and pests, Reporting and recordkeeping requirements.

Dated: January 29, 2024.

Edward Messina,

Director, Office of Pesticide Programs.

Therefore, 40 CFR chapter I is amended as follows:

PART 180—TOLERANCES AND EXEMPTIONS FOR PESTICIDE CHEMICAL RESIDUES IN FOOD

■ 1. The authority citation for part 180 continues to read as follows:

Authority: 21 U.S.C. 321(q), 346a and 371.

■ 2. Add § 180.1406 to subpart D to read as follows:

§ 180.1406 U1-AGTX-Ta1b-QA protein; exemption from the requirement of a tolerance.

An exemption from the requirement of a tolerance is established for residues of U1-AGTX-Ta1b-QA protein in or on all food commodities when used in accordance with label directions and good agricultural practices.

[FR Doc. 2024–02787 Filed 2–9–24; 8:45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 405, 410, 411, 414, 415, 418, 422, 423, 424, 425, 455, 489, 491, 495, 498, and 600

[CMS–1784–F2]

RIN 0938–AV07

Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program; Corrections

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Final rule; correction and correcting amendment.

SUMMARY: This document corrects technical and typographical errors in the final rule that appeared in the November 16, 2023 issue of the **Federal Register**, entitled ''Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program'' (referred to hereafter as the ''CY 2024 PFS final rule''). The effective date was January 1, 2024.

DATES: This correcting document is effective February 12, 2024 and is applicable beginning January 1, 2024.

FOR FURTHER INFORMATION CONTACT:

MedicarePhysicianFeeSchedule@cms.hhs.gov, for any issues not identified below. Please indicate the specific issue in the subject line of the email.

MedicarePhysicianFeeSchedule@cms.hhs.gov, for the following issues: caregiver training services, community health integration services, and principal illness navigation services; telehealth and other services involving communications technology; PFS conversion factor; and PFS payment for evaluation and management services.

Sabrina Ahmed, (410) 786–7499, or *SharedSavingsProgram@cms.hhs.gov,* for issues related to the Medicare Shared Savings Program (Shared Savings Program) Quality performance standard and quality reporting requirements.

Janae James, (410) 786–0801, or *SharedSavingsProgram@cms.hhs.gov,* for issues related to Shared Savings Program beneficiary assignment.

Frank Whelan (410) 786–1302, for issues related to Medicare and Medicaid Provider and Supplier Enrollment

Renee O'Neill, (410) 786–8821, *MIPSEngagementTeam@cms.hhs.gov.*

SUPPLEMENTARY INFORMATION:

I. Background

In FR Doc. 2023–24184 of November 16, 2023, the CY 2024 PFS final rule (88 FR 78818), there were technical errors that are identified and corrected in this correcting document. These corrections are applicable as if they had been included in the CY 2024 PFS final rule, which was effective January 1, 2024.

II. Summary of Errors

A. Summary of Errors in the Preamble

1. On page 78867, in the table titled ''TABLE 11: CY 2024 Medicare Telehealth Services List'' which continues through page 78871, we inadvertently omitted four rows of services.

2. On page 78876, second column, fourth full paragraph, line 2, we inadvertently omitted qualifying language before the reference to telehealth services and neglected to include a reference to further background information.

3. On page 78918, third column, second full paragraph, second sentence, we neglected to include a clarifying phrase.

4. On page 78920, first column, first full paragraph, we inadvertently omitted a clarifying phrase.

5. On page 78944, first column, first full paragraph we inadvertently included incorrect language in the final code descriptor for HCPCS code G0023.

6. On page 78949, first column, first full paragraph, we made a typographical error when finalizing limitations on PIN services.

7. On pages 78956 through 78957 in the table titled ''TABLE 14: CY 2024 Work RVUs for New, Revised, and Potentially Misvalued Codes,'' the code descriptor listed for HCPCS code G0019 inadvertently was not updated to reflect the final code descriptors as stated in the preamble text.

8. On pages 78958 through 78959 in the table titled ''TABLE 14: CY 2024 Work RVUs for New, Revised, and Potentially Misvalued Codes,'' the code descriptors listed for HCPCS codes G0022 and G0023 inadvertently were not updated to reflect the final code descriptors as stated in the preamble text.

9. On pages 78959 through 78960 in the table titled ''TABLE 14: CY 2024 Work RVUs for New, Revised, and Potentially Misvalued Codes,'' the code descriptor listed for HCPCS code G0140 inadvertently was not updated to reflect the final code descriptor as stated in the preamble text.

10. On page 78975, we inadvertently omitted a sentence to restate the final policy we adopted for the inherent complexity add-on code (G2211).

11. On page 79075, third column, first full paragraph, line 19, two G-codes for PIN services were inadvertently omitted.

12. On page 79112 in the table titled, ''TABLE 28: Final APP Reporting Requirements and Quality Performance Standard for Performance Year 2024 and Subsequent Performance Years'', we inadvertently included language regarding a MIPS Quality performance category score.

13. On page 79112 in the table titled, ''TABLE 28: Final APP Reporting Requirements and Quality Performance Standard for Performance Year 2024 and Subsequent Performance Years'', we made a typographical error in identifying the APP measure.

14. On page 79113 in the table titled, ''TABLE 29: Measures included in the APP Measure Set for Performance Year 2024 and Subsequent Performance

Years'', we made a typographical error in identifying the Quality ID#: 321 for the Measure Type. We also inadvertently included a related incorrect footnote.

15. On page 79121, we inadvertently included language referencing Table 30: 40th Percentile MIPS Quality Performance Category Scores Using Current and Finalized Methodology.

16. On page 79121 in the table titled, ''TABLE 30: 40th Percentile MIPS Quality Performance Category Scores Using Current and Finalized Methodology'', the last row of the table for Performance Year 2022 is incorrect due to a formatting error.

17. On page 79131, we made a typographical error in reference to 42 CFR part 414, subpart O.

18. On page 79144, we made a typographical error in the section reference to the Regulatory Impact Analysis in the CY 2024 PFS proposed rule.

19. On page 79172, there is an error in the description of the definition of ACO professional in section 1899(c)(1)(A) of the Act.

20. On page 79189, there are typographical errors in the references to Table numbers in the final rule.

21. On page 79240, we inadvertently included language that referenced Tables.

22. On page 79379, in the table titled ''TABLE 60: Illustration of Point System and Associated Adjustments Comparison between the CY 2023 Performance Period/2025 MIPS Payment Year and the CY 2024 Performance Period/2026 MIPS Payment Year'', we made typographical errors in the MIPS Adjustment columns for the 2023 and 2024 Performance Periods.

23. On page 79437, in the table titled ''TABLE 83: Summary of Quality Measure Inventory Finalized for the CY 2024 Performance Period'',

a. We made typographical errors in the # Measures heading titles.

b. We made typographical errors in the number of eCQM Specifications measures finalized for CY 2024.

24. On page 79467, there are two typographical errors in the table titled ''TABLE 116: Calculation of the CY 2024 PFS Conversion Factor''.

25. On page 79506, there is a typographical error in the title of ''TABLE 131: Description of MIPS Eligibility Status for CY 2023 Performance Period/2025 MIPS Payment Year Using CY 2023 PFS Final Rule Assumptions''.

26. On page 79506, there is a typographical error in two footnotes of the table titled ''TABLE 131: Description of MIPS Eligibility Status for CY 2023 Performance Period/2025 MIPS Payment Year Using CY 2023 PFS Final Rule Assumptions''.

27. On page 79519, we made a typographical error in the reference to the MIPS payment year.

28. On page 79522, in the table titled ''TABLE 143: Accounting Statement for Provisions for Medicare Shared Savings Program (CYs 2024–2033)'', there are typographical errors in the references to Table numbers.

B. Summary of Errors in the Regulations Text

1. On page 79538, at § 414.1405(b)(9)(iii), there is a typographical error in the reference to the MIPS payment year.

2. On page 79542, third column, lines 19, 23, and 26 contain typographical errors.

C. Summary of Errors in the Addenda

1. On page 79939 of APPENDIX 1: MIPS QUALITY MEASURES, TABLE D.45: One-Time Screening for Hepatitis C Virus (HCV) for all Patients includes incorrect language to be removed in the substantive changes row.

2. On page 80015 of APPENDIX 3: MVP INVENTORY, TABLE B.2: Optimal Care for Kidney Health MVP we inadvertently omitted language in the last paragraph of the Comments and Responses section.

3. On pages 80013, 80016, and 80026 of APPENDIX 3: MVP INVENTORY, corresponding to TABLE B.2: Optimal Care for Kidney Health MVP, TABLE B.3: Optimal Care for Patients with Episodic Neurological Conditions MVP, and TABLE B.6: Advancing Rheumatology Patient Care MVP, respectively, we included an incorrect collection type for measure Q130: Documentation of Current Medications in the Medical Record.

III. Waiver of Proposed Rulemaking

Under 5 U.S.C. 553(b) of the Administrative Procedure Act (the APA), the agency is required to publish a notice of the proposed rule in the **Federal Register** before the provisions of a rule take effect. Similarly, section 1871(b)(1) of the Social Security Act (the Act) requires the Secretary to provide for notice of the proposed rule in the **Federal Register** and provide a period of not less than 60 days for public comment. In addition, section 553(d) of the APA and section 1871(e)(1)(B)(i) of the Act mandate a 30-day delay in effective date after issuance or publication of a rule. Sections 553(b)(B) and 553(d)(3) of the APA provide for exceptions from the APA notice and comment, and delay in effective date requirements. In cases in which these exceptions apply, sections 1871(b)(2)(C) and 1871(e)(1)(B)(ii) of the Act provide exceptions from the notice, 60-day comment period, and delay in effective date requirements of the Act as well. Section 553(b)(B) of the APA and section 1871(b)(2)(C) of the Act authorize an agency to dispense with normal notice and comment rulemaking procedures for good cause if the agency makes a finding that the notice and comment process is impracticable, unnecessary, or contrary to the public interest, and includes a statement of the finding and the reasons for it in the rule. In addition, section 553(d)(3) of the APA and section 1871(e)(1)(B)(ii) allow the agency to avoid the 30-day delay in effective date where such delay is contrary to the public interest and the agency includes in the rule a statement of the finding and the reasons for it.

In our view, this correcting document does not constitute a rulemaking that would be subject to these requirements. This document merely corrects technical errors in the CY 2024 PFS final rule. The corrections contained in this document are consistent with, and do not make substantive changes to, the policies and payment methodologies that were proposed, subject to notice and comment procedures, and adopted in the CY 2024 PFS final rule. As a result, the corrections made through this correcting document are intended to resolve inadvertent errors so that the rule accurately reflects the policies adopted in the final rule. Even if this were a rulemaking to which the notice and comment and delayed effective date requirements applied, we find that there is good cause to waive such requirements. Undertaking further notice and comment procedures to incorporate the corrections in this document into the CY 2024 PFS final rule or delaying the effective date of the corrections would be contrary to the public interest because it is in the public interest to ensure that the rule accurately reflects our policies as of the date they take effect. Further, such procedures would be unnecessary because we are not making any substantive revisions to the final rule, but rather, we are simply correcting the **Federal Register** document to reflect the policies that we previously proposed, received public comment on, and subsequently finalized in the final rule. For these reasons, we believe there is good cause to waive the requirements for notice and comment and delay in effective date.

IV. Correction of Errors

In FR Doc. 2023–24184 of November 16, 2023 (88 FR 78818), make the following corrections:

A. Correction of Errors in the Preamble

1. On page 78867, the table titled ''TABLE 11: CY 2024 Medicare Telehealth Services List'', the table is corrected to insert the following additional rows after the row for HCPCS code 0373T:

HCPCS	Short Descriptor	Audio-Only?	Category
0591T	Hlth&wb coaching indiv 1st	Yes	provisional
0592T	Hlth&wb coaching indiv f-up	Yes	provisional
0593T	Hlth&wb coaching indiv group	Yes	provisional
77427	Radiation tx management x5	No	provisional

2. On page 78876, second column, fourth full paragraph,

a. Line 2, the phrase ''telehealth services'' is corrected to read ''DSMT and therapy telehealth services''.

b. Line 6, the language ''modifier '95.' '' is corrected to read ''modifier '95.' For further background, we refer readers to pgs. 44–45, 80–81 of our FAQ available at *https://www.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf*.''

3. On page 78918, third column, second full paragraph, second sentence that reads ''If caregivers are trained in a group, practitioners would not bill individually for each caregiver''. is corrected to read: ''If caregivers for the same beneficiary are trained in a group, practitioners would not bill individually for each caregiver''.

4. On page 78920, first column, first full paragraph, line 9, that reads ''a median group size of five caregivers'' is corrected to read ''a median group size of caregivers for five beneficiaries''.

5. On page 78944, first column, first full paragraph for code G0023, lines 5 and 6, the phrase ''certified peer specialist'' is deleted.

6. On page 78949, first column, first full paragraph, line 3 that reads ''services can be provided more than'' is corrected to read ''services cannot be provided more than''.

7. Beginning on page 78956, in the last row and continuing on page 78957, in the table titled, ''TABLE 14: CY 2024 Work RVUs for New, Revised, and Potentially Misvalued Codes'', the entry for HCPCS code G0019 is replaced in its entirety with the following:

BILLING CODE P

G0019	Community health integration services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner; 60 minutes per calendar month, in the following activities to address social determinants of health (SDOH) need(s) that are significantly limiting the ability to diagnose or treat problem(s) addressed in an initiating visit: • Person-centered assessment, performed to better understand the individualized context of the intersection between the SDOH need(s) and the problem(s) addressed in the initiating visit. ++ Conducting a person-centered assessment to understand patient's life story, strengths, needs, goals, preferences and desired outcomes, including understanding cultural and linguistic factors and including unmet SDOH needs (that are not separately billed). ++ Facilitating patient-driven goalsetting and establishing an action plan. ++ Providing tailored support to the patient as needed to accomplish the practitioner's treatment plan. • Practitioner, Home-, and Community-Based Care Coordination ++ Coordinating receipt of needed services from healthcare practitioners, providers, and facilities; and from home- and community-based service providers, social service providers, and caregiver (if applicable). ++ Communication with practitioners, home- and community-based service providers, hospitals, and skilled nursing facilities (or other health care facilities) regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors. ++ Coordination of care transitions between and among health care practitioners and settings, including transitions involving referral to other clinicians; follow-up after an emergency department visit; or follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities. ++ Facilitating access to community based social services (e.g., housing, utilities, transportation, food assistance) to address the SDOH need(s). • Health education—Helping the patient contextualize health education provided by the patient's treatment team with the patient's individual needs, goals, and preferences, in the context of the SDOH need(s), and educating the patient on how to best participate in medical decision-making. • Building patient self-advocacy skills, so that the patient can interact with members of the health care team and related community-based services addressing the SDOH need(s), in ways that are more likely to promote personalized and effective diagnosis or treatment. • Health care access/health system navigation ++ Helping the patient access healthcare, including identifying appropriate practitioners or providers for clinical care and helping secure appointments with them. • Facilitating behavioral change as necessary for meeting diagnosis and treatment goals, including promoting patient motivation to participate in care and reach person-centered diagnosis or treatment goals. • Facilitating and providing social and emotional support to help the patient cope with the problem(s) addressed in the initiating visit, the SDOH need(s), and adjust daily routines to better meet diagnosis and treatment goals. • Leveraging lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals.	NEW	1.00	1.00	No

8. Beginning on page 78958, in the second and third rows and continuing on page 78959, in the table titled, ''TABLE 14: CY 2024 Work RVUs for New, Revised, and Potentially Misvalued Codes'', the entries for HCPCS codes G0022 and G0023 are replaced in their entirety with the following:

G0022	Community health integration services, each additional 30 minutes per calendar month (List separately in addition to G0019).	NEW	0.70	0.70	No
G0023	Principal Illness Navigation services by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a patient navigator; 60 minutes per calendar month, in the following activities: • Person-centered assessment, performed to better understand the individual context of the serious, high-risk condition. ++ Conducting a person-centered assessment to understand the patient's life story, strengths, needs, goals, preferences, and desired outcomes, including understanding cultural and linguistic factors and including unmet SDOH needs (that are not separately billed). ++ Facilitating patient-driven goal setting and establishing an action plan. ++ Providing tailored support as needed to accomplish the practitioner's treatment plan. • Identifying or referring patient (and caregiver or family, if applicable) to appropriate supportive services. • Practitioner, Home, and Community-Based Care Coordination. ++ Coordinating receipt of needed services from healthcare practitioners, providers, and facilities; home- and community-based service providers; and caregiver (if applicable). ++ Communication with practitioners, home-, and community-based service providers, hospitals, and skilled nursing facilities (or other health care facilities) regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors. ++ Coordination of care transitions between and among health care practitioners and settings, including transitions involving referral to other clinicians; follow-up after an emergency department visit; or follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities. ++ Facilitating access to community-based social services (e.g., housing, utilities, transportation, food assistance) as needed to address SDOH need(s). • Health education—Helping the patient contextualize health education provided by the patient's treatment team with the patient's individual needs, goals, preferences, and SDOH need(s), and educating the patient (and caregiver if applicable) on how to best participate in medical decision-making. • Building patient self-advocacy skills, so that the patient can interact with members of the health care team and related community-based services (as needed), in ways that are more likely to promote personalized and effective treatment of their condition. • Health care access/health system navigation. ++ Helping the patient access healthcare, including identifying appropriate practitioners or providers for clinical care, and helping secure appointments with them. ++ Providing the patient with information/resources to consider participation in clinical trials or clinical research as applicable. • Facilitating behavioral change as necessary for meeting diagnosis and treatment goals, including promoting patient motivation to participate in care and reach person-centered diagnosis or treatment goals. • Facilitating and providing social and emotional support to help the patient cope with the condition, SDOH need(s), and adjust daily routines to better meet diagnosis and treatment goals. • Leverage knowledge of the serious, high-risk condition and/or lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals.	NEW	1.00	1.00	No

9. Beginning on page 78959, in the last row and continuing on page 78960, in the table titled, ''TABLE 14: CY 2024 Work RVUs for New, Revised, and Potentially Misvalued Codes'', the entry for HCPCS code G0140 is replaced in its entirety with the following:

G0140	Principal Illness Navigation—Peer Support by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a certified peer specialist; 60 minutes per calendar month, in the following activities: • Person-centered interview, performed to better understand the individual context of the serious, high-risk condition. ++ Conducting a person-centered interview to understand the patient's life story, strengths, needs, goals, preferences, and desired outcomes, including understanding cultural and linguistic factors, and including unmet SDOH needs (that are not billed separately). ++ Facilitating patient-driven goal setting and establishing an action plan. ++ Providing tailored support as needed to accomplish the person-centered goals in the practitioner's treatment plan. • Identifying or referring patient (and caregiver or family, if applicable) to appropriate supportive services. • Practitioner, Home, and Community-Based Care Communication ++ Assist the patient in communicating with their practitioners, home-, and community-based service providers, hospitals, and skilled nursing facilities (or other health care facilities) regarding the patient's psychosocial strengths and needs, goals, preferences, and desired outcomes, including cultural and linguistic factors. ++ Facilitating access to community-based social services (e.g., housing, utilities, transportation, food assistance) as needed to address SDOH need(s). • Health education—Helping the patient contextualize health education provided by the patient's treatment team with the patient's individual needs, goals, preferences, and SDOH need(s), and educating the patient (and caregiver if applicable) on how to best participate in medical decision-making. • Building patient self-advocacy skills, so that the patient can interact with members of the health care team and related community-based services (as needed), in ways that are more likely to promote personalized and effective treatment of their condition. • Developing and proposing strategies to help meet person-centered treatment goals and supporting the patient in using chosen strategies to reach person-centered treatment goals. • Facilitating and providing social and emotional support to help the patient cope with the condition, SDOH need(s), and adjust daily routines to better meet person-centered diagnosis and treatment goals. • Leverage knowledge of the serious, high-risk condition and/or lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals.	NEW	1.00	1.00	No

BILLING CODE C

10. On page 78975, first column, first full paragraph, line 26, the phrase that reads ''this policy is implemented.'' is corrected to read, ''this policy is implemented. We are finalizing as proposed that payment will not be made for the inherent complexity add-on code (G2211) when billed with an O/O E/M service reported with modifier −25.''

11. On page 79075, third column, first full paragraph, line 19 that reads ''G0022, G0023, and G0024 respectively'' is corrected to read ''G0022, G0023, G0024, G0140 and G0146, respectively.''

12. On page 79112, in the table titled, ''TABLE 28: Final APP Reporting Requirements and Quality Performance Standard for Performance Year 2024 and Subsequent Performance Years'', second column, third row, second paragraph, lines 4 through 6, the phrase that reads ''and receives a MIPS Quality performance category score under § 414.1380(b)(1)'' is removed.

13. On page 79112, in the table titled ''TABLE 28: Final APP Reporting Requirements and Quality Performance Standard for Performance Year 2024 and Subsequent Performance Years'', second column, third row, third paragraph, line 6, the phrase that reads ''in the APP measure would'' is corrected to read ''in the APP measure set would''.

14. On page 79113, in the table titled ''TABLE 29: Measures included in the APP Measure Set for Performance Year 2024 and Subsequent Performance Years'', sixth column, second row, the identifier ''PRO–PM *'' is corrected to read ''Patient Engagement/Experience''.

The related footnote ''* Patient-reported outcome-based performance measure (PRO–PM) is a performance measure that is based on patient-reported outcome measure (PROM) data aggregated for an accountable healthcare entity.'' is removed.

15. On page 79121, third column, lines 4 through 6, the sentence that reads ''We note that Table 30 is same as Table 29 that was included in the CY 2024 PFS proposed rule (88 FR 52432).'' is removed.

16. On page 79121, in the table titled ''TABLE 30: 40th Percentile MIPS Quality Performance Category Scores Using Current and Finalized Methodology'', that reads:

TABLE 30: 40th Percentile MIPS Quality Performance Category Scores Using Current and Finalized Methodology

Performance Year		Actual 40th percentile MIPS Quality performance category score*	40th percentile MIPS Quality performance category score using historical methodology
2018		70.80*	--
2019		70.82*	--
2020		75.59*	--
2021		77.83*	--
2022	77.73^	72.40 (estimated for illustrative purposes) **	

is corrected to read:

TABLE 30: 40th Percentile MIPS Quality Performance Category Scores Using Current and Finalized Methodology

Performance Year	Actual 40th percentile MIPS Quality performance category score*	40th percentile MIPS Quality performance category score using historical methodology
2018	70.80*	--
2019	70.82*	--
2020	75.59*	--
2021	77.83*	--
2022	77.73^	72.40 (estimated for illustrative purposes) **

17. On page 79131, second column, second full paragraph, first bullet, line 5 that reads ''subpart Oat the individual, group,'' is corrected to read ''subpart O at the individual, group,''.

18. On page 79144, third column, line 23, the reference that reads ''section VI.E.'' is corrected to read ''section VII.E.''.

19. On page 79172, third column, second full paragraph, lines 10 through 14, that reads ''furnished by an ACO professional who is a physician (as defined in section 1861(r)(1)) of the Act), or a practitioner that is a PA, NP, CNS (as defined in section 1842(b)(18)(C)(i) of the Act).'' is corrected to read ''furnished by an ACO professional who is a physician.''

20. On page 79189:

a. The third column, first full paragraph, line 1 the phrase that reads ''Tables 41 and 42'' is corrected to read ''Tables 42 and 43''.

b. The third column, first full paragraph, line 8, the phrase that reads ''Tables 39 and 40'' is corrected to read ''Tables 40 and 41''.

21. On page 79240, the first column, first paragraph, lines 8 and 9 the phrase that reads ''as displayed in Tables 46A and 46B'' is deleted.

22. On page 79379, in the table titled ''TABLE 60: Illustration of Point System and Associated Adjustments Comparison between the CY 2023 Performance Period/2025 MIPS Payment Year and the CY 2024 Performance Period/2026 MIPS Payment Year'':

a. Second column, fourth row, line 3 that reads ''sliding scale ranges from 0 to 9% for scores from 75.00 to 100.00'' is corrected to read ''sliding scale ranges from greater than 0% to 9% for scores from 75.01 to 100.00.''; and

b. Fourth column, fourth row, line 3 that reads ''linear sliding scale ranges from 0 to 9% for scores from 86.00 to 100.00'' is corrected to read ''linear sliding scale ranges from greater than 0% to 9% for scores from 75.01 to 100.00.''.

23. On page 79437, in the table titled ''TABLE 83: Summary of Quality Measure Inventory Finalized for the CY 2024 Performance Period'', fifth column, row 4, that reads:

Collection Type	# Measures as New	# Measures for Removal*	# Measures with a Substantive Change*	# Measures for CY 2024*
eCQM Specifications	0	-3	26	44

is corrected to read:

Collection Type	# Measures Finalized as New	# Measures Finalized for Removal*	# Measures Finalized with a Substantive Change*	# Measures Finalized for CY 2024*
eCQM Specifications	0	-3	26	46

24. On page 79467, in the table titled ''TABLE 116: Calculation of the CY 2024 PFS Conversion Factor'', that reads:

CY 2023 Conversion Factor		33.8872
Conversion Factor without the CAA, 2023 (2.5 Percent Increase for CY 2023)		33.0607
CY 2024 RVU Budget Neutrality Adjustment	-2.20 percent (0.9780)	
CY 2024 1.25 Percent Increase Provided by the CAA, 2023	1.25 percent (1.0125)	
CY 2024 Conversion Factor		**32.7375**

is corrected to read:

CY 2023 Conversion Factor		33.8872
Conversion Factor without the CAA, 2023 (2.5 Percent Increase for CY 2023)		33.0607
CY 2024 RVU Budget Neutrality Adjustment	-2.18 percent (0.9782)	
CY 2024 1.25 Percent Increase Provided by the CAA, 2023	1.25 percent (1.0125)	
CY 2024 Conversion Factor		**32.7442**

25. On page 79506, in the table titled ''TABLE 131: Description of MIPS Eligibility Status for CY 2023 Performance Period/2025 MIPS Payment Year Using CY 2023 PFS Final Rule Assumptions'', the title of the table is corrected to read ''TABLE 131: Description of MIPS Eligibility Status for CY 2024 Performance Period/2026 MIPS Payment Year Using CY 2023 PFS Final Rule Assumptions''.

26. On page 79506, in the table titled ''TABLE 131: Description of MIPS Eligibility Status for CY 2023 Performance Period/2025 MIPS Payment Year Using CY 2023 PFS Final Rule Assumptions'', the first and second footnotes which read:

''* Participation excludes facility-based clinicians who do not have scores in the 2021 MIPS submission data.

** Allowed charges estimated in 2021 dollars. Low-volume threshold is calculated using allowed charges. MIPS payment adjustments are applied to the paid amount.''

are corrected to read:

''* Participation excludes facility-based clinicians who do not have scores in 2022 MIPS submission data.

** Allowed charges estimated in 2022 dollars. Low-volume threshold is calculated using allowed charges. MIPS payment adjustments are applied to the paid amount.''

27. On page 79519, third column, first full paragraph, line 7, the phrase that reads ''2025 MIPS payment year.'' is corrected to read ''2026 MIPS payment year.''

28. On page 79522, in the table titled ''TABLE 143: Accounting Statement for Provisions for Medicare Shared Savings Program (CYs 2024–2033)'', fifth column, third and fourth full rows, the phrase that reads ''Tables 120 through 123'' is corrected to read ''Tables 123 through 126''.

B. Correction of Errors in the Addenda

29. On page 79939 of APPENDIX 1: MIPS QUALITY MEASURES, TABLE D.45: One-Time Screening for Hepatitis C Virus (HCV) for all Patients, row 6, Substantive Change: in the section titled:

Updated denominator: Updated:

THERE ARE TWO SUBMISSION CRITERIA FOR THIS MEASURE:

First full paragraph, lines 6 through 8 that read: ''For accountability reporting in the CMS MIPS program, the rate for submission criteria 2 is used for performance, however, both performance rates must be submitted.'' is to be removed.

30. On page 80015 of APPENDIX 3: MVP INVENTORY, TABLE B.2: Optimal Care for Kidney Health MVP language in the last paragraph of the Comments and Responses section should read: ''After consideration of public comments, we are finalizing the *Optimal Care for Kidney Health MVP* with modifications in Table B.2 for the CY 2024 performance period/2026 MIPS payment year and future years.''

31. On pages 80013, 80016, and 80026 of APPENDIX 3: MVP INVENTORY, corresponding to TABLE B.2: Optimal Care for Kidney Health MVP, TABLE B.3: Optimal Care for Patients with Episodic Neurological Conditions MVP, and TABLE B.6: Advancing Rheumatology Patient Care MVP, respectively, the Collection Type for measure Q130 is corrected by removing ''Medicare Part B Claims Measure Specifications'' and reads ''eCQM Specifications, MIPS CQMs Specifications)''.

List of Subjects

42 CFR Part 414

Administrative practice and procedure, Biologics, Diseases, Drugs, Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

42 CFR 424

Emergency medical services, Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, CMS corrects 42 CFR parts 414 and 424 by making the following correcting amendments:

PART 414—PAYMENT FOR PART B MEDICAL AND OTHER HEALTH SERVICES

■ 1. The authority citation for part 414 continues to read as follows:

Authority: 42 U.S.C. 1302, 1395hh, and 1395rr(b)(1).

§ 414.1405 [Amended]

■ 2. Amend § 414.1405 in paragraph (b)(9)(iii) by removing the phrase ''2025 MIPS payment year'' and adding in its place the phrase ''2026 MIPS payment year''.

PART 424—CONDITIONS FOR MEDICARE PAYMENT

■ 3. The authority citation for part 424 continues to read as follows:

Authority: 42 U.S.C. 1302 and 1395hh.

■ 4. Amend § 424.541 by—
■ a. Removing paragraphs (a)(2)(ii)(B)(*3*) through (*5*); and
■ b. Adding paragraphs (a)(3) through (5).

The additions read as follows:

§ 424.541 Stay of enrollment.

(a) * * *

(3) A stay of enrollment lasts no longer than 60 days from the postmark date of the notification letter, which is the effective date of the stay.

(4) CMS notifies the affected provider or supplier in writing of the imposition of the stay.

(5) A stay of enrollment ends on the date on which CMS or its contractor determines that the provider or supplier has resumed compliance with all Medicare enrollment requirements in Title 42 or the day after the 60-day stay period expires, whichever occurs first.

* * * * *

Elizabeth J. Gramling,

Executive Secretary to the Department, Department of Health and Human Services.

[FR Doc. 2024–02705 Filed 2–8–24; 4:15 pm]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Part 170

Health Information Technology Standards, Implementation Specifications, and Certification Criteria and Certification Programs for Health Information Technology

CFR Correction

This rule is being published by the Office of the Federal Register to correct an editorial or technical error that appeared in the most recent annual revision of the Code of Federal Regulations.

In Title 45 of the Code of Federal Regulations, Parts 140 to 199, revised as of October 1, 2023, amend section 170.580 by reinstating paragraph (a)(3)(ii) to read as follows:

§ 170.580 ONC review of certified health IT.

* * * * *

(a) * * *

(3) * * *

(ii) ONC may assert exclusive review of certified health IT as to any matters under review by ONC and any similar matters under surveillance by an ONC–ACB.

* * * * *

[FR Doc. 2024–02940 Filed 2–9–24; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

45 CFR Chapter III

RIN 0970–AC99

Elimination of the Tribal Non-Federal Share Requirement

AGENCY: Office of Child Support Services (OCSS), Administration for Children and Families (ACF), Department of Health and Human Services (HHS).

ACTION: Final rule.

SUMMARY: OCSS eliminates the non-Federal share of program expenditures requirement for Tribal child support programs, including the 90/10 and 80/20 cost sharing rates. Based upon the experiences of and consultations with Tribes and Tribal organizations, we have determined that the non-Federal share requirement limits growth, causes disruptions, and creates instability.

DATES: This rule is effective October 1, 2024.

FOR FURTHER INFORMATION CONTACT: Janice McDaniel, Program Specialist, Division of Policy and Training, OCSS, telephone (202) 969–3874. Email inquiries to *ocss.dpt@acf.hhs.gov.* Telecommunications Relay users may dial 711 first.

SUPPLEMENTARY INFORMATION:

I. Statutory Authority

This final rule is published in accordance with section 455(f) of the Social Security Act (the Act) (42 U.S.C. 655(f)). Section 455(f) of the Act requires the Secretary to issue regulations governing the grants to Tribes and Tribal organizations operating child support programs.

This final rule is also published under the authority granted to the Secretary of Health and Human Services by section 1102 of the Act (42 U.S.C. 1302). Section 1102 of the Act authorizes the Secretary to publish regulations, not inconsistent with the Act, as may be necessary for the efficient administration of the functions with which the Secretary is responsible under the Act.

II. Public Consultation

Since the inception of the Tribal child support program, OCSS has conducted numerous face-to-face and virtual Tribal Consultations and listening sessions to discuss the longstanding issue of the non-Federal share requirement and the cost sharing rates.