the number of patients who screened positive for interpersonal safety) divided by the number of patients 18 years or older on the date of admission screened for all five HRSNs. The measure is reported as five separate rates—one for each HRSN, each calculated with the same denominator.

(2) Review by the Measure Applications Partnership

We included the Screen Positive Rate for Social Drivers of Health measure on the publicly available MUC List, a list of measures under consideration for use in various Medicare programs.[178] The CBE-convened MAP Health Equity Advisory Group reviewed the MUC List and the Screen Positive Rate for Social Drivers of Health measure (MUC 2022–050) in detail on December 6 through 7, 2022.[179] The MAP Health Equity Advisory Group expressed support for the collection of data related to social drivers of health, but raised concerns regarding public reporting of these data and potential repetition of asking patients the same questions across settings.[180]

In addition, on December 8 through 9, 2022, the MAP Rural Health Advisory Group reviewed the 2022 MUC List, which was also reviewed by the MAP Hospital Workgroup on December 13 through 14, 2022.[181] The MAP Rural Health Advisory Group noted potential reporting challenges including the potential masking of health disparities that are underrepresented in some areas and that sample size and populations served may be an issue but also expressed support that the measure seeks to advance the drivers of health and serves as a starting point to determine where screening is occurring. The MAP Hospital Workgroup recommended conditional support of the measure for rulemaking pending: (1) endorsement by the CBE to address reliability and validity concerns; (2) attentiveness to how results are shared and contextualized for public reporting; and (3) examination of any differences in reported rates by reporting process (that is, to assess whether reported rates are the same or different across IPFs and other facilities that may use different processes to report their data).[182] Thereafter, the MAP Coordinating Committee deliberated on January 24 through 25, 2023, and ultimately voted to conditionally support the Screen Positive Rate for Social Drivers of Health measure for rulemaking with the same conditions.[183]

We agree with the MAP Coordinating Committee's support for the proposed Screen Positive Rate for Social Drivers of Health measure. We believe this measure, alongside the Screening for Social Drivers of Health measure, establishes an important foundation to prioritizing the achievement of health equity among IPFs participating in the IPFQR Program. Our approach to developing health equity measures is incremental, and we believe that health equity outcomes in the IPFQR Program will inform future efforts to advance and achieve health equity by IPFs. We believe this measure to be a building block that lays the groundwork for a future meaningful suite of measures that would assess IPF progress in providing high-quality healthcare for all patients, regardless of social risk factors or demographic characteristics.

(3) CBE Endorsement

We have not submitted this measure for CBE endorsement at this time. Although section 1886(s)(4)(D)(i) of the Act generally requires that measures specified by the Secretary must be endorsed by the entity with a contract under section 1890(a) of the Act, section 1886(s)(4)(D)(ii) of the Act states that in the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a) of the Act, the Secretary may specify a measure that is not so endorsed as long as due consideration is given to a measure that has been endorsed or adopted by a consensus organization identified by the Secretary. We reviewed measures endorsed by consensus organizations and were unable to identify any other measures on this topic endorsed by a consensus organization; therefore, we believe the exception in section 1886(s)(4)(D)(ii) of the Act applies.

c. Data Collection, Submission, and Reporting

We believe incremental implementation of the Screen Positive Rate for Social Drivers of Health measure, by permitting one year of voluntary reporting prior to mandatory reporting, will allow IPFs who are not

[177] We have updated this language to read ''all five HRSNs'' as opposed to ''an HRSN'' to update the language on the 2022 MUC List: *https://mmshub.cms.gov/sites/default/files/2022-MUC-List.xlsx.*

[178] Centers for Medicare & Medicaid Services. List of Measures Under Consideration for December 1, 2022. Available at: *https://mmshub.cms.gov/measure-lifecycle/measure-implementation/pre-rulemaking/lists-and-reports.*

[179] Centers for Medicare & Medicaid Services. 2022–2023 MAP Final Recommendations. Available at: *https://mmshub.cms.gov/measure-lifecycle/measure-implementation/pre-rulemaking/lists-and-reports.*

[180] Centers for Medicare & Medicaid Services. 2022–2023 MAP Final Recommendations. Available at: *https://mmshub.cms.gov/measure-lifecycle/measure-implementation/pre-rulemaking/lists-and-reports.*

[181] Centers for Medicare & Medicaid Services. 2022–2023 MAP Final Recommendations. Available at: *https://mmshub.cms.gov/measure-lifecycle/measure-implementation/pre-rulemaking/lists-and-reports.*

[182] Centers for Medicare & Medicaid Services. 2022–2023 MAP Final Recommendations. Available at: *https://mmshub.cms.gov/measure-lifecycle/measure-implementation/pre-rulemaking/lists-and-reports.*

[183] Centers for Medicare & Medicaid Services. 2022–2023 MAP Final Recommendations. Available at: *https://mmshub.cms.gov/measure-lifecycle/measure-implementation/pre-rulemaking/lists-and-reports.*

yet screening patients for HRSNs to get experience with the measure and equally allow IPFs who already undertake screening efforts to report data already being collected. Therefore, we proposed voluntary reporting of this measure, along with the Screening for Social Drivers of Health measure described in section VI.D.3 of this final rule, beginning with the data collected in CY 2024, which will be reported to CMS in CY 2025 followed by mandatory reporting beginning with data collected in CY 2025, which will be reported to CMS in CY 2026 and affect FY 2027 payment determination.

While this measure will require IPFs to collect patient-level data on their patients' social drivers of health screening results, we proposed to adopt this measure as an aggregate measure (that is, IPFs would be required to submit only numerator results for each of the five screening areas and the number of patients screened for all five of the HRSNs). IPFs are required to submit information for aggregate chart-abstracted measures once annually using a CMS-approved web-based data collection tool available within the HQR System (previously referred to as the QualityNet Secure Portal). We refer readers to section VI.I of this final rule (Form, Manner, and Timing of Quality Data Submission) for more details on our previously finalized data submission and deadline requirements across measure types.

We invited public comment on our proposal.

We note that we have addressed comments that broadly referred to both the Screening for Social Drivers of Health measure and the Screen Positive Rate for Social Drivers of Health measure in the previous section of this final rule (VI.D.3.).

Comment: Many commenters supported adoption of the Screen Positive Rate for Social Drivers of Health measure. Some commenters stated that knowing which patients have each of these HRSNs will help IPFs better understand patients' needs, improve care coordination with outpatient and community resources, increase the dignity and respect with which patients are treated, and support development of patient-centered treatment plans.

Response: We thank commenters for their support of the Screen Positive Rate for Social Drivers of Health measure. We agree that HRSNs are critical factors that impact patient outcomes, and increased knowledge about patients' HRSNs will help IPFs shape goals associated with health equity. Further, we agree that collecting these data will help IPFs improve coordination with outpatient and community resources to better deliver patient-centered care.

Comment: One commenter stated that access to these data will be useful for patient advocates to be able to identify IPFs that are more experienced with treating patients with more intensive resource needs.

Response: We agree with the commenter that publicly reporting these data might help patients with more intensive resource needs select IPFs that are more familiar with treating patients with that level of need. We note, however, that the measure is intended to provide information to IPFs on the level of unmet need among their patients and potentially in the community, and not for comparison between IPFs (88 FR 21286).

Comment: Some commenters expressed concern that publicly reporting these data may lead to inaccurate perceptions of the quality of care at IPFs that treat high volumes of patients who screen positive for one or more HRSNs. Several of these commenters stated that IPF patients may also have more unmet HRSNs than those at acute care hospitals so the data may be further misleading if the two settings are compared.

Response: We appreciate the commenters' concerns. The measure is intended to provide information to IPFs on the level of unmet need among their patients and potentially in the community, and not for comparison between IPFs (88 FR 21286). We believe public reporting of healthcare quality data promotes transparency in the delivery of care by increasing the involvement of leadership in healthcare quality improvement, creating a sense of accountability, helping to focus organizational priorities, and providing a means of delivering important healthcare information to consumers and patient advocates. We intend to conduct outreach and education with providers and patients to share information about the two Social Drivers of Health measures in conjunction with public reporting.

Comment: One commenter expressed the belief that reporting five separate rates, individually reflecting the proportion of patients who screened positive for each of the five HRSNs, is a flawed methodology because it may not yield reliable and valid comparisons. Another commenter expressly supported reporting five separate rates for this measure to improve transparency.

Response: We believe that reporting a separate screen positive rate for each of the five HRSNs will provide important information to IPFs, the communities that they serve, and policy makers. Because different community-based resources are appropriate to address each of the five HRSNs, we believe that reporting each of these rates separately will provide reliable and valid information to identify which communities are most in need of which resources to better enable support in addressing the most prevalent HRSNs.

Comment: Several commenters recommended that we develop outcome measures related to each of the five HRSNs for future adoption in this and other quality reporting programs.

Response: We thank commenters for their feedback. We view the two Social Drivers of Health measures as a first step towards development of a long-term strategy to integrate social drivers of health data into IPF quality performance measurement as part of our broader commitment to health equity. We will continue to take all comments, concerns, and suggestions into account and will consider them as part of any potential new measure development in future notice-and-comment rulemaking.

Comment: One commenter requested clarification on how to define a positive screening on a tool with a reporting scale.

Response: Because the reported value of screening results could vary among different screening tools or instruments, we recommend that IPFs carefully review the supporting materials that accompany each tool to understand how to properly administer the instrument and interpret results when selecting a screening instrument for their patient population.

Comment: One commenter did not support adoption of the Screen Positive Rate for Social Drivers of Health measure because the commenter expressed their belief that only IPFs would be able to use the data regarding their patient population and that they will already have the data from performing the screening.

Response: We respectfully disagree and believe that there are multiple interested parties who will be able to use data regarding IPFs' patient populations, including patients and their caregivers, patient advocacy organizations, local community services organizations, and federal, state, and local policy makers. We also believe that the measure will facilitate systematic gathering of such data in a manner that provides information to IPFs on the level of unmet need among their patients that many IPFs do not compile currently.

Final Decision: After consideration of the public comments we received, we

are finalizing adoption of the Screen Positive Rate for Social Drivers of Health measure as proposed.

5. Adoption of the Psychiatric Inpatient Experience (PIX) Survey Beginning With Voluntary Reporting of CY 2025 Data Followed by Mandatory Reporting Beginning With CY 2026 Data/FY 2028 Payment Determination

a. Background

We believe that a comprehensive approach to quality must include directly reported feedback regarding facility, provider, and payer performance. Therefore, we have consistently stated our commitment to identifying an appropriate patient experience of care measure for the IPF setting and adopting this measure in the IPFQR Program at the first opportunity (77 FR 53646, 78 FR 50897, 79 FR 45964 through 45965, 80 FR 46714 through 46715, 82 FR 38470 through 38471, 83 FR 38596, 84 FR 38467, 85 FR 47043, 86 FR 42654 through 42656, and 87 FR 46846).

In the FY 2014 IPPS/LTCH PPS final rule, we adopted a voluntary information collection regarding whether IPFs participating in the IPFQR Program assess patient experience of inpatient behavioral health services using a standardized instrument and for IPFs that answer ''Yes'' to indicate the name of the survey that they administer (78 FR 50896 through 50897). In the FY 2015 IPF PPS final rule, we adopted this information collection as the Assessment of Patient Experience of Care measure beginning with the FY 2016 payment determination (79 FR 45964 through 45965). Data collected for the FY 2018 payment determination (that is, data collected in CY 2016) showed that while the majority of IPFs (approximately 76 percent) were collecting patient experience of care data through a standardized instrument, there was a wide variation in the instrument being used. The data for CY 2016 indicated that the most widely used survey instrument was not in the public domain and was used by less than 30 percent of the IPFs that used a patient experience survey. In the FY 2015 IPF PPS final rule, we indicated our intention to adopt a standardized measure of patient experience of care for the IPFQR Program (79 FR 45964 through 45965).

In the FY 2019 IPF PPS final rule, we removed the Assessment of Patient Experience of Care measure from the IPFQR Program, because we believed that we had collected sufficient information to inform development of a patient experience of care measure (83 FR 38596 through 38597). In the FY 2020 IPF PPS final rule, we summarized our analysis of the results of the Assessment of Patient Experience of Care measure and requested feedback on potential adoption of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey for the IPFQR Program (84 FR 38467). In response to our request, many commenters expressed concern that the HCAHPS survey was not specified for the IPF setting and recommended that CMS identify a survey that has been developed for and tested in the IPF setting. Furthermore, in the FY 2021 IPF PPS proposed rule, we did not propose any updates to the IPFQR Program; however, we received many comments requesting that we adopt a patient experience of care measure in the IPFQR Program, which we summarized in the FY 2021 IPF PPS final rule (85 FR 47043). We received similar input strongly advocating for a patient experience of care measure for the IPFQR Program in response to a solicitation of comments on potential measures for the IPFQR Program in the FY 2022 IPF PPS proposed rule (86 FR 19511 through 19512), which we summarized in the FY 2022 IPF PPS final rule (86 FR 42654 through 42656). Many of these comments were from patients and their families and described how meaningful such a measure would be for individuals who receive services from IPFs. Though we did not solicit input on a patient experience of care measure in the FY 2023 IPF PPS proposed rule, we received many comments strongly recommending that we adopt such a measure, which we summarized in the FY 2023 IPF PPS final rule (87 FR 46846). Since publication of the FY 2023 IPF PPS final rule, section 4125(c) of the Consolidated Appropriations Act, 2023 (Pub. L. 117–328) was enacted, which amends section 1886(s)(4) of the Act to require that the quality measures specified for the IPFQR Program must include a quality measure of patients' perspective on care not later than the FY 2031 payment determination.

We have continued to review publicly available patient experience of care instruments to identify such an instrument specified for, and tested in, the IPF setting. In our review, we identified the Psychiatric Inpatient Experience (PIX) survey as a publicly available survey instrument developed for and tested in the IPF setting. Pursuant to the Meaningful Measures 2.0 Framework, this measure addresses the ''Person-Centered'' priority area, as well as the ''Individual and Caregiver Voice'' foundation and aligns with our commitment to prioritize outcome and patient-reported measures.[184] This measure also aligns with the CMS National Quality Strategy Goal 4 ''Foster Engagement.'' It also supports the Behavioral Health Strategy goal of ''Strengthen Equity and Quality in Behavioral Health Care.'' [185] Furthermore, this measure supports the new Universal Foundation domain of ''Person-Centered Care.'' [186]

b. Overview of Measure

The PIX survey was developed by a team at the Yale University, Yale New Haven Psychiatric Hospital to address the gap in available experience of care surveys, specifically the lack of publicly available, minimally burdensome, psychometrically validated surveys specified for the IPF setting.[187] The interdisciplinary team that developed this survey, including researchers and clinicians, conducted the following steps in developing the survey: (1) literature review; (2) patient focus groups; (3) solicitation of input from a patient and family advisory council; (4) review of content validity with an expert panel; (5) development of survey; and (6) survey testing within the Yale New Haven Psychiatric Hospital system.[188]

The resulting survey contains 23 items in four domains. Patients can respond to each of the 23 items using a five-point Likert scale (that is, strongly disagree, somewhat disagree, neutral, somewhat agree, strongly agree) or choose that the item does not apply. The four domains are:

- Relationship with Treatment Team;
- Nursing Presence;
- Treatment Effectiveness; and
- Healing Environment.[189]

[184] Centers for Medicare & Medicaid Services. Meaningful Measures 2.0: Moving from Measure Reduction to Modernization. Available at: *https://www.cms.gov/meaningful-measures-20-moving-measure-reduction-modernization.*

[185] CMS. (2022). CMS Behavioral Health Strategy. Available at *https://www.cms.gov/cms-behavioral-health-strategy.* Accessed on February 20, 2023.

[186] *https://www.nejm.org/doi/full/10.1056/NEJMp2215539.*

[187] Klemanski DH, Barnes T, Bautista C, Tancreti C, Klink B, Dix E. Development and Validation of the Psychiatric Inpatient Experience (PIX) Survey: A Novel Measure of Patient Experience Quality Improvement. *Journal of Patient Experience.* 2022;9. doi:10.1177/23743735221105671

[188] Klemanski DH, Barnes T, Bautista C, Tancreti C, Klink B, Dix E. Development and Validation of the Psychiatric Inpatient Experience (PIX) Survey: A Novel Measure of Patient Experience Quality Improvement. *Journal of Patient Experience.* 2022;9. doi:10.1177/23743735221105671.

[189] Klemanski DH, Barnes T, Bautista C, Tancreti C, Klink B, Dix E. Development and Validation of the Psychiatric Inpatient Experience (PIX) Survey:

Continued

The PIX survey is distributed to patients by administrative staff at a time beginning 24 hours prior to planned discharge. The survey, which is available in both English and Spanish and in accessible formats can be completed prior to discharge using either a paper copy of the survey or an electronic version of the survey via tablet computer.[190] For a complete list of survey questions, including which questions are elements of each domain, we refer readers to the description of the survey in the Journal of Patient Experience: .

(1) Measure Calculation

(a) Cohort

The cohort for this measure is all patients discharged from an IPF during the reporting period who do not meet one of the following exclusions: (1) patients who are under 13 years of age at time of discharge, and (2) patients who are unable to complete the survey due to cognitive or intellectual limitations. The sampling procedures that IPFs can apply to the PIX survey measure are described in section VI.I.6 of this final rule.

(b) Calculation

The measure will be reported as five separate rates, one for each of the four domains of the PIX survey and one overall rate. Each of these rates will be calculated from patient responses on the PIX survey and then publicly reported on the Care Compare website (or successor CMS website). We will report the mean rates for each domain as well as the overall mean rate on the Care Compare website (or successor CMS website). To calculate the mean scores, we will assign a numerical value ranging from 1 (Strongly Disagree) to 5 (Strongly Agree). We will then calculate the average response by adding the values of all responses and dividing that value by the number of responses, excluding questions that were omitted or to which the patient selected ''Does Not Apply.''

(2) Review by the Measure Applications Partnership (MAP)

We included the PIX survey measure on the publicly available ''List of Measures Under Consideration for December 1, 2022'' (MUC List), a list of measures under consideration for use in various Medicare programs.[191] The CBE-convened Measure Applications Partnership (MAP) reviewed the MUC List and discussed the potential use of the PIX survey for the IPFQR Program.

The MAP Health Equity Advisory Group agreed that well-constructed patient experience of care measures are an important indicator of quality care. Overall, the MAP Health Equity Advisory Group expressed that this measure is a ''step in the right direction for behavioral health.'' [192]

In addition, on December 8 through 9, 2022, the MAP Rural Health Workgroup reviewed the 2022 MUC List and expressed support for this measure, with patient support being especially strong. Some members of the MAP Rural Health Advisory Group were concerned about operational challenges, specifically costs related to implementation and maintenance and potential bias if the surveying occurs prior to discharge.[193]

The MAP Hospital workgroup reviewed the 2022 MUC List on December 13 through 14, 2022. The MAP Hospital workgroup conditionally supported the measure for rulemaking, while emphasizing the importance of including patient reported experience of care data in the IPFQR Program. The MAP Hospital workgroup's conditions for support included endorsement by the CBE and additional testing data for this measure, specifically: (1) data from testing of the measure in a variety of settings (including urban, rural, safety net providers, and others), (2) data regarding survey results depending on the timing of survey administration (pre- versus post-discharge), (3) data regarding patient factors (for example, voluntary versus involuntary admissions), and (4) data regarding of mode of administration (for example, email versus mail) that may affect performance.[194] Thereafter, the MAP Coordinating Committee deliberated on January 24 through 25, 2023 and ultimately voted to uphold the Hospital Workgroup's recommendation to conditionally support the PIX survey measure for rulemaking pending the same conditions as the MAP Hospital workgroup.[195]

We believe that the testing that has been conducted on the PIX survey demonstrates that it is a valid and reliable tool for measuring patient experience of care in IPFs, and that the results from this initial testing are generalizable across IPFs. However, we agree with the MAP Hospital workgroup that additional testing of this measure could help better understand measure results, including any differences in measure results that were not analyzed during the PIX survey's initial testing. Therefore, the measure developer intends to conduct additional testing of the PIX survey prior to public reporting of the measure data, and we proposed a voluntary reporting period before beginning mandatory reporting of the PIX survey.[196]

(3) CBE Endorsement

The measure developer has not submitted this measure for CBE endorsement at this time. The developer does intend to submit this measure for endorsement in the future, following additional testing as recommended by the MAP Hospital workgroup. Although section 1886(s)(4)(D)(i) of the Act generally requires that measures specified by the Secretary must be endorsed by the entity with a contract under section 1890(a) of the Act, section 1886(s)(4)(D)(ii) of the Act states that in the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a) of the Act, the Secretary may specify a measure that is not so endorsed as long as due consideration is given to a measure that has been endorsed or adopted by a consensus organization identified by the Secretary.

We reviewed measures endorsed by consensus organizations and were

A Novel Measure of Patient Experience Quality Improvement. *Journal of Patient Experience.* 2022;9. doi:10.1177/23743735221105671.

[190] Klemanski DH, Barnes T, Bautista C, Tancreti C, Klink B, Dix E. Development and Validation of the Psychiatric Inpatient Experience (PIX) Survey: A Novel Measure of Patient Experience Quality Improvement. *Journal of Patient Experience.* 2022;9. doi:10.1177/23743735221105671.

[191] Centers for Medicare & Medicaid Services. List of Measures Under Consideration for December 1, 2022. Available at: *https://mmshub.cms.gov/measure-lifecycle/measure-implementation/pre-rulemaking/lists-and-reports.*

[192] Centers for Medicare & Medicaid Services. 2022–2023 MAP Final Recommendations. Available at: *https://mmshub.cms.gov/measure-lifecycle/measure-implementation/pre-rulemaking/lists-and-reports.*

[193] Centers for Medicare & Medicaid Services. 2022–2023 MAP Final Recommendations. Available at: *https://mmshub.cms.gov/measure-lifecycle/measure-implementation/pre-rulemaking/lists-and-reports.*

[194] Centers for Medicare & Medicaid Services. 2022–2023 MAP Final Recommendations. Available at: *https://mmshub.cms.gov/measure-lifecycle/measure-implementation/pre-rulemaking/lists-and-reports.*

[195] Centers for Medicare & Medicaid Services. 2022–2023 MAP Final Recommendations. Available at: *https://mmshub.cms.gov/measure-lifecycle/measure-implementation/pre-rulemaking/lists-and-reports.*

[196] We note that in the FY 2024 IPF PPS proposed rule we inadvertently stated in section V.5.b.(2) ''Review by the MAP'' of the proposal that we were providing a two-year voluntary reporting period (88 FR 21289), which was inconsistent with our proposal to provide a one-year voluntary reporting period (88 FR 21290). As noted throughout the proposed rule, we proposed that voluntary reporting would begin with CY 2025 data and mandatory reporting would begin with CY 2026 data. We have corrected the above error here.

unable to identify any other measures on this topic endorsed by a consensus organization. We did identify the Experience of Care and Health Outcomes (ECHO) Survey measure (CBE #008); however, this measure has had its endorsement removed as of the spring 2020 cycle. Additionally, the ECHO Survey was developed and tested for outpatient behavioral health, not the inpatient setting. Additionally, we identified the Patient Experience of Psychiatric Care as Measured by the Inpatient Consumer Survey (ICS) measure (CBE #0726). This measure has also had its endorsement removed as of the spring 2018 cycle. As neither of these two measures is endorsed at this time, we believe the exception in section 1886(s)(4)(D)(ii) of the Act applies.

c Data Collection, Submission and Reporting

IPFs will be responsible for administering the survey and collecting data on survey responses, because the PIX survey is administered beginning 24 hours prior to a patient's planned discharge. Therefore, IPFs will collect the data in a manner similar to the collection of data for chart-abstracted measures or other patient screening measures. That is, the IPFs will collect data in the facility and then report these data to CMS using the methods described in section VI.I.4 of this final rule, ''Data Submission Requirements,'' under ''Procedural Requirements.''

Because we anticipate that many IPFs, which already administer different patient experience of care survey instruments to their patients, will need to transition to the PIX survey, we proposed a voluntary reporting period beginning with data from CY 2025, which will be reported to CMS in CY 2026. We will then require IPFs to report data for the PIX survey measure beginning with data collected during CY 2026, to be reported to CMS during CY 2027 and affecting the FY 2028 payment determination.

We invited comments on our proposal.

Comment: Many commenters strongly supported the PIX survey measure. These commenters expressed that the measure addresses a long-standing measure gap in the IPFQR Program, which these commenters characterized as discriminatory, and specifically supported the PIX survey instrument because it was developed with input from people with lived experience in the IPF setting. Some of these commenters representing patients and their families provided descriptions of their own and their family members' lived experiences to explain how important such a survey opportunity would be to IPF patients. Some commenters stated that patients are especially vulnerable during inpatient treatment and that psychological distress can be exacerbated in this setting. These commenters expressed that collecting data regarding the patients' experiences of care can improve patient-centered, trauma-informed care in which patients are treated with dignity and respect. Other commenters stated that formal patient feedback motivates improved care. One commenter stated that collection and public reporting of these data would assist community-based providers in identifying IPFs to which to refer patients. Other commenters stated that surveying IPF patients regarding their experience of care is a form of treating them with dignity and respect, empowering them, and showing that their experiences are important. Several commenters stated that survey data can be tied to other data sets to support research. Another commenter expressed that IPFs will be able to compare themselves to other IPFs, which could motivate quality improvement.

Response: We thank commenters for their support of the PIX survey measure. We agree that adoption of a patient experience of care measure for the IPF setting addresses a long-standing measure gap, encourages patient-centered care, and shows that we believe that the patient's experience is a critical element of providing quality care.

Comment: Some commenters expressed concern regarding measuring patient experience of care prior to discharge. Some of these commenters expressed that patients may feel unsafe responding honestly at any point prior to discharge because of a fear of retaliation for unfavorable responses. These commenters recommended providing an option for patients to respond post-discharge (such as providing a paper copy of the survey with a sealable, addressed envelope to return the survey after completing it). Another commenter stated that the setting in which the survey is administered, and time provided to complete the survey, could lead to variation in results and recommended administering the survey post-discharge. Many commenters recommended allowing vendors to collect and report the data for IPFs. Other commenters were specifically concerned regarding the 24 hours prior to discharge time period for administering the survey. Some of these commenters stated that there are many clinical activities occurring during this phase of the patient's stay and that adding another step may be burdensome for staff and patients. Other commenters concerned about the 24 hour prior to discharge time period expressed that discharge timelines are often uncertain, and therefore it may be difficult to know when the 24 hours prior to discharge window has started, especially for patients with long stays.

Response: We would like to clarify that, if it is not possible for a patient to complete the survey prior to discharge, the facility should provide a sealable, addressed envelope for the patient to return the survey following discharge. This situation could apply in situations in which the patient would prefer more time or privacy to complete the survey, in situations in which there are competing clinical priorities prior to discharge, or in situations in which there is uncertainty regarding the timing of a patient's discharge. However, we caution IPFs that relying exclusively on the mail-back option may prevent the IPF from meeting the measure's minimum sampling requirements. If the IPF is able to meet the minimum sampling requirements and chooses to use a vendor to receive paper surveys, aggregate and analyze data provided through the surveys, or to report these data to CMS on the IPF's behalf, that would be consistent with the measure methodology and specifications.

Comment: Many commenters expressed support for surveying patients regarding their experience of care, but expressed that they already have tools or vendors in place and that transitioning to the PIX survey would be disruptive. Some commenters specifically stated that this transition would disrupt their historical trend data. One commenter expressed concern that patients complete too many experience surveys and recommended that CMS select one tool based on an evaluation of all current surveys. Some commenters expressed a preference for a CAHPS survey because these surveys are used in other care settings and are the core element of the CMS Foundational Measurement Strategy to address the person-centered care domain. Other commenters stated that patients with primary psychiatric diagnoses continue to be excluded from HCAHPS and that, even if this exclusion were removed, by adopting the PIX survey, data about patient experience in an IPF would not be comparable to data regarding patient experience in general acute care hospitals. Other commenters recommended that CMS allow IPFs to select their own patient experience instrument provided that it addresses

the domains addressed by the PIX survey.

Response: We recognize that many IPFs already use patient experience of care survey instruments or vendors to administer and collect survey instruments on behalf of IPFs, and that there is a burden for these IPFs to transition to a new survey instrument and administration and collection process. We further recognize that historical quality improvement trend data and analytical processes may be impacted for these IPFs who already use other patient experience of care survey instruments. We considered allowing IPFs to select their own patient experience data collection instrument provided that it addresses the domains addressed by the PIX survey. However, we believe that using a single, standardized instrument to assess patient experience of care across both freestanding IPFs and those psychiatric units in acute care hospitals will provide comparability of experience data. We believe that publicly reporting patient experience of care data that allows for comparisons between IPFs will be most meaningful to patients and their caregivers, and will allow IPFs to compare their measure results to similar IPFs as part of their quality improvement initiative. We understand commenters' concern that by adopting a different patient experience of care measure in the IPF setting than that for general acute care hospitals (that is, the HCAHPS survey) measure results will not be comparable across these settings, even if HCAHPS is expanded to patients with primary psychiatric diagnoses in the general acute care setting. However, in response to our previous RFIs about incorporating a patient experience of care measure in the IPFQR Program, many commenters (representing patients, patient advocates, caregivers, IPFs, and provider associations) recommended that we adopt a patient experience of care measure that was developed specifically for patients receiving care in IPFs (84 FR 38467). These commenters stated that there are elements of care, such as group therapy, that are unique to the IPF setting and stated that a survey for this setting should specifically address these elements of care. Because it was developed specifically for this setting, with input from patients and their caregivers, the PIX survey does include questions regarding these unique elements of care, whereas the HCAHPS survey does not.

With respect to concerns regarding loss of trend data, we have proposed to adopt the measure for mandatory reporting beginning with CY 2026 data (which will be submitted to CMS in CY 2027 and affect FY 2028 payment determination) to provide additional time for IPFs to transition to this new survey. We wish to clarify that IPFs will be permitted to add questions to the survey, so if there are specific metrics that an IPF wishes to continue tracking, they will be able to do so. We believe that IPFs will have sufficient time prior to when mandatory reporting of this measure begins with the FY 2028 payment determination to determine which questions will be most appropriate to add to the survey without overburdening patients, or how to compare results from patient responses to the PIX survey to those of their existing surveys.

We believe that the commenter who referenced the CMS Foundational Measurement Strategy was referring to the CMS Universal Foundation,[197] which includes setting specific versions of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. We considered potential adoption of a CAHPS measure for the IPFQR Program and solicited comment on this in the FY 2020 IPF PPS proposed rule (84 FR 16986 through 16987) and summarized the responses to this request in the FY 2020 IPF PPS final rule (84 FR 38467). Following our review of the HCAHPS survey and responses to that request for information, we determined that the PIX survey is more appropriate for the IPFQR Program since it has been developed and tested specifically for IPFs and with the input of individuals with lived experience with care in this setting. Therefore, while the HCAHPS survey is appropriate for the general acute care setting, we believe that the PIX survey is a more appropriate instrument for measuring patient experience of care in the IPF setting.

Comment: Many commenters expressed concern that the PIX survey has not been sufficiently tested for national implementation. These commenters specifically noted a lack of testing in diverse geographic settings (including testing for differences in performance in urban versus rural settings), lack of testing which compares this survey to other inpatient consumer surveys, lack of information about the correlation coefficients for the proposed domains, lack of reliability coefficients to determine the survey's internal consistency, lack of demographic data regarding patients who respond versus those who do not, lack of testing among the forensically and/or involuntarily admitted populations, lack of longitudinal testing, and lack of testing with facilities which have an average length of stay greater than 10 days. Some commenters recommended additional testing with volunteer IPFs prior to implementation as a mandatory measure. Some of these commenters recommended postponing mandatory adoption to ensure sufficient testing. One commenter expressed concern that the PIX survey does not clearly connect questions to key outcomes, and recommended further research and testing to identify these connections.

Response: We understand commenters' concerns regarding the testing of the PIX survey measure. We recognize that this is a relatively new instrument. We note that the measure developer is continuing to test this instrument to further address these questions and concerns prior to the national implementation of the measure. To increase time for testing and to better identify information that will need to be provided during education and outreach sessions prior to public reporting, we proposed and are adopting mandatory reporting of this measure for the FY 2028 payment determination, which would not require IPFs to begin administering and collecting responses to the PIX survey until CY 2026.

Comment: Some commenters expressed concern that this survey instrument is only available in a limited number of languages and recommended translation into additional languages to improve accessibility for all patients. Some of these commenters recommended adding supportive services to help those with language barriers or limited health literacy complete the survey.

Response: The measure developer has translated the survey from English into Spanish, Mandarin, and Farsi. The measure developer is currently working to translate the survey into other frequently requested languages (including, French, Arabic, and Japanese). For patients who have language barriers, the measure developer is currently developing survey administration guidelines for best practices in survey administration to enhance the accessibility of the PIX survey. These include but are not limited to screen readers, the use of visual cueing (for example, using simple emojis that correspond with the Likert scale options), and the ability to request assistance in completing the survey. Options for phone surveys and the use of interpreters will also be included in these guidelines. Finally, the measure developer will add a question to the survey to indicate if the survey was

[197] *https://www.cms.gov/aligning-quality-measures-across-cms-universal-foundation.*

completed with assistance. We anticipate that the updated survey will be available during FY 2023 so that IPFs can review it during their implementation planning in advance of the performance period for voluntary reporting (that is CY 2025).

Comment: Some commenters requested clarification regarding whether facilities could add their own elements to the survey to maintain historical trend data regarding questions that are important among their specific patient populations. Other commenters specifically requested the inclusion of a free-text comment section.

Response: Individual facilities can add supplemental items to the survey instrument provided that they do not amend or remove the key elements of the PIX survey in order to collect data for and report on this measure. We note that IPFs may not factor supplemental items into existing scoring procedures as this would affect reliability and validity of this measure. Furthermore, we encourage facilities to consider the number of supplemental questions so as not to overburden or fatigue patients in completing the survey instrument.

Comment: One commenter recommended allowing patients to complete surveys regularly throughout their stay.

Response: Although we believe that this may be unduly burdensome to patients and create administrative and logistical burden for facilities, this is not inconsistent with reporting data on the PIX survey for this measure if the IPF only includes data for surveys administered according to the PIX survey measure's guidelines (specifically, PIX surveys administered beginning 24 hours prior to discharge) in the measure results reported to CMS.

Comment: Several commenters recommended additional questions, topics, and domains that they believe would be important to include in a patient experience of care survey for the IPF setting. These topics included: (1) data on racial and ethnic disparities in diagnosing, treating, and providing care; (2) addressing patients' spiritual needs; (3) progress towards remediating life circumstances that precipitated the hospitalization; (4) perceptions of discharge planning and aftercare; (5) follow-up appointment availability (were they offered and scheduled); (6) staff cultural competency; (7) family involvement in treatment; (8) nurses' performance; (9) quantity of food; (10) overall rating; (11) wait time; and (12) family and caregiver perspectives.

Response: We note that the PIX survey was developed by an interdisciplinary team with input from patients and a patient and family advisory council to address items that are important to patients in this setting of care. However, as discussed previously, individual facilities can add supplemental items to the survey to address issues important to their patient populations or that are significant in the historical trend data.

Comment: One commenter stated that frequency measurement (which asks patients to recall how often something happened) versus evaluative measurement (which asks patients to identify how well their needs were met) can influence the magnitude of differences when evaluating patient experience by race and ethnicity. This commenter specifically noted that evaluative measures are typically better at identifying disparities than frequency-based measures and recommended considering this in developing a survey for this setting.

Response: The PIX survey uses an evaluative measurement (which asks patients to evaluate their experience of their care) approach with a Likert Scale (that is, strongly disagree, somewhat disagree, neutral, somewhat agree, strongly agree, and does not apply) versus a frequency style of evaluation (which asks patients to report whether or how frequently something occurred).

We agree with the commenter that one strength of the evaluative measurement approach is the ability to better identify disparities and detect inequities and note that this was a factor in the survey design of the PIX survey.[198]

Comment: Many commenters recommended that the survey be administered by a peer or advocate to reduce concerns regarding retaliation.

Response: We appreciate this recommendation and believe that peer advocates could assist with survey administration with minimal training. The measure developer is currently developing survey administration guidelines which will incorporate information on the appropriate training for staff (including peer advocates) who will be responsible for survey administration. We anticipate that these guidelines will be available during FY 2023 so that IPFs can review them during their implementation planning in advance of the performance period for voluntary reporting (that is, CY 2025).

Comment: Several commenters had questions regarding public reporting of these data for this measure. One commenter requested clarification regarding whether the data would be publicly reported. Another commenter recommended that the data be accompanied by patient demographic and clinical information to allow for stratification and analysis.

Response: As described in section VI.H of the FY 2024 IPF PPS proposed rule, we have an established policy for publicly displaying the data submitted by IPFs for the IPFQR Program (88 FR 21299 through 21300). Consistent with that policy, we intend to publicly report these data. Specifically, in accordance with section 1886(s)(4)(E) of the Act, data that an IPF submits to CMS for the IPFQR Program will be made publicly available on a CMS website after providing the IPF an opportunity to review the data to be made public. In the FY 2013 IPPS/LTCH PPS final rule (77 FR 53653 through 53654), we adopted procedures for making data submitted under the IPFQR Program available to the public, after an IPF has the opportunity to review such data prior to public display, as required by section 1886(s)(4)(E) of the Act. We adopted modifications to these procedural requirements in the FY 2014 IPPS/LTCH PPS final rule (78 FR 50897 through 50898), and the FY 2017 IPPS/LTCH PPS final rule (81 FR 57248 through 57249). Specifically, IPFs will have a period of 30 days to review and submit corrections to errors resulting from CMS calculations prior to the data being made public.

We agree that the intersectionality of patient characteristics, including the categorization of clinical populations would provide useful information for researchers and potentially for patients and caregivers in selecting a facility at which to receive care. However, we note that the survey is anonymous and therefore cannot be linked to patients' clinical data. The measure developer specifically omitted clinical characterizations because of patients' concerns regarding discrimination, retaliation, and uncertainty about their suspected versus diagnosed conditions. We will consider the appropriateness and feasibility of including demographic data with publicly reported measure results for future public reporting.

Comment: Several commenters requested clarification on how the data would be collected and reported. Some of these commenters stated that IPFs with limited technological resources would find it hard to implement this survey. Some of these commenters further stated that without sufficient technological resources this survey

[198] Linacre JM. Optimizing rating scale category effectiveness. J Appl Meas. 2002;3(1):85–106. PMID: 11997586.

would be burdensome for IPFs to administer.

Response: IPFs will collect data in the facility and then report these data to CMS using the methods described in section VI.I.4 of this final rule, that is ''Data Submission Requirements'' under ''Procedural Requirements.'' This aligns with previously finalized policies for submitting data on chart-abstracted measures. We recognize that this may be burdensome for IPFs; however, given the importance of including a patient experience of care measure in the IPFQR Program, we believe that the benefit of adopting this measure outweighs this burden.

Comment: One commenter requested clarification regarding whether IPFs would be required to respond to patients to resolve issues identified in the PIX survey prior to the patient's discharge. Another commenter expressed concern that patients may include a threat to self or others in their survey response which would require IPFs to review responses to ensure that such threats were addressed prior to discharge.

Response: We wish to clarify that the PIX survey is an anonymous survey. Therefore, it would not be possible for IPFs to address input from individual patients, either prior to or after discharge. We note that there are no questions on the PIX survey, which is a series of 23 items to which patients respond using a five-point Likert scale (that is, strongly disagree, somewhat disagree, neutral, somewhat agree, strongly agree) or choose that the item does not apply, that address a patient's potential threat to self or others. We acknowledge the possibility that, during IPF staff's administration of the survey, the patient may express to the staff member a potential threat to self or others. However, we believe the IPF will be able to train its staff to appropriately respond to and notify clinical and other staff of the patient's potential threat to self or others as with any other situation where IPF staff interact with IPF patients.

Comment: One commenter requested clarification regarding whether completing the survey would be mandatory for patients. Another commenter expressed concern that behavioral health patients often refuse to complete surveys.

Response: We agree that some patients may choose not to complete a survey. We note that, consistent with our proposal in the FY 2024 IPF PPS proposed rule (88 FR 21301), we are requiring IPFs to develop sampling plans that ensure that IPFs are able to submit data for 300 completed PIX surveys per year. IPFs would be required to sample from every month throughout the entire reporting period and not stop sampling or curtail ongoing interview activities once a certain number of completed surveys has been attained. We recommend that in developing sampling plans, IPFs consider the predicted rate of non-completion to ensure that they reach 300 completed PIX surveys.

Comment: Several commenters requested clarification regarding whether patients would be able to have assistance, such as from a family member, friend, or peer support specialist, to complete the survey if the patient is unable to complete the survey. One commenter requested clarification regarding whether a parent or guardian would be required to complete the survey for minors.

Response: The PIX survey is suitable for individuals of all ages within the measure cohort, which includes patients who are 13 or older at time of discharge. The survey was tested with adolescents aged 13 to17 and testing found that they were able to complete it without any significant differences in scores compared to adults. Nonetheless, we understand that some individuals may require assistance, and patients must be offered the option to seek help from staff, a caregiver (including parents or guardians), or a peer. Additionally, the measure developer is updating the survey to include a question asking if the patient received any assistance while completing it. We anticipate that the updated survey will be available during FY 2023 so that IPFs can review it during their implementation planning in advance of the performance period for voluntary reporting (that is CY 2025)

Comment: Several commenters expressed concern that the exclusion of patients who are unable to complete the survey due to cognitive or intellectual limitations could lead to subjective exclusions and create bias in the survey administration. Several of these commenters recommended removing this exclusion, and other commenters recommended providing standardized definitions that IPFs could apply.

Response: The measure developer is currently developing guidelines for best practices in survey administration to enhance the accessibility of the PIX survey and sampling integrity. All patients, including people with intellectual and development disabilities, must have an opportunity to participate in or benefit from the survey equal to that afforded to others. We anticipate that these guidelines will be available during FY 2023 so that IPFs can review them during their implementation planning in advance of the performance period for voluntary reporting (that is, CY 2025). We will communicate the availability of these guidelines through regular sub-regulatory communications.

We note that patients who are unable to complete the survey unaided on the basis of a disability must be offered reasonable modifications, such as the use of visual cueing (for example, using simple emojis that correspond with the Likert scale options). We believe that inclusivity is a key priority of adopting a patient experience of care survey and emphasize the importance of maximizing accessibility for all patients.

Comment: Several commenters expressed concern that the data collected by this survey may not be sufficient to improve patient experience. Another commenter requested clarification regarding whether the survey has been shown to improve patient outcomes. One commenter expressed concern about the Healing Environment domain in the PIX survey instrument because regulations and licensing requirements heavily restrict the environment of the IPF. One commenter expressed concern that IPFs do not have the resources to improve care based on the results of the PIX survey.

Response: We believe that a comprehensive approach to quality must include directly reported feedback from patients. We have consistently stated our commitment to identifying a patient experience of care measure for the IPF setting, and in our measure strategies, including the Meaningful Measures 2.0 Framework, the CMS National Quality Strategy, the Behavioral Health Strategy, and the Universal Foundation, we have consistently identified the need for person-centered care and engagement. Furthermore, we note that a review of 55 studies found that within these studies it was more common to find positive associations between patient experience and patient safety and clinical effectiveness than no associations.[199] However, including a measure of patient experience demonstrates that a positive patient experience is an important goal in its own right. This is supported by consistently strong patient and caregiver input requesting such a measure be adopted in the IPFQR Program and emphasizing that such a measure is an important element of showing that we

[199] Doyle, c. Lennox, L, and Bell, D. A systematic review of evidence on the links between patient experience and clinical safety and effectiveness. BMJ Open. Available at: *https://bmjopen.bmj.com/content/3/1/e001570.*

believe that IPF patients should be treated with dignity and respect in an environment in which their voices matter as part of a patient-centered care experience. Additionally, we believe that having a nationally standardized patient experience of care measure will allow IPFs to compare their patient experience results with the results of other IPFs. This will allow IPFs to identify opportunities for improvement, including to their Healing Environment score, within the regulatory and licensure constraints under which IPFs operate. That is, if other similar IPFs score higher in the Healing Environment domain despite operating within the same regulatory and licensure constraints, this will highlight the opportunity for the IPF to improve its Healing Environment.

Comment: One commenter expressed concern that the domain names do not appear to match the substance of the questions within the domain. This commenter expressed concern that there may be overlap or inconsistencies between the use of ''treatment team'' and ''nursing team.''

Response: We appreciate this concern; however, we believe the domain labels have been appropriately applied. Specifically, the four-domain survey aligned with the theoretical basis of patient experience and was chosen through extensive focus group testing. Further, decisions around domains and their labels were based on the degree to which individual items statistically coalesced around central themes. We noted that patients in focus groups rarely distinguished roles among their care teams. Functionally, medical providers and social workers operate in a collaborative framework to guide treatment and coordinate aftercare. Thus, questions about patients' relationships with their treatment team center around their interactions with those who provide medical and therapeutic care. The Nursing Presence domain was identified as a separate domain due to the distinctive nature of nurses' roles in comprehensively caring for all patients on the unit in support of the treatment team. We agree with the measure developer that this important distinction merited a separate domain to represent the unique work of the varying team members with whom patients interact.

Comment: Some commenters expressed concerns that this measure has not been endorsed by the CBE.

Response: We note that following additional testing, the measure developer intends to submit this measure to the CBE for endorsement. While we recognize the value of measures undergoing CBE endorsement review, given the urgency of adopting a patient experience of care measure for this setting, as there are currently no CBE-endorsed measures that address IPF patient experience of care, we believe it is important to implement this measure beginning with voluntary reporting of CY 2025 data followed by mandatory reporting beginning with CY 2026 data, reported to CMS in CY 2027 and affecting the FY 2028 payment determination. We note that under section 1886(s)(4)(D)(ii) of the Act the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary. We reviewed measures endorsed by consensus organizations and were unable to identify any other measures on this topic endorsed by a consensus organization, and therefore, we believe the exception in section 1886(s)(4)(D)(ii) of the Act applies.

Comment: One commenter requested clarification on who developed the survey, whether it is proprietary, and if so, how IPFs will obtain licenses to use the survey.

Response: As described in the FY 2024 IPF PPS proposed rule (88 FR 21288), the PIX survey was developed by a team at the Yale University, Yale New Haven Psychiatric Hospital and is in the public domain. We note that the measure developer is currently developing guidelines for best practices in survey administration, and we strongly encourage staff who will be responsible for administering the survey to review these guidelines as soon as they become available. Because the measure developer has made the PIX survey available in the public domain, there is no certification or license required to administer the PIX survey.

Comment: One commenter expressed concern that there are too many questions for patients to complete.

Response: We understand the importance of balancing the number of survey questions to improve completion rates with minimal burden to the patient, while including a sufficient range of questions to address the most important aspects of patients' experiences about the care they received. We note that the PIX survey has 23 items, which is comparable to the number of questions in other patient experience of care survey instruments. Specifically, two other surveys which address inpatient care include the HCAHPS survey, which has 29 questions, and the Inpatient Consumer Survey (ICS), which has 28 items.

Comment: One commenter opposed adopting this survey in a pay-for-performance program.

Response: We note that the IPFQR Program is a pay-for-reporting program (that is, IPFs that comply with all requirements and submit required data under the IPFQR Program receive their full payment update) and that there are not currently any Medicare pay-for-performance programs (that is, programs which adjust payment based on the performance on measures) which address the IPF setting.

Comment: Some commenters requested clarification regarding whether the measure would be scored with ''top-box'' scoring or with mean scores, because the MUC List and the proposed rule described different methods.

Response: We considered ''top-box'' scoring and mean scores as we identified an approach to adopting and publicly reporting the PIX survey measure in the IPFQR Program. Specifically, we considered modeling the ''top-box'' scoring used for reporting performance on the HCAHPS measure in which data are reported based on the percent of respondents who selected the most positive response (that is, the ''top-box''). However, we believe that mean scores (that is, the numerical average calculated by assigning each response a numerical value from 1—the least positive, to 5 the most positive, summing the scores, and dividing that value by the number of responses) provide information that is more meaningful to patients and their caregivers who are more likely to be familiar with mean scores as opposed to ''top-box'' scores. Therefore, we decided to propose mean scores, which we described in the FY 2024 IPF PPS proposed rule (88 FR 21289). We note that the MUC list submission acknowledged the possibility that mean scores would be useful for reporting with the statement that ''it may be useful for the distribution of total Likert-scale responses to be made available during initial implementation.''

Comment: One commenter expressed support for reporting separate rates for each domain in addition to the overall rate. This commenter stated that this level of data will improve patient choice and support IPFs' quality improvement efforts.

Response: We thank this commenter for the support and agree that the increased level of detail will improve patient choice and support IPF's quality improvement efforts.

Comment: Several commenters requested clarification regarding

whether there will be a one-year or two-year voluntary reporting period.

Response: We wish to clarify that, consistent with our proposal in the FY 2024 IPF PPS proposed rule (88 FR 21290), there will be a 1-year voluntary reporting period. IPFs that wish to participate in the voluntary reporting period will be able to report CY 2025 data to CMS in CY 2026. Beginning with CY 2026 data, which will be reported to CMS in CY 2027, all IPFs will be required to report these data to CMS and failure to do so would affect their payment determination for FY 2028.

Comment: Several commenters expressed support for adoption of this measure for voluntary reporting of CY 2025 data in CY 2026 followed by mandatory reporting beginning with CY 2026 data affecting the FY 2028 payment determination to ensure there is a patient experience measure in the IPFQR Program as soon as technically feasible.

Response: We thank these commenters for their support.

Final Decision: After consideration of the public comments we received, we are finalizing adoption of the PIX survey measure as proposed.

E. Modification of the COVID–19 Vaccination Coverage Among Healthcare Personnel (HCP) Measure Beginning With the Quarter 4 CY 2023 Reporting Period/FY 2025 Payment Determination

1. Background

On January 31, 2020, the Secretary of the Department of Health and Human Services declared a public health emergency (PHE) for the United States in response to the global outbreak of SARS–COV–2, a novel (new) coronavirus that causes a disease named ''coronavirus disease 2019'' (COVID–19).[200] Subsequently, multiple quality reporting programs including the Hospital IQR Program (86 FR 45374) and the IPFQR Program (86 FR 42633 through 42640) adopted the COVID–19 Vaccination Coverage Among Healthcare Personnel (HCP) measure. The COVID–19 Vaccination Coverage Among Healthcare Personnel (HCP) measure adopted in the IPFQR Program in the FY 2022 IPF PPS final rule (86 FR 42633 through 42650) requires each IPF to calculate the percentage of HCP eligible to work in the IPF for at least one day during the reporting period, excluding persons with contraindications to the COVID–19 vaccine, who have received a complete vaccination course against SARS-CoV–2 (86 FR 42633 through 42640).

COVID–19 has continued to spread domestically and around the world with more than 103.9 million cases and 1.13 million deaths in the United States as of June 19,2023.[201] In recognition of the ongoing significance and complexity of COVID–19, the Secretary renewed the PHE on April 21, 2020, July 23, 2020, October 2, 2020, January 7, 2021, April 15, 2021, July 19, 2021, October 15, 2021, January 14, 2022, April 12, 2022, July 15, 2022, October 13, 2022, January 11, 2023, and February 9, 2023.[202] While the PHE status ended on May 11, 2023,[203] HHS has stated that the public health response to COVID–19 remains a public health priority with a whole of government approach to combatting the virus, including through vaccination efforts.[204]

In the FY 2022 IPF PPS final rule (86 FR 42633 through 42635) and in our Revised Guidance for Staff Vaccination Requirements,[205] we stated that vaccination is a critical part of the nation's strategy to effectively counter the spread of COVID–19. We continue to believe it is important to incentivize and track HCP vaccination through quality measurement across care settings, including IPFs, in order to protect HCP, patients, and caregivers, and to help sustain the ability of HCP to continue serving their communities throughout the PHE and beyond.

At the time we issued the FY 2022 IPF PPS final rule where we adopted the COVID–19 Vaccination Coverage Among Healthcare Personnel (HCP) measure, the Food and Drug Administration (FDA) had issued emergency use authorizations (EUAs) for initial and primary adult vaccines manufactured by Pfizer-BioNTech,[206] Moderna,[207] and Janssen.[208] On August 23, 2021, the FDA issued an approval for the Pfizer-BioNTech vaccine, now marketed as Comirnaty.[209] The FDA issued approval for the Moderna vaccine, marketed as Spikevax, on January 31, 2022 [210] and an EUA for the Novavax adjuvanted vaccine on July 13, 2022.[211] The FDA also issued EUAs for COVID–19 single vaccine booster doses in September 2021 [212] and October 2021 [213] for certain populations and in November 2021 [214] for all individuals 18 years of age and older. EUAs were subsequently issued for a second vaccine booster dose in March 2022 [215]

[200] U.S. Dept of Health and Human Services, Office of the Assistant Secretary for Preparedness and Response. (2020). Determination that a Public Health Emergency Exists. Available at: *https://www.phe.gov/emergency/news/healthactions/phe/Pages/2019-nCoV.aspx.*

[201] Centers for Disease Control and Prevention. COVID Data Tracker. Accessed February 13, 2023. Available at: *https://covid.cdc.gov/covid-data-tracker/#datatracker-home.*

[202] U.S. Dept. of Health and Human Services. Office of the Assistant Secretary for Preparedness and Response. (2023). Renewal of Determination that a Public Health Emergency Exists. Available at: *https://aspr.hhs.gov/legal/PHE/Pages/covid19-11Jan23.aspx.*

[203] *https://www.whitehouse.gov/wp-content/uploads/2023/01/SAP-H.R.-382-H.J.-Res.-7.pdf.*

[204] U.S. Dept. of Health and Human Services. Fact Sheet: COVID–19 Public Health Emergency Transition Roadmap. February 9, 2023. Available at: *https://www.hhs.gov/about/news/2023/02/09/fact-sheet-covid-19-public-health-emergency-transition-roadmap.html.*

[205] Centers for Medicare & Medicaid Services. Revised Guidance for Staff Vaccination Requirements QSO–23–02–ALL. October 26, 2022. Available at: *https://www.cms.gov/files/document/qs0-23-02-all.pdf.*

[206] Food and Drug Administration. (December 2020). FDA Takes Key Action in Fight Against COVID–19 By Issuing Emergency Use Authorization for First COVID–19 Vaccine. Available at: *https://www.fda.gov/news-events/press-announcements/fda-takes-key-action-fight-against-covid-19-issuing-emergency-use-authorization-first-covid-19.*

[207] Food and Drug Administration. (December 2020). FDA Takes Additional Action in Fight Against COVID–19 By Issuing Emergency Use Authorization for Second COVID–19 Vaccine. Available at: *https://www.fda.gov/news-events/press-announcements/fda-takes-additional-action-fight-against-covid-19-issuing-emergency-use-authorization-second-covid.*

[208] Food and Drug Administration. (February 2021). FDA Issues Emergency Use Authorization for Third COVID–19 Vaccine. Available at: *https://www.fda.gov/news-events/press-announcements/fda-issues-emergency-use-authorization-third-covid-19-vaccine.*

[209] Food and Drug Administration. (August 2021). FDA Approves First COVID–19 Vaccine. Available at: *https://www.fda.gov/news-events/press-announcements/fda-approves-first-covid-19-vaccine.*

[210] Food and Drug Administration. (January 2022). Coronavirus (COVID–19) Update: FDA Takes Key Action by Approving Second COVID–19 Vaccine. Available at: *https:/www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-takes-key-action-approving-second-covid-19-vaccine.*

[211] Food and Drug Administration. (July 2022). Coronavirus (COVID–19) Update: FDA Authorizes Emergency Use of Novavax COVID–19 Vaccine, Adjuvanted. Available at: *https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-authorizes-emergency-use-novavax-covid-19-vaccine-adjuvanted.*

[212] Food and Drug Administration. (September 2021). FDA Authorizes Booster Dose of Pfizer-BioNTech COVID–19 Vaccine for Certain Populations. Available at: *https://www.fda.gov/news-events/press-announcements/fda-authorizes-booster-dose-pfizer-biontech-covid-19-vaccine-certain-populations.*

[213] Food and Drug Administration. (October 2021). Coronavirus (COVID–19) Update: FDA Takes Additional Actions on the Use of a Booster Dose for COVID–19 Vaccines. Available at: *https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-takes-additional-actions-use-booster-dose-covid-19-vaccines.*

[214] Food and Drug Administration. (November 2021). Coronavirus (COVID–19) Update: FDA Expands Eligibility for COVID–19 Vaccine Boosters. Available at: *https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-expands-eligibility-covid-19-vaccine-boosters.*

[215] Food and Drug Administration. (March 2022). Coronavirus (COVID–19) Update: FDA Authorizes

and for bivalent or ''updated'' booster doses in August 2022.[216]

In the FY 2022 IPF PPS final rule, we stated that data demonstrating the effectiveness of COVID–19 vaccines to prevent asymptomatic infection or transmission of SARS–COV–2, the novel (new) coronavirus that causes COVID–19, were limited (86 FR 42634). While the impact of COVID–19 vaccines on asymptomatic infection and transmission was not yet fully known at the time of the FY 2022 IPF PPS final rule, there were robust data available on COVID–19 vaccine effectiveness across multiple populations against symptomatic infection, hospitalization, and death. Two-dose COVID–19 vaccines from Pfizer-BioNTech and Moderna had been found to be 88 percent and 93 percent effective against hospitalization for COVID–19, respectively, over 6 months for adults over age 18 without immunocompromising conditions.[217] During a SARS–COV–2 surge in the spring and summer of 2021, 92 percent of COVID–19 hospitalizations and 91 percent of COVID–19-associated deaths were reported among persons not fully vaccinated.[218] Real-world studies of population-level vaccine effectiveness indicated similarly high rates of effectiveness in preventing SARS–COV–2 infection among frontline workers in multiple industries, with a 90 percent effectiveness in preventing symptomatic and asymptomatic infection from December 2020 through August 2021.[219] Vaccines have also been highly effective in real-world conditions (that is, vaccines have continued to be highly effective in conditions other than clinical trials) at preventing COVID–19 in HCP with up to 96 percent effectiveness for fully vaccinated HCP, including those at risk for severe infection and those in racial and ethnic groups disproportionately affected by COVID–19.[220] In the presence of high community prevalence of COVID–19, residents of nursing homes with low staff vaccination coverage had cases of COVID–19-related deaths 195 percent higher than those among residents of nursing homes with high staff vaccination coverage.[221] Currently available data demonstrate that COVID–19 vaccines are effective and prevent severe disease, including hospitalization, and death.

As SARS–COV–2 persists and evolves, our COVID–19 vaccination strategy must remain responsive. When we adopted the COVID–19 Vaccination Coverage Among HCP measure in the FY 2022 IPF PPS final rule, we stated that the need for booster doses of the COVID–19 vaccine had not been established and no additional doses had been recommended (86 FR 42639). We also stated that we believed the numerator was sufficiently broad to include potential future boosters as part of a ''complete vaccination course'' and that the measure was sufficiently specified to address boosters (86 FR 42639). Since we adopted the COVID–19 Vaccination Coverage Among HCP measure in the FY 2022 IPF PPS final rule, new variants of SARS–COV–2 have emerged around the world and within the United States. Specifically, the Omicron variant (and its related subvariants) is listed as a variant of concern by the Centers for Disease Control and Prevention (CDC) because it spreads more easily than earlier variants.[222] Vaccine manufacturers have responded to the Omicron variant by developing bivalent COVID–19 vaccines, which include a component of the original virus strain to provide broad protection against COVID–19 and a component of the Omicron variant to provide better protection against COVID–19 caused by the Omicron variant.[223] These booster doses of the bivalent COVID–19 vaccine have been shown to increase immune response to SARS–COV–2 variants, including Omicron, particularly in individuals who are more than 6 months removed from receipt of their primary series.[224] The FDA issued EUAs for two bivalent COVID–19 vaccine booster doses, one from Pfizer-BioNTech [225] and one from Moderna,[226] and strongly encourages anyone who is eligible to consider receiving a booster dose with a bivalent COVID–19 vaccine to provide better protection against currently circulating variants.[227] COVID–19 booster doses are associated with a greater reduction in infections among HCP and their patients relative to those who only received primary series vaccination. One study showed a rate of breakthrough infections among HCP who received only the two-dose regimen of the COVID–19 vaccine of 21.4 percent compared to a rate of 0.7 percent among HCP who received a third dose of the COVID–19 vaccine.[228]

Despite the efficacy of COVID–19 vaccination generally, data submitted to the CDC via the National Healthcare Safety Network (NHSN) demonstrate clinically significant variation in booster dose vaccination rates across facilities, including IPFs. During the first quarter of 2022, IPFs reported a median

Second Booster Dose of Two COVID–19 Vaccines for Older and Immunocompromised Individuals. Available at: *https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-authorizes-second-booster-dose-two-covid-19-vaccines-older-and.*

[216] Food and Drug Administration. (August 2022). Coronavirus (COVID–19) Update: FDA Authorizes Moderna, Pfizer-BioNTech Bivalent COVID–19 Vaccines for Use as a Booster Dose. Available at: *https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-authorizes-moderna-pfizer-biontech-bivalent-covid-19-vaccines-use.*

[217] Centers for Disease Control and Prevention. (September 24, 2021). Morbidity and Mortality Weekly Report (MMWR). Comparative Effectiveness of Moderna, Pfizer-BioNTech, and Janssen (Johnson & Johnson) Vaccines in Preventing COVID–19 Hospitalizations Among Adults Without Immunocompromising Conditions—United States, March-August 2021. Available at: *https://cdc.gov/mmwr/volumes/70/wr/mm7038e1.htm?s_cid=mm7038e1_w.*

[218] Centers for Disease Control and Prevention. (September 10, 2021). Morbidity and Mortality Weekly Report (MMWR). Monitoring Incidence of COVID–19 Cases, Hospitalizations, and Deaths, by Vaccination Status—13 U.S. Jurisdictions, April 4–July 17, 2021. Available at: https://cdc.gov.mmwr/volumes/70/wr/mm7037e1.htm.

[219] Centers for Disease Control and Prevention. (August 27, 2021). Morbidity and Mortality Weekly Report (MMWR). Effectiveness of COVID–19 Vaccines in Preventing SARS–COV–2 Infection Among Frontline Workers Before and During B.1.617.2 (Delta) Variant Predominance—Eight U.S. Locations, December 2020–August 2021. Available at: *https://cdc.gov/mmwr/volume/70/wr/mm7034e4.htm*

[220] Pilishivi, T. et al. (December 2022). Effectiveness of mRNA Covid-19 Vaccine among U.S. Health Care Personnel. New England Journal of Medicine. 2021 Dec 16;385(25):e90. Available online at: *https://pubmed.ncbi.nlm.nih.gov/34551224/.*

[221] McGarry BE et al. (January 2022). Nursing Home Staff Vaccination and Covid-19 Outcomes. New England Journal of Medicine. 2022 Jan 27;386(4):397–398. Available online at: *https://pubmed.ncbi.nlm.nih.gov/34879189/.*

[222] Centers for Disease Control and Prevention. (August 2021). Variants of the Virus. Available at: *https://www.cdc.gov/coronavirus/2019-ncov/variants/index.html.*

[223] Food and Drug Administration. (November 2022). COVID–19 Bivalent Vaccine Boosters.

[224] Chalkias, S et al. (October 2022). A Bivalent Omicron-Containing Booster Vaccine against Covid-19. N Engl J Med 2022; 387:1279–1291. Available online at: *https://www.nejm.org/doi/full/10.1056/NEJMoa2208343.*

[225] Food and Drug Administration. (November 2022). Pfizer-BioNTech COVID–19 Vaccines. Available at: *https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/pfizer-biontech-covid-19-vaccines.*

[226] Food and Drug Administration. (November 2022). Moderna COVID–19 Vaccines. Available at: *https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/moderna-covid-19-vaccines.*

[227] Food and Drug Administration. (August 2022). Coronavirus (COVID–19) Update: FDA Authorizes Moderna, Pfizer-BioNTech Bivalent COVID–19 Vaccines for Use as a Booster Dose. Available at: *https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-authorizes-moderna-pfizer-biontech-bivalent-covid-19-vaccines-use.*

[228] Oster Y et al. (May 2022). The effect of a third BNT162b2 vaccine on breakthrough infections in health care workers: a cohort analysis. Clin Microbiol Infect. 2022 May;28(5): 735.e1–735.e3. Available online at: *https://pubmed.ncbi.nlm.nih.gov/35143997/.*

coverage rate of booster or additional dose(s) of 19.1 percent, with an interquartile range of 8.7 percent to 37.9 percent. These data, which show a performance gap in booster coverage, indicate that there is opportunity to improve booster vaccination coverage among HCP in IPFs.[229]

We believe that vaccination remains the most effective means to prevent the worst consequences of COVID–19, including severe illness, hospitalization, and death. Given the availability of vaccine efficacy data, EUAs issued by the FDA for bivalent boosters, the continued presence of SARS–COV–2 in the United States, and variance among rates of booster dose vaccination, it is important to modify the COVID–19 Vaccination Coverage Among HCP measure to refer explicitly to HCP who receive primary series and booster vaccine doses in a timely manner. Given the persistent spread of COVID–19, we continue to believe that monitoring and surveillance of vaccination rates among HCP is important and provides patients, beneficiaries, and their caregivers with information to support informed decision-making.

Beginning with the fourth quarter of the CY 2023 reporting period/FY 2025 payment determination, we proposed to modify the COVID–19 Vaccination Coverage Among HCP measure in the IPFQR Program to replace the term ''complete vaccination course'' with the term ''up-to-date'' in the HCP vaccination definition. We also proposed to update the numerator to specify the time frames within which an HCP is considered ''up-to-date'' with recommended COVID–19 vaccines, including booster doses.

In the FY 2022 IPF PPS final rule (86 FR 42638), we stated, and reiterate now, that the COVID–19 Vaccination Coverage Among HCP measure is a process measure that assesses HCP vaccination coverage rates. Unlike outcome measures, process measures do not assess a particular clinical outcome.

2. Overview of Measure

The proposed COVID–19 Vaccination Coverage Among HCP measure is a process measure developed by the CDC to track COVID–19 vaccination coverage among HCP in settings such as acute care facilities, including IPFs, and post-acute care facilities.

We refer readers to the FY 2022 IPF PPS final rule (86 FR 42635 through 42636) for more information on the initial review of the current COVID–19 Vaccination Coverage Among HCP measure by the Measure Applications Partnership (MAP). We included an updated version of the proposed modification of the COVID–19 Vaccination Coverage Among HCP measure on the list of measures under consideration (MUC List), which is published annually on behalf of CMS by the CBE with which the Secretary must contract as required by section 1890(a) of the Act, for the 2022 to 2023 pre-rulemaking cycle for consideration by the MAP.

In December 2022, the MAP Hospital Workgroup discussed the proposed modification of the COVID–19 Vaccination Coverage Among HCP measure. The MAP Hospital Workgroup stated that the proposed modification of the current measure captures ''up-to-date'' vaccination information in accordance with the CDC's recommendations, which have been updated since their initial development. Additionally, the MAP Hospital Workgroup appreciated that the modified measure's denominator is broader and simplified from seven categories of healthcare personnel to four.[230]

During review on December 6 and 7, 2022, the MAP Health Equity Advisory Group highlighted the importance of COVID–19 measures and asked whether the proposed modified measure excludes individuals with contraindications to Food and Drug Administration (FDA) authorized or approved COVID–19 vaccines, and whether the measure will be stratified by demographic factors.[231] The CDC, the measure developer for this measure, responded to the question regarding individuals with contraindications by confirming that HCP with contraindications to the vaccines are excluded from the measure denominator. The CDC further explained that the modified measure will not be stratified since the data are submitted at an aggregate rather than an individual level.

During review on December 8 through 9, 2022, the MAP Rural Health Advisory Group expressed concerns about data collection burden, citing that collection is performed manually and that small rural hospitals may not have employee health software.[232] The measure developer (that is, the CDC) acknowledged the challenge of getting adequate documentation and emphasized the goal to ensure the measure does not present a burden on providers. The measure developer also noted that the model used for this measure is based on the Influenza Vaccination Coverage Among HCP measure (CBE #0431), and it intends to utilize a similar approach to the modified COVID–19 Vaccination Coverage Among HCP measure if vaccination strategy becomes seasonal. The modified COVID–19 Vaccination Coverage Among HCP measure received conditional support for rulemaking pending testing indicating the measure is reliable and valid, and endorsement by the CBE. The MAP noted that the previous version of the measure received endorsement from the CBE (CBE #3636)[233] and that the CDC intends to submit the proposed updated measure for endorsement.

a. Measure Specifications

The modification of the COVID–19 Vaccination Coverage Among HCP measure will require that IPFs continue to collect data at least one week each month for each of the three months in a quarter.

The denominator is the number of HCP eligible to work in the facility for at least one day during the reporting period, excluding persons with contraindications to COVID–19 vaccination that are described by the CDC.[234] There are not any changes to the denominator exclusions for the current COVID–19 Vaccination Coverage Among HCP measure, and the modified COVID–19 Vaccination Coverage Among HCP measure will continue to exclude otherwise denominator-eligible HCPs with contraindications as defined by the CDC.[235] IPFs report the following four

[229] Measure Applications Partnership (MAP) Hospital Workgroup Preliminary Analyses. Available at: *https://mmshub.cms.gov/sites/default/files/map-hospital-measure-specifications-manual-2022.pdf.*

[230] Centers for Medicare & Medicaid Services. 2022–2023 MAP Final Recommendations. Available at: *https://mmshub.cms.gov/measure-lifecycle/measure-implementation/pre-rulemaking/lists-and-reports.*

[231] Centers for Medicare & Medicaid Services. 2022–2023 MAP Final Recommendations. Available at: *https://mmshub.cms.gov/measure-lifecycle/measure-implementation/pre-rulemaking/lists-and-reports.*

[232] Centers for Medicare & Medicaid Services. 2022–2023 MAP Final Recommendations. Available at: *https://mmshub.cms.gov/measure-lifecycle/measure-implementation/pre-rulemaking/lists-and-reports.*

[233] Centers for Medicare & Medicaid Services. 2022–2023 MAP Final Recommendations. Available at: *https://mmshub.cms.gov/measure-lifecycle/measure-implementation/pre-rulemaking/lists-and-reports.* and CMS Measures Inventory Tool. Available at: *https://cmit.cms.gov/cmit/#/MeasureView?variantId=5273&sectionNumber=1.*

[234] Centers for Disease Control and Prevention. (2022). Contraindications and precautions. Available at: *https://www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us.html#contraindications.*

[235] Centers for Disease Control and Prevention. (2022). Contraindications and precautions. Available at: *https://www.cdc.gov/vaccines/covid-*

categories of HCP to NHSN [236]; the first three categories are included in the measure denominator:

1. *Employees:* This category includes all persons who receive a direct paycheck from the IPF (that is, on the IPF's payroll), regardless of clinical responsibility or patient contact.

2. *Licensed independent practitioners (LIPs):* This category includes physicians (MD, DO), advanced practice nurses, and physician assistants who are affiliated with the IPF but are not directly employed by it (that is, they do not receive a paycheck from the IPF), regardless of clinical responsibility or patient contact. Post-residency fellows are also included in this category if they are not on the IPF's payroll.

3. *Adult students/trainees and volunteers:* This category includes medical, nursing, or other health professional students, interns, medical residents, or volunteers aged 18 or older who are affiliated with the healthcare facility, but are not directly employed by it (that is, they do not receive a paycheck from the facility), regardless of clinical responsibility or patient contact.

4. *Other contract personnel:* Contract personnel are defined as persons providing care, treatment, or services at the IPF through a contract who do not fall into any of the previously discussed denominator categories. Please note that this also includes vendors providing care, treatment, or services at the facility who may or may not be paid through a contract. Facilities are required to enter data on other contract personnel for submission in the NHSN application, but reporting for this category is not included in the COVID–19 Vaccination Coverage Among HCP measure.

The numerator is the cumulative number of HCP in the denominator population who are ''up-to-date'' with CDC recommended COVID–19 vaccines. IPFs would refer to the CDC's guidance, to determine the then-applicable definition of ''up-to-date,'' as of the first day of the applicable reporting quarter. The CDC's guidance can be found at: *https://www.cdc.gov/nhsn/pdfs/hps/covidvax/UpToDateGuidance-508.pdf*. For purposes of NHSN surveillance, the CDC used the following definition of ''up-to-date'' during the fourth quarter of CY 2022 surveillance period (September 26, 2022 through December 25, 2022):

1. Individuals who received an updated bivalent [237] booster dose, or

2a. Individuals who received their last booster dose less than 2 months ago, or

2b. Individuals who completed their primary series [238] less than 2 months ago.

Subsequent to the publication of the FY 2024 IPF PPS proposed rule, the CDC has updated the definition of ''up-to-date'' for the second quarter of CY 2023 surveillance period:

1. Individuals who received an updated bivalent [239] booster dose, or

2. Individuals who completed their primary series [240] less than 2 months ago.

We refer readers to *https://www.cdc.gov/nhsn/nqf/index.html* for more details on the modified measure specifications.

We proposed that public reporting of the modified version of the COVID–19 Vaccination Coverage Among HCP measure would begin with the October 2024 Care Compare refresh, or as soon as technically feasible after that refresh.

b. CBE Endorsement

The current version of the COVID–19 Vaccination Coverage Among HCP measure received CBE endorsement (CBE #3636, ''Quarterly Reporting of COVID–19 Vaccination Coverage Among Healthcare Personnel'') on July 26, 2022.[241]

Although section 1886(s)(4)(D)(i) of the Act generally requires that measures specified by the Secretary must be endorsed by the entity with a contract under section 1890(a) of the Act, section 1886(s)(4)(D)(ii) of the Act states that in the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a) of the Act, the Secretary may specify a measure that is not so endorsed as long as due consideration is given to a measure that has been endorsed or adopted by a consensus organization identified by the Secretary.

We reviewed measures endorsed by consensus organizations and were unable to identify any other measures on this topic endorsed by a consensus organization; therefore, we believe the exception in section 1886(s)(4)(D)(ii) of the Act applies. The CDC, as the measure developer, is currently pursuing endorsement for the modified version of the measure as the current version of the measure has already received endorsement.

3. Data Collection, Submission, and Reporting

We refer readers to the FY 2022 IPF PPS final rule (86 FR 42636 through 42640) for information on data submission and reporting of the current COVID–19 Vaccination Coverage Among HCP measure. While we did not propose any changes to the data submission or reporting process, we proposed that reporting of the updated modified measure would begin with the fourth quarter of CY 2023 reporting period for FY 2025 payment determination. Beginning with the FY 2026 payment determination, we proposed that IPFs would be required to submit data for the modified measure for the entire calendar year.

Under the data submission and reporting process, IPFs collect the numerator and denominator for the COVID–19 Vaccination Coverage Among HCP measure for at least one self-selected week during each month of the reporting quarter and submit the data to the CDC's National Health Safety Network (NHSN) Healthcare Personnel Safety (HPS) Component before the quarterly deadline. If an IPF submits more than one week of data in a month, the CDC would use most recent week's data to calculate the measure results which would be publicly reported. Each quarter, the CDC calculates a single quarterly COVID–19 HCP vaccination coverage rate for each IPF, which is calculated by taking the average of the data from the three weekly rates submitted by the IPF for that quarter. CMS publicly reports each quarterly COVID–19 HCP vaccination coverage rate as calculated by the CDC based on the data IPFs submit to the NHSN (86 FR 42636 through 42640).

We invited public comment on our proposal.

Comment: Some commenters supported the proposed modification to the COVID–19 Vaccination Coverage Among HCP measure. One of these commenters stated that the modified specifications would lead to increased vaccination and booster adoption among

19/clinical-considerations/interim-considerations-us.html#contraindications.

[236] *https://www.cdc.gov/nhsn/pdfs/nqf/covid-vax-hcpcoverage-rev-2023-508.pdf.*

[237] The updated (bivalent) Moderna and Pfizer-BioNTech boosters target the most recent Omicron subvariants. The updated (bivalent) boosters were recommended by the CDC on 9/2/2022. As of this date, the original, monovalent mRNA vaccines are no longer authorized as a booster dose for people ages 12 years and older.

[238] Completing a primary series means receiving a two-dose series of a COVID–19 vaccine or a single dose of Janssen/J&J COVID–19 vaccine.

[239] The updated (bivalent) Moderna and Pfizer-BioNTech boosters target the most recent Omicron subvariants. The updated (bivalent) boosters were recommended by the CDC on 9/2/2022. As of this date, the original, monovalent mRNA vaccines are no longer authorized as a booster dose for people ages 12 years and older.

[240] Completing a primary series means receiving a two-dose series of a COVID–19 vaccine or a single dose of Janssen/J&J COVID–19 vaccine.

[241] CMS Measures Inventor Tool. COVID–19 Vaccination Coverage among Healthcare Personnel. Available at: *https://cmit.cms.gov/cmit/#/MeasureView?variantId=5273&sectionNumber=1.*

HCP. One commenter stated that patients with mental illness are more vulnerable to COVID–19 driving the increased need for their providers to be vaccinated.

Response: We thank the commenters for their support. We agree that vaccination plays a critical part of the nation's strategy to effectively counter the spread of COVID–19. We continue to believe it is important to incentivize and track rates of vaccination among HCP through quality measurement across care settings, including the IPF setting, in order to protect healthcare workers, patients, and caregivers, and to help sustain the ability of HCP in each of these care settings to continue serving their communities.

Comment: Several commenters did not support updating the specifications for the COVID–19 Vaccination Coverage Among HCP measure because the PHE has expired and the Conditions of Participation (COPs) for hospitals have been revised to no longer require reporting of these data. Some of these commenters requested clarification regarding whether the change in COPs means that we will remove the measure from our quality reporting programs. One commenter expressed concern that retaining measurement of COVID–19 Vaccination Coverage Among HCP after the vaccination requirement has been removed from COPs sends an inconsistent message regarding CMS's priorities.

Response: As commenters noted, the PHE for COVID–19 expired on May 11, 2023.[242] Since May 11, 2023, some state and federal reporting requirements have changed. While CMS requirements for Medicare and Medicaid-certified providers and suppliers to ensure that their staff were fully vaccinated for COVID–19 have ended with the expiration of the COVID–19 PHE (88 FR 36488), CMS revised the hospital and critical access hospitals (CAHs) infection prevention and control Condition of Participation so that hospitals and CAHs will continue to report on a reduced number of COVID–19 data elements after the conclusion of the COVID- 19 PHE until April 30, 2024, unless the Secretary establishes an earlier end date.[243] While these changes may impact certain aspects of facility reporting on COVID–19 data, we note that the reporting requirements of the IPFQR Program are distinct from those related to the expiration of the COVID–19 PHE and facilities participating in the IPFQR Program are required to report the COVID–19 Vaccination Coverage Among HCP measure. We further note that in our final rule removing staff vaccination requirements, we clarified that we were aligning our approach with that for other infectious diseases, specifically influenza, and that we would encourage ongoing COVID–19 vaccination through our quality reporting and value-based incentive programs (88 FR 38486).

We believe this measure continues to align with our goals to promote wellness and disease prevention. Under CMS' Meaningful Measures Framework 2.0, the COVID–19 Vaccination Coverage Among HCP measure addresses the quality priorities of ''Immunizations'' and ''Public Health'' through the Meaningful Measures Area of ''Wellness and Prevention.'' Under the National Quality Strategy, the measure addresses the goal of ''Safety'' under the priority area ''Safety and Resiliency.'' Our response to COVID–19 is not fully dependent on the emergency declaration for the COVID–19 PHE and, beyond the end of the COVID–19 PHE, we continue to work to protect individuals and communities from the virus and its worst impacts by supporting access to COVID–19 vaccines, treatments, and tests.

Comment: Many commenters did not support updating the COVID–19 Vaccination Coverage Among HCP measure because of concerns that the frequency of changes to the CDC's definition of ''up-to-date'' combined with the uncertainty around future vaccination schedules creates unnecessary burden for facilities. Some of these commenters recommended allowing voluntary reporting until the appropriate definitions and guidance are stable. One commenter stated that understanding how changing guidelines apply to all members of staff (such as those with risk factors) is burdensome. Others stated that publicly reporting these data may not be meaningful to consumers due to the changing definitions and the time lag between collection and public reporting.

Response: Since the adoption of the current version of the measure, the public health response to COVID–19 has necessarily adapted to respond to the changing nature of the virus's transmission and community spread. When we finalized the adoption of the COVID–19 Vaccination Coverage Among HCP measure in the FY 2022 IPF PPS final rule (86 FR 42640), we received several comments encouraging us to continue to update the measure as new evidence on COVID–19 continues to arise and we stated our intention to continue to work with partners including FDA and CDC to consider any updates to the measure in future rulemaking as appropriate. We believe that the measure modification aligns with the CDC's responsive approach to COVID–19 and will continue to support vaccination as the most effective means to prevent the worst consequences of COVID–19, including severe illness, hospitalization, and death. We agree with commenters who observe that there is a delay between data collection and public reporting for this measure and note that such a delay exists for all measures in the IPFQR Program. However, we believe that the data will provide meaningful information to consumers in making healthcare decisions because the data will be able to reflect differences between IPFs in COVID–19 vaccination coverage among HCP even if the data do not reflect immediate vaccination rates.

Comment: Many commenters recommended that CMS reduce the mandatory reporting frequency to quarterly or to annually to reduce reporting burden for facilities. Some of these commenters stated that this mirrors the reporting schedule for the Influenza Vaccination Coverage Among HCP measure which is in some quality reporting programs.

Response: As we stated in the FY 2024 IPF PPS proposed rule (88 FR 21292), the measure developer noted that the model used for this measure is based on the Influenza Vaccination Coverage Among HCP measure (CBE #0431), and it intends to utilize a similar approach to the modified COVID–19 Vaccination Coverage Among HCP measure if vaccination strategy becomes seasonal. We continue to monitor COVID–19 as part of our public health response and will consider information we collect to inform any potential action that may address seasonality in future rulemaking.

Comment: Some commenters expressed concern that the COVID–19 Vaccination Coverage Among HCP measure has not been endorsed by the CBE.

Response: The current version of the measure received CBE endorsement (CBE #3636, ''Quarterly Reporting of COVID–19 Vaccination Coverage Among Healthcare Personnel'') on July 26, 2022. As we stated in the FY 2024 IPF PPS proposed rule (88 FR 21292 through 21293), in the case of a specified area or medical topic

[242] U.S. Dept. of Health and Human Services. Fact Sheet: COVID–19 Public Health Emergency Transition Roadmap. February 9, 2023. Available at: *https://www.hhs.gov/about/news/2023/02/09/fact-sheet-covid-19-public-health-emergency-transition-roadmap.html.*

[243] *https://www.hhs.gov/about/news/2023/05/09/fact-sheet-end-of-the-covid-19-public-health-emergency.html.*

determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a) of the Act, the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary. As discussed in section V.E.2.b. of the proposed rule (88 FR 21292 through 21293) and this final rule, we reviewed measures endorsed by consensus organizations and were unable to identify any other measures on this topic endorsed by a consensus organization; therefore, we believe the exception for non- CBE- endorsed measures applies. The measure steward, CDC, is currently pursuing endorsement for the modified version of the measure as the current version of the measure has already received endorsement.

Comment: Some commenters recommended that CMS include an exclusion for sincerely held religious beliefs to adhere to HHS Office of Civil Rights Guidance. Some of these commenters also requested the measure be updated to track the number of HCP who decline vaccination. Several commenters stated that there are many factors beyond an IPF's control (such as weather, holidays, vaccine supply, etc.) that may affect performance on this measure.

Response: We recognize that there are many reasons, including religious objections or concerns regarding an individual HCP's specific health status which may lead individual HCP to decline vaccination. The CDC's NHSN tool allows facilities to report on the number of HCP who were offered a vaccination but declined for religious or philosophical objections.[244] We understand the commenters' concern that there are many factors outside of an IPF's control that could affect vaccination coverage; however, we believe that all IPFs face such concerns and that public reporting of these data can help patients and their caregivers identify which IPFs have better vaccination coverage among their HCP. Furthermore, we believe that reporting of the measure based on one week per month over three months will allow some seasonal or other effects to be mitigated. We wish to emphasize that neither the modified measure nor the current version of the measure mandate vaccines. The COVID–19 Vaccination Coverage Among HCP measure only requires reporting of vaccination rates for successful program participation.

Final Decision: After consideration of the public comments we received, we are finalizing modification of the COVID–19 Vaccination Coverage Among HCP measure as proposed.

F. Removal or Retention of IPFQR Program Measures

1. Background

In the FY 2018 IPPS/LTCH PPS final rule (82 FR 38463 through 38465) and FY 2019 IPF PPS final rule (83 FR 38591 through 38593), we adopted several considerations for removing or retaining measures within the IPFQR Program.

Specifically, we have adopted eight factors that we consider when evaluating whether to propose a measure for removal from the IPFQR Program. These factors are: (1) measure performance among IPFs is so high and unvarying that meaningful distinctions and improvements in performance can no longer be made (''topped out'' measures); (2) measure does not align with current clinical guidelines or practice; (3) measure can be replaced by a more broadly applicable measure (across setting or populations) or a measure that is more proximal in time to desired patient outcomes for the particular topic; (4) measure performance or improvement does not result in better patient outcomes; (5) measure can be replaced by a measure more strongly associated with desired patient outcomes for the particular topic; (6) measure collection or public reporting leads to negative intended consequences other than patient harm; (7) measure is not feasible to implement as specified; and (8) the costs associated with a measure outweigh the benefit of its continued use in the program. For measure removal factor one, we specified that a measure is ''topped out'' if it meets the following criteria: (1) statistically indistinguishable performance at the 75th and 90th percentiles; and (2) the truncated coefficient of variation is less than or equal to 0.10.

We also adopted three factors for consideration in determining whether to retain a measure in the IPFQR Program, even if the measure meets one or more factors for removal. These retention factors are: (1) measure aligns with other CMS and HHS policy goals, such as those delineated in the National Quality Strategy and CMS Quality Strategy; (2) measure aligns with other CMS programs, including other quality reporting programs; and (3) measure supports efforts to move IPFs towards reporting electronic measures. In the FY 2018 IPPS/LTCH PPS final rule (82 FR 38464), we stated that these removal and retention factors are considerations that we consider in balancing the benefits and drawbacks of removing or retaining measures on a case-by-case basis.

Since adoption, we have not proposed any changes to these policies for removal or retention and refer readers to the FY 2018 IPPS/LTCH PPS final rule (82 FR 38463 through 38465) and the FY 2019 IPF PPS final rule (83 FR 38591 through 38593) for more information. We did not propose any updates to these measure retention and removal policies. We proposed to codify these previously adopted policies at § 412.433(e).

We welcomed comments on this proposal.

Comment: One commenter recommended an additional factor, relevance and importance of the measure to patients, for CMS to consider when deciding whether to remove or modify a measure in the IPFQR. The commenter stated this was consistent with TEPs which inform the measure development process and would improve the patient centeredness of the program.

Response: We appreciate this recommendation and will consider it in the future as we continue to evaluate all elements of the IPFQR Program.

Final Decision: After consideration of the public comments we received, we are finalizing codification of our measure retention and removal policies as proposed.

2. Measures for Removal

We continue to evaluate our measure set against these removal and retention factors on an ongoing basis. In this continual evaluation of the IPFQR Program measure set under our Meaningful Measures Framework and according to our measure removal and retention factors, we identified two measures that we believe are appropriate to remove from the IPFQR Program beginning with the FY 2025 payment determination. Our discussion of these measures follows.

a. Removal of the Patients Discharged on Multiple Antipsychotic Medications With Appropriate Justification (HBIPS–5) (Previously Endorsed Under CBE #0560) Measure Beginning With FY 2025 Payment Determination

[244] *https://www.cdc.gov/nhsn/forms/COVIDVax.HCP_.FORM_May2022-508.pdf.*

As we assessed our existing measure set to ensure that it remains appropriate for the IPFQR Program, we determined that measure removal factor two (that is, measure does not align with current clinical guidelines or practice) applies to the Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification (HBIPS–5) (CBE #560) measure due to the American Psychiatric Association's (APA's) updated guidelines for patients with schizophrenia.

We adopted the HBIPS–5 measure in the FY 2013 IPPS/LTCH PPS final rule as part of a set with the Patients Discharged on Multiple Antipsychotic Medications (HBIPS–4) (previously endorsed under CBE #0552) measure because of the belief that these two measures would help reduce unnecessary use of multiple antipsychotics, which would lead to better clinical outcomes and reduced side effects for patients (77 FR 53649 through 53650). We subsequently removed the HBIPS–4 measure in the FY 2016 IPF PPS final rule (80 FR 46695 through 46696). As we described in that final rule, following our adoption of these measures, some experts, including the CBE, provided input that the HBIPS–4 measure did not provide meaningful information about the quality of care received by IPF patients. This led to the removal of the HBIPS–4 measure's CBE endorsement in January 2014. During the CBE's review of the HBIPS–4 measure in 2014, the CBE observed that the HBIPS–4 and HBIPS–5 measures could be collected and reported separately and expressed that the HBIPS–5 measure should be retained in the IPFQR Program as it continued to provide meaningful quality of care information (80 FR 046695 through 46696).

Evidence supporting development and adoption of the HBIPS–5 measure included the APA Workgroup on Schizophrenia's 2004 Practice Guideline for the Treatment of Patients with Schizophrenia. These guidelines stated that the ''combinations of antipsychotics . . . should be justified by strong documentation that the patient is not equally benefited by monotherapy.'' [245] In December 2019, the APA Board of Trustees approved updated guidelines for treatment of patients with schizophrenia.[246] The updated guidelines are based on evolving clinical knowledge and have increased focus and specificity of recommendations for the use of pharmacotherapy; they also underscore the importance of patient preference and shared-decision making.[247] These guidelines no longer contain the recommendation that combinations of antipsychotics should be justified by strong documentation that patients are not equally benefited by monotherapy. Therefore, the guidelines that originally supported the HBIPS–5 measure have changed substantially, and the HBIPS–5 measure is no longer aligned with current clinical guidelines and practice.

Furthermore, the HBIPS–5 measure is no longer supported by the measure steward (that is, The Joint Commission), who withdrew it from the CBE endorsement process in 2019. As a result, the HBIPS–5 measure lost its CBE endorsement in October 2019.[248] Subsequent to this, the CBE-convened MAP's discussion of measure set removal for 2021–2022 included a discussion of this measure. Because the HBIPS–5 measure no longer aligns with clinical guidelines and is no longer CBE endorsed due to lack of support from the measure developer, the MAP recommended that the measure should be removed from the IPFQR Program.[249]

We agree with the MAP's assessment that the measure no longer aligns with clinical guidelines and therefore proposed to remove the measure from the IPFQR Program beginning with the FY 2025 payment determination. We note that data for the FY 2024 payment determination represents care provided in CY 2022 and will be reported to CMS prior to the publication of this FY 2024 IPF PPS final rule; therefore, the FY 2025 payment determination is the first period for which we can remove this measure.

We invited comments on our proposal.

Comment: Many commenters supported removing HBIPS–5 from the IPFQR Program. These commenters agreed that the measure no longer aligns with the updated clinical guidance from the APA.

Response: We thank these commenters for their support.

Comment: Several commenters expressed concern about the long-term effects of psychotropic medications, especially antipsychotics, and recommended that CMS defer removal until additional research can be performed to ensure there are minimal long-term effects of antipsychotic medications.

Response: We appreciate commenters' concern about the long-term effects of psychotropic medications. We note that our proposed removal of the measure was based on the updated APA guidelines for treatment of patients with schizophrenia. These guidelines underwent a rigorous review process prior to being updated, which included a review of the benefits and harms of each treatment.[250]

Final Decision: After consideration of the public comments we received, we are finalizing removal of the Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification (HBIPS–5) measure as proposed.

b. Removal of the Tobacco Use Brief Intervention Provided or Offered and Tobacco Use Brief Intervention (TOB–2/2a) Measure Beginning With the FY 2025 Payment Determination

We adopted the Tobacco Use Brief Intervention Provided or Offered and Tobacco Use Brief Intervention (TOB–2/2a) measure in the FY 2015 IPF PPS final rule (79 FR 45971 through 45972) because of our belief that it is important to address the common comorbidity of tobacco use among IPF patients. The TOB–2/2a measure requires IPFs to chart-abstract measure data on a sample of IPF patient records, in accordance with established sampling policies (80 FR 46717 through 46719). When we introduced the TOB–2/2a measure to the IPFQR Program, the benefits of this measure were high because IPF performance was not consistent with respect to, and there were no other measures addressing, provision of tobacco use cessation counseling or treatment. At the time, the TOB–2/2a measure provided a means of distinguishing IPF performance regarding, and incentivized facilities to improve rates of, treatment for this common comorbidity. To further address tobacco use, we subsequently adopted the Tobacco Use Treatment Provided or Offered at Discharge and

[245] *https://www.researchgate.net/publication/298561608_Practice_guideline_for_the_treatment_of_patients_with_schizophrenia_second_edition.*

[246] *https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.2020.177901.*

[247] The American Psychiatric Association. Practice Guideline for the Treatment of Patients with Schizophrenia, Third Edition. Available at: *https://psychiatryonline.org/doi/book/10.1176/appi.books.9780890424841.* Accessed on February 15, 2023.

[248] CMS Measures Inventory Tool. Patients Discharged on multiple antipsychotic medications with appropriate justification. Available at: *https://cmit.cms.gov/cmit/#/MeasureView?variantId=1141&sectionNumber=1.*

[249] MAP 2021–2022 Considerations for Implementing Measures in Federal Programs. Available at: *https://mmshub.cms.gov/sites/default/files/map_2021-2022_considerations_for_implementing_measures_in_federal_programs_final_report.pdf.*

[250] *https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/Clinical%20Practice%20Guidelines/Guideline-Development-Process.pdf.*

Tobacco Use Treatment at Discharge (TOB–3/3a) measure in the FY 2016 IPF PPS final rule (80 FR 46696 through 46699).

In the FY 2022 IPF PPS proposed rule, we proposed to remove the Tobacco Use Brief Intervention Provided or Offered and Tobacco Use Brief Intervention (TOB–2/2a) measure from the IPFQR Program beginning with the FY 2024 payment determination under our measure removal factor 8, the costs associated with a measure outweigh the benefit of its continued use in the program (86 FR 19508 through 19509). We expressed our belief that the quality improvement benefits from the TOB–2/2a measure had greatly diminished because performance had leveled off, that is overall performance on the measure was no longer improving. We took this to mean that most IPFs routinely offer tobacco use brief interventions.

In the FY 2022 IPF PPS proposed rule, we also expressed our belief that the costs of maintaining this measure are high because costs are multi-faceted and include not only the IPFs' burden associated with reporting, but also our costs associated with implementing and maintaining the measure (86 FR 19508 through 19509). Additionally, we must expend resources in maintaining information collection systems, analyzing reported data, and providing public reporting of the collected information. We expressed that, for this measure, IPF information collection burden and related costs associated with reporting this measure to CMS were high because the measure is a chart-abstracted measure. Furthermore, we observed CMS incurs costs associated with the program oversight of the measure for public display.

However, in the FY 2022 IPF PPS final rule, we did not finalize our proposal to remove the Tobacco Use Brief Intervention Provided or Offered and Tobacco Use Brief Intervention (TOB–2/2a) measure (86 FR 42648 through 42651). We stated that, following review of the public comments we received, we believed the benefits of continuing to encourage facilities to offer tobacco use brief interventions were greater than we had estimated. We noted that these benefits included the potential for IPFs to continue improving performance on the TOB–2/2a measure, the importance of tobacco use interventions due to increased tobacco use during the COVID–19 pandemic, and this measure's potential influence on other quality improvement activities related to tobacco use.

In our continual evaluation of the IPFQR Program measure set under our Meaningful Measures Framework and according to our measure removal and retention factors, we observed that having two measures addressing tobacco use, which are both associated with relatively high information collection burden, may not appropriately balance costs and benefits within the program. While we believe that both the TOB–2/2a measure and the TOB–3/3a measure address clinically important interventions to address smoking in this population, we believe that the overall cost associated with retaining both of these measures outweighs the benefit of having two measures to address treatment for the same comorbidity among the same patient population.

Both measures capture information about tobacco cessation counseling and FDA-approved tobacco cessation medications. The difference between the measures is that the TOB–2/2a measure captures whether the tobacco cessation counseling and FDA-approved tobacco cessation medications were offered or refused during the inpatient stay, while the TOB–3/3a measure captures whether a referral to outpatient tobacco cessation counseling and FDA-approved tobacco cessation medications were offered or refused at the time of the patient's discharge.

As we considered each of these measures, we determined that it would be more appropriate to retain the TOB–3/3a measure in the IPFQR Program, that is, to remove the TOB–2/2a measure instead of the TOB–3/3a measure, because there is more opportunity for improvement on the TOB–3/3a measure. Specifically, the performance on the TOB–3/3a measure is lower than performance on the TOB–2/2a measure. National performance on TOB–2 and 2a measure and TOB–3 and 3a measure for the last five payment determination years in the IPFQR Program is presented in Table 19. Given the relatively high performance on the TOB–2/2a measure compared to the TOB–3/3a measure, we believe that retaining the TOB–3/3a measure, and removing the TOB–2/2a measure, would provide more opportunity to drive improvement among IPFs; therefore, would potentially impact more patients.

TABLE 19: NATIONAL PERFORMANCE ON TOB-2 AND TOB-2A AND TOB-3 AND TOB-3A FROM CY 2017 THROUGH CY 2021

Performance Period/Payment Determination Year	TOB-2 Performance	TOB-2a Performance	TOB-3 Performance	TOB-3a Performance
CY 2017/FY 2019	79.7%	44.9%	54.1%	15.0%
CY 2018/FY 2020	81.0%	46.2%	57.5%	17.8%
CY 2019/FY 2021	82.0%	46.8%	59.9%	21.6%
CY 2020/FY 2022	80.4%	44.9%	60.7%	21.7%
CY 2021/FY 2023	72.2%	39.0%	57.4%	18.3%

As described earlier in this section VI.F.2.b of this final rule, because the TOB–2/2a measure has a high cost (especially due to its high information collection burden), we believe that these high costs are no longer greater than the benefits of retaining this measure. Therefore, we believe measure removal factor 8 (that is, the costs associated with a measure outweigh the benefit of its continued use in the IPFQR Program), applies to the TOB–2/2a measure.

Furthermore, the TOB–2/2a measure is no longer supported by the measure steward (that is, The Joint Commission), who withdrew it from the CBE endorsement process in 2018. Therefore, the TOB–2/2a measure has not been CBE endorsed since October 2018.[251]

[251] CMS Measures Inventory Tool. Tobacco Use Treatment Provided or Offered. Available at:

Continued

Subsequent to this, the CBE-convened MAP's discussion of measure set removal for 2021and 2022 included a discussion of this measure. Because the TOB–2/2a measure is a high-cost measure and is no longer CBE endorsed, the MAP recommended that we remove the measure from the IPFQR Program.[252]

We agree with the MAP that this is a high-cost measure. Furthermore, we recognize that it is similar to the other tobacco use measure in the IPFQR Program measure set (that is, the TOB–3/3a measure) which we did not propose to remove. Therefore, we proposed to remove Tobacco Use Brief Intervention Provided or Offered and Tobacco Use Brief Intervention (TOB–2/2a) measure under our measure removal factor 8, ''the costs associated with a measure outweigh the benefit of its continued use in the program,'' beginning with FY 2025 payment determination. We note that data for the FY 2024 payment determination represents care provided in CY 2022 and will be reported to CMS prior to the publication of this FY 2024 IPF PPS final rule; therefore, the FY 2025 payment determination is the first period for which we can remove this measure.

We invited public comment on this proposal.

Comment: Many commenters supported removal of the TOB–2/2a measure because it will reduce burden with minimal impact on patient outcomes due to the retention of the TOB–3/3a measure. Some of these commenters stated that the TOB–3/3a measure has more room for improvement and is more likely to lead to improved patient outcomes.

Response: We thank these commenters for their support.

Comment: Many commenters opposed removal of the TOB–2/2a measure. These commenters stated that tobacco use is a common comorbidity among this patient population that leads to negative long-term health outcomes. These commenters expressed that the TOB–2/2a and TOB–3/3a measures both address important interventions to reduce tobacco use and therefore recommended retaining both measures. Some of these commenters expressed concern that, without the TOB–2/2a measure, IPFs will not offer tobacco use interventions in the inpatient setting which represents a missed opportunity to increase the likelihood that these patients will quit using tobacco. Some of these commenters stated that there is still room for improvement on the TOB–2/2a measure.

Response: We agree with commenters that tobacco use is a common comorbidity among this patient population that leads to negative long-term health outcomes. We remain committed to the screening, counseling and provision of smoking intervention services in this population of patients. We note that studies have demonstrated that during the acute hospital stay, there is no statistically significant increase in smoking cessation for non-intensive counseling interventions, such as brief intervention,[253] which is what TOB–2/2a measures. We will retain TOB–3/3a which focuses on the provision of smoking cessation referral and treatment for smoking cessation at discharge, to be continued in the ambulatory setting, which studies have shown a greater benefit to the patient. Even though we are finalizing the removal of the TOB–2/2a measure, and therefore IPFs and IPFs will no longer be required to collect and submit TOB–2/2a data to CMS, IPFs are still encouraged to continue to provide smoking cessation counseling and brief interventions during the psychiatric stay as determined appropriate by the patient's provider and patient. We appreciate commenters concerns and will continue to monitor whether additional measures related to smoking cessation and/or intensive behavioral counseling are necessary. We also support the extensive other work that is being done by HHS and the broader Administration to reduce smoking, including the framework proposed by the Office of the Assistant Secretary for Health (OASH) (88 FR 42377).

We agree with commenters that TOB–2/2a and TOB–3/3a both address important interventions (that is, tobacco use treatment brief intervention provided or offered during the inpatient stay and tobacco use treatment provided or offered at discharge) and that there is still room for improvement for both measures. While it is possible that, without the TOB–2/2a measure, some IPFs may stop providing inpatient tobacco use interventions prior to during the patient's discharge planning, we continue to believe that the benefit of having two measures to address this comorbidity does not outweigh the significant reporting burden for IPF's associated with these specific measures. We note that we believe that the benefits of tobacco use interventions during the inpatient stay are high; however, we do not believe the benefits of measuring these interventions along with similar interventions at discharge are sufficiently high to outweigh the burden.

Final Decision: After consideration of the public comments we received, we are finalizing removal of the Tobacco Use Brief Intervention Provided or Offered and Tobacco Use Brief Intervention measure as proposed.

G. Summary of IPFQR Program Measures

1. IPFQR Program Measures for the FY 2024 Payment Determination

We did not propose any changes to our measure set for the FY 2024 payment determination. The 14 measures which will be in the program for FY 2024 payment determination are shown in Table 20.

https://cmit.cms.gov/cmit/#/MeasureView?variantId=1818&sectionNumber=1.

[252] MAP 2021–2022 Considerations for Implementing Measures in Federal Programs. Available at: *https://mmshub.cms.gov/sites/default/files/map_2021-2022_considerations_for_implementing_measures_in_federal_programs_final_report.pdf.*

[253] : Rigotti NA, Clair C, Munafò MR, Stead LF. Interventions for smoking cessation in hospitalised patients. Cochrane Database Syst Rev. 2012 May 16;5(5):CD001837. doi: 10.1002/14651858.CD001837.pub3. PMID: 22592676; PMCID: PMC4498489. Available at:: *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4498489/.*

TABLE 20: IPFQR PROGRAM MEASURE SET FOR THE FY 2024 PAYMENT DETERMINATION

CBE #	Measure ID	Measure
0640	HBIPS-2	Hours of Physical Restraint Use
0641	HBIPS-3	Hours of Seclusion Use
0560*	HBIPS-5	Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification
N/A	FAPH	Follow-Up After Psychiatric Hospitalization
N/A*	SUB-2 and SUB-2a	Alcohol Use Brief Intervention Provided or Offered and SUB-2a Alcohol Use Brief Intervention
N/A*	SUB-3 and SUB-3a	Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge
N/A*	TOB-2 and TOB-2a	Tobacco Use Treatment Provided or Offered and TOB-2a Tobacco Use Treatment
N/A*	TOB-3 and TOB-3a	Tobacco Use Treatment Provided or Offered at Discharge and TOB-3a Tobacco Use Treatment at Discharge
1659	IMM-2	Influenza Immunization
N/A*	N/A	Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
N/A	N/A	Screening for Metabolic Disorders
2860	N/A	Thirty-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility
3205	Med Cont.	Medication Continuation Following Inpatient Psychiatric Discharge
3636	N/A	COVID-19 Healthcare Personnel (HCP) Vaccination Measure

* Measure is no longer endorsed by the CBE but was endorsed at the time of adoption. We note that although section 1886(s)(4)(D)(i) of the Act generally requires measures specified by the Secretary be endorsed by the entity with a contract under section be endorsed by the entity with a contract under section 1890(a) of the Act, section 1886(s)(4)(D)(ii) states that in the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a) of the Act, the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary. We attempted to find available measures for each of these clinical topics that have been endorsed or adopted by a consensus organization and found no other feasible and practical measures on the topics for the IPF setting.

2. IPFQR Program Measures for the FY 2025 Payment Determination

In this final rule. we are removing two measures for the FY 2025 payment determination and subsequent years. We also are modifying one measure for the FY 2025 payment determination and subsequent years. The 12 measures, which will be in the program for FY 2025 payment determination are shown Table 21.

TABLE 21: IPFQR PROGRAM MEASURE SET FOR THE FY 2025 PAYMENT DETERMINATION

CBE #	Measure ID	Measure
0640	HBIPS-2	Hours of Physical Restraint Use
0641	HBIPS-3	Hours of Seclusion Use
N/A	FAPH	Follow-Up After Psychiatric Hospitalization
1659	IMM-2	Influenza Immunization
N/A*	SUB-2 and SUB-2a	Alcohol Use Brief Intervention Provided or Offered and SUB-2a Alcohol Use Brief Intervention
N/A*	SUB-3 and SUB-3a	Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge
N/A*	TOB-3 and TOB-3a	Tobacco Use Treatment Provided or Offered at Discharge and TOB-3a Tobacco Use Treatment at Discharge
N/A*	N/A	Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
N/A	N/A	Screening for Metabolic Disorders
2860	N/A	Thirty-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility
3205	Med Cont.	Medication Continuation Following Inpatient Psychiatric Discharge
N/A	N/A	Modified COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP)[1]

* Measure is no longer endorsed by the CBE but was endorsed at the time of adoption. We note that although section 1886(s)(4)(D)(i) of the Act generally requires measures specified by the Secretary be endorsed by the entity with a contract under section 1890(a) of the Act, section 1886(s)(4)(D)(ii) states that in the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a) of the Act, the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary. We attempted to find available measures for each of these clinical topics that have been endorsed or adopted by a consensus organization and found no other feasible and practical measures on the topics for the IPF setting.

We are modifying the COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP) measure in section VI.E of this final rule.

3. IPFQR Program Measures for the FY 2026 Payment Determination

The measure set for FY 2026 payment determination and subsequent years will include 13 mandatory and two voluntary measures. This includes the 12 mandatory measures listed in Table 21 of this final rule for the FY 2025 payment determination and subsequent years, as well as the one mandatory measure and two voluntary measures we adopted for the FY 2026 payment determination and subsequent years. The measures which will be in the program for FY 2026 payment determination are shown Table 22.

TABLE 22: IPFQR PROGRAM MEASURE SET FOR THE FY 2026 PAYMENT DETERMINATION

CBE #	Measure ID	Measure
Mandatory **Measures**		
0640	HBIPS-2	Hours of Physical Restraint Use
0641	HBIPS-3	Hours of Seclusion Use
N/A	FAPH	Follow-Up After Psychiatric Hospitalization
1659	IMM-2	Influenza Immunization
N/A*	SUB-2 and SUB-2a	Alcohol Use Brief Intervention Provided or Offered and SUB-2a Alcohol Use Brief Intervention
N/A*	SUB-3 and SUB-3a	Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge
N/A*	TOB-3 and TOB-3a	Tobacco Use Treatment Provided or Offered at Discharge and TOB-3a Tobacco Use Treatment at Discharge
N/A*	N/A	Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
N/A	N/A	Screening for Metabolic Disorders
2860	N/A	Thirty-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility
3205	Med Cont.	Medication Continuation Following Inpatient Psychiatric Discharge
N/A	N/A	Modified COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP)[1]
N/A	Facility Commitment	Facility Commitment to Health Equity[2]
Voluntary Measures		
N/A	Screening for SDOH	Screening for Social Drivers of Health[3]
N/A	Screen Positive	Screen Positive Rate for Social Drivers of Health[4]

* Measure is no longer endorsed by the CBE but was endorsed at time of adoption. We note that although section 1886(s)(4)(D)(i) of the Act generally requires measures specified by the Secretary be endorsed by the entity with a contract under section 1890(a) of the Act, section 1886(s)(4)(D)(ii) states that in the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a) of the Act, the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary. We attempted to find available measures for each of these clinical topics that have been endorsed or adopted by a consensus organization and found no other feasible and practical measures on the topics for the IPF setting.

[1] We are modifying the COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP) measure in section VI.E. of this final rule.

[2] We have adopted the Facility Commitment measure in section VI.D.2. of this final rule.

[3] We have adopted voluntary reporting of the Screening for SDOH measure in section VI.D.3. of this final rule.

[4] We have adopted voluntary reporting of the Screen Positive Rate for SDOH measure in section VI.D.4 of this final rule.

4. IPFQR Program Measures for the FY 2027 IPFQR Program's Payment Determination

The measure set for the FY 2027 payment determination and subsequent years, will include 15 mandatory measures and one voluntary measure. This includes the 13 mandatory measures listed in Table 22 of this final rule for the FY 2026 payment determination and subsequent years, as well as the two measures which we are requiring for the FY 2027 payment determination and subsequent years. It also includes the one new voluntary measure adopted in section VI.D.5 of this final rule. The measures which we are finalizing for the FY 2027 payment determination and subsequent years are shown Table 23.

TABLE 23: IPFQR PROGRAM MEASURE SET FOR THE FY 2027 PAYMENT DETERMINATION

CBE #	Measure ID	Measure
Required Measures		
0640	HBIPS-2	Hours of Physical Restraint Use
0641	HBIPS-3	Hours of Seclusion Use
N/A	FAPH	Follow-Up After Psychiatric Hospitalization
1659	IMM-2	Influenza Immunization
N/A*	SUB-2 and SUB-2a	Alcohol Use Brief Intervention Provided or Offered and SUB-2a Alcohol Use Brief Intervention
N/A*	SUB-3 and SUB-3a	Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge
N/A*	TOB-3 and TOB-3a	Tobacco Use Treatment Provided or Offered at Discharge and TOB-3a Tobacco Use Treatment at Discharge
N/A*	N/A	Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
N/A	N/A	Screening for Metabolic Disorders
2860	N/A	Thirty-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility
3205	Med Cont	Medication Continuation Following Inpatient Psychiatric Discharge
N/A	N/A	Modified COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP)[1]
N/A	Facility Commitment	Facility Commitment to Health Equity[2]
N/A	Screening for SDOH	Screening for Social Drivers of Health[3]
N/A	Screen Positive	Screen Positive Rate for Social Drivers of Health[4]
Voluntary Measure		
N/A	PIX	Psychiatric Inpatient Experience Survey[5]

* Measure is no longer endorsed by the CBE but was endorsed at time of adoption. Although section 1886(s)(4)(D)(i) of the Act generally requires that any measures specified by the Secretary must be endorsed by the entity with a contract under section 1890(a) of the Act, section 1886(s)(4)(D)(ii) states that in the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a) of the Act, the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary. We attempted to find available measures for each of these clinical topics that have been endorsed or adopted by a consensus organization and found no other feasible and practical measures on the topics for the IPF setting.

[1] We are modifying the COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP) measure in section VI.E. of this final rule.

[2] We have adopted the Facility Commitment measure in section VI.D.2. of this final rule.

[3] We have adopted the Screening for SDOH measure in section VI.D.3. of this final rule.

[4] We have adopted the Screen Positive measure in section VI.D.4. of this final rule.

[5] We have adopted voluntary reporting of the Psychiatric Inpatient Experience (PIX) survey measure for the FY 2027 payment determination in section VI.D.5. of this final rule

5. IPFQR Program Measures for the FY 2028 Payment Determination

The measure set for the FY 2028 payment determination and subsequent years will include 16 mandatory measures. This includes the 15 mandatory measures listed in Table 23 of this final rule for the FY 2027 payment determination as well as the measure which we finalized beginning with the FY 2028 payment determination. The measures which will be in the program beginning with the FY 2028 payment determination are shown Table 24.

TABLE 24: IPFQR PROGRAM MEASURE SET FOR THE FY 2029 PAYMENT DETERMINATION

CBE #	Measure ID	Measure
0640	HBIPS-2	Hours of Physical Restraint Use
0641	HBIPS-3	Hours of Seclusion Use
N/A	FAPH	Follow-Up After Psychiatric Hospitalization
1659	IMM-2	Influenza Immunization
N/A*	SUB-2 and SUB-2a	Alcohol Use Brief Intervention Provided or Offered and SUB-2a Alcohol Use Brief Intervention
N/A*	SUB-3 and SUB-3a	Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge
N/A*	TOB-3 and TOB-3a	Tobacco Use Treatment Provided or Offered at Discharge and TOB-3a Tobacco Use Treatment at Discharge
N/A*	N/A	Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
N/A	N/A	Screening for Metabolic Disorders
2860	N/A	Thirty-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility
3205	Med Cont	Medication Continuation Following Inpatient Psychiatric Discharge
N/A	N/A	Modified COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP)[1]
N/A	Facility Commitment	Facility Commitment to Health Equity[2]
N/A	Screening for SDOH	Screening for Social Drivers of Health[3]
N/A	Screen Positive	Screen Positive Rate for Social Drivers of Health[4]
N/A	PIX	Psychiatric Inpatient Experience Survey[5]

* Measure is no longer endorsed by the CBE but was endorsed at time of adoption. Although section 1886(s)(4)(D)(i) of the Act generally requires that any measures specified by the Secretary must be endorsed by the entity with a contract under section 1890(a) of the Act, section 1886(s)(4)(D)(ii) states that in the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a) of the Act, the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary. We attempted to find available measures for each of these clinical topics that have been endorsed or adopted by a consensus organization and found no other feasible and practical measures on the topics for the IPF setting.

[1] We are modifying the COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP) measure in section VI.E. of this final rule.
[2] We have adopted the Facility Commitment measure in section VI.D.2. of this final rule.
[3] We have adopted the Screening for SDOH measure in section VI.D.3. of this final rule.
[4] We have adopted the Screen Positive measure in section VI.D.4. of this final rule.

[5] We have adopted mandatory reporting of the Psychiatric Inpatient Experience (PIX) survey measure for FY 2028 payment determination in section VI.D.5. of this final rule

H. Public Display and Review Requirements

In the FY 2013 IPPS/LTCH PPS final rule (77 FR 53653 through 53654), we adopted procedures for making data submitted under the IPFQR Program available to the public, after an IPF has the opportunity to review such data prior to public display, as required by section 1886(s)(4)(E) of the Act. We adopted modifications to these procedural requirements in the FY 2014 IPPS/LTCH PPS final rule (78 FR 50897 through 50898), and the FY 2017 IPPS/LTCH PPS final rule (81 FR 57248 through 57249).

Specifically, the IPFQR Program adopted a policy to provide IPFs a 30-day period to review their data, and submit corrections to errors resulting from CMS calculations, prior to public display on a CMS website. The IPFQR Program notifies IPFs of the exact timeframes for this preview period and public display through subregulatory guidance. We did not propose any changes to these requirements.

We proposed to codify the procedural requirements for public reporting of IPFQR Program data at § 412.433(g). If finalized, paragraph (g) would provide that IPFs will have a period of 30 days

to review data on quality measures that CMS received under the IPFQR Program, and submit corrections to errors resulting from CMS calculations, prior to CMS publishing this data on a CMS website.

We welcomed comments on our proposal to codify these policies.

We did not receive any comments on this proposal.

Final Decision: We are finalizing codification of these policies.

I. Form, Manner, and Timing of Quality Data Submission for the FY 2024 Payment Determination and Subsequent Years

1. Procedural Requirements for the FY 2024 Payment Determination and Subsequent Years

We refer readers to the FY 2013 IPPS/LTCH PPS final rule (77 FR 53654 through 53655), the FY 2014 IPPS/LTCH PPS final rule (78 FR 50898 through 50899), the FY 2018 IPPS/LTCH PPS final rule (82 FR 38471 through 38472), and the FY 2022 IPF PPS final rule (86 FR 42656 through 42657) for our previously finalized procedural requirements for participation in, and withdrawal from, the IPFQR Program, as well as data submission requirements. We did not propose any changes to our previously finalized procedural requirements.

We proposed to codify these procedural requirements for participation in the IPFQR Program at § 412.433(b) through (d). Paragraphs (b) through (d) will set forth the procedural requirements for an IPF to register for, or withdraw from, participation in the IPFQR Program and to submit the required data on measures in a form and manner and time specified by CMS.

We welcomed comments on our proposal to codify these policies.

We did not receive any comments on this proposal.

Final Decision: We are finalizing codification of the procedural requirements for participation in the IPFQR Program at § 412.433(b) through (d). We are finalizing the regulation text as proposed except to replace references to ''QualityNet'' with ''CMS-designated information system'' and update the description of the registration process because we inadvertently referred to QualityNet in the proposed rule. We have migrated to a new internet system for many quality reporting programs, and we use the term ''CMS-designated information system'' to refer both to that system and any future updates to it.

2. Data Submission Requirements for the FY 2025 Payment Determination and Subsequent Years

We refer readers to the FY 2013 IPPS/LTCH PPS final rule (77 FR 53655 through 53657), the FY 2014 IPPS/LTCH PPS final rule (78 FR 50899 through 50900), the FY 2018 IPPS/LTCH PPS final rule (82 FR 38472 through 38473), and the FY 2022 IPF PPS final rule (86 FR 42657 through 42661) for our previously finalized data submission requirements.

The measure we are modifying beginning with the FY 2025 payment determination—the COVID–19 Vaccination Coverage Among HCP measure—requires facilities to report data on the number of HCP who have received a complete vaccination course of a COVID–19 vaccine through the Centers for Disease Control and Prevention's (CDC's) National Healthcare Safety Network (NHSN). We are updating this measure to no longer refer to ''complete vaccination course'' but instead to refer to ''up-to-date'' vaccination, as described in section VI.E. of this final rule.

We did not propose any updates to the form, manner, and timing of data submission for the COVID–19 Vaccination Coverage Among HCP measure and refer readers to the FY 2022 IPF PPS final rule (86 FR 42657) for these policies.

3. Data Submission Requirements for the FY 2026 Payment Determination and Subsequent Years

In sections VI.D 3 and VI.D.4 of this final rule, we are adopting measures for voluntary reporting for the FY 2026 IPFQR Program and mandatory reporting for the FY 2027 IPFQR Program's payment determination and subsequent years. These measures are the Screening for Social Drivers of Health measure and Screen Positive Rate for Social Drivers of Health measure. We proposed that our previously finalized data submission requirements, specifically, our previously finalized data submission requirements for aggregate data reporting described in the FY 2018 IPPS/LTCH PPS final rule (82 FR 38472 through 38473) would apply to these measures.

We invited public comment on our proposal.

We did not receive any public comments on this proposal.

Final Decision: We are finalizing our proposal for data submission requirements for the FY 2026 payment determination and subsequent years.

4. Data Submission Requirements for the FY 2027 Payment Determination and Subsequent Years

In section VI.D.5. of this final rule, we are adopting one patient-reported measure, Psychiatric Inpatient Experience (PIX) measure for voluntary reporting beginning with the CY 2025 performance period (the data for which will be submitted to CMS during CY 2026) and mandatory reporting beginning with the FY 2028 payment determination (that is, data from the CY 2026 performance period submitted to CMS during CY 2027). Because, unlike other patient experience of care measures, this measure is collected by facilities prior to discharge, we proposed that facilities would report these data using the patient-level data reporting described in the FY 2022 IPF PPS final rule (86 FR 42658 through 42661).

We invited public comment on our proposal.

We did not receive any public comments on this proposal.

Final Decision: We are finalizing our proposal for data submission requirements for the FY 2027 payment determination and subsequent years. We note that reporting these data will be voluntary for the FY 2027 payment determination and will be mandatory beginning with the FY 2028 payment determination.

5. Data Validation Pilot Beginning With Data Submitted in CY 2025

As discussed in the FY 2019 IPF PPS final rule (83 FR 28607) and in the FY 2022 IPF PPS final rule (86 FR 42661), we are concerned that the ability to detect error is lower for aggregate measure data reporting than for patient-level data reporting (that is, data regarding each patient included in a measure and, for example, whether the patient was included in the numerator and denominator of the measure). In the FY 2022 IPF PPS final rule, we noted that adoption of patient-level data requirements would enable us to adopt a data validation policy for the IPFQR Program in the future (86 FR 42661). We believe that it would be appropriate to develop such a policy incrementally through adoption of a data validation pilot prior to national implementation of data validation within the IPFQR Program. We sought public input on a potential data validation pilot, and many commenters supported the concept of data validation following implementation of patient-level reporting (86 FR 42661). In the FY 2022 IPF PPS final rule, we adopted mandatory patient-level reporting

beginning with data submitted in CY 2023 affecting the FY 2024 payment determination and reflecting care provided during CY 2022 (86 FR 42658 through 42661).

We are now finalizing a data validation pilot beginning with data submitted in CY 2025 (reflecting care provided during CY 2024). When we sought public comment on a data validation pilot in the FY 2022 IPF PPS proposed rule (86 FR 19515), we requested input on potential elements of such a pilot, including the number of measures and the number of participating IPFs. As summarized in the FY 2022 IPF PPS final rule (86 FR 42661), one commenter recommended selecting two measures and 200 IPFs for this pilot. We considered that recommendation; however, to align with validation policies in our other quality reporting programs, we decided to request a specific number of charts. Specifically, we proposed to request eight charts per quarter from each IPF as opposed to requesting all of the charts that each facility used to calculate one or more specific measures. We also decided to initiate our pilot with fewer IPFs than the commenter recommended to limit the burden associated with this pilot.

We also reviewed the validation policies of other quality reporting programs. We specifically reviewed the Hospital IQR Program's chart-abstracted measure validation policies described in the FY 2017 IPPS/LTCH PPS final rule (81 FR 57179 through 57180), the Hospital IQR Program's pilot for eCQM validation described in the FY 2015 IPPS/LTCH PPS final rule (79 FR 50262 through 50273), the Hospital Outpatient Quality Reporting (OQR) Program's planned pilot of data validation as described in the CY 2009 OPPS/ASC final rule (73 FR 68502), and the Hospital OQR Program's finalized validation policies as described in the CY 2012 OPPS/ASC final rule (76 FR 74485) and the CY 2018 OPPS/ASC final rule (82 FR 59441 through 5944) because these programs are also pay-for-reporting programs, like the IPFQR Program.

Following our review of the validation policies within these programs, we proposed a validation pilot in which we would randomly select on an annual basis up to 100 IPFs and request each selected IPF to provide to CMS eight charts per quarter, a total of 32 charts per year, used to calculate all chart-based measures beginning with data submitted in CY 2025. We believe that randomly selecting up to 100 IPFs would provide a sufficiently large set of IPFs to meaningfully test our validation procedures while minimizing burden for IPFs. We will specify the timeline and mechanism for submitting data in our data requests to individual IPFs that have been selected to participate in the validation pilot. We note that consistent with the Hospital IQR Program, we will reimburse IPFs for the cost of submitting charts for validation at a rate of $3.00 per chart (85 FR 58949).

Because this is a voluntary pilot, we recognize that some selected IPFs will not participate; however, we believe that this pilot would be beneficial for IPFs that do participate as an opportunity to receive education and feedback on the data they submit prior to future proposal and adoption of a validation requirement in the IPFQR Program.

We invited comments on our proposal.

Comment: Several commenters expressed support for the data validation pilot.

Response: We thank these commenters for their support.

Comment: Several commenters provided recommendations for the data validation pilot. One commenter suggested allowing participants to opt into the pilot as opposed to selecting potential participants. One commenter requested that CMS ensure that the individuals doing the data validation have clinical expertise in the psychiatric setting to ensure appropriate interpretation of data. Another commenter recommended that CMS complete the pilot and analyze the data generated by the pilot prior to proposing and adopting a full data validation program.

Response: We thank these commenters for their input. We note that the data validation pilot described in this section is based on validation programs in other quality reporting programs. We believe that selecting IPFs to participate will allow us to test our processes for selection and notification and therefore we believe that this will be a more effective test than allowing IPFs to opt into the pilot. We note that participation in the data validation pilot will be voluntary for the IPFs which we select. We will consider recommendations for qualifications for personnel to perform the data validation and for analysis of the results as we implement this program. We believe it is appropriate to develop a data validation policy incrementally through adoption of a data validation pilot prior to national implementation of data validation within the IPFQR Program. We intend to analyze data collected through this data validation pilot to inform development of a future nationally implemented data validation program. We note that while we will analyze data collected through the data validation pilot in developing the program for national implementation, the pilot will be ongoing until national implementation so that we can continue to collect data and IPFs can continue to receive education and feedback on the data they submit.

Comment: One commenter expressed that a data validation pilot with payment ramifications is premature because patient-level data submission is still new to the IPFQR Program, because CMS has not sufficiently defined the pilot elements, and because it is unclear that there would be auditors with sufficient clinical expertise. Another commenter recommended that CMS use the data in the future IPF patient assessment instrument (PAI) to validate quality measure data. Another commenter recommended postponing this pilot until the financial and staffing shortages caused by the COVID–19 pandemic have been resolved.

Response: We note that the participation in the data validation pilot is voluntary, and that IPFs will not receive any payment penalties during the data validation program's pilot period. With respect to the future IPF PAI, we will consider the potential interplay between data elements included in the PAI and IPFQR Program quality measure data for validation purposes, but believe those considerations are premature as a PAI has not yet been implemented for the IPF setting. Finally, we recognize that healthcare providers, including IPFs, are still recovering from the effects of the COVID–19 pandemic, but note that participation in the data validation pilot is voluntary.

Comment: One commenter stated that the reimbursement rate of $3.00/chart is insufficient to cover the time and materials associated with participating in the pilot.

Response: We understand the commenters concern that $3.00/chart may not cover the time and materials associated with participating in the pilot. We note that this reimbursement is consistent with the reimbursement rates for submitting charts for validation in other quality reporting programs. However, we intend to use the pilot program to identify potential modifications prior to adopting a full validation program. We will consider the appropriateness of our reimbursement at that time.

Final Decision: After consideration of the public comments we received, we are finalizing our data validation pilot as proposed.

6. Quality Measure Sampling Requirements

We refer readers to the FY 2013 IPPS/LTCH PPS final rule (77 FR 53657 through 53658), the FY 2014 IPPS/LTCH PPS final rule (78 FR 50901 through 50902), the FY 2016 IPF PPS final rule (80 FR 46717 through 46719), and the FY 2019 IPF PPS final rule (83 FR 38607 through 38608) for discussions of our previously finalized sampling policies.

Because the Facility Commitment to Health Equity measure proposed in section VI.D.2 of this final rule is a structural attestation measure, these policies do not apply to that measure. Additionally, because the Screening for Social Drivers of Health measure (described in section VI.D.3 of this final rule) applies to all patients and the Screen Positive Rate for Social Drivers of Health measure (described in section VI.D.4 of this final rule) applies to all patients who have been screened for health-related social needs (HRSNs), our previously finalized sampling policies would not apply to these two measures. As described in the FY 2022 IPF PPS final rule, our sampling policies do not apply to the COVID–19 Vaccination Coverage Among Healthcare Personnel measure because the denominator is all healthcare personnel (86 FR 42661).

Generally, we have applied our sampling procedures to chart-abstracted measures, where appropriate (that is, where the measure does not require application to the entire patient population). However, because the PIX survey measure is a patient reported measure, we have considered whether our sampling procedures for chart-abstracted measures are appropriate for this measure. After consideration of our current sampling procedures and sampling for patient reported measures in other quality reporting programs (specifically, the requirements for reporting the HCAHPS measure), we proposed that the PIX survey measure (described in section VI.D.5 of this final rule) would be eligible for sampling but would not be included in the global sample. Instead, we proposed that sampling for this measure would align with sampling for the HCAHPS survey measure in acute care hospitals and the Hospital IQR Program as described in the HCAHPS Quality Assurance Guidelines.[254] Specifically, we proposed to require IPFs to develop sampling plans that ensure that IPFs are able to submit data for 300 completed PIX surveys per year. IPFs will be required to sample from every month throughout the entire reporting period and not stop sampling or curtail ongoing interview activities once a certain number of completed surveys has been attained. IPFs that are unable to reach 300 completed surveys through sampling will be required to submit data on survey results for all eligible patient discharges.

We invited public comment on our proposal.

Comment: One commenter recommended allowing facilities to apply their sampling methodologies to the Screening for Social Drivers of Health measure and the Screen Positive Rate for Social Drivers of Health measure to reduce burden.

Response: We acknowledge that applying sampling methodologies for these two measures would impact abstraction and reporting burden. We have proposed these measures to align with other quality reporting and value-based purchasing programs (specifically, the Hospital IQR Program) as well as the same measure proposals for the PPS-Exempt Cancer Hospital Quality Reporting Program in the FY 2024 IPPS/LTCH PPS proposed rule (88 FR 27122 through 27130) and the End-Stage Renal Disease (ESRD) Quality Incentive Program in the CY 2024 ESRD Prospective Payment System proposed rule (88 FR 42509 through 42518). We note that the Hospital IQR Program adopted these two measures without sampling in the FY 2023 IPPS/LTCH PPS final rule (87 FR 49191 through 49220). We believe that adopting these measures consistently across programs will increase the cross-setting comparability of measure results for the Screening for Social Drivers of Health measure; provide more information regarding community needs for specific communities that are served by multiple healthcare organizations for the Screen Positive Rate for Social Drivers of Health measure; and ensure that we are consistently conveying the importance of identifying and addressing HRSNs across all settings.

Comment: Several commenters recommended that CMS establish a statistically valid random sampling process for all IPFs to apply for the PIX survey measure to ensure that selection bias does not occur.

Response: We will provide updated guidance for developing sampling plans and other implementation guidance for the PIX survey measure. This guidance will align with sampling guidance for the HCAHPS measure in the Hospital IQR Program.

Comment: One commenter requested clarification regarding whether all patients would be eligible for inclusion in the sample for the PIX survey measure or only Medicare patients.

Response: To the extent feasible we believe that it is important to include all patients in our quality reporting measures. While some measures do not allow inclusion of all patients (specifically, measures abstracted from Medicare claims data); there are no feasibility issues which require the PIX survey measure to be limited to patients covered by any specific payer. Therefore, all patients, regardless of payer, are included in the population from which the sample for this measure is selected.

Comment: One commenter requested clarification regarding whether IPFs that were unable to reach 300 completed surveys would be penalized.

Response: IPFs that are unable to reach 300 completed PIX surveys because of the size or characteristics of their patient population should submit data on all eligible patients. IPFs that meet this requirement would not be penalized for not submitting data on 300 completed PIX surveys.

Final Decision: We are finalizing our proposals related to sampling for the newly adopted measures.

7. Non-Measure Data Collection

We refer readers to the FY 2015 IPF PPS final rule (79 FR 45973), the FY 2016 IPF PPS final rule (80 FR 46717), and the FY 2019 IPF PPS final rule (83 FR 38608) for our previously finalized non-measure data collection policies. We did not propose any changes to these policies.

8. Data Accuracy and Completeness Acknowledgement (DACA) Requirements

We refer readers to the FY 2013 IPPS/LTCH PPS final rule (77 FR 53658) for our previously finalized DACA requirements. We did not propose any changes to these policies.

J. Reconsideration and Appeals Procedures

We refer readers to 42 CFR 412.434 for the IPFQR Program's reconsideration and appeals procedures. We did not propose any changes to these policies.

K. Extraordinary Circumstances Exceptions (ECE) Policy

We refer readers to the FY 2013 IPPS/LTCH PPS final rule (77 FR 53659 through 53660), the FY 2014 IPPS/LTCH PPS final rule (78 FR 50903), the FY 2015 IPF PPS final rule (79 FR 45978), and the FY 2018 IPPS/LTCH PPS final rule (82 FR 38473 through 38474) for our previously finalized Extraordinary

[254] HCHAPS Quality Assurance Guidelines, Version 17.0. March 2022. Available at: *https://hcahpsonline.org/globalassets/hcahps/quality-assurance/2022_qag_v17.0.pdf.*

Circumstances Exceptions policies. We did not propose any changes to these policies.

We proposed to codify the ECE policies at § 412.433(f). As finalized, paragraph (f) provides that we may grant an exception to one or more data submission deadlines and requirements in the event of extraordinary circumstances beyond the control of the IPF either in response to a request by the IPF or at our discretion if we determine an extraordinary circumstance occurred.

We solicited comments on our proposal to codify these policies.

We did not receive any comments on this proposal.

Final Decision: We are finalizing our proposal to codify these policies.

VII. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501 *et seq.*), we are required to provide 30-day notice in the **Federal Register** and solicit public comment before a ''collection of information'' requirement is submitted to the Office of Management and Budget (OMB) for review and approval. For the purposes of the PRA and this section of the preamble, collection of information is defined under 5 CFR 1320.3(c) of the PRA's implementing regulations.

To fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the PRA requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

Our April 10, 2023 (88 FR 21238) proposed rule solicited public comment on each of the aforementioned issues for the following sections of the rule that contained information collection requirements beginning in CY 2024 through CY 2027. A summary of these comments and our responses is in section VII.C of this final rule. The remaining provisions are not associated with any information collection requirements. In that regard they are not subject to the requirements of the PRA and are not addressed under this section of the preamble. For this rule's full burden implications, please see the Regulatory Impact Analysis under section VIII of this final rule.

A. Wage Estimates

To derive average costs for this FY 2024 IPF PPS final rule, we used data from the U.S. Bureau of Labor Statistics' (BLS') May 2021 National Occupational Employment and Wage Estimates for all salary estimates (*https://www.bls.gov/oes/2021/may/oes292072.htm*). In this regard, Table 25 presents BLS' median hourly wage for Medical Records Specialists [255] (the occupation title that we have estimated is appropriate for completing data collection and reporting under the IPFQR Program), our estimated cost of fringe benefits and other indirect costs (calculated at 100 percent of salary), and our adjusted hourly wage.

TABLE 25: WAGE ASSUMPTIONS FOR THE IPFQR PROGRAM

Occupation Title	Occupation Code	Median Hourly Wage ($/hour)	Fringe Benefits and Other Indirect Costs ($/hour)	Adjusted Hourly Wage ($/hour)
Medical Records Specialists	29-2072	22.43	22.43	44.86

As indicated, we are adjusting our hourly wage estimates by a factor of 100 percent. This is necessarily a rough adjustment, both because fringe benefits and other indirect costs vary significantly from employer to employer, and because methods of estimating these costs vary widely from study to study. Nonetheless, we believe that doubling the hourly wage to estimate the total cost is a reasonably accurate estimation method.

In the FY 2022 IPF PPS final rule (86 FR 42662), which was the most recent rule in which we adopted updates to the IPFQR Program, we estimated that reporting measures for the IPFQR Program could be accomplished by a Medical Records and Health Information Technician (BLS Occupation Code: 29–2072) with a median hourly wage of $20.50/hour (BLS, May 2019). We note that since the publication of the FY 2022 IPF PPS final rule, the BLS occupation category of 'Medical Records and Health Information Technician (BLS Occupation Code: 29–2071)' has been replaced with 'Medical Records Specialist (BLS Occupation Code: 29–2072). Therefore, in the FY 2024 IPF PPS proposed rule, we proposed to adjust our cost estimates using BLS' May 2021 median wage rate figure of $22.43/hour, an increase of $1.93/hour ($22.43/hour–$20.50/hour). When factoring in our overhead and other indirect cost adjustments, the wage is increased by $3.86/hour ($44.86/hour–$41.00/hour).

We have also estimated the average hourly cost for patients undertaking administrative and other tasks on their own time. Based on recommendations from the Valuing Time in U.S. Department of Health and Human Services Regulatory Impact Analyses [256] guidance we have estimated a post-tax wage of $20.71/hr. The Valuing Time in U.S. Department of Health and Human Services Regulatory Impact Analyses: Conceptual Framework and Best Practices identifies the approach for valuing time when individuals undertake activities on their own time. To derive the costs for patients, a measurement of the usual weekly earnings of wage and salary workers of $998, divided by 40 hours to calculate an hourly pre-tax wage rate of $24.95/hour. This rate is adjusted downwards by an estimate of the effective tax rate for median income households of about 17 percent, resulting in the post-tax hourly wage rate of $20.71/hour. Unlike our State and private sector wage adjustments, we are not adjusting beneficiary wages for fringe benefits and other indirect costs since the individuals' activities, if any, will occur outside the scope of their employment.

[255] We have previously estimated that labor performed could be accomplished by Medical Records and Health Information Technician staff and note that this BLS occupation category has been replaced with Medical Records Specialists.

[256] *https://aspe.hhs.gov/sites/default/files/private/pdf/257746/VOT.pdf.*

B. Information Collection Requirements (ICRs) Regarding the IPFQR Program

The following changes will be submitted to OMB for approval under control number 0938–1171 (CMS–10432). We are not making changes to any of the data collection instruments that are currently approved under that control number. We are, however, adopting one new instrument, the Psychiatric Inpatient Experience survey, to calculate the patient experience of care measure described in section VI.D.5 of this final rule.

In section VII.B.1 of this final rule, we restate our currently approved burden estimates. In section VII.B.2 of this final rule, we estimate the changes in burden associated with the policies finalized in this rule and updated estimates for wage rates, facility counts, and case counts. Then in section VII.B.3 of this final rule, we provide an overview of the total estimated burden.

1. Currently Approved Burden

For a detailed discussion of the burden for the IPFQR Program requirements that we have previously adopted, we refer readers to the FY 2022 IPF PPS final rule (86 FR 42661 through 42672).

Table 26 provides an overview of our currently approved burden estimates.

TABLE 26: CURRENTLY APPROVED BURDEN
OMB CONTROL NUMBER 0938-1171 (CMS-10432)

Measure/ Response Description	# Respondents (Facilities)	Estimated Responses per Facility	Total Annual Responses	Time per Response (hours)	Annual Time per Facility (hours)	Total Annual Time (hours)	Total Annual Cost ($)
Hours of Physical Restraint Use	1,634	1,346	2,199,364	0.25	336.50	549,841	22,543,481
Hours of Seclusion Use	1,634	1,346	2,199,364	0.25	336.50	549,841	22,543,481
Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification	1,634	609*	995,106	0.25	152.25	248,776.5	10,199,836.50
Alcohol Use Brief Intervention Provided or Offered (SUB-2 and SUB-2a)	1,634	609*	995,106	0.25	152.25	248,776.5	10,199,836.50
Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and Alcohol and Other Drug Use Disorder Treatment at Discharge (SUB-3 and SUB-3a)	1,634	609*	995,106	0.25	152.25	248,776.5	10,199,836.50
Tobacco Use Treatment Provided or Offered and Tobacco Use Treatment (TOB-2 and TOB-2a)	1,634	609*	995,106	0.25	152.25	248,776.5	10,199,836.50
Tobacco Use Treatment Provided or Offered at Discharge and Tobacco Use Treatment at Discharge (TOB-3 and TOB-3a)	1,634	609*	995,106	0.25	152.25	248,776.5	10,199,836.50
Influenza Immunization	1,634	609*	995,106	0.25	152.25	248,776.5	10,199,836.50
Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	1,634	609*	995,106	0.25	152.25	248,776.5	10,199,836.50
Screening for Metabolic Disorders	1,634	609*	995,106	0.25	152.25	248,776.5	10,199,836.50
Thirty-day all-cause unplanned readmission following psychiatric hospitalization in an IPF	0	0**	0	0	0	0	0
Medication	0	0**	0	0	0	0	0

Measure/ Response Description	# Respondents (Facilities)	Estimated Responses per Facility	Total Annual Responses	Time per Response (hours)	Annual Time per Facility (hours)	Total Annual Time (hours)	Total Annual Cost ($)
Continuation Following Inpatient Psychiatric Discharge							
COVID-19 Vaccination Rate Among Healthcare Personnel	0	0***	0	0	0	0	0
Follow-Up After Psychiatric Hospitalization	0	0**	0	0	0	0	0
SUBTOTAL	1,634	7,564	12,359,576	N/A	1,891	3,089,894	126,685,654
Non-Measure Data Collection and Reporting	1,634	4	6,536	0.5	2.0	3,268	133,988
TOTAL	1,634	7,568	12,366,112	Varies	1,893	3,093,162	126,819,642

* Under our previously finalized "global sample" (80 FR 46717 through 46718) we allow facilities to apply the same sampling methodology to all measures eligible for sampling. In the FY 2016 IPF PPS final rule (80 FR 46718), we finalized that facilities with between 609 and 3,056 cases that choose to participate in the global sample would be mandatory to report data for 609 cases. Because facilities are only mandatory to submit data on a number specified by the global sampling methodology, rather than abstracting data for all patients or applying measure specific sampling methodologies, we believe that the number of cases under the global sample is a good approximation of facility burden associated with these measures. Therefore, for the average IPF discharge rate of 1,346 discharges the global sample requires abstraction of 609 records.

** CMS will collect these data using Medicare Part A and Part B claims; therefore, these measures will not require facilities to submit data on any cases.

*** The COVID-19 HCP measure will be calculated using data submitted to the CDC under a separate OMB control number (0920-1317).

2. Adjustments Due to Changes in This Final Rule

We are finalizing provisions that impact policies beginning with the FY 2025 through FY 2028 payment determinations. For the purposes of calculating burden, we attribute the costs to the year in which the costs begin. For example, data submission for the measures that affect the FY 2025 payment determination occurs during CY 2024 and generally reflects care provided during CY 2023. The following discussion describes the burden changes for policies attributed to the year in which the costs begin. For the policies in this final rule, those years are CY 2024 through CY 2027.

Additionally, in the FY 2022 IPF PPS final rule (86 FR 42661 through 42672), which is the most recent rule that updated the IPFQR Program policies, we estimated that there were 1,634 participating IPFs and that (for measures that require reporting on the entire patient population) these IPFs will report on an average of 1,346 cases per IPF. In this FY 2024 IPF PPS final rule, we are adjusting our IPF count and case estimates by using the most recent data available. Specifically, we estimate that there are now approximately 1,596 facilities (a decrease of 38 facilities) and an average of 1,261 cases per facility (a decrease of 85 cases per facility). We will update our estimates, as applicable, using these revised estimates in the following subsections.

a. Policies Affecting Data Reporting Beginning in CY 2023

In section VI.E. of this final rule, we are modifying the COVID–19 Vaccination Coverage Among Healthcare Personnel (HCP) measure beginning with data reflecting the fourth quarter of CY 2023 affecting the FY 2025 payment determination. We do not believe that this modification (that is, a change in terminology to refer to ''up-to-date'' instead of ''complete vaccination course'') will impact our currently approved IPF information collection requirements or burden estimates because the modified measure will be calculated using data already being submitted by IPFs to the CDC for healthcare safety surveillance under the CDC's OMB control number 0920–1317. In this regard, the CDC owns the requirements and burden that fall under that control number, including those of the COVID–19 Vaccination Coverage Among HCP measure.

b. Policies Affecting Burden Beginning With CY 2024

(1) Updates Affecting Facility Reporting Burden

In section VI.F.2 of this final rule, we are removing two measures beginning with the FY 2025 payment determination. Data for these measures would have been submitted in CY 2024, so we are estimating the reduced burden to occur in CY 2024. The two measures are:

- Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification (HBIPS–5); and
- Tobacco Use Treatment Provided or Offered and Tobacco Use Treatment (TOB–2 and TOB–2a).

Using our currently approved burden estimates as a baseline, the changes associated with removing these measures are: a decrease of 1,990,212 responses, a decrease of 497,553 hours, and a decrease of $20,339,673 as set forth in Table 27.

TABLE 27: UPDATES TO BURDEN ASSOCIATED WITH MEASURE REMOVALS

Measure/ Response Description	# Respondents (Facilities) (a)	Estimated Responses per Facility (b)	Total Annual Responses (c)=(a)x(b)	Time per Response (hours) (d)	Annual Time per Facility (hours) (e)=(b)x(d)	Total Annual Time (hours) (f)=(a)x(e)	Total Annual Cost ($) (g)=(f) x $41.00/hour
Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification	1,634	(609*)	(995,106)	0.25	(152.25)	(248,776.5)	(10,199,836.50)
Tobacco Use Treatment Provided or Offered and Tobacco Use Treatment (TOB-2 and TOB-2a)	1,634	(609*)	(995,106)	0.25	(152.25)	(248,776.5)	(10,199,836.50)
TOTAL	1,634	(1,218)	(1,990,212)	0.25	(304.5)	(497,553)	(20,339,673)

* Under our previously finalized "global sample" (80 FR 46717 through 46718) we allow facilities to apply the same sampling methodology to all measures eligible for sampling. In the FY 2016 IPF PPS final rule (80 FR 46718), we finalized that facilities with between 609 and 3,056 cases that choose to participate in the global sample will be required to report data for 609 cases. Because facilities are only required to submit data on a number specified by the global sampling methodology, rather than abstracting data for all patients or applying measure specific sampling methodologies, we believe that the number of cases under the global sample is a good approximation of facility burden associated with these measures. Therefore, for the average IPF discharge rate of 1,346 discharges the global sample requires abstraction of 609 records.

Additionally, we are applying our updated wage rate (from $41.00/hour to $44.86/hour), case count (from 1,346 to 1,261), and facility counts (from 1,634 to 1,596) to the remaining measure set and program requirements for data submission in CY 2024. See Table 28 and 29 for information on the effects of these updates. Specifically, we estimate that there are now approximately 1,596 facilities (a decrease of 38 facilities) and an average of 1,261 cases per facility (a decrease of 85 cases per facility). We also estimate a wage increase of $3.86/hour as described in section VI.A of this final rule. Our previous estimate shows that the two measures which do not allow sampling had 1,346 cases per measure and the six remaining measures which do allow sampling require 609 cases per measure per facility. We have estimated that these measures will take 0.25 hours per case. The effects of the updated hourly wage are set forth in Table 28.

TABLE 28: EFFECTS OF UPDATED HOURLY WAGE

Data collection type	Number of measures	Number of estimated cases per measure per facility	Total number of cases per facility	Effort per case (hours)	Total effort per facility (hours)	Change in cost per facility ($) (effort * 3.86/hour)
Non-sampling measures	2	1,346	2,692	0.25	673	2,597.78
Sampling measures	6	609	3,654	0.25	913.5	3,526.11
Non-Measure Data	1	4	4	0.5	2	7.72
Total Change per Facility						6,131.61

The remaining calculations will use the updated hourly wage to calculate the effects of other updates.

Our active burden estimates account for 1,346 cases for measures that do not allow sampling. Based on more recent data, we are updating our estimate for measures that do not allow sampling to 1,261 cases per IPF (a decrease of 85

cases for each of the 2 measures which do not allow sampling). This is equivalent to 138,890 cases across the 1,634 IPFs (85 cases × 1,634 IPFs) in our previous estimate for each measure. We are not changing our estimated case counts for measures that allow sampling. We continue to assume an average of 0.25 hours of effort per case. Therefore, this change in cases reflects a total annual effort of 42.5 hours per facility (2 measures * 85 cases per measure * 0.25 hours per case) at a cost of $1,907 (42.5 hours * $44.86/hour).

As indicated above we estimate a reduction of 38 facilities based on updated numbers. Table 29 shows the effects of this reduction in facilities on the reporting burden associated with each measure type.

TABLE 29: EFFECTS OF UPDATED FACILITY COUNTS

Measure Type	Number of Measures	Number of Estimated Cases (per measure per facility)	Cases per Facility	Effort per case	Effort per facility	Change in Annual Effort for removing 38 facilities (hours)	Change in Annual Effort for removing 38 facilities (dollars)
Non Sampling	2	1,261	2,522	0.25	630.5	(23,959)	(1,074,800.74)
Sampling	6	609	3,654	0.25	913.5	(34,713)	(1,557,225.18)
Non-Measure Data Collection	1	4	4	0.5	2	(76)	(3,409.36)
TOTAL	**9**	**Varies**	**6,180**	**Varies**	**1,546**	**(58,748)**	**(2,635,435.28)**

We note that at 6,180 cases per facility, removing 38 facilities from our estimate removes a total of 234,840 cases (6,180 cases per facility * 38 facilities).

The total effects of changes for the CY 2024 calendar year on our burden estimates are summarized in Table 30.

Table 30: Total CY 2024 Facility Information Collection Burden Changes

	Total Responses	Total Annual Time (hours)	Total Annual Cost ($)
Remove Two Measures (See Table 27)	(1,990,212)	(497,553)	(20,339,673)
Update Wage Estimate (See Table 28)	N/A	N/A	10,019,051
Update Case Estimate	(277,280)	(69,445)	(3,115,303)
Update Facility Estimate (See Table 29)	(234,840)	(58,748)	(2,635,435)
Total	**(2,502,332)**	**(625,746)**	**(16,071,360)**

(2) Updates Affecting Patient Survey Burden

In section VI.D.3 of this final rule, we are adopting the Screening for Social Drivers of Health measure beginning with a voluntary data submission in CY 2025 (reflecting care provided in CY 2024). IPFs will be able to collect data and report the measure via multiple methods, potentially including administrative claims data, electronic clinical data, standardized patient assessments, or patient-reported data and surveys. For additional information on these methods, we refer readers to section VI.D.3.c of this final rule. We believe that most IPFs will likely collect data during the patient intake process. Because this measure reflects care provided in CY 2024, the burden for administering the screening to patients will occur during CY 2024.

Under OMB Control Number 0938–1022 (CMS–10210) and the FY 2022 IPPS/LTCH PPS final rule (87 FR 49385 through 49386), the Hospital IQR Program, which adopted the Screening for Social Drivers of Health measure, estimates that it will take 2 minutes (0.033 hr) per patient to complete the selected screening instrument. The Hospital IQR Program also estimated that during the voluntary reporting period roughly 50 percent of hospitals will survey 50 percent of patients (87 FR 49385 through 49386).

We agree with these estimates and believe that a similar proportion of IPFs will participate in the voluntary reporting period. As described in section VII.A of this final rule, we estimate the cost of patients' time for completing surveys to be $20.71/hour. Using these estimates, we believe that during the voluntary reporting period the annual burden of surveying IPF patients will be 503,139 responses [(1,596 facilities × 50 percent of facilities) × (1,261 patients per facility × 50 percent of patients)], 16,604 hours (503,139 responses × 0.033 hours/response] at a cost of $343,869 (16,604 hours × $20.71/hour). These estimates are summarized in Table 31.

TABLE 31: TOTAL CY 2024 PATIENT SURVEY BURDEN CHANGES

	Total Responses	Total Annual Time (hours)	Total Annual Cost ($)
Screening for Social Drivers of Health	503,139	16,603.59	343,860.29

c. Policies Affecting Burden Beginning With CY 2025

(1) Updates Affecting Facility Reporting Burden

In section VI.I.5 of this final rule, we are adopting a data validation pilot for the IPFQR Program. Under this pilot we will reimburse hospitals directly for expenses associated with submission of charts for clinical process of care measure data validation. Because we will reimburse facilities directly for these expenses we do not believe that this pilot will increase information collection burden.

In section VI.D.2. of this final rule, we are adopting the Facility Commitment to Health Equity measure beginning with the FY 2026 payment determination. Data for this attestation measure will be submitted during CY 2025. Consistent with our burden estimate from the Hospital IQR Program, when we adopted the similar Hospital Commitment to Health Equity measure in the FY 2023 IPPS/LTCH PPS final rule, we estimated an average of 10 minutes per facility for a medical records specialist to collect and report this information (87 FR 49385). We recognize that some IPFs may take more than 10 minutes to collect this information, especially in the first year of reporting; however, we believe that many IPFs will require less than 10 minutes. In addition, we believe that many IPFs will be able to submit similar responses in future years. Using the estimate of 10 minutes (0.167 hour) per IPF per year at $44.86/hour for a medical records specialist, we estimate that this policy will result in a total annual burden increase of 267 hours (0.167 hours × 1,596 IPFs) at a cost of $11,956.63 (267 hours × $44.86/hour) across all participating IPFs.

In sections VI.D.3 and VI.D.4 of this final rule, we are adopting the Screening for Social Drivers of Health measure and the associated Screen Positive Rate for Social Drivers of Health measure beginning with a voluntary data submission in CY 2025 (reflecting care provided in CY 2024). We described our anticipated burden (16,604 hours at a cost of $343,869) for administering the screening in the previous section because this burden will accrue during CY 2024. The burden associated with reporting each of these measures to CMS will occur during CY 2025. We anticipate that the burden for reporting the two measures will be consistent with the burden for other web-based submissions, such as the Facility Commitment to Health Equity measure described previously in this section and for similar measures adopted in the Ambulatory Surgical Center Quality Reporting (ASCQR) Program (OMB control number 0938–1270; CMS–10530), which we have estimated to have a reporting burden of 10 minutes (0.167 hours) per facility. We note that for the voluntary reporting year we have estimated only 50 percent or 798 IPFs (1,596 IPFs × 0.50) will report these data. Therefore, we estimate the burden associated with reporting of each of these measures to be 133 hours (0.167 hr. × 798 IPFs) at a cost of $5,966 (133 hr. × $44.86/hour) for a medical records specialist) for the voluntary reporting period. These estimates are summarized in Table 32.

TABLE 32: TOTAL CY 2025 FACILITY INFORMATION COLLECTION BURDEN CHANGES

Measure/ Response Description	# Respondents (Facilities)	Estimated Responses per Facility	Total Annual Responses	Time per Response (hours)	Annual Time per Facility (hours)	Total Annual Time (hours)	Total Annual Cost ($)
Facility Commitment to Health Equity	1,596	1	1,596	0.167	0.167	267	11,978
Screening for Social Drivers of Health	798	1	798	0.167	0.167	133	5,966
Screen Positive Rate for Social Drivers of Health	798	1	798	0.167	0.167	133	5,966
Totals	1,596	3	3,192	0.167	0.167	534	23,911

(2) Updates Affecting Patient Survey Burden

Beginning with CY 2025, IPFs will need to screen 100 percent of their patients to prepare for mandatory reporting of the Screening for Social Drivers of Health measure in CY 2026 (for the FY 2027 payment determination). Therefore, we estimate that 100 percent of IPFs will screen 100 percent of their patients. We recognize that this may be an overestimate as some IPFs may choose not to participate and some patients may opt out of screening or be unable to provide responses; however, we believe that the numbers of IPFs and patients opting out will be relatively small and therefore 100 percent will be a reasonable approximation.

Using the facility counts (1,596 facilities), patient counts (1,261 patients per facility), average hourly earnings ($20.71/hour), and time per response (10 min or 0.033 hours) described previously, we estimate the burden of surveying IPF patients for health-related social needs (HRSNs) under the Screening for Social Drivers of Health and Screen Positive Rate for Social Drivers of Health measures will be 66,414 hours (1,596 facilities × 1,261 patients per facility × 0.033 hr) at a cost of $1,375,434 (66,414 hour × $20.71/hour) across all patients. We note that 16,604 hours and $343,960 of this burden was accounted for in our analysis of the burden of the voluntary reporting period described in section VII.B.2.c.(2). Therefore, the incremental burden of switching to mandatory reporting is 49,810 hours (66,414 hours–16,604 hours) and $1,031,474 ($1,375,434–$343,960).

Additionally, in section VI.D.5 of this final rule, we are adopting the Psychiatric Inpatient Experience (PIX) survey measure beginning with voluntary data submission in CY 2026. To prepare for data submission in 2026, IPFs will begin administering this survey in CY 2025. We believe 50 percent or 798 (1,596 facilities × 0.50) of IPFs would begin collecting these data for the voluntary data submission period. We note that we proposed to allow IPFs with more than 300 eligible discharges to sample, which would require these facilities to survey 300 patients. Because the questions on the PIX survey are similar in content and response options to the questions on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, we believe that it will take patients a similar amount of time to respond to these questions. In the Information Collection Request associated with OMB control number 0938–0981 (CMS–10102), we have estimated this time to be 7.25 minutes (0.121 hours).

Therefore, we believe that the burden associated with conducting the PIX survey in CY 2025 will be 28,967 hours (798 facilities × 300 patients/facility × 0.121 hours/response) at a cost of $599,907 (28,967 hours × $20.71/hour).

Our estimates for the CY 2025 total patient survey burden changes are summarized in Table 33.

TABLE 33: TOTAL CY 2025 PATIENT SURVEY BURDEN CHANGES

	Total Responses	Total Annual Time (hours)	Total Annual Cost ($)
Screening for Social Drivers of Health	1,509,417	49,811	1,031,580
PIX Survey	239,400	28,967	599,915
Totals	**1,748,817**	**78,778**	**1,631,496**

d. Policies Affecting Burden Beginning With CY 2026

(1) Updates Affecting Facility Reporting Burden

Beginning with CY 2026 data submission (affecting the FY 2027 payment determination), we estimate that 100 percent of IPFs will submit data on the Screening for Social Drivers of Health measure and Screen Positive Rate for Social Drivers of Health measure. Because we have already accounted for 50 percent of facilities submitting voluntary data on these measures, the incremental burden is the burden associated with the remaining 50 percent of facilities submitting data; that is, we estimate this burden to be 266 hours at a cost of $11,933. We also believe that 50 percent of facilities will submit data on the PIX survey measure for the voluntary reporting period in CY 2025. Because the data for this measure will require calculating an average of scores across a sample of patient surveys, we anticipate that the information collection and reporting burden for this measure will be approximately 15 minutes (0.25 hours) per patient for whom they are reporting data. The burden associated with reporting the Screening for Social Drivers of Health measure, the Screen Positive Rate for Social Drivers of Health measure, and the PIX survey measure to CMS is described in Table 34.

TABLE 34 TOTAL CY 2026 FACILITY INFORMATION COLLECTION BURDEN CHANGES

Measure/ Response Description	# Respondents (Facilities)	Estimated Responses per Facility	Total Annual Responses	Time per Response (hours)	Annual Time per Facility (hours)	Total Annual Time (hours)	Total Annual Cost ($)
Screening for Social Drivers of Health	798	1	798	0.167	0.167	133	5,978
Screen Positive Rate for Social `Drivers of Health	798	1	798	0.167	0.167	133	5.978
PIX Survey	798	300	239,400	0.25	75	59,850	2,684,871
Totals	**798**	**302**	**240,996**	**Varies**	**75.33**	**60,116**	**2,696,827**

(2) Updates Affecting Patient Survey Burden

Because reporting the PIX survey measure will be mandatory for the FY 2028 payment determination, the remaining 50 percent of facilities (those which did not participate in the voluntary reporting period) will begin surveying patients in CY 2026. To prepare for data submission of the PIX survey measure to CMS in CY 2027, IPFs that had not previously begun administering the PIX survey will begin administering this survey in CY 2026. The incremental burden of these 50 percent of facilities administering the survey will be equivalent to the burden associated with the 50 percent of facilities that participated in the voluntary reporting in CY 2025. These estimates are summarized in Table 35.

TABLE 35: TOTAL CY 2026 PATIENT SURVEY BURDEN CHANGES

	Total Responses	Total Annual Time (hours)	Total Annual Cost ($)
PIX Survey	239,400 (798 facilities x 300 responses/facility)	28,967 (239,400 responses x 0.121 hours/response)	599,915 (28,967 hours x $20.71/hour)

e. Policies Affecting Facility Reporting Burden Beginning With CY 2027

For data submission occurring in CY 2027, submission on the PIX survey measure will be mandatory, therefore, we believe that an additional 50 percent of facilities will report the measure (that is, the 50 percent of facilities not previously accounted for under the voluntary reporting period). Therefore, we estimate that the incremental increase in burden for IPFs associated with this requirement will be reporting by the 50 percent of facilities that had not previously reported the PIX survey measure. This burden is set forth in Table 36.

TABLE 36: TOTAL CY 2027 FACILITY INFORMATION COLLECTION BURDEN CHANGES

Measure/ Response Description	#Respondents (Facilities)	Estimated Responses per Facility	Total Annual Responses	Time per Response (hours)	Annual Time per Facility (hours)	Total Annual Time (hours)	Total Annual Cost ($)
PIX Survey	798	300	239,400 (798 facilities x 300 responses per facility)	0.25	75 (300 responses per facility x 0.25 hours/response)	59,850 (75 hours per facility * 798 facilities)	2,684,871 (59,850 hours x $44.86/hour)

3. Overall Burden Summary

Table 37 summarizes the incremental changes in burden for IPFs associated with policies for data collection and submission in CYs 2024 through 2027 as well as updates to our estimated wage rate, facility counts, and case counts.

TABLE 37: INCREMENTAL CHANGES IN FACILITY BURDEN

	Total Responses	**Total Annual Time (hours)**	**Total Annual Cost ($)**
Changes Associated with CY 2024 Updates	(2,502,832)	(625,746)	(16,131,359)
Changes Associated with CY 2025 Updates	3,192	534	23,911
Changes Associated with CY 2026 Updates	240,996	60,116	2,696,827
Changes Associated with CY 2027 Updates	239,400	59,850	2,684,871
Total	(2,018,244)	(505,246)	(10,725,750)

Table 38 summarizes the incremental changes in burden for patients due to data collection associated with proposed policies for data collection and submission in CYs 2024 through CY 2026.

TABLE 38: INCREMENTAL CHANGES IN SURVEY BURDEN FOR PATIENTS

	Total Responses	**Total Annual Time (hours)**	**Total Annual Cost ($)**
Changes Associated with CY 2024 Updates	503,139	16,604	343,860
Changes Associated with CY 2025 Updates	1,748,817	78,778	1,631,496
Changes Associated with CY 2026 Updates	239,400	28,967	599,915
Changes Associated with CY 2027 Updates	No changes	No changes	No changes
Totals	2,491,356	124,349	2,575,271

Table 39 summarizes the total annual change in burden associated with the IPFQR Program's finalized policies in this final rule. These figures are calculated by adding the annual changes in Table 37 with the annual changes in Table 38. We note that these figures represent the changes to our previously approved burden (set forth in Table 26 of this final rule).

TABLE 39: TOTAL ANNUAL CHANGES IN BURDEN ASSOCIATED WITH THE IPFQR PROGRAM

	Total Responses	Total Annual Time (hours)	Total Annual Cost ($)
CY 2024 Facility Changes	(2,502,832)	(625,746)	(16,131,359)
CY 2024 Patient Changes	503,139	16,604	343,860
CY 2024 Subtotal	*(1,999,693)*	*(609,142)*	*(15,787,499)*
CY 2025 Facility Changes	3,192	534	23,911
CY 2025 Patient Changes	1,748,817	78,778	1,631,496
CY 2025 Subtotal	*1,752,009*	*79,312*	*1,655,407*
CY 2026 Facility Changes	240,996	60,116	2,696,827
CY 2026 Patient Changes	239,400	28,967	599,915
CY 2026 Subtotal	*480,396*	*89,083*	*3,296,742*
CY 2027 Facility Changes	239,400	59,850	2,684,871
CY 2027 Patient Changes	0	0	0
CY 2027 Subtotal	*239,400*	*59,850*	*2,684,871*
Total	472,112	(380,897)	(8,150,479)

C. Comments Received on the Proposed Collection of Information Requirements

We solicited public comment on our estimated burden associated with the information collection requirements.

The following comments were received.

Comment: Several commenters expressed concern that the policies under the IPFQR Program will be burdensome, and some commenters specifically noted burden related to the PIX survey. One commenter expressed the belief that removing two measures while adopting four measures would increase overall burden.

Response: We understand commenters' concerns that some of the policies under the IPFQR Program may contribute to IPF reporting burden. With respect to the PIX survey, we do not believe that administering a patient experience of care survey will be unduly burdensome for the majority of IPFs that previously self-reported that they already administer such a survey when responding to the IPFQR Program's former Assessment of Patient Experience of Care measure. We recognize that there will be some non-recurring burden for these IPFs to transition to the newly adopted survey. With respect to the concern that removing two measures while adopting four measures would increase the overall burden, we note that the measures we are removing are chart-abstracted measures with high reporting burden. We estimate that the newly adopted measures require less time to calculate and report. Therefore, we believe that our estimate that the overall burden of the IPFQR Program will be decreased by these policies is accurate.

VIII. Regulatory Impact Analysis

A. Statement of Need

This rule finalizes updates to the prospective payment rates for Medicare inpatient hospital services provided by IPFs for discharges occurring during FY 2024 (October 1, 2023 through September 30, 2024). We are finalizing our proposal to apply a 2021-based IPF market basket increase for FY 2024 of 3.5 percent, less the productivity adjustment of 0.2 percentage point as required by 1886(s)(2)(A)(i) of the Act for a final total FY 2024 payment rate update of 3.3 percent. In this final rule, we are finalizing our proposal to update the outlier fixed dollar loss threshold amount, update the IPF labor-related share, and update the IPF wage index to reflect the FY 2024 hospital inpatient wage index. Section 1886(s)(3)(4) of the Act requires IPFs to report data in accordance with the requirements of the IPFQR Program for purposes of measuring and making publicly available information on health care quality, and links the quality data submission to the annual applicable percentage increase.

B. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), Executive Order 14094 entitled ''Modernizing Regulatory Review'' (April 6, 2023), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999), and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). The Executive Order 14094 entitled ''Modernizing Regulatory Review'' (hereinafter, the Modernizing E.O.) amends section 3(f)(1) of Executive Order 12866 (Regulatory Planning and Review). The amended section 3(f) of Executive Order 12866 defines a ''significant regulatory action'' as an action that is likely to result in a rule: (1) having an annual effect on the economy of $200 million or more in any 1 year (adjusted every 3 years by the Administrator of OIRA for changes in gross domestic product), 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,

territorial, or tribal governments or communities; (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising legal or policy issues for which centralized review would meaningfully further the President's priorities or the principles set forth in the order, as specifically authorized in a timely manner by the Administrator of OIRA in each case.

A regulatory impact analysis (RIA) must be prepared for major rules with significant regulatory action(s) and/or with significant effects as per section 3(f)(1) ($200 million or more in any 1 year). We estimate that the total impact of these changes for FY 2024 payments compared to FY 2023 payments will be a net increase of approximately $70 million. This reflects a $95 million increase from the update to the payment rates (+$100 million due to the FY 2024IPF market basket update of 3.5 percent, and −$5 million for the productivity adjustment of 0.2 percentage point), as well as a $25 million decrease as a result of the update to the outlier threshold amount. Outlier payments are estimated to change from 2.9 percent in FY 2023 to 2.0 percent of total estimated IPF payments in FY 2024.

Based on our estimates, OMB's Office of Information and Regulatory Affairs has determined that this rulemaking is not significant per section 3(f)(1) as measured by the $200 million threshold or more in any 1 year. Nevertheless, this rule is a major rule, and accordingly, we have prepared a Regulatory Impact Analysis that to the best of our ability presents the costs and benefits of the rulemaking. Therefore, OMB has reviewed this final regulation, and we have provided the following assessment of its impact.

C. Detailed Economic Analysis

In this section, we discuss the historical background of the IPF PPS and the impact of this final rule on the Federal Medicare budget and on IPFs.

1. Budgetary Impact

As discussed in the November 2004 and RY 2007 IPF PPS final rules, we applied a budget neutrality factor to the Federal per diem base rate and ECT payment per treatment to ensure that total estimated payments under the IPF PPS in the implementation period will equal the amount that would have been paid if the IPF PPS had not been implemented. This Budget neutrality factor included the following components: Outlier adjustment, stop loss adjustment, and the behavioral offset. As discussed in the RY 2009 IPF PPS notice (73 FR 25711), the stop-loss adjustment is no longer applicable under the IPF PPS.

As discussed in section III.D.1 of this final rule, we proposed to update the wage index and labor-related share in a budget neutral manner by applying a wage index budget neutrality factor to the Federal per diem base rate and ECT payment per treatment. Therefore, the budgetary impact to the Medicare program of this final rule will be due to the IPF market basket update for FY 2024 of 3.5 percent (see section IV.A.2 of this final rule) reduced by the productivity adjustment of 0.2 percentage point as required by section 1886(s)(2)(A)(i) of the Act and the update to the outlier fixed dollar loss threshold amount.

We estimate that the FY 2024 impact will be a net increase of $70 million in payments to IPF providers. This reflects an estimated $95 million increase from the update to the payment rates and a $25 million decrease due to the update to the outlier threshold amount to set total estimated outlier payments at 2.0 percent of total estimated payments in FY 2024. This estimate does not include the implementation of the mandatory 2.0 percentage point reduction of the productivity-adjusted IPF market basket update factor for any IPF that fails to meet the IPF quality reporting requirements (as discussed in section IV.B.2. of this final rule).

2. Impact on Providers

To show the impact on providers of the changes to the IPF PPS discussed in this final rule, we compare estimated payments under the proposed IPF PPS rates and factors for FY 2024 versus those under FY 2023. We determined the percent change in the estimated FY 2024 IPF PPS payments compared to the estimated FY 2023 IPF PPS payments for each category of IPFs. In addition, for each category of IPFs, we have included the estimated percent change in payments resulting from the final update to the outlier fixed dollar loss threshold amount; the updated wage index data including the final labor-related share; and the final IPF market basket update for FY 2024, as reduced by the final productivity adjustment according to section 1886(s)(2)(A)(i) of the Act.

To illustrate the impacts of the FY 2024 changes in this final rule, our analysis begins with FY 2022 IPF PPS claims (based on the 2022 MedPAR claims, March 2023 update). We estimate FY 2023 IPF PPS payments using these 2022 claims, the finalized FY 2023 IPF PPS Federal per diem base rates, and the finalized FY 2023 IPF PPS patient and facility level adjustment factors (as published in the FY 2023 IPF PPS final rule (87 FR 46846)). We then estimate the FY 2024 outlier payments based on these simulated FY 2023 IPF PPS payments using the same methodology that we used to set the initial outlier threshold amount in the RY 2007 IPF PPS final rule (71 FR 27072 and 27073), which is also the same methodology that we used to update the outlier threshold amounts for years 2008 through 2022, where total outlier payments are maintained at 2 percent of total estimated FY 2023 IPF PPS payments. We note that in the FY 2023 final rule (87 FR 46862 through 46864) we excluded providers from our simulation of IPF PPS payments for FY 2022 and FY 2023 if their change in estimated average cost per day was outside 3 standard deviations from the mean. As discussed in section IV.E.2 of this final rule, we did not propose to apply this methodology for FY 2024.

Each of the following changes is added incrementally to this baseline model in order for us to isolate the effects of each change:

- The update to the outlier fixed dollar loss threshold amount.
- The FY 2024 IPF wage index and the FY 2024 labor-related share.
- The IPF market basket update for FY 2024 of 3.5 percent less the productivity adjustment of 0.2 percentage point in accordance with section 1886(s)(2)(A)(i) of the Act for a final IPF payment rate update of 3.3 percent.

Our column comparison in Table 40 illustrates the percent change in payments from FY 2023 (that is, October 1, 2022, to September 30, 2023) to FY 2024 (that is, October 1, 2023, to September 30, 2024) including all the payment policy changes.

TABLE 40: FY 2024 IPF PPS Payment Impacts

[Percent Change in columns 3 through 5]

Facility by Type	Number of Facilities	Outlier	Wage Index FY24, LRS, and 5% Cap	Total Percent Change*
(1)	(2)	(3)	(4)	(5)
All Facilities	1,479	-0.9	0.0	2.3
Total Urban	1,204	-1.0	0.1	2.4
Urban unit	687	-1.5	0.2	2.0
Urban hospital	517	-0.4	0.0	2.9
Total Rural	275	-0.6	-0.7	2.0
Rural unit	214	-0.6	-0.7	2.0
Rural hospital	61	-0.5	-0.8	1.9
By Type of Ownership:				
Freestanding IPFs				
Urban Psychiatric Hospitals				
Government	119	-1.4	0.1	2.0
Non-Profit	98	-0.5	0.5	3.4
For-Profit	300	-0.2	-0.2	2.9
Rural Psychiatric Hospitals				
Government	31	-0.7	-0.3	2.3
Non-Profit	13	-2.1	-0.1	0.9
For-Profit	17	0.0	-1.3	2.0
IPF Units				
Urban				
Government	99	-2.6	0.7	1.3
Non-Profit	449	-1.4	0.3	2.1
For-Profit	139	-0.6	-0.5	2.2
Rural				
Government	51	-0.4	-0.6	2.2
Non-Profit	120	-0.7	-0.6	1.9
For-Profit	43	-0.4	-0.9	2.0
By Teaching Status:				
Non-teaching	1,282	-0.7	-0.2	2.4
Less than 10% interns and residents to beds	97	-1.7	0.9	2.5
10% to 30% interns and residents to beds	70	-1.9	0.3	1.7
More than 30% interns and residents to beds	30	-2.0	0.7	2.0
By Region:				
New England	105	-1.3	-0.6	1.4
Mid-Atlantic	202	-1.5	1.1	2.9
South Atlantic	229	-0.5	0.2	3.0
East North Central	240	-0.6	-0.7	2.0

Facility by Type	Number of Facilities	Outlier	Wage Index FY24, LRS, and 5% Cap	Total Percent Change*
East South Central	149	-0.6	-0.7	1.9
West North Central	105	-1.8	0.0	1.4
West South Central	215	-0.6	0.0	2.7
Mountain	106	-0.7	-1.0	1.6
Pacific	128	-1.1	0.4	2.7
By Bed Size:				
Psychiatric Hospitals				
Beds: 0-24	91	-0.8	-0.3	2.2
Beds: 25-49	84	-0.1	-0.7	2.4
Beds: 50-75	87	-0.1	-0.2	3.0
Beds: 76 +	316	-0.5	0.2	3.0
Psychiatric Units				
Beds: 0-24	484	-1.0	-0.4	1.9
Beds: 25-49	240	-1.2	0.1	2.3
Beds: 50-75	105	-1.4	0.0	1.8
Beds: 76 +	72	-2.1	0.8	1.9

* This column includes the impact of the updates in columns (3) through (4) above, and of the IPF market basket update for FY 2024 of 3.5 percent, reduced by 0.2 percentage point for the productivity adjustment as required by section 1886(s)(2)(A)(i) of the Act.

3. Impact Results

Table 40 displays the results of our analysis. The table groups IPFs into the categories listed here based on characteristics provided in the Provider of Services file, the IPF PSF, and cost report data from the Healthcare Cost Report Information System:

- Facility Type.
- Location.
- Teaching Status Adjustment.
- Census Region.
- Size.

The top row of the table shows the overall impact on the 1,479 IPFs included in the analysis. In column 2, we present the number of facilities of each type that had information available in the PSF and had claims in the MedPAR dataset for FY 2022.

In column 3, we present the effects of the update to the outlier fixed dollar loss threshold amount. We estimate that IPF outlier payments as a percentage of total IPF payments are 2.9 percent in FY 2023. Therefore, we adjusted the outlier threshold amount to set total estimated outlier payments equal to 2.0 percent of total payments in FY 2024. The estimated change in total IPF payments for FY 2024, therefore, includes an approximate 0.9 percent decrease in payments because we expect the outlier portion of total payments to decrease from approximately 2.9 percent to 2.0 percent.

The overall impact of the estimated decrease to payments due to updating the outlier fixed dollar loss threshold (as shown in column 3 of Table 3), across all hospital groups, is a 0.9 percentage point decrease. The largest decrease in payments due to this change is estimated to be 2.6 percent for urban government unit IPFs.

In column 4, we present the effects of the budget-neutral update to the IPF wage index, the Labor-Related Share (LRS), and the 5-percent cap on any decrease to a provider's wage index from its wage index in the prior year. This represents the effect of using the concurrent hospital wage data as discussed in section IV.D.1.a of this final rule. That is, the impact represented in this column reflects the update from the FY 2023 IPF wage index to the FY 2024 IPF wage index, which includes basing the FY 2024 IPF wage index on the FY 2024 pre-floor, pre-reclassified IPPS hospital wage index data, applying a 5-percent cap on any decrease to a provider's wage index from its wage index in the prior year, and updating the LRS from 77.4 percent in FY 2023 to 78.7 percent in FY 2024. We note that there is no projected change in aggregate payments to IPFs, as indicated in the first row of column 4; however, there will be distributional effects among different categories of IPFs. For example, we estimate the largest increase in payments to be 1.1 percent for Mid-Atlantic IPFs, and the largest decrease in payments to be 1.3 percent for freestanding, rural, for-profit IPFs.

Column 5 incorporates the FY 2024 IPF market basket update of 3.5 percent reduced by 0.2 percentage point for the productivity adjustment as required by section 1886(s)(2)(A)(i) of the Act. This includes rebasing the IPF market basket to reflect a 2021 base year.

Overall, IPFs are estimated to experience a net increase in payments as a result of the updates in this final rule. IPF payments are estimated to increase by 2.4 percent in urban areas and 2.0 percent in rural areas. The largest payment increases are estimated at 3.4 percent for freestanding, urban, non-profit IPFs.

4. Effect on Beneficiaries

Under the FY 2024 IPF PPS, IPFs will continue to receive payment based on the average resources consumed by patients for each day. Our longstanding payment methodology reflects the differences in patient resource use and costs among IPFs, as required under section 124 of the BBRA. We expect that updating IPF PPS rates in this final rule will improve or maintain beneficiary access to high quality care by ensuring that payment rates reflect the best available data on the resources involved in inpatient psychiatric care and the

costs of these resources. We continue to expect that paying prospectively for IPF services under the FY 2024 IPF PPS will enhance the efficiency of the Medicare program.

As discussed in sections VI.D.3 and VI.D.4 of this final rule, we expect that additional IPFQR Program measures will support improving care for patients with health-related social needs. We also believe that our data validation pilot is an important step towards ensuring that the data beneficiaries and their caregivers access on Care Compare (or a successor CMS website) are accurate and reliable. Based on the input from patients and their caregivers regarding the importance of having a patient experience of care measure for the IPF setting in which they note many benefits (including, but not limited to helping patients select facilities in which to receive care, providing patients an opportunity to be heard, and increasing alignment between general acute and acute psychiatric settings). We believe that our PIX survey measure will have positive effects on patients and their caregivers. Therefore, we expect that the updates to the IPFQR Program will improve quality for beneficiaries.

5. Effects of the Updates to the IPFQR Program

In section VI.D.3 of this final rule, we are adopting the Screening for Social Drivers of Health measure for the IPFQR Program beginning with voluntary reporting of CY 2024 data, and with mandatory reporting of CY 2025 data for the FY 2027 payment determination. For IPFs that are not currently administering some screening mechanism and elect to begin doing so as a result of this policy, there will be some non-recurring costs associated with changes in workflow and information systems to collect the data. The extent of these costs is difficult to quantify as different facilities may utilize different modes of data collection (for example, paper-based, electronically patient-directed and clinician-facilitated). In addition, depending on the method of data collection utilized, the time mandatory to complete the survey may add a negligible amount of time to patient visits.

In section VI.D.5 of this final rule, we are adopting the Psychiatric Inpatient Experience (PIX) survey measure. There may be some non-recurring costs associated with changes in workflow and information systems to administer this survey and collect the data. The extent of these costs is difficult to quantify as different facilities currently have different practices for surveying patients to gather information on their experiences of care.

In addition, for the IPFQR Program, we are adopting the Facility Commitment to Health Equity measure and the Screen Positive for Social Drivers of Health measure, as well as to update the COVID–19 Vaccination Coverage Among HCP measure. These updates will not impact providers workflows or information systems to collect or report the data, and because they represent processes of care or structural data that the IPFs will already have in place, we do not believe they will incur costs for providers beyond the recurring information collection costs (described in section VII.B of this final rule).

Finally, we are removing two chart-abstracted measures from the IPFQR Program. We believe that the impact of removing the Tobacco Use Brief Intervention Provided or Offered and Tobacco Use Brief Intervention Provided (TOB–2/2a) measure will be minimal as we do not believe that IPFs will update their workflow to no longer provide brief tobacco cessation interventions to patients who use tobacco. However, we believe that there may be some simplification of workflows and clinical documentation associated with the removal of the Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification (HBIPS–5) measure because IPFs will no longer have to ensure the presence of appropriate documentation for the use of multiple antipsychotics. For more information on the updated clinical guidelines regarding polypharmacy for patients with schizophrenia, we refer readers to section VI.F.2.a of this final rule.

As discussed in section IV.B.2 of this final rule and in accordance with section 1886(s)(4)(A)(i) of the Act, we will apply a 2-percentage point reduction to the FY 2024 market basket update for IPFs that have failed to comply with the IPFQR Program requirements for FY 2024, including reporting on the mandatory measures. In section IV.B.2 of this final rule, we discuss how the 2-percentage point reduction will be applied. For the FY 2023 payment determination, of the 1,596 IPFs eligible for the IPFQR Program, 6 IPFs did not receive the full market basket update because of the IPFQR Program; 2 of these IPFs chose not to participate and 4 did not meet the requirements of the program. Thus, we estimate that the IPFQR Program will have a negligible impact on overall IPF payments for FY 2024.

Based on the IPFQR Program policies in this final rule, we estimate a total decrease in burden of 380,897 hours across all IPFs, resulting in a total decrease in information collection cost of $8.15 million across all IPFs. Further information on these estimates can be found in section VII.B of this final rule.

We intend to closely monitor the effects of the IPFQR Program on IPFs and help facilitate successful reporting outcomes through ongoing stakeholder education, national trainings, and a technical help desk.

6. Regulatory Review Costs

If regulations impose administrative costs on private entities, such as the time needed to read and interpret this final rule, we should estimate the cost associated with regulatory review. Due to the uncertainty involved with accurately quantifying the number of entities that will be directly impacted and will review this final rule, we assume that the total number of unique commenters on the most recent IPF PPS proposed rule will be the number of reviewers of this final rule. For this FY 2024 IPF PPS final rule, the most recent IPF PPS proposed rule was the FY 2024 IPF PPS proposed rule, and we received 2,506 unique comments on this proposed rule. We acknowledge that this assumption may understate or overstate the costs of reviewing this final rule. It is possible that not all commenters reviewed the FY 2024 IPF PPS proposed rule in detail, and it is also possible that some reviewers chose not to comment on that proposed rule. For these reasons, we thought that the number of commenters will be a fair estimate of the number of reviewers who are directly impacted by this final rule. We solicited comments on this assumption.

We also recognize that different types of entities are in many cases affected by mutually exclusive sections of this final rule; therefore, for the purposes of our estimate, we assume that each reviewer reads approximately 50 percent of this final rule. Using the May, 2022 mean (average) wage information from the BLS for medical and health service managers (Code 11–9111), we estimate that the cost of reviewing this final rule is $123.06 per hour, including overhead and fringe benefits *https://www.bls.gov/oes/current/oes119111.htm.* Assuming an average reading speed of 250 words per minute, we estimate that it will take approximately 198 minutes (3.3 hours) for the staff to review half of this final rule (49,500), which contains a total of approximately 99,000 words. For each IPF that reviews the final rule, the estimated cost is ($3.3 \times \$123.06$) or

$406.10. Therefore, we estimate that the total cost of reviewing this final rule is $1,017,686.60 ($406.10 × 2,506 reviewers).

D. Alternatives Considered

The statute does not specify an update strategy for the IPF PPS and is broadly written to give the Secretary discretion in establishing an update methodology. We continue to believe it is appropriate to routinely update the IPF PPS so that it reflects the best available data about differences in patient resource use and costs among IPFs as required by the statute. Therefore, we are finalizing our proposal to: Update the IPF PPS using the methodology published in the November 2004 IPF PPS final rule; apply the 2021-based IPF market basket update for FY 2024 of 3.5 percent reduced by the productivity adjustment of 0.2 percentage point as required by section 1886(s)(2)(A)(i) of the Act along with the wage index budget neutrality adjustment to update the payment rates; and use a FY 2024 IPF wage index which uses the FY 2024 pre-floor, pre-reclassified IPPS hospital wage index as its basis.

Lastly, we solicited comments on alternative methodologies that could be appropriate for establishing the FY 2024 outlier fixed dollar loss threshold.

E. Accounting Statement

As required by OMB Circular A–4 (*https://www.whitehouse.gov/wp-content/uploads/legacy_drupal_files/omb/circulars/A4/a-4.pdf*), in Table 41, we have prepared an accounting statement showing the classification of the expenditures associated with the updates to the IPF wage index and payment rates in this final rule. Table 41 provides our best estimate of the increase in Medicare payments under the IPF PPS as a result of the changes presented in this final rule and is based on 1,479 IPFs with data available in the PSF and with claims in our FY 2022 MedPAR claims dataset. Lastly, Table 41 also includes our best estimate of the costs of reviewing and understanding this final rule.

TABLE 41: Accounting Statement: Classification of Estimated Costs and Transfers

Category	Primary estimate ($million/year)	Units	
		Year dollars	Period covered
Regulatory Review Costs	1.0	FY 2021	FY 2024
Annualized Monetized Transfers from Federal Government to IPF Medicare Providers	70	FY 2024	FY 2024

F. Regulatory Flexibility Act

The RFA requires agencies to analyze options for regulatory relief of small entities if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most IPFs and most other providers and suppliers are small entities, either by nonprofit status or having revenues of $8 million to $41.5 million or less in any 1 year. Individuals and states are not included in the definition of a small entity.

Because we lack data on individual hospital receipts, we cannot determine the number of small proprietary IPFs or the proportion of IPFs' revenue derived from Medicare payments. Therefore, we assume that all IPFs are considered small entities.

The Department of Health and Human Services generally uses a revenue impact of 3 to 5 percent as a significance threshold under the RFA. As shown in Table 40, we estimate that the overall revenue impact of this final rule on all IPFs is to increase estimated Medicare payments by 2.3 percent. As a result, since the estimated impact of this final rule is a net increase in revenue across almost all categories of IPFs, the Secretary has determined that this final rule will have a positive revenue impact on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a metropolitan statistical area and has fewer than 100 beds. As discussed in section VIII.C.2 of this final rule, the rates and policies set forth in this final rule will not have an adverse impact on the rural hospitals based on the data of the 211 rural excluded psychiatric units and 61 rural psychiatric hospitals in our database of 1,479 IPFs for which data were available. Therefore, the Secretary has determined that this final rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

G. Unfunded Mandate Reform Act (UMRA)

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2023, that threshold is approximately $177 million. This final rule does not mandate any requirements for state, local, or tribal governments, or for the private sector. This final rule will not impose a mandate that will result in the expenditure by state, local, and tribal governments, in the aggregate, or by the private sector, of more than $177 million in any 1 year.

H. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule that imposes substantial direct requirement costs on state and local governments, preempts state law, or otherwise has Federalism implications. This final rule does not impose substantial direct costs on state

or local governments or preempt state law.

Chiquita Brooks-LaSure, Administrator of the Centers for Medicare & Medicaid Services, approved this document on July 24, 2023.

List of Subjects in 42 CFR Part 412

Administrative practice and procedure, Health facilities, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR part 412 as set forth below:

PART 412—PROSPECTIVE PAYMENT SYSTEMS PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

■ 1. The authority citation for part 412 continues to read as follows:

Authority: 42 U.S.C. 1302 and 1395hh.

■ 2. Section 412.25 is amended by revising paragraph (c) to read as follows:

§ 412.25 Excluded hospital units: Common requirements.

* * * * *

(c) The status of a hospital unit may be changed from not excluded to excluded or excluded to not excluded at any time during a cost reporting period, but only if the hospital notifies the fiscal intermediary and the CMS Regional Office in writing of the change at least 30 days before the date of the change, and maintains the information needed to accurately determine costs that are or are not attributable to the hospital unit. A change in the status of a hospital unit from not excluded to excluded or excluded to not excluded that is made during a cost reporting period must remain in effect for the rest of that cost reporting period.

* * * * *

■ 3. Section 412.433 is added to read as follows:

§ 412.433 Procedural requirements under the IPFQR Program.

(a) *Statutory authority.* Section 1886(s)(4) of the Act requires the Secretary to implement a quality reporting program for inpatient psychiatric hospitals and psychiatric units. Under section 1886(s)(4) of the Act, for an IPF paid under the IPF PPS that fails to submit data required for the quality measures selected by the Secretary in a form and manner and at a time specified by the Secretary, we reduce the otherwise applicable annual update to the standard Federal rate by 2.0 percentage points with respect to the applicable fiscal year.

(b) *Participation in the IPFQR Program.* To participate in the IPFQR Program, an IPF (as defined under § 412.402) that is paid under the IPF PPS must:

(1) Register and maintain an account on the CMS-designated information system before beginning to report data, identification of a security official is necessary to complete such registration; and

(2) Submit a notice of participation (NOP).

(c) *Withdrawal from the IPFQR Program.* An IPF may withdraw from the IPFQR Program by changing the NOP status in the secure portion of the CMS-designated information system. The IPF may withdraw at any time up to and including August 15 before the beginning of each respective payment determination year. A withdrawn IPF is subject to a reduced annual payment update as specified under paragraph (a) of this section and is mandatory to renew participation as specified in paragraph (b) of this section in order to participate in any future year of the IPFQR Program.

(d) *Submission of IPFQR Program data.* In general, except as provided in paragraph (f) of this section, IPFs that participate in the IPFQR Program must submit to CMS data on measures selected under section 1886(s)(4)(D) of the Act and specified non-measure data in a form and manner, and at a time specified by CMS.

(e) *Quality measure updates, retention, and removal.* (1) *General rule for updates to quality measures.* CMS uses rulemaking to make substantive updates to the specifications of measures used in the IPFQR Program

(2) *General rule for the retention of quality measures.* Quality measures adopted for the IPFQR Program measure set for a previous payment determination year are retained for use in subsequent payment determination years, except when they are removed, suspended, or modified as set forth in paragraph (3) of this section.

(3) *Measure removal, suspension, or modification through the rulemaking process.* CMS will use the regular rulemaking process to remove, suspend, or modify quality measures in the IPFQR Program to allow for public comment.

(i) *Factors for consideration in removal or replacement of quality measures.* CMS will weigh whether to remove or modify measures based on the following factors:

(A) Factor 1: Measure performance among IPFs is so high and unvarying that meaningful distinctions and improvements in performance can no longer be made;

(B) Factor 2: Measure does not align with current clinical guidelines or practice;

(C) Factor 3: Measure can be replaced by a more broadly applicable measure (across settings or populations) or a measure that is more proximal in time to desired patient outcomes for the particular topic;

(D) Factor 4: Measure performance or improvement does not result in better patient outcomes;

(E) Factor 5: Measure can be replaced by a measure that is more strongly associated with desired patient outcomes for the particular topic;

(F) Factor 6: Measure collection or public reporting leads to negative unintended consequences other than patient harm;

(G) Factor 7: Measure is not feasible to implement as specified; and

(H) Factor 8: The costs associated with a measure outweigh the benefit of its continued use in the program.

(ii) *Retention.* CMS may retain a quality measure that meets one or more of the measure removal factors described in paragraph (i) of this subsection if the continued collection of data on the quality measure would align with other CMS and HHS policy goals, align with other CMS programs, or support efforts to move IPFs toward reporting electronic measures.

(f) *Extraordinary circumstances exception.* CMS may grant an exception to one or more data submissions deadlines and requirements in the event of extraordinary circumstances beyond the control of the IPF, such as when an act of nature affects an entire region or locale or a systemic problem with one of CMS's data collection systems directly or indirectly affects data submission. CMS may grant an exception as follows:

(1) Upon request by the IPF.

(2) At the discretion of CMS. CMS may grant exceptions to IPFs that have not requested them when CMS determines that an extraordinary circumstance has occurred.

(g) *Public reporting of IPFQR Program data.* Data that an IPF submits to CMS for the IPFQR Program will be made publicly available on a CMS website after providing the IPF an opportunity to review the data to be made public. IPFs will have a period of 30 days to review and submit corrections to errors resulting from CMS calculations prior to the data being made public.

Xavier Becerra,

Secretary, Department of Health and Human Services.

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Part IV

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Parts 418 and 424
Medicare Program; FY 2024 Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, Hospice Quality Reporting Program Requirements, and Hospice Certifying Physician Provider Enrollment Requirements; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 418 and 424

[CMS–1787–F]

RIN 0938–AV10

Medicare Program; FY 2024 Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, Hospice Quality Reporting Program Requirements, and Hospice Certifying Physician Provider Enrollment Requirements

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Final rule.

SUMMARY: This final rule updates the hospice wage index, payment rates, and aggregate cap amount for Fiscal Year (FY) 2024. This rule discusses the comments received regarding information related to the provision of higher levels of hospice care; spending patterns for non-hospice services provided during the election of the hospice benefit; ownership transparency; equipping patients and caregivers with information to inform hospice selection; and ways to examine health equity under the hospice benefit. This rule also finalizes conforming regulations text changes related to the expiration of the COVID–19 public health emergency. In addition, this rule updates the Hospice Quality Reporting Program; discusses the Hospice Outcomes and Patient Evaluation tool; provides an update on Health Equity and future quality measures; and provides updates on the Consumer Assessment of Healthcare Providers and Systems, Hospice Survey Mode Experiment. This rule also codifies hospice data submission thresholds and discusses updates to hospice survey and enforcement procedures. Additionally, the rule requires hospice certifying physicians to be Medicare-enrolled or to have validly opted-out.

DATES: These regulations are effective on October 1, 2023. The implementation date for the provider enrollment provisions in this final rule is May 1, 2024.

FOR FURTHER INFORMATION CONTACT: For general questions about hospice payment policy, send your inquiry via email to: *hospicepolicy@cms.hhs.gov.*

For questions regarding the CAHPS® Hospice Survey, contact Lauren Fuentes at (410) 786–2290.

For questions regarding the hospice conditions of participation (CoPs), contact Mary Rossi-Coajou at (410) 786–6051.

For questions regarding the hospice public reporting, contact Charles Padgett at (410) 786–2811.

For questions regarding the hospice quality reporting program, contact Jermama Keys at (410) 786–7778.

For questions regarding hospice certifying physician provider enrollment, contact Frank Whelan at (410) 786–1302.

For information regarding the hospice special focus program, send your inquiry via email to *QSOG_hospice@cms.hhs.gov.*

SUPPLEMENTARY INFORMATION:

I. Executive Summary

A. Purpose

This final rule updates the hospice wage index, payment rates, and cap amount for Fiscal Year (FY) 2024 as required under section 1814(i) of the Social Security Act (the Act). This rule discusses the comments received regarding information related to the provision of higher levels of hospice care; spending patterns for non-hospice services provided during the election of the hospice benefit; ownership transparency; equipping patients and caregivers with information to inform hospice selection; and ways to examine health equity under the hospice benefit and finalizes regulations text changes to align with the expiration of the COVID–19 public health emergency (PHE). This final rule also discusses updates to the Hospice Quality Reporting Program (HQRP) and the further development of the Hospice Outcomes and Patient Evaluation (HOPE) tool with national beta test analyses; and discusses updates on Health Equity and future quality measures (QMs). It also provides updates on the Consumer Assessment of Healthcare Providers and Systems (CAHPS), Hospice Survey Mode Experiment. This rule codifies hospice data submission thresholds and discusses updates to hospice survey and enforcement procedures.

In addition, this final rule finalizes provider enrollment requirements for certifying physicians for hospice services. This rule also finalizes text changes to regulations that align with the expiration of the COVID–19 PHE.

B. Summary of the Major Provisions

In section III.A of this final rule, we discuss the comments received related to the following: increasing access to higher levels of hospice care; our analysis of non-hospice spending during a hospice election; ownership transparency; hospice election decision-making; and ways to examine health equity under the hospice benefit.

In section III.B of this rule, we finalize the FY 2024 hospice payment update percentage of 3.1 percent, update the hospice payment rates and the hospice cap amount for FY 2024 by the hospice payment update percentage of 3.1 percent. We also discuss the finalized text changes to the regulations related to the expiration of the COVID–19 PHE.

In section III.C of this final rule, we update the HQRP including the HOPE tool and update the Health Equity and future quality measures; update the CAHPS® Hospice Survey Mode Experiment; and finalize our proposal to codify the hospice data submission threshold.

In section III.D of this final rule, we update the hospice survey and enforcement procedures.

Finally, in section III.E of this final rule, we discuss our requirement that physicians who certify hospice services for Medicare beneficiaries be enrolled in or validly opted-out of Medicare as a prerequisite for the payment of the hospice service in question.

C. Summary of Impacts

The overall economic impact of this final rule is estimated to be $780 million in increased payments to hospices in FY 2024.

II. Background

A. Hospice Care

Hospice care is a comprehensive, holistic approach to treatment that recognizes the impending death of a terminally ill individual and warrants a change in the focus from curative care to palliative care for relief of pain and for symptom management. Medicare regulations define ''palliative care'' as patient and family centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice (§ 418.3). Palliative care is at the core of hospice philosophy and care practices and is a critical component of the Medicare hospice benefit.

The goal of hospice care is to help terminally ill individuals continue life with minimal disruption to normal activities while remaining primarily in the home environment. A hospice uses an interdisciplinary approach to deliver medical, nursing, social, psychological,

emotional, and spiritual services through a collaboration of professionals and other caregivers, with the goal of making the beneficiary as physically and emotionally comfortable as possible. Hospice is compassionate beneficiary and family/caregiver-centered care for those who are terminally ill.

As referenced in our regulations at § 418.22(b)(1), to be eligible for Medicare hospice services, the patient's attending physician (if any) and the hospice medical director must certify that the individual is ''terminally ill,'' as defined in section 1861(dd)(3)(A) of the Act and our regulations at § 418.3; that is, the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course. The regulations at § 418.22(b)(2) require that clinical information and other documentation that support the medical prognosis accompany the certification and be filed in the medical record with it and regulations at § 418.22(b)(3) require that the certification and recertification forms include a brief narrative explanation of the clinical findings that support a life expectancy of 6 months or less.

Under the Medicare hospice benefit, the election of hospice care is a patient choice and once a terminally ill patient elects to receive hospice care, a hospice interdisciplinary group is essential in the seamless provision of primarily home-based services. The hospice interdisciplinary group works with the beneficiary, family, and caregivers to develop a coordinated, comprehensive care plan; reduce unnecessary diagnostics or ineffective therapies; and maintain ongoing communication with individuals and their families about changes in their condition. The beneficiary's care plan will shift over time to meet the changing needs of the individual, family, and caregiver(s) as the individual approaches the end of life.

If, in the judgment of the hospice interdisciplinary group, which includes the hospice physician, the patient's symptoms cannot be effectively managed at home, then the patient is eligible for general inpatient care (GIP), a more medically intense level of care. GIP must be provided in a Medicare-certified hospice freestanding facility, skilled nursing facility, or hospital. GIP is provided to ensure that any new or worsening symptoms are intensively addressed so that the beneficiary can return to their home and continue to receive routine home care. Limited, short-term, intermittent, inpatient respite care (IRC) is also available because of the absence or need for relief of the family or other caregivers. Additionally, an individual can receive continuous home care (CHC) during a period of crisis in which an individual requires continuous care to achieve palliation or management of acute medical symptoms so that the individual can remain at home. CHC may be covered for as much as 24 hours a day, and these periods must be predominantly nursing care, in accordance with the regulations at § 418.204. A minimum of 8 hours of nursing care or nursing and aide care must be furnished on a particular day to qualify for the CHC rate (§ 418.302(e)(4)).

Hospices covered by this rule must comply with applicable civil rights laws, including section 1557 of the Affordable Care Act, section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act, which require covered programs to take appropriate steps to ensure effective communication with patients with disabilities and patient companions with disabilities, including the provisions of auxiliary aids and services when necessary for effective communication.[1] Further information may be found at: *http://www.hhs.gov/ocr/civilrights.*

Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color or national origin in federally assisted programs or activities. This includes a requirement that recipients of Federal financial assistance take reasonable steps to provide meaningful access to their programs or activities to individuals with limited English proficiency (LEP) (Lau v. Nichols, 414 U.S. 563 (1974)). Similarly, Section 1557's implementing regulation requires covered entities to take reasonable steps to provide meaningful access to LEP individuals in federally funded health programs and activities (45 CFR 92.101(a)). Meaningful access may require the provision of services and translated materials (45 CFR 92.101(a)(2)).

B. Services Covered by the Medicare Hospice Benefit

Coverage under the Medicare hospice benefit requires that hospice services must be reasonable and necessary for the palliation and management of the terminal illness and related conditions. Section 1861(dd)(1) of the Act establishes the services that are to be rendered by a Medicare-certified hospice program. These covered services include: nursing care; physical therapy; occupational therapy; speech-language pathology therapy; medical social services; home health aide services (called hospice aide services); physician services; homemaker services; medical supplies (including drugs and biologicals); medical appliances; counseling services (including dietary counseling); short-term inpatient care in a hospital, nursing facility, or hospice inpatient facility (including both respite care and procedures necessary for pain control and acute or chronic symptom management); continuous home care during periods of crisis, and only as necessary, to maintain the terminally ill individual at home; and any other item or service which is specified in the plan of care and for which payment may otherwise be made under Medicare, in accordance with Title XVIII of the Act.

Section 1814(a)(7)(B) of the Act requires that a written plan for providing hospice care to a beneficiary, who is a hospice patient, be established before care is provided by, or under arrangements made by, the hospice program; and that the written plan be periodically reviewed by the beneficiary's attending physician (if any), the hospice medical director, and an interdisciplinary group (section 1861(dd)(2)(B) of the Act). The services offered under the Medicare hospice benefit must be available to beneficiaries as needed, 24 hours a day, 7 days a week (section 1861(dd)(2)(A)(i) of the Act).

Upon the implementation of the hospice benefit, the Congress also expected hospices to continue to use volunteer services, although Medicare does not pay for these volunteer services (section 1861(dd)(2)(E) of the Act). As stated in the Health Care Financing Administration's (now Centers for Medicare & Medicaid Services (CMS)) proposed rule ''Medicare Program; Hospice Care (48 FR 38149), the hospice must have an interdisciplinary group composed of paid hospice employees as well as hospice volunteers, and that ''the hospice benefit and the resulting Medicare reimbursement is not intended to diminish the voluntary spirit of hospices.'' This expectation supports the hospice philosophy of community based, holistic, comprehensive, and compassionate end of life care.

C. Medicare Payment for Hospice Care

Sections 1812(d), 1813(a)(4), 1814(a)(7), 1814(i), and 1861(dd) of the Act, and the regulations in 42 CFR part

[1] Hospices receiving Medicare Part A funds or other federal financial assistance from the Department are also subject to additional federal civil rights laws, including the Age Discrimination Act, and are subject to conscience and religious freedom laws where applicable.

418, establish eligibility requirements, payment standards and procedures; define covered services; and delineate the conditions a hospice must meet to be approved for participation in the Medicare program. Part 418, subpart G, provides for a per diem payment based on one of four prospectively determined rate categories of hospice care (RHC, CHC, IRC, and GIP), based on each day a qualified Medicare beneficiary is under hospice care (once the individual has elected the benefit). This per diem payment is meant to cover all hospice services and items needed to manage the beneficiary's care, as required by section 1861(dd) (1) of the Act.

While payment made to hospices is to cover all items, services, and drugs for the palliation and management of the terminal illness and related conditions, federal funds cannot be used for prohibited activities, even in the context of a per diem payment. While a recent article in a policy journal [2] discussed the potential role hospices could play in medical aid in dying (MAID) where such practices have been legalized in certain states, the Assisted Suicide Funding Restriction Act of 1997 (Pub. L. 105–12, April 30, 1997) prohibits the use of federal funds to provide or pay for any health care item or service or health benefit coverage for the purpose of causing, or assisting to cause, the death of any individual including ''mercy killing, euthanasia, or assisted suicide''. However, the prohibition does not pertain to the provision of an item or service for the purpose of alleviating pain or discomfort, even if such use may increase the risk of death, so long as the item or service is not furnished for the specific purpose of causing or accelerating death.

The Medicare hospice benefit had been revised and refined since its implementation after various Acts of Congress and Medicare rules. For a historical list of changes and regulatory actions, we refer readers to the background section of previous Hospice Wage Index and Payment Rate Update rules.[3]

III. Provisions of the Final Rule

A. Hospice Utilization and Spending Patterns

In the FY 2024 Hospice Wage Index and Rate Update proposed rule (88 FR 20022), CMS provided data analysis on hospice utilization trends from FY 2013 through FY 2022. The analysis included data on the number of beneficiaries using the hospice benefit, live discharges, reported diagnoses on hospice claims, Medicare hospice spending, Parts A, B and D non-hospice spending during a hospice election, as well as services used outside of the hospice benefit while a patient is under a hospice election. The proposed rule solicited comments from the public, hospice providers, patients, and advocates regarding utilization of, and barriers to higher levels of hospice care and complex palliative treatments; our analysis of non-hospice spending during a hospice election; ownership transparency; and hospice election decision making. Additionally, we solicited comments on ways to examine health equity under the hospice benefit. Several commenters thanked CMS for continuing to incorporate monitoring and data analysis into its proposed hospice payment rule.

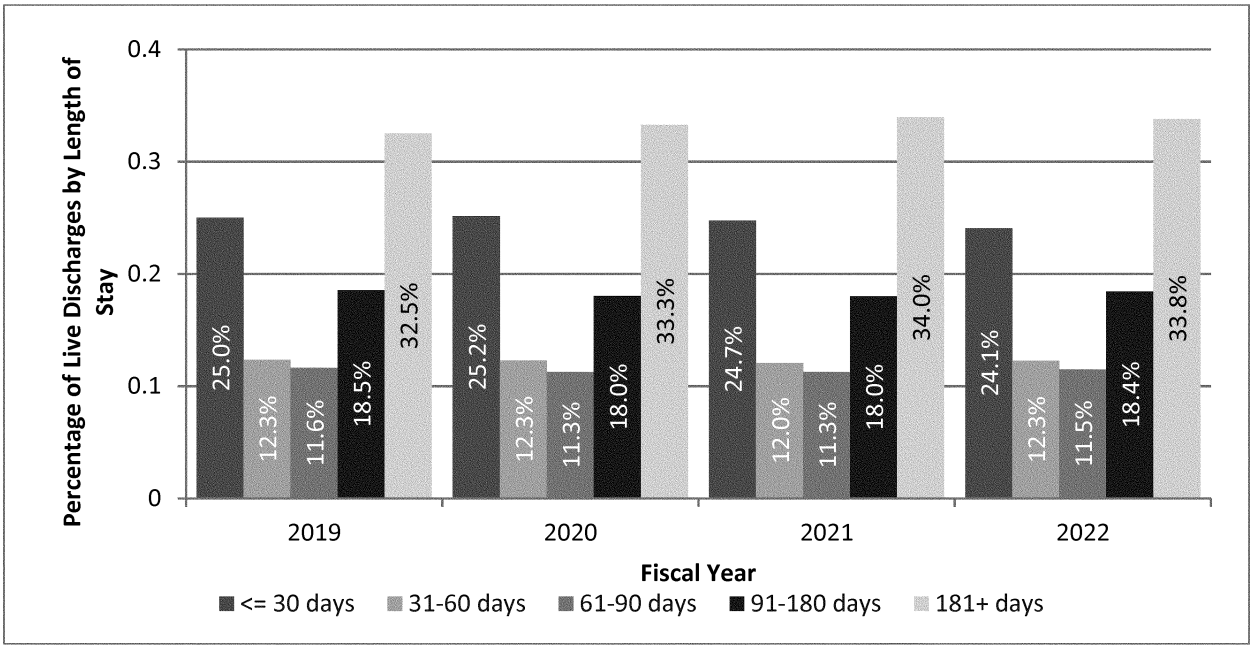
1. Correction to Figure 3 in the FY 2024 Hospice Proposed Rule

In the FY 2024 Hospice Wage Index and Rate Update proposed rule (88 FR 20032), we inadvertently provided incorrect data for Figure 3. Figure 3—Length of Stay Intervals Distribution for Live Discharges, FYs 2019 to 2022 is corrected to read as follows:

[2] Nelson, R., Should Medical Aid in Dying Be Part of Hospice Care? Medscape Nurses. February 26, 2020. *https://www.medscape.com/viewarticle/925769#vp_1.*

[3] Hospice Regulations and Notices. *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Hospice-Regulations-and-Notices.*

Figure 3: Length of Stay Intervals Distribution for Live Discharges, FYs 2019 to 2022



Source: Analysis of data for FY 2019 through FY 2022 accessed from the CCW on May 11, 2023.
Notes: All hospice claims examined list a discharge status code (meaning claims were excluded if they listed status code 30, indicating they were a continuing patient). Discharges ending in death had a discharge status code of 40, 41, or 42. Any claims not already excluded or that indicated a discharge resulting from death were considered live discharges.

2. Request for Information (RFI) on Hospice Utilization; Non-Hospice Spending; Ownership Transparency; and Hospice Election Decision-Making

As we continue to focus on improved access and value within the hospice benefit, in the FY 2024 Hospice Wage Index and Rate Update proposed rule (88 FR 20022), we solicited comments from the public, including hospice providers as well as patients and advocates, regarding certain notable trends in the analysis that coincide with hospice misinformation obtained anecdotally from beneficiaries; that is, information related to the provision of higher levels of hospice care (specifically, CHC, IRC, and GIP) and procedures (specifically, chemotherapy/radiation, blood transfusions, or dialysis) administered for palliation when a patient is under a hospice election. We queried interested parties on potentially restrictive admission policies for beneficiaries requiring higher-intensity end-of-life and/or palliative care, the frequency and modality in which hospices educate themselves on the distinction between curative and complex palliative treatments, and the way they communicate this information to patients throughout the hospice election. We solicited comments specifically on how hospices address financial risks associated with providing such services, overcome barriers to providing higher intensity levels of hospice care and complex palliative treatments, and provide necessary information to patients and families about coverage, staffing levels, staff encounters, and utilization of higher levels of care. We asked for feedback on how CMS can work with hospice providers to ensure Medicare beneficiaries and their families are aware of the coverage under the hospice benefit and how we can enhance transparency in ownership trends for beneficiaries selecting hospice care. More generally, we solicited comments on how CMS can assist hospices in better serving vulnerable and underserved populations and address barriers to access.

In total, we received 39 comments in response to our request for information on hospice utilization, non-hospice spending, ownership transparency, and hospice election decision-making. These comments and our responses are summarized in this section of the rule.

Comment: Commenters expressed general concerns about potential admission policies that could restrict access to higher cost end-of-life palliative care and discussed inconsistencies in beneficiary access to treatments that may be based on specific hospice policy or disease states. They emphasized the need for definitive instruction and clear expectations from CMS regarding expectations of hospice providers in determining curative versus palliative treatment coverage under the hospice benefit. Respondents stated that in providing this additional guidance CMS should be mindful of the importance of individual hospice policies; however, education and clear guidance from CMS is crucial in avoiding confusion as to what treatments can be provided under the hospice benefit.

Commenters also identified general challenges that could lead to barriers to providing higher levels of hospice care, such as limited bed capacity in skilled nursing facilities, difficulties in obtaining and maintaining contracts with inpatient facilities, staffing challenges/volunteer shortages, and restrictive rules on the provision of GIP and CHC. Recommendations included exploring options for in-home respite care, extending the duration of inpatient respite care, and providing CHC during

the actively dying phase to improve patient care and reduce unnecessary hospitalizations, as it was noted that current policy guidance is not clear as to whether it is permissible to provide GIP and/or CHC only during periods of active crisis or if it could be provided during the entirety of the ''active dying'' phase.

Commenters also highlighted increased costs associated with providing complex palliative treatments and higher intensity levels of hospice care and they stated that these costs may pose financial risks to hospices when enrolling such patients. Respondents strongly suggested exploring flexibilities or additional payments (recommendations included the implementation of a risk adjusted, add-on and/or outlier payment models) to ensure appropriate payment and timely hospice admission. Several commenters requested that CMS address the potential correlation between costs and financial risks associated with providing complex palliative treatments (that is, chemotherapy/radiation, blood transfusions or dialysis), stating that the current bundled per diem payment is not reflective of the increased expenses associated with higher-cost and outlier patient subgroups.

Commenters emphasized the need for CMS education directed towards patients and families about transitioning from curative interventions to palliative interventions at the time of hospice admission. Specifically, a few commenters suggested that the Patient Notification of Hospice Non-Covered Items, Services, and Drugs should be provided to all prospective patients at the time of hospice election or as part of the care plan. Commenters suggestions also included clarifying coverage for procedures related to the primary diagnosis and exploring the use of Advanced Beneficiary Notices (ABNs). Commenters noted that hospice providers, non-hospice providers, Medicare beneficiaries, and their families need more information to understand these distinctions and that hospice providers must share the information with patients at the time of election and throughout the hospice election. However, to the contrary, several other interested parties raised concerns about administrative burden regarding the provision of more information during a period in which beneficiaries and their families are overwhelmed and that such education may not serve its intended purpose.

Commenters raised concerns about the growth of non-hospice spending for beneficiaries who elect hospice, particularly with those hospice agencies who intentionally focus on long-term, low-cost patients, as the analysis included in the proposed rule highlighted these spending patterns. Respondents discussed potential policies beyond prior authorization and the hospice election statement addendum, to ensure appropriate coverage of prescription drugs and services related to terminal illnesses and related conditions for hospice patients. They suggested the need for additional coordination and communication between hospices, providers, and Part D plans to streamline the coverage process and ensure timely access to necessary medications and services.

Regarding CMS' inquiry on how to increase transparency to promote informed decision-making when choosing a hospice, respondents recommended providing public information about hospice staffing levels, frequency of hospice staff encounters, and utilization of higher levels of care. They suggested including this information on Medicare's Care Compare website or other accessible platforms to ensure transparency and facilitate informed decision-making. They also suggested CMS improve transparency around ownership trends and provide information about hospice ownership publicly, as ultimately, this information would be helpful for beneficiaries seeking to select a hospice for end-of-life care. Respondents recommended differentiating between nonprofit and for-profit hospices and examining ownership trends.

Response: We appreciate the comments and suggestions received regarding hospice utilization, non-hospice spending, ownership transparency, and hospice election decision-making. We acknowledge commenters' statements and concerns related to the increase in non-hospice spending, barriers associated with the provision of GIP, IRC, CHC and complex palliative procedures (such as chemotherapy/radiation, blood transfusions, or dialysis) under the hospice election, as well as the financial risks associated with providing these services.

Regarding the use of CHC during the active dying phase, as established in 1983 Hospice Care final rule (48 FR 56008) and amended in the FY 2010 Hospice Wage Index final rule (74 FR 39384), we would like to remind commenters that a period of crisis is a period in which a patient requires continuous care, which is predominantly nursing care, to achieve palliation or management of acute medical symptoms and thus CHC may be provided only during a period of crisis as necessary to maintain an individual at home. A patient who is actively dying may or may not require continuous home care and each patient must be evaluated to determine the intensity of care needs. If a patient is having a period of crisis, requires a minimum of 8 hours of nursing, hospice aide, and/or homemaker care during a 24-hour day, which begins and ends at midnight, and is actively dying, then continuous home care can be provided. We continue to encourage hospice visits when the patient is actively dying, and where the need for greater family and caregivers support is evident, by reminding readers of the service intensity add-on (SIA) payment in the last 7 days of life, as finalized in the FY 2016 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements (80 FR 47142).

Overall, the insights and suggestions provided by all respondents will help inform our policy-making measures and will aid our efforts of continuous improvements to hospice policies to ensure better access and quality of care for Medicare beneficiaries. We intend to consider all comments and suggestions to potentially enhance policy development, address barriers, and promote transparency under the hospice benefit for potential future rulemaking.

3. RFI on Health Equity Under the Hospice Benefit

In the FY 2024 Hospice Wage Index and Rate Update proposed rule (88 FR 20022), CMS solicited comments from interested parties on health equity under the hospice benefit. The proposed rule also solicited comments from the public, hospice providers, patients, and advocates regarding how hospices are measuring impact on health equity, barriers in electing and accessing hospice care, and challenges faced by hospices in collecting and analyzing information related to social determinants of health (SDOH). We also solicited comments on what data should be collected to evaluate health equity, geographical area indices that can be used to assess disparities in hospice, and how CMS can collect and share information to help hospices serve vulnerable and underserved populations and address barriers to access.

We received 20 comments in response to our request for information on health equity under the hospice benefit. The following is a summary of these comments:

Comment: Commenters described the various barriers and challenges in collecting information on SDOH and health equity data, such as patient resistance, difficulty in appropriately

recording SDOH using electronic medical records (EMR), lack of specificity in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) questionnaires provided to patients' families, and limited resources for data collection. One commenter suggested that CMS should change the terminology used from ''health equity'' to ''healthcare equity'' to capture what can be measured in terms of processes of care or outcomes of care. Commenters also noted their efforts to employ and recruit diverse staff to better represent and serve underserved populations, in addition to holding trainings to address any barriers patients may experience related to SDOH. Commenters provided recommendations for CMS to consider, such as developing educational tools about cultural norms to facilitate discussions about hospice care, and implementing a nationally recognized, standardized, and required assessment tool with data elements collecting SDOH data. They suggested examples of SDOH data that should be collected that included health literacy, race, ethnicity and language data, sexual orientation and gender identity data, housing security, air and water pollution, food security, living in heat islands, and access to health care. One commenter also suggested that any health equity data elements should be exempt from the Hospice Quality Reporting Program (HQRP) data completion threshold due to the sensitivity and potential communication issues present at end of life. Several commenters also recommended the development of a universal database accessible across the government to enable programs to accurately assess the extent of the disparities and barriers existing today and to measure progress made by hospice in promoting health equity over time.

Response: We appreciate the comments provided in response to our request for information regarding health equity under the hospice benefit. We plan to consider these comments and suggestions for potential future rulemaking as we explore all opportunities to collect and measure data impacting health equity, examine barriers in electing and accessing hospice care, assess disparities in the provision of care, and improve how CMS can help hospices serve vulnerable and underserved populations. Public input is very valuable for the continuing development of CMS' health equity efforts and broader commitment to health equity; a key pillar of our strategic vision as further described here, *https://www.cms.gov/files/document/health-equity-fact-sheet.pdf.*

B. FY 2024 Hospice Wage Index and Rate Update

1. FY 2024 Hospice Wage Index

The hospice wage index is used to adjust payment rates for hospices under the Medicare program to reflect local differences in area wage levels, based on the location where services are furnished. The hospice wage index utilizes the wage adjustment factors used by the Secretary for purposes of section 1886(d)(3)(E) of the Act for hospital wage adjustments. Our regulations at § 418.306(c) require each labor market to be established using the most current hospital wage data available, including any changes made by the Office of Management and Budget (OMB) to the Metropolitan Statistical Areas (MSAs) definitions.

In general, OMB issues major revisions to statistical areas every 10 years, based on the results of the decennial census. However, OMB occasionally issues minor updates and revisions to statistical areas in the years between the decennial censuses. On March 6, 2020, OMB issued Bulletin No. 20–01, which provided updates to and superseded OMB Bulletin No. 18–04 that was issued on September 14, 2018. The attachments to OMB Bulletin No. 20–01 provided detailed information on the update to statistical areas since September 14, 2018, and were based on the application of the 2010 Standards for Delineating Metropolitan and Micropolitan Statistical Areas to Census Bureau population estimates for July 1, 2017, and July 1, 2018. For a copy of this bulletin, we refer readers to the following website: *https://www.whitehouse.gov/wp-content/uploads/2020/03/Bulletin-20-01.pdf.* In OMB Bulletin No. 20–01, OMB announced one new Micropolitan Statistical Area, one new component of an existing Combined Statistical Area (CSA), and changes to New England City and Town Area (NECTA) delineations. In the FY 2021 Hospice Wage Index final rule (85 FR 47070), we stated that if appropriate, we would propose any updates from OMB Bulletin No. 20–01 in future rulemaking. After reviewing OMB Bulletin No. 20–01, we determined that the changes in Bulletin 20–01 encompassed delineation changes that would not affect the Medicare wage index for FY 2022. Specifically, the updates consisted of changes to NECTA delineations and the redesignation of a single rural county into a newly created Micropolitan Statistical Area. The Medicare wage index does not utilize NECTA definitions, and, as most recently discussed in the FY 2021 Hospice Wage Index final rule (85 FR 47070), we include hospitals located in Micropolitan Statistical areas in each state's rural wage index.

In the FY 2020 Hospice Wage Index final rule (84 FR 38484), we finalized the proposal to use the current FY's hospital wage index data to calculate the hospice wage index values. In the FY 2021 Hospice Wage Index final rule (85 FR 47070), we adopted the revised OMB delineations with a 5-percent cap on wage index decreases, where the estimated reduction in a geographic area's wage index would be capped at 5 percent in FY 2021 and no cap would be applied to wage index decreases for the second year (FY 2022). In the FY 2023 Hospice Wage Index final rule (87 FR 45673), we finalized for FY 2023 and subsequent years, the application of a permanent 5-percent cap on any decrease to a geographic area's wage index from its wage index in the prior year, regardless of the circumstances causing the decline, so that a geographic area's wage index would not be less than 95 percent of its wage index calculated in the prior FY.

For FY 2024, the final hospice wage index is based on the FY 2024 hospital pre-floor, pre-reclassified wage index for hospital cost reporting periods beginning on or after October 1, 2019 and before October 1, 2020 (FY 2020 cost report data). The final FY 2024 hospice wage index does not take into account any geographic reclassification of hospitals, including those in accordance with section 1886(d)(8)(B) or 1886(d)(10) of the Act. The final FY 2024 hospice wage index includes a 5-percent cap on wage index decreases. The appropriate wage index value would be applied to the labor portion of the hospice payment rate based on the geographic area in which the beneficiary resides when receiving RHC or CHC. The appropriate wage index value is applied to the labor portion of the payment rate based on the geographic location of the facility for beneficiaries receiving GIP or IRC.

In the FY 2006 Hospice Wage Index final rule (70 FR 45135), we adopted the policy that, for urban labor markets without a hospital from which hospital wage index data could be derived, all the core-based statistical areas (CBSAs) within the state would be used to calculate a statewide urban average pre-floor, pre-reclassified hospital wage index value to use as a reasonable proxy for these areas. For FY 2024, the only CBSA without a hospital from which hospital wage data can be derived is 25980, Hinesville-Fort Stewart, Georgia

and the wage index value for Hinesville-Fort Stewart, Georgia is 0.8732.

To address rural areas where there were no hospitals, and thus no hospital wage data on which to base the calculation of the hospice wage index, in the FY 2008 Hospice Wage Index final rule (72 FR 50217 through 50218), we implemented a methodology to update the hospice wage index for rural areas without hospital wage data. In cases where there was a rural area without rural hospital wage data, we would use the average pre-floor, pre-reclassified hospital wage index data from all contiguous CBSAs, to represent a reasonable proxy for the rural area. The term ''contiguous'' means sharing a border (72 FR 50217). Currently, the only rural area without a hospital from which hospital wage data could be derived is Puerto Rico. However, for rural Puerto Rico, we would not apply this methodology due to the distinct economic circumstances that exist there (for example, due to the close proximity of almost all of Puerto Rico's various urban areas to non-urban areas, this methodology would produce a wage index for rural Puerto Rico that is higher than that in half of its urban areas); instead, we would continue to use the most recent wage index previously available for that area. For FY 2024, we proposed to continue using the most recent pre-floor, pre-reclassified hospital wage index value available for Puerto Rico, which is 0.4047, subsequently adjusted by the hospice floor.

As described in the August 8, 1997 Hospice Wage Index final rule (62 FR 42860), the pre-floor and pre-reclassified hospital wage index is used as the raw wage index for the hospice benefit. These raw wage index values are subject to application of the hospice floor to compute the hospice wage index used to determine payments to hospices. As previously discussed, the pre-floor, pre-reclassified hospital wage index values below 0.8 would be further adjusted by a 15 percent increase subject to a maximum wage index value of 0.8. For example, if County A has a pre-floor, pre-reclassified hospital wage index value of 0.3994, we would multiply 0.3994 by 1.15, which equals 0.4593. Since 0.4593 is not greater than 0.8, then County A's hospice wage index would be 0.4593. In another example, if County B has a pre-floor, pre-reclassified hospital wage index value of 0.7440, we would multiply 0.7440 by 1.15, which equals 0.8556. Because 0.8556 is greater than 0.8, County B's hospice wage index would be 0.8.

The final hospice wage index applicable for FY 2024 (October 1, 2023 through September 30, 2024) is available on the CMS website at: *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Hospice-Wage-Index.html.*

We received 15 comments on the proposed FY 2024 hospice wage index from various stakeholders, including hospices and national industry associations. A summary of these comments and our responses to those comments are as follows:

Comment: A few commenters expressed concern with the CBSA designations and wage index values assigned to their geographic areas. Several commenters representing hospices in Coeur d'Alene, ID stated that the economy and cost-of-living of Coeur d'Alene, ID is not reflective of the rest of the Idaho region, but rather is reflective of the ''Pacific'' region that includes the Spokane, WA CBSA. These commenters recommended that Coeur d'Alene, ID be reassigned to the Spokane, WA CBSA and assigned the wage index value of that CBSA. Another commenter stated that hospices in Montgomery County, MD should be paid the same as hospices in the Washington, DC area because Montgomery County, MD has a similar cost of living as Washington, DC and shares the same labor market when competing for labor. This commenter recommended that the wage index for the Montgomery County/Fredrick, MD CBSA be reassigned to the Washington, DC CBSA or be assigned the highest wage index valuation from among the MSAs metropolitan divisions for the purpose of hospice Medicare payment for a time limited period, such as five years, in order to evaluate the impact on Montgomery County hospices.

Response: We thank the commenters for these recommendations. However, we have used CBSAs for determining hospice payments since FY 2006 and continue to believe that the OMB's geographic area delineations represent a useful proxy for differentiating between labor markets and that the geographic area delineations are appropriate for use in determining Medicare hospice payments. CBSAs provide a uniform and consistent basis for determining statistical area delineations, based on long-standing statistical standards maintained by OMB. Further, OMB conducts periodic review of the standards to ensure their continued usefulness and relevance. Additionally, other provider types, such as Inpatient Prospective Payment System (IPPS) hospitals, home health agencies (HHAs), skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), and dialysis facilities, all use CBSAs to define their labor market areas. Therefore, we believe it is important to apply this method consistently among providers. Using the most current OMB delineations provides an accurate representation of geographic variation in wage levels; therefore, we do not believe it would be appropriate to allow hospices in Coeur d'Alene, ID or Montgomery County, MD to be reassigned into a higher CBSA designation. However, if OMB redesignates Coeur d'Alene, ID or Montgomery County, MD into the Spokane, WA or the Washington, DC CBSAs (respectively), we would propose this change in future rulemaking consistent with our longstanding approach of adopting OMB statistical area delineations outlined in the most recent OMB bulletins.

Comment: A few commenters expressed concern that the wage index values assigned to rural areas negatively impacts rural hospice care. One commenter stated that hospices that serve rural patients receiving services in their homes are subject to a trend of reduced wage index values, creating a continued reduction in their Medicare rates as compared to the national average. Another commenter recommended that CMS assign the wage index value based on a hospice's office location rather than the beneficiary's location. This commenter suggested that it costs more for their hospice to serve rural areas due to the great distance they are required to travel despite being paid at only 80 percent of the wage index.

Response: We thank the commenters for their recommendations. We understand there are variables in providing care that are unique to both urban and rural areas. For instance, rural hospices note higher mileage costs between patients, while urban hospices note additional costs associated with necessary security measures and traffic congestion. However, these factors do not result in lower hospice wage index values in rural areas versus urban areas. The hospice wage index reflects the wages that inpatient hospitals pay in their local geographic areas. Regarding the recommendation to assign the wage index value based on the location of the hospice's office, we continue to believe that is more appropriate to assign the wage index value based on the site of service (the location of the beneficiary) rather than the hospice's office location. Therefore, we apply the wage index value to the labor portion of the hospice payment rate based on the geographic area in which the beneficiary resides when receiving RHC or CHC and the

geographic location of the facility for beneficiaries receiving GIP or IRC.

Comment: Several commenters recommended more far-reaching revisions and reforms to the wage index methodology used under Medicare fee-for-service. These recommendations included: geographic reclassification, implementing an out-migration adjustment for non-hospital providers using the post floor- post reclassified IPPS wage index as the basis for the hospice wage index, and reinstituting the rural floor policy so that no hospice is paid below the rural floor for their state. Another commenter recommended CMS explore policies that seek to reduce the continual wage index disparities between high wage index hospices and low wage index hospices such as has been done in the hospital space. Finally, MedPAC recommended that Congress repeal the existing Medicare wage index statutes, including current exceptions, and require the Secretary to phase in new Medicare wage index systems for hospitals and other types of providers that: use all-employer, occupation-level wage data with different occupation weights for the wage index of each provider type; reflect local area level differences in wages between and within metropolitan statistical areas and statewide rural areas; and smooth wage index differences across adjacent local areas.

Response: We appreciate the commenters' recommendations; however, these comments are outside the scope of the proposed rule. Any changes regarding the adjustment of the hospice payments to account for geographic wage differences, beyond the wage index proposals discussed in the FY 2024 Hospice Wage Index and Rate Update proposed rule, would have to go through notice and comment rulemaking. While CMS and other interested parties, such as MedPAC, have explored potential alternatives to the current CBSA-based labor market system, no consensus has been achieved regarding how best to implement a replacement system. we believe that in the absence of hospice specific wage data, using the pre-floor, pre-reclassified hospital wage data is appropriate and reasonable for hospice payments. Additionally, the regulations that govern hospice payment do not provide a mechanism for allowing hospices to seek geographic reclassification or to utilize the rural floor provisions that exist for IPPS hospitals. The reclassification provision found in section 1886(d)(10) of the Act is specific to hospitals. Section 4410(a) of the Balanced Budget Act of 1997 (Pub. L. 105–33) provides that the area wage index applicable to any hospital that is located in an urban area of a state may not be less than the area wage index applicable to hospitals located in rural areas in that state. This rural floor provision is also specific to hospitals. Because the reclassification provision and the hospital rural floor applies only to hospitals, and not to hospices, we continue to believe the use of the pre-floor and pre-reclassified hospital wage index results is the most appropriate adjustment to the labor portion of the hospice payment rates. This position is longstanding and consistent with other Medicare payment systems (for example, SNF PPS, IRF PPS, and HH PPS). However, the hospice wage index does include the hospice floor, which is applicable to all CBSAs, both rural and urban. The hospice floor adjusts pre-floor, pre-reclassified hospital wage index values below 0.8 by a 15 percent increase subject to a maximum wage index value of 0.8.

Comment: One commenter recommended lowering the permanent 5-percent cap on wage index decreases to a 3-percent cap to protect hospice providers who are already operating with negative or razor-thin operating margins.

Response: We thank the commenter for their recommendation. However, this is outside the scope of the proposed rule. The policy to apply a permanent 5-percent cap on wage index decreases was finalized in the FY 2023 hospice final rule (87 FR 45677). Any changes to the permanent cap policy would have to be proposed and finalized through the rulemaking process and we have not proposed to make any changes to the cap policy for the upcoming fiscal year.

Final Decision: We are finalizing our proposal to use the FY 2024 pre-floor, pre-reclassified hospital wage index data as the basis for the FY 2024 hospice wage index. The wage index applicable for FY 2024 is available on our website at: *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Hospice-Wage-Index.* The hospice wage index for FY 2024 is effective October 1, 2023 through September 30, 2024.

2. FY 2024 Hospice Payment Update Percentage

Section 4441(a) of the BBA (Pub. L. 105–33) amended section 1814(i)(1)(C)(ii)(VI) of the Act to establish updates to hospice rates for FYs 1998 through 2002. Hospice rates were to be updated by a factor equal to the inpatient hospital market basket percentage increase set out under section 1886(b)(3)(B)(iii) of the Act, minus 1 percentage point. Payment rates for FYs since 2002 have been updated according to section 1814(i)(1)(C)(ii)(VII) of the Act, which states that the update to the payment rates for subsequent FYs must be the inpatient hospital market basket percentage increase for that FY. In the FY 2022 IPPS final rule we finalized the rebased and revised IPPS market basket to reflect a 2018 base year. We refer readers to the FY 2022 IPPS final rule (86 FR 45194 through 45208) for further information.

Section 3401(g) of the Affordable Care Act mandated that, starting with FY 2013 (and in subsequent FYs), the hospice payment update percentage would be annually reduced by changes in economy-wide productivity as specified in section 1886(b)(3)(B)(xi)(II) of the Act. The statute defines the productivity adjustment to be equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multifactor productivity (MFP) as projected by the Secretary for the 10-year period ending with the applicable FY, year, cost reporting period, or other annual period) (the ''productivity adjustment''). The United States Department of Labor's Bureau of Labor Statistics (BLS) publishes the official measures of productivity for the United States economy. We note that previously the productivity measure referenced in section 1886(b)(3)(B)(xi)(II) was published by BLS as private nonfarm business multifactor productivity. Beginning with the November 18, 2021 release of productivity data, BLS replaced the term ''multifactor productivity'' with ''total factor productivity'' (TFP). BLS noted that this is a change in terminology only and would not affect the data or methodology. As a result of the BLS name change, the productivity measure referenced in section 1886(b)(3)(B)(xi)(II) of the Act is now published by BLS as ''private nonfarm business total factor productivity.'' However, as mentioned, the data and methods are unchanged. We refer readers to *http://www.bls.gov* for the BLS historical published TFP data. A complete description of IGI's TFP projection methodology is available on the CMS website at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketResearch.* In addition, in the FY 2022 IPPS final rule (86 FR 45214), we noted that beginning with FY 2022, CMS changed the name of this adjustment to refer to it as the

''productivity adjustment'' rather than the ''MFP adjustment''.

In the FY 2024 Hospice Wage Index and Payment Rate Update proposed rule (88 FR 20039), we proposed to apply a market basket percentage increase of 3.0 percent for FY 2024 using the most current estimate of the inpatient hospital market basket (based on IHS Global Inc.'s fourth quarter 2022 forecast with historical data through the third quarter of 2022). Due to the requirements at sections 1886(b)(3)(B)(xi)(II) and 1814(i)(1)(C)(v) of the Act, the proposed inpatient hospital market basket percentage increase for FY 2024 of 3.0 percent is required to be reduced by a productivity adjustment as mandated by the Affordable Care Act (estimated in the proposed rule to be 0.2 percentage point for FY 2024). Therefore, the proposed hospice payment update percentage for FY 2024 was 2.8 percent. We stated that if more recent data became available after the publication of the proposed rule and before the publication of the final rule (for example, a more recent estimate of the inpatient hospital market basket update or productivity adjustment), we would use such data, if appropriate, to determine the hospice payment update percentage for FY 2024 in the final rule. For this final rule, based on IHS Global Inc.'s (IGI) second quarter 2023 forecast with historical data through the first quarter of 2023, the inpatient hospital market basket percentage increase for FY 2024 is 3.3 percent. The forecast of the productivity adjustment for FY 2024 for this final rule, based on IGI's second quarter 2023 forecast, is 0.2 percent. Therefore, the hospice payment update percentage for FY 2024, based on more recent data, is 3.1 percent.

We continue to believe it is appropriate to routinely update the hospice payment system so that it reflects the best available data about differences in patient resource use and costs among hospices as required by the statute. Therefore, we are updating hospice payments using the methodology outlined and apply the 2018-based IPPS market basket percentage increase for FY 2024 of 3.3 percent, reduced by the statutorily required productivity adjustment of 0.2 percentage point along with the wage index budget neutrality adjustment to update the payment rates. We are using the FY 2024 hospice wage index, which uses the FY 2024 pre-floor, pre-reclassified IPPS hospital wage index as its basis.

In the FY 2022 Hospice Wage Index final rule (86 FR 42532 through 42539), we rebased and revised the labor shares for RHC, CHC, GIP, and IRC using MCR data for freestanding hospices (CMS Form 1984–14, OMB Control Number 0938–0758) from 2018. The current labor portion of the payment rates are: RHC, 66.0 percent; CHC, 75.2 percent; GIP, 63.5 percent; and IRC, 61.0 percent. The non-labor portion is equal to 100 percent minus the labor portion for each level of care. The non-labor portion of the payment rates are as follows: RHC, 34.0 percent; CHC, 24.8 percent; GIP, 36.5 percent; and IRC, 39.0 percent.

We received 40 comments on the proposed hospice update percentage of 2.8 percent. A summary of the comments and our responses to those comments are as follows:

Comment: Two commenters, including MedPAC, expressed support for the proposed payment update percentage. MedPAC, stated that they believe the statutorily required market basket payment update for FY 2024 is adequate for hospice payments. The Commission stated that the March 2023 MedPAC report found that indicators of payment adequacy for hospices—including beneficiary access to care, quality of care, provider access to capital, and Medicare payments relative to providers' costs—are generally positive. In particular, the report found that 2020 Medicare margins were 14.2 percent and projected 2023 Medicare margins to be around 8 percent.

Response: We thank commenters for their support.

Comment: Many commenters expressed appreciation for the proposed 2.8 percent increase to hospice payment rates, yet also expressed concern that the proposed update is inadequate. These commenters highlighted that they have experienced unprecedented wage and inflationary pressures over the last several years. They stated that wage costs reflect the majority of expenses and in order to recruit and retain staff they have had to dramatically increase salary and benefit costs as well as rely on more contract labor. They also state that inflation for other goods and services, such as drugs and medical supplies, have contributed to a significant increase in operating costs. Some commenters stated that increased transportation costs, like gasoline prices, have a disproportionate impact on hospice providers, particularly those serving rural patients.

Response: We appreciate the support for the statutorily required hospice payment update, and understand commenter concerns; however, as directed by section 1814(i)(1)(C)(ii)(VII) of the Act, we are required to update hospice payments by the Inpatient Hospital PPS (IPPS) market basket percentage increase (as defined in section 1886(b)(3)(B)(iii)) for the fiscal year, adjusted for productivity (as required by section 1814(i)(1)(C)(iv)(I) of the Act). Section 1886(b)(3)(B)(iii) of the Act defines the market basket percentage increase to be based on an index of appropriately weighted indicators of changes in wages and prices which are representative of the mix of goods and services included in such inpatient hospital services. The 2018-based IPPS market basket is a fixed-weight, Laspeyres-type index that measures price changes over time and would not reflect increases in costs associated with changes in the volume or intensity of input goods and services. As such, the inpatient hospital market basket percentage increase would reflect the prospective price pressures described by the commenters during a high inflation period (such as faster wage growth or higher energy prices) but might not reflect other factors that could increase costs such as the quantity of labor used or any shifts between contract and staff nurses. We note that cost changes (that is, the product of price and quantities) would only be reflected when a market basket is rebased, and the base year weights are updated to a more recent time period.

We agree with the commenters that recent higher inflationary trends have impacted the outlook for price growth over the next several quarters. At the time of the FY 2024 Hospice proposed rule, based on IGI's fourth quarter 2022 forecast with historical data through the third quarter of 2022, the 2018-based inpatient hospital market basket percentage increase was forecasted to be 3.0 percent for FY 2024 reflecting a 3.9-percent forecasted compensation price increase. As stated, in the FY 2024 Hospice proposed rule, we proposed that if more recent data became available, we would use such data, if appropriate, to derive the final FY 2024 inpatient hospital market basket update for the final rule. For this final rule, we are using an updated forecast of the price proxies underlying the market basket that incorporates more recent historical data and reflects a revised outlook regarding the U.S. economy, including compensation and inflationary pressures. As stated previously, based on IGI's second quarter 2023 forecast with historical data through first quarter 2023, the FY 2024 inpatient hospital market basket percentage increase is 3.3 percent (reflecting forecasted compensation price growth of 4.3 percent) and the FY 2024 productivity adjustment is 0.2 percentage point. After consideration of

the comments received, for FY 2024, the final hospice payment update is 3.1 percent (3.3 percent inpatient hospital market basket percentage increase less a 0.2 percentage point productivity adjustment), compared to the proposed hospice payment update for FY 2024 of 2.8 percent.

Comment: Several commenters stated that the IPPS market basket reflects a 2018 base year and while more recent final data may not yet be available, it should be clear that providers' cost structures have changed since 2018. Commenters were also concerned that the lag in the cost reporting and other structures and/or indexes that are used as inputs in determining hospice payment in this proposed rule fail to capture the inflationary pressures that providers must bear to provide care in real time and request that CMS consider this fact for the final rule.

Response: The IPPS market basket measures price changes (including changes in the prices for wages and salaries) over time and would not reflect increases in costs associated with changes in the volume or intensity of input goods and services until the market basket is rebased. We appreciate the commenter's request to rebase the IPPS market basket more frequently. Section 404 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108–173) states the Secretary shall establish a frequency for revising the cost weights of the IPPS market basket more frequently than once every 5 years. We established a rebasing frequency of every four years, in part because the cost weights obtained from the Medicare cost reports do not indicate much of a change in the weights from year to year. The most recent rebasing of the IPPS market basket was for the FY 2022 payment update (86 FR 45194 through 45207) and reflected a base year of 2018 costs. Despite this established frequency, we regularly monitor the Medicare cost report data to assess whether a rebasing is technically appropriate, and we will continue to do so in the future. In this Medicare report we share some preliminary analysis of the Medicare cost report data for IPPS hospitals for 2021 that became available for this final rule. For 2021, the IPPS compensation cost weight is estimated to be about 1 percentage point lower than the 2018-based IPPS market basket compensation cost weight of 53.0 percent and reflects a combined decrease in the salary and benefit cost weights that is larger than the increase in the contract labor cost weight. The major cost categories that preliminarily show an increase in the cost weight over this period are pharmaceuticals (proxied by the PPI—Commodity—Special Index—Pharmaceuticals for human use, prescription) and home office contract labor compensation costs (which, would be proxied by the ECI for Professional and Related workers). We plan to review the 2021 Medicare cost report data in more detail as well as 2022 Medicare cost report data as soon as complete information is available and evaluate these data for future rebasing of the IPPS market basket.

Comment: Many commenters stated that the unprecedented magnitude of the market basket forecast error over 2021 and 2022 warrants special consideration to avoid significant long-term underfunding of the hospice benefit and to help address current workforce challenges. Several commenters noted that in FY 2021 and FY 2022, CMS forecasted 2.4 percent and 2.7 percent cost inflation while the commenters stated that the actual cost inflation borne by hospice providers was 3.1 percent and 5.7 percent respectively, which the commenters calculated to be a 3.7 percent payment update error. Commenters requested that CMS use the special exceptions and adjustments authority to apply a one-time cumulative retrospective adjustment of 3.7 percent for FYs 2021 and 2022 to ensure that Medicare payments more accurately reflect the cost of providing hospice care. The commenters highlighted that the law does not prohibit CMS from adjusting the annual IPPS operating market basket increase (and by extension, the annual hospice rate increases) based on later known errors in historical forecasting. Several of the commenters stated that unlike other healthcare providers, such as hospitals, hospices have a large percentage (nearly 90 percent) of their revenues that originate from the Medicare program. They state that any insufficient payments from Medicare will have a more significant impact on hospice providers revenue since they do not have the ability to negotiate higher rates with private insurers.

Response: We thank the commenters for their recommendation. However, the inpatient hospital market basket percentage increases are required by law to be set prospectively, which means that the update relies on a mix of both historical data for part of the period for which the update is calculated and forecasted data for the remainder. There is currently no mechanism to adjust for market basket forecast error in the hospice payment update. Furthermore, beginning in 1989, the Congress gave hospices their first increase (20 percent) in payment since 1986 and tied future increases to the annual increase in the hospital market basket through a provision contained in the Omnibus Budget Reconciliation Act of 1989. While the projected inpatient hospital market basket percentage increases for FY 2021 and FY 2022 were underforecast (actual increases less forecasted increases were positive), this was largely due to unanticipated inflationary and labor market pressures as the economy emerged from the COVID–19 PHE. Importantly, the hospital market basket has been used for many years to update hospice payment rates and an analysis of the forecast error over a longer period of time shows that the forecast error has been both positive and negative. For example, the 10-year cumulative forecast error (excluding FY 2018 when the hospice payment update was statutorily required to be 1.0 percent) showed a negative forecast error (that is, forecasted increases were greater than actual increases), of 0.9 percentage point (2013–2022). In addition, for each year from 2012 through 2020 (again excluding 2018), the final FY inpatient hospital market basket percentage increase (implemented in the final rule) was higher than the actual inpatient hospital market basket percentage increase once historical data were available; with 7 out of the 8 years having a forecast error greater than 0.5 percentage point (in absolute terms). Only considering the forecast error for years when the final inpatient hospital market basket percentage increase was lower than the actual inpatient hospital market basket percentage increase does not consider the numerous years that providers benefited from the forecast error.

Comment: One commenter stated concern about the quality of cost report data, especially with regard to capturing labor costs. They specifically recommend that the cost reports be amended to allow for a greater breakdown of costs for contracted versus hospice-administered inpatient services to apportion the labor share appropriately. Additionally, the commenter requested that CMS clarify how frequently they intend to update the labor shares component moving forward and clarify the development and methodology around the ''standardization factor''.

Response: While we did not solicit comments on the quality of cost report data, we appreciate the commenter's request for future changes to the hospice cost report and we will consider this comment when working on any future modifications to the hospice cost report.

Comment: A few commenters cited the resumption of the sequestration policy in 2022 as a concern regarding the adequacy of the proposed payment update percentage.

Response: We note that Medicare sequestration affects all payment systems and is not unique to the Medicare hospice benefit or the statutory authority governing the payment rate update. As such, comments regarding sequestration are outside the scope of this final rule.

Final Decision: We are finalizing the hospice payment update percentage of 3.1 percent for FY 2024. Based on IHS Global, Inc.'s more recent forecast of the inpatient hospital market basket percentage increase and the productivity adjustment, the hospice payment update percentage for FY 2024 will be 3.1 percent for hospices that submit the required quality data and −0.9 percent (FY 2024 hospice payment update of 3.1 percent minus 4 percentage points) for hospices that do not submit the required quality data.

3. FY 2024 Hospice Payment Rates

There are four payment categories that are distinguished by the location and intensity of the hospice services provided. The base payments are adjusted for geographic differences in wages by multiplying the labor share, which varies by category, of each base rate by the applicable hospice wage index. A hospice is paid the RHC rate for each day the beneficiary is enrolled in hospice, unless the hospice provides CHC, IRC, or GIP. CHC is provided during a period of patient crisis to maintain the patient at home; IRC is short-term care to allow the usual caregiver to rest and be relieved from caregiving; and GIP care is intended to treat symptoms that cannot be managed in another setting.

As discussed in the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47172), we implemented two different RHC payment rates, one RHC rate for the first 60 days and a second RHC rate for days 61 and beyond. In addition, in that final rule, we implemented an SIA payment for RHC when direct patient care is provided by an RN or social worker during the last 7 days of the beneficiary's life. The SIA payment is equal to the CHC hourly rate multiplied by the hours of nursing or social work provided (up to 4 hours total) that occurred on the day of service if certain criteria are met. To maintain budget neutrality, as required under section 1814(i)(6)(D)(ii) of the Act, the new RHC rates were adjusted by a service intensity add-on budget neutrality factor (SBNF). The SBNF is used to reduce the overall RHC rate in order to ensure that SIA payments are budget neutral. At the beginning of every FY, SIA utilization is compared to the prior year in order calculate a budget neutrality adjustment.

In the FY 2017 Hospice Wage Index and Rate Update final rule (81 FR 52156), we initiated a policy of applying a wage index standardization factor to hospice payments in order to eliminate the aggregate effect of annual variations in hospital wage data. For FY 2024 hospice rate setting, we are continuing our longstanding policy of using the most recent data available. Specifically, we are using FY 2022 claims data for the FY 2024 payment rate updates. In order to calculate the wage index standardization factor, we simulate total payments using FY 2022 hospice utilization claims data with the FY 2023 wage index (pre-floor, pre-reclassified hospital wage index with the hospice floor, and the 5-percent cap on wage index decreases) and FY 2023 payment rates and compare it to our simulation of total payments using FY 2022 utilization claims data, the FY 2024 hospice wage index (pre-floor, pre-reclassified hospital wage index with hospice floor, and the 5-percent cap on wage index decreases) and FY 2023 payment rates. By dividing payments for each level of care (RHC days 1 through 60, RHC days 61+, CHC, IRC, and GIP) using the FY 2023 wage index and payment rates for each level of care by the FY 2024 wage index and FY 2023 payment rates, we obtain a wage index standardization factor for each level of care. The wage index standardization factors for each level of care are shown in the Tables 1 and 2.

The FY 2024 RHC rates are shown in Table 1. The FY 2024 payment rates for CHC, IRC, and GIP are shown in Table 2.

TABLE 1: FY 2024 Hospice RHC Payment Rates

Code	Description	FY 2023 Payment Rates	SIA Budget Neutrality Factor	Wage Index Standardization Factor	FY 2024 Hospice Payment Update	FY 2024 Payment Rates
651	**Routine Home Care (days 1-60)**	$211.34	1.0009	1.0011	1.031	$218.33
651	**Routine Home Care (days 61+)**	$167.00	1.0000	1.0010	1.031	$172.35

TABLE 2: FY 2024 Hospice CHC, IRC, and GIP Payment Rates

Code	Description	FY 2023 Payment Rates	Wage Index Standardization Factor	FY 2024 Hospice Payment Update	FY 2024 Payment Rates
652	**Continuous Home Care Full Rate = 24 hours of care.**	$1,522.04 ($63.42 per hour)	0.9976	1.031	$1,565.46 ($65.23 per hour)
655	**Inpatient Respite Care**	$492.10	1.0007	1.031	$507.71
656	**General Inpatient Care**	$1,110.76	1.0001	1.031	$1,145.31

Sections 1814(i)(5)(A) through (C) of the Act require that hospices submit quality data, based on measures to be specified by the Secretary. In the FY 2012 Hospice Wage Index and Rate Update final rule (76 FR 47320 through 47324), we implemented a HQRP as required by those sections. Hospices were required to begin collecting quality data in October 2012 and submit those quality data in 2013. Section 1814(i)(5)(A)(i) of the Act requires that beginning with FY 2014 through FY 2023, the Secretary shall reduce the market basket percentage increase by 2 percentage points for any hospice that does not comply with the quality data submission requirements with respect to that FY. Section 1814(i)(5)(A)(i) of the Act was amended by section 407(b) of Division CC, Title IV of the CAA, 2021 to change the payment reduction for failing to meet hospice quality reporting requirements from 2 to 4 percentage points. This policy would apply beginning with the FY 2024 Annual Payment Update (APU) that is based on CY 2022 quality data. Specifically, the Act requires that, for FY 2014 through FY 2023, the Secretary shall reduce the market basket percentage increase by 2 percentage points and beginning with the FY 2024 APU and for each subsequent year, the Secretary shall reduce the market basket percentage increase by 4 percentage points for any hospice that does not comply with the quality data submission requirements for that FY. The FY 2024 rates for hospices that do not submit the required quality data would be updated by −0.9 percent, which is the FY 2024 hospice payment update percentage of 3.1 percent minus 4 percentage points. These rates are shown in Tables 3 and 4.

TABLE 3: FY 2024 Hospice RHC Payment Rates for Hospices That DO NOT Submit the Required Quality Data

Code	Description	FY 2023 Payment Rates	SIA Budget Neutrality Factor	Wage Index Standardization Factor	FY 2024 Hospice Payment Update of 3.1% minus 4 percentage points = -0.9%	FY 2024 Payment Rates
651	**Routine Home Care (days 1-60)**	$211.34	1.0009	1.0011	0.991	$209.86
651	**Routine Home Care (days 61+)**	$167.00	1.0000	1.0010	0.991	$165.66

TABLE 4: FY 2024 Hospice CHC, IRC, and GIP Payment Rates for Hospices That DO NOT Submit the Required Quality Data

Code	Description	FY 2023 Payment Rates	Wage Index Standardization Factor	FY 2024 Hospice Payment Update of 3.1% minus 4 percentage points = -0.9%	FY 2024 Payment Rates
652	**Continuous Home Care Full Rate = 24 hours of care.**	$1,522.04 ($63.42 per hour)	0.9976	0.991	$1,504.72 ($62.70 per hour)
655	**Inpatient Respite Care**	$492.10	1.0007	0.991	$488.01
656	**General Inpatient Care**	$1,110.76	1.0001	0.991	$1,100.87

We did not receive any comments on the proposed FY 2024 hospice payment rates.

Final Decision: We are finalizing the FY 2024 payment rates in accordance with statutorily mandated requirements.

4. Hospice Cap Amount for FY 2024

As discussed in the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47183), we implemented changes mandated by the IMPACT Act of 2014. Specifically, we stated that for accounting years that end after September 30, 2016 and before October 1, 2025, the hospice cap is updated by the hospice payment update percentage rather than using the CPI–U. Division CC, section 404 of the CAA, 2021 extended the accounting years impacted by the adjustment made to the hospice cap calculation until 2030. In the FY 2022 Hospice Wage Index final rule (86 FR 42539), we finalized conforming regulations text changes at § 418.309 to reflect the provisions of the CAA, 2021. Division P, section 312 of the CAA, 2022 amended section 1814(i)(2)(B) of the Act and extended the provision that mandates the hospice cap be updated by the hospice payment update percentage (hospital market basket percentage increase reduced by the productivity adjustment) rather than the CPI–U for accounting years that end after September 30, 2016 and before October 1, 2031. Division FF, section 4162 of the CAA, 2023 amended section 1814(i)(2)(B) of the Act and extended the provision that currently mandates the hospice cap be updated by the hospice payment update percentage (hospital market basket percentage increase reduced by the productivity adjustment) rather than the CPI–U for accounting years that end after September 30, 2016 and before October 1, 2032. Before the enactment of this provision, the hospice cap update was set to revert to the original methodology of updating the annual cap amount by the CPI–U beginning on October 1, 2031. Therefore, for accounting years that end after September 30, 2016 and before October 1, 2032, the hospice cap amount is updated by the hospice payment update percentage rather than the CPI–U. As a result of the changes mandated by the CAA, 2023, we are proposing conforming regulation text changes at § 418.309 to reflect the new language added to section 1814(i)(2)(B) of the Act.

The hospice cap amount for the FY 2024 cap year is $33,494.01, which is equal to the FY 2023 cap amount ($32,486.92) updated by the FY 2024 hospice payment update percentage of 3.1 percent.

We received a few comments regarding the hospice cap amount. A summary of these comments and our responses to those comments are as follows:

Comment: One commenter expressed support for the FY 2024 hospice cap.

Response: We thank the commenter for their support.

Comment: A few commenters, including MedPAC, opposed an increase to the hospice cap. One commenter suggested that reducing the hospice cap level would generate savings to the hospice program and encourage all providers to focus on enhancing efforts to meet hospice eligibility and provide care for all beneficiaries. Another commenter stated that there are data that support that a lower cap results in fewer agencies exceeding it. This commenter believes that reducing the cap could decrease hospice spending by a significant amount and recommended that the cap remain at its current amount $32,486.92 with reconsideration of the cap being wage-adjusted. MedPAC recommended that the hospice aggregate cap be wage adjusted and reduced by 20 percent.

Response: We thank the commenters for their recommendations to improve the hospice cap; however, we are required by law to update the hospice cap amount from the preceding year by the hospice payment update percentage, in accordance with section 1814(i)(2)(B)(ii) of the Act. Therefore, we do not have the statutory authority to reduce the aggregate cap amount.

Final Decision: We are finalizing the update to the hospice cap amount for FY 2024 in accordance with statutorily mandated requirements.

5. Conforming Text Revisions for Telehealth Services

In the FY 2024 Hospice Wage Index and Rate Update proposed rule (88 FR 20041), we proposed to revise the regulations text at § 418.22(a)(4)(ii) in accordance with Division FF, section 4113(f) of the CAA, 2023, effective January 1, 2024. Additionally, we proposed to remove § 418.204(d), effective retroactively to May 12, 2023 to align with the end of the COVID–19 PHE. In the first COVID–19 interim final rule ''Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency'' (85 FR 19230, 19289) (April 6, 2020), we amended the hospice regulations at § 418.204 on an interim basis to specify that when a patient is receiving routine home care,

hospices could provide services via a telecommunications system, if it is feasible and appropriate to ensure that Medicare patients can continue receiving services that are reasonable and necessary for the palliation and management of a patients' terminal illness and related conditions without jeopardizing the patients' health or the health of those who are providing such services during the COVID–19 PHE. We stated that this change was effective for the duration of the COVID–19 PHE. Specifically, we proposed to:

- Revise § 418.22(a)(4)(ii), which outlines the certification of terminal illness requirements to add ''or through December 31, 2024, whichever is later'' after ''During a Public Health Emergency, as defined in § 400.200 of this chapter.''
- Revise § 418.204, to remove subsection (d) to eliminate the use of technology in furnishing services during a PHE.

We received several comments regarding the regulations text revisions for telehealth services. A summary of these comments and our responses to those comments are as follows:

Comment: In general commenters appreciated the extension of the telehealth face-to-face coverage through the end of calendar year 2024. Commenters highlighted the benefits to patients and families, particularly in rural areas. Many commenters encouraged CMS to consider making this a permanent provision. Commenters cited benefits of continuing telehealth under hospice, such as helping to alleviate staffing concerns and enhanced streamlining of hospice admission.

Response: We thank commenters for their consideration of the regulation changes regarding the use of telehealth under the Medicare hospice benefit and we agree that the use of telehealth benefits patients and their families, particularly in rural areas. We note that, at this time, the statute only authorized the Secretary extend this flexibility through December 31, 2024. Additionally, while we acknowledge the usefulness of telehealth, we continue to believe that hospice at its core is a benefit best provided in-person and stress the importance of in-person services. Currently, we do not have plans to make this provision permanent, nor do we believe that we have the statutory authority to do so.

Comment: Some commenters encouraged CMS to develop modifiers or codes for telehealth services and require reporting on the hospice claim, similar to what was finalized in the CY 2023 HH PPS final rule, and to allow that these costs be considered allowable administrative costs on the hospice agency cost report.

Response: We will take into consideration comments requesting that supplemental telehealth contact be reported on hospice claims and as allowable administrative costs; however, upon expiration of the face-to-face flexibility on December 31, 2024, we would expect telehealth services be summarily limited to follow-up contact with patients and would not expect to see the provision of hospice services furnished via telecommunications systems. As such, the value of claims reporting for this type of contact is not apparent at this time.

Final Decision: We are finalizing the conforming regulations text revisions for telehealth as proposed.

C. Updates to the Hospice Quality Reporting Program (HQRP)

1. Background and Statutory Authority

The Hospice Quality Reporting Program (HQRP) specifies reporting requirements for the Hospice Item Set (HIS), administrative data, and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Hospice Survey. Section 1814(i)(5) of the Act requires the Secretary to establish and maintain a quality reporting program for hospices. Section 1814(i)(5)(A)(i) of the Act was amended by section 407(b) of Division CC, Title IV of the CAA, 2021 to change the payment reduction for failing to meet hospice quality reporting requirements from 2 to 4 percentage points. Specifically, the Act requires that, beginning with FY 2014 through FY 2023, the Secretary shall reduce the market basket percentage increase by 2 percentage points and beginning with the FY 2024 APU and for each subsequent year, the Secretary shall reduce the market basket percentage increase by 4 percentage points for any hospice that does not comply with the quality data submission requirements for that FY. This payment penalty increase to 4 percent is statutorily required; as discussed in the following paragraphs, we proposed to codify its application and set completeness thresholds at § 418.312(j).

Depending on the amount of the annual update for a particular year, a reduction of 4 percentage points beginning in FY 2024 could result in the annual inpatient hospital market basket percentage increase being less than zero percent for a FY and may result in payment rates that are less than payment rates for the preceding FY. Any reduction based on failure to comply with the reporting requirements, as required by section 1814(i)(5)(B) of the Act, would apply only for the specified year. Typically, about 18 percent of Medicare-certified hospices are found non-compliant with the HQRP reporting requirements and subject to the APU payment reduction for a given FY.

In the FY 2022 Hospice Wage Index and Payment Rate Update final rule (86 FR 42552), we finalized two new measures using claims data: (1) Hospice Visits in the Last Days of Life (HVLDL); and (2) Hospice Care Index (HCI). We also finalized a policy that claims-based measures would use 8 quarters of data in order to publicly report on more hospices.

In addition, we removed the seven Hospice Item Set (HIS) Process Measures from the program as individual measures and public reporting because the HIS Comprehensive Assessment Measure is sufficient for measuring care at admission without the seven individual process measures. For a detailed discussion of the historical use for measure selection and removal for the HQRP quality measures, we refer readers to the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47142) and the FY 2019 Hospice Wage Index and Rate Update final rule (83 FR 38622). In the FY 2022 Hospice Wage Index and Rate Update final rule (86 FR 42553), we finalized § 418.312(b)(2), which requires hospices to provide administrative data, including claims-based measures, as part of the HQRP requirements for § 418.306(b). In that same final rule, we provided CAHPS Hospice Survey updates. We finalized temporary changes to our public reporting policies based on the March 27, 2020 memorandum [4] and provided another tip sheet, referred to as the ''Third Edition HQRP Public Reporting Tip Sheet'' on the HQRP Requirements and Best Practices web page.

As finalized in the FY 2022 Hospice Wage Index and Payment Rate Update final rule (86 FR 42552), public reporting of the two new claims-based quality measures (QMs), the Hospice Visits in Last Days of Life (HVLDL) and the Hospice Care Index (HCI) is available on the Care Compare/Provider

[4] Exceptions and Extensions for Quality Reporting Requirements for Acute Care Hospitals, PPS-Exempt Cancer Hospitals, Inpatient Psychiatric Facilities, Skilled Nursing Facilities, Home Health Agencies, Hospices, Inpatient Rehabilitation Facilities, Long-Term Care Hospitals, Ambulatory Surgical Centers, Renal Dialysis Facilities, and MIPS Eligible Clinicians Affected by COVID–19 are available at: *https://www.cms.gov/files/document/guidance-memo-exceptions-and-extensions-quality-reporting-and-value-based-purchasing-programs.pdf.*

Data Catalogue (PDC) web pages as of the August 2022 refresh. In the FY 2023 Hospice proposed rule, we did not propose any new quality measures. However, we provided updates on already-adopted measures. Table 5 shows current quality measures finalized since the FY 2022 Hospice Wage Index and Payment Rate Update final rule.

TABLE: 5 Quality Measures in Effect for the Hospice Quality Reporting Program

Hospice Quality Reporting Program
Hospice Item Set
Hospice and Palliative Care Composite Process Measure—HIS-Comprehensive Assessment Measure at Admission includes: 1. Patients Treated with an Opioid who are Given a Bowel Regimen 2. Pain Screening 3. Pain Assessment 4. Dyspnea Treatment 5. Dyspnea Screening 6. Treatment Preferences 7. Beliefs/Values Addressed (if desired by the patient)
Administrative Data, including Claims-based Measures
Hospice Visits in Last Days of Life (HVLDL)
Hospice Care Index (HCI) 1. Continuous Home Care (CHC) or General Inpatient (GIP) Provided 2. Gaps in Skilled Nursing Visits 3. Early Live Discharges 4. Late Live Discharges 5. Burdensome Transitions (Type 1)–Live Discharges from Hospice Followed by Hospitalization and Subsequent Hospice Readmission 6. Burdensome Transitions (Type 2)–Live Discharges from Hospice Followed by Hospitalization with the Patient Dying in the Hospital 7. Per-beneficiary Medicare Spending 8. Skilled Nursing Care Minutes per Routine Home Care (RHC) Day 9. Skilled Nursing Minutes on Weekends 10. Visits Near Death
CAHPS Hospice Survey
CAHPS Hospice Survey 1. Communication with Family 2. Getting timely help 3. Treating patient with respect 4. Emotional and spiritual support 5. Help for pain and symptoms 6. Training family to care for the patient. 7. Rating of this hospice 8. Willing to recommend this hospice

2. Hospice Outcomes & Patient Evaluation (HOPE) Update

As finalized in the FY 2020 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements final rule (84 FR 38484), we are developing a hospice instrument named Hospice Outcomes & Patient Evaluation (HOPE). Our primary objectives for HOPE are to provide quality data for the HQRP requirements through standardized data collection; and provide additional clinical data that could inform future payment refinements. To the extent that the instrument utilizes data already being collected for the Hospice QRP, our statutory authority for the HOPE instrument derives from section 1814(i)(5)(C) of the Act. In addition, statutory language at section 1861(aa)(2)(G) of the Act permits the Secretary to impose ''such other requirements as the Secretary may find necessary in the interest of the health and safety of the individuals who are provided care and services.''

The HOPE tool will be a component of implementing high-quality and safe hospice care for patients, both in Medicare and non-Medicare. HOPE would also contribute to the patient's plan of care through providing patient data ongoing throughout the hospice stay. By providing data from multiple time points across the hospice stay, HOPE would provide information to hospice providers to improve practice and care quality. HOPE is intended to provide quality data to calculate outcomes and develop additional quality measures.

We stated in the FY 2022 Hospice Wage Index and Payment Update final rule (86 FR 42528) that while the standardized patient assessment data elements for certain post-acute care providers required under the IMPACT Act of 2014 are not applicable to hospices, it would be reasonable to include some of those standardized elements that appropriately and feasibly apply to hospice to the extent permitted by our statutory authority. Many patients move through other providers within the healthcare system to hospice. Therefore, considering tracking key demographic and social risk factor items that apply to hospice could support our goals for continuity of care, overall patient care and well-being, development of infrastructure for the interoperability of electronic health information, and health equity which is also discussed in this rule.

In the FY 2023 Hospice Final Rule (87 FR 45669), we outlined the testing phases HOPE has undergone, including cognitive, pilot, alpha testing, and national beta field testing. National beta testing, completed at the end of October 2022, allowed us to obtain input from participating hospice teams about the assessment instrument and field testing to refine and support the final draft items and time points for HOPE. It also allowed us to estimate the time to complete the HOPE data items and establish the interrater reliability of each item.

We continue HOPE development in accordance with the Blueprint for the CMS Measures Management System. The development of HOPE is grounded in information gathering activities to identify and refine hospice domains and candidate items. We appreciate the industry's and trade associations' engagement in providing input through information sharing activities, including listening sessions, expert interviews, key stakeholder interviews, and focus groups to support HOPE development. As CMS proceeds with the refinement of HOPE, we will continue to engage with stakeholders through sub-regulatory channels. We intend to continue to host HQRP Forums to allow hospices and other interested parties to engage with us on the latest updates and ask questions on the development of HOPE and related quality measures as appropriate. We also have a dedicated email account, *HospiceAssessment@cms.hhs.gov,* for comments about HOPE. We will use field test results to create a final version of HOPE to propose in future rulemaking for national implementation. We will continue to inform all stakeholders throughout this process by using a variety of sub-regulatory channels and regular HQRP communication strategies, such as Open-Door Forums (ODF), Medicare Learning Network (MLN), *CMS.gov* website announcements, listserv messaging, and other ad hoc publicly announced opportunities. We appreciate the support for HOPE and reiterate our commitment to providing updates and engaging stakeholders through sub-regulatory means. HOPE updates can be found at: *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/HOPE* and engagement opportunities, including those regarding HOPE are at: *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-QRP-Provider-Engagement-Opportunities.*

We plan to provide additional information regarding HOPE testing results on the HQRP website in fall of 2023.

Comment: Public comments generally supported development of HOPE. However, commenters requested more stakeholder engagement and a generous implementation lead time. Several comments expressed concern about the potential administrative burden or workflow changes the new instrument would impose. Some commenters expressed interest in the role HOPE will play in advancing health equity, including voicing support for the collection of social risk data, including social determinants of health (SDOH) data. One commenter recommended that CMS review LCD guidelines in the context of health equity. One commenter encouraged CMS to recognize the role of occupational therapists within the IDG while finalizing HOPE.

Response: We appreciate all stakeholders' input regarding HOPE development and will take these comments into consideration. We are committed to developing and implementing HOPE with a minimum burden to stakeholders. Additional information about HOPE will be presented to the public as appropriate.

3. Update on Future Quality Measure (QM) Development

In the FY 2020 Hospice Wage Index and Payment Rate Update final rule (84 FR 38484), we provided updates related to CMS's process for identifying high priority areas of quality measurement and improvement and for developing quality measures that address those priorities. Information on the current HQRP quality measures can be found at: *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Current-Measures.*

In this final rule, we provide updates on the status of current HQRP measures, and the development of hospice quality measure concepts based on the future use of HOPE, administrative, and health equity data. On July 26, 2022, the CBE endorsed the claims-based Hospice Visits in the Last Days of Life measure (HVLDL). More information can be found on the HQRP Quality Measure Development web page: *https://www.cms.gov/medicare/hospice-quality-reporting-program/quality-measure-development.* CMS intends to develop several quality measures based on information collected by HOPE when it is implemented. Currently, CMS intends to develop at least two HOPE-based process and outcome quality measures: (1) Timely Reassessment of Pain Impact; and (2) Timely Reassessment of Non-Pain Symptom Impact. Additional information about CMS's HOPE-based measure development efforts is available in the 2021 technical expert panel (TEP) Summary Reports and the 2021 Information Gathering Report, available at: *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-QRP-Provider-Engagement-Opportunities.*

Comment: Commenters were generally supportive of the two HOPE-based measures currently in development, but also requested additional information about the measure specifications and more stakeholder engagement opportunities. One commenter expressed concern about added regulatory burdens or workflow changes from adopting new quality measures. Several commenters encouraged CMS to allow reassessments to be completed telephonically or via remote patient monitoring (RPM), or to allow any member of the interdisciplinary care team to perform the assessment. Some commenters suggested reducing the reassessment

timeframe to one day instead of two, especially if the reassessment were allowed to be conducted telephonically. Commenters encouraged CMS to develop outcome measures as well as process measures, and to incorporate patient preferences into future quality measures.

Response: We appreciate all stakeholders' input regarding quality measure development and will take these comments into consideration for future QM development initiatives. We remain committed to building a robust, evidence-based set of HQRP measures that holistically and reliably reflect the quality of hospice care.

As development of the HOPE-based quality measures Timely Reassessment of Pain Impact and Timely Reassessment of Non-Pain Symptom Impact continues, CMS will keep stakeholders informed of progress and will offer opportunities for stakeholders to learn more and provide feedback. We appreciate the input regarding quality measure development and will take these comments into consideration for future QM development initiatives. We are committed to the Meaningful Measures Initiative (*https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/CMS-Quality-Strategy*) and Measures Management System Blueprint (*https://mmshub.cms.gov/blueprint-measure-lifecycle-overview*) that informs and guides quality measure development priorities and processes.

4. Health Equity Updates Related to HQRP

a. Background

In the FY 2023 Hospice Payment Rate Update proposed rule (87 FR 19442), we included a Request for Information (RFI) on hospices' current health equity activities and a future approach to advancing health equity in hospice. We define health equity as ''the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.'' We are working to advance health equity by designing, implementing, and operationalizing policies and programs that support health for all the people served by our programs, eliminating avoidable differences in health outcomes experienced by people who are disadvantaged or underserved, and providing the care and support that our enrollees need to thrive. CMS' goals outlined in the *CMS Framework for Health Equity 2022–2023* are in line with Executive Order 13985, ''Advancing Racial Equity and Support for Underserved Communities Through the Federal Government.'' [5] The goals included in the *CMS Framework for Health Equity* serve to further advance health equity, expand coverage, and improve health outcomes for the more than 170 million individuals supported by our programs, and sets a foundation and priorities for our work, including: strengthening our infrastructure for assessment, creating synergies across the health care system to drive structural change, and identifying and working to eliminate barriers to CMS-supported benefits, services, and coverage.

In addition to the *CMS Framework for Health Equity,* CMS seeks to ''advance health equity'' as one of eight goals comprising the CMS National Quality Strategy (NQS).[6] The NQS identifies a wide range of potential quality levers that can support our advancement of equity, including: establishing a standardized approach for patient-reported data and stratification; employing quality and value-based programs to publicly report and incentivize closing equity gaps; and developing equity-focused performance metrics, regulations, oversight strategies, and quality improvement initiatives.

A goal of this NQS is to address persistent disparities that underly our healthcare system. Racial disparities, in particular, are estimated to cost the U.S. $93 billion in excess medical costs and $42B in lost productivity per year, in addition to economic losses due to premature deaths.[7] At the same time, racial and ethnic diversity has increased in recent years with an increase in the percentage of people who identify as two or more races accounting for most of the change, rising from 2.9 percent to 10.2 percent between 2010 and 2020.[8] Therefore, we need to consider ways to reduce disparities, achieve equity, and support our diverse population through the way we measure quality and display of data.

We solicited public comments via the aforementioned RFI on a potential health equity structural composite measure in the Hospice Quality Reporting Program. We refer readers to the FY 2023 Hospice Payment Rate Update final rule (87 FR 45669) for a summary of the public comments and suggestions received in response to the health equity RFI.

We took these comments into account, and we continue to work to develop policies, quality measures, and measurement strategies on this important topic. After considering public comments, CMS decided to convene a health equity technical expert panel to provide additional input to inform the development of health equity quality measures. The work of this technical expert panel is described in detail below.

Home Health and Hospice Health Equity Technical Expert Panel

To support new health equity measure development, the Home Health and Hospice Health Equity Technical Expert Panel (Home Health & Hospice HE TEP) was convened by a CMS contractor in Fall 2022. The Home Health & Hospice HE TEP comprised health equity experts from hospice and home health settings, specializing in quality assurance, patient advocacy, clinical work, and measure development. The TEP was charged with providing input on a potential cross-setting health equity structural composite measure concept as set forth in the FY 2023 Hospice Payment Rate Update proposed rule (87 FR 19442) as part of an RFI related to the HQRP Health Equity Initiative. Specifically, the TEP assessed the face validity and feasibility of the potential structural measure. The TEP also provided input on possible confidential feedback report options to be used for monitoring health equity. TEP members also had the opportunity to provide ideas for additional health equity measure concepts or approaches to addressing health equity in hospice and home health settings.

Broad themes that recurred throughout discussions were community access and alignment between the community population and the organization's patient population. A detailed summary of the Home Health & Hospice HE TEP meetings and final TEP recommendations is available on the Hospice QRP Health Equity web page: *https://www.cms.gov/medicare/hospice-*

[5] *https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/.*

[6] Centers for Medicare & Medicaid Services. What is the CMS Quality Strategy? Available at: *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/CMS-Quality-Strategy.*

[7] Ani Turner, The Business Case for Racial Equity, A Strategy for Growth, W.K. Kellogg Foundation and Altarum, April 2018.

[8] 2022 National Healthcare Quality and Disparities Report. Content last reviewed November 2022. Agency for Healthcare Research and Quality, Rockville, MD. *https://www.ahrq.gov/research/findings/nhqrdr/nhqdr22/index.html.*

quality-reporting-program/hospice-qrp-health-equity. CMS is taking the TEP feedback into consideration as we continue to develop health equity concepts and policies related to HQRP.

Universal Foundation

To further the goals of the CMS National Quality Strategy (NQS), CMS leaders from across the Agency have come together to move towards a building-block approach to streamline quality measures across CMS quality programs for the adult and pediatric populations. This ''Universal Foundation'' of quality measure will focus provider attention, reduce burden, identify disparities in care, prioritize development of interoperable, digital quality measures, allow for cross-comparisons across programs, and help identify measurement gaps. The development and implementation of the Preliminary Adult and Pediatric Universal Foundation Measures will promote the best, safest, and most equitable care for individuals as we all come together on these critical quality areas. As CMS moves forward with the Universal Foundation, we will be working to identify foundational measures in other specific settings and populations to support further measure alignment across CMS programs as applicable.

To learn more the impact and next steps of the Universal Foundation, read the recent publication of 'Aligning Quality Measures Across CMS—the Universal Foundation' in the New England Journal of Medicine.

b. Anticipated Future State

Possible Future Health Equity Efforts

We are committed to developing approaches to meaningfully incorporate the advancement of health equity into the HQRP. One consideration is including social determinants of health into our quality measures and data stratification. Social determinants of health—social, economic, environmental, and community conditions—may have a stronger influence on the population's health and well-being than services delivered by practitioners and healthcare delivery organizations.[9] Given these impacts, measure stratification is important. Measure stratification helps identify disparities by calculating quality measure outcomes separately for different beneficiary populations. By looking at measure results for different populations separately, CMS and providers can see how care outcomes may differ between certain patient populations in a way that would not be apparent from an overall score (that is, a score averaged over all beneficiaries). This helps CMS to better fulfill our health equity goals. For example, when certain quality measures from the past two decades related to healthcare outcomes for children are stratified by race, ethnicity, and income, they show that important health disparities have been narrowed, because outcomes for children in the lowest income households and for Black and Hispanic children improved faster than outcomes for children in the highest income households or for White children.[10] This differential impact would not be apparent without stratification. This work supports our desire to understand with providers what can be learned from stratifying our quality measures by race, ethnicity, and income.

As part of our efforts to advance health equity in hospice, we are taking into consideration the health equity measures used in other health care provider settings. There are social determinants of health (SDOH) data items in the standardized patient assessment instruments used in the post-acute care (PAC) settings, and data items related to social drivers of health in acute care settings such as the hospital inpatient quality reporting program. We see value in aligning SDOH data items across all care settings and might consider adding SDOH data items used by other care settings into HQRP as we develop future health equity quality measures under our HQRP statutory authority.[11] This would further the NQS to align quality measures across our programs as part of the Universal Foundation.[12]

As we move this important work forward, we will continue to take input from hospice stakeholders into account and monitor the application of proposed health equity policies across CMS and other HHS initiatives. The Initial Proposals for Updating OMB's Race and Ethnicity Statistical Standards, 88 FR 5375, sought public comments through April 27, 2023. Also, the Office of the National Coordinator for Health IT (ONC) welcomes input on data classes and data elements for future versions of the United States Core Data for Interoperability (USCDI)—a standardized set of health data classes and constituent data elements for nationwide, interoperable health information exchange.[13] In addition, while the anticipated health equity efforts that impact policy changes would proceed through the notice and comment rulemaking process, other activities would be completed through sub-regulatory channels and regular communication strategies, such as Open-Door Forums, Medicare Learning Network, *CMS.gov* website announcements, listserv messaging, and other opportunities.

Comment: Commenters generally encouraged CMS to expand health equity measurement. However, several commenters encouraged CMS to wait until HOPE is implemented to better utilize that instrument for health equity measurement. These commenters expressed concern about implementing new health equity measures without an established instrument that could be used to track relevant patient data. Another commenter suggested that CMS review LCD guidelines for health equity guidance.

Response: We appreciate all stakeholder feedback received regarding health equity. These comments will help inform our future efforts to incorporate health equity and social determinants of health into HQRP. We will consider the implications of HOPE implementation for ongoing health equity efforts.

5. CAHPS Hospice Survey Updates

CAHPS Hospice Survey Mode Experiment

In the FY 2023 Hospice Payment Rate Update final rule (87 FR 45669), we provided information on a mode experiment CMS conducted in 2021. The purpose of the experiment was to test:

- A web-mail mode (email invitation to a web survey, with mail follow-up to non-responders).
- A revised survey version, which is shorter and simpler than the current survey, and includes new questions on topics suggested by stakeholders.
- Modifications to survey administration protocols designed to improve overall response rates, such as a prenotification letter and extended field period.

Fifty-six large hospices participated in the mode experiment, representing a range of geographic regions, ownership,

[9] 2022 National Healthcare Quality and Disparities Report. Content last reviewed November 2022. Agency for Healthcare Research and Quality, Rockville, MD. *https://www.ahrq.gov/research/findings/nhqrdr/nhqdr22/index.html.*

[10] 2022 National Healthcare Quality and Disparities Report. Content last reviewed November 2022. Agency for Healthcare Research and Quality, Rockville, MD. *https://www.ahrq.gov/research/findings/nhqrdr/nhqdr22/index.html.*

[11] *https://www.nejm.org/doi/full/10.1056/NEJMp2215539,* February 1, 2023.

[12] *https://www.nejm.org/doi/full/10.1056/NEJMp2215539,* February 1, 2023.

[13] *https://www.healthit.gov/sites/isa/files/2023-01/Draft-USCDI-Version-4-January-2023-Final.pdf.*

and past performance on the CAHPS Hospice Survey. A total of 15,515 decedents/caregivers were randomly sampled from these hospices. Sampled decedents/caregivers were randomly assigned to one of four modes of administration (mail only, telephone only, mail-telephone, webmail); mail only cases were randomly assigned to be administered either the revised or the current survey.

The information received on the CAHPS Hospice Survey Mode Experiment CMS conducted in 2021, resulted in the following findings:

- Response rates to the revised survey were 35.1 percent in mail only mode, 31.5 percent in telephone only mode, 45.3 percent in mail-telephone, and 39.7 percent in webmail mode.
- Response rates to web-mail mode were similar to mail only mode for those without email addresses (35.2 percent vs. 34.4 percent), but 13 percentage points higher for those with email addresses (49.6 percent vs. 36.7 percent).
- Response rates to mail-only administration of the revised and current survey were similar (35.1 percent vs. 34.2 percent).
- Mailing of a prenotification letter resulted in an increased response rate of 2.4 percentage points.
- Extending the field period to 49 days (from the current 42 days) resulted in an increased response rate of 2.5 percentage points in the mail only mode.

In addition, the following changes were tested as part of the revised CAHPS Hospice Survey:

- Removal of one survey item regarding confusing or contradictory information from the Hospice Team Communication measure.
- Replacement of the multi-item Getting Hospice Care Training measure with a new, one-item summary measure.
- Addition of a new, two-item Care Preferences measure.
- Simplified wording to component items in the Hospice Team Communication, Getting Timely Care, and Treating Family Member with Respect measures.

CMS will use mode experiment results to inform decisions about potential changes to administration protocols and survey instrument content. Potential measure changes will be submitted to the Measures Under Consideration (MUC) process in 2023 and may be proposed in future rulemaking. We are not finalizing any changes in this rule.

Comment: Commenters overwhelmingly supported implementation of a web based CAHPS® Hospice Survey mode. Several commenters also encouraged CMS to review the CAHPS® Hospice Survey through an equity lens, including looking for opportunities to increase response rates for non-English-speaking families, making the survey available in more languages, and ensuring that survey questions are culturally sensitive. Several commenters recommended that CMS shorten or simplify the survey to make it easier for caregivers to complete. One commenter asked CMS to provide more clarification to caregivers of patients who resided in facilities or had recent hospitalizations, as caregivers may become confused about which survey applies to each care setting. Once commenter encouraged CMS to collect CAHPS® Hospice Survey responses from families and caregivers closer to the time of a patient's death. Another commenter observed that the CAHPS® Hospice Survey is unique, as the individual who completes the survey is not the patient who received the service and may have different perceptions of the care provided. One commenter also encouraged CMS to update Care Compare without explicit suggested updates.

Response: We thank commenters for their interest in the CAHPS® Hospice Survey. We appreciate the support of a web-based mode of survey administration and simpler CAHPS® Hospice Survey instrument. If and when a web-based mode is made available as one of the approved modes of CAHPS Hospice Survey administration, hospices would continue to have the option to choose among all approved modes (that is, web-based mode would not be required). Prior to introducing a revised survey instrument and/or new approved mode of administration, we will release detailed information regarding proposed changes to survey instrument content, survey administration protocols, and data adjustment procedures needed to promote fair comparisons between hospices selecting different modes of survey administration.

The CAHPS® Hospice Survey will continue to be completed by caregivers. The Hospice CAHPS Survey is completed by the primary caregiver out of respect for the patient receiving end of life care. We believe it would not be appropriate to have hospice patients fill out a survey about the care they are receiving at the very end of their life. We will also consider opportunities to make the CAHPS® Hospice Survey easier for caregivers to understand and complete.

We will consider commenters' feedback and suggestions in the context of ongoing efforts to improve health equity. We also encourage hospices to consider their patient/caregiver population and work with their survey vendor to determine the best mode of data collection.

6. Form, Manner, and Timing of Quality Data Submission

a. Statutory Penalty for Failure to Report

Section 1814(i)(5)(C) of the Act requires that each hospice submit data to the Secretary on quality measures specified by the Secretary. The data must be submitted in a form and manner, and at a time specified by the Secretary. Section 1814(i)(5)(A)(i) of the Act was amended by the CAA, 2021 and the payment reduction for failing to meet hospice quality reporting requirements is increased from 2 percent to 4 percent beginning with FY 2024. The Act requires that, beginning with FY 2014 through FY 2023, the Secretary shall reduce the market basket percentage increase by 2 percentage points and then beginning in FY 2024 and for each subsequent year, the Secretary shall reduce the market basket percentage increase by 4 percentage points for any hospice that does not comply with the quality data submission requirements for that FY. In the FY 2023 Hospice Wage Index and Payment Rate Update proposed rule (87 FR 19442), we revised our regulations at § 418.306(b)(2) in accordance with this statutory change (86 FR 42605). We are not proposing any new public reporting proposals in this rule.

b. Compliance

HQRP Compliance requires understanding three timeframes for both HIS and CAHPS: (1) The relevant Reporting Year, payment FY and the Reference Year. The ''Reporting Year'' (HIS)/''Data Collection Year'' (CAHPS). This timeframe is based on the calendar year (CY). It is the same CY for both HIS and CAHPS. If the CAHPS Data Collection year is CY 2023, then the HIS reporting year is also CY 2023; (2) The APU is subsequently applied to FY payments based on compliance in the corresponding Reporting Year/Data Collection Year; and (3) For the CAHPS Hospice Survey, the Reference Year is the CY before the Data Collection Year. The Reference Year applies to hospices submitting a size exemption from the CAHPS survey (there is no similar exemption for HIS). For example, for the CY 2023 data collection year, the Reference Year, is CY 2022. This means providers seeking a size exemption for CAHPS in CY 2023 will base it on their

hospice size in CY 2022. Submission requirements are codified in § 418.312.

For every CY, all Medicare-certified hospices are required to submit HIS and CAHPS data according to the requirements in § 418.312. Table 6 summarizes the three timeframes. It illustrates how the CY interacts with the FY payments, covering the CY 2022 through CY 2025 data collection periods and the corresponding APU application from FY 2024 through FY 2027.

TABLE 6: HQRP Reporting Requirements and Corresponding Annual Payment Updates

Reporting Year for HIS and Data Collection Year for CAHPS data	Annual Payment Update Impacts Payments for the FY	Reference Year for CAHPS Size Exemption (CAHPS only)
CY 2022	FY 2024 APU	CY 2021
CY 2023	FY 2025 APU	CY 2022
CY 2024	FY 2026 APU	CY 2023
CY 2025	FY 2027 APU	CY 2024

As illustrated in Table 7, CY 2022 data submissions compliance impacts the FY 2024 APU. CY 2023 data submissions compliance impacts the FY 2025 APU. CY 2024 data submissions compliance impacts FY 2026 APU. This CY data submission impacting FY APU pattern follows for subsequent years.

c. Submission of Data Requirements

As finalized in the FY 2016 Hospice Wage Index and Payment Rate Update final rule (80 FR 47142, 47192), hospices' compliance with HIS requirements beginning with the FY 2020 APU determination (that is, based on HIS Admission and Discharge records submitted in CY 2018) are based on a timeliness threshold of 90 percent. This means CMS requires that hospices submit 90 percent of all required HIS records within 30 days of the event (that is, patient's admission or discharge), known. The 90-percent threshold is hereafter referred to as the timeliness compliance threshold. Ninety percent of all required HIS records must be submitted and accepted within the 30-day submission deadline to avoid the statutorily-mandated payment penalty. Hospice compliance with claims data requirements is based on administrative data collection. Since Medicare claims data are already collected from claims, hospices are considered 100 percent compliant with the submission of these data for the HQRP. There is no additional submission requirement for administrative data.

To comply with CMS' quality reporting requirements for CAHPS, hospices are required to collect data monthly using the CAHPS Hospice Survey. Hospices comply by utilizing a CMS-approved third-party vendor. Approved Hospice CAHPS vendors must successfully submit data on the hospice's behalf to the CAHPS Hospice Survey Data Center. A list of the approved vendors can be found on the CAHPS Hospice Survey website: *www.hospicecahpssurvey.org.* Table 7. HQRP Compliance Checklist illustrates the APU and timeliness threshold requirements.

TABLE 7: HQRP Compliance Checklist

Annual Payment Update	HIS	CAHPS
FY 2024	Submit at least 90 percent of all HIS records or its successor instrument within 30 days of the event date (patient's admission or discharge) for patient admissions/discharges occurring 1/1/22 – 12/31/22.	Ongoing monthly participation in the Hospice CAHPS survey 1/1/2022 – 12/31/2022
FY 2025	Submit at least 90 percent of all HIS records or its successor instrument within 30 days of the event date (patient's admission or discharge) for patient admissions/discharges occurring 1/1/23 – 12/31/23.	Ongoing monthly participation in the Hospice CAHPS survey 1/1/2023 – 12/31/2023
FY 2026	Submit at least 90 percent of all HIS records or its successor instrument within 30 days of the event date (patient's admission or discharge) for patient admissions/discharges occurring 1/1/24 – 12/31/24.	Ongoing monthly participation in the Hospice CAHPS survey 1/1/2024 – 12/31/2024
FY 2027	Submit at least 90 percent of all HIS records or its successor instrument within 30 days of the event date (patient's admission or discharge) for patient admissions/discharges occurring 1/1/25 – 12/31/25.	Ongoing monthly participation in the Hospice CAHPS survey 1/1/2025 – 12/31/2025

Note: The data source for the claims-based measures will be Medicare claims data that are already collected and submitted to CMS. There is no additional submission requirement for administrative data (Medicare claims), and hospices with claims data are 100-percent compliant with this requirement.

Most hospices that fail to meet HQRP requirements do so because they miss the 90 percent threshold. We offer many training and education opportunities through our website, which are available 24/7, 365 days per year, to enable hospice staff to learn at the pace and time of their choice. We want hospices to be successful with meeting the HQRP requirements. We encourage hospices to use the website at: *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Quality-Reporting-Training-Training-and-Education-Library*. For more information about HQRP Requirements, we refer readers to visit the frequently-updated HQRP website and especially the Best Practice, Education and Training Library, and Help Desk web pages at: *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting*. We also encourage readers to visit the HQRP web page and sign-up for the Hospice Quality ListServ to stay informed about HQRP.

d. Codification of HQRP Data Completion Thresholds

As previously noted, we proposed to add a new paragraph (j) to § 418.312 for data completion thresholds. In the FY 2016 Hospice Wage Index final rule (80 FR 47192 through 47193), we finalized HQRP thresholds for completeness of HQRP data submissions. To ensure that hospices are meeting an acceptable standard for completeness of submitted data, we finalized the policy that, beginning with the FY 2018 HQRP, hospices must meet or exceed one data submission threshold. Hospices must meet or exceed a data submission threshold set at 90 percent of all required HIS or successor instrument records within 30 days of the event (that is, patient's admission or discharge).

Under our finalized policy, some assessment data did not obtain a response and, in those circumstances, are not ''missing'' nor is the data incomplete. For example, in the case of a patient who does not have any of the medical conditions in a ''check all that apply'' listing, the absence of a response of a health condition indicates that the condition is not present, and it would be incorrect to consider the absence of such data as missing in a threshold determination.

In the FY 2017 Hospice Wage Index proposed rule, we received comments on our previously finalized policies for form, manner, and timing of data collection. These public comments were considered and summarized in the FY 2017 Hospice Wage Index final rule. In the FY 2022 Hospice Wage Index and Payment Rate Update final rule and the FY 2023 Hospice Wage Index and Payment Rate Update final rule, we provided an HQRP Compliance Checklist, which illustrated additional details about how the compliance thresholds applied to APUs by FY.

We proposed to, and are finalizing the decision to, codify these data completeness thresholds at § 418.312(j)(1) for measures data collected using the HIS or a successor

instrument. Under this section, we proposed to codify our requirement that hospices must meet or exceed a data submission threshold set at 90 percent of all required HIS or successor instrument records within 30 days of the event (that is, patient's admission or discharge) and submit the data through the CMS designated data submission systems. This threshold would apply to all HIS or successor instrument-based measures and data elements adopted into HQRP. We are also finalizing the decision to codify § 418.312(j)(2) that a hospice must meet or exceed this threshold to avoid receiving a 4-percentage point reduction to its annual payment update for a given FY as codified at § 418.306(b)(2).

We solicited public comment on our proposal to codify in regulations text the HQRP data completion thresholds at § 418.312(j) for measures and standardized patient assessment elements collected using the HIS or successor instrument and compliance threshold to avoid receiving 4 percentage point reduction as described under § 418.306(b)(2).

Comment: One commenter supported CMS's proposal to codify the data submission requirements, but encouraged CMS to amend the requirements in future rulemaking once HOPE is officially proposed for data collection. One commenter expressed concern that the proposed data submission threshold would be overly burdensome for hospices that are already struggling with technological or other barriers to meeting HQRP requirements.

Response: We appreciate stakeholders' feedback and engagement related to HQRP. We are finalizing the data submission thresholds regulation text at § 418.312(j) as established in prior rulemaking. We may consider revisions to data collection thresholds when implementing HOPE in future rulemaking. The 4 percent APU penalty is established at § 418.306(b)(2).

D. Establishing Hospice Program Survey and Enforcement Procedures Under the Medicare Program; Provisions Update (CAA, 2021, Section 407)

Division CC, section 407 of the CAA, 2021, amended Part A of Title XVIII of the Act to add a new section 1822, and amended sections 1864(a) and 1865(b) of the Act, establishing new hospice program survey and enforcement requirements, required public reporting of survey information, and a new hospice hotline.

This law (CAA, 2021) requires public reporting of hospice program surveys conducted by both State Agencies (SAs) and Accrediting Organizations (AOs), as well as enforcement actions taken as a result of these surveys on the CMS website in a manner that is prominent, easily accessible, searchable, and presented in a readily understandable format. It removes the prohibition at section 1865(b) of the Act of public disclosure of hospice surveys performed by AOs, and requires that AOs use the same survey deficiency reports as SAs (Form CMS–2567, ''Statement of Deficiencies'' or a successor form) to report survey findings.

The CAA, 2021 also requires hospice programs to measure and reduce inconsistency in the application of survey results among all hospice program surveyors, and requires the Secretary to provide comprehensive training and testing of SA and AO hospice program surveyors, including training with respect to review of written plans of care. The CAA, 2021 prohibits SA surveyors from surveying hospice programs for which they have worked in the last 2 years or have a financial interest, requires hospice program SAs and AOs to use a multidisciplinary team of individuals for surveys conducted with more than one surveyor to include at least one RN and provides that each SA must establish a dedicated toll-free hotline to collect, maintain, and update information on hospice programs and to receive complaints.

The provisions in the CAA, 2021 also direct the Secretary to create a Special Focus Program (SFP) for poor-performing hospice programs, sets out authority for imposing enforcement remedies for noncompliant hospice programs, and requires the development and implementation of a range of remedies as well as procedures for appealing determinations regarding these remedies. These remedies can be imposed instead of, or in addition to, termination of a hospice programs' participation in the Medicare program. The remedies include civil money penalties (CMPs), suspension of all or part of payments, and appointment of temporary management to oversee operations.

In the CY 2022 Home Health Prospective Payment System (HH PPS) final rule (86 FR 62240), we addressed provisions related to the hospice survey enforcement and other activities described in this section. A summary of the finalized CAA, 2021 provisions can be found in the CY 2022 HH PPS final rule: *https://www.govinfo.gov/content/pkg/FR-2021-11-09/pdf/2021-23993.pdf.* We finalized all the CAA provisions in CY 2022 rulemaking except for special focus program (SFP). As outlined in the CY 2022 HH PPS final rule, we stated that we would take into account comments that we received and work on a revised proposal, seeking additional collaboration with stakeholders to further develop the methodology for the SFP since the publication of the CY 2022 HH PPS final rule.

In the FY 2023 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements (87 FR 45669) final rule, we affirmed our intention to initiate a hospice special focus program Technical Expert Panel (TEP) to provide input on the structure and methodology of the SFP. Public comments received in response to the FY 2023 Hospice Wage Index and Payment Rate Update proposed rule were generally supportive of CMS's efforts to establish an SFP and to convene a TEP to provide feedback on the development of the SFP. A TEP convened by a CMS contractor provided feedback and considerations on the preliminary SFP concepts, including the development of a methodology to identify hospice poor-performers, as well as graduation and termination criteria, and public reporting. A 30-day call for nominations was held July 14 through August 14, 2022 and nine TEP members were selected, representing a diverse range of experience and expertise related to hospice care and quality. Details from the TEP meetings, including their recommendations, are available in the TEP summary report [14] on the CMS website at *https://www.cms.gov/medicare/quality-safety-oversight-certification-compliance/hospice-special-focus-program.* The final TEP feedback is publicly available on the CMS website.

Accordingly, we proposed to implement an SFP in the CY 2024 Home Health Prospective Payment Update Rate proposed rule, which will be available on the Home Health Prospective Payment System Regulations and Notices page of the CMS website: *https://www.federalregister.gov/public-inspection/2023-14044/medicare-program-calendar-year-2024-home-health-prospective-payment-system-rate-update-home-health.*

Comment: Several public comments expressed concerns about the SFP and asked for further information as CMS designs this program. Commenters emphasized the need for a standardized survey process and increased training to better educate surveyors on hospice regulations. Some commenters

[14] 2022 Technical Expert Panel and Stakeholder Listening Sessions: Hospice Special Focus Program Summary Report (April 28, 2023).

expressed concern about a quota system being used for the SFP. Commenters encouraged CMS to focus on problematic and non-compliant hospices and asked that non-compliant hospices receive an opportunity to rectify their issues prior to being penalized. One comment simply noted and appreciated the SFP update.

Response: We appreciate stakeholders' interest and engagement related to the hospice SFP. We will consider these comments as we continue to develop the SFP.

E. Hospice Certifying Physician Enrollment

1. Medicare Provider Enrollment

Section 1866(j)(1)(A) of the Act requires the Secretary to establish a process for the enrollment of providers and suppliers into the Medicare program. The overarching purpose of the enrollment process is to help confirm that providers and suppliers furnishing services or items (or ordering/certifying the provision thereof) to Medicare beneficiaries meet all applicable federal and state requirements. The process is, to an extent, a ''gatekeeper'' that prevents unqualified and potentially fraudulent individuals and entities from entering and inappropriately billing Medicare. Since 2006, we have undertaken rulemaking efforts to outline our enrollment procedures. These regulations are generally codified in 42 CFR part 424, subpart P (currently §§ 424.500 through 424.575 and hereafter occasionally referenced as subpart P). They address, among other things, requirements that providers and suppliers must meet to enroll in Medicare.

As outlined in § 424.510, one requirement is that the provider or supplier must complete, sign, and submit to its assigned Medicare Administrative Contractor (MAC) the appropriate enrollment form, typically the Form CMS–855 (OMB Control No. 0938–0685). The Form CMS–855, which can be submitted via paper or electronically through the internet-based Provider Enrollment, Chain, and Ownership System (PECOS) process (SORN: 09–70–0532), collects important information about the provider or supplier. Such data includes, but is not limited to, general identifying information (for example, legal business name), licensure and/or certification data, and practice locations. After receiving the provider's or supplier's initial enrollment application, CMS or the MAC reviews and confirms the information thereon and determines whether the provider or supplier meets all applicable Medicare requirements. We believe this screening process has greatly assisted CMS in executing its responsibility to prevent Medicare fraud, waste, and abuse.

As previously mentioned, over the years we have issued various final rules pertaining to provider enrollment. These rules were intended not only to clarify or strengthen certain components of the enrollment process but also to enable us to take further action against providers and suppliers: (1) engaging (or potentially engaging) in fraudulent or abusive behavior; (2) presenting a risk of harm to Medicare beneficiaries or the Medicare Trust Funds; or (3) that are otherwise unqualified to furnish Medicare services or items. Consistent with this, and for reasons explained in section III.E.2. of this rule, we proposed to require physicians who certify hospice services for Medicare beneficiaries (hereafter occasionally referenced as ''hospice physicians'') to be enrolled in or validly opted-out of Medicare as a prerequisite for the payment of the hospice service in question.

2. Statutory and Policy Background

Section 6405(a) of the Affordable Care Act (which amended section 1834(a)(11)(B) of the Act) states that the Secretary may require that a physician ordering durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) be enrolled in Medicare for payment for the DMEPOS item to be made. Section 6405(b) of the Affordable Care Act (which amended sections 1814(a)(2) and 1835(a)(2) of the Act) contains a similar provision regarding the certification of a physician (or certain eligible professionals) for Part A and B home health services. Section 6405(c) of the Affordable Care Act, meanwhile, authorizes the Secretary to extend the requirements of sections 6405(a) and (b) to all other categories of items or services under title XVIII of the Act (including covered Part D drugs) that are ordered, prescribed, or referred by a physician or eligible professional enrolled in Medicare under section 1866(j) of the Act.

Pursuant to this authority, we finalized 42 CFR 424.507(a) and (b) in an April 27, 2012 final rule titled ''Medicare and Medicaid Programs; Changes in Provider and Supplier Enrollment, Ordering and Referring, and Documentation Requirements; and Changes in Provider Agreements'' (77 FR 25284). Sections 424.507(a) and (b) collectively state that for payment to be made for ordered imaging services, clinical laboratory services, DMEPOS items, or home health services, the service or item must have been ordered or certified by a physician or, when permitted, an eligible professional who—(1) is enrolled in Medicare in an approved status; or (2) has a valid opt-out affidavit on file with a Part A and B MAC. The purpose of § 424.507(a) and (b) is to confirm that the physicians and eligible professionals who order or certify the items and services referenced in those paragraphs are qualified.

We constantly review program integrity trends to determine whether certain provider and supplier types and services warrant closer scrutiny from a provider enrollment perspective. During this process, we have remained ready to propose expansions to § 424.507(a) and (b) should circumstances warrant. We believe that the latter situation currently exists with respect to hospices.

The OIG in July 2018 issued a study titled ''Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity'' (OEI–02–16–00570). This report noted that Medicare in 2016 spent about $16.7 billion for hospice care for 1.4 million beneficiaries, up from $9.2 billion for fewer than 1 million beneficiaries in 2006.'' [15] The report described how some hospice fraud schemes involved paying recruiters to target beneficiaries who are not eligible for hospice care; other schemes involved physicians falsely certifying beneficiaries as terminally ill when they were not.[16] (Pursuant to 42 CFR 418.20(b), a physician must certify the beneficiary as being terminally ill for the beneficiary to be eligible to elect hospice care.) The OIG cited several examples of this behavior, including the following:

- Two certifying physicians from a California hospice were convicted of health care fraud for falsely certifying beneficiaries as terminally ill. The false certifications were part of a wider fraud scheme that the hospice owner organized. The scheme involved illegal payments to patient recruiters for bringing in beneficiaries, establishing fraudulent diagnoses, and altering medical records.[17]
- A Mississippi hospice owner used patient recruiters to solicit beneficiaries who were not eligible for hospice care. These patients were unaware of their enrollment in hospice care. The owner submitted fraudulent charges and received more than $1 million from Medicare.[18]

[15] *https://oig.hhs.gov/oei/reports/oei-02-16-00570.pdf,* p. 1.

[16] Ibid., 6.

[17] Ibid., p. 7.

[18] Ibid.

• A Minnesota-based hospice chain agreed to pay $18 million to resolve allegations that it improperly billed Medicare for care provided to beneficiaries who were ineligible for hospice because they were not terminally ill. The hospice chain also allegedly discouraged physicians from discharging ineligible beneficiaries.[19]

• A hospice physician improperly certified a beneficiary who a hospital determined to be in ''good shape'' only days before as terminally ill.[20]

• A hospice falsely informed a beneficiary that she could remain on a liver transplant list even if she chose hospice care. However, she was removed from the transplant list when she elected hospice care. When the beneficiary learned of this, she ceased hospice care so she could be reinstated on the transplant list.[21]

• A physician received kickbacks for recruiting beneficiaries, many of whom were not terminally ill but seeking opioids.[22]

More generally, the OIG expressed concern that: (1) beneficiaries are put at risk when they are inappropriately enrolled in hospice care because they might be unwittingly forgoing needed treatment; [23] (2) ''some hospice physicians are not always meeting requirements when certifying beneficiaries for hospice care;'' [24] and (3) hospice fraud schemes are growing.[25]

The Government Accountability Office (GAO) in October 2019 issued a report titled, ''Medicare Hospice Care: Opportunities Exist to Strengthen CMS Oversight of Hospice Providers'' (GAO–20–10).[26] The GAO observed therein that the number of: (1) Medicare hospice beneficiaries had almost tripled to nearly 1.5 million by FY 2017; and (2) Medicare hospice providers had doubled.[27] The GAO stated that in light of this growth: ''It is imperative that CMS's oversight of the quality of Medicare hospice care keeps pace with changes so that the agency can ensure the health and safety of these terminally ill beneficiaries.'' [28]

In light of the foregoing, we believe that expanding § 424.507(a) and (b) to include hospice services could strengthen the program integrity aspect of physician certifications. The careful screening that the enrollment process entails would help us determine whether the physician meets all federal and state requirements (such as licensure) or presents any program integrity risks, such as past final adverse actions (as that term is defined in § 424.502). If an unenrolled physician certifies a Medicare beneficiary's need for hospice care, we have insufficient background on the physician to know whether he or she was qualified to do so or has an adverse history. We believe that some of the aforementioned examples of improper behavior the OIG found can be at least partially avoided through closer vetting of the physician. Moreover, the screening process could help foster beneficiary health and safety by ensuring the physician is appropriately licensed.

3. Proposed Provisions

Using our authority under section 6405(c) of the Affordable Care Act, we accordingly proposed the following revisions to § 424.507.

First, the current title of § 424.507(b) states, ''Conditions for payment of claims for covered home health services''. We proposed to add ''and hospice'' between ''health'' and ''services'' to account for our intended inclusion of hospice services within § 424.507(b).

Second, the introductory paragraph of § 424.507(b) reads: ''To receive payment for covered Part A or Part B home health services, a provider's home health services claim must meet all of the following requirements:'' To accommodate hospice services, we proposed to revise this to state: ''To receive payment for covered Part A or Part B home health services or for covered hospice services, a provider's home health or hospice services claim must meet all of the following requirements:''

Third, the opening language of § 424.507(b)(1) states: ''The ordering/certifying physician, or the ordering/certifying physician assistant, nurse practitioner, or clinical nurse specialist working in accordance with State law . . .''. Under 42 CFR 418.22(b), and as alluded to previously, only a physician (which can include the hospice's medical director) can certify that the beneficiary is terminally ill. We proposed to revise the beginning of § 424.507(b)(1) to state: ''The ordering/certifying physician for hospice or home health services, or, for home health services, the ordering/certifying physician assistant, nurse practitioner, or clinical nurse specialist working in accordance with State law . . .''. This would help clarify that § 424.507(b)(1) should not be read to imply that the eligible professionals listed therein can certify the beneficiary's terminal status.

Fourth, §§ 418.22(c)(1)(i) and (ii) state that for the initial 90-day hospice period, the following physicians, respectively, must certify that the beneficiary is terminally ill: (1) the hospice's medical director or the physician member of the hospice interdisciplinary group (hereafter occasionally referenced collectively as the ''hospice physician''); and (2) the individual's attending physician (who must meet the definition of physician in § 410.20) if the beneficiary has one. For subsequent hospice periods, § 418.22(c)(2) states that only one of the physicians in § 418.22(c)(1)(i) must provide the certification. Given the hospice program integrity concerns previously mentioned, we believed that each certification required under § 418.22(c) should be by an enrolled or validly opted-out physician. Therefore, we proposed to add § 424.507(b)(3) to reflect this requirement and would refer therein to the requirements of § 418.22(c).

4. Comments Received and Responses

We received approximately 21 pieces of timely correspondence in response to our proposal. These comments are summarized below. Our responses are also included.

Comment: Several commenters supported our proposal. One commenter stated that it could help identify physicians who engage in fraudulent or abusive behavior that puts Medicare beneficiaries at risk.

Response: We appreciate the commenters' support.

Comment: Several commenters expressed concern about the impact of requiring the hospice physician to be enrolled. Their concerns fell into three principal categories. First, they believed that having to ascertain the physician's enrollment/opt-out status would be administratively burdensome on hospices, with one commenter stating that home health agencies (HHAs) have been similarly burdened when verifying the enrollment/opt-out status of the home health certifying physician. Second, if the hospice physician is neither enrolled nor opted-out, the hospice will need to find another hospice physician (such as the physician member of the hospice interdisciplinary group) to sign the certification, which could postpone patient care. Third, various hospices employ or contract with physicians who are neither enrolled nor opted-out by choice. The commenters believed some of these physicians would resign or end

[19] Ibid.
[20] Ibid., p. 6.
[21] Ibid.
[22] Ibid., p. 12.
[23] Ibid., p. 6.
[24] Ibid., p. 12.
[25] Ibid.
[26] *https://www.gao.gov/assets/gao-20-10.pdf.*
[27] Ibid., p. 25.
[28] Ibid.

their contract with the hospice rather than enroll or opt-out, hence requiring the hospice to hire replacement physicians. This could prove difficult, however, because requiring the hospice physician to be enrolled or opted-out might limit the pool of prospective physicians, since some physicians will not wish to seek employment or a contractual relationship with the hospice if they have to enroll or opt-out. Especially in rural areas, this could result in further shortages of hospice physicians, which, in turn, might harm patient care.

Response: We appreciate these comments and address them as follows.

We do not foresee a significant administrative burden associated with confirming the hospice physician's and attending physician's enrollment/opt-out statuses. Hospices can quickly verify said status using the CMS ordering and referring data file (ORDF),[29] which lists all Medicare-enrolled and opted-out physicians. HHAs, DMEPOS suppliers, and suppliers of clinical laboratory and imaging services currently use this same means of verifying an ordering/certifying/referring physician's enrollment/opt-out status, and we have not been notified by these providers and suppliers of any substantial burden associated with this activity.

Concerning the commenters' second and third assertions, we believe the situations they cite regarding unenrolled or non-opted out hospice physicians will be exceedingly rare. We estimated in the ICR section of the proposed rule that 2,173 certifying physicians would need to enroll or opt-out in order to certify hospice services. This is a very small number given the universe of over 2 million physicians nationwide, and most certifying physicians are already enrolled or opted-out. We are also confident that the vast preponderance of those who currently are not will choose to enroll or opt-out, and one commenter, in fact, agreed with this based on feedback received from the hospice community. Indeed, this was our experience when we implemented the aforementioned DMEPOS, HHA, and imaging and clinical laboratory services requirement; in general, those physicians and practitioners who were neither enrolled nor opted-out elected to complete the enrollment/opt-out process in order to continue ordering/certifying/referring the services and items in question. We believe the same will occur with our hospice proposal, and we do not expect the physician shortages or postponements in care that the commenters mentioned to occur.

Comment: A number of commenters opposed our proposed requirement in new § 424.507(b)(3) to also require the beneficiary's attending physician to be enrolled/opted-out. Their concerns were generally as follows.

First, requiring the attending physician's enrollment/opt-out infringes upon the patient's right to choose their designated attending physician.

Second, if the attending physician is neither enrolled nor opted-out, the beneficiary would have to find a new attending physician if they wish to have one. This could delay the patient's hospice admission and their consequent ability to receive pain management and palliative care. The patient may even be too ill to select a new attending physician or may pass before making their selection. All of this would place a tremendous and unnecessary burden on the beneficiary and their family or representative. Commenters stated that these vulnerable patients in such cases should not have to effectively end their relationship with the attending physician (who, in many cases, may have been the patient's primary care physician for years) in order to receive hospice services.

Third, and in the previous scenario, the hospice, too, would be burdened. The hospice would have to communicate the attending physician's non-enrollment/opt-out status to the beneficiary and, in some cases, assist in finding a new one. Moreover, the hospice may have received a directive from the designated attending physician to address immediate patient needs but would have to re-obtain the directive from a different physician, during which delay the patient may pass.

Fourth, commenters stated that simply requiring the hospice physician to be enrolled or opted-out should be a sufficient program integrity safeguard since both the hospice physician and the attending physician (if the beneficiary has one) must certify the initial hospice episode. The attending physician can thus further verify the validity of the hospice physician's certification.

In addition, a commenter contended that since the hospice physician oversees the beneficiary's plan of care per 42 CFR 418.56(a)(1)(i), this physician's enrollment or opt-out status alone should serve as an adequate payment safeguard without the need to require the attending physician to be enrolled or opted-out.

Response: We appreciate these comments and understand the concerns expressed. We address them in turn.

First, we do not believe our requirement would infringe upon any beneficiary right to choose their attending physician. The beneficiary would not only retain the ability to select a new attending physician if their chosen one is unenrolled/non-opted out but also need not choose to have one at all. Furthermore, this attending physician requirement only applies to the signing of the initial certification. It does not prohibit the beneficiary's desired attending physician from treating the beneficiary in the hospice and then billing for these services under Part B, though we note that in that case the physician must be enrolled. We therefore respectively disagree that our requirement restricts the patient's right to select their attending physician or compels the beneficiary to terminate any relationship therewith. Our proposal, to reiterate, is strictly limited to the attending physician's initial certification and does not affect the larger beneficiary-physician relationship.

Second, and as we previously explained with respect to hospice physicians, we believe the situation the commenters describe will be extremely rare. In the overwhelming preponderance of cases, a beneficiary's attending physician furnishes services to many patients other than the beneficiary; for instance, many attending physicians have a private practice that treats numerous patients for matters unrelated to hospice certifications. This means that the attending physician is very likely already enrolled/opted-out and hence can sign the hospice beneficiary's certification. We reemphasize that the number of unenrolled and non-opted out physicians who certify hospice services is very small and that, in our view, these physicians would choose to enroll or opt-out pursuant to our requirement.

Concerning the commenters' third assertion, we again do not anticipate the excessive burdens on the hospice community (including compliance with the 2-day period) that the commenters cite given the very small number of currently unenrolled and non-opted out certifying physicians.

Finally, we disagree with the commenters' contention that merely requiring the hospice physician's enrollment/opt-out status should be adequate to meet CMS' program integrity concerns. To the contrary, our definition of attending physician in § 418.3 describes the latter as being identified by the beneficiary, at the time he or she elects to receive hospice care, as having the most significant role in the

[29] *https://data.cms.gov/provider-characteristics/medicare-provider-supplier-enrollment/order-and-referring/data.*

determination and delivery of the individual's medical care. Given this relationship, we believe it is particularly important that the attending physician be properly screened before furnishing the required certifying statement.

Comment: A commenter asked CMS to clarify that the term ''ordering/certifying physician'' for purposes of our proposal does not include the referring/attending physician.

Response: We are finalizing our proposal that attending physicians must be enrolled or opted-out to certify hospice services. We note, however, that the term ''ordering'' is largely immaterial for purposes of the certifications required per § 418.22. That is, in the context of § 424.507, ''ordering and certifying'' collectively references all the services and items addressed in § 424.507 that a physician or practitioner may order or certify. Yet ''ordering'' mostly pertains to DMEPOS items and clinical laboratory and imaging services, whereas hospice and home health services involve certification of the need for said services. As such, the remainder of this section III.E will simply reference the ''certification'' of hospice services rather than the ''ordering or certifying'' thereof.

Comment: A commenter sought elucidation on two issues. The first was whether and how the hospice must document that the attending physician's enrollment or opt-out status was verified. The second was how the hospice should proceed if the patient's chosen attending physician is neither enrolled nor opted-out; the commenter asked whether the patient in that case is deemed ineligible for hospice care or the hospice should assign its own attending physician.

Response: Section 424.507(b) does not itself require the documentation of verification of the attending physician's enrollment/opt-out status. However, the hospice is ultimately responsible for confirming this status. Concerning the commenter's second issue, if the patient designates an attending physician that is neither enrolled nor opted-out, the certification of terminal illness for the initial 90-day benefit period would not be valid under § 418.22(c). If the beneficiary wants to designate a different attending physician, they may choose to do so. If they elect not to designate an attending physician, only the hospice certifying physician would certify the beneficiary's eligibility for the hospice benefit and he or she must be enrolled or opted-out. This is because the requirement that the hospice certifying physician and the designated attending physician both must sign the initial certification only applies if the beneficiary designates an attending physician. If the beneficiary does not have one, only the hospice certifying physician must sign the certification.

Comment: Several commenters recommended that CMS delay implementation of our proposal in order to allow physicians enough time to enroll or opt-out and for CMS to (1) make system changes and (2) perform outreach. They stated that hospices, too, will need time to educate their employed physicians, contracted physicians, and prospective patients. Suggestions included a 1-year delay.

Response: We agree that a delay in implementation is warranted for the reasons the commenters outlined. We believe that an additional seven-months is ample time to ensure certifying hospice and attending physicians meet all Medicare requirements, given the pressing program integrity concerns as previously discussed. Further, we believe a May 1, 2024 implementation date strikes a sound balance between addressing our payment safeguard concerns while giving stakeholders time to prepare. Accordingly, unenrolled and non-opted out hospice and attending physicians will have until April 30, 2024 to enroll or opt-out before the denial of hospice claims commences on May 1, 2024 per § 424.507(b).

Comment: Several commenters asked whether unenrolled and non-opted-out physicians can serve as hospice medical directors.

Response: Our provision is restricted to the matter of payment of hospice Medicare claims and the certifications addressed in § 418.22 in the sole context of provider enrollment. Put otherwise, the hospice physician, whether the medical director or physician member of the interdisciplinary group, must be enrolled or opted-out to certify beneficiary eligibility and for payment to consequently be made.

Comment: Commenters expressed concern that if the patient must designate a new attending physician because the physician is neither enrolled nor opted-out, the hospice may be unable to obtain a new certification from a new attending physician within the required 2-day timeframe from the effective date of the hospice election period. (Per § 418.22(a)(3)(i), if the hospice cannot obtain the written certification required under § 418.22(a)(1) within 2 calendar days after an election period begins, it must obtain an oral certification within 2 calendar days and the written certification before it submits a claim for payment.) Commenters stated that this would negatively impact the hospice from a financial perspective since payment could be denied due to a late certification. Additionally, a commenter outlined a scenario where a patient or representative designates an attending physician on the election statement who is neither enrolled nor opted-out; when the hospice realizes that this is the case the patient may have passed, or the hospice cannot contact the patient's representative to change the designated attending physician on the election statement. This commenter further asked whether the hospice must include the attending physician listed on the election statement on the hospice claim form in such situations.

Response: As we previously stated, there is a very small number of currently unenrolled and non-opted-out certifying physicians, so we do not believe this will be a common issue. Hospices should check the ORDF to determine the designated attending physician's enrolled/opt-out status. A good standard of practice would be for the hospice to check the ORDF in real time at the time the patient or representative is signing the election statement that includes the designation of an attending physician, or very shortly thereafter. As outlined in § 418.22, a certification of terminal illness can be completed up to 15 days prior to the start of the election period. Additionally, as outlined in § 418.24(b)(4), the election statement must include the effective date of the election, which may be the first day of hospice care or a later date, but may be no earlier than the date of the election statement. These flexibilities in our regulations should allow hospices to ensure that they are complying with the requirement for the certifying physician(s) to be enrolled or opted-out of Medicare. The designated attending physician listed on the hospice election statement must match the information contained in the ''Attending Provider Name and Identifiers'' field on the institutional claim if the attending physician is a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) or the ''Other Provider Name and Identifiers'' field on the institutional claim if the designated attending physician is a nurse practitioner or physician assistant. To change the designated attending physician, the patient or representative must sign a statement that outlines the change in accordance with the regulations at § 418.24(h).

Comment: A commenter asked how CMS would identify when the attending physician is a physician assistant or nurse practitioner and waive the claim from enrollment edits.

Response: An attending physician is defined in § 418.3 as one of the following:

- A Doctor of Medicine (M.D.) or osteopathy (D.O.) legally authorized to practice medicine and surgery by the state in which he or she performs that function or action;
- A nurse practitioner who meets the training, education, and experience requirements as described in § 410.75(b); or
- A physician assistant who meets the requirements of § 410.74(c).

However, section 1814(a)(7)(A)(i)(I) of the Act does not permit a nurse practitioner or a physician assistant to certify that the patient is terminally ill. As outlined in the Medicare Claims Processing Manual, Section 30.3 of Chapter 11, the ''Attending Provider Name and Identifiers'' field on the institutional claim form is to contain the National Provider Identifier (NPI) and name of the attending physician currently responsible for certifying the terminal illness and signing the individual's plan of care for medical care and treatment. If the patient does not have an attending physician that is a D.O. or M.D., the hospice would enter the NPI and name of the hospice medical director or physician member of the interdisciplinary group that certified that the patient is terminally ill. As outlined in the Medicare Claims Processing Manual, Section 30.3 of Chapter 11, the ''Other Provider Name and Identifiers'' field on the institutional claim form is to contain the NPI and name of attending physician if such attending provider is a nurse practitioner or physician assistant. In this case, the ''Attending Provider Name and Identifiers'' field would contain the NPI and name of the hospice medical director or physician member of the hospice interdisciplinary group that certified that the patient was terminally ill. When implementing claims processing edits to check for whether the attending physician (if an M.D. or D.O.) and hospice physician are enrolled or opted-out of Medicare, we would do so using PECOS, which can identify whether an NPI is associated with a nurse practitioner or physician assistant. If the NPI and name of a nurse practitioner or physician assistant appears in the ''Other Provider Name and Identifiers'' field on the institutional claim form, we would not deny the hospice claim if such nurse practitioner or physician assistant was not enrolled or opted-out of Medicare.

Comment: A commenter asked how our provision and the rationale for it relates to or impacts: (1) 42 CFR 405.455(b), which prevents Medicare Advantage (MA) plans from paying for services rendered by opted-out physicians; (2) the ''MA Hospice Carve-In''; and (3) the home health face-to-face requirement (HHFFR) in 42 CFR 424.22.

Response: Our provision is unrelated to MA or the HHFFR. Sections 424.507(a) and (b) only apply to Medicare Part A and Part B and do not pertain to MA payment. Too, whereas § 405.455(b) addresses services rendered by opt-out physicians, § 424.507(a) and (b) are restricted to the ordering/certifying/referring of services or items. As for the HHFFR, program integrity, like with our proposed provision, was a consideration in its promulgation. Yet the HHFFR is otherwise unrelated to the hospice enrollment/opt-out requirement. For instance, while § 424.507(b) will require enrollment/opt-out status for the hospice physician and the attending physician, satisfaction of the HHFFR under § 424.22 does not require the certifying physician or allowed practitioner (as that latter term is described in § 424.22) to be enrolled/opted-out.

Comment: A commenter asked whether there are any temporal limitations on certifications issued by an opted-out physician.

Response: Although we are somewhat unclear as to the commenter's precise question, we believe the commenter is inquiring whether a certification signed by a hospice physician or attending physician under § 418.22 that has opted-out is only valid for a certain period of time. Our proposal does not change any existing policies in § 418.22 with respect to the length of time for which a particular certification remains valid. It only addresses the required enrollment/opt-out status of the certifying physician and attending physician.

Comment: In a vein akin to the previous comment, several commenters sought clarification about two issues regarding the duration of the certification and benefit period. First, they asked whether the hospice physician and attending physician must be enrolled/opted-out for the entire benefit period attached to the certification/recertification. Second, they asked whether, if the certifying physician or attending physician later becomes unenrolled and non-opted-out, the hospice must obtain a new certification and, if so, whether this would impact the benefit period days and any associated face-to-face encounter timing.

Response: The hospice physician and attending physician need only be enrolled/opted-out at the time they make the certification or recertification. They need not remain enrolled/opted-out during the patient's entire certification and benefit period and, if they become unenrolled and non-opted-out, the hospice need not secure a new certification to replace the one the previously enrolled/opted-out physician signed.

Comment: Several commenters asked CMS to clarify that physicians who complete the Form CMS–855 enrollment application per our proposal would neither have to list ''Hospice and Palliative Medicine'' as their specialty designation (specialty code 17) nor specify ''Hospice'' as among the services they are delivering. They explained that some attending physicians do not routinely refer patients to hospice and may not anticipate being designated as a hospice attending physician when they complete the Medicare enrollment application.

Response: We agree with this comment to the extent it pertains to an attending physician under our proposal. For hospice physicians, however, and as with all physicians who complete the Form CMS–855, it is important that they accurately and truthfully disclose on the application their primary specialty. If the hospice physician's primary specialty is indeed hospice/palliative care, this must be reported.

Comment: Several commenters suggested that in lieu of our proposal, CMS should focus on other means of identifying potentially problematic hospices, such as: (1) identifying parties that own multiple independent hospices with different state licenses and National Provider Identifiers; and (2) hospices that are co-located within the same physical site. Other commenters stated that measures such as a moratorium on new hospice licenses in overserved areas and greater scrutiny of high-risk hospices would be more effective in stopping problematic hospices than requiring physician enrollment.

Response: We do not believe our efforts to address hospice program integrity and quality of care concerns need to reflect an ''either/or'' approach, whereby the adoption of one measure mandates the exclusion of another. There are multiple facets of the hospice arena that are concerning to us, and our hospice certifying proposal is directly aimed at ensuring that physicians who certify hospice services are adequately vetted and are confirmed to meet Medicare requirements. In other words, this precise concern of ours must be addressed via a specific measure, and there is no better means of doing so than our proposal.

Comment: A commenter asked CMS to identify in future rulemaking: (1) the volume of fraudulent hospice referrals from non-Medicare enrolled physicians; and (2) outline the administrative burden of this proposal on hospices and not merely physicians. This would allow stakeholders to furnish substantive feedback that could help CMS make informed policy decisions that improve program integrity without creating unnecessary barriers to services.

Response: We will update the regulatory impact analysis to include an estimate of the hour and cost burden our provision could have on hospices. As for the volume of fraudulent hospice certifications from unenrolled and non-opted-out physicians, our available information is mostly limited to enrolled parties. Nonetheless, the close scrutiny and screening the enrollment process furnishes has helped ensure that Medicare payments are only made to qualified providers and suppliers and, more pertinently, that DMEPOS, HHA, imaging, and clinical laboratory items and services are ordered/certified by physicians and practitioners who meet Medicare requirements. We believe this will be the case with our hospice provision, too.

Comment: A commenter urged CMS to ensure that hospices can ascertain a physician's enrollment or opt-out status as easily as possible. Although, the commenter noted, enrollment data may be available online, the ability to search such data should be as intuitive and streamlined as possible to limit burden on hospices.

Response: We agree. We note that the ORDF has given providers and suppliers a simple, expeditious means of confirming a physician's or practitioner's enrollment or opt-out status. We will work closely with the hospice community when implementing this provision and will furnish education and outreach, particularly regarding the matter of enrollment/opt-out status verification.

Comment: A commenter stated that our proposed requirement may not resolve concerns related to inappropriate certification and should be further considered before implementation to avoid adding barriers to care. The commenter explained that given the short-stay of many patients, it is important not to impose administrative steps that could delay care.

Response: As with all of our provider enrollment regulatory proposals, we carefully considered our hospice enrollment/opt-out provision before proposing it and believe it is the best means of closing the vulnerability of unscreened hospice physicians certifying hospice services. While we recognize that hospice stays are often short, we believe that most currently unenrolled/non-opted-out hospice physicians and attending physicians (both categories of which we believe, as previously mentioned, are very few) will enroll or opt-out per our requirements.

Comment: Several commenters did not believe our proposal would significantly aid in preventing hospice fraudulent behavior because false certifications will not be identified by the enrollment verification when claims are processed. They added that many fraudulent activities that CMS cited in the proposed rule (and highlighted by the OIG and media reports) involve parties other than physicians; for instance, the proposed rule identified activities such as paying recruiters to target ineligible beneficiaries and false certifications being part of wider fraud schemes orchestrated by hospice owners and operators, not by individual physicians.

Response: We note two things. One is that the principal purpose of the enrollment process is to prevent fraud from occurring in the first place by screening providers and suppliers before they enroll in Medicare and submit claims. Described otherwise, the aim is not to wait until claims are submitted to detect fraud but to keep fraudulent parties from participating in Medicare altogether. This reflects CMS' desire to avoid a ''pay-and-chase'' approach whereby we pay claims and, if we find fraud associated with that payment, attempt to recoup the monies and take action against the provider or supplier. By being proactive, we can stop such activity before it begins. This is the objective behind our hospice provision. Carefully screening hospice physicians and attending physicians (such as for felony convictions, sanctions, etc.) before they are able to certify Medicare hospice services will, we believe, significantly reduce the risk that problematic physicians will furnish false certifications. The second point is that while some hospice fraud schemes do not directly involve certifying physicians, some do. Indeed, we previously noted cases where physicians made false certifications. We also identified several instances of such conduct in the recently published CY 2024 Home Health Prospective Payment System proposed rule (88 FR 43654).[30] We stress that simply because a certain fraud scheme was devised by the hospice's owner or manager rather than the hospice physician does not excuse any participation therein by the latter.

Comment: A commenter requested that CMS create an exception to our requirement when the hospice makes a good-faith effort to determine but cannot confirm the enrollment status of the certifying or attending physician. The commenter stated this would prevent unnecessary delays to hospice election and care.

Response: We respectfully disagree. For reasons already outlined, we believe it is critical that hospice and attending certifying physicians be enrolled or opted-out. We also believe the ORDF will enable hospices to expeditiously ascertain the physician's enrollment/opt-out status. This has been the general experience of other Medicare providers and suppliers (such as HHAs) who must verify the enrollment/opt-out status of physicians and practitioners who order or certify the services or items referenced in § 424.507.

Comment: Several commenters asked whether CMS will update the ORDF to include a column for hospices (similar to the existing columns for DMEPOS and HHAs).

Response: We will update the file to accommodate hospices.

Comment: Commenters recommended that CMS provide education to physicians and hospices about the enrollment requirements, processes, list of services, and taxonomy codes relevant to our provision.

Response: CMS will indeed furnish extensive education to the hospice community and physicians on the matters the commenters' referenced.

5. Final Provisions

We are finalizing our hospice enrollment provisions as proposed, though the implementation date for these provisions will be May 1, 2024.

IV. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and

[30] ''Medicare Program; Calendar Year (CY) 2024 Home Health (HH) Prospective Payment System Rate Update; HH Quality Reporting Program Requirements; HH Value-Based Purchasing Expanded Model Requirements; Home Intravenous Immune Globulin Items and Services; Hospice Informal Dispute Resolution and Special Focus Program Requirements, Certain Requirements for Durable Medical Equipment Prosthetics and Orthotics Supplies; and Provider and Supplier Enrollment Requirements.''

approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We solicited public comment on each of these issues for the following sections of this rule that contain information collection requirements.

A. Hospice Certifying Physician Enrollment

As finalized in section III E. of this rule, physicians who certify hospice services for Medicare beneficiaries must be enrolled in or validly opted-out of Medicare as a prerequisite for payment of the hospice service in question. Most certifying physicians are already Medicare-enrolled or validly opted-out. Nonetheless, we noted in the proposed rule that, per CMS data, approximately 2,173 physicians who certify Medicare hospice services are not. These physicians, as already stated, would have to enroll or opt-out under our provision. However, we recently reconsidered this estimate and, based on the latest data, have determined that there are only 1,382 physicians who would have to enroll or opt-out pursuant to our requirement. We will use this figure in our final burden projections.

Strictly for purposes of establishing an estimate, we project that the average physician will complete a Form CMS–855O enrollment application (Medicare Enrollment Application—Registration for Eligible Ordering and Referring Physicians and Non-Physician Practitioners—OMB Control No.: 0938–1135) rather than an opt-out affidavit to comply with our requirements. Per previous estimates, it would take approximately 0.5 hours for a physician to complete the Form CMS–855O application.

According to the most recent wage data provided by the Bureau of Labor Statistics (BLS) for May 2022 (see *http://www.bls.gov/oes/current/oes_nat.htm*), the mean hourly wage for the general category of ''Physicians, All Other'' is $114.76. With fringe benefits and overhead, the total per hour rate is $229.52. The foregoing wage figures are outlined in Table 8:

TABLE 8: National Occupational Employment and Wage Estimates

Occupation title	Occupation code	Mean hourly wage ($/hr)	Fringe benefits and overhead ($/hr)	Adjusted hourly wage ($/hr)
Physicians, All Other	29-1216	114.76	114.76	229.52

We project that our provision will therefore result in a 691-hour burden (1,382 × 0.5 hr) at a cost of $158,598 (691 × $229.52). (Most of these physicians will enroll during the first year of our provision in order to continue certifying hospice services.) Averaged over the 3-year OMB-approval period, this results in annual burdens of 230 hours and $52,866. This burden will be updated as part of a separate Paperwork Reduction Act submission.

We received no comments on our proposed ICR estimates and are finalizing our revised projections as described.

B. Codification of HQRP Data Completeness Thresholds

The codifications to the HQRP data completeness thresholds reflects the same thresholds which have been applied to the HQRP since the FY 2018 Hospice Final Rule. As such, this rule does not impose any additional collection of information burden on hospices.

V. Regulatory Impact Analysis

A. Statement of Need

1. Hospice Payment

This final rule meets the requirements of our regulations at § 418.306(c) and (d), which require annual issuance, in the **Federal Register**, of the hospice wage index based on the most current available CMS hospital wage data, including any changes to the definitions of CBSAs or previously used Metropolitan Statistical Areas (MSAs), as well as any changes to the methodology for determining the per diem payment rates. This rule updates the payment rates for each of the categories of hospice care, described in § 418.302(b), for FY 2024 as required under section 1814(i)(1)(C)(ii)(VII) of the Act. The payment rate updates are subject to changes in economy-wide productivity as specified in section 1886(b)(3)(B)(xi)(II) of the Act.

2. Hospice Quality Reporting Program

Sections 1814(i)(5)(A) through (C) of the Act authorizes the HQRP which requires that hospices submit quality data, based on measures to be specified by the Secretary. In the FY 2012 Hospice Wage Index and Rate Update final rule (76 FR 47320 through 47324), we implemented a HQRP as required by those sections. Hospices were required to begin collecting quality data in October 2012 and submit those quality data in 2013. Section 1814(i)(5)(A)(i) of the Act requires that beginning with FY 2014 through FY 2023, the Secretary shall reduce the market basket update by 2 percentage points for any hospice that does not comply with the quality data submission requirements with respect to that FY. Section 1814(i)(5)(A)(i) of the Act was amended by section 407(b) of Division CC, Title IV of the CAA, 2021 to change the payment reduction for failing to meet hospice quality reporting requirements from 2 to 4 percentage points. This policy will apply beginning with the FY 2024 annual payment update (APU) that is based on CY 2022 quality data. Specifically, the Act requires that, for FY 2014 through FY 2023, the Secretary shall reduce the market basket update by 2 percentage points and beginning with the FY 2024 APU and for each subsequent year, the Secretary shall reduce the market basket update by 4 percentage points for any hospice that does not comply with the quality data submission requirements for that FY.

3. Impact of Hospice Ordering/Certifying Physician Enrollment

We proposed that physicians who certify hospice services must be enrolled in or opted-out of Medicare in order to do so. This proposal was needed so that CMS could screen the certifying physician to ensure that they are qualified to certify services (for

example, licensed, do not have adverse legal actions, etc.). Via this screening process, we can help protect beneficiaries and the Trust Funds from unqualified and problematic physicians.

B. Overall Impacts

1. Hospice Payment

We estimate that the aggregate impact of the payment provisions in this final rule would result in an estimated increase of $780 million in payments to hospices, resulting from the hospice payment update percentage of 3.1 percent for FY 2024. The impact analysis of this rule represents the projected effects of the changes in hospice payments from FY 2023 to FY 2024. Using the most recent complete data available at the time of rulemaking, in this case FY 2022 hospice claims data as of May 11, 2023, we simulate total payments using the FY 2023 wage index (pre-floor, pre-reclassified hospital wage index with the hospice floor, and the 5-percent cap on wage index decreases) and FY 2023 payment rates and compare it to our simulation of total payments using FY 2022 utilization claims data, the FY 2024 hospice wage index (pre-floor, pre-reclassified hospital wage index with hospice floor, and the 5-percent cap on wage index decreases) and FY 2023 payment rates. By dividing payments for each level of care (RHC days 1 through 60, RHC days 61+, CHC, IRC, and GIP) using the FY 2023 wage index and payment rates for each level of care by the FY 2024 wage index and FY 2023 payment rates, we obtain a wage index standardization factor for each level of care. We apply the wage index standardization factors so that the aggregate simulated payments do not increase or decrease due to changes in the wage index.

Certain events may limit the scope or accuracy of our impact analysis, because such an analysis is susceptible to forecasting errors due to other changes in the forecasted impact time period. The nature of the Medicare program is such that the changes may interact, and the complexity of the interaction of these changes could make it difficult to predict accurately the full scope of the impact upon hospices.

We have examined the impacts of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 14094 on Modernizing Regulatory Review (April 6, 2023), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96 354), section 1102(b) of the Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999), and the Congressional Review Act (CRA) (5 U.S.C. 804(2)).

Executive Orders 12866 (as amended by E.O. 14094) and E.O. 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Executive Order 14094 amends 3(f) of Executive Order 12866 to define a ''significant regulatory action'' as an action that is likely to result in a rule that: (1) has an annual effect on the economy of $200 million or more in any 1 year, 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, territorial, or tribal governments or communities; (2) creates a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially alters the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising legal or policy issues for which centralized review would meaningfully further the President's priorities or the principles set forth in this Executive Order.

A regulatory impact analysis (RIA) must be prepared for major rules with significant regulatory action/s and/or with significant effects as per section 3(f)(1) of $200 million or more in any 1 year. Based on our estimates, OMB'S Office of Information and Regulatory Affairs has determined this rulemaking significant under section 3(f)(1) of E.O. 12866. Accordingly, we have prepared a regulatory impact analysis presents the costs and benefits of the rulemaking to the best of our ability.

C. Detailed Economic Analysis

1. Hospice Payment Update for FY 2024

The FY 2024 hospice payment impacts appear in Table 9. We tabulate the resulting payments according to the classifications (for example, provider type, geographic region, facility size), and compare the difference between current and future payments to determine the overall impact. The first column shows the breakdown of all hospices by provider type and control (non-profit, for-profit, government, other), facility location, facility size. The second column shows the number of hospices in each of the categories in the first column. The third column shows the effect of using the FY 2024 updated wage index data with a 5-percent cap on wage index decreases. This represents the effect of moving from the FY 2023 hospice wage index to the FY 2024 hospice wage index. The aggregate impact of the changes in column three is zero percent, due to the hospice wage index standardization factor. However, there are distributional effects of the FY 2024 hospice wage index. The fourth column shows the effect of the hospice payment update percentage as mandated by section 1814(i)(1)(C) of the Act and is consistent for all providers. The hospice payment update percentage of 3.1 percent is based on the 3.3 percent inpatient hospital market basket percentage increase, reduced by a 0.2 percentage point productivity adjustment. The fifth column shows the total effect of the updated wage data and the hospice payment update percentage on FY 2024 hospice payments but does not include the effect of moving from the 2 percent reduction to the 4 percent reduction for failure to report quality data. It is projected aggregate payments would increase by 3.1 percent; assuming hospices do not change their billing practices. As illustrated in Table 9, the combined effects of all the proposals vary by specific types of providers and by location. We note that simulated payments are based on utilization in FY 2022 as seen on Medicare hospice claims (accessed from the CCW on May 11, 2023) and only include payments related to the level of care and do not include payments related to the service intensity add-on.

As illustrated in Table 9, the combined effects of all the proposals vary by specific types of providers and by location.

TABLE 9: Impact to Hospices for FY 2024

Hospice Subgroup	Hospices	FY 2024 Updated Wage Data	FY 2024 Hospice Payment Update (%)	Overall Total Impact for FY 2024
All Hospices	5,653	0.0%	3.1%	3.1%
Hospice Type and Control				
Freestanding/Non-Profit	559	-0.1%	3.1%	3.0%
Freestanding/For-Profit	4,013	0.0%	3.1%	3.1%
Freestanding/Government	38	-0.4%	3.1%	2.7%
Freestanding/Other	371	0.2%	3.1%	3.3%
Facility/HHA Based/Non-Profit	328	-0.1%	3.1%	3.0%
Facility/HHA Based/For-Profit	187	-0.4%	3.1%	2.7%
Facility/HHA Based/Government	72	0.2%	3.1%	3.3%
Facility/HHA Based/Other	85	0.0%	3.1%	3.1%
Subtotal: Freestanding Facility Type	4,981	0.0%	3.1%	3.1%

Subtotal: Facility/HHA Based Facility Type	672	-0.1%	3.1%	3.0%
Subtotal: Non-Profit	887	-0.1%	3.1%	3.0%
Subtotal: For Profit	4,200	0.0%	3.1%	3.1%
Subtotal: Government	110	-0.1%	3.1%	3.0%
Subtotal: Other	456	0.2%	3.1%	3.3%
Hospice Type and Control: Rural				
Freestanding/Non-Profit	127	-0.3%	3.1%	2.8%
Freestanding/For-Profit	354	-0.3%	3.1%	2.8%
Freestanding/Government	22	-0.8%	3.1%	2.3%
Freestanding/Other	55	-0.2%	3.1%	2.9%
Facility/HHA Based/Non-Profit	126	-0.4%	3.1%	2.7%
Facility/HHA Based/For-Profit	51	-0.1%	3.1%	3.0%
Facility/HHA Based/Government	56	-0.2%	3.1%	2.9%
Facility/HHA Based/Other	47	-0.3%	3.1%	2.8%
Hospice Type and Control: Urban				
Freestanding/Non-Profit	432	-0.1%	3.1%	3.0%
Freestanding/For-Profit	3,659	0.0%	3.1%	3.1%
Freestanding/Government	16	-0.3%	3.1%	2.8%
Freestanding/Other	316	0.3%	3.1%	3.4%
Facility/HHA Based/Non-Profit	202	0.0%	3.1%	3.1%
Facility/HHA Based/For-Profit	136	-0.5%	3.1%	2.6%
Facility/HHA Based/Government	16	0.4%	3.1%	3.5%
Facility/HHA Based/Other	38	0.1%	3.1%	3.2%
Hospice Location: Urban or Rural				
Rural	838	-0.3%	3.1%	2.8%
Urban	4,815	0.0%	3.1%	3.1%
Hospice Location: Region of the Country (Census Division)				
New England	152	-0.7%	3.1%	2.4%
Middle Atlantic	284	0.5%	3.1%	3.6%
South Atlantic	608	0.3%	3.1%	3.4%
East North Central	592	-0.5%	3.1%	2.6%
East South Central	255	0.0%	3.1%	3.1%
West North Central	420	-0.1%	3.1%	3.0%
West South Central	1,104	0.2%	3.1%	3.3%
Mountain	591	-0.5%	3.1%	2.6%
Pacific	1,598	0.1%	3.1%	3.2%
Outlying	49	-1.6%	3.1%	1.5%
Hospice Size				
0 – 3,499 RHC Days (Small)	1,422	0.1%	3.1%	3.2%
3,500-19,999 RHC Days (Medium)	2,554	-0.1%	3.1%	3.0%
20,000+ RHC Days (Large)	1,677	0.0%	3.1%	3.1%

Source: FY 2022 hospice claims data from CCW accessed on May 11, 2023.

Note: The overall total impact reflects the addition of the individual impacts, which includes the wage index impact as well as the 3.1 percent hospice payment update percentage. However, it does not include the effect of moving from the 2 percent reduction to the 4 percent reduction for failure to report quality data.

Region Key:
New England=Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont
Middle Atlantic=Pennsylvania, New Jersey, New York
South Atlantic=Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia
East North Central=Illinois, Indiana, Michigan, Ohio, Wisconsin
East South Central=Alabama, Kentucky, Mississippi, Tennessee
West North Central=Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, South Dakota
West South Central=Arkansas, Louisiana, Oklahoma, Texas
Mountain=Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming
Pacific= Alaska, California, Hawaii, Oregon, Washington

2. Regulatory Review Cost Estimation

If regulations impose administrative costs on private entities, such as the time needed to read and interpret this rule, we should estimate the cost associated with regulatory review. Due to the uncertainty involved with accurately quantifying the number of entities that will review this rule, we assume that the total number of unique commenters on this year's proposed rule will be the number of reviewers of this final rule. We acknowledge that this assumption may understate or overstate the costs of reviewing this rule. It is possible that not all commenters reviewed this year's rule in detail, and it is also possible that some reviewers chose not to comment on the proposed rule. For these reasons we believe that the number of past commenters would be a fair estimate of the number of reviewers of this final rule. We welcomed public comments on the approach in estimating the number of entities that would review the proposed rule. We did not receive any public comments specific to our solicitation.

We also recognize that different types of entities are in many cases affected by mutually exclusive sections of this rule, and therefore for the purposes of our estimate we assume that each reviewer reads approximately 50 percent of the rule. We sought public comments on this assumption, and we did not receive any public comments.

Using the occupational wage information from the BLS for medical and health service managers (Code 11–9111) from May 2022; we estimate that the cost of reviewing this rule is $115.22 per hour, including overhead and fringe benefits (*https://www.bls.gov/oes/current/oes119111.htm*). This final rule consists of approximately 32,000 words. Assuming an average reading speed of 250 words per minute, it would take approximately 2 hours for staff to review half of it. For each hospice that reviews the rule, the estimated cost is $230.44 (2 hours × $115.22). Therefore, we estimate that the total cost of reviewing this regulation is $8,756.72 ($115.22 × 76 reviewers).

3. Impacts for the Hospice Quality Reporting Program for FY 2024

The HQRP requires the active collection under OMB control number #0938–1153 (CMS 10390; expiration 02/29/2024) of the Hospice Items Set (HIS) and CAHPS® Hospice Survey (OMB control number 0938–1257 (CMS–10537; expiration 12/31/2023). Failure to submit data required under section 1814(i)(5) of the Act with respect to a CY will result in the reduction of the annual hospice market basket percentage increase otherwise applicable to a hospice for that calendar year. From FY 2014 through FY 2023, hospices that failed to report quality data had their market basket percentage increase reduced by 2 percentage points. As noted in section C.5. of this final rule, section 1814(i)(5)(A)(i) of the Act was amended by section 407(b) of Division CC, Title IV of the CAA, 2021 (Pub. L. 116–260) to change the payment reduction for failing to meet hospice quality reporting requirements to 4 percentage points, beginning with FY 2024. This section analyzes the estimated impact of the transition from 2 percentage points to 4 percentage points.

Based on historical performance trends, we estimate that roughly 18.4 percent of hospices (an estimated 1,049 out of approximately 5,700 active hospices) will fail to receive the full annual percentage increase in FY 2024, if active Medicare-certified hospices perform similarly in CY 2022 to hospice performance in previous years. We project that the 4 percentage point penalty for hospices will represent approximately $82.4 million in hospice payment dollars during the reporting period, out of an estimated total $23.9 billion paid to all hospices. The net impact of the policy change from 2 percent APU penalty to 4 percent APU penalty is estimated to be $41.2 million.

4. Impact of Hospice Certifying Physician Enrollment

We believe there will be two main impacts of this provision. The first is the ICR burden outlined in section IV of this rule regarding the completion of the Form CMS–855O, which we projected to be 691 hours and $158,598 over a 3-year period, or 230 hours or $52,866 per year. The second involves the burden the hospice will incur in verifying the physician's enrollment/opt-out status. There are approximately 6,712 Medicare-enrolled hospices. Based on our experience with providers and suppliers such as HHAs and DMEPOS suppliers, we believe it will take a hospice approximately 5 minutes to confirm the enrollment/opt-out status of the certifying physician(s). Solely for purposes of establishing a projection, we will estimate that there are roughly 1.7 million Medicare hospice beneficiaries per year (or, on average, 253 per hospice) (1.7 million/6,712), this results in an annual hour burden of 141,455 hours (6,712 × 253 × 0.0833). In terms of cost, we believe that the hospice's administrative personnel will typically confirm the physician's enrollment/opt-out status. Consequently, we will use the following wage category and hourly rate from the BLS May 2022 National Occupational Employment and Wage Estimates for all salary estimates (*http://www.bls.gov/oes/current/oes_nat.htm*):

TABLE 10: NATIONAL OCCUPATIONAL EMPLOYMENT AND WAGE ESTIMATES

Occupation Title	Occupation Code	Mean Hourly Wage ($/hr)	Fringe Benefits and Overhead ($/hr)	Adjusted Hourly Wage ($/hr)
Office and Administrative Support Workers, All Other	43-9199	20.75	20.75	41.50

This results in an estimated annual cost of $5,870,383 ($141,455 × $41.50).

D. Alternatives Considered

1. Hospice Payment

Since the hospice payment update percentage is determined based on statutory requirements at section 1814(i)(1)(C) of the Act, we did not consider updating the hospice payment rates by the payment update percentage. The 3.1 percent hospice payment update percentage for FY 2024 is based on a 3.3 percent inpatient hospital market basket percentage increase for FY 2024, reduced by a 0.2 percentage point productivity adjustment. Payment rates since FY 2002 have been updated according to section 1814(i)(1)(C)(ii)(VII) of the Act, which states that the update to the payment rates for subsequent years must be the market basket percentage increase for that FY. Section 3401(g) of the Affordable Care Act also mandates that, starting with FY 2013 (and in subsequent years), the hospice payment update percentage will be annually reduced by changes in economy-wide productivity as specified in section 1886(b)(3)(B)(xi)(II) of the Act.

2. Hospice Quality Reporting Program

We did not consider any alternatives in this final rule.

3. Hospice Physician Enrollment

We did not consider any alternatives to our proposal to require physicians who certify hospice services for Medicare beneficiaries to be enrolled/opted-out as a prerequisite for the payment of the hospice service in question. This is because the enrollment process is the only available, feasible means of ascertaining the physician's compliance with all applicable requirements and whether he or she has any adverse legal history.

E. Accounting Statement

As required by OMB Circular A–4 (available at *https://www.whitehouse.gov/sites/whitehouse.gov/files/omb/circulars/A4/a-4.pdf*), in Table 11, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this final rule. Table 11 provides our best estimate of the possible changes in Medicare payments under the hospice benefit as a result of the policies in this rule. This estimate is based on the data for 5,653 hospices in our impact analysis file, which was constructed using FY 2022 claims (accessed from the CCW on May 11, 2023). All expenditures are classified as transfers to hospices.

TABLE 11: Accounting Statement
Classification of Estimated Transfers and Costs, From FY 2023 to FY 2024

Category	Transfers
Annualized Monetized Transfers	$780 million*
From Whom to Whom?	Federal Government to Medicare Hospices
Category	**Costs**
Annualized Monetized Costs Associated with Changes in APU Reductions due to Data Submission Requirements	$41.2 million**

*The increase of $780 million in transfer payments is a result of the 3.1 percent hospice payment update compared to payments in FY 2023.

**The $41.2 million is the amount CMS is projected to recoup based on the increased penalty for hospices that fail to meet HQRP data submission requirements, Compared to APU penalties in FY 2023.

F. Regulatory Flexibility Act (RFA)

The RFA requires agencies to analyze options for regulatory relief of small entities if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. We consider all hospices as small entities as that term is used in the RFA. The North American Industry Classification System (NAICS) was adopted in 1997 and is the current standard used by the Federal statistical agencies related to the U.S. business economy. There is no NAICS code specific to hospice services. Therefore, we utilized the NAICS U.S. industry title ''Home Health Care Services'' and corresponding NAICS

code 621610 in determining impacts for small entities. The NAICS code 621610 has a size standard of $19 million.[31] Table 12 shows the number of firms, revenue, and estimated impact per home health care service category.

TABLE 12: NUMBER OF FIRMS, REVENUE, AND ESTIMATED IMPACT OF HOME HEALTH CARE SERVICES BY NAICS CODE 621610

NAICS Code	NAICS Description	Enterprise Size	Number of Firms	Receipts ($1,000)	Estimated Impact ($1,000) per Enterprise Size
621610	Home Health Care Services	<100	5,861	210,697	$35.95
621610	Home Health Care Services	100-499	5,687	1,504,668	$264.58
621610	Home Health Care Services	500-999	3,342	2,430,807	$727.35
621610	Home Health Care Services	1,000-2,499	4,434	7,040,174	$1,587.77
621610	Home Health Care Services	2,500-4,999	1,951	6,657,387	$3,412.29
621610	Home Health Care Services	5,000-7,499	672	3,912,082	$5,821.55
621610	Home Health Care Services	7,500-9,999	356	2,910,943	$8,176.81
621610	Home Health Care Services	10,000-14,999	346	3,767,710	$10,889.34
621610	Home Health Care Services	15,000-19,999	191	2,750,180	$14,398.85
621610	Home Health Care Services	≥20,000	961	51,776,636	$53,877.87
621610	Home Health Care Services	Total	23,801	82,961,284	$3,485.62

Source: Data obtained from United States Census Bureau table "us_6digitnaics_rcptsize_2017" (SOURCE: 2017 County Business Patterns and Economic Census) Release Date: 5/28/2021: https://www2.census.gov/programs-surveys/susb/tables/2017/
Notes: Estimated impact is calculated as Receipts ($1,000)/Number of firms.

The Department of Health and Human Services practice in interpreting the RFA is to consider effects economically ''significant'' only if greater than 5 percent of providers reach a threshold of 3 to 5 percent or more of total revenue or total costs. The majority of hospice visits are Medicare paid visits and therefore the majority of hospice's revenue consists of Medicare payments. Based on our analysis, we conclude that the policies finalized in this rule would result in an estimated total impact of 3 to 5 percent or more on Medicare revenue for greater than 5 percent of hospices. Therefore, the Secretary has certified that this hospice final rule would have significant economic impact on a substantial number of small entities. We estimate that the net impact of the policies in this rule is a 3.1 percent or approximately $780 million in increased revenue to hospices in FY 2024. The 3.1 percent increase in expenditures when comparing FY 2023 payments to estimated FY 2024 payments is reflected in the last column of the first row in Table 9 and is driven solely by the impact of the hospice payment update percentage reflected in the fourth column of the impact table. In addition, small hospices would experience a greater estimated increase (3.2 percent), compared to large hospices (3.1 percent) due to the updated wage index. Further detail is presented in Table 9, by hospice type and location.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a MSA and has fewer than 100 beds. This rule will only affect hospices. Therefore, the Secretary has determined that this rule will not have a significant impact on the operations of a substantial number of small rural hospitals (see Table 12).

G. Unfunded Mandates Reform Act (UMRA)

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2023, that threshold is approximately $177 million. This rule is not anticipated to have an effect on state, local, or tribal governments, in the aggregate, or on the private sector of $177 million or more in any 1 year.

H. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on state and local governments, preempts state law, or otherwise has Federalism implications. We have reviewed this rule under these criteria of Executive Order 13132 and have determined that it will not impose substantial direct costs on state or local governments.

I. Conclusion

We estimate that aggregate payments to hospices in FY 2024 will increase by $780 million as a result of the hospice payment update, compared to payments in FY 2023. We estimate that in FY 2024, hospices in urban areas will experience, on average, a 3.1 percent increase in estimated payments compared to FY 2023; while hospices in rural areas will experience, on average, a 2.8 percent increase in estimated payments compared to FY 2023. Hospices providing services in the Middle Atlantic and South Atlantic regions would experience the largest estimated increases in payments of 3.6 percent and 3.4 percent, respectively. Hospices serving patients in areas in the Outlying regions would experience, on

[31] *https://www.sba.gov/sites/sbagov/files/2023-03/Table%20of%20Size%20Standards_Effective%20March%2017%2C%202023%20%281%29%20%281%29_0.pdf.*

average, the lowest estimated increase of 1.5 percent in FY 2024 payments.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

Chiquita Brooks-LaSure, Administrator of the Centers for Medicare & Medicaid Services, approved this document on July 25, 2023.

List of Subjects

42 CFR Part 418

Health facilities, Hospice care, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 424

Health facilities, Health professions, Medicare Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR chapter IV as set forth below.

PART 418—HOSPICE CARE

■ 1. The authority citation for part 418 continues to read as follows:

Authority: 42 U.S.C. 1302 and 1395hh.

■ 2. Amend § 418.22 by revising paragraph (a)(4)(ii) to read as follows:

§ 418.22 Certification of terminal illness.

* * * * *

(a) * * *

(4) * * *

(ii) During a Public Health Emergency, as defined in § 400.200 of this chapter, or through December 31, 2024, whichever is later, if the face-to-face encounter conducted by a hospice physician or hospice nurse practitioner is for the sole purpose of hospice recertification, such encounter may occur via a telecommunications technology and is considered an administrative expense. *Telecommunications technology* means the use of interactive multimedia communications equipment that includes, at a minimum, the use of audio and video equipment permitting two-way, real-time interactive communication between the patient and the distant site hospice physician or hospice nurse practitioner.

* * * * *

§ 418.204 [Amended]

■ 3. Amend § 418.204 by removing paragraph (d).

§ 418.309 [Amended]

■ 4. In § 418.309 amend paragraphs (a)(1) and (2) by removing the date ''October 1, 2030'' and adding in its place the date ''October 1, 2032''.

■ 5. Amend § 418.312 by adding paragraph (j) to read as follows

§ 418.312 Data submission requirements under the hospice quality reporting program

* * * * *

(j) *Data completion thresholds.* (1) Hospices must meet or exceed data submission threshold set at 90 percent of all required HIS or successor instrument records within 30-days of the beneficiary's admission or discharge and submitted through the CMS designated data submission systems.

(2) A hospice must meet or exceed the data submission compliance threshold in paragraph (j)(1) of this section to avoid receiving a 4-percentage point reduction to its annual payment update for a given FY as described under § 412.306(b)(2) of this chapter.

PART 424—CONDITIONS FOR MEDICARE PAYMENT

■ 6. The authority citation for part 424 continues to read as follows:

Authority: 42 U.S.C. 1302 and 1395hh.

■ 7. Amend § 424.507 by—

■ a. Revising paragraphs (b) introductory text and (b)(1) introductory text; and

■ b. Adding new paragraph (b)(3).

The revisions and addition read as follows:

§ 424.507 Ordering covered items and services for Medicare beneficiaries.

* * * * *

(b) *Conditions for payment of claims for covered home health and hospice services.* To receive payment for covered Part A or Part B home health services or for covered hospice services, a provider's home health or hospice services claim must meet all of the following requirements:

(1) The ordering/certifying physician for hospice or home health services, or, for home health services, the ordering/certifying physician assistant, nurse practitioner, or clinical nurse specialist working in accordance with State law, must meet all of the following requirements:

* * * * *

(3) For claims for hospice services, the requirements of this paragraph (b) apply with respect to any physician described in § 418.22(c) of this chapter who made the applicable certification described in § 418.22(c) of this chapter.

* * * * *

Xavier Becerra,

Secretary, Department of Health and Human Services.

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Part V

The President

Executive Order 14104—Federal Research and Development in Support of Domestic Manufacturing and United States Jobs

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Presidential Documents

Title 3—

The President

Executive Order 14104 of July 28, 2023

Federal Research and Development in Support of Domestic Manufacturing and United States Jobs

By the authority vested in me as President by the Constitution and the laws of the United States of America, it is hereby ordered as follows:

Section 1. *Policy.* The United States maintains an unparalleled innovation ecosystem with world-class universities, Federal laboratories, research centers, and technology incubators, supported in part by Federal investment. Our world is healthier, smarter, more connected, and more sustainable because of Federal taxpayers' investment in discovery and innovation that has supported the commercialization of new products and services.

My Administration has prioritized support for our unique innovation ecosystem by reinvesting across sectors in research and development (R&D), demonstrations, education, and the necessary infrastructure to accelerate the transition of discoveries quickly from the lab to the marketplace.

This investment is designed to produce cutting-edge technologies that support the competitiveness, domestic manufacturing capacity, and well-being of the United States economy; United States workers; our communities; and our national security. Ensuring the commercialization of federally funded inventions by United States manufacturers—while maintaining intellectual property rights—will build on the successful legacy of the United States in spurring economic growth and enhancing United States competitiveness through R&D. It will also further our joint R&D work with partners and allies to strengthen the resilience of global critical supply chains and secure America's leadership in delivering a net-zero emissions economy by no later than 2050.

Therefore, it is the policy of my Administration that when new technologies and products are developed with support from the United States Government, they will be manufactured in the United States whenever feasible and consistent with applicable law.

Sec. 2. *Coordination and Consultation.* (a) The Assistant to the President for National Security Affairs, the Assistant to the President for Economic Policy, and the Director of the Office of Science and Technology Policy (OSTP) shall coordinate the executive branch actions necessary to implement this order through the interagency process identified in National Security Memorandum 2 of February 4, 2021 (Renewing the National Security Council System).

(b) In implementing this order, the heads of executive departments and agencies (agencies) shall, as appropriate and consistent with applicable law, consult outside stakeholders—such as those in industry; academia, including Historically Black Colleges and Universities, Tribal Colleges and Universities, and other Minority Serving Institutions; non-governmental organizations; communities; labor unions; and State, local, Tribal, and territorial governments—in order to implement the policy identified in section 1 of this order.

Sec. 3. *Strengthening Domestic Manufacturing.* (a) The Secretary of Defense, the Secretary of Agriculture, the Secretary of Commerce, the Secretary of Health and Human Services, the Secretary of Transportation, the Secretary of Energy, the Secretary of Homeland Security, the Director of the National Science Foundation, and the Administrator of the National Aeronautics and

Space Administration should consider domestic manufacturing in Federal R&D funding agreement solicitations, as appropriate and consistent with applicable law. These agency heads shall also consider how their respective agencies' R&D funding agreements support broader domestic manufacturing objectives, including the development of production facilities and capabilities broadly supportive of United States manufacturing, as appropriate and consistent with applicable law.

(b) The Director of OSTP, working through the National Science and Technology Council (NSTC) and in coordination with the Director of the Office of Management and Budget's Made in America Office (Made in America Director) and the heads of agencies identified in subsection (a) of this section, shall seek to add ''domestic manufacturing'' to future interagency technology R&D roadmaps, as appropriate. The Director of OSTP shall endeavor to standardize the format of domestic manufacturing considerations in technology R&D roadmaps to ensure that industry, the research community, and agencies create the conditions for new technologies to be produced in the United States once they are commercialized.

(c) In collaboration with the Administrator of the Small Business Administration (SBA), the heads of agencies participating in the Small Business Innovation Research and Small Business Technology Transfer programs are encouraged to advance a coordinated interagency approach to innovation and research solicitations with the goals of reducing barriers to program participation, streamlining access to funding opportunities, and encouraging production of new technologies in the United States. The heads of these agencies are further encouraged to collaborate with the SBA to support small businesses transitioning technologies from intramural and extramural labs to commercial markets.

(d) The heads of agencies that have statutory Other Transaction Authority, or that can use other business arrangements authorized by the Congress, are encouraged, when appropriate, to consider using these authorities to purchase or invest in leading-edge technologies to support their production in the United States. If these agencies use these authorities to purchase or invest in the development of new technologies, the terms of these purchases and investments should ensure that the product is substantially manufactured in the United States, as appropriate and consistent with applicable law.

(e) To further support the commercialization and production in the United States of technologies developed, in part, through federally funded R&D, the heads of agencies identified in subsection (a) of this section are encouraged to establish or enhance the technology transfer and commercialization capabilities of their agencies.

Sec. 4. *Modernizing Reporting of Invention Utilization.* (a) In an effort to streamline reporting requirements for recipients of Federal R&D funding agreements, the heads of agencies identified in section 3(a) of this order should seek to make reporting on the utilization of ''subject inventions'' (as defined in 35 U.S.C. 201(e)) easier and consistent across the United States Government.

(b) To incentivize domestic manufacturing through the reporting of invention disclosures and the utilization of those inventions, the heads of agencies identified in section 3(a) of this order shall require recipients of Federal R&D funding agreements to track and update the awarding agency on the location in which subject inventions are manufactured.

(c) The heads of agencies identified in section 3(a) of this order should require recipients of Federal R&D funding agreements to report annually to the awarding agency the names of licensees and manufacturing locations of the applicable subject inventions.

(d) Within 60 days of the date of this order, the Secretary of Commerce, through the Director of the National Institute of Standards and Technology (NIST) and in consultation with the Office of Management and Budget (OMB), should develop award terms and conditions regarding the reporting

requirements in subsections (a) through (c) of this section to be implemented by each awarding agency identified in section 3(a) of this order. Award terms and conditions shall ensure that the reporting of the information specified in subsections (b) and (c) of this section protects business confidential information, consistent with 35 U.S.C. 202(c)(5), while providing increased visibility to taxpayers on the use of Federal R&D funding in support of domestic manufacturing and job creation.

(e) The Secretary of Commerce, through the Director of NIST and in consultation with the Interagency Working Group for Bayh-Dole, shall consider developing an action plan, including resource requirements, to transition all agencies identified in section 3(a) of this order to the iEdison reporting system to track unclassified subject inventions, patents, and related utilization reports by calendar year 2025. The Secretary of Commerce shall submit the action plan to the Director of OMB within 1 year of the date of this order.

(f) Not later than 120 days after issuance of any final regulations implementing the action plan described in subsection (e) of this section, the heads of agencies identified in section 3(a) of this order shall report to the Director of OMB and the Director of OSTP on steps their respective agencies have taken to transition all unclassified reporting to iEdison by the end of calendar year 2025. These reports may include resource needs and timelines for implementation.

(g) Within 180 days of the date of this order, the Secretary of Commerce, through the Director of NIST and in consultation with the Interagency Working Group for Bayh-Dole, should develop common invention utilization questions (utilization questions), allowing agencies to add agency-specific questions.

(i) The utilization questions should be used by all agencies by May 1, 2024, for subject inventions that a Federal R&D funding agreement recipient has elected to retain title on or after the date of this order.

(ii) The utilization questions should require information on the locations where subject inventions are produced or are used to produce a product.

(iii) The Secretary of Commerce, through the Director of NIST, and the heads of other agencies should aim to minimize the reporting burden on recipients of Federal R&D funding agreements associated with the utilization questions, in accordance with the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*) and applicable OMB guidance.

(h) Within 2 years after the date of this order and annually thereafter, the heads of agencies identified in section 3(a) of this order shall submit reports to the Made in America Director on the utilization of inventions that were developed through their previous R&D funding agreements and reported after the date of this order, including where products embodying a subject invention or produced through the use of a subject invention were manufactured.

Sec. 5. *Securing Critical and Emerging Technologies Through Domestic Manufacturing.* (a) Within 90 days of the date of this order, the heads of agencies identified in section 3(a) of this order shall consider whether ''exceptional circumstances'' exist warranting a determination that a restriction of the right to retain title to any subject invention funded by their respective agencies' R&D funding agreements will better promote the policy and objectives of the Bayh-Dole Act, as appropriate and consistent with applicable law, including 35 U.S.C. 202(a). Such consideration shall include evaluation of whether ''exceptional circumstances'' exist to warrant the extension of the requirement to manufacture ''substantially in the United States'' to recipients of Federal R&D funding agreements, to non-exclusive licensees of subject inventions, and for use or sale of subject inventions outside the United States, as appropriate and consistent with applicable law, including 35 U.S.C. 202(a). In considering the issuance of such determinations for these purposes, the heads of agencies identified in section 3(a) of this order shall:

(i) consider measures for technologies important to the United States economy and national security, including critical and emerging technologies such as energy storage, quantum information science, artificial intelligence and machine learning, semiconductors and microelectronics, and advanced manufacturing; and

(ii) consider narrowly tailoring terms related to enhanced United States manufacturing while encouraging technology transfer and commercialization, and allowing small businesses and nonprofit organizations to retain ownership of and commercialize their federally funded subject inventions.

(b) The heads of agencies identified in section 3(a) of this order shall consider whether other measures are needed to promote domestic manufacturing of subject inventions funded by their respective agencies.

Sec. 6. *Implementation of this Order.* (a) Within 2 years of the date of this order and annually thereafter for 5 years, the heads of agencies identified in section 3(a) of this order shall submit a report on their respective agencies' implementation of this order to the Director of OMB and the Director of OSTP.

(b) Each report shall include, to the extent possible, a review of this order's effectiveness in using the R&D funding agreements of the agencies identified in section 3(a) of this order to support domestic manufacturing, United States industrial competitiveness, and job creation.

(c) Each report shall include, to the extent possible, identification of any challenges to implementation of this order or to the effectiveness of this order in accomplishing the policy goals described in section 1 of this order, as well as recommendations to address such challenges.

Sec. 7. *Improving the Waiver Process.* (a) Under the Bayh-Dole Act, agencies may waive the requirement that certain products embodying the subject invention or produced through the use of the subject invention be ''manufactured substantially in the United States'' if, as specified in 35 U.S.C. 204, ''reasonable but unsuccessful efforts have been made to grant licenses on similar terms to potential licensees that would be likely to manufacture substantially in the United States'' or ''under the circumstances domestic manufacture is not commercially feasible.''

(b) Every agency should consider developing a process by which the agency may waive the domestic manufacturing requirements for agency-funded technology or technology developed under an agency funding opportunity without a request from a recipient of a Federal R&D funding agreement. As part of its process, an agency should seek concurrence from the Made in America Director to waive the domestic manufacturing requirements, and should set forth specific factors that may support a waiver, including whether the manufacture of the technology outside the United States is in the economic or national security interest of the United States.

(c) The heads of agencies identified in section 3(a) of this order shall ensure that the waiver process for their agency is rigorous, timely, transparent, and consistent, with due regard for all applicable authorities, including Executive Order 14005 of January 25, 2021 (Ensuring the Future Is Made in All of America by All of America's Workers), and the Bayh-Dole Act's requirement that a waiver be available when reasonable but unsuccessful efforts have been made to license to a company that could substantially manufacture in the United States, or when domestic manufacture is not commercially feasible.

(d) The Secretary of Commerce, through the Director of NIST and in consultation with the Interagency Working Group for Bayh-Dole, the NSTC Lab-to-Market Subcommittee, and the Made in America Director, shall provide guidance to agencies on the factors and considerations that should be weighed in determining whether domestic manufacturing is not commercially feasible. Guidance shall be designed to help applicants understand the factors an agency will consider when evaluating a waiver application, and should ensure that a determination of the commercial feasibility of manufacturing abroad is not based on substandard or unacceptable working

conditions. Within 90 days of the date of this order, the Secretary of Commerce, through the Director of NIST, shall make the guidance available for public comment.

(e) Within 90 days of the date of this order, the Secretary of Commerce, through the Director of NIST and in consultation with the Interagency Working Group for Bayh-Dole, shall develop common waiver application questions for use by all agencies.

(i) The common waiver application questions should include as relevant criteria, as appropriate and consistent with applicable law:

(A) how the waiver will be used;

(B) why it is important that the subject invention be brought to market;

(C) any potential economic and national security impacts of manufacturing the subject invention abroad;

(D) the benefits that will accrue to domestic manufacturing and United States jobs as a result of the subject invention being brought to market;

(E) whether the applicant is proposing an exclusive or non-exclusive license; and

(F) the conditions under which the subject invention would be manufactured abroad, including unionization of workplaces, health and safety standards, labor and wage laws, and environmental impacts.

(ii) Given the need to maintain agency flexibility, the heads of agencies identified in section 3(a) of this order may add questions to the common waiver application questions, but they should do so sparingly and only as needed to accomplish the policy set forth in this order within their respective agencies' existing authorities.

(f) The heads of agencies identified in section 3(a) of this order shall adopt the common waiver application questions, to the extent consistent with applicable law.

(g) The heads of agencies identified in section 3(a) of this order should acknowledge receipt of waiver applications within 10 business days, to the extent practicable. Once an applicant submits a waiver request application, the reviewing agency should seek to finalize its decision, including negotiations with the applicant as needed, as soon as possible.

(h) Within 270 days of the date of this order, the heads of agencies identified in section 3(a) of this order shall establish agency guidelines for negotiating with waiver applicants to retain as much value or benefit to the United States as possible, as appropriate and consistent with applicable law, while considering technical, business, social, environmental, and economic realities. In assessing a waiver's value to the United States economy, the heads of agencies identified in section 3(a) of this order should consider, as appropriate and in addition to any other relevant factors, potential benefits to domestic manufacturing competitiveness, to United States job creation, and to United States economic and national security.

(i) The heads of agencies identified in section 3(a) of this order should consider limiting waivers to applicants that commit to manufacture in locations that maintain a market economy and for specific agreed-upon purposes.

(ii) The heads of agencies identified in section 3(a) of this order should expect waiver applicants to deliver alternative benefits to the United States as part of an agreement to grant the waiver. Consideration of alternative benefits may include direct or indirect investment in domestic plants and equipment, the creation of high-quality domestic jobs, or further domestic development of the subject invention.

(i) Beginning in fiscal year 2024 and on an annual basis thereafter, the heads of agencies identified in section 3(a) of this order shall provide to the Secretary of Commerce, through the Interagency Working Group for Bayh-Dole, a summary of each waiver application received, approved, and

rejected. The summary shall include the terms of any approved waiver and the processing time needed to reach a decision.

(i) The Secretary of Commerce, through the Interagency Working Group for Bayh-Dole, shall publish a periodic summary of the waiver applications in aggregate that describes common reasons for waiver requests, processing times by agency, and recommended policy responses to common challenges.

(ii) Agencies shall ensure that the information submitted for publication to the Secretary of Commerce, through the Interagency Working Group for Bayh-Dole, appropriately protects business confidential and sensitive information provided by waiver applicants as part of their justification for the waiver, consistent with 35 U.S.C. 202(c)(5). However, the names of applicants seeking a waiver and a summary of the benefits the waiver recipients will provide to the United States should be made available to the public, to the extent permitted by law.

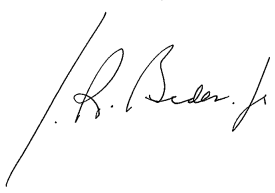
Sec. 8. *General Provisions.* (a) Nothing in this order shall be construed to impair or otherwise affect:

(i) the authority granted by law to an executive department or agency, or the head thereof; or

(ii) the functions of the Director of OMB relating to budgetary, administrative, or legislative proposals.

(b) This order shall be implemented consistent with applicable law and subject to the availability of appropriations.

(c) This order is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.



THE WHITE HOUSE,
July 28, 2023.

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