(6) The COTP or a designated representative may terminate the event or the operation of any vessel at any time it is deemed necessary for the protection of life or property.

(d) *Enforcement periods.* This section will be enforced from 9 a.m. through 6 p.m. on May 4, 2024, and May 5, 2024. Breaks in the racing will occur during the enforcement periods, which will allow for vessels to pass through the safety zone. The COTP or a designated representative will provide notice of enforcement appropriate per paragraph.

(e) *Informational broadcasts.* The COTP or a designated representative will inform the public of the effective period for the safety zone as well as any changes in the dates and times of enforcement through Local Notice to Mariners (LNMs), Broadcast Notices to Mariners (BNMs), and/or Marine Safety Information Bulletins (MSIBs) as appropriate.

Dated: April 24, 2024.

Anthony R. Migliorini,

Captain, U.S. Coast Guard, Captain of the Port, Marine Safety Unit Port Arthur.

[FR Doc. 2024–09259 Filed 4–29–24; 8:45 am]

BILLING CODE 9110–04–P

DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 17

RIN 2900–AR55

CHAMPVA Coverage of Audio-Only Telehealth, Mental Health Services, and Cost Sharing for Certain Contraceptive Services and Contraceptive Products Approved, Cleared, or Granted by FDA

AGENCY: Department of Veterans Affairs.

ACTION: Final rule.

SUMMARY: The Department of Veterans Affairs (VA) adopts as final, with changes, a proposed rule to amend its medical regulations regarding Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) coverage to remove the exclusion for audio-only telehealth, remove current quantitative limitations on mental health/substance use disorder coverage, remove the current requirement for pre-authorization for outpatient mental health visits in excess of 23 per calendar year and/or more than two (2) sessions per week, and exempt certain contraceptive services and prescription and nonprescription contraceptive products that are approved, cleared, or granted by the U.S. Food and Drug Administration (FDA) from cost sharing requirements.

DATES: This rule is effective May 30, 2024.

FOR FURTHER INFORMATION CONTACT: Joseph Duran, Director, Policy, Office of Integrated Veteran Care (OIVC), Veterans Health Administration (VHA), Department of Veterans Affairs, Ptarmigan at Cherry Creek, Denver, CO 80209; 303–370–1637 (this is not a toll-free number).

SUPPLEMENTARY INFORMATION: On October 24, 2022, VA published a proposed rule in the **Federal Register** (87 FR 64190) that would amend CHAMPVA exclusions to allow coverage of telephonic (audio-only) medical visits. VA also proposed removing specified quantitative limits on coverage for inpatient and outpatient mental health/substance use disorder (SUD) care appointments, *i.e.,* inpatient and outpatient mental health services, residential treatment, institutional services for partial hospitalization, substance withdrawal management in a hospital setting or rehabilitation facility, outpatient SUD services, and family therapy for SUD. This would align the delivery of CHAMPVA mental health/SUD care with the Department of Defense (DoD) TRICARE program, current standards of practice in mental health and SUD care, and the goals of the Mental Health Parity and Addiction Equity Act of 2008. 87 FR at 64193. VA also proposed removing the current preauthorization requirement for outpatient mental health visits in excess of 23 per calendar year and/or more than two (2) sessions per week. In addition, VA proposed removing cost sharing requirements for certain contraceptive services and prescription or nonprescription contraceptive products that are approved, cleared, or granted by the FDA.

VA provided a 30-day comment period, which ended on November 23, 2022. VA received 14 comments on the proposed rule, of which 7 comments were supportive and did not suggest changes or clarifications from the proposed rule. Commenters generally expressed support for all the proposed changes, but we received substantive comments with recommendations for change on audio telehealth coverage as well as the cost sharing exemption for contraceptives. We address these substantive comments below. Based on these comments, VA adopts the proposed rule as final, with changes.

Audio-Only Telehealth

VA proposed amending its regulations to remove the exclusion of audio-only telehealth for CHAMPVA beneficiaries for services provided on or after May 12, 2020. As proposed, the amendment would apply retroactively and allow reimbursement of medically necessary audio-only telehealth services for CHAMPVA beneficiaries dating back to the date TRICARE published a similar interim final rulemaking (85 FR 27927 May 12, 2020). CHAMPVA beneficiaries would be required to file a claim for reimbursement within 180 days of the effective date of a final rulemaking.

One commenter suggested VA publish guidance to providers and patients related to the retroactive reimbursement period notice. The commenter suggested VA send text alerts notifying beneficiaries on how to file a claim for reimbursement. VA thanks the commenter for the suggestion and VA will take it into consideration, but utilization of specific communication methods for outreach is outside the scope of this rulemaking. However, we note that VA does have a communications plan in place to alert potential beneficiaries as well as providers of this retroactive change in audio-only telehealth coverage. We make no changes based on this comment.

The remaining six comments suggested changes to the proposed rule. All of the comments recommended changes related to the coverage and cost sharing requirements for contraceptive services and products.

Before addressing these comments, we first correct an erroneous statement we made at the proposed rule stage. When we proposed amending § 17.272(a)(28) to provide for CHAMPVA coverage of nonprescription contraceptives used as emergency contraceptives we incorrectly indicated in the proposed rule that TRICARE does not provide coverage for nonprescription contraceptives used as emergency contraception. In accordance with 10 U.S.C. 1074g(a)(2)(F), as implemented by 32 CFR 199.21(h)(5), the TRICARE Pharmacy Benefits Program covers over the counter Levonorgestrel 1.5 mg tablet (*e.g.,* Plan B One-Step) as emergency contraception at no cost if obtained at a military medical treatment facility or retail pharmacy (not home delivery).

Comments That Suggested That CHAMPVA Should Expand Coverage for Nonprescription Contraceptives and Exempt Nonprescription Contraceptives From Cost Sharing Requirements

VA proposed amending § 17.274 to exempt contraceptive services, and contraceptive products approved, cleared, or granted by FDA from cost

sharing requirements. We proposed amending § 17.274 by adding a new paragraph (f) to state that cost sharing and annual deductible requirements under 38 CFR 17.274(a) and (b) do not apply to: (1) surgical insertion, removal, and replacement of intrauterine systems and contraceptive implants; (2) measurement for, and purchase of, contraceptive diaphragms or similar FDA approved, cleared, or granted medical devices, including remeasurement and replacement; (3) prescription contraceptives, and prescription or nonprescription contraceptives used as emergency contraceptives; (4) surgical sterilization; and (5) outpatient care or evaluation associated with provision of services listed in proposed paragraph (f)(1) through (4). We also proposed amending § 17.272(a)(28) to state that nonprescription contraceptives are excluded from CHAMPVA coverage, except those non-prescription contraceptives used as emergency contraceptives.

All six substantive comments suggested that CHAMPVA coverage of contraceptives should include all nonprescription contraceptives. Most of these comments generally suggested that VA should expand coverage to all nonprescription contraceptives. We note that the Department of Health and Human Services (HHS), the Department of the Treasury, and the Department of Labor have historically interpreted the ACA as not requiring coverage of contraceptives without cost-sharing unless the individual has a prescription for the preventive product.

Other commenters provided additional reasons for providing coverage for the additional nonprescription contraceptives. For instance, one commenter explained that nonprescription contraceptives are an important option, especially for those who face barriers to care such as living in rural areas or are without reliable transportation. Another commenter explained that it was critical to provide nonprescription contraceptives because there are barriers to obtaining prescription-only contraception and the FDA is considering allowing certain prescription daily birth control pills to become over the counter instead of prescription-based. Another commenter stated that every individual is different and has different contraceptive needs and therefore all options should be covered without cost sharing.

One commenter noted that any cost associated with contraception, even a small amount, could be a barrier for individuals to access needed contraception. This commenter suggested specific changes to the regulatory text to reflect their suggested changes. The commenter suggested that VA: remove that language in proposed § 17.272(a)(28) that would have excluded coverage of nonprescription contraceptives; revise the language in § 17.272(a)(75) to include coverage for nonprescription contraceptives; and revise § 17.274(f)(3) to exempt all nonprescription contraceptives from cost sharing requirements. The commenter stated that these changes would effectively allow CHAMPVA coverage for both prescription and nonprescription contraceptives and exempt them all from cost sharing requirements.

We make no changes based on comments suggesting that VA should expand coverage to all nonprescription contraceptives. TRICARE does not cover over the counter contraceptives such as condoms, nonprescription spermicidal foams, jellies or sprays. CHAMPVA similarly excludes these items from plan coverage. We note that the ACA does not currently require private health insurers or Medicaid plans to cover these items without cost sharing and without a prescription. We also note that VA is required under 38 U.S.C. 1781(b) to provide CHAMPVA care in the same or similar manner to TRICARE, not the ACA.

We agree with commenters that any cost associated with contraception could be a barrier for individuals to access contraception. Similar concerns are seen with copayment obligations for health care and medication. The issue is not exclusive to CHAMPVA beneficiaries. As noted, TRICARE excludes coverage for prophylactics (condoms), spermicidal foams, jellies, and sprays not requiring a prescription.

In addition, we note here that in July 2023 the FDA has approved an oral contraceptive Opill (norgestrel) for nonprescription use to prevent pregnancy—the first daily oral contraceptive approved for use in the U.S. without a prescription. Opill is now commercially available for purchase without a prescription at pharmacies, convenience stores and grocery stores, as well as online. While VA makes no changes in this rulemaking regarding cost sharing for non-emergency contraceptives not requiring a prescription, VA will consider further amendments to facilitate access to certain family planning options including daily oral contraceptives approved, granted, or cleared by the FDA not requiring a prescription, such as Opill.

We stated in the proposed rule that TRICARE currently requires cost sharing for certain family planning care and services not provided by a military medical treatment facility (87 FR 64194), but did not specify how the proposed rule differed from TRICARE relative to cost sharing for contraceptives and family planning. Currently TRICARE covers reversible medical contraceptives with no cost-share as a preventive health benefit. TRICARE is also covering tubal sterilization procedures with no cost-shares for certain TRICARE-enrolled beneficiaries when the care is sought and delivered by a network provider as a clinical preventive service. By law, applicable cost sharing still applies to oral contraceptives and other prescription pharmaceutical agents dispensed through the TRICARE Pharmacy Benefit Program.

As background, the law directs VA to provide CHAMPVA beneficiaries with medical care ''in the same *or similar* manner and subject to the same *or similar* limitations as medical care'' furnished to DoD TRICARE Select beneficiaries. 38 U.S.C. 1781(b) (emphases added). That text recognizes differences may exist between the two programs' respective beneficiary populations and their needs. Further, CHAMPVA beneficiaries (unlike TRICARE beneficiaries) include family caregivers of veterans, not just eligible dependents. 38 U.S.C. 1720G(a)(3)(A)(ii)(IV). Congress did not require that CHAMPVA coverage be identical to that provided under TRICARE. VA has previously regulated to provide CHAMPVA benefits beyond those benefits offered by TRICARE if providing such health care would better promote the long-term health of CHAMPVA beneficiaries. Thus, consistent with the statute's plain meaning, VA provides CHAMPVA beneficiaries certain care that is ''similar,'' but not necessarily identical, to care provided to beneficiaries of TRICARE.

The distinctions made by TRICARE relative to copayment obligations are based on whether the service is prescribed or provided by a military medical treatment facility or a network provider, and in a few cases, the TRICARE plan in which the sponsor is enrolled. Several factors are weighed by VA when determining if a specific type of CHAMPVA benefit coverage should differ from that under TRICARE, including the makeup of the beneficiary population eligible for CHAMPVA (see 38 CFR 17.271(a), as well as agency priorities and policy considerations.

Eligibility for TRICARE is broader than that for CHAMPVA. CHAMPVA eligibility categories include the spouse

or child of a veteran who has been adjudicated by VA as having a permanent and total service-connected disability; the surviving spouse or child of a veteran who died as a result of an adjudicated service-connected condition(s); or who at the time of death was adjudicated permanently and totally disabled from a service-connected condition(s); the surviving spouse or child of a person who died on active military service and in the line of duty and not due to such person's own misconduct; certain individuals designated as a Primary Family Caregiver; and, an eligible child who is pursuing a course of instruction approved under 38 U.S.C. chapter 36, and who incurs a disabling illness or injury while pursuing such course of instruction. By contrast, TRICARE eligibility categories include active duty service members and their family members; retirees and their families; family members of activated Guard/Reserve members; non-activated Guard/Reserve members and their families who qualify for care under the Transitional Assistance Management Program; retired Guard/Reserve members at age 60 and their families; certain survivors; Medal of Honor recipients and their families; and, qualified former spouses. As noted, cost sharing obligations for certain types of contraceptive care or services under TRICARE is dependent on whether the patient is active duty or whether the care or service is prescribed by a network provider.

VA's motto is ''to fulfill President Lincoln's promise to care for those who have served in our nation's military and for their families, caregivers, and survivors.'' We do not believe TRICARE's statutorily required copayment obligations for these listed contraceptive and family planning services and products compels VA to follow suit. As explained above, those eligible for CHAMPVA are the spouse, surviving spouse, child, and caregiver of a qualifying veteran sponsor which in most cases is either a VA rated permanently and totally disabled veteran or a veteran that died of a VA rated service-connected condition, and not otherwise eligible for TRICARE. We note that removing the cost sharing obligation alleviates any further financial burden on such households. VA believes that exempting the services and products listed in § 17.274(f) from cost sharing will benefit CHAMPVA beneficiaries and will retain that exemption in the final rule, with changes as explained below.

Comments That Requested Other Changes From the Proposed Rule

In addition to the issues above related to coverage and cost sharing for nonprescription contraceptives, two of the six commenters raised other issues. One of the commenters also suggested that language in proposed § 17.274(f) was not clear as to whether CHAMPVA coverage of contraceptives would include only those contraceptive methods and services expressly listed in paragraph (f), or also include ''similar'' contraceptive methods and services and FDA-approved, cleared, or granted products. This commenter stated that, without clarification, § 17.274(f) as proposed could be read to not cover those products that might be approved, cleared, or granted by the FDA in the future, and specifically stated that VA should ensure the inclusion of injectable contraceptives as an express type of contraceptive to be covered. The commenter suggested revising § 17.274(f)(1) as proposed to remove the word ''[S]urgical'' at the beginning of paragraph (f)(1) and adding at the end of the paragraph language that reads ''or similar FDA approved, granted, or cleared contraceptives that require insertion, removal, and replacement by a health care provider.'' This commenter also suggested adding a new paragraph (f)(3) to ensure explicit coverage of injectable contraceptives or similar FDA approved, granted, or cleared contraceptives that require administration by a health care provider. In adding a new paragraph (f)(3), the commenter lastly suggested that a renumbered paragraph (f)(4) (pertaining to exempting prescription contraceptives, and nonprescription contraceptives used as emergency contraceptives) should include at the end language that qualifies such contraceptives be those ''approved, granted, or cleared by the FDA.''

VA agrees with the commenter's suggestions and makes the following changes accordingly. VA revises § 17.274(f)(1) as proposed to remove the word ''[S]urgical'' from the beginning of the paragraph and, at the end of the paragraph, add language to ensure that similar FDA approved, granted, or cleared contraceptives requiring insertion, removal and replacement by a health care provider would be covered. VA will also add a new § 17.274(f)(3) to ensure that injectable contraceptives or similar FDA approved, granted, or cleared contraceptives that require administration by a health care provider would be covered. By adding a new § 17.274(f)(3), we will renumber paragraphs (f)(3) through (f)(5) as proposed to be paragraphs (f)(4) through (f)(6), respectively, and will revise renumbered paragraph (f)(4) to add language that clarifies all prescription, or nonprescription contraceptives used as emergency contraceptives, must otherwise be ''approved, granted, or cleared by the FDA.''

Finally, another commenter suggested that VA policy be amended to allow a prescription for up to 13-month supply of combined hormonal methods of contraceptives to improve contraceptive continuation. We do not make changes from the proposed rule based on this comment as it relates to a clinical practice matter beyond the scope of the proposed rule. We note that a patient's condition may change over time, requiring an adjustment of medication. In addition, a 12-month duration of a prescription corresponds to the scheduling of annual comprehensive care visits. VA policy permits a 12-month supply of combined hormonal methods of contraceptives, and a VA medical facility may have standard operating procedures in place allowing extension of fills greater than 12 months in certain circumstances.

Current VHA Directive 1108.07(1), General Pharmacy Service Requirements, establishes that prescriptions must generally be filled for no more than a maximum three-month (90-day) supply of medication at a time, although exceptions can be made for non-controlled medications and supplies and for oral contraceptives. Therefore, VA pharmacies are already authorized to fill a longer term of this medication when requested by the CHAMPVA beneficiary and the health care provider under the CHAMPVA In-house Treatment Initiative (CITI) program. For CHAMPVA services furnished by non-VA providers, VA does cover such prescriptions for a maximum 90-day supply of medication per fill with three refills if prescribed by the non-VA health care provider and filled by the non-VA pharmacy. See CHAMPVA Operational Policy Manual chapter 2, section 22.1. VA intends to amend this section of the operational manual to allow for an exception for oral contraceptives.

Based on the rationale set forth here and in the supplementary information to the proposed rule, VA adopts the proposed rule as final, with changes.

Executive Orders 12866, 13563, and 14094

Executive Order 12866 (Regulatory Planning and Review) directs agencies to assess the costs and benefits of available regulatory alternatives and, when regulation is necessary, to select

regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, and other advantages; distributive impacts; and equity). Executive Order 13563 (Improving Regulation and Regulatory Review) emphasizes the importance of quantifying both costs and benefits, reducing costs, harmonizing rules, and promoting flexibility. Executive Order 14094 (Executive Order on Modernizing Regulatory Review) supplements and reaffirms the principles, structures, and definitions governing contemporary regulatory review established in Executive Order 12866 of September 30, 1993 (Regulatory Planning and Review), and Executive Order 13563 of January 18, 2011 (Improving Regulation and Regulatory Review). The Office of Information and Regulatory Affairs has determined that this rulemaking is a significant regulatory action under Executive Order 12866, as amended by Executive Order 14094. The Regulatory Impact Analysis associated with this rulemaking can be found as a supporting document at *www.regulations.gov.*

Regulatory Flexibility Act

The Secretary hereby certifies that this final rule will not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act (5 U.S.C. 601–612). The factual basis for this certification is that this regulation updates CHAMPVA coverage to remove the exclusion for audio-only telehealth, removes limitations on outpatient mental health visits, and exempts certain contraceptive services and contraceptive products that are approved, cleared, or granted by the FDA from cost sharing requirements. It also removes the exclusion of CHAMPVA coverage for nonprescription contraception used in an emergency. The changes to the regulation only affect individuals who are CHAMPVA beneficiaries. Absent this rulemaking, health care providers who may be small entities would still receive payment for services, the payment would be from the CHAMPVA beneficiary and not from VA. Therefore, pursuant to 5 U.S.C. 605(b), the initial and final regulatory flexibility analysis requirements of 5 U.S.C. 603 and 604 do not apply.

Unfunded Mandates

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

Paperwork Reduction Act

This rule includes provisions constituting a revision to a collection of information under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3521) that require approval by OMB. Accordingly, under 44 U.S.C. 3507(d), VA has submitted a copy of this rulemaking action to OMB for review and approval.

OMB assigns control numbers to collections of information it approves. VA may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. In this case, OMB previously assigned OMB Control Number 2900–0219 to an information collection that will be revised through this regulation. The information collection under 2900–0219 has a current Paperwork Reduction Act (PRA) clearance that expires on October 31, 2024. If OMB does not approve the revision to this collection of information, as requested, VA will immediately remove the provisions containing the collection of information or take such other action as is directed by OMB.

The collection of information associated with this rulemaking contained in 38 CFR 17.272 addresses only the revised number of respondents attributable to this rulemaking. OMB previously approved the part of the information collection under 2900–0219 related to filing of CHAMPVA health benefits claims using VA Form 10–7959a for a total of 9,167 burden hours, based on an estimate of 55,000 respondents annually. Section 17.272(a)(44) would remove the exclusion of CHAMPVA benefits coverage for audio-only telehealth. Previously denied claims for audio-only telehealth would have to be resubmitted by the provider, or by the CHAMPVA beneficiary if the beneficiary has already paid for that medical service, using VA Form 10–7959a with supporting evidence. VA anticipates that the number of respondents submitting claims will increase as a result of this rulemaking. Applying the anticipated increase to 74,914 annual respondents, at 10 minutes per response, VA estimates an increase in the annual burden to 12,486 hours for respondents submitting claims using VA Form 10–7959a.

Estimated cost to respondents per year: VA estimates the annual cost to respondents to be $371,583.36. This is based on Bureau of Labor Statistics mean hourly wage data for BLS wage code ''00–0000 All Occupations'' of $29.76 per hour × 12,486 hours.

A notice of this revision to the information collection under 2900–0219 was published in the proposed rule on October 24, 2022, at 87 FR pages 64190–64196. VA did not receive any public comments related to the increase in the burden hours for the revised information collection.

Congressional Review Act

Pursuant to the Congressional Review Act (5 U.S.C. 801 *et seq.*), the Office of Information and Regulatory Affairs designated this rule as not a major rule, as defined by 5 U.S.C. 804(2).

List of Subjects in 38 CFR Part 17

Administrative practice and procedure, Claims, Health care, Health facilities, Health professions, Health records, Medical devices, Mental health programs, Veterans.

Signing Authority

Denis McDonough, Secretary of Veterans Affairs, approved this document on April 17, 2024, and authorized the undersigned to sign and submit the document to the Office of the Federal Register for publication electronically as an official document of the Department of Veterans Affairs.

Consuela Benjamin,

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

For the reasons stated in the preamble, the Department of Veterans Affairs (VA) amends 38 CFR part 17 as follows:

PART 17—MEDICAL

■ 1. The general authority citation for part 17 continues to read as follows:

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

* * * * *

■ 2. Amend § 17.272 by:
■ a. Revising paragraphs (a)(28) and (a)(44);
■ b. Removing paragraphs (a)(57) through (62);
■ c. Redesignating paragraphs (a)(63) through (83) as paragraphs (a)(57) through (77), respectively.

The revisions read as follows:

§ 17.272 Benefits limitations/exclusions.

(a) * * *

(28) Nonprescription contraceptives, except those non-prescription contraceptives used as emergency contraceptives.

* * * * *

(44) Telephone Services, with the following exceptions:

(i) Services or advice rendered by telephone (audio only) on or after May 12, 2020, are not excluded when the services are otherwise covered CHAMPVA services provided through this modality and are medically necessary and appropriate.

(ii) A diagnostic or monitoring procedure which incorporates electronic transmission of data or remote detection and measurement of a condition, activity, or function (biotelemetry) is covered when:

(A) The procedure, without electronic data transmission, is a covered benefit;

(B) The addition of electronic data transmission or biotelemetry improves the management of a clinical condition in defined circumstances; and

(C) The electronic data or biotelemetry device has been classified by the U.S. Food and Drug Administration, either separately or as part of a system, for use consistent with the medical condition and clinical management of such condition.

* * * * *

§ 17.273 [Amended]

■ 3. Amend § 17.273 by removing paragraph (c), and redesignating paragraphs (d) through (f) as paragraphs (c) through (e), respectively.

■ 4. Amend § 17.274 by adding paragraph (f) to read as follows:

§ 17.274 Cost sharing.

* * * * *

(f) Cost sharing and annual deductible requirements under paragraphs (a) and (b) of this section do not apply to:

(1) Insertion, removal, and replacement of intrauterine systems, contraceptive implants, or similar FDA approved, granted, or cleared contraceptives that require insertion, removal, and replacement by a health care provider;

(2) Measurement for, and purchase of, contraceptive diaphragms or similar FDA approved, cleared, or granted medical devices, including remeasurement and replacement;

(3) Administration of injectable contraceptives or similar FDA approved, granted, or cleared contraceptives that require administration by a health care provider;

(4) Prescription contraceptives, and prescription or nonprescription contraceptives used as emergency contraceptives, approved, granted, or cleared by the FDA;

(5) Surgical sterilization; and

(6) Outpatient care or evaluation associated with provision of family planning services listed in paragraphs (f)(1) through (5) of this section.

[FR Doc. 2024–09072 Filed 4–29–24; 8:45 am]

BILLING CODE 8320–01–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[EPA–R01–OAR–2023–0188; FRL–11025–03–R1]

Air Plan Approval; New Hampshire; Reasonable Available Control Technology for the 2008 and 2015 Ozone Standards

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final rule.

SUMMARY: The Environmental Protection Agency (EPA) is approving State Implementation Plan (SIP) revisions submitted by the State of New Hampshire. The revisions establish NO_X reasonably available control technology (RACT) requirements for coal-fired cyclone boilers located in the state, portions of New Hampshire's NO_X RACT certifications for the 2008 and 2015 ozone standards that pertain to requirements for coal-fired cyclone boilers, and withdrawal from the SIP of two previously issued RACT orders. This action is being taken in accordance with the Clean Air Act (CAA).

DATES: This rule is effective on May 30, 2024.

ADDRESSES: EPA has established a docket for this action under Docket Identification No. EPA–R01–OAR–2023–0188. All documents in the docket are listed on the *https://www.regulations.gov* website. Although listed in the index, some information is not publicly available, *i.e.,* CBI 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 at *https://www.regulations.gov* or at the U.S. Environmental Protection Agency, EPA Region 1 Regional Office, Air and Radiation Division, 5 Post Office Square—Suite 100, Boston, MA. EPA requests that if at all possible, you contact 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 legal holidays and facility closures due to COVID–19.

FOR FURTHER INFORMATION CONTACT: Bob McConnell, Environmental Engineer, Air and Radiation Division (Mail Code 5–MD), U.S. Environmental Protection Agency, Region 1, 5 Post Office Square, Suite 100, Boston, Massachusetts, 02109–3912; (617) 918–1046; *mcconnell.robert@epa.gov*.

SUPPLEMENTARY INFORMATION:

Throughout this document whenever ''we,'' ''us,'' or ''our'' is used, we mean EPA.

Table of Contents

I. Background and Purpose

On July 10, 2023 (88 FR 43483), EPA published a Notice of Proposed Rulemaking (NPRM) for the State of New Hampshire. The NPRM proposed to determine that the State has adopted regulations meeting the requirements for reasonably available control technology (RACT) for the 2008 and 2015 ozone national ambient air quality standards (NAAQS), to approve amendments to a related regulation that New Hampshire revised as part of its RACT certifications for these two NAAQS, to approve a revision to the State's definition of emergency generator, and removal from the SIP of two previously issued RACT orders affecting coal-fired cyclone boilers operated by Merrimack Station located in Bow, New Hampshire. EPA received a comment letter from the Sierra Club dated August 9, 2023, that opposed New Hampshire's NO_X RACT limits applicable to coal-fired cyclone boilers. We approved the portions of the proposal unaffected by this comment letter in a final rule published on September 6, 2023 (88 FR 60893). In this final rule, we are approving the remaining portions of these SIP revisions, which include requirements within New Hampshire's Env-A 1300 establishing RACT requirements for coal-fired electrical cyclone boilers, the portions of New Hampshire's NO_X RACT certifications for the 2008 and 2015 ozone standards that pertain to requirements for coal-fired cyclone boilers, and we are taking final action to withdraw from the New Hampshire SIP two RACT orders that contain less stringent requirements for cyclone boilers. Please see our July 10, 2023 proposed rule for additional background