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DEPARTMENT OF AGRICULTURE

Office of the Secretary

7 CFR Part 2

RIN 0503–AA63

Delegations of Authority; Correction

AGENCY: Office of the Secretary, USDA.

ACTION: Final rule; correction.

SUMMARY: The U.S. Department of Agriculture (USDA) is correcting a final rule that appeared in the **Federal Register** on July 26, 2022. The document amended the delegations of authority of the Secretary of Agriculture and other general officers of the Department. This document corrects an error in the amendatory instructions for one of the delegations in the final rule.

DATES: Effective September 7, 2022.

FOR FURTHER INFORMATION CONTACT: Melissa McClellan, Office of the General Counsel, (202) 720–5565, *melissa.mcclellan@usda.gov.*

SUPPLEMENTARY INFORMATION: In FR Doc. 2022–15742 appearing on page 44265 in the **Federal Register** of Tuesday, July 26, 2022, the following correction is made:

§ 2.16 [Corrected]

■ 1. On page 44267, in the first column, in amendment 8, the instruction ''Amend § 2.16 by revising paragraphs (a)(1)(xxviii)(B) and (a)(12) to read as follows:'' is corrected to read ''Amend § 2.16 by revising paragraph (a)(1)(xxviii)(B) and adding paragraph (a)(12) to read as follows:''.

Janie S. Hipp,

General Counsel.

[FR Doc. 2022–19238 Filed 9–6–22; 8:45 am]

BILLING CODE 3410–90–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. FAA–2022–0148; Project Identifier AD–2021–00922–T; Amendment 39–22110; AD 2022–14–05]

RIN 2120–AA64

Airworthiness Directives; The Boeing Company Airplanes

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule.

SUMMARY: The FAA is superseding Airworthiness Directive (AD) 2015–12–03, which applied to certain The Boeing Company Model 777–200, –200LR, –300, and –300ER series airplanes. AD 2015–12–03 required repetitive freeplay inspections and lubrication of the right and left elevators, rudder, and rudder tab, and related investigative and corrective actions if necessary. This AD was prompted by engineering testing which revealed that the force being applied to the elevator to detect excessive freeplay was insufficient. This AD continues to require certain actions in AD 2015–12–03 for certain airplanes, and requires revising the existing maintenance or inspection program, as applicable, for certain other airplanes, to incorporate a revised or new elevator freeplay maintenance procedure, as applicable. This AD also adds airplanes to the applicability. The FAA is issuing this AD to address the unsafe condition on these products.

DATES: This AD is effective October 12, 2022.

The Director of the Federal Register approved the incorporation by reference of a certain publication listed in this AD as of October 12, 2022.

The Director of the Federal Register approved the incorporation by reference of a certain other publication listed in this AD as of July 21, 2015 (80 FR 34252, June 16, 2015).

ADDRESSES: 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; internet *https://www.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 *https://www.regulations.gov* by searching for and locating Docket No. FAA–2022–0148.

Examining the AD Docket

You may examine the AD docket at *https://www.regulations.gov* by searching for and locating Docket No. FAA–2022–0148; 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.

FOR FURTHER INFORMATION CONTACT: Luis Cortez-Muniz, Aerospace Engineer, Airframe Section, FAA, Seattle ACO Branch, 2200 South 216th St., Des Moines, WA 98198; phone and fax: (206) 231–3958; email: *Luis.A.Cortez-Muniz@faa.gov.*

SUPPLEMENTARY INFORMATION:

Background

The FAA issued a notice of proposed rulemaking (NPRM) to amend 14 CFR part 39 to supersede AD 2015–12–03, Amendment 39–18176 (80 FR 34252, June 16, 2015) (AD 2015–12–03). AD 2015–12–03 applied to certain The Boeing Company Model 777–200, –200LR, –300, and –300ER series airplanes. The NPRM published in the **Federal Register** on March 24, 2022 (87 FR 16654). The NPRM was prompted by the manufacturer's determination that the procedure for the rudder freeplay inspection available at the time did not properly detect excessive freeplay in the rudder control load loop. The NPRM was also prompted by engineering testing which revealed that the force being applied to the elevator to detect excessive freeplay was insufficient. In the NPRM, the FAA proposed to continue to require certain actions in AD 2015–12–03 for certain airplanes, and to require revising the existing maintenance or inspection program, as applicable, for certain other airplanes, to incorporate a revised or new elevator

freeplay maintenance procedure, as applicable. The NPRM also proposed to add airplanes to the applicability. The FAA is issuing this AD to address excessive wear in the load loop components of the control surfaces, which could lead to excessive freeplay of the control surfaces, flutter, and consequent loss of control of the airplane.

Discussion of Final Airworthiness Directive

Comments

The FAA received comments from The Air Line Pilots Association, International (ALPA) and Boeing, who supported the NPRM without change.

The FAA received additional comments from United Airlines. The following presents the comments received on the NPRM and the FAA's response.

Request for Exception To Correct Service Information Typographical Error

United Airlines (UAL) asked that the FAA consider including an exception in paragraph (i) of the proposed AD due to a typographical error in Boeing Special Attention Service Bulletin 777–27–0062, Revision 4, dated July 15, 2021. UAL stated that it identified a typographical error in Appendix A, paragraph 1.f., ''Freeplay Inspection,'' in the CAUTION note just before step (6). UAL added that the note shows the conversion of 84 square inches as 5,420 square centimeters; however, 84 square inches calculates to 542 square centimeters.

The FAA agrees that Appendix A of the referenced service information contains a typographical error, as described by the commenter. Therefore, that FAA has added an exception to paragraph (i)(5) of this AD which states that where Appendix A, paragraph 1.f., ''Freeplay Inspection,'' of Boeing Special Attention Service Bulletin 777–27–0062, Revision 4, dated July 15, 2021, specifies to use a pad that distributes the force over an area of 84 square inches (5,420 square centimeters) or more, this AD requires using a pad that distributes the force over an area of 84 square inches (542 square centimeters) or more. The FAA also revised the introductory text to paragraph (i)(5) to specify that a new exception has been added.

Conclusion

The FAA reviewed the relevant data, considered any comments received, and determined that air safety requires adopting this AD as proposed. Except for minor editorial changes, and any other change described previously, 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 Special Attention Service Bulletin 777–27–0062, Revision 4, dated July 15, 2021. This service information specifies procedures for changing the elevator freeplay instructions by adding changes to the input force, elevator freeplay limit, and power control unit (PCU) bypass test setup.

This AD also requires Boeing Special Attention Service Bulletin 777–27–0062, Revision 2, dated January 27, 2014, which the Director of the Federal Register approved for incorporation by reference as of July 21, 2015 (80 FR 34252, June 16, 2015).

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 281 airplanes of U.S. registry. The FAA estimates the following costs to comply with this AD:

ESTIMATED COSTS

Required actions	Labor cost	Parts cost	Cost per product	Cost on U.S. operators (218)
Measurement (inspection), elevator.	4 work-hours × $85 per hour = $340 per measurement (inspection) cycle.	$0	$340 per measurement (inspection) cycle.	$74,120 per measurement (inspection) cycle.
Lubrication, elevator	17 work-hours × $85 per hour = $1,445 per lubrication cycle.	0	$1,445 per lubrication cycle	$315,010 per lubrication cycle.
Measurement (inspection), rudder.	4 work-hours × $85 per hour = $340 per measurement (inspection) cycle.	0	$340 per measurement (inspection) cycle.	$74,230 per measurement (inspection) cycle.
Lubrication, rudder	7 work-hours × $85 per hour = $595 per lubrication cycle.	0	$595 per lubrication cycle	$129,710 per lubrication cycle.
Measurement (inspection), rudder tab.	3 work-hours × $85 per hour = $255 per measurement (inspection) cycle.	0	$255 per measurement (inspection) cycle.	$55,590 per measurement (inspection) cycle.
Lubrication, rudder tab	5 work-hours × $85 per hour = $425 per lubrication cycle.	0	$425 per lubrication cycle	$92,650 per lubrication cycle

The FAA has received no definitive data that would enable the agency to provide cost estimates for the on-condition corrective actions specified in this AD.

The FAA has determined that revising the existing maintenance or inspection program takes an average of 90 work-hours per operator, although the agency recognizes that this number may vary from operator to operator. Since operators incorporate maintenance or inspection program changes for their affected fleet(s), the FAA has determined that a per-operator estimate is more accurate than a per-airplane estimate. Therefore, the FAA estimates the average total cost per Model 777F operator to be $7,650 (90 work-hours × $85 per work-hour).

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:

■ a. Removing Airworthiness Directive (AD) 2015–12–03, Amendment 39–18176 (80 FR 34252, June 16, 2015); and

■ b. Adding the following new AD:

2022–14–05 The Boeing Company: Amendment 39–22110; Docket No. FAA–2022–0148; Project Identifier AD–2021–00922–T.

(a) Effective Date

This airworthiness directive (AD) is effective October 12, 2022.

(b) Affected ADs

This AD replaces AD 2015–12–03, Amendment 39–18176 (80 FR 34252, June 16, 2015) (AD 2015–12–03).

(c) Applicability

This AD applies to The Boeing Company airplanes, certificated in any category, identified in paragraphs (c)(1) and (2) of this AD.

(1) All Model 777–200, –200LR, –300, and –300ER series airplanes.

(2) Model 777F airplanes with an original airworthiness certificate or original export certificate of airworthiness issued on or before the effective date of this AD.

(d) Subject

Air Transport Association (ATA) of America Code 27, Flight Controls.

(e) Unsafe Condition

This AD was prompted by the manufacturer's determination that the procedure for the rudder freeplay inspection available at the time did not properly detect excessive freeplay in the rudder control load loop. This AD was also prompted by engineering testing that revealed that the force being applied to the elevator to detect excessive freeplay was insufficient. The FAA is issuing this AD to address excessive wear in the load loop components of the control surfaces, which could lead to excessive freeplay of the control surfaces, flutter, and consequent loss of control of the airplane.

(f) Compliance

Comply with this AD within the compliance times specified, unless already done.

(g) Retained Repetitive Inspections of Elevators, Rudder, and Rudder Tab, With Revised Service Information

This paragraph restates the requirements of paragraph (g) of AD 2015–12–03, with revised service information. For Model 777–200, –200LR, –300, and –300ER series airplanes: At the applicable times specified in tables 1, 2, and 3 of paragraph 1.E., ''Compliance,'' of Boeing Special Attention Service Bulletin 777–27–0062, Revision 2, dated January 27, 2014, or Revision 4, dated July 15, 2021, except as provided by paragraph (i)(1) of this AD: Inspect the freeplay of the right and left elevators, rudder, and rudder tab by accomplishing all of the actions specified in Parts 1, 3, and 5 of the Accomplishment Instructions of Boeing Special Attention Service Bulletin 777–27–0062, Revision 2, dated January 27, 2014, or Revision 4, dated July 15, 2021, except as provided by paragraphs (i)(2) through (5) of this AD. Repeat the inspections thereafter at the intervals specified in tables 1, 2, and 3 of paragraph 1.E., ''Compliance,'' of Boeing Special Attention Service Bulletin 777–27–0062, Revision 2, dated January 27, 2014, or Revision 4, dated July 15, 2021. If, during any inspection required by this paragraph, the freeplay exceeds any applicable measurement specified in Part 1, 3, and 5, as applicable, of the Accomplishment Instructions of Boeing Special Attention Service Bulletin 777–27–0062, Revision 2, dated January 27, 2014, or Revision 4, dated July 15, 2021, before further flight, do the applicable corrective actions in accordance with Part 1, 3, and 5 of the Accomplishment Instructions of Boeing Special Attention Service Bulletin 777–27–0062, Revision 2, dated January 27, 2014, or Revision 4, dated July 15, 2021. After the effective date of this AD use only Boeing Special Attention Service Bulletin 777–27–0062, Revision 4, dated July 15, 2021.

(h) Retained Repetitive Lubrication, With Revised Service Information

This paragraph restates the requirements of paragraph (h) of AD 2015–12–03, with revised service information. For Model 777–200, –200LR, –300, and –300ER series airplanes: At the applicable times specified in tables 1, 2, and 3 of paragraph 1.E., ''Compliance,'' of Boeing Special Attention Service Bulletin 777–27–0062, Revision 2, dated January 27, 2014, or Revision 4, dated July 15, 2021, except as provided by paragraph (i)(1) of this AD: Lubricate the elevator components, rudder components, and rudder tab components, by accomplishing all of the actions specified in Parts 2, 4, and 6 of the Accomplishment Instructions of Boeing Special Attention Service Bulletin 777–27–0062, Revision 2, dated January 27, 2014, or Revision 4, dated July 15, 2021. Repeat the lubrication thereafter at the interval specified in tables 1, 2, and 3 of paragraph 1.E., ''Compliance,'' of Boeing Special Attention Service Bulletin 777–27–0062, Revision 2, dated January 27, 2014, or Revision 4, dated July 15, 2021. After the effective date of this AD use only Boeing Special Attention Service Bulletin 777–27–0062, Revision 4, dated July 15, 2021.

(i) Exceptions to Service Information Specifications, With Revised Service Information and a New Exception

This paragraph restates the requirements of paragraph (i) of AD 2015–12–03, with revised service information and a new exception, for Model 777–200, –200LR, –300, and –300ER series airplanes.

(1) Where Boeing Special Attention Service Bulletin 777–27–0062, Revision 2, dated January 27, 2014, and Revision 4, dated July 15, 2021, specify a compliance time ''after the original issue date on this service bulletin,'' this AD requires compliance within the specified compliance time after July 25, 2007 (the effective date of AD 2007–13–05, Amendment 39–15109 (72 FR 33856, June 20, 2007)). After the effective date of this AD, only Boeing Special Attention Service Bulletin 777–27–0062, Revision 4, dated July 15, 2021, may be used.

(2) Where Appendix B, paragraph 1.f., ''Freeplay Inspection,'' step (8), of Boeing Special Attention Service Bulletin 777–27–0062, Revision 2, dated January 27, 2014, specifies that the center of the pad must be within 1.0 inch (13 millimeters) of the center line of the rib rivets in the rudder tab, this AD requires that the center of the tab must be within 1.0 inch (25 millimeters) of the center line of the rib rivets in the rudder tab.

(3) Where Appendix C, paragraph 1.e., ''Rudder Tab Surface Freeplay—Inspection,''

step (2) and step (6), of Boeing Special Attention Service Bulletin 777–27–0062, Revision 2, dated January 27, 2014, specify that the placement of the force gage and pad should be within one inch of the centerline line of the middle rudder power control unit (PCU) rib and at 12 +/− 1 inch (305 +/− 72 millimeters) forward of the rudder tab trailing edge, this AD requires placement of the force gage and pad within one inch of the centerline line of the middle rudder PCU rib and at 12 +/− 1 inch (305 +/− 25 millimeters) forward of the rudder tab trailing edge.

(4) Where Appendix C, paragraph 1.e., ''Rudder Tab Surface Freeplay—Inspection,'' step (3), of Boeing Special Attention Service Bulletin 777–27–0062, Revision 2, dated January 27, 2014, specifies to apply a 30 +/− pound (133 +/− 14 newton) force, this AD requires applying a 30 +/− 3 pound force (133 +/− 14 newton) force.

(5) Where the CAUTION note just before step (6) of Appendix A, paragraph 1.f., ''Freeplay Inspection,'' of Boeing Special Attention Service Bulletin 777–27–0062, Revision 4, dated July 15, 2021, specifies using a pad that distributes the force over an area of 84 square inches (5,420 square centimeters) or more, this AD requires using a pad that distributes the force over an area of 84 square inches (542 square centimeters) or more.

(j) New Maintenance or Inspection Program Revision

For Model 777F airplanes: Within 30 days after the effective date of this AD, revise the 777F elevator freeplay maintenance procedure in the existing maintenance or inspection program, as applicable, by doing the actions specified in paragraphs (j)(1) through (3) of this AD.

(1) Remove the existing hydraulic depressurization PCU test setup procedure step and replace it by incorporating the information specified in figure 1 to paragraph (j) of this AD.

(2) Revise the jack test force used to push the elevator up to 225 +/− 10 lb (102.1 +/− 4.5 kg).

(3) Revise the elevator freeplay dial indicator limit to 0.34 in. (152 mm) or less.

Figure 1 to paragraph (j): *Circuit breaker elevator freeplay test setup*

Do these steps to prepare for the freeplay inspection:

NOTE: Each PCU can be inspected in any order, as long as the setup for the inspection is performed per the steps below.

a) To inspect the left elevator outboard PCU, do these steps:

1. Open this circuit breaker and install safety tag:

Power Supply Assembly Center, M24301

Row	Col	Number	Name
A	7	CBA7-C	ELEV PCU

2. Make sure that the left elevator inboard PCU is in bypass mode

b) To inspect the left elevator inboard PCU, do these steps:

1. Open this circuit breaker and install safety tag:

Power Supply Assembly Left, M24101

Row	Col	Number	Name
A	7	CBA7-L	ELEV PCU

2. Make sure that the left elevator outboard PCU is in bypass mode.

c) To inspect the right elevator inboard PCU, do these steps:

1. Open this circuit breaker and install safety tag:

Left Power Management Panel, P110

Row	Col	Number	Name
K	27	C27609	ELEV PCU RIB (BLK)/ROB(BYP)

2. Make sure that the right elevator outboard PCU is in bypass mode.

d) To inspect the right elevator outboard PCU, do these steps:

1. Open this circuit breaker and install safety tag:

Power Supply Assembly Right, M24201

Row	Col	Number	Name
A	7	CBA7-R	ELEV PCU

2. Make sure that the right elevator inboard PCU is in bypass mode.

Note 1 to paragraph (j): Refer to AMM task 27–31–09–200–801, dated September 5, 2021, for additional guidance.

(k) No Alternative Actions or Intervals

After the existing maintenance or inspection program has been revised as required by paragraph (j) of this AD, no alternative actions (*e.g.,* inspections) or intervals may be used unless the actions or intervals are approved as an alternative method of compliance (AMOC) in accordance with the procedures specified in paragraph (m) of this AD.

(l) Credit for Previous Actions

This paragraph provides credit for the actions specified in paragraphs (g) and (h) of this AD, if those actions were performed before the effective date of this AD using Boeing Special Attention Service Bulletin 777–27–0062, Revision 3, dated October 9, 2015.

(m) Alternative Methods of Compliance (AMOCs)

(1) The Manager, Seattle ACO 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 (n)(1) 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, Seattle ACO 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.

(4) AMOCs approved previously for the freeplay measurements of the right and left rudder tab required by AD 2015–12–03, are approved as AMOCs for the corresponding provisions of this AD.

(5) AMOCs approved previously for the freeplay measurements of the rudder required by AD 2015–12–03, are approved as AMOCs for the corresponding provisions of this AD.

(6) AMOCs approved previously for the repetitive lubrications required by AD 2015–12–03, are approved as AMOCs for the corresponding provisions of this AD.

(n) Related Information

(1) For more information about this AD, contact Luis Cortez-Muniz, Aerospace Engineer, Airframe Section, FAA, Seattle ACO Branch, 2200 South 216th St., Des Moines, WA 98198; phone and fax: (206) 231–3958; email: *Luis.A.Cortez-Muniz@faa.gov*.

(2) Service information identified in this AD that is not incorporated by reference is available at the addresses specified in paragraphs (o)(5) and (6) of this AD.

(o) 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 this AD specifies otherwise.

(3) The following service information was approved for IBR on October 12, 2022.

(i) Boeing Special Attention Service Bulletin 777–27–0062, Revision 4, dated July 15, 2021.

(ii) [Reserved]

(4) The following service information was approved for IBR on July 21, 2015 (80 FR 34252, June 16, 2015).

(i) Boeing Special Attention Service Bulletin 777–27–0062, Revision 2, dated January 27, 2014.

(ii) [Reserved]

(5) 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; internet *https://www.myboeingfleet.com*.

(6) 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.

(7) 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, email *fr.inspection@nara.gov,* or go to: *https://www.archives.gov/federal-register/cfr/ibr-locations.html*.

Issued on June 27, 2022.

Christina Underwood,

Acting Director, Compliance & Airworthiness Division, Aircraft Certification Service.

[FR Doc. 2022–19221 Filed 9–6–22; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. FAA–2022–0514; Project Identifier AD–2022–00357–E; Amendment 39–22155; AD 2022–18–04]

RIN 2120–AA64

Airworthiness Directives; General Electric Company Turbofan Engines

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule.

SUMMARY: The FAA is adopting a new airworthiness directive (AD) for certain General Electric Company (GE) GEnx–1B model turbofan engines. This AD was prompted by several reports of fuel leaks caused by high cycle fatigue (HCF) cracks found at the braze joints on fuel manifolds, and the subsequent manufacturer redesign of the high-pressure turbine (HPT) fuel hose variable stator vane (VSV) manifold, VSV fuel hose manifold, low-pressure turbine (LPT) fuel hose variable bleed valve (VBV) manifold, and VBV fuel hose manifold. This AD requires removal and replacement of the fuel hydraulic lines. The FAA is issuing this AD to address the unsafe condition on these products.

DATES: This AD is effective October 12, 2022.

The Director of the Federal Register approved the incorporation by reference of a certain publication listed in this AD as of October 12, 2022.

ADDRESSES: For service information identified in this final rule, contact General Electric Company, 1 Neumann Way, Cincinnati, OH 45215; phone: (513) 552–3272; email: *aviation.fleetsupport@ge.com;* website: *www.ge.com.* You may view this service information at the FAA, Airworthiness Products Section, Operational Safety Branch, 1200 District Avenue, Burlington, MA 01803. For information on the availability of this material at the FAA, call (817) 222–5110. It is also available at *www.regulations.gov* by searching for and locating Docket No. FAA–2022–0514.

Examining the AD Docket

You may examine the AD docket at *https://www.regulations.gov* by searching for and locating Docket No. FAA–2022–0514; 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.

FOR FURTHER INFORMATION CONTACT: Alexei Marqueen, Aviation Safety Engineer, ECO Branch, FAA, 1200 District Avenue, Burlington, MA 01803; phone: (781) 238–7178; email: *Alexei.T.Marqueen@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 certain GE GEnx–1B model turbofan engines. The NPRM published in the **Federal Register** on June 3, 2022 (87 FR 33658). The NPRM was prompted by several reports of fuel manifold leaks resulting in multiple flight delays and cancellations on four separate occasions between 2018 and 2021 on airplanes with GEnx–1B model turbofan engines installed. The manufacturer's investigation revealed that variations in braze coverage and braze fillet radii caused high stress concentration factors at the braze block joints, leading to HCF failure in the tube bundles with brazed joints. As a result of its investigation, the manufacturer determined that the HPT fuel hose VSV manifold, VSV fuel hose manifold, LPT fuel hose VBV manifold, and VBV fuel hose manifold required redesign by replacing all braze features and cushioned clamps with block clamps. In the NPRM, the FAA proposed to require the removal and replacement of the fuel hydraulic lines. The FAA is issuing this

AD to address the unsafe condition on these products.

Discussion of Final Airworthiness Directive

Comments

The FAA received comments from five commenters. Commenters included the Air Line Pilots Association, International, American Airlines, The Boeing Company, United Airlines, and an anonymous commenter. All commenters supported the NPRM without change.

Conclusion

The FAA reviewed the relevant data, considered the comments received, and determined that air safety requires adopting the 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.

Related Service Information Under 1 CFR Part 51

The FAA reviewed GE GEnx–1B Service Bulletin 73–0099 R00, dated February 28, 2022. This service information specifies procedures for the removal and replacement of the fuel hydraulic lines. 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 298 engines installed on 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
Remove fuel hydraulic lines	2 work-hours × $85 per hour = $170	$0	$170	$50,660
Install redesigned fuel hydraulic lines	2.50 work-hours × $85 per hour = $212.50	232,000	232,212.50	69,199,325

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:

2022–18–04 General Electric Company: Amendment 39–22155; Docket No. FAA–2022–0514; Project Identifier AD–2022–00357–E.

(a) Effective Date

This airworthiness directive (AD) is effective October 12, 2022.

(b) Affected ADs

None.

(c) Applicability

General Electric Company (GE) GEnx–1B64, GEnx–1B64/P1, GEnx–1B64/P2, GEnx–1B67, GEnx–1B67/P1, GEnx–1B67/P2, GEnx–1B70, GEnx–1B70/75/P1, GEnx–1B70/75/P2, GEnx–1B70/P1, GEnx–1B70/P2, GEnx–1B70C/P1, GEnx–1B70C/P2, GEnx–1B74/75/P1, GEnx–1B74/75/P2, GEnx–1B76/P2, and GEnx–1B76A/P2 model turbofan engines with engine serial numbers 956–102 through 958–775, inclusive, 958–795, and 958–802.

(d) Subject

Joint Aircraft System Component (JASC) Code 7310, Engine Fuel Distribution.

(e) Unsafe Condition

This AD was prompted by several reports of fuel leaks caused by high cycle fatigue cracks found at the braze joints on certain GEnx–1B fuel manifolds. The FAA is issuing this AD to prevent fuel leaks on the variable bypass valve and variable stator vane fuel hose manifolds. The unsafe condition, if not addressed, could result in engine fire and damage to the airplane.

(f) Compliance

Comply with this AD within the compliance times specified, unless already done.

(g) Required Actions

At the next engine shop visit after the effective date of this AD, remove and replace the fuel hydraulic lines using the Accomplishment Instructions, paragraphs 3.A and 3.B, of GE GEnx–1B Service Bulletin (SB) 73–0099 R00, dated February 28, 2022.

(h) Definition

For the purpose of this AD, an ''engine shop visit''' is the induction of an engine into the shop for maintenance involving the separation of pairs of major mating engine case flanges, except for the following situations, which do not constitute an engine shop visit:

(1) Separation of engine flanges solely for the purposes of transportation of the engine without subsequent maintenance.

(2) Separation of engine flanges solely for the purposes of replacing the fan or propulsor without subsequent maintenance.

(i) Alternative Methods of Compliance (AMOCs)

(1) The Manager, ECO 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 local Flight Standards district 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 and email to: *ANE-AD-AMOC@faa.gov.*

(2) Before using any approved AMOC, notify your appropriate principal inspector, or lacking a principal inspector, the manager of the local flight standards district office/certificate holding district office.

(j) Related Information

For more information about this AD, contact Alexei Marqueen, Aviation Safety Engineer, ECO Branch, FAA, 1200 District Avenue, Burlington, MA 01803; phone: (781) 238–7178; email: *Alexei.T.Marqueen@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) GE GEnx–1B Service Bulletin 73–0099 R00, dated February 28, 2022.

(ii) [Reserved]

(3) For service information identified in this AD, contact General Electric Company, 1 Neumann Way, Cincinnati, OH 45215; phone: (513) 552–3272; email: *aviation.fleetsupport@ge.com;* website: *www.ge.com.*

(4) You may view this service information at FAA, Airworthiness Products Section, Operational Safety Branch, 1200 District Avenue, Burlington, MA 01803. For information on the availability of this material at the FAA, call (817) 222–5110.

(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, email: *fr.inspection@nara.gov,* or go to: *www.archives.gov/federal-register/cfr/ibr-locations.html.*

Issued on August 17, 2022.

Christina Underwood,

Acting Director, Compliance & Airworthiness Division, Aircraft Certification Service.

[FR Doc. 2022–19189 Filed 9–6–22; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

21 CFR Part 73

[Docket No. FDA–2018–C–1007]

Listing of Color Additives; of Color Additives Exempt From Certification; Antarctic Krill Meal; Confirmation of Effective Date

AGENCY: Food and Drug Administration, Department of Health and Human Services (HHS).

ACTION: Final rule; confirmation of effective date.

SUMMARY: The Food and Drug Administration (FDA or we) is confirming the effective date of June 10, 2022, for the final rule that appeared in the **Federal Register** of May 10, 2022, and that amended the color additive regulations to provide for the safe use of Antarctic krill meal, composed of the ground and dried tissue of *Euphausia superba,* with or without the lipid fraction, for use in the feed of salmonid fish, to enhance the color of their flesh.

DATES: Effective date of final rule published in the **Federal Register** of May 10, 2022 (87 FR 27931) confirmed: June 10, 2022.

ADDRESSES: For access to the docket to read background documents or comments received, go to *https://www.regulations.gov* and insert the docket number found in brackets in the heading of this final rule into the ''Search'' box and follow the prompts, and/or go to the Dockets Management Staff, 5630 Fishers Lane, Rm. 1061, Rockville, MD 20852.

FOR FURTHER INFORMATION CONTACT: Stephen DiFranco, Center for Food Safety and Applied Nutrition, Food and Drug Administration, 5001 Campus Dr., College Park, MD 20740, 240–402–2710.

SUPPLEMENTARY INFORMATION: In the **Federal Register** of May 10, 2022 (87 FR 27931), we amended the color additive regulations in part 73 (21 CFR part 73), ''Listing of Color Additives Exempt From Certification,'' to add a new § 73.32, ''Antarctic krill meal.'' The new regulation provides for the safe use of Antarctic krill meal, composed of the ground and dried tissue of *Euphausia superba,* with or without the lipid fraction, for use in the feed of salmonid fish, to enhance the color of their flesh.

We gave interested persons until June 10, 2022, to file objections or requests for a hearing. We received no objections or requests for a hearing on the final rule. Therefore, we find that the effective date of the final rule that published in the **Federal Register** of May 10, 2022, should be confirmed.

List of Subjects in 21 CFR Part 73

Color additives, Cosmetics, Drugs, Foods, Medical devices.

Therefore, under the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321, 341, 342, 343, 348, 351, 352, 355, 361, 362, 371, 379e) and under authority delegated to the Commissioner of Food and Drugs, we are giving notice that no objections or requests for a hearing were filed in response to the May 10, 2022, final rule. Accordingly, the amendments issued thereby became effective June 10, 2022.

Dated: August 30, 2022.

Lauren K. Roth,

Associate Commissioner for Policy.

[FR Doc. 2022–19277 Filed 9–6–22; 8:45 am]

BILLING CODE 4164–01–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 100

[Docket Number USCG–2022–0467]

RIN 1625–AA08

Special Local Regulation; Atlantic Intracoastal Waterway, Morehead City, NC

AGENCY: Coast Guard, Department of Homeland Security (DHS).

ACTION: Temporary final rule.

SUMMARY: The Coast Guard is establishing a temporary special local regulation (SLR) for certain navigable waters of the Atlantic Intracoastal Waterway (AICW) and Beaufort Inlet in Morehead City, North Carolina. This SLR restricts vessel traffic on the AICW and Beaufort Inlet during high-speed boat races. The restriction of vessel traffic movement in the SLR is to protect participants and spectators from the hazards posed by these events. Entry of vessels or persons into this regulated area is prohibited unless specifically authorized by the Captain of the Port (COTP) North Carolina or a designated representative.

DATES: This rule is effective from 10 a.m. on September 9, 2022, until 4 p.m. on September 11, 2022. The SLR will be enforced from 10 a.m. to 4 p.m. on September 9, 2022, and those same hours on September 11, 2022.

ADDRESSES: To view documents mentioned in this preamble as being

available in the docket, go to *https://www.regulations.gov,* type USCG–2022–0467 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 Ken Farah, Waterways Management Division, U.S. Coast Guard Sector North Carolina, Wilmington, NC; telephone 910–772–2221, email *ncmarineevents@uscg.mil.*

SUPPLEMENTARY INFORMATION:

I. Table of Abbreviations

CFR Code of Federal Regulations
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 it would be impracticable and contrary to the public interest. The Coast Guard was unable to publish an NPRM and hold a comment period for this rulemaking due to the short time period from the event and required publication of this rule. Immediate action is needed to protect persons and vessels from the hazards associated with this event. A final rule needs to be in place by September 10, 2022, to minimize potential danger to the participants and the public during the event.

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 public interest because immediate action is needed to protect persons and vessels from the hazards associated with this event on September 9 and 11, 2022.

III. Legal Authority and Need for Rule

The Coast Guard is issuing this rule under authority in 46 U.S.C. 70041. The COTP North Carolina has determined that potential hazards associated with the Crystal Coast Grand Prix race, scheduled for 10 a.m. through 4 p.m. on September 9, 2022, and those same hours on September 11, 2022, is a safety concern for mariners during a high speed boat race on portions of the Atlantic Intra Coastal Waterway (AICW) and Beaufort Inlet in Morehead City, North Carolina. This rule is necessary to protect safety of life from the potential hazards associated with the high-speed boat race.

IV. Discussion of the Rule

This rule establishes an SLR on a portion of the AICW and Beaufort Inlet from 10 a.m. on September 9, 2022, until 4 p.m. on September 11, 2022. The SLR will be enforced from 10 a.m. to 4 p.m. on September 9, 2022, and those same hours on September 11, 2022. The time of enforcement will be broadcast locally over VHF–FM marine radio.

The regulated area encompasses approximately 1.5 square miles and will include all navigable waters of the AICW and Beaufort Inlet, North Carolina, from approximate positions: latitude 34°42′55″ N, longitude 076°43′15″ W, then east to latitude 34°42′56″ N, longitude 076°42′13″ W, then east to latitude 34°42′57″ N, longitude 076°41′41″ W, then east to latitude 34°42′57″ N, longitude 076°41′25″ W, then south east to latitude 34°42′23″ N, longitude 076°40′44″ W, then south to latitude 34°41′59″ N, longitude 076°40′43″ W, then north west to latitude 34°42′32″ N, longitude 076°42′14″ W, then west to latitude 34°42′32″ N, longitude 076°43′15″ W, then north to its point of origin.

This SLR provides additional information about areas within the regulated area and their definitions. These areas include ''Race Area,'' ''Spectator Area,'' and ''Buffer Area.''

The size of the regulated area is intended to ensure the safety of life on these navigable waters before, during, and after activities associated with the boat race, scheduled from 10 a.m. to 4 p.m. on September 9, 2022, and September 11, 2022. The COTP and the Coast Guard Event Patrol Commander (PATCOM) have authority to forbid and control the movement of all vessels and persons, including event participants, in the regulated area. When hailed or signaled by an official patrol, a vessel or person in the regulated area must immediately comply with the directions given by the COTP or Event PATCOM. If a person or vessel fails to follow such directions, the Coast Guard may expel them from the area, issue them a citation for failure to comply, or both.

Except for Crystal Coast Grand Prix race participants and vessels already at berth, a vessel or person must get permission from the COTP or Event PATCOM to remain in the regulated area and before entering the regulated area. Vessel operators must request permission to enter and transit through the regulated area by contacting the Event PATCOM on VHF–FM channel 16. Vessel traffic will be able to safely transit the regulated area once the Event PATCOM deems it safe to do so. A vessel within the regulated area must operate at safe speed that minimizes wake. A person or vessel not registered with the event sponsor as a participant or assigned as official patrols will be considered a spectator. Official Patrols are any vessel assigned or approved by the Commander, Coast Guard Sector North Carolina with a commissioned, warrant, or petty officer on board and displaying a Coast Guard ensign. Official Patrols enforcing this regulated area can be contacted on VHF–FM channel 16 and channel 22A.

If permission is granted by the COTP or Event PATCOM, a person or vessel will be allowed to enter the regulated area or pass directly through the regulated area as instructed. Vessels must operate at a safe speed that minimizes wake while within the regulated area. A spectator vessel must not loiter within the Race area, Buffer Zone, or navigable channel while within the regulated area. Official patrol vessels will direct spectators to the designated spectator area. Only participant vessels will be allowed to enter the Race Area, and the Buffer Zone, if necessary.

The duration of this SLR is intended to protect participants and spectators on the navigable waters of the AICW and Beafort Inlet during the high-speed boat race. Vessels may request permission to pass through the SLR between race heats. No vessel or person will be permitted to enter the SLR without obtaining permission from the COTP North Carolina or a designated representative. The regulatory text appears at the end of this document.

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 Executive Order 12866. 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, and duration of the SLR. Vessel traffic will not be allowed to enter or transit a portion of the AICW or Beaufort Inlet during an active race event from 10 a.m. through 4 p.m. on both September 10, 2022, and September 12, 2022. The Coast Guard will transmit a Broadcast Notice to Mariners via VHF–FM marine channel 16 regarding the enforcement period of the SLR. This rule allows vessels to request permission to pass through the regulated area between race heats.

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 will 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 an SLR to be enforced during active race events. It will be enforced a total of 6 hours while in effect. It is categorically excluded from further review under paragraph L61 of Appendix A, Table 1 of DHS Instruction Manual 023–01–001–01, Rev. 1. A Memorandum for Record 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 100

Marine safety, Navigation (water), Reporting and recordkeeping requirements, Waterways.

For the reasons discussed in the preamble, the Coast Guard amends 33 CFR part 100 as follows:

PART 100—SAFETY OF LIFE ON NAVIGABLE WATERS

■ 1. The authority citation for part 100 continues to read as follows:

Authority: 46 U.S.C. 70041; 33 CFR 1.05–1.

■ 2. Add § 100.T05–0467 to read as follows:

§ 100.T05–0467 Crystal Coast Grand Prix, Morehead City, NC.

(a) *Regulated areas.* The regulations in this section apply to the following areas:

(1) *Race area.* The race area is all navigable waters of the Atlantic Intracoastal Waterway (AICW) and Beaufort Inlet, North Carolina, from approximate positions: latitude 34°42′52″ N, longitude 076°43′16″ W, then east to latitude 34°42′52.2″ N, longitude 076°42′11.04″ W, then east to latitude 34°42′53.76″ N, longitude 076°41′38.04″ W, then southeast to latitude 34°42′10.8″ N, longitude 076°40′44.4″ W, then south to latitude 34°42′4.3″ N, longitude 076°40′48.1″ W, then northwest to latitude 34°42′47.34″ N, longitude 076°41′49″ W, then west to latitude 34°42′50″ N, longitude 076°43′16″ W, then north to the point of origin.

(2) *Spectator area.* The spectator area is all waters of the AICW, North Carolina, from approximate positions: latitude 34°42′42″ N, longitude 076°43′15″ W, then east to latitude 34°42′41″ N, longitude 076°42′14″ W, then south to latitude 34°42′32″ N, longitude 076°42′14″ W, then west to latitude 34°42′32″ N, longitude 076°43′15″ W, then north to the point of origin.

(3) *Buffer area.* The buffer area is all waters of the AICW and Beaufort Inlet, North Carolina, from approximate positions: latitude 34°42′55″ N, longitude 076°43′15″ W, then east to latitude 34°42′56″ N, longitude 076°42′13″ W, then east to latitude 34°42′57″ N, longitude 076°41′41″ W, then east to latitude 34°42′57″ N, longitude 076°41′25″ W, then south east to latitude 34°42′23″ N, longitude 076°40′44″ W, then south to latitude 34°41′59″ N, longitude 076°40′43″ W, then north west to latitude 34°42′41″ N, longitude 076°42′05″ W, then west to latitude 34°42′42″ N, longitude 076°43′15″ W, then north to its point of origin.

(b) *Definitions.* As used in this section—

Buffer area is a neutral area that surrounds the perimeter of the race area within the regulated area described by this section. The purpose of a buffer area is to minimize potential collision conflicts with marine event participants and spectator vessels or nearby transiting vessels. This area provides separation between a race area and a specified spectator area or other vessels that are operating in the vicinity of the regulated area established by the special local regulation (SLR) in this section.

Captain of the Port means the Commander, Sector North Carolina.

Designated representative means a Coast Guard Patrol Commander, including a Coast Guard commissioned, warrant, or petty officer designated by the Captain of the Port North Carolina (COTP) for the enforcement of the safety zone.

Spectator means a person or vessel not registered with the event sponsor as participants or assigned as official patrols.

Spectator area is an area described by a line bound by coordinates provided in latitude and longitude that outlines the boundary of a spectator area within the regulated area defined by paragraph (a)(2) of this section.

(c) *Regulations.* (1) Everyone other than participants are prohibited from entering, transiting through, anchoring in, or getting underway within the regulated area described in the race area in paragraph (a)(1) of this section unless authorized by the COTP North Carolina or their designated representative.

(2) Everyone other than participants, including spectators, may be directed by a designated representative to the regulated area described in paragraph (a) of this section, where they must remain while the SLR in this section is being enforced unless otherwise authorized or directed by a designated representative.

(3) To seek permission to enter the regulated area, contact the COTP by calling the Sector North Carolina Command Center at 910–343–3882 or contact the COTP's designated representative on Marine band Radio, VHF–FM channel 16 (156.8 MHz). Those in the regulated area must comply with all lawful orders or directions given to them by the COTP or the designated representative.

(d) *Enforcement officials.* The U.S. Coast Guard may be assisted in the patrol and enforcement of the safety zone by Federal, State, and local agencies.

(e) *Enforcement.* The SLR in this section will be enforced from 10 a.m. through 4 p.m. on September 9, 2022, and those same hours on September 11, 2022.

Dated: August 30, 2022.

Matthew J. Baer,

Captain, U.S. Coast Guard, Captain of the Port North Carolina.

[FR Doc. 2022–19309 Filed 9–6–22; 8:45 am]

BILLING CODE 9110–04–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 117

[Docket No. USCG–2022–0298]

Drawbridge Operation Regulation; Pascagoula River, Pascagoula, MS

AGENCY: Coast Guard, Department of Homeland Security (DHS).

ACTION: Notification of temporary deviation from regulations; request for comments.

SUMMARY: The Coast Guard has issued a temporary deviation from how the CSX Transportation railroad drawbridge across the Pascagoula River, mile 1.5, Pascagoula, MS will be operated. The bridge will continue to open according to the drawbridge regulations but the bridge tender will operate this bridge from a remote location at the CSX railroad terminal in Mobile, Alabama. The Coast Guard is seeking comments from the public regarding these proposed changes.

DATES: This deviation is effective from 7 a.m. on September 7, 2022, until March 6, 2023.

Comments and relate material must reach the Coast Guard on or before November 7, 2022.

ADDRESSES: You may submit comments identified by docket number USCG–2022–0298 using Federal Decision Making Portal at *https://www.regulations.gov.*

See the ''Public Participation and Request for Comments'' portion of the **SUPPLEMENTARY INFORMATION** for instructions on submitting comments.

FOR FURTHER INFORMATION CONTACT: If you have questions on this test deviation, call or email Douglas Blakemore, Eighth Coast Guard District Bridge Administration Branch Chief at (504) 671–2128 or *Douglas.A.Blakemore@uscg.mil.*

SUPPLEMENTARY INFORMATION:

I. Background, Purpose and Legal Basis

The CSX Transportation railroad drawbridge crosses the Pascagoula River, mile 1.5, Pascagoula, MS. The bridge will continue to open according to the drawbridge regulations but the bridge tender will operate this bridge from a remote location at the CSX railroad terminal in Mobile, Alabama. This bridge has an eight foot vertical clearance at mean high water, an unlimited vertical clearance when in the open to vessel position and a 140′ horizontal clearance. The bridge operates according to 33 CFR 117.5.

CSX Transportation has requested to operate this bridge remotely from their railroad terminal in Mobile, AL. CSX has installed a remote operation system at the bridge and a remote control center, located in Mobile, AL. At the bridge, CSX has installed infrared cameras, closed circuit cameras and TVs, communication systems and information technology systems on the bridge that allow an operator from Mobile to monitor and control the bridge. This waterway is used primarily by recreational boats and small towing vessels and opens to vessels approximately 17 times per day.

The Coast Guard will evaluate the impact of this test on vessels by analyzing CSX bridge tender logs and public comments.

The Coast Guard will also inform the users of the waterways through our Local and Broadcast Notices to Mariners of the change in operating schedule for the bridge so that vessel operators can arrange their transits to minimize any impact caused by the test deviation.

The Coast Guard published a notice of proposed rulemaking under the same name and docket number as this test deviation at 87 FR 50276 (August 16, 2022). Both documents can be found at *https://www.regulations.gov* and comments can be made to either document. In accordance with 33 CFR 117.35(e), the drawbridge must return to its regular operating schedule immediately at the end of the effective period of this temporary deviation. This deviation from the operating regulations is authorized under 33 CFR 117.35.

II. Public Participation and Request for Comments

We view public participation as essential to effective rulemaking, and will consider all comments and material received during the comment period. Your comment can help shape the outcome of this rulemaking. If you submit a comment, please include the docket number for this rulemaking, indicate the specific section of this document to which each comment applies, and provide a reason for each suggestion or recommendation.

Submitting comments. We encourage you to submit comments through the Federal Decision Making Portal at *https://www.regulations.gov.* To do so, go to *https://www.regulations.gov,* type USCG–2022–0298 in the search box and click ''Search.'' Next, look for this document in the Search Results column, and click on it. Then click on the Comment option. If your material cannot be submitted using *https://www.regulations.gov,* contact the person in the **FOR FURTHER INFORMATION CONTACT** section of this document for alternate instructions.

View material in the docket. To view documents mentioned in this proposed rule as being available in the docket, find the docket as described in the previous paragraph, and then select ''Supporting & Related Material'' in the Document Type column. Public comments will also be placed in our online docket and can be viewed by following instructions on the *https://www.regulations.gov* Frequently Asked Questions web page. We review all comments received, but we will only post comments that address the topic of the proposed rule. We may choose not to post off-topic, inappropriate, or duplicate comments that we receive. Additionally, if you go to the online docket and sign up for email alerts, you will be notified when comments are posted or a final rule is published of any posting or updates to the docket.

We accept anonymous comments. Comments we post to *https://www.regulations.gov* will include any personal information you have provided. For more about privacy and submissions in response to this document, see DHS's eRulemaking System of Records notice (85 FR 14226, March 11, 2020).

Dated: August 16, 2022.

Douglas Blakemore,

Chief, Bridge Administration Branch, U.S. Coast Guard, Eighth Coast Guard District.

[FR Doc. 2022–19269 Filed 9–6–22; 8:45 am]

BILLING CODE 9110–04–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 117

[Docket No. USCG–2022–0299]

Drawbridge Operation Regulation; Bay St. Louis, Bay St. Louis, MS

AGENCY: Coast Guard, Department of Homeland Security (DHS).

ACTION: Notification of temporary deviation from regulations; request for comments.

SUMMARY: The Coast Guard has issued a temporary deviation from how the CSX Transportation railroad drawbridge across Bay St. Louis, mile 0.5, Bay St. Louis, MS will be operated. The bridge will continue to open according to the drawbridge regulations but the bridge tender will operate this bridge from a remote location at the CSX railroad terminal in Mobile, Alabama. The Coast Guard is seeking comments from the public regarding these proposed changes.

DATES: This deviation is effective from 7 a.m. on September 7, 2022, until March 6, 2023.

Comments and relate material must reach the Coast Guard on or before November 7, 2022.

ADDRESSES: You may submit comments identified by docket number USCG–2022–0299 using Federal Decision Making Portal at *https://www.regulations.gov.*

See the ''Public Participation and Request for Comments'' portion of the **SUPPLEMENTARY INFORMATION** for instructions on submitting comments.

FOR FURTHER INFORMATION CONTACT: If you have questions on this test deviation, call or email Douglas Blakemore, Eighth Coast Guard District Bridge Administration Branch Chief at (504) 671–2128 or *Douglas.A.Blakemore@uscg.mil.*

SUPPLEMENTARY INFORMATION:

I. Background, Purpose and Legal Basis

The CSX Transportation railroad drawbridge crosses the Bay St. Louis, mile 0.5, Bay St. Louis, MS. The bridge will continue to open according to the drawbridge regulations but the bridge tender will operate this bridge from a remote location at the CSX railroad terminal in Mobile, Alabama. This bridge has a 13 foot vertical clearance at mean high water, an unlimited vertical clearance when in the open to vessel position and a 100' horizontal clearance. The bridge operates according to 33 CFR 117.5.

CSX Transportation has requested to operate this bridge remotely from their railroad terminal in Mobile, AL. CSX has installed a remote operation system at the bridge and a remote control center, located in Mobile, AL. At the bridge, CSX has installed infrared cameras, closed circuit cameras and TVs, communication systems and information technology systems on the bridge that allow an operator from Mobile to monitor and control the bridge. This waterway is used primarily by recreational boats and small towing vessels and opens to vessels approximately 6 times per day.

The Coast Guard will evaluate the impact of this test on vessels by analyzing CSX bridge tender logs and public comments.

The Coast Guard will also inform the users of the waterways through our Local and Broadcast Notices to Mariners of the change in operating schedule for the bridge so that vessel operators can arrange their transits to minimize any impact caused by the test deviation.

The Coast Guard published a notice of proposed rulemaking under the same name and docket number as this test deviation at 87 FR 49793 (August 12, 2022). Both documents can be found at *https://www.regulations.gov* and comments can be made to either document. In accordance with 33 CFR 117.35(e), the drawbridge must return to its regular operating schedule immediately at the end of the effective period of this temporary deviation. This deviation from the operating regulations is authorized under 33 CFR 117.35.

II. Public Participation and Request for Comments

We view public participation as essential to effective rulemaking, and will consider all comments and material received during the comment period. Your comment can help shape the outcome of this rulemaking. If you submit a comment, please include the docket number for this rulemaking, indicate the specific section of this

document to which each comment applies, and provide a reason for each suggestion or recommendation.

Submitting comments. We encourage you to submit comments through the Federal Decision Making Portal at *https://www.regulations.gov.* To do so, go to *https://www.regulations.gov,* type USCG–2022–0299 in the search box and click ''Search.'' Next, look for this document in the Search Results column, and click on it. Then click on the Comment option. If your material cannot be submitted using *https://www.regulations.gov,* contact the person in the **FOR FURTHER INFORMATION CONTACT** section of this document for alternate instructions.

View material in the docket. To view documents mentioned in this proposed rule as being available in the docket, find the docket as described in the previous paragraph, and then select ''Supporting & Related Material'' in the Document Type column. Public comments will also be placed in our online docket and can be viewed by following instructions on the *https://www.regulations.gov* Frequently Asked Questions web page. We review all comments received, but we will only post comments that address the topic of the proposed rule. We may choose not to post off-topic, inappropriate, or duplicate comments that we receive. Additionally, if you go to the online docket and sign up for email alerts, you will be notified when comments are posted or a final rule is published of any posting or updates to the docket.

We accept anonymous comments. Comments we post to *https://www.regulations.gov* will include any personal information you have provided. For more about privacy and submissions in response to this document, see DHS's eRulemaking System of Records notice (85 FR 14226, March 11, 2020).

Dated: August 16, 2022.

Douglas Blakemore,

Chief, Bridge Administration Branch, U.S. Coast Guard, Eighth Coast Guard District.

[FR Doc. 2022–19270 Filed 9–6–22; 8:45 am]

BILLING CODE 9110–04–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 180

[EPA–HQ–OPP–2022–0390; FRL–10122–01–OCSPP]

Oxirane, 2-(phenoxymethyl)-, polymer with oxirane, monobutyl ether, block; Tolerance Exemption

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final rule.

SUMMARY: This regulation establishes an exemption from the requirement of a tolerance for residues of Oxirane, 2-(phenoxymethyl)-, polymer with oxirane, monobutyl ether, block, when used as an inert ingredient in a pesticide chemical formulation. Spring Regulatory Sciences (SRS) on behalf of Stepan Company (Stepan) submitted a petition to EPA under the Federal Food, Drug, and Cosmetic Act (FFDCA), requesting an exemption from the requirement of a tolerance. This regulation eliminates the need to establish a maximum permissible level for residues of Oxirane, 2-(phenoxymethyl)-, polymer with oxirane, monobutyl ether, block, on food or feed commodities.

DATES: This regulation is September 7, 2022. Objections and requests for hearings must be received on or before November 7, 2022, and must be filed in accordance with the instructions provided in 40 CFR part 178 (see also Unit I.C. of the **SUPPLEMENTARY INFORMATION**).

ADDRESSES: The docket for this action, identified by docket identification (ID) number EPA–HQ–OPP–2022–0390, is available at *https://www.regulations.gov* or at the Office of Pesticide Programs Regulatory Public Docket (OPP Docket) in the Environmental Protection Agency Docket Center (EPA/DC), West William Jefferson Clinton Bldg., Rm. 3334, 1301 Constitution Ave. NW, Washington, DC 20460–0001. The Public Reading Room is open from 8:30 a.m. to 4:30 p.m., Monday through Friday, excluding legal holidays. The telephone number for the Public Reading Room and the OPP Docket is (202) 566–1744. For the latest status information on EPA/DC services, docket access, visit *https://www.epa.gov/dockets.*

FOR FURTHER INFORMATION CONTACT: Marietta Echeverria, Registration Division (7505T), Office of Pesticide Programs, Environmental Protection Agency, 1200 Pennsylvania Ave. NW, Washington, DC 20460–0001; main telephone number: (202) 566–1030; email address: *RDFRNotices@epa.gov.*

SUPPLEMENTARY INFORMATION:

I. General Information

A. Does this action apply to me?

You may be potentially affected by this action if you are an agricultural producer, food manufacturer, or pesticide manufacturer. The following list of North American Industrial Classification System (NAICS) codes is not intended to be exhaustive, but rather provides a guide to help readers determine whether this document applies to them. Potentially affected entities may include:

- Crop production (NAICS code 111).
- Animal production (NAICS code 112).
- Food manufacturing (NAICS code 311).
- Pesticide manufacturing (NAICS code 32532).

B. How can I get electronic access to other related information?

You may access a frequently updated electronic version of 40 CFR part 180 through the Office of the Federal Register's e-CFR site at *https://www.ecfr.gov/current/title-40.*

C. Can I file an objection or hearing request?

Under FFDCA section 408(g), 21 U.S.C. 346a, any person may file an objection to any aspect of this regulation and may also request a hearing on those objections. You must file your objection or request a hearing on this regulation in accordance with the instructions provided in 40 CFR part 178. To ensure proper receipt by EPA, you must identify docket ID number EPA–HQ–OPP–2022–0390 in the subject line on the first page of your submission. All objections and requests for a hearing must be in writing and must be received by the Hearing Clerk on or before November 7, 2022. Addresses for mail and hand delivery of objections and hearing requests are provided in 40 CFR 178.25(b).

In addition to filing an objection or hearing request with the Hearing Clerk as described in 40 CFR part 178, please submit a copy of the filing (excluding any Confidential Business Information (CBI)) for inclusion in the public docket. Information not marked confidential pursuant to 40 CFR part 2 may be disclosed publicly by EPA without prior notice. Submit the non-CBI copy of your objection or hearing request, identified by docket ID number EPA–HQ–OPP–2022–0390, by one of the following methods.

• *Federal eRulemaking Portal: https://www.regulations.gov*. Follow the online instructions for submitting comments. Do not submit electronically any information you consider to be CBI or other information whose disclosure is restricted by statute.

• *Mail:* OPP Docket, Environmental Protection Agency Docket Center (EPA/DC), (28221T), 1200 Pennsylvania Ave. NW, Washington, DC 20460–0001.

• *Hand Delivery:* To make special arrangements for hand delivery or delivery of boxed information, please follow the instructions at *https://www.epa.gov/dockets/contacts.html*.

Additional instructions on commenting or visiting the docket, along with more information about dockets generally, is available at *https://www.epa.gov/dockets*.

II. Background and Statutory Findings

In the **Federal Register** of July 20, 2022 (87 FR 43232) (FRL–9410–03–OCSPP), EPA issued a document pursuant to FFDCA section 408, 21 U.S.C. 346a, announcing the receipt of a pesticide petition (PP IN–11645) filed by Spring Regulatory Sciences (SRS) on behalf of Stepan Company (Stepan), 22 W Frontage Rd., Northfield, IL 60093. The petition requested that 40 CFR 180.960 be amended by establishing an exemption from the requirement of a tolerance for residues of Oxirane, 2-(phenoxymethyl)-, polymer with oxirane, monobutyl ether, block; CAS Reg. No.1010819–15–4. That document included a summary of the petition prepared by the petitioner and solicited comments on the petitioner's request. The Agency did not receive any comments.

Section 408(c)(2)(A)(i) of FFDCA allows EPA to establish an exemption from the requirement for a tolerance (the legal limit for a pesticide chemical residue in or on a food) only if EPA determines that the exemption is ''safe.'' Section 408(c)(2)(A)(ii) of FFDCA defines ''safe'' to mean that ''there is a reasonable certainty that no harm will result from aggregate exposure to the pesticide chemical residue, including all anticipated dietary exposures and all other exposures for which there is reliable information.'' This includes exposure through drinking water and use in residential settings but does not include occupational exposure. Section 408(b)(2)(C) of FFDCA requires EPA to give special consideration to exposure of infants and children to the pesticide chemical residue in establishing an exemption from the requirement of a tolerance and to ''ensure that there is a reasonable certainty that no harm will result to infants and children from aggregate exposure to the pesticide chemical residue . . . '' and specifies factors EPA is to consider in establishing an exemption.

III. Risk Assessment and Statutory Findings

EPA establishes exemptions from the requirement of a tolerance only in those cases where it can be shown that the risks from aggregate exposure to pesticide chemical residues under reasonably foreseeable circumstances will pose no appreciable risks to human health. In order to determine the risks from aggregate exposure to pesticide inert ingredients, the Agency considers the toxicity of the inert in conjunction with possible exposure to residues of the inert ingredient through food, drinking water, and through other exposures that occur as a result of pesticide use in residential settings. If EPA is able to determine that a finite tolerance is not necessary to ensure that there is a reasonable certainty that no harm will result from aggregate exposure to the inert ingredient, an exemption from the requirement of a tolerance may be established.

Consistent with FFDCA section 408(b)(2)(D), EPA has reviewed the available scientific data and other relevant information in support of this action and considered its validity, completeness and reliability and the relationship of this information to human risk. EPA has also considered available information concerning the variability of the sensitivities of major identifiable subgroups of consumers, including infants and children. In the case of certain chemical substances that are defined as polymers, the Agency has established a set of criteria to identify categories of polymers expected to present minimal or no risk. The definition of a polymer is given in 40 CFR 723.250(b) and the exclusion criteria for identifying these low-risk polymers are described in 40 CFR 723.250(d). Oxirane, 2-(phenoxymethyl)-, polymer with oxirane, monobutyl ether, block, conforms to the definition of a polymer given in 40 CFR 723.250(b) and meets the following criteria that are used to identify low-risk polymers.

1. The polymer is not a cationic polymer nor is it reasonably anticipated to become a cationic polymer in a natural aquatic environment.

2. The polymer does contain as an integral part of its composition the atomic elements carbon, hydrogen, and oxygen.

3. The polymer does not contain as an integral part of its composition, except as impurities, any element other than those listed in 40 CFR 723.250(d)(2)(ii).

4. The polymer is neither designed nor can it be reasonably anticipated to substantially degrade, decompose, or depolymerize: An adequate biodegradation study (MRID 51712402) was submitted for Oxirane, 2-(phenoxymethyl)-, polymer with oxirane, monobutyl ether, block, showing lack of biodegradation.

5. The polymer is manufactured or imported from monomers and/or reactants that are already included on the Toxic Substances Control Act (TSCA) Chemical Substance Inventory or manufactured under an applicable TSCA section 5 exemption.

6. The polymer is not a water absorbing polymer with a number average molecular weight (MW) greater than or equal to 10,000 Daltons.

7. The polymer does not contain certain perfluoroalkyl moieties consisting of a CF3- or longer chain length as listed in 40 CFR 723.250(d)(6).

Additionally, the polymer also meets as required the following exemption criteria specified in 40 CFR 723.250(e).

The polymer's number average MW of 2300 is greater than 1,000 and less than 10,000 Daltons. The polymer contains less than 10% oligomeric material below MW 500 and less than 25% oligomeric material below MW 1,000, and the polymer does not contain any reactive functional groups.

Thus, Oxirane, 2-(phenoxymethyl)-, polymer with oxirane, monobutyl ether, block, meets the criteria for a polymer to be considered low risk under 40 CFR 723.250. Based on its conformance to the criteria in this unit, no mammalian toxicity is anticipated from dietary, inhalation, or dermal exposure to Oxirane, 2-(phenoxymethyl)-, polymer with oxirane, monobutyl ether, block.

IV. Aggregate Exposures

For the purposes of assessing potential exposure under this exemption, EPA considered that Oxirane, 2-(phenoxymethyl)-, polymer with oxirane, monobutyl ether, block, could be present in all raw and processed agricultural commodities and drinking water, and that non-occupational non-dietary exposure was possible. The number average MW of Oxirane, 2-(phenoxymethyl)-, polymer with oxirane, monobutyl ether, block, is 2300 Daltons. Generally, a polymer of this size would be poorly absorbed through the intact gastrointestinal tract or through intact human skin. Since Oxirane, 2-(phenoxymethyl)-, polymer with oxirane, monobutyl ether, block, conform to the criteria that identify a low-risk polymer, there are no concerns

for risks associated with any potential exposure scenarios that are reasonably foreseeable. The Agency has determined that a tolerance is not necessary to protect the public health.

V. Cumulative Effects From Substances With a Common Mechanism of Toxicity

Section 408(b)(2)(D)(v) of FFDCA requires that, when considering whether to establish, modify, or revoke a tolerance, the Agency consider ''available information'' concerning the cumulative effects of a particular pesticide's residues and ''other substances that have a common mechanism of toxicity.'' EPA has not found Oxirane, 2-(phenoxymethyl)-, polymer with oxirane, monobutyl ether, block, to share a common mechanism of toxicity with any other substances, and Oxirane, 2-(phenoxymethyl)-, polymer with oxirane, monobutyl ether, block, does not appear to produce a toxic metabolite produced by other substances. For the purposes of this tolerance action, therefore, EPA has assumed that Oxirane, 2-(phenoxymethyl)-, polymer with oxirane, monobutyl ether, block, does not have a common mechanism of toxicity with other substances. For information regarding EPA's efforts to determine which chemicals have a common mechanism of toxicity and to evaluate the cumulative effects of such chemicals, see EPA's website at *https://www.epa.gov/pesticides/cumulative*.

VI. Additional Safety Factor for the Protection of Infants and Children

Section 408(b)(2)(C) of FFDCA provides that EPA shall apply an additional tenfold margin of safety for infants and children in the case of threshold effects to account for prenatal and postnatal toxicity and the completeness of the data base unless EPA concludes that a different margin of safety will be safe for infants and children. Due to the expected low toxicity of Oxirane, 2-(phenoxymethyl)-, polymer with oxirane, monobutyl ether, block, EPA has not used a safety factor analysis to assess the risk. For the same reasons the additional tenfold safety factor is unnecessary.

VII. Determination of Safety

Based on the conformance to the criteria used to identify a low-risk polymer, EPA concludes that there is a reasonable certainty of no harm to the U.S. population, including infants and children, from aggregate exposure to residues of Oxirane, 2-(phenoxymethyl)-, polymer with oxirane, monobutyl ether, block.

VIII. Other Considerations

Analytical Enforcement Methodology

An analytical method is not required for enforcement purposes since the Agency is establishing an exemption from the requirement of a tolerance without any numerical limitation.

IX. Conclusion

Accordingly, EPA finds that exempting residues of Oxirane, 2-(phenoxymethyl)-, polymer with oxirane, monobutyl ether, block, from the requirement of a tolerance will be safe.

X. Statutory and Executive Order Reviews

This action establishes a tolerance under FFDCA section 408(d) in response to a petition submitted to the Agency. The Office of Management and Budget (OMB) has exempted these types of actions from review under Executive Order 12866, entitled ''Regulatory Planning and Review'' (58 FR 51735, October 4, 1993). Because this action has been exempted from review under Executive Order 12866, this action is not subject to Executive Order 13211, entitled ''Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution, or Use'' (66 FR 28355, May 22, 2001), or Executive Order 13045, entitled ''Protection of Children from Environmental Health Risks and Safety Risks'' (62 FR 19885, April 23, 1997). This action does not contain any information collections subject to OMB approval under the Paperwork Reduction Act (PRA) (44 U.S.C. 3501 *et seq.*), nor does it require any special considerations under Executive Order 12898, entitled ''Federal Actions to Address Environmental Justice in Minority Populations and Low-Income Populations'' (59 FR 7629, February 16, 1994).

Since tolerances and exemptions that are established on the basis of a petition under FFDCA section 408(d), such as the tolerance in this final rule, do not require the issuance of a proposed rule, the requirements of the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 *et seq.*), do not apply.

This action directly regulates growers, food processors, food handlers, and food retailers, not States or Tribes, nor does this action alter the relationships or distribution of power and responsibilities established by Congress in the preemption provisions of FFDCA section 408(n)(4). As such, the Agency has determined that this action will not have a substantial direct effect on States or Tribal Governments, on the relationship between the National Government and the States or Tribal Governments, or on the distribution of power and responsibilities among the various levels of government or between the Federal Government and Indian Tribes. Thus, the Agency has determined that Executive Order 13132, entitled ''Federalism'' (64 FR 43255, August 10, 1999), and Executive Order 13175, entitled ''Consultation and Coordination with Indian Tribal Governments'' (65 FR 67249, November 9, 2000), do not apply to this action. In addition, this action does not impose any enforceable duty or contain any unfunded mandate as described under Title II of the Unfunded Mandates Reform Act (UMRA) (2 U.S.C. 1501 *et seq.*).

This action does not involve any technical standards that would require Agency consideration of voluntary consensus standards pursuant to section 12(d) of the National Technology Transfer and Advancement Act (NTTAA) (15 U.S.C. 272 note).

XI. Congressional Review Act

Pursuant to the Congressional Review Act (5 U.S.C. 801 *et seq.*), EPA will submit a report containing this rule 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**. This action is not a ''major rule'' as defined by 5 U.S.C. 804(2).

List of Subjects in 40 CFR Part 180

Environmental protection, Administrative practice and procedure, Agricultural commodities, Pesticides and pests, Reporting and recordkeeping requirements.

Dated: September 1, 2022.

Marietta Echeverria,

Acting Director, Registration Division, Office of Pesticide Programs.

Therefore, for the reasons stated in the preamble, EPA is amending 40 CFR chapter I 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. In § 180.960, by adding, in alphabetical order, the polymer ''Oxirane, 2-(phenoxymethyl)-, polymer with oxirane, monobutyl ether, block, minimum number average molecular weight (in amu), 2300 Daltons'' to the table to read as follows:

§ 180.960 Polymers; exemptions from the requirement of a tolerance.

* * * * *

TABLE 1 TO § 180.960

Polymer	CAS No.
* * * * * * *	
Oxirane, 2-(phenoxymethyl)-, polymer with oxirane, monobutyl ether, block, minimum number average molecular weight (in amu), 2300 Daltons	CAS Reg. No. 1010819–15–4.
* * * * * * *	

[FR Doc. 2022–19295 Filed 9–6–22; 8:45 am]
BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 180

[EPA–HQ–OPP–2018–0520; FRL–10188–01–OCSPP]

Thymol; Exemption From the Requirement of a Tolerance

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final rule.

SUMMARY: This regulation establishes an exemption from the requirement of a tolerance for residues of thymol (5-methyl-2-isopropyl-1-phenol) in or on all food commodities when used in accordance with good agricultural practices. Sci Reg, Inc., on behalf of Eden Research PLC, 6 Priory Ct., Priory Court Business Park, Poulton, Cirencester, GL7 5JB, United Kingdom, submitted a petition to EPA under the Federal Food, Drug, and Cosmetic Act (FFDCA), requesting an exemption from the requirement of a tolerance. This regulation eliminates the need to establish a maximum permissible level for residues of thymol when used in accordance with this exemption.

DATES: This regulation is effective September 7, 2022. Objections and requests for hearings must be received on or before November 7, 2022, and must be filed in accordance with the instructions provided in 40 CFR part 178 (see also Unit I.C. of the **SUPPLEMENTARY INFORMATION**).

ADDRESSES: The docket for this action, identified by docket identification (ID) number EPA–HQ–OPP–2018–0520, is available at *https://www.regulations.gov* or at the Office of Pesticide Programs Regulatory Public Docket (OPP Docket) in the Environmental Protection Agency Docket Center (EPA/DC), West William Jefferson Clinton Bldg., Rm. 3334, 1301 Constitution Ave. NW, Washington, DC 20460–0001. The Public Reading Room is open from 8:30 a.m. to 4:30 p.m., Monday through Friday, excluding legal holidays. The telephone number for the Public Reading Room and the OPP Docket is (202) 566–1744. For the latest status information on EPA/DC services, docket access, visit *https://www.epa.gov/dockets.*

FOR FURTHER INFORMATION CONTACT: Charles Smith, Biopesticides and Pollution Prevention Division (7511P), Office of Pesticide Programs, Environmental Protection Agency, 1200 Pennsylvania Ave. NW, Washington, DC 20460–0001; main telephone number: (703) 305–7090; email address: *BPPDFRNotices@epa.gov.*

SUPPLEMENTARY INFORMATION:

I. General Information

A. Does this action apply to me?

You may be potentially affected by this action if you are an agricultural producer, food manufacturer, or pesticide manufacturer. The following list of North American Industrial Classification System (NAICS) codes is not intended to be exhaustive, but rather provides a guide to help readers determine whether this document applies to them. Potentially affected entities may include:

- Crop production (NAICS code 111).
- Animal production (NAICS code 112).
- Food manufacturing (NAICS code 311).
- Pesticide manufacturing (NAICS code 32532).

B. How can I get electronic access to other related information?

You may access a frequently updated electronic version of 40 CFR part 180 through the Office of the Federal Register's e-CFR site at *https://www.ecfr.gov/current/title-40.*

C. How can I file an objection or hearing request?

Under FFDCA section 408(g), 21 U.S.C. 346a(g), any person may file an objection to any aspect of this regulation and may also request a hearing on those objections. You must file your objection or request a hearing on this regulation in accordance with the instructions provided in 40 CFR part 178. To ensure proper receipt by EPA, you must identify docket ID number EPA–HQ–OPP–2018–0520 in the subject line on the first page of your submission. All objections and requests for a hearing must be in writing and must be received by the Hearing Clerk on or before November 7, 2022. Addresses for mail and hand delivery of objections and hearing requests are provided in 40 CFR 178.25(b).

In addition to filing an objection or hearing request with the Hearing Clerk as described in 40 CFR part 178, please submit a copy of the filing (excluding any Confidential Business Information (CBI)) for inclusion in the public docket. Information not marked confidential pursuant to 40 CFR part 2 may be disclosed publicly by EPA without prior notice. Submit the non-CBI copy of your objection or hearing request, identified by docket ID number EPA–HQ–OPP–2018–0520 by one of the following methods:

- *Federal eRulemaking Portal: https://www.regulations.gov.* Follow the online instructions for submitting comments. Do not submit electronically any information you consider to be CBI or other information whose disclosure is restricted by statute.
- *Mail:* OPP Docket, Environmental Protection Agency Docket Center (EPA/DC), (28221T), 1200 Pennsylvania Ave. NW, Washington, DC 20460–0001.
- *Hand Delivery:* To make special arrangements for hand delivery or delivery of boxed information, please follow the instructions at *https://www.epa.gov/dockets.*

Additional instructions on commenting or visiting the docket, along with more information about dockets generally, is available at *https://www.epa.gov/dockets.*

II. Background and Statutory Findings

In the **Federal Register** of August 24, 2018 (83 FR 42818) (FRL–9982–37), EPA issued a document pursuant to FFDCA section 408(d)(3), 21 U.S.C. 346a(d)(3), announcing the filing of a pesticide tolerance petition (PP 8F8680) by Eden Research PLC, 6 Priory Ct., Priory Court Business Park, Poulton, Cirencester, GL7 5JB, United Kingdom (c/o SciReg, Inc., 12733 Director's Loop, Woodbridge, VA 22192). The petition requested that 40 CFR part 180 be amended by establishing an exemption from the requirement of a tolerance for residues of thymol (5-methyl-2-isopropyl-1-phenol) in or on raw agricultural commodities and processed foods when used in accordance with good agricultural practices. That document referenced a summary of the petition prepared by the petitioner Eden Research plc, c/o SciReg, Inc., which is available in the docket, *https://www.regulations.gov.* There were no substantive comments received in response to the notice of filing.

III. Aggregate Risk Assessment and Determination of Safety

Section 408(c)(2)(A)(i) of FFDCA allows EPA to establish an exemption from the requirement for a tolerance (the legal limit for a pesticide chemical residue in or on a food) only if EPA determines that the exemption is ''safe.'' Section 408(c)(2)(A)(ii) of FFDCA defines ''safe'' to mean that ''there is a reasonable certainty that no harm will result from aggregate exposure to the pesticide chemical residue, including all anticipated dietary exposures and all other exposures for which there is reliable information.'' This includes exposure through drinking water and in residential settings but does not include occupational exposure. Pursuant to FFDCA section 408(c)(2)(B), in establishing or maintaining in effect an exemption from the requirement of a tolerance, EPA must take into account the factors set forth in FFDCA section 408(b)(2)(C), which require EPA to give special consideration to exposure of infants and children to the pesticide chemical residue in establishing a tolerance and to ''ensure that there is a reasonable certainty that no harm will result to infants and children from aggregate exposure to the pesticide chemical residue. . . . '' Additionally, FFDCA section 408(b)(2)(D) requires that the Agency consider ''available information concerning the cumulative effects of a particular pesticide's residues'' and ''other substances that have a common mechanism of toxicity.''

EPA establishes exemptions from the requirement of a tolerance only in those cases where it can be clearly demonstrated that the risks from aggregate exposure to pesticide chemical residues under reasonably foreseeable circumstances will pose no harm to human health. If EPA is able to determine that a tolerance is not necessary to ensure that there is a reasonable certainty that no harm will result from aggregate exposure to the pesticide chemical residue, an exemption from the requirement of a tolerance may be established.

Consistent with FFDCA section 408(c)(2)(A), and the factors specified in FFDCA section 408(c)(2)(B), EPA has reviewed the available scientific data and other relevant information in support of this action. EPA has sufficient data to assess the hazards of and to make a determination on aggregate exposure for thymol including exposure resulting from the exemption established by this action. EPA's assessment of exposures and risks associated with thymol follows.

IV. Toxicological Profile

Thymol is a constituent of oil of thyme, a naturally occurring mixture of compounds in the plant, *Thymus vulgaris.* Thymol has long been a regular part of the human diet and is listed as an approved food additive by FDA (21 CFR 172.515). Thymol has a long history of safe use as a direct food additive. Additionally, the source plant (thyme), from which thymol is extracted, is acknowledged by FDA as generally recognized as safe (GRAS) (21 CFR 182.10 and 182.20).

In conducting its hazard assessment for thymol, EPA relied on data from the open scientific literature which includes a combined repeated dose oral toxicity study with the reproduction/developmental toxicity screening test, genotoxicity studies, and a 6-month inhalation study. In these data, no adverse effects were seen at the highest dose tested of 200 mg/kg/day. For guideline studies, EPA generally recommends testing at a limit dose of 1000 mg/kg/day. However, based on the data reviewed from the open literature along with a body of knowledge regarding thymol such as its low toxicity; rapid degradation into the environment; and natural occurrence and widespread use in foods that are commonly consumed and a part of the human diet, EPA would not expect to see adverse effects at higher doses.

Regarding the overall acute toxicological profile of thymol, the active ingredient is of minimal toxicity. Thymol is of low acute oral toxicity (Toxicity Category III), inhalation toxicity (Toxicity Category IV) and dermal toxicity (Toxicity Category III). It is corrosive to the skin and eye (Toxicity Category I) and may or may not be a dermal sensitizer (inconclusive).

With regard to subchronic oral, dermal and inhalation toxicity, EPA granted waivers for these data requirements based on a weight of the evidence approach (WOE). Specific to the 90-day oral toxicity, as stated in section IV. of this document, thymol has a documented and long history of use as a direct food additive as a flavoring agent and preservative. Moreover, thymol is commonly consumed as it is used in ice cream, non-alcoholic beverages, candy, baked goods, chewing gum, lime blossom honey and pesto sauce. In a thymol report from the European Medicines Evaluation Agency, the Committee of Experts on Flavoring Substances of the Council of Europe established an upper limit of 50 mg/kg in food and 10 mg/kg in beverages.

Regarding the 90-day dermal toxicity, thymol is a constituent of oil of thyme, a naturally occurring mixture in the plant *Thymus vulgaris* (thyme). It is currently used in cosmetics and human medicine. For example, oil of thyme and thymol have been proposed for use as a skin penetration enhancer for transdermal drug delivery. In addition, all dermal margins of exposure (MOEs) were well above the Agency's Level of Concern (LOC) of 100. MOE's for occupational handler exposure range from 980 to 22,000.

In terms of the 90 day-inhalation toxicity, thymol has low inhalation toxicity. In human medicine, it is administered via inhalation to treat a range of infections in the upper respiratory tract and is added to the anesthetic halothane as a preservative and is inhaled by patients undergoing surgery. Furthermore, the MOEs calculated using a POD of 200 mg/kg/day were significantly above 10X the LOC of 100 for inhalation exposure scenarios, ranging from 370,000 to 8,000,000.

EPA granted a waiver for the developmental data requirement due to thymol's long history of exposure to the human population without apparent toxic effects. It has long been a part of the human diet and is recognized as a GRAS essential oil by FDA (21 CFR 182.20). Furthermore, in a reproductive safety assessment, no adverse effects were seen up to a dose of 1,875 mg/kg, the highest dose tested.

In terms of mutagenicity, the active ingredient was determined to be non-mutagenic, and no adverse effects were identified relative to either

developmental toxicity or reproductive toxicity.

In conclusion, there were no adverse subchronic effects for any oral, dermal, inhalation, or developmental routes of exposure and as stated previously, EPA has granted a waiver of these data requirements based on a WOE approach for the subchronic toxicity testing considering all the available thymol hazard and exposure data. This WOE approach includes the following rationale:

1. Exposure from all routes and in all scenarios of thymol is considered to be negligible due to the following reasons: (a) Thymol is moderately volatile with a vapor pressure of 3.4 Pa @25oC; volatilization from both moist and dry soil surfaces is expected due to thymol's Henry's Law Constant of 4.44 × 10-3 atm/m3/mol and vapor pressure; thymol is expected to exist solely as a vapor in the ambient atmosphere, which would be readily degraded in the atmosphere by reaction with photochemically-produced hydroxyl radicals; the half-life for this reaction in the air is estimated to be 3.6 hours; (b) In a batch system using an activated sludge inoculum, thymol was found to be 94.8% readily biodegradable with a degradation rate of 15.6 mg COD/g-hr.

2. Thymol is naturally occurring and has long been part of the normal human diet. It is currently FDA-approved for use as a synthetic flavoring (21 CFR 172.515), a preservative, a direct food additive, and an indirect food additive in adhesives (21 CFR 175.105).

3. Thymol demonstrates low toxicity throughout its toxicity database. No adverse effects were observed to highest dose tested (200 mg/kg/day) in thymol's toxicity database. The database includes a combined repeated dose oral toxicity study with the reproduction/developmental toxicity screening test, several genotoxicity studies, and a 6-month inhalation study. Data from the open literature indicates that thymol is rapidly metabolized as well as rapidly excreted. Thus, high levels of thymol would likely not be found present in the body after 24 hours, with the majority of thymol and related metabolites being eliminated through the urine after 6 hours.

4. Pesticidal use of thymol is unlikely to contribute significantly to overall human exposure for the following reasons: (a) Thymol is naturally-occuring, and thus humans have had a long history of exposure to it. (b) It is FDA-approved for use as direct food additive. (c) Thymol is currently used in foods, cosmetics, and human medicine. (d) Dietary exposure is expected to be low based on thymol's physical/chemical properties (readily biodegradable, non-persistent). (e) Limited thymol residue data is available on honey, however extrapolating from this information, thymol residues on grapevine and other food crops would not be significantly greater and therefore not contribute significantly to the overall dietary exposure of thymol.

A. Toxicological Points of Departure/Levels of Concern

Based on the toxicological profile, EPA did not identify any toxicological endpoints of concern for assessing risk for this chemical.

B. Exposure Assessment

1. *Dietary exposure from food, feed uses, and drinking water.* Thymol naturally occurs in foods, is widely used as a food additive, and is consumed by humans through the diet. As part of its qualitative risk assessment for thymol, the Agency considered the potential for any additional dietary exposure to residues of thymol from its proposed use as a fungicide and nematicide on agricultural use sites. EPA concludes that such dietary (food and drinking water) exposures are likely to be negligible, due to the short half-life and biodegradable nature of thymol. A quantitative dietary exposure assessment was not conducted since a toxicological endpoint for risk assessment was not identified.

2. *Residential exposure.* The term ''residential exposure'' is used in this document to refer to non-occupational, non-dietary exposure. Currently, thymol is not registered for any pesticidal uses that would result in residential exposure. Residential exposure may occur from non-pesticidal uses such as essential oils, household cleaning products, and mouthwash. However, a quantitative residential exposure assessment was not conducted since a toxicological endpoint for risk assessment was not identified.

3. *Cumulative effects from substances with a common mechanism of toxicity.* Section 408(b)(2)(D)(v) of FFDCA requires that, when considering whether to establish a tolerance exemption, the Agency consider ''available information'' concerning the cumulative effects of a particular pesticide's residues and ''other substances that have a common mechanism of toxicity.'' EPA has not found that thymol shares a common mechanism of toxicity with any other substances, and thymol does not appear to produce a toxic metabolite produced by other substances. For the purposes of this tolerance action, therefore, EPA has assumed thymol does not have a common mechanism of toxicity with other substances. For information regarding EPA's efforts to determine which chemicals have a common mechanism of toxicity and to evaluate the cumulative effects of such chemicals, see EPA's website at *https://www.epa.gov/pesticide-science-and-assessing-pesticide-risks/cumulative-assessment-risk-pesticides.*

C. Safety Factor for Infants and Children

FFDCA Section 408(b)(2)(C) provides that EPA shall retain an additional tenfold (10X) margin of safety for infants and children in the case of threshold effects to account for prenatal and postnatal toxicity and the completeness of the database on toxicity and exposure unless EPA determines based on reliable data that a different margin of safety will be safe for infants and children. This additional margin of safety is commonly referred to as the Food Quality Protection Act (FQPA) safety factor. In applying this provision, EPA either retains the default value of 10X, or uses a different additional safety factor when reliable data available to EPA support the choice of a different factor. EPA has determined that a qualitative risk assessment rather than a quantitative risk assessment would be most appropriate for the proposed use based on the toxicity profile of this active ingredient along with a long history of human exposure of thymol. For this reason, a FQPA safety factor is not required at this time.

D. Aggregate Risks

Based on the available data and information, EPA has concluded that a qualitative aggregate risk assessment is appropriate to support this action, and that risks of concern are not anticipated from aggregate exposure to thymol. This conclusion is based on the minimal toxicity of thymol, long history of human exposure to thymol, and expected rapid degradation of thymol in the environment. A full explanation of the data upon which EPA relied and its risk assessment based on those data can be found in the December 15, 2021, document entitled ''Risk Assessment for FIFRA Section 3 Registrations of Thymol Technical, containing 99.34%% Thymol as its Active Ingredient, Mevalone, containing 6.42% Thymol, as an Active Ingredient, and Cedroz, Containing 11.9% Thymol as its Active Ingredient. Tolerance Exemption Petition for Thymol''. This document, as well as other relevant information, is available in the docket for this action as described under **ADDRESSES**.

V. Determination of Safety for U.S. Population, Infants and Children

Based on the Agency's assessment, EPA concludes that there is reasonable certainty that no harm will result to the U.S. population, including infants and children, from aggregate exposure to residues of thymol. Therefore, the establishment of an exemption from the requirement of a tolerance for residues of thymol (5-methyl-2-isopropyl-1-phenol) in or on all food commodities when used in accordance with good agricultural practices is safe under FFDCA section 408.

VI. Other Considerations

Analytical Enforcement Methodology

An analytical method is not required for enforcement purposes since the Agency is establishing an exemption from the requirement of a tolerance without any numerical limitation.

VII. Conclusion

Therefore, an exemption from the requirement of a tolerance is established for residues of thymol (5-methyl-2-isopropyl-1-phenol) in or on all food commodities when used in accordance with good agricultural practices.

In addition, as a housekeeping measure, EPA is removing time-limited exemptions from the requirement of a tolerance for residues of thymol on honey and honeycomb in connection with use of the pesticide under section 18 emergency exemptions granted by the EPA. These exemptions expired on June 30, 2007.

VIII. Statutory and Executive Order Reviews

This action establishes an exemption from the requirement of a tolerance under FFDCA section 408(d) in response to a petition submitted to the Agency. The Office of Management and Budget (OMB) has exempted these types of actions from review under Executive Order 12866, entitled ''Regulatory Planning and Review'' (58 FR 51735, October 4, 1993). Because this action has been exempted from review under Executive Order 12866, this action is not subject to Executive Order 13211, entitled ''Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution, or Use'' (66 FR 28355, May 22, 2001), or Executive Order 13045, entitled ''Protection of Children from Environmental Health Risks and Safety Risks'' (62 FR 19885, April 23, 1997). This action does not contain any information collections subject to OMB approval under the Paperwork Reduction Act (PRA), 44 U.S.C. 3501 *et seq.,* nor does it require any special considerations under Executive Order 12898, entitled ''Federal Actions to Address Environmental Justice in Minority Populations and Low-Income Populations'' (59 FR 7629, February 16, 1994).

Since tolerances and exemptions that are established on the basis of a petition under FFDCA section 408(d), such as the tolerance exemption in this final rule, do not require the issuance of a proposed rule, the requirements of the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 *et seq.*), do not apply. This action directly regulates growers, food processors, food handlers, and food retailers, not States or Tribes, nor does this action alter the relationships or distribution of power and responsibilities established by Congress in the preemption provisions of FFDCA section 408(n)(4). As such, the Agency has determined that this action will not have a substantial direct effect on States or Tribal Governments, on the relationship between the National Government and the States or Tribal Governments, or on the distribution of power and responsibilities among the various levels of government or between the Federal Government and Indian Tribes. Thus, the Agency has determined that Executive Order 13132, entitled ''Federalism'' (64 FR 43255, August 10, 1999), and Executive Order 13175, entitled ''Consultation and Coordination with Indian Tribal Governments'' (65 FR 67249, November 9, 2000), do not apply to this action. In addition, this action does not impose any enforceable duty or contain any unfunded mandate as described under Title II of the Unfunded Mandates Reform Act (UMRA) (2 U.S.C. 1501 *et seq.*).

This action does not involve any technical standards that would require Agency consideration of voluntary consensus standards pursuant to section 12(d) of the National Technology Transfer and Advancement Act (NTTAA) (15 U.S.C. 272 note).

IX. Congressional Review Act

Pursuant to the Congressional Review Act (5 U.S.C. 801 *et seq.*), EPA will submit a report containing this rule 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**. This action is not a ''major rule'' as defined by 5 U.S.C. 804(2).

List of Subjects in 40 CFR Part 180

Environmental protection, Administrative practice and procedure, Agricultural commodities, Pesticides and pests, Reporting and recordkeeping requirements.

Dated: September 1, 2022.

Charles Smith,

Director, Biopesticides and Pollution Prevention Division, Office of Pesticide Programs.

Therefore, for the reasons stated in the preamble, EPA is amending 40 CFR chapter I 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. Amend § 180.1240 by revising paragraph (a) to read as follows:

§ 180.1240 Thymol; exemption from the requirement of a tolerance.

(a) An exemption from the requirement of a tolerance is established for thymol (5-methyl-2-isopropyl-1-phenol) in or on all food commodities when used in accordance with good agricultural practices.

* * * * *

[FR Doc. 2022–19294 Filed 9–6–22; 8:45 am]

BILLING CODE 6560–50–P

CORPORATION FOR NATIONAL AND COMMUNITY SERVICE

45 CFR Part 2502

RIN 3045–AA77

Employee Indemnification Regulations

AGENCY: Corporation for National and Community Service.

ACTION: Final rule.

SUMMARY: The Corporation for National and Community Service (operating as AmeriCorps), is finalizing regulations to indemnify AmeriCorps employees who, because of conduct taken within the scope of employment with AmeriCorps, have a verdict, judgment, monetary award, or personal damages claim issued against them that is not otherwise covered by the Federal Tort Claims Act. These regulations set out how AmeriCorps employees may request indemnification or settlement of a claim and the circumstances in which AmeriCorps may approve indemnification or settlement of a claim.

DATES: Effective November 7, 2022.

FOR FURTHER INFORMATION CONTACT: Kiara Rhodes, Associate General

Counsel, Corporation for National and Community Service, 250 E Street SW, Washington, DC 20525, *PublicComments@cns.gov,* 202–606–6709.

SUPPLEMENTARY INFORMATION:

I. Background

This rule addresses indemnification of AmeriCorps employees in circumstances not covered by the Federal Employee Liability Reform and Tort Compensation Act of 1988 (FELRTCA), 28 U.S.C. 2679(b)(1), or the Federal Tort Claims Act (FTCA), 28 U.S.C. 1346(b). FELRTCA provides that, with certain exceptions, the FTCA is the exclusive remedy for injuries caused by a Federal employee acting in the scope of employment, such that the United States must be substituted as the defendant and the claim must proceed against the Government under the FTCA. *See* 28 U.S.C. 2679(b)(1). The exceptions, for which substitution is not available, are claims brought for a violation of the Constitution and claims authorized by and brought for a violation of a Federal statute. *See* 28 U.S.C. 2679(b)(2). In these claims, the individual is sued in their personal capacity. For instance, lawsuits against Federal employees in their personal capacities for alleged constitutional violations are available under certain circumstances since the Supreme Court's decision in *Bivens* v. *Six Unknown Named Agents of the Federal Bureau of Narcotics,* 403 U.S. 388 (1971). The *Bivens* decision was the first time that the Supreme Court recognized an implied cause of action directly under the Constitution for personal-capacity claims for alleged constitutional violations. In rare circumstances, even a State or common law claim might be brought against a Federal employee for whom the United States has formally substituted itself, but for which a court rejected substitution, and in these cases too, the individual could be liable in their personal capacity.

AmeriCorps believes that actions against its employees in their personal capacities and the potential for a judgment against agency employees may hinder the agency's effectiveness in meeting its mission. AmeriCorps employees' ability to carry out functions related to volunteer management and grant-making depends on the willingness of the employees to make decisions and take actions that may expose them to liability. Uncertainty regarding the potential for a personal liability claim resulting in monetary judgment may intimidate employees, stifle creativity and initiative, and limit decisive action. The threat of personal liability for a decision made or action taken as part of official duties can adversely affect AmeriCorps' achievement of its mission. The adoption of these regulations permitting indemnification would afford AmeriCorps employees the same protection given to Federal employees in several other government agencies, including the Federal Trade Commission, Agency for International Development, Commodity Futures Trading Commission, Department of Commerce, Department of Education, Department of Health and Human Services, Department of the Interior, and the Department of Justice.

This final rule would address these situations when an AmeriCorps employee is sued in their personal capacity for conduct performed in the scope of their employment, by providing the process for AmeriCorps employees to request indemnification or settlement of a claim and the circumstances in which AmeriCorps may approve indemnification or settlement of a claim.

II. Development of This Rule

AmeriCorps proposed this rule on May 26, 2022. *See* 87 FR 31967. AmeriCorps received one comment during the public comment period. First, the commenter stated that the rule would create a lack of access to justice.

Response: The rule has no effect on any person's access to justice. Nothing in the rule would prevent or deter an individual from raising a claim against a current or former AmeriCorps employee or from obtaining a judgment against them.

The commenter also stated that a focus should be on preventing employees from overstepping their bounds rather than indemnifying them, and that the rule would embolden federal employees in committing injustices because they will be indemnified and undermine public trust.

Response: The rule does not provide employees with the ability or authority to act illegally or outside the scope of their employment. Federal employees face a number of consequences, including but not limited to termination and other legal action, that prevent them from ''overstepping their bounds'' and committing injustices. Neither does the rule guarantee indemnification of employees; rather, it establishes a process for employees and former employees to seek indemnification for claims against them personally for conduct giving rise to the claims that was taken within the scope of their employment with AmeriCorps. The ultimate decision as to whether indemnification is appropriate is left to the AmeriCorps Chief Executive Officer.

Finally, the commenter states that the rule is extremely broad in that it would indemnify former employees and allow AmeriCorps to decide whether to indemnify in its sole discretion.

Inclusion of former AmeriCorps employees in the rule is necessary because a lawsuit may be brought against an individual related to actions conducted in the scope of their employment with AmeriCorps, even though AmeriCorps may no longer employ that individual. The final rule therefore continues to include former employees in its scope. The final rule also includes the provision stating that AmeriCorps will decide in its sole discretion whether to indemnify an individual. This provision is not overly broad because it includes criteria upon which AmeriCorps will base this decision (namely, that the AmeriCorps employee's conduct giving rise to the verdict, judgment, monetary award, or claim was taken within the scope of their employment; that the indemnification or settlement is in AmeriCorps' best interest; and that appropriated funds are available for the indemnification or settlement). *See* § 2502.40. It is appropriate for AmeriCorps' determination as to whether these criteria are met to be within AmeriCorps' sole discretion because determination of whether the indemnification is in the agency's best interest is subjective and therefore necessarily non-reviewable.

AmeriCorps did not make any edits to the proposed rule as a result of the comment.

III. Scope and Summary of the Final Rule

The rule would allow AmeriCorps to indemnify a present or former AmeriCorps employee who is personally named as a defendant in a legal proceeding for conduct arising within the scope of their employment when the FTCA does not apply because (1) the claim alleges the conduct is a violation of the Constitution; or (2) the claim alleges a violation of a Federal statute that authorizes the claim; or (3) the claim is brought under State or common law against a Federal employee for whom the United States has formally substituted itself, but for which a court rejected substitution. The regulations would permit AmeriCorps to indemnify an Agency employee who suffers an adverse verdict, judgment, or other monetary award, provided that the

actions giving rise to the judgment were taken within the scope of employment, and that AmeriCorps determines that the indemnification is in its interest. The regulations would also allow AmeriCorps to settle a claim brought against an employee in their individual capacity by the payment of funds, upon a similar determination. Generally, AmeriCorps will not entertain a request to indemnify a personal damage claim against an employee before entry of an adverse verdict, judgment, or monetary award. However, in certain cases, AmeriCorps may determine that exceptional circumstances justify the earlier indemnification or payment of a settlement amount. The rule would provide procedures for present or former AmeriCorps employees to follow if they are personally named in these types of lawsuits and wish to be indemnified, and also would provide procedures for AmeriCorps' review of requests for indemnification.

IV. Regulatory Analyses

A. Executive Orders 12866 and 13563

Executive Orders (E.O.s) 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). E.O. 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility. The Office of Information and Regulatory Affairs in the Office of Management and Budget has determined that this is not a significant regulatory action.

B. Congressional Review Act (Small Business Regulatory Enforcement Fairness Act of 1996, Title II, Subtitle E)

As required by the Congressional Review Act (5 U.S.C. 801–808) before an interim or final rule takes effect, AmeriCorps will submit for an interim or final rule a report to each chamber of the Congress and to the Comptroller General of the United States. A major rule cannot take effect until 60 days after it is published in the **Federal Register**. The Office of Information and Regulatory Affairs in the Office of Management and Budget anticipates that this will not be a major rule under 5 U.S.C. 804 because this rule will not result in (1) an annual effect on the economy of $100 million or more; (2) a major increase in costs or prices for consumers, individual industries, Federal, state, or local government agencies, or geographic regions; or (3) significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic and export markets.

C. Regulatory Flexibility Act

As required by the Regulatory Flexibility Act of 1980 (5 U.S.C. 601 *et seq.*), AmeriCorps certifies that this rule will not have a significant economic impact on a substantial number of small entities. Therefore, AmeriCorps has not performed the initial regulatory flexibility analysis that is required under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*) for rules that are expected to have such results.

D. Unfunded Mandates Reform Act of 1995

For purposes of Title II of the Unfunded Mandates Reform Act of 1995, 2 U.S.C. 1531–1538, as well as Executive Order 12875, this regulatory action does not contain any Federal mandate that may result in increased expenditures in either Federal, State, local, or Tribal governments in the aggregate, or impose an annual burden exceeding $100 million on the private sector.

E. Paperwork Reduction Act (PRA)

Under the PRA, an agency may not conduct or sponsor a collection of information unless the collections of information display valid control numbers. This rule does not contain information collection requirements within the meaning of the Paperwork Reduction Act, 44 U.S.C. 3501–3520.

F. Executive Order 13132, Federalism

Executive Order 13132, Federalism, prohibits an agency from publishing any rule that has federalism implications if the rule imposes substantial direct compliance costs on State and local governments and is not required by statute, or the rule preempts State law, unless the agency meets the consultation and funding requirements of section 6 of the Executive order. This rule does not have any federalism implications, as described above.

G. Takings (E.O. 12630)

This rule does not affect a taking of private property or otherwise have taking implications under Executive Order 12630 because this rule does not affect individual property rights protected by the Fifth Amendment or involve a compensable ''taking.'' A takings implication assessment is not required.

H. Civil Justice Reform (E.O. 12988)

This rule complies with the requirements of Executive Order 12988. Specifically, this rule: (a) meets the criteria of section 3(a) requiring that all regulations be reviewed to eliminate errors and ambiguity and be written to minimize litigation; and (b) meets the criteria of section 3(b)(2) requiring that all regulations be written in clear language and contain clear legal standards.

I. Consultation With Indian Tribes (E.O. 13175)

AmeriCorps recognizes the inherent sovereignty of Indian Tribes and their right to self-governance. We have evaluated this rule under the AmeriCorps consultation policy and the criteria in E.O. 13175 and determined that this rule does not impose substantial direct effects on federally recognized Tribes.

List of Subjects in 45 CFR Part 2502

Administrative practice and procedure, Government employees, Indemnity payments.

For the reasons discussed in the preamble, under the authority of 42 U.S.C. 12651c(c), the Corporation for National and Community Service amends chapter XXV of title 45 of the Code of Federal Regulations by adding part 2502 to read as follows:

PART 2502—EMPLOYEE INDEMNIFICATION REGULATIONS

Sec.

Authority: 28 U.S.C. 2679(b)(1); 42 U.S.C. 12651c(c).

§ 2502.10 Purpose.

The purpose of this part is to provide the procedures for indemnification of

AmeriCorps employees who are personally named in certain legal proceedings not covered by the Federal Tort Claims Act (FTCA) or the Federal Employee Liability Reform and Tort Compensation Act (FELRTCA) when AmeriCorps determines both that the actions arose within the scope of their AmeriCorps employment and that indemnification is in the agency's interest. These determinations are matters of agency discretion.

§ 2502.20 Applicability.

(a) This part is applicable to all former and current AmeriCorps employees, including special Government employees.

(b) This part does not apply to volunteers, service members, contractors, or any other individuals who may be affiliated with AmeriCorps, but not employed by the agency.

§ 2502.30 Definitions.

AmeriCorps means the Corporation for National and Community Service.

AmeriCorps employee means a current or former employee of the Corporation for National and Community Service, regardless of whether the individual was an employee before the Corporation for National and Community Service began operating under the name AmeriCorps.

CEO means the AmeriCorps Chief Executive Officer or their designee.

Covered claim means a claim seeking damages against an employee personally (or against their estate) for personal injury, death, or loss of property, resulting from the employee's activities, when AmeriCorps determines both that the actions arose within the scope of their office or employment but are not covered by the Federal Tort Claims Act (FTCA) or the Federal Employee Liability Reform and Tort Compensation Act (FELRTCA).

General Counsel means the AmeriCorps General Counsel or their designee.

§ 2502.40 Under what circumstances may AmeriCorps indemnify employees?

AmeriCorps may, at its sole discretion, indemnify an AmeriCorps employee for a verdict, judgment, or other monetary award rendered against the employee personally in a claim or may settle or compromise a personal damages claim against an AmeriCorps employee if:

(a) The CEO determines that the AmeriCorps employee's conduct giving rise to the verdict, judgment, monetary award, or claim was taken within the scope of their employment;

(b) The CEO determines that the indemnification or settlement is in AmeriCorps' best interest; and

(c) AmeriCorps appropriated funds are available for the indemnification or settlement.

§ 2502.50 At what point in a legal proceeding will AmeriCorps consider a request to indemnify the employee?

(a) AmeriCorps may settle or compromise a claim against an AmeriCorps employee at any time.

(b) Unless there are exceptional circumstances, as determined by the CEO, AmeriCorps will not consider a request to indemnify a claim before entry of an adverse verdict, judgment, or award.

§ 2502.60 What types of legal proceedings may an AmeriCorps employee seek indemnification or settlement for?

An AmeriCorps employee may seek indemnification or settlement in any civil action or proceeding brought, in any court, for a covered claim.

§ 2502.70 What must an AmeriCorps employee do if served with process or pleadings that includes a covered claim?

An AmeriCorps employee who is named as a defendant (or the personal representative of the AmeriCorps employee's estate) in a legal proceeding that includes a covered claim and who wishes to seek indemnification must promptly notify their supervisor, who then promptly notifies the Office of General Counsel. Former employees must directly notify the Office of General Counsel.

§ 2502.80 What may the General Counsel do upon receipt of the process and pleadings and report of circumstances?

Where appropriate, the General Counsel may request that the Department of Justice provide legal representation for the AmeriCorps employee.

§ 2502.90 How may an AmeriCorps employee request indemnification?

To request indemnification for a verdict, judgment, award, or settlement proposal of a covered claim, the AmeriCorps employee must:

(a) Have complied with the requirements of § 2502.70.

(b) Submit a written request, via their supervisor, to the head of the employee's office, or (in the case a former employee) directly to the Office of General Counsel. The written request must include appropriate documentation, including copies of the verdict, judgment, award, or settlement proposal.

§ 2502.100 How will AmeriCorps handle the request for indemnification?

(a) The head of the office or their designee will review the employee's request and submit all of the following to the General Counsel:

(1) The original or a copy of the employee's request.

(2) A recommendation to approve or deny the request.

(3) A detailed analysis of the basis for a recommendation.

(4) A certification from the Chief Financial Officer as to whether the agency has funds available to pay the indemnification.

(b) The General Counsel will:

(1) Review the circumstances of the incident that gave rise to the action or proceeding, and all data relevant to the question of whether the employee was acting within the scope of their employment.

(2) Where appropriate, seek the views of the U.S. Department of Justice and/or the U.S. Attorney for the district encompassing the location where the action or proceeding is brought.

(3) Prepare a recommendation to approve or deny the request.

(4) Forward the request, the accompanying documentation, and the General Counsel's recommendation to the CEO for a decision.

Dated: August 22, 2022.

Fernando Laguarda,

General Counsel.

[FR Doc. 2022–19322 Filed 9–6–22; 8:45 am]

BILLING CODE 6050–28–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 79

[CG Docket No. 05–231; FCC 14–12 and FCC 16–17; FR ID 103115]

Closed Captioning of Video Programming; Telecommunications for the Deaf and Hard of Hearing, Inc., Petition for Rulemaking; Corrections

AGENCY: Federal Communications Commission.

ACTION: Correcting amendments.

SUMMARY: This document corrects the final rules portion of **Federal Register** documents published on March 31, 2014, and August 23, 2016. These **Federal Register** documents inadvertently listed several erroneous cross-references and a typographical error. This document corrects the final regulation.

DATES: Effective September 7, 2022.

ADDRESSES: Federal Communications Commission, 45 L Street NE, Washington, DC 20554.

FOR FURTHER INFORMATION CONTACT: Joshua Mendelsohn, Consumer and Governmental Affairs Bureau, (202) 559–7304, or email: *Joshua.Mendelsohn@fcc.gov.*

SUPPLEMENTARY INFORMATION: A typographical error and a cross-reference error were introduced as part of the March 31, 2014, **Federal Register** document published at 79 FR 17911. Specifically, a period is missing between two sentences in 47 CFR 79.1(a)(11), and a cross-reference to 47 CFR 79(k)(4) in 47 CFR 79.1(k)(2)(xviii) is being corrected to cross-reference 47 CFR 79.1(k)(3). In addition, three cross-reference errors were introduced as part of the August 23, 2016, **Federal Register** document published at 81 FR 57473. Specifically, cross-references in 47 CFR 79.1(g)(9)(ii), (iii), and (iv) incorrectly cited to § 79.1(g)(8)(i) and (ii) of the Commission's rules; these citations are being corrected to cross-reference § 79.1(g)(9)(i) and (ii) of the Commission's rules.

List of Subjects in 47 CFR Part 79

Cable television operators, Communications equipment, Multichannel video programming distributors (MVPDs), Satellite television service providers.

Federal Communications Commission.

Katura Jackson,

Federal Register Liaison Officer.

Final Rules

Accordingly, 47 CFR part 79 is corrected by making the following correcting amendments:

PART 79—ACCESSIBILITY OF VIDEO PROGRAMMING

■ 1. The authority citation for part 79 continues to read as follows:

Authority: 47 U.S.C. 151, 152(a), 154(i), 303, 307, 309, 310, 330, 544a, 613, 617.

■ 2. Amend § 79.1 by revising paragraphs (a)(11), (g)(9)(ii), (iii), and (iv), and (k)(2)(xviii) to read as follows:

§ 79.1 Closed captioning of televised video programming.

(a) * * *

(11) *Video programming distributor.* Any television broadcast station licensed by the Commission and any multichannel video programming distributor as defined in § 76.1000(e) of this chapter, and any other distributor of video programming for residential reception that delivers such programming directly to the home and is subject to the jurisdiction of the Commission. An entity contracting for program distribution over a video programming distributor that is itself exempt from captioning that programming pursuant to paragraph (e)(9) of this section shall itself be treated as a video programming distributor for purposes of this section. To the extent such video programming is not otherwise exempt from captioning, the entity that contracts for its distribution shall be required to comply with the closed captioning requirements of this section.

* * * * *

(g) * * *

(9) * * *

(ii) *Corrective action plan.* If, after the date for a video programming distributor or video programmer to respond to a notification under paragraph (g)(9)(i) of this section, the Commission subsequently notifies the video programming distributor or video programmer that there is further evidence indicating a pattern or trend of noncompliance with the Commission's rules for quality of closed captioning, the video programming distributor or video programmer shall submit to the Commission, within thirty (30) days after the date of such subsequent notification, a written action plan describing specific measures it will take to bring the video programming distributor's or video programmer's closed captioning performance into compliance with the Commission's closed captioning quality rules. In addition, the video programming distributor or video programmer shall conduct spot checks of its closed captioning quality performance and report to the Commission on the results of such action plan and spot checks 180 days after the submission of such action plan.

(iii) *Continued evidence of a pattern or trend of noncompliance.* If, after the date for submission of a report on the results of an action plan and spot checks pursuant to paragraph (g)(9)(ii) of this section, the Commission finds continued evidence of a pattern or trend of noncompliance, additional enforcement actions may be taken, which may include admonishments, forfeitures, and other corrective actions.

(iv) *Enforcement action.* The Commission may take enforcement action, which may include admonishments, forfeitures, and other corrective actions, without providing a video programming distributor or video programmer the opportunity for an initial response to a pattern or trend of noncompliance or a corrective action plan, or both, under paragraphs (g)(9)(i) and (ii) of this section, for a systemic closed captioning quality problem or an intentional and deliberate violation of the Commission's rules for the quality of closed captioning.

* * * * *

(k) * * *

(2) * * *

(xviii) Ensure that all contracted captioners adhere to the Real-Time Captioners Best Practices contained in paragraph (k)(3) of this section.

* * * * *

[FR Doc. 2022–19222 Filed 9–6–22; 8:45 am]

BILLING CODE 6712–01–P

DEPARTMENT OF TRANSPORTATION

Federal Motor Carrier Safety Administration

49 CFR Part 395

[Docket No. FMCSA–2022–0189]

Assessment of the Continued Need for COVID–19 Emergency Declaration, Regulatory Relief for Commercial Motor Vehicle Operations

AGENCY: Federal Motor Carrier Safety Administration (FMCSA), Department of Transportation (DOT).

ACTION: Request for comments.

SUMMARY: On August 31, 2022, FMCSA announced the extension of its coronavirus disease 2019 (COVID–19) Emergency Declaration which provides regulatory relief for motor carriers and drivers engaged in providing direct assistance in continued support of the Nation's COVID–19 national emergency. The extension of the emergency declaration expires on October 15, 2022. FMCSA (the ''Agency'') seeks public comment concerning the extent to which motor carriers currently rely on the emergency declaration to deliver certain commodities and whether there has been any impact on safety.

DATES: Comments on this document must be received by September 21, 2022.

ADDRESSES: You may submit comments identified by Federal Docket Management System Number FMCSA–2022–0189 by any of the following methods:

• *Federal eRulemaking Portal: www.regulations.gov.* See the Public Participation and Request for Comments section below for further information.

• *Mail:* Dockets Operations, U.S. Department of Transportation, 1200 New Jersey Avenue SE, West Building, Ground Floor, Room W12–140, Washington, DC 20590–0001.

• *Hand Delivery or Courier:* West Building, Ground Floor, Room W12–140, 1200 New Jersey Avenue SE, between 9 a.m. and 5 p.m. E.T., Monday through Friday, except Federal holidays.

• *Fax:* (202) 493–2251.

Each submission must include the Agency name and the docket number (FMCSA–2022–0189) for this document. Note that DOT posts all comments received without change to *www.regulations.gov,* including any personal information included in a comment. Please see the Privacy Act heading below.

Docket: For access to the docket to read background documents or comments, go to *www.regulations.gov* at any time or visit Room W12–140 on the ground level of the West Building, 1200 New Jersey Avenue SE, Washington, DC, between 9 a.m. and 5 p.m., ET, Monday through Friday, except Federal holidays. To be sure someone is there to help you, please call (202) 366–9317 or (202) 366–9826 before visiting Dockets Operations.

Privacy Act: In accordance with 49 U.S.C. 31315(b), DOT solicits comments from the public to better inform its exemption process. 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 *www.transportation.gov/privacy,* the comments are searchable by the name of the submitter.

FOR FURTHER INFORMATION CONTACT: Mr. Richard Clemente, Driver and Carrier Operations Division, Office of Carrier, Driver, and Vehicle Safety Standards, FMCSA, at (202) 366–2722 or *MCPSD@dot.gov.* If you have questions on viewing or submitting material to the docket, contact Dockets Operations at (202) 366–9826.

SUPPLEMENTARY INFORMATION:

Background

On May 27, 2022, FMCSA issued a declaration that the Nation's ongoing response to the COVID–19 national emergency warrants an extension and amendment of Emergency Declaration No. 2020–002. The extension and amendment of the Emergency Declaration continued the relief from certain requirements in 49 CFR part 395 of the Federal Motor Carrier Safety Regulations for interstate motor carriers and drivers operating in the 50 States and the District of Columbia. The extension of the emergency declaration issued on May 27, 2022, expired on August 31, 2022.

FMCSA first issued Emergency Declaration No. 2020–002 in response to the March 13, 2020, declaration of a national emergency under 42 U.S.C. 5191(b) related to COVID–19, and the immediate risk COVID–19 presented to public health and welfare. FMCSA subsequently modified Emergency Declaration No. 2020–002 concerning the categories of supplies, equipment, and persons covered by the Emergency Declaration to respond to changing needs for emergency relief.

The May 27, 2022, announcement explained that the continuation of the exemption and associated regulatory relief in accordance with 49 CFR 390.25, was necessary because the presidentially declared emergency remains in place, persistent issues arising out of COVID–19 continue to affect the U.S. including impacts on supply chains, and nationwide reporting continues to demonstrate substantial ongoing use of the regulatory relief under Emergency Declaration No. 2020–002.

With the August 31, 2022, announcement, the Agency extended the modified Emergency Declaration No. 2020–002 as amended on May 27, 2022, such that subject to the restrictions and conditions set forth in the declaration motor carriers and drivers providing direct assistance in support of relief efforts related to the COVID–19 public health emergency are granted emergency relief from 49 CFR 395.3, maximum driving time for property-carrying vehicles. Direct assistance means transportation and other relief services provided by a motor carrier or its driver(s) incident to the immediate restoration of essential services (such as medical care) or essential supplies during the COVID–19 emergency.

The extension of the modified Emergency Declaration No. 2020–002 provides regulatory relief for commercial motor vehicle operations providing direct assistance in support of emergency relief efforts related to COVID–19 and is limited to transportation of: (1) livestock and livestock feed; (2) medical supplies and equipment related to the testing, diagnosis, and treatment of COVID–19; (3) vaccines, constituent products, and medical supplies and equipment including ancillary supplies/kits for the administration of vaccines, related to the prevention of COVID–19; (4) supplies and equipment necessary for community safety, sanitation, and prevention of community transmission of COVID–19 such as masks, gloves, hand sanitizer, soap, and disinfectants; (5) food, paper products, and other groceries for emergency restocking of distribution centers or stores; and (6) gasoline, diesel, diesel exhaust fluid, jet fuel, ethyl alcohol, and heating fuel including propane, natural gas, and heating oil. Direct assistance does not include non-emergency transportation of qualifying commodities or routine commercial deliveries, including mixed loads with a nominal quantity of qualifying emergency relief added to obtain the benefits of this emergency declaration. To be eligible for the exemption, the transportation must be both (1) of qualifying commodities and (2) incident to the immediate restoration of those essential supplies.

Request for Comments

FMCSA believes the emergency declaration and subsequent extensions have provided the transportation industry essential regulatory relief in supporting the Nation's efforts to address the challenges associated with responding to the COVID–19 emergency. Since September 2021, FMCSA has requested that motor carriers operating under the emergency declaration report certain information to the Agency. This information included the number of trips conducted under the declaration and the commodities transported. Based on a review of the carriers' self-reported information, the primary categories of commodities transported under the declaration are: food, paper products and other groceries for emergency restocking of distributions centers or stores; and livestock and livestock feed. Two categories which have seen the usage between October 2021 and July 2022 decrease by almost 50 percent are: medical supplies and equipment related to the testing, diagnosis, and treatment of COVID–19; and supplies and equipment necessary for community safety, sanitation, and prevention of community transmission of COVID–19.

The Agency seeks public comment on the usage of the emergency declaration for the covered products. Specifically, if the usage is fit for the intended purpose of the limited relief. Commenters are encouraged to share with the Agency the source of the data or information and provide recommendations on additional actions the Agency should consider in monitoring the use of the declaration. Further, any data or information the Agency should use in

determining whether continued extension or modification of the declaration is needed. The Agency also seeks public comment on the safety and supply chain impacts of the emergency declaration.

Robin Hutcheson,

Deputy Administrator.

[FR Doc. 2022–19304 Filed 9–6–22; 8:45 am]

BILLING CODE 4910–EX–P

Proposed Rules

Federal Register
Vol. 87, No. 172
Wednesday, September 7, 2022

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 AGRICULTURE

Animal and Plant Health Inspection Service

9 CFR Parts 50, 51, 52, 52, 54, 55, and 56

[Docket No. APHIS–2021–0010]

RIN 0579–AE65

Animal and Plant Health Inspection Service Indemnity Regulations

AGENCY: Animal and Plant Health Inspection Service, USDA.

ACTION: Advance notice of proposed rulemaking and request for comments.

SUMMARY: We are soliciting public comment on a new approach to indemnity value determination and a new framework for the indemnity regulations. These parts address payment of indemnity for the destruction and disposition of animals the Animal and Plant Health Inspection Service (APHIS) classifies as infected with, suspect of, or exposed to diseases of concern, to eradicate and control foreign animal diseases, emerging diseases, and program diseases. The current regulations for valuing animals for the purpose of indemnification vary from species to species and, in some cases, disease to disease within a species. The new approach would harmonize how APHIS determines animal values and deals with costs associated with transportation, cleaning, disposal, and other points at which variations occur in how APHIS manages indemnity and compensation.

DATES: We will consider all comments that we receive on or before November 7, 2022.

ADDRESSES: You may submit comments by either of the following methods:

- *Federal eRulemaking Portal:* Go to *www.regulations.gov.* Enter APHIS–2021–0010 in the Search field. Select the Documents tab, then select the Comment button in the list of documents.
- *Postal Mail/Commercial Delivery:* Send your comment to Docket No. APHIS–2021–0010, Regulatory Analysis and Development, PPD, APHIS, Station 3A–03.8, 4700 River Road, Unit 118, Riverdale, MD 20737–1238.

Supporting documents and any comments we receive on this docket may be viewed at *Regulations.gov* or in our reading room, which is located in Room 1620 of the USDA South Building, 14th Street and Independence Avenue SW, Washington, DC. Normal reading room hours are 8 a.m. to 4:30 p.m., Monday through Friday, except holidays. To be sure someone is there to help you, please call (202) 799–7039 before coming.

FOR FURTHER INFORMATION CONTACT: Dr. Michael Carter, Commodity Policy Advisor, Strategy and Policy, Veterinary Services, 4700 River Road, Riverdale MD 20737; Phone: (301) 851–3510.

SUPPLEMENTARY INFORMATION:

Background

The Animal Health Protection Act (7 U.S.C. 8301–8317) gives authority to the Secretary of Agriculture to hold, seize, quarantine, treat, destroy, dispose of, or take other remedial action as needed to prevent the introduction and spread of livestock pests and diseases within the United States. The Act also directs the Secretary to compensate the owner of any animal, article, facility, or means of conveyance that the Secretary requires to be destroyed. This compensation includes the payment of indemnity, which is monetary payment made to a livestock owner for animals and animal products taken or destroyed to control or eradicate a disease. These authorities have been delegated to the Animal and Plant Health Inspection Service (APHIS).

The current regulations for valuing animals for the purpose of compensation, known as the indemnity regulations, vary from species to species and, in some cases, disease to disease within a species. The methods disease programs use range from specifying outdated flat rates to requiring in-person appraisal, with in-person appraisal being the most common method specified in the regulations.

In-person appraisal presents some significant difficulties. It works best for isolated incidents of slow-moving diseases of livestock. However, when APHIS encounters a widespread and fast-moving outbreak, such as occurred in 2014–2015 and again in 2022 with highly pathogenic avian influenza (HPAI), the rapid transmission of the disease can overwhelm the ability to provide timely and complete appraisal of fair market value using in-person appraisers. Additionally, third-party appraisal requires significant safeguards to ensure transparent and equitable appraisal, such as APHIS training of appraisers and robust review of records submitted by appraisers, and APHIS' resources to provide such safeguards have become increasingly limited over the years.

We are soliciting comments on an approach, discussed below, to restructure the indemnity regulations in 9 CFR parts 50 through 56 (referred to below as the regulations). The regulations currently provide for the payment of indemnity to owners of certain animals destroyed because APHIS classifies them as infected by, suspect of, or exposed to diseases of concern, for the purpose of eradicating and controlling foreign animal diseases, emerging diseases, and program diseases.

Part 50 provides conditions for the payment of indemnity for animals destroyed because of tuberculosis; part 51 for animals destroyed because of brucellosis; and part 52 for swine destroyed because of pseudorabies. Part 53 provides conditions for the payment of indemnity for animals destroyed because of foreign animal diseases, such as foot-and-mouth disease, contagious pleuropneumonia, Newcastle disease, HPAI, infectious salmon anemia, spring viremia of carp, as well as any other communicable disease of livestock or poultry that the Secretary decides constitutes an emergency and threatens the livestock or poultry of the United States. Part 54 contains our regulations governing indemnification for scrapie in sheep and goats, while part 55 contains our regulations governing indemnification for chronic wasting disease in captive cervids. Finally, part 56 contains our regulations governing indemnification for poultry destroyed because of H5/H7 low pathogenic avian influenza.

Within the regulations, many of the processes used for requesting and obtaining indemnity are similar from part to part, despite the disease agent and species in question differing among

the parts. For example, the parts generally require requests for indemnity to be presented on forms furnished by APHIS,[1] and they require the claimant to report any salvage derived from the sale of the animals, any indemnity already paid for the animals by parties other than APHIS, and any existing mortgage against the animals.

However, while the processes for qualifying for and obtaining indemnity are often similar, the processes within the regulations for valuing animals for the purpose of indemnification vary from species to species and, in some cases, disease to disease within a species. For example, whereas the regulations governing indemnification for cattle that are destroyed because of exposure to brucellosis allow for either a flat rate indemnification or appraisal of fair market value, the regulations governing indemnification of cattle destroyed because of exposure to tuberculosis require appraisal of fair market value. Additionally, while the regulations governing indemnification of cattle destroyed because of exposure to tuberculosis specify that the appraiser of fair market value must be selected by APHIS, the regulations governing indemnification of cattle destroyed because of exposure to brucellosis contain no such specification.

At this time, we are considering two structural changes to the indemnity regulations. First, we are considering standardizing use of an annual indemnity value table for livestock species. APHIS is also contemplating a framework to consolidate all commodity indemnity regulations under a single unified section in part 50. Parts 51 through 56 would be removed, and the numbers reserved.

Indemnity Value Table

APHIS is considering standardizing use of an annual indemnity value table for livestock [2] species, with allowances for appraisal only when an indemnity value cannot be calculated using the tables, or when a producer elects to appeal the indemnity value based on extraordinary circumstances surrounding the livestock or poultry at issue. The table, found at *https://www.aphis.usda.gov/animal_health/downloads/usda-commercial-values-2022.pdf,* includes explanation of methods of calculation and sources. APHIS currently maintains such a table. However, because its use is not specified within the regulations, its use is not standardized.

In standardized use of an indemnity value table, the regulations we are considering would state that APHIS would determine indemnification values annually and publish the values online. Notification of the revised values would be provided through a notice published in the **Federal Register**. With this standardization, APHIS would also provide indemnity values by animal classes similar to the Farm Service Agency's (FSA) Livestock Indemnity Program.[3] Categories will include animal classes such as non-adult (400–799 pounds) beef steers, sire rams of breeding age, and ducks 12 months of age or older. APHIS will work with other U.S. Department of Agriculture (USDA) agencies to develop common methods for determining animal classes and values for the standardized table.

A standardized approach would eliminate the different indemnity values used in different disease programs for the same species, such as in the example above regarding the discrepancy between indemnification for brucellosis in cattle and indemnification for tuberculosis in cattle. It would also resolve several known operational challenges with indemnification based on fair market appraisal by an appraiser. The first operational challenge is that appraisal of fair market value by an appraiser works best for isolated incidents of significant, but slow-moving, diseases of livestock and poultry. When a widespread and quickly moving outbreak occurs, such as the 2014–2015 outbreak of HPAI in which 7.4 million turkeys and 43 million egg-layers/pullet chickens were determined to be affected with HPAI, the rapid transmission of the disease can overwhelm the ability to provide timely and complete appraisal of fair market value using in-person appraisers. The second operational challenge is that a regulatory framework that is based primarily on third-party appraisal requires significant safeguards to ensure consistent and transparent appraisal, such as APHIS training of the appraisers and establishing mechanisms for thorough review of the appraisal records submitted to APHIS. APHIS' resources to provide such training and review of such records have become extremely limited.

APHIS seeks public comment on this approach, with a specific focus on how this approach may affect members of the public, as well as how any alternative suggestions may improve the indemnity regulations.

Consolidation of Indemnity Regulations

APHIS is also contemplating a framework to consolidate all commodity indemnity regulations under a single unified section in part 50. Parts 51 through 56 would be removed, and the numbers reserved.

As noted above, many of the sections within parts 51 through 56 contain substantially similar regulatory provisions regarding the process for requesting and obtaining indemnity, and they could be consolidated into a single part with minor changes to verbiage and no changes to operational practices. The consolidated part would, however, harmonize how APHIS addresses value determination, compensation for cleaning and disposal, and other instances in which variations occur within the current parts.

While APHIS believes a single harmonized part would effectively address most indemnification cases, we are seeking input on whether there are any species, commodity classes or intended uses within a species, or other considerations that would merit their own part. We are also seeking input on any sections where the disease management approach could be significantly altered by such consolidation of the indemnification process.

Below, we discuss section by section our current thinking regarding a consolidated part 50.

Definitions

This section would define livestock classes, diseases, and disease status important for the interpretation of the regulations. We anticipate that the definitions would generally be drawn from and consistent with the definitions currently in the regulations. We invite comment on whether any of the current definitions should be revised. We also invite comment on whether any definitions should be added to those currently in the regulations.

Applicability

This section would list the species and diseases that fall under these regulations. Diseases would be reorganized and split into two different categories for which APHIS may provide indemnity: (1) Foreign animal

[1] The paperwork and recordkeeping activities described in this document are included under the following OMB control numbers: 0579–0007, 0579–0047, 0579–0065, 0579–0101, 0579–0146, 0579–0189, 0579–0192, and 0579–0195.

[2] Please note that the Animal Health Protection Act, pursuant to which authority this document is being issued, defines livestock as: ''All farm-raised animals.'' This includes bees, farmed aquaculture, poultry, and animals maintained in captivity on a farm.

[3] The FSA Livestock Indemnity Program regulations are found at 7 CFR 1416.301 through 1416.306. Further information about the program is found at: *https://www.fsa.usda.gov/Assets/USDA-FSA-Public/usdafiles/FactSheets/livestock_indemnity_program_lip-fact_sheet.pdf.*

diseases and emerging diseases; and (2) domestic program diseases.

For the former category, APHIS would maintain a list online of the foreign animal diseases and emerging diseases for which we may pay indemnity. APHIS would publish changes to the list in a notice in the **Federal Register** and state the basis for the change. As a baseline, this list would contain the diseases currently listed in part 53 of the regulations (Foot-and-mouth disease, contagious pleuropneumonia, Newcastle disease, HPAI, infectious salmon anemia, and spring viremia of carp), as well as classical bovine spongiform encephalopathy. The regulations would continue to recognize the potential for other communicable diseases of livestock or poultry that the Secretary decides constitute an emergency and threaten the livestock or poultry of the United States.

In addition to the foreign animal diseases and emerging diseases listed above, APHIS would group together the following domestic diseases:

- *Cattle and Bison:* Bovine tuberculosis, bovine brucellosis.
- *Captive Cervids:* Bovine tuberculosis, bovine brucellosis, and chronic wasting disease.
- *Goats:* Scrapie, bovine tuberculosis, and brucellosis.
- *Sheep:* Scrapie, bovine tuberculosis, brucellosis.
- *Swine:* Pseudorabies, brucellosis, and bovine tuberculosis when associated with bovine tuberculosis cattle herds.
- *Poultry:* H5/L7 low pathogenic avian influenza.

Testing and Records of Tests

This section would discuss requirements for test records that document eligibility for indemnity for the animals. Parts 50 and 51 currently contain such requirements, and they are very similar to each other. At this time, we are not considering substantial changes from the language already in the regulations. However, we invite public comment on any challenges that may have arisen with the current requirements and how they might be addressed.

Payments to Owners

This section would provide for the possibility of compensation to owners for costs other than the destruction of the animals, and, if so, what costs APHIS could compensate. It would also set forth requirements for forms required by APHIS regarding the compensation for animals, the cost of disposition of covered animals, the cost of material destroyed, and the expenses associated with destruction. This section would consolidate existing language from the current regulations; we are not considering substantial changes to the current practice. However, we again invite public comment on any challenges that may have arisen with the current requirements and how they might be addressed.

Claims Not Allowed

This section would provide additional conditions for certain disease agents that affect whether indemnity can be claimed. Again, we are not currently considering substantial changes from the requirements currently in the regulations but invite public comment on challenges associated with the current requirements and how they may be addressed.

Identification

This section would describe the identification requirements of the animals that qualify for indemnification and the timeline for such identifications. For those disease programs that do not have identification requirements, we would refer to the requirements in 9 CFR part 86 (the Animal Disease Traceability regulations) for official identification. We are also considering removing reactor and suspect branding and reactor tags as forms of reactor and suspect identification for animals that qualify for indemnification for brucellosis because APHIS no longer uses such identification within the domestic brucellosis eradication program.

Determination of Indemnity

APHIS is considering substantial changes to this section. With the consolidation of parts 50 to 56, APHIS is proposing to standardize how animals are valued for all commodities regardless of disease program. As noted above, APHIS is considering generally harmonizing its approach to animal valuation with that of FSA. The tables produced by APHIS and FSA would use the same calculations and data sets for the value determination. APHIS would update the indemnity values for APHIS program use annually and post them to the APHIS website. These values would be determined by the meat, egg production, and dairy or breeding value of the animals using publicly verifiable data sources. Animals would be valued in categories by species and type. APHIS has created a 2022 indemnity values document for commercial production animal classes, and it can be viewed on the APHIS website at *https://www.aphis.usda.gov/animal_health/downloads/usda-commercial-values-2022.pdf.* This document describes in detail how the values for each class of animal would be determined.

When APHIS needs to indemnify a species or class of animal that is not listed in the tables (*e.g.,* if an emerging disease were to impact a species of livestock for which indemnity is currently not provided, or if indemnity were sought for organic animals or animals subject to value-added production practices), APHIS would determine whether there is sufficient representative data from industry sources and professional appraisal groups to determine a national value for the species or class of animal. If there is such a national value, APHIS would amend the table to add the new category and issue a notice in the **Federal Register** announcing the new values. If APHIS cannot identify a national value based on available data, APHIS would require appraisal by an APHIS-approved appraiser. This could be an appraiser APHIS selects, or alternatively, an appraiser the owner of the animals selects and pays, and whom APHIS determines to meet certain professional standards and not to be in a material conflict of interest in appraising the animals.

An owner could appeal the indemnity value set forth in a table or the appraised value provided by an appraiser selected by APHIS. To do so, the owner would have to secure an alternate appraisal by an appraiser he or she selects and pays for at his or her own expense. APHIS would require that the appraiser meet certain professional standards and not to be in a material conflict of interest regarding appraising the animals. During an incident requiring remediation, costs incurred are the producer's responsibility up to the point the necessary indemnity paperwork is signed.

In addition to general comments about the suitability of this approach, APHIS requests comment on whether there are any species or classes not covered either by FSA's tables or APHIS' own tables for which APHIS should develop a value for indemnification and any recommended data sources available for determining national values for these classes.

Cap on Values Paid by APHIS

Currently, APHIS has a cap on several animal commodities, such as $3000 for individual cattle under the Tuberculosis Eradication Program. However, APHIS is considering removing these since the annual table value would be the amount APHIS would indemnify under most circumstances. We invite comment on

whether, if APHIS cannot calculate a table value for the animals, caps should be in place and at what values APHIS should set those caps.

Mortgages

As noted above, the regulations generally require owners to indicate whether the animals for which indemnification is being requested are subject to any mortgage. We are not currently considering substantial changes from the requirements currently in the regulations but invite public comment on challenges associated with the current requirements and how they may be addressed.

Joint Ownership/Contract Raisers

The regulations in part 56 provide for payment of indemnity or compensation to both poultry owners and contractors who raise poultry for others. We are considering whether to expand this to other commodities as well since more commodity groups are using contract raisers. We are seeking information about how other industries use contractors and how indemnification and compensation might work in those industries.

Salvage Values

There are times that the meat from indemnified animals can be salvaged during disease eradication efforts. This is part of industry's contribution to the indemnification process. This section would describe how the amount APHIS pays a producer is modified when value from the animals can be salvaged. This section is not expected to change significantly from the current regulations, but we invite public comment on challenges associated with the current regulations and how they may be addressed.

Destruction and Disposal

Language in this section would largely remain the same with some harmonization between the disease programs. For the most part, language would be similar to that which is used for herd depopulations. APHIS is also considering harmonizing what material qualifies for destruction under this section. For example, if APHIS determines that material such as feed from premises affected by a foreign animal disease needs to be destroyed, APHIS would, in most cases, indemnify it. For program diseases, APHIS will need to make this determination for a regulated disease on the basis of the disease itself and the likelihood of further transmission if the feed or other material is later used.

Cleaning and Disinfection of Premises, Conveyances, and Materials

APHIS is considering harmonizing the language across all commodities as to what cleaning costs are covered when APHIS requires cleaning and disinfection prior to repopulating a facility. APHIS currently will cover cleaning and disinfection costs after removing animals for foreign animal diseases, but not for program diseases. Harmonizing across all diseases will likely increase APHIS' costs and potentially lower the available funds for indemnifying animals. Again, we are inviting public comment on challenges associated with the current requirements and whether greater harmonization is needed.

Pre-Exposure Biosecurity Requirements for Herds/Flocks

Currently, in order for a producer or owner to receive indemnity for poultry destroyed because of avian influenza, the producer must meet pre-exposure biosecurity requirements. There are similar requirements for farmed aquaculture with respect to infectious salmon anemia. APHIS is considering expanding this approach to other commodity groups. APHIS is seeking input as to whether similar approaches can be put in place for other animal commodities and what would constitute basic biosecurity protocols as minimum standards. APHIS is also interested in the issues and impact this would have on producers for each of the commodities if these requirements are included as a condition of indemnification.

Post-Exposure Biosecurity Requirements

Post-exposure biosecurity requirements are already built into the various disease programs. In most cases, these are in effect as an affected herd or flock plan that the producer must adhere to as a condition for future indemnification. APHIS would like to harmonize the requirements within animal commodity groups to the extent possible, and APHIS seeks public comment on ways by which we might do this.

Environmental Impacts

APHIS seeks public comment on how the above framework may implicate the ''human environment,'' as this phrase is understood within the context of the National Environmental Policy Act (NEPA). Comments will help inform APHIS as to the applicability of NEPA to modifications to the indemnity regulations.

Economic Considerations

APHIS seeks public comment on economic cost considerations associated with the above framework. Particularly, we are interested in receiving comment as to whether there are any instances in which the proposed approach to calculating indemnity could result in substantial economic impacts for producers relative to the current regulations, as well as instances in which the consolidation and harmonization identified above could result in costs or benefits for affected parties.

Authority: 7 U.S.C. 8301–8317; 7 CFR 2.22, 2.80, and 371.4.

Done in Washington, DC, this 31st day of August 2022.

Jennifer Moffitt,

Undersecretary, United States Department of Agriculture.

[FR Doc. 2022–19260 Filed 9–6–22; 8:45 am]

BILLING CODE 3410–34–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. FAA–2022–1070; Project Identifier MCAI–2021–00686–R]

RIN 2120–AA64

Airworthiness Directives; Airbus Helicopters Deutschland GmbH (AHD) (Type Certificates Previously Held by Messerschmitt-Bolkow-Blohm [MBB], and Eurocopter Deutschland GmbH [ECD]) Helicopters

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of proposed rulemaking (NPRM).

SUMMARY: The FAA proposes to supersede airworthiness directive (AD) 77–04–06, which applies to Messerschmitt-Bolkow-Blohm (MBB) (now Airbus Helicopters Deutschland GmbH (AHD)) Model BO–105A and BO–105 C helicopters; AD 2002–13–06, which applies to certain Eurocopter Deutschland GmbH (ECD) (now Airbus Helicopters Deutschland GmbH (AHD)) Model BO–105A, BO–105C, BO–105 C–2, BO–105 CB–2, BO–105 CB–4, BO–105 CS–2, BO–105 CBS–2, BO–105S, and BO–105LS A–1 helicopters; AD 2016–25–14, which applies to certain Airbus Helicopters Deutschland GmbH (AHD) Model BO–105LS A–3 helicopters; and AD 2021–10–14, which applies to certain Airbus Helicopters Deutschland GmbH (AHD) Model BO–105A, BO–

105C, BO–105S, and BO–105LS A–3 helicopters. AD 77–04–06 requires reducing the life limit on certain main rotor gearbox (MGB) supports. AD 2002–13–06 requires determining the calendar age, number of flights, and flight hours time-in-service (TIS) on certain tension-torsion (TT) straps; revising the Airworthiness Limitations Schedule (ALS) of the existing maintenance manual; removing and replacing each TT strap that has exceeded its life limit, or if the TT strap's total hours TIS or number of flights and age are not known; and modifying certain parts. AD 2016–25–14 requires establishing a life limit for certain TT straps and removing certain parts that have exceeded the new life limit. AD 2021–10–14 requires replacement of certain TT straps with serviceable parts, and implementation of a new storage life limit for certain TT straps. Since the FAA issued those ADs, new and more restrictive airworthiness limitations have been issued. This proposed AD would require incorporating into existing maintenance records requirements (airworthiness limitations) as specified in a European Union Aviation Safety Agency (EASA) AD, which is proposed for incorporation by reference (IBR). This proposed AD would also prohibit the installation of certain part-numbered TT straps. The FAA is proposing this AD to address the unsafe condition on these products.

DATES: The FAA must receive comments on this proposed AD by October 24, 2022.

ADDRESSES: You may send comments, using the procedures found in 14 CFR 11.43 and 11.45, by any of the following methods:

- *Federal eRulemaking Portal:* Go to *www.regulations.gov.* Follow the instructions for submitting comments.
- *Fax:* (202) 493–2251.
- *Mail:* U.S. Department of Transportation, Docket Operations, M–30, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE, Washington, DC 20590.
- *Hand Delivery:* Deliver to Mail address above between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

For EASA material that is proposed for IBR in this NPRM, contact EASA, Konrad-Adenauer-Ufer 3, 50668 Cologne, Germany; telephone +49 221 8999 000; email *ADs@easa.europa.eu;* internet *www.easa.europa.eu.* You may find the EASA material on the EASA website at *https://ad.easa.europa.eu.* For Airbus Helicopters service information identified in this NPRM, contact Airbus Helicopters, 2701 North Forum Drive, Grand Prairie, TX 75052; telephone (972) 641–0000 or (800) 232–0323; fax (972) 641–3775; or at *www.airbus.com/helicopters/services/technical-support.html.* You may view this material at the FAA, Office of the Regional Counsel, Southwest Region, 10101 Hillwood Pkwy., Room 6N–321, Fort Worth, TX 76177. For information on the availability of this material at the FAA, call (817) 222–5110. EASA material that is IBRed is also available at *www.regulations.gov* by searching for and locating Docket No. FAA–2022–1070.

Examining the AD Docket

You may examine the AD docket at *www.regulations.gov* by searching for and locating Docket No. FAA–2022–1070; 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 NPRM, the EASA AD, any comments received, and other information. The street address for Docket Operations is listed above.

FOR FURTHER INFORMATION CONTACT: Kristi Bradley, COS Program Manager, COS Program Management Section, Operational Safety Branch, Compliance & Airworthiness Division, FAA, 10101 Hillwood Parkway, Fort Worth, TX 76177; telephone (817) 222–5110; email *kristin.bradley@faa.gov.*

SUPPLEMENTARY INFORMATION:

Comments Invited

The FAA invites you to send any written relevant data, views, or arguments about this proposal. Send your comments to an address listed under **ADDRESSES**. Include ''Docket No. FAA–2022–1070; Project Identifier MCAI–2021–00686–R'' at the beginning of your comments. The most helpful comments reference a specific portion of the proposal, explain the reason for any recommended change, and include supporting data. The FAA will consider all comments received by the closing date and may amend this proposal because of those comments.

Except for Confidential Business Information (CBI) as described in the following paragraph, and other information as described in 14 CFR 11.35, the FAA will post all comments received, without change, to *www.regulations.gov,* including any personal information you provide. The agency will also post a report summarizing each substantive verbal contact received about this NPRM.

Confidential Business Information

CBI is commercial or financial information that is both customarily and actually treated as private by its owner. Under the Freedom of Information Act (FOIA) (5 U.S.C. 552), CBI is exempt from public disclosure. If your comments responsive to this NPRM contain commercial or financial information that is customarily treated as private, that you actually treat as private, and that is relevant or responsive to this NPRM, it is important that you clearly designate the submitted comments as CBI. Please mark each page of your submission containing CBI as ''PROPIN.'' The FAA will treat such marked submissions as confidential under the FOIA, and they will not be placed in the public docket of this NPRM. Submissions containing CBI should be sent to Kristi Bradley, COS Program Manager, COS Program Management Section, Operational Safety Branch, Compliance & Airworthiness Division, FAA, 10101 Hillwood Parkway, Fort Worth, TX 76177; telephone (817) 222–5110; email *Kristin.bradley@faa.gov.* Any commentary that the FAA receives that is not specifically designated as CBI will be placed in the public docket for this rulemaking.

Background

The FAA issued AD 77–04–06, Amendment 39–2835 (42 FR 9670, February 17, 1977; amended 44 FR 46783, August 9, 1979) (AD 77–04–06) for Messerschmitt-Bolkow-Blohm (MBB) Model BO–105A and BO–105C helicopters. AD 77–04–06 was prompted by reports of internal corrosion of the MGB supports, which could significantly reduce the structural strength and service life. After AD 77–04–06 was issued, the FAA determined based on service experience and additional test investigations the total hours TIS for certain part-numbered MGB supports could be increased. Accordingly, the FAA amended AD 77–04–06 by issuing Amendment 39–3528 (44 FR 46783, August 9, 1979), which increased the life limit for the MGB supports to 6,800 hours TIS.

The FAA issued AD 2002–13–06, Amendment 39–12794 (67 FR 43526, June 28, 2002) (AD 2002–13–06) for Eurocopter Deutschland GmbH (ECD) Model BO–105A, BO–105C, BO–105 C–2, BO–105 CB–2, BO–105 CB–4, BO–105S, BO–105 CS–2, BO–105 CBS–2, BO–105 CBS–4, and BO–105LS A–1 helicopters, with main rotor (MR) head assembly, part number (P/N) 105–14101, and TT strap P/N 2602559 or 2606576, installed. AD 2002–13–06 was prompted by an accident in which an MR blade separated from a Eurocopter Model MBB–BK 117 helicopter due to fatigue failure of a TT strap; the same part-numbered TT strap is used on

Model BO–105 helicopters. AD 2002–13–06 was also prompted by the determination that an additional life limit for certain part-numbered TT straps needs to be established. AD 2002–13–06 requires creating a component log card or equivalent record and determining the calendar age, number of flights, and flight hours TIS on certain part-numbered TT straps; removing and replacing any TT strap that has exceeded its life limit, or the total hours TIS or number of flights and age are not known; and modifying certain MR heads before certain part-numbered TT straps are installed. AD 2002–13–06 also requires revising the ALS of the existing maintenance manual to reflect these new life limits.

The FAA issued AD 2016–25–14, Amendment 39–18740 (81 FR 94944, December 27, 2016) (AD 2016–25–14) for Airbus Helicopters Deutschland GmbH Model BO–105LS A–3 helicopters with TT strap P/N 2604067 or P/N 117–14110 installed. AD 2016–25–14 was prompted by the determination that life limits have been introduced for certain part-numbered TT straps installed on the helicopter lifting system, and during the revision of the ALS for the existing Model BO–105LS A–3 maintenance manual, the life limit for the TT strap was inadvertently deleted. AD 2016–25–14 requires inspecting the helicopter records to determine if there is a life limit of 25,000 flights, or 10 years since the date of manufacturer, whichever occurs first, for the TT straps. Depending on the inspection results, AD 2016–25–14 requires establishing a life limit if none exists; revising the ALS of the existing maintenance manual, and creating a component history card or equivalent record to reflect this life limit; and replacing each TT strap that has reached or exceeded its life limit.

The FAA issued AD 2021–10–14, Amendment 39–21547 (86 FR 27268, May 20, 2021) (AD 2021–10–14) for Airbus Helicopters Deutschland GmbH Model BO–105A, BO–105C, BO–105S, and BO105LS A–3 helicopters equipped with a certain TT strap. AD 2021–10–14 was prompted by the FAA's determination that aging of the elastomeric material in a TT strap could affect the structural characteristics of the TT strap. AD 2021–10–14 requires replacement of certain TT straps with serviceable parts and implementation of a new storage life limit for TT straps.

Actions Since AD 77–04–06, AD 2002–13–06, AD 2016–25–14, and AD 2021–10–14 Were Issued

Since the FAA issued AD 77–04–06, AD 2002–13–06, AD 2016–25–14, and AD 2021–10–14, EASA, which is the Technical Agent for the Member States of the European Union, issued EASA AD 2021–0142, dated June 17, 2021 (EASA AD 2021–0142), which superseded EASA AD 2019–0024, dated February 4, 2019 (which prompted AD 2021–10–14); EASA AD 2015–0042, dated March 9, 2015 (which prompted AD 2016–25–14); EASA AD 2013–0015, dated January 16, 2013; EASA AD 2010–0153, dated July 27, 2010; Luftfahrt-Bundesamt (LBA) Germany AD 2001–281, dated October 18, 2001 (which prompted AD 2002–13–06); and LBA Germany AD 76–136/2, dated October 5, 1978 (which prompted AD 77–04–06). EASA issued AD 2021–0142 to correct an unsafe condition for Airbus Helicopters Deutschland GmbH (AHD), formerly Eurocopter Deutschland GmbH, Eurocopter Hubschrauber Deutschland GmbH, Messerschmitt-Bölkow-Blohm GmbH; Eurocopter Canada Ltd, formerly Messerschmitt-Bölkow-Blohm Helicopter Canada Limited, Model BO105 A, BO105 C, BO105 D, BO105 S, BO105 LS A–1, and BO105 LS A–3 helicopters, all variants, all serial numbers, including BO105 LS A–3 helicopters modified in accordance with EASA Supplemental Type Certificate (STC) 10039633, or previously LBA Germany STC EMZ NR. 0654/3058 (commercially known as ''Superlifter''). EASA advises the airworthiness limitations for AHD Model BO105 helicopters are defined and published in the AHD BO105 Aircraft Maintenance Manual (AMM) Chapter 101–15—ALS, Issue 2, Revision 31 (for BO105 A, BO105 C, BO105 D, BO105 S, and BO105 LS A–1 helicopters); AHD BO105 LS A–3 AMM Chapter 101–15—ALS, Issue 4, Revision 7 (for BO105 LS A–3 helicopters); and AHD BO105 LS A–3 AMM Appendix 010, Issue 1, Revision 4 (for BO105 LS A–3 'Superlifter' helicopters); as applicable.

EASA advises the instructions contained in ''the applicable ALS'' as defined in EASA AD 2021–0142 have been identified as mandatory actions for continued airworthiness, and failure to comply with those instructions could result in an unsafe condition. Accordingly, EASA AD 2021–0142 requires accomplishment of the actions specified in ''the applicable ALS,'' as defined in EASA AD 2021–0142. The FAA is proposing this AD to address the failure of certain parts, which could result in the loss of control of the helicopter. See EASA AD 2021–0142 for additional background information.

Additionally, the actions required to address the unsafe conditions in AD 77–04–06, AD 2002–13–06, AD 2016–25–14, and AD 2021–10–14 are included in ''the applicable ALS,'' as defined in EASA AD 2021–0142. Therefore, the FAA is proposing to supersede AD 77–04–06, AD 2002–13–06, AD 2016–25–14, and AD 2021–10–14 in order to reduce the burden on operators by requiring compliance with a single FAA AD in lieu of multiple FAA ADs.

AD 77–04–06 requires replacing MGB support P/N 105–10161 and 105–10162 with serviceable supports within the next 10 hours TIS after the effective date of AD 77–04–06 or prior to the accumulation of 6,800 hours TIS on the supports, whichever occurs later, and, thereafter, continue to replace the supports prior to the accumulation of 6,800 hours TIS. EASA AD 2021–0142 requires incorporating ''the applicable ALS,'' as defined in EASA AD 2021–0142, which identifies the same life limit for these MGB supports as that required by AD 77–04–06. Therefore, the FAA is proposing to supersede AD 77–04–06 in order to reduce the burden on operators.

AD 2002–13–06 requires creating a component log card or equivalent record and determining the calendar age, number of flights, and flight hours TIS on certain part-numbered TT straps; inspecting and replacing certain TT straps, as necessary; and modifying certain main rotor heads if alternate TT straps are installed. This action also establishes an additional life limit for certain part-numbered TT straps. EASA AD 2021–0142 requires incorporating the limitations described in ''the applicable ALS,'' as defined in EASA AD 2021–0142, into the approved aircraft maintenance program and introduces a new storage life limit of 5 years for certain TT straps.

AD 2016–25–14 requires inspecting the ALS of the applicable maintenance manual for your helicopter or the Instructions for Continued Airworthiness (ICA) and the component history card or equivalent record for TT strap P/N 2604067 and P/N 117–14110 and determining whether those records specify a life limit of 25,000 flights or 10 years since the date of manufacture, whichever occurs first. If the ALS, ICA, component history card, or equivalent record do not specify a life limit for the TT straps, or if they specify a life limit other than 25,000 flights or 10 years since the date of manufacture, whichever occurs first, AD 2016–25–14 requires revising the existing ALS or ICA by establishing a life limit for each TT strap P/N 2604067 and P/N 117–14110 of 25,000 flights or 10 years since the date of manufacture, whichever occurs first. AD 2016–25–14 also requires removing from service each TT

strap that has reached or exceeded its life limit. EASA AD 2021–0142 requires incorporating ''the applicable ALS,'' as defined in EASA AD 2021–0142, into the approved aircraft maintenance program and introduces a new storage life limit of 5 years for certain TT straps.

AD 2021–10–14 requires replacement of certain TT straps with serviceable parts and implementation of a new storage life limit for TT straps. After AD 2021–10–14 was issued, EASA issued AD 2021–0142, which requires incorporating ''the applicable ALS,'' as defined in EASA AD 2021–0142, into the approved aircraft maintenance program. The FAA determined that the life limits in AD 2021–10–14 for Bendix TT strap P/Ns 2604067 and 117–14110 were incorrectly stated as 40,000 flight cycles for Model BO105LS A–3 helicopters. This proposed AD would correct the life limit to 25,000 flight cycles or 10 years, whichever occurs first, which is the life limit in ''the applicable ALS,'' as defined in EASA AD 2021–0142.

Additionally, the FAA determined that AD 2021–10–14 incorrectly stated the life limits for Bendix TT strap P/Ns 2606576 and 2602559 as 40,000 flight cycles for Model BO105A, BO105C, and BO105S helicopters. This proposed AD would correct the life limit to 15,600 flight cycles, 2,400 hours TIS, or 10 years, whichever occurs first, which is the life limit in ''the applicable ALS,'' as defined in EASA AD 2021–0142.

FAA's Determination

These helicopters have been approved by EASA and are approved for operation in the United States. Pursuant to the FAA's bilateral agreement with the European Union, EASA has notified the FAA about the unsafe condition described in its AD. The FAA is proposing this AD after evaluating all known relevant information and determining that the unsafe condition described previously is likely to exist or develop on other helicopters of the same type design.

Related Service Information Under 1 CFR Part 51

EASA AD 2021–0142 requires replacing certain components before exceeding their applicable life limit. EASA AD 2021–0142 also prohibits installing Bendix TT-strap P/N 2602559, P/N 2606576, P/N 2604067, or P/N 117–14110, and requires revising the approved aircraft maintenance program (AMP) by incorporating the limitations described in ''the applicable ALS'' as defined in EASA AD 2021–0142.

This material is reasonably available because the interested parties have access to it through their normal course of business or by the means identified in the **ADDRESSES** section.

Other Related Service Information

The FAA reviewed Airbus Helicopters BO 105 Maintenance Manual (MM), Revision 31, dated December 15, 2020, for Model BO–105A, BO–105C, BO–105 D, BO–105S, and BO–105LS A–1 helicopters; Airbus Helicopters BO 105 LS A–3 MM, Revision 7, dated November 27, 2018, for Model BO–105 LS A–3 helicopters; and Airbus Helicopters MM BO 105 LS A–3 ''Super Lifter'' Appendix 010, Revision 4, dated March 28, 2019, for BO 105 LS A–3 ''Superlifter'' helicopters.

This service information specifies certain actions and associated thresholds and intervals, including life limits and maintenance tasks. These requirements (airworthiness limitations) include new life limits, including cure dates and storage life limits, for certain part-numbered TT straps.

Proposed AD Requirements in This NPRM

This proposed AD would require incorporating into existing maintenance records requirements (airworthiness limitations), which are specified in EASA AD 2021–0142 described previously, except as discussed under ''Differences Between this Proposed AD and EASA AD 2021–0142.'' This proposed AD would also prohibit the installation of Bendix TT-straps having certain P/Ns.

ADs Mandating Airworthiness Limitations

The FAA has previously mandated airworthiness limitations by mandating each airworthiness limitation task (*e.g.,* inspections and replacements (life limits)) as an AD requirement or issuing ADs that require revising the ALS of the existing maintenance manual or instructions for continued airworthiness to incorporate new or revised inspections and life limits. This proposed AD, however, would require operators to incorporate into maintenance records required by 14 CFR 91.417(a)(2) or 135.439(a)(2), as applicable for your rotorcraft, the requirements (airworthiness limitations) specified in EASA AD 2021–0142. The FAA does not intend this as a substantive change. For these ADs, the ALS requirements for operators are the same but are complied with differently. Requiring the incorporation of the new ALS requirements into the existing maintenance records, rather than requiring individual ALS tasks (*e.g.,* repetitive inspections and replacements), requires operators to record AD compliance once after updating the maintenance records, rather than after every time the ALS task is completed.

In addition, paragraph (h) of the proposed AD allows operators to incorporate later approved revisions of the applicable ALS as specified in the provisions of the ''Ref. Publications'' section of EASA AD 2021–0142 without the need for an alternative method of compliance (AMOC).

Explanation of Required Compliance Information

In the FAA's ongoing efforts to improve the efficiency of the AD process, the FAA developed a process to use some civil aviation authority (CAA) ADs as the primary source of information for compliance with requirements for corresponding FAA ADs. The FAA has been coordinating this process with manufacturers and CAAs. As a result, the FAA proposes to incorporate EASA AD 2021–0142 by reference in the FAA final rule. This proposed AD would, therefore, require compliance with EASA AD 2021–0142 through that incorporation, except for any differences identified as exceptions in the regulatory text of this proposed AD. Service information referenced in EASA AD 2021–0142 for compliance will be available at *https://www.regulations.gov* by searching for and locating Docket No. FAA–2022–1070 after the FAA final rule is published.

Differences Between This Proposed AD and EASA AD 2021–0142

This proposed AD does not require compliance with paragraphs (3), (4), and (5) of EASA AD 2021–0142.

EASA AD 2021–0142 is applicable to Model BO–105D helicopters, whereas this proposed AD is not because Model BO–105D helicopters are not certificated by the FAA and are not included on the U.S. type certificate data sheet. EASA AD 2021–0142 is applicable to Model BO–105 LS A–3 helicopters modified in accordance with EASA STC 10039633, or previously LBA Germany STC EMZ NR. 0654/3058 (commercially known as ''Superlifter''), whereas this proposed AD would apply to Model BO–105 LS A–3 helicopters modified in accordance with STC SR00043RD.

Costs of Compliance

The FAA estimates that this AD, if adopted as proposed, would affect 67 helicopters of U.S. Registry. Labor rates are estimated at $85 per work-hour. Based on these numbers, the FAA

estimates the following costs to comply with this proposed AD.

Incorporating requirements (airworthiness limitations) into existing maintenance records would take about 2 work-hours for an estimated cost of $170 per helicopter and $11,390 for the U.S. fleet.

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

The FAA determined that this proposed AD would not have federalism implications under Executive Order 13132. This proposed AD would 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 this proposed regulation:

(1) Is not a ''significant regulatory action'' under Executive Order 12866,

(2) Would not affect intrastate aviation in Alaska, and

(3) Would 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 Proposed Amendment

Accordingly, under the authority delegated to me by the Administrator, the FAA proposes to amend 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:

■ a. Removing Airworthiness Directive 77–04–06, Amendment 39–2835 (42 FR 9670, February 17, 1977; amended 44 FR 46783, August 9, 1979); Airworthiness Directive 2002–13–06, Amendment 39–12794 (67 FR 43526, June 28, 2002); Airworthiness Directive 2016–25–14, Amendment 39–18740 (81 FR 94944, December 27, 2016); and Airworthiness Directive 2021–10–14, Amendment 39–21547 (86 FR 27268, May 20, 2021); and

■ b. Adding the following new airworthiness directive:

Airbus Helicopters Deutschland GmbH (AHD): Docket No. FAA–2022–1070; Project Identifier MCAI–2021–00686–R.

(a) Comments Due Date

The FAA must receive comments on this airworthiness directive (AD) by October 24, 2022.

(b) Affected ADs

This AD replaces the ADs specified in paragraphs (b)(1) through (4) of this AD.

(1) AD 77–04–06, Amendment 39–2835 (42 FR 9670, February 17, 1977; amended 44 FR 46783, August 9, 1979).

(2) AD 2002–13–06, Amendment 39–12794 (67 FR 43526, June 28, 2002).

(3) AD 2016–25–14, Amendment 39–18740 (81 FR 94944, December 27, 2016).

(4) AD 2021–10–14, Amendment 39–21547 (86 FR 27268, May 20, 2021).

Note 1 to paragraph (b): The requirements of this AD capture the latest tasks and life limits required to prevent the unsafe conditions addressed by the ADs that are identified in paragraphs (b)(1) through (4) of this AD.

(c) Applicability

This AD applies to all Airbus Helicopters Deutschland GmbH (AHD) Model BO–105A, BO–105C, BO–105S, BO–105LS A–1, and BO–105LS A–3 helicopters, including BO–105LS A–3 helicopters modified in accordance with Supplemental Type Certificate SR00043RD, certificated in any category.

(d) Subject

Joint Aircraft Service Component (JASC) Code: 6300, Main Rotor Drive System.

(e) Unsafe Condition

This AD was prompted by new and more restrictive airworthiness limitations. The FAA is issuing this AD to address the failure of certain parts, which could result in the loss of control of the helicopter.

(f) Compliance

Comply with this AD within the compliance times specified, unless already done.

(g) Required Actions

(1) Within 30 days after the effective date of this AD, incorporate into maintenance records required by 14 CFR 91.417(a)(2) or 135.439(a)(2), as applicable for your model and configuration helicopter, the requirements (airworthiness limitations) specified in paragraphs (1.1), (1.2), and (1.3), and the Definitions section, of European Union Aviation Safety Agency (EASA) AD 2021–0142, dated June 17, 2021 (EASA AD 2021–0142). Where paragraphs (1.2) and (1.3) of EASA AD 2021–0142 refer to its effective date, this AD requires using the effective date of this AD.

(2) As of the effective date of this AD, comply with the parts installation prohibition specified in paragraph (2) of EASA AD 2021–0142.

(h) Provisions for Alternative Requirements (Airworthiness Limitations)

After the actions required by paragraph (g)(1) of this AD have been done, no alternative requirements (airworthiness limitations) are allowed unless they are approved as specified in the provisions of the ''Ref. Publications'' section of EASA AD 2021–0142.

(i) Special Flight Permit

Special flight permits, as described in 14 CFR 21.197 and 21.199, are prohibited.

(j) Alternative Methods of Compliance (AMOCs)

(1) The Manager, International Validation 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 local Flight Standards District Office, as appropriate. If sending information directly to the manager of the International Validation Branch, send it to the attention of the person identified in paragraph (k)(2) of this AD. Information may be emailed to: *9-AVS-AIR-730-AMOC@faa.gov.*

(2) Before using any approved AMOC, notify your appropriate principal inspector, or lacking a principal inspector, the manager of the local flight standards district office/certificate holding district office.

(k) Related Information

(1) For EASA AD 2021–0142, contact EASA, Konrad-Adenauer-Ufer 3, 50668 Cologne, Germany; telephone +49 221 8999 000; email *ADs@easa.europa.eu;* internet *www.easa.europa.eu.* You may find the EASA material on the EASA website at *https://ad.easa.europa.eu.* You may view this material at the FAA, Office of the Regional Counsel, Southwest Region, 10101 Hillwood Pkwy., Room 6N–321, Fort Worth, TX 76177. For information on the availability of this material at the FAA, call (817) 222–5110. This material may be found in the AD docket at *www.regulations.gov* by searching for and locating Docket No. FAA–2022–1070.

(2) For more information about this AD, contact Kristi Bradley, COS Program Manager, COS Program Management Section, Operational Safety Branch, Compliance & Airworthiness Division, FAA, 10101 Hillwood Parkway, Fort Worth, TX 76177; telephone (817) 222–5110; email *kristin.bradley@faa.gov.*

Issued on August 31, 2022.

Christina Underwood,

Acting Director, Compliance & Airworthiness Division, Aircraft Certification Service.

[FR Doc. 2022–19220 Filed 9–6–22; 8:45 am]

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COMMODITY FUTURES TRADING COMMISSION

RIN 3038–AF31

SECURITIES AND EXCHANGE COMMISSION

17 CFR Parts 275 and 279

[Release No. IA–6083; File No. S7–22–22]

RIN 3235–AN13

Form PF; Reporting Requirements for All Filers and Large Hedge Fund Advisers

Correction

In proposed rule document 2022–17724 appearing on pages 53832–53985 in the issue of Thursday, September 1, 2022, make the following correction:

§ 279.9 [Corrected]

On page 53900, in the second column, amendatory instruction 4 is corrected to read as set forth below:

§ 279.9 Form PF, reporting by investment advisers to private funds.

4. Form PF [referenced in § 279.9] is revised to read as follows. The revised version of Form PF is attached as Appendix A.

Note: The text of Form PF does not, and the amendments will not, appear in the Code of Federal Regulations.

[FR Doc. C1–2022–17724 Filed 9–6–22; 8:45 am]

BILLING CODE 0099–10–D

NATIONAL LABOR RELATIONS BOARD

29 CFR Part 103

RIN 3142–AA21

Standard for Determining Joint-Employer Status

AGENCY: National Labor Relations Board.

ACTION: Notice of proposed rulemaking; request for comments.

SUMMARY: This notice of proposed rulemaking (NPRM) proposes to rescind and replace the final rule entitled ''Joint Employer Status Under the National Labor Relations Act,'' which was published on February 26, 2020 and took effect on April 27, 2020. The proposed rule would revise the standard for determining whether two employers, as defined in section 2(2) of the National Labor Relations Act (NLRA or Act), are joint employers of particular employees within the meaning of section 2(3) of the Act. The proposed changes are designed to explicitly ground the joint-employer standard in established common-law agency principles and provide relevant guidance to parties covered by the Act regarding their rights and responsibilities when more than one statutory employer possesses the authority to control or exercises the power to control particular employees' essential terms and conditions of employment.

DATES: Comments regarding this proposed rule must be received by the National Labor Relations Board (NLRB or Board) on or before November 7, 2022. Comments replying to comments submitted during the initial comment period must be received by the Board on or before November 21, 2002. Reply comments should be limited to replying to comments previously filed by other parties. No late comments will be accepted. Requests for extensions of time will be granted only for good cause shown.

ADDRESSES:

Internet—Federal eRulemaking Portal. Electronic comments may be submitted through *http://www.regulations.gov*. Follow the instructions for submitting comments.

Delivery—Comments may be submitted by mail or hand delivery to: Roxanne L. Rothschild, Executive Secretary, National Labor Relations Board, 1015 Half Street SE, Washington, DC 20570–0001.

For important information concerning the submission of comments and their treatment, see **SUPPLEMENTARY INFORMATION**.

FOR FURTHER INFORMATION CONTACT: Roxanne L. Rothschild, Executive Secretary, National Labor Relations Board, 1015 Half Street SE, Washington, DC 20570–0001, (202) 273–1940 (this is not a toll-free number), 1–866–315–6572 (TTY/TDD).

SUPPLEMENTARY INFORMATION:

I. Submission of Comments

Because of security precautions, the Board continues to experience delays in U.S. mail delivery. You should take this into consideration when preparing to meet the deadline for submitting comments. It is not necessary to mail comments if they have been filed electronically with *regulations.gov*. If you mail comments, the Board recommends that you confirm receipt of your delivered comments by contacting (202) 273–1940 (this is not a toll-free number). Individuals with hearing impairments may call 1–866–315–6572 (TTY/TDD). Because of precautions in place due to COVID–19, the Board recommends that comments be submitted electronically or by mail rather than by hand delivery. If you feel you must hand deliver comments to the Board, hand delivery will be accepted by appointment only. Please call (202) 273–1940 to arrange for hand delivery of comments. Please note that there may be a delay in the electronic posting of hand-delivered and mail comments due to the needs for safe handling and manual scanning of the comments. The Board strongly encourages electronic filing over mail or hand delivery of comments.

Only comments submitted through *http://www.regulations.gov,* mailed or hand delivered per the procedure described above will be accepted; ex parte communications received by the Board will be made part of the rulemaking record and will be treated as comments only insofar as appropriate. Comments will be available for public inspection at *http://www.regulations.gov* and during normal business hours (8:30 a.m. to 5 p.m. EST) at the above address.

As soon as practicable, the Board will post all comments received on *http://www.regulations.gov*. The website *http://www.regulations.gov* is the Federal eRulemaking portal, and all comments posted there are available and accessible to the public. The Board requests that comments include full citations or internet links to any authority relied upon. If a comment cites a source that is not publicly available, the Board requests that the commenter submit a copy of that source along with its comment.

The Board will not make any changes to the comments, including any personal information provided therein. The Board cautions commenters not to include personal information such as Social Security numbers, personal addresses, telephone numbers, and email addresses in their comments, as such submitted information will become viewable by the public via the *http://www.regulations.gov* website. It is a commenter's responsibility to safeguard their information. Comments submitted through *http://www.regulations.gov* will

not include the commenter's email address unless the commenter chooses to include that information as part of their comment.

II. Background

As described more fully below, in 2015, the Board restored and clarified its traditional, common-law based standard for determining whether two employers, as defined in section 2(2) of the Act, are joint employers of particular employees within the meaning of section 2(3) of the Act. See *Browning-Ferris Industries of California, Inc., d/b/a BFI Newby Island Recyclery,* 362 NLRB 1599 (2015) (*BFI*). Consistent with established common-law agency principles, and rejecting prior limitations established without explanation, the Board announced that it would consider evidence of reserved and indirect control over employees' essential terms and conditions of employment when analyzing joint-employer status.

While *BFI* was pending on review before the United States Court of Appeals for the District of Columbia Circuit, and following a change in the Board's composition, the Board issued a notice of proposed rulemaking with the goal of establishing a joint-employer standard that departed in significant respects from *BFI.* During the comment period, the District of Columbia Circuit issued its decision in *Browning-Ferris Industries of California, Inc.* v. *NLRB,* 911 F.3d 1195, 1222 (D.C. Cir. 2018), upholding ''as fully consistent with the common law the Board's determination that both reserved authority to control and indirect control can be relevant factors in the joint-employer analysis,'' and remanding the case to the Board to refine the new standard. Thereafter, the Board issued a final rule that again constrained the joint-employer standard. Because the Board believes, contrary to our dissenting colleagues and subject to comments, that the 2020 final rule (2020 Rule) repeats the errors that the Board corrected in *BFI,* it proposes to rescind that standard and replace it with a new rule that incorporates the *BFI* standard and responds to the District of Columbia Circuit's invitation for the Board to refine that standard in its 2018 decision on review.

A. Statutory Background

Section 2(2) of the National Labor Relations Act defines an ''employer'' to include ''any person acting as an agent of an employer, *directly or indirectly.*'' 29 U.S.C. 152(2) (emphasis added). In turn, the Act provides that the ''term 'employee' shall include any employee, and shall not be limited to the employees of a particular employer, unless [the Act] explicitly states otherwise . . . .'' Id. 152(3).

Section 7 of the Act provides that employees shall have the right to self-organization, to form, join, or assist labor organizations, to bargain collectively through representatives of their own choosing, and to engage in other concerted activities for the purpose of collective bargaining or other mutual aid or protection and to refrain from any or all such activities. 29 U.S.C. 157. Section 9(c) of the Act authorizes the Board to process a representation petition when employees wish to be represented for collective bargaining and their employer declines to recognize their representative. 29 U.S.C. 159(c). And section 8(a)(5) makes it an unfair labor practice for an employer to refuse to bargain collectively with the representatives of his employees. 29 U.S.C. 158(a)(5).

The Act does not specifically address situations in which statutory employees are employed jointly by two or more statutory employers (*i.e.,* it is silent as to the definition of ''joint employer''), but, as discussed below, the Board, with court approval, has long applied common-law agency principles to determine when one or more entities share or codetermine the essential terms and conditions of employment of a particular group of employees.

B. The Development of Joint-Employer Law Under the National Labor Relations Act

In *Boire* v. *Greyhound Corp.,* 376 U.S. 473, 481 (1964), a representation case involving the relationship between a company operating a bus terminal and its cleaning contractor, the Supreme Court explained that the question of whether Greyhound ''possessed sufficient control over the work of the employees to qualify as a joint employer'' was ''essentially a factual question'' for the Board to determine.[1] The Board's subsequent decision in *Greyhound Corp.,* 153 NLRB 1488 (1965), enfd. 368 F.2d 776 (5th Cir. 1966), completed that task. Specifically, the Board found, and the Fifth Circuit affirmed, that Greyhound and the cleaning contractor were joint employers of the employees at issue because they ''share[d], or codetermine[d], those matters governing essential terms and conditions of employment.'' *Greyhound Corp.,* 153 NLRB at 1495.

For nearly two decades after *Greyhound,* the Board treated the right to control employees' work and their terms and conditions of employment as determinative in the joint-employer analysis. During this period, the Board's joint-employer analysis generally did not turn on whether both putative joint employers actually or directly exercised control. In cases involving reserved control, the Board found it probative when a putative joint employer retained the contractual power to reject or terminate workers,[2] establish or approve wage rates,[3] set working hours and schedules,[4] approve overtime,[5] dictate the number of workers to be supplied,[6] determine ''the manner and method of work performance,'' [7] ''inspect and approve work,'' [8] and terminate the contractual agreement itself at will.[9] Reviewing courts endorsed the Board's consideration of reserved control as probative in the joint-employer analysis.[10]

Similarly, the Board found a putative joint employer's indirect exercise of control over employees' essential terms and conditions of employment probative in the joint-employer analysis during this period.[11] The Board found evidence of joint-employer status where a putative joint employer inspected another firm's employees' work, communicated work directives through the other firm's supervisors, and exercised the power to open and close the facility based on production

[1] *Boire* v. *Greyhound Corp.* did not directly pass upon the test for joint-employer status. The Supreme Court's primary holding in that case was that the courts lacked subject-matter jurisdiction to enjoin the Board from making a joint-employer determination under *Leedom* v. *Kyne,* 358 U.S. 154 (1958). Thus, following the Supreme Court's decision, the Board was able to resolve the merits of the joint-employer question, subject to the statutory judicial review process.

[2] See *Lowery Trucking Co.,* 177 NLRB 13, 15 (1969), enfd. sub nom. *Ace-Alkire Freight Lines* v. *NLRB,* 431 F.2d 280 (8th Cir. 1970) (observing that ''[w]hile [putative employer] never rejected a driver hired by [supplier], it had the right to do so''); *Ref-Chem Co.,* 169 NLRB 376, 379 (1968), enf. denied on other grounds 418 F.2d 127 (5th Cir. 1969); *Jewel Tea Co.,* 162 NLRB 508, 510 (1966).

[3] See *Ref-Chem Co.,* supra, 169 NLRB at 379; *Harvey Aluminum,* 147 NLRB 1287, 1289 (1964).

[4] See *Jewel Tea,* supra, 162 NLRB at 510; *Mobil Oil Corp.,* 219 NLRB 511, 516 (1975), enf. denied on other grounds sub nom. *Alaska Roughnecks and Drillers Assn.* v. *NLRB,* 555 F.2d 732 (9th Cir. 1977).

[5] *Ref-Chem Co.* v. *NLRB,* supra, 418 F.2d at 129.

[6] *Harvey Aluminum,* supra, 147 NLRB at 1289; *Mobil Oil,* supra, 219 NLRB at 516.

[7] *Value Village,* 161 NLRB 603, 607 (1966).

[8] *Ref-Chem Co.* v. *NLRB,* supra, 418 F.2d at 129.

[9] *Value Village,* supra, 161 NLRB at 607; *Mobil Oil,* supra, 219 NLRB at 516.

[10] See *Carrier Corp.* v. *NLRB,* 768 F.2d 778, 781 (6th Cir. 1985); *International Chemical Workers Union Local 483* v. *NLRB,* 561 F.2d 253, 255 (D.C. Cir. 1977); *Ace-Alkire Freight Lines* v. *NLRB,* supra, 431 F.2d at 282; *Ref-Chem Co.* v. *NLRB,* supra, 418 F.2d at 129.

[11] See *Floyd Epperson,* 202 NLRB 23, 23 (1973), enfd. 491 F.2d 1390 (6th Cir. 1974).

needs.[12] The Board also found evidence of joint-employer status where a putative joint employer held ''day-to-day responsibility for the overall operations'' at a facility and determined the nature of work assignments, even though that entity ''did not exercise direct supervisory authority'' over the employees.[13] And, the Board assigned weight to evidence showing that a putative joint employer wielded indirect control over wages through a variety of contractual arrangements.[14]

In 1981, the Third Circuit endorsed the Board's ''share or codetermine'' formulation of the joint-employer standard. *NLRB* v. *Browning-Ferris Industries of Pennsylvania, Inc.,* 691 F.2d 1117, 1123 (3d Cir. 1982), enfg. 259 NLRB 148 (1981). Although subsequent Board decisions cited the Third Circuit's decision as a correct statement of law, those decisions also began imposing additional requirements that, the Board now believes, lacked a clear basis in established common-law agency principles or prior Board or court decisions. See *TLI, Inc.,* 271 NLRB 798 (1984), and *Laerco Transportation,* 269 NLRB 324 (1984). Specifically, subsequent Board decisions introduced three control-related restrictions requiring (1) that a putative joint employer ''actually'' exercise control, (2) that such control be ''direct and immediate,'' and (3) that such control not be ''limited and routine.'' See, *e.g., AM Property Holding Corp.,* 350 NLRB 998, 999–1003 (2007), enfd. in relevant part sub nom. *Service Employees International Union, Local 32BJ* v. *NLRB,* 647 F.3d 435 (2d Cir. 2011); *Airborne Express,* 338 NLRB 597, 597 (2002); *Flagstaff Medical Center,* 357 NLRB 659, 666–667 (2011).[15] By introducing these additional requirements, *TLI*/*Laerco* and their progeny departed, without explanation, from the Board's longstanding approach, which the Board is inclined to believe was consistent with the common law.

In 2015, the Board clarified its joint-employer standard in *Browning-Ferris Industries of California, Inc., d/b/a BFI Newby Island Recyclery,* 362 NLRB 1599 (2015) (*BFI*), a representation case, and applied that standard retroactively to find that two employers jointly employed the employees in the petitioned-for unit. Consistent with Supreme Court decisions and pre-1984 Board precedent, *BFI* sought to firmly ground the joint-employer standard in established common-law agency principles.[16] As the *BFI* Board explained, under the new joint-employer standard:

> [T]he Board may find that two or more statutory employers are joint employers of the same statutory employees if they ''*share or codetermine those matters governing the essential terms and conditions of employment.*'' In determining whether a putative joint employer meets this standard, the initial inquiry is whether there is a common-law employment relationship with the employees in question.

362 NLRB at 1600 (emphasis added) (quoting *NLRB* v. *Browning-Ferris Industries of Pennsylvania, Inc.,* 691 F.2d 1117, 1123 (3d Cir. 1982), enfg. 259 NLRB 148 (1981)).[17]

The *BFI* Board also addressed an important element of the ''share or codetermine'' test: the definition of ''the essential terms and conditions of employment'' that a joint employer must control. The *BFI* Board, in keeping with the Board's longstanding practice, took ''an inclusive approach in defining 'essential terms and conditions of employment.' '' 362 NLRB at 1613. Citing prior Board and judicial decisions, the Board identified a ''non-exhaustive list of bargaining subjects,'' which included: hiring, firing, discipline, supervision, direction, wages, hours, dictating the number of workers to be supplied, scheduling, seniority, overtime, assigning work, and determining the manner and method of work performance. Id.

The *BFI* Board also eliminated the restrictive requirements that had been introduced into Board law after the Third Circuit's 1982 *Browning-Ferris* decision. *BFI* explained that these control-related restrictions were contrary to common-law agency principles and that the Board would ''no longer require that a joint employer not only possess the authority to control employees' terms and conditions of employment, but must also exercise that authority, and do so directly, immediately, and not in a 'limited and routine' manner.'' Id. at 1600, 1613–1614. Instead, it held that the ''right to control, in the common-law sense, is probative of joint-employer status, as is the actual exercise of control, whether direct or indirect.'' Id. at 1614. The Board overruled contrary precedent.[18]

On September 14, 2018, while *BFI* was pending before the U.S. Court of Appeals for the District of Columbia Circuit on review,[19] a divided Board issued a notice of proposed rulemaking to establish a new joint-employer standard.[20] The 2018 NPRM proposed to return to the more restrictive pre-*BFI* approach to determining joint-employer status. Specifically, the proposed rule provided that a ''putative joint employer must possess and actually exercise substantial direct and immediate control over the employees' terms and conditions of employment in a manner that is not limited and routine.'' Id. at 46696–46697.

On December 28, 2018, the U.S. Court of Appeals for the District of Columbia Circuit issued its decision in *BFI. Browning-Ferris Industries of California, Inc.* v. *NLRB (BFI),* 911 F.3d 1195 (D.C. Cir. 2018). The District of Columbia Circuit ''uph[e]ld as fully consistent with the common law the Board's

[12] See *Hamburg Industries,* 193 NLRB 67, 67 (1971); *International Trailer Co.,* 133 NLRB 1527, 1529 (1961), enfd. sub nom. *NLRB* v. *Gibraltar Industries,* 307 F.2d 428 (1962), cert. denied 372 U.S. 911 (1963).

[13] *Clayton B. Metcalf,* 223 NLRB 642, 643 (1976).

[14] *Hamburg Industries,* supra, 193 NLRB at 67–68 (assigning weight to putative employer's ''indirect control over wages'' via cost-plus arrangement); *Hoskins Ready-Mix,* 161 NLRB 1492, 1493 (1966) (same, noting that user employer would be the ''ultimate source of any wage increases'' for workers); *Ref-Chem Co.,* supra, 169 NLRB at 379 (supplier could not make any wage modification without securing approval of the user). See also *Industrial Personnel Corp.* v. *NLRB,* 657 F.2d 226, 229 (8th Cir. 1981) (relying on the Board's finding that user employer reimbursed supplier for employees' wages).

[15] See also *Southern California Gas Co.,* 302 NLRB 456, 461–462 (1991); *Goodyear Tire and Rubber Co.,* 312 NLRB 674, 677–678 (1993).

[16] See, *e.g., NLRB* v. *United Insurance Co. of America* 390 U.S. 254, 256–258 (1968) (applying common-law test to determine whether insurance agents were statutory employees or independent contractors).

[17] See also 362 NLRB at 1613–1614 (articulating restated standard and explaining that ''[t]he common-law definition of an employment relationship establishes the outer limits of a permissible joint-employer standard under the Act''). The *BFI* Board further explained that ''[i]f this common-law employment relationship exists, the inquiry then turns to whether the putative joint employer possesses sufficient control over employees' essential terms and conditions of employment to permit meaningful collective bargaining.'' Id. at 1600.

[18] See 362 NLRB at 1614 (overruling *AM Property Holding Corp.,* 350 NLRB 998 (2007), enfd. in relevant part sub nom. *Service Employees Int'l Union, Local 32BJ* v. *NLRB,* 647 F.3d 435 (2d Cir. 2011); *Airborne Express,* 338 NLRB 597 (2002), *TLI, Inc.,* 271 NLRB 798 (1984), enfd. mem. 772 F.2d 894 (3d Cir. 1985); and *Laerco Transportation,* 269 NLRB 324 (1984)).

[19] After the Board certified the petitioning union, BFI refused to bargain. The Board found that BFI's refusal to bargain violated Sec. 8(a)(5) and (1) of the Act. See *Browning-Ferris Industries of California, Inc.,* 363 NLRB No. 95 (2016). BFI sought review of the *BFI* decision by the District of Columbia Circuit.

While *BFI* was pending before the District of Columbia Circuit, the Board overruled *BFI* in *Hy-Brand Industrial Contractors, Ltd.,* 365 NLRB No. 156 (2017). Thereafter, *Hy-Brand* was vacated, and the Board explained that because the decision was vacated, the ''overruling of the *Browning-Ferris* decision is of no force or effect.'' *Hy-Brand Industrial Contractors, Ltd.,* 366 NLRB No. 26, slip op. at 1 (2018).

[20] See *The Standard for Determining Joint-Employer Status,* 83 FR 46681 (Sept. 14, 2018). Then-Member McFerran dissented.

determination that both reserved authority to control and indirect control can be relevant factors in the joint-employer analysis.'' Id. at 1222. The court affirmed that ''under Supreme Court and circuit precedent, the National Labor Relations Act's test for joint-employer status is determined by the common law of agency.'' Id. at 1206. In addition, the court agreed that the ''Board's conclusion that an employer's authorized or reserved right to control is relevant evidence of a joint-employer relationship wholly accords with traditional common-law principles of agency.'' Id. at 1213. The court found that the Board ''correctly discerned'' that under the common law, ''indirect control can be a relevant factor in the joint-employer inquiry.'' Id. at 1216.

Despite broadly upholding the Board's *BFI* joint-employer standard, the District of Columbia Circuit reversed the Board's ''articulation and application of the indirect-control element'' to the extent that the Board did not ''distinguish between indirect control that the common law of agency considers intrinsic to ordinary third-party contracting relationships, and indirect control over the essential terms and conditions of employment.'' Id. at 1222–1223. In remanding the case to the Board, the court identified as key the ''common-law principle that a joint employer's control—whether direct or indirect, exercised or reserved—must bear on the 'essential terms and conditions of employment' . . . and not on the routine components of a company-to-company contract.'' Id. at 1221 (citation omitted).[21]

On February 26, 2020, the Board promulgated its final joint-employer rule.[22] Although the Board acknowledged the District of Columbia Circuit's approval of the *BFI* Board's use of common-law agency principles in fashioning its joint-employer standard, the Board emphasized that ''the court recognized that [*BFI*] did not present the issue of whether either indirect control or a contractually reserved but unexercised right to control can be dispositive of joint-employer status absent evidence of exercised direct and immediate control.'' Id. at 11185. As a result, the Board explained that it modified the proposed rule to ''factor in'' an entity's indirect and reserved control over essential terms and conditions of employment or mandatory subjects of bargaining, but only to the extent that such indirect and/or reserved control ''supplements and reinforces'' evidence that the entity also possesses or exercises direct and immediate control over essential terms and conditions of employment. Id. at 11185–11186, 11194–11198, and 11236.

The Board also included several additional definitions in the final rule. Id. at 11192–11193. The final rule specifically explained that to show that an entity ''shares or codetermines'' the essential terms and conditions of another employer's employees, ''the entity must possess and exercise such substantial direct and immediate control over one or more essential terms or conditions of their employment as would warrant finding that the entity meaningfully affects matters relating to the employment relationship with those employees.' '' Id. at 11186 and 11236. The Board also retained the requirement that a joint employer exercise ''substantial direct and immediate control'' and defined that term to mean ''direct and immediate control that has a regular or continuous consequential effect on an essential term or condition of employment of another employer's employees.'' Id. at 11203–11205 and 11236. The final rule also specified that control is not ''substantial'' if it is ''only exercised on a sporadic, isolated, or de minimis basis.'' Id. at 11236. The final rule also defined ''indirect control'' as ''indirect control over essential terms and conditions of employment of another employer's employees but not control or influence over setting the objectives, basic ground rules, or expectations for another entity's performance under a contract.'' Id. at 11236. The Board provided an ''exhaustive'' list of essential terms and conditions of employment that included ''wages, benefits, hours of work, hiring, discharge, discipline, supervision, and direction'' and which the Board noted was ''expanded and made exclusive.'' Id. at 11186, 11205 and 11235–11236.[23]

III. Validity and Desirability of Rulemaking

Section 6 of the Act provides that ''[t]he Board shall have authority from time to time to make, amend, and rescind, in the manner prescribed by the Administrative Procedure Act, such rules and regulations as may be necessary to carry out the provisions of this Act.'' 29 U.S.C. 156. See also *American Hospital Assn.* v. *NLRB,* 499 U.S. 606 (1991); *NLRB* v. *Bell Aerospace Co.,* 416 U.S. 267, 294 (1974) (''[T]he choice between rulemaking and adjudication lies in the first instance within the Board's discretion.''); *NLRB* v. *Wyman-Gordon Co.,* 394 U.S. 759 (1969).

For nearly the entirety of the Act's history, the Board has developed its joint-employer jurisprudence through case-by-case adjudication. The Board's 2020 Rule represented a significant departure from this precedent, for the first time formulating a joint-employer standard through the Board's rulemaking authority. In comparison to rulemaking, adjudication possesses a number of benefits when determining joint-employer relationships. The issue of common-law joint-employer status is a highly fact-specific one, which may be better suited to individualized determination on a case-by-case basis.[24] Further, an exhaustive, ''one-size-fits-all'' rule may be an inappropriate mechanism to address the complex and fact-specific scenarios presented by sophisticated contracting arrangements in the modern workplace.

Subject to comments, the Board nevertheless believes that rescinding the 2020 Rule and setting forth a revised joint-employer standard through rulemaking is desirable for several reasons. First, the Board believes, subject to comments, that the 2020 Rule's approach to defining joint-

[21] On remand, the Board declined the District of Columbia Circuit's invitation to clarify and refine the joint-employer standard. Instead, the Board found that any retroactive application of a refined standard would be manifestly unjust. The Board therefore dismissed the complaint and amended the certification of representative to remove BFI as a joint employer. *Browning-Ferris Industries of California, Inc. d/b/a BFI Newby Island Recyclery,* 369 NLRB No. 139, slip op. at 1 (2020). Thereafter, a divided Board denied the union's motion for reconsideration. *Browning-Ferris Industries of California, Inc. d/b/a BFI Newby Island Recyclery,* 370 NLRB No. 86 (2021).

On July 29, 2022, the District of Columbia Circuit found the Board's retroactivity analysis erroneous and granted the union's petition for review and vacated the Board's order dismissing the complaint and amending the certification of representative. *Sanitary Truck Drivers & Helpers Local 350, International Brotherhood of Teamsters* v. *NLRB,* ---- F.4th ----, 2022 WL 3008026 (D.C. Cir. 2022).

[22] *Joint Employer Status Under the National Labor Relations Act,* 85 FR 11184 (Feb. 26, 2020). Then-Member McFerran's term had ended on December 16, 2019.

[23] On September 17, 2021, the Service Employees International Union (SEIU) filed a complaint in the U.S. District Court for the District of Columbia, Case No. 21–cv–2443, challenging the final joint-employer rule and seeking declaratory judgment and injunctive relief. SEIU's lawsuit alleged, inter alia, that the Board's final rule ''arbitrarily and capriciously'' excluded health and safety matters from the rule's exhaustive list of essential terms and conditions of employment. On December 10, the Office of Information and Regulatory Affairs (OIRA) published the fall unified regulatory agenda, which contained an entry for the Board's planned joint-employer rulemaking. Thereafter, on December 22, 2021, SEIU and the Board filed a joint motion to stay the proceeding, which the court granted on January 6, 2022.

[24] See 362 NLRB at 1614 (noting that ''issues [of joint-employer status] are best examined and resolved in the context of specific factual circumstances.'').

employer status wrongly departs from common-law agency principles, which the National Labor Relations Act makes applicable in this context. In the Board's view, the 2020 Rule again incorporates control-based restrictions that unnecessarily narrow the common law and which threaten to undermine the goals of Federal labor law. By expressly grounding the joint-employer standard in the common law, the proposed rule would avoid repeating the errors the Board made beginning in the mid-1980s and incorporated again in the 2020 Rule. Instead, the proposed rule would restore the Board's focus on whether a putative joint employer possesses the authority to control or exercises the power to control particular employees' essential terms and conditions of employment, consistent with the common law and relevant court decisions. Finally, the proposed rule responds to the District of Columbia Circuit's invitation for the Board to ''erect some legal scaffolding'' to ensure that the joint-employer standard appropriately focuses on forms of reserved and indirect control that bear on employees' essential terms and conditions of employment.[25]

Moreover, the Board believes that establishing a definite, readily available standard will assist employers and labor organizations in complying with the Act. In addition, because the joint-employer standard has changed several times in the past decade, the Board sees a heightened need to seek public comment on this important area of labor law. The Board also seeks to establish a rule regarding joint employers' bargaining obligations and potential unfair labor practice liability that correctly reflects both background legal principles and the National Labor Relations Act's public policy of ''encouraging the practice and procedure of collective bargaining'' and maximizing employees' ''full freedom of association, self-organization, and designation of representatives of their own choosing, for the purpose of negotiating the terms and conditions of their employment or other mutual aid or protection.'' 29 U.S.C. 151. While no rule can eliminate the prospect of all litigation in this fact-intensive area of law, it is the Board's hope that the proposed rule, codifying what we view as the essential elements of a joint employer relationship, will reduce uncertainty and litigation over the basic parameters of joint-employer status. The Board therefore tentatively believes rulemaking to have determinate advantages over addressing joint-employer issues purely through adjudication.

[25] See *BFI,* 911 F.3d at 1220.

IV. The Proposed Rule

The proposed rule would codify the Board's longstanding joint-employer standard, approved by the Third Circuit and the District of Columbia Circuit Court of Appeals, which provides that an employer is a joint employer of particular employees if the employer has an employment relationship with those employees under established common-law agency principles and the employer shares or codetermines those matters governing at least one of the employees' essential terms and conditions of employment. Consistent with common-law agency principles and the District of Columbia Circuit's decision in *BFI,* the Board believes, subject to comments, that a party asserting a joint-employment relationship may establish joint-employer status with evidence of indirect and reserved forms of control, so long as those forms of control bear on employees' essential terms and conditions of employment. The proposed rule reflects the Board's preliminary view, subject to comments, that the Act's purposes of promoting collective bargaining and stabilizing labor relations are best served when two or more statutory employers that each possess some authority to control or exercise the power to control employees' essential terms and conditions of employment are parties to bargaining over those employees' working conditions.[26]

A. Proposal To Clarify That an Employer Is an Employer of Particular Employees if the Employer Has an Employment Relationship With Those Employees Under Common-Law Agency Principles

Proposed § 103.40(a) provides that an employer, as defined by section 2(2) of the National Labor Relations Act, is an employer of particular employees, as defined by section 2(3) of the Act, if the employer has an employment relationship with those employees under common-law agency principles. Proposed § 103.40(a) would explicitly ground the Board's joint-employer analysis in common-law agency principles, consistent with the Board and District of Columbia Circuit decisions in *BFI.* As the Supreme Court has explained, common-law agency principles apply when construing Federal statutes whose terms are interpreted under the common law.[27] Relevant sources of common-law agency principles are not hard to find. Subject to comments and as set forth further below, the Board believes that such sources include primary articulations of these principles by common-law judges as well compendiums, reports, and restatements of common law decisions such as the *Restatement (Second) of Agency* (1958), and early court decisions addressing ''master-servant relations.'' [28]

As the District of Columbia Circuit has recognized, both the first *Restatement of Agency* and the *Restatement (Third) of Agency* ''identify the 'right to control' as a relevant factor in establishing [an] . . . employment relationship.'' *BFI,* 911 F.3d at 1213. Going farther, the *Restatement (Second) of Agency* (1958) makes clear that the right to control is the touchstone of the common-law employment relationship. Thus, as the District of Columbia Circuit explained in *BFI,* ''the 'right to control'

[26] The proposed rule does not incorporate *BFI*'s requirement that a ''putative joint employer possess[ ] sufficient control over employees' essential terms and conditions of employment to permit meaningful collective bargaining.'' 362 NLRB at 1600. However, the Board's initial view, subject to comments, is that by focusing on whether a putative joint employer possesses the authority to control or exercises the power to control employees' essential terms and conditions of employment, any required bargaining under the new standard will necessarily be meaningful. We emphasize that, consistent with *BFI,* the proposed rule would only require a putative joint employer to bargain over those essential terms and conditions of employment it possesses the authority to control or over which it exercises the power to control.

[27] See *NLRB* v. *Town & Country Electric, Inc.,* 516 U.S. 85, 92–95 (1995) (where Congress has used the term ''employee'' in a statute without clearly defining it, the Court assumes that Congress ''intended to describe the conventional master-servant relationship as understood by common-law agency doctrine''). See also *Clackamas Gastroenterology Associates, P.C.* v. *Wells,* 538 U.S. 440, 448–449 (2003); *Nationwide Mutual Insurance Co.* v. *Darden,* 503 U.S. 318, 322–324 (1992); *Community for Creative Non-Violence* v. *Reid,* 490 U.S. 730, 740, 752 fn. 31 (1989); *Kelley* v. *Southern Pacific Co.,* 419 U.S. 318, 323–324 (1974); *NLRB* v. *United Insurance Co. of* America, 390 U.S. 254, 256–258 (1968).

[28] As described above, the employer-employee relationship under the Act is the common-law employer-employee relationship, which is also described (particularly in older sources) using the term ''master-servant relations.'' Beginning in the late 19th century, American legal commentators began to use the terms ''master-servant'' and ''employer-employee'' interchangeably. See, *e.g.,* Horace Gray Wood, *A Treatise on the Law of Master and Servant; Covering the Relation, Duties and Liabilities of Employers and Employees* (1877). The *Restatement (Second) of Agency* and other secondary sources from the early to mid-20th century similarly treat these sets of terms as synonymous. See *Restatement (Second of Agency),* sec. 2 cmt. d (''The word 'employee' is commonly used in current statutes to indicate the type of person herein described as servant.''); 35 Am. Jur. Master and Servant sec. 2 (1st ed. 1941) (''The relationship of employer and employee is the same as that of master and servant.''). Accordingly, we refer elsewhere in the NPRM to the ''employer-employee'' relations and the ''employer-employee relationship.''

runs like a *leitmotif* through the *Restatement (Second) of Agency*.'' 911 F.3d at 1211. The *Restatement's* definitions of ''master'' and ''servant'' confirm that the right to control is sufficient to establish an employment relationship. The *Restatement* defines ''master'' as ''a principal who employs an agent to perform service in his affairs and who controls or has the right to control the physical conduct of the other in the performance of the service.'' *Restatement (Second) of Agency,* sec. 2(1). In turn, the *Restatement* defines ''servant'' as ''a person employed to perform services in the affairs of another and who with respect to the physical conduct in the performance of the services is subject to the other's control or right to control.'' Id. sec. 220(1).

The Board believes, subject to comments, that making the common-law employer-employee relationship foundational to the joint-employer analysis is consistent with the District of Columbia Circuit's statement that the Board must apply the NLRA in a manner that ''is bounded by the common-law's definition of a joint employer'' and ''color within the common-law lines identified by the judiciary.'' 911 F.3d at 1208.

B. Proposal To Establish That Two or More Employers of the Same Particular Employees Are Joint Employers of Those Employees if the Employers Share or Codetermine Those Matters Governing Employees' Essential Terms and Conditions of Employment

Proposed § 103.40(b) first recognizes, as did the 2020 Rule, that the joint-employer issue arises (and the same test applies) in all contexts under the Act, including both representation and unfair labor practice case contexts. Cf. *BFI of Pennsylvania,* 691 F.2d at 1119, 1125 (enforcing a Board order holding joint employers jointly responsible for remedying discharges that violated section 8(a)(3) and (1) of the Act).

Proposed § 103.40(b) also incorporates the principle from *BFI* that ''the existence of a common-law employment relationship is necessary, but not sufficient, to find joint-employer status.'' 362 NLRB at 1610. The proposed rule states that ''two or more employers of the same particular employees are joint employers of those employees if the employers share or codetermine those matters governing employees' essential terms and conditions of employment.'' By including this language, proposed § 103.40(b) codifies the longstanding core of the joint-employer test, consistent with the formulation of the standard that several Courts of Appeals (notably, the Third Circuit and the District of Columbia Circuit) have endorsed. See *BFI,* 911 F.3d at 1209 (citing *Dunkin' Donuts Mid-Atlantic Distribution Center* v. *NLRB,* 363 F.3d 437, 440 (D.C. Cir. 2004)); *NLRB* v. *Browning-Ferris Industries of Pennsylvania, Inc.,* 691 F.2d 1117, 1124 (3d Cir. 1982). See also *3750 Orange Place Limited Partnership* v. *NLRB,* 333 F.3d 646, 660 (6th Cir. 2003); *Holyoke Visiting Nurses Assn.* v. *NLRB,* 11 F.3d 302, 306 (1st Cir. 1993).

C. Proposal To Define ''Share or Codetermine Those Matters Governing Employees' Essential Terms and Conditions of Employment'' to Mean for an Employer To Possess the Authority To Control (Whether Directly, Indirectly, or Both), or To Exercise the Power To Control (Whether Directly, Indirectly, or Both), One or More of the Employees' Essential Terms and Conditions of Employment

Proposed § 103.40(c) seeks to define the terms ''share or codetermine those matters governing employees' essential terms and conditions of employment'' that appear in proposed § 103.40(b). The proposed rule would define ''share or codetermine'' to mean ''for an employer to possess the authority to control (whether directly, indirectly, or both), or to exercise the power to control (whether directly, indirectly, or both), one or more of the employees' essential terms and conditions of employment.'' Proposed § 103.40(c) incorporates the view of the *BFI* Board and the District of Columbia Circuit that evidence of the authorized or reserved right to control, as well as evidence of the exercise of control (whether direct or indirect, including control through an intermediary, as discussed further below) is probative evidence of the type of control over employees' essential terms and conditions of employment that is necessary to establish joint-employer status.

The Board believes, subject to comments, that this definition of ''share or codetermine'' is consistent with common-law agency principles and avoids one of the key errors of the 2020 Rule. Thus, proposed § 103.40(c) clarifies that evidence that a putative joint employer possesses the authority or exercises the power to control one or more of the employees' essential terms and conditions of employment is relevant to the joint-employer inquiry, regardless of whether such control is direct or indirect. By contrast, § 103.40(a) of the 2020 Rule required a putative joint employer to ''possess and exercise substantial direct and immediate control over essential terms and conditions of employment,'' and, in turn, § 103.40(d) defined ''substantial direct and immediate control'' as ''direct and immediate control that has a regular or continuous consequential effect on an essential term or condition of employment of another employer's employees.'' [29] Like the additional control-related restrictions the Board began introducing in the mid-1980's in *TLI/Laerco* and their progeny,[30] these definitions in the 2020 Rule wrongly depart from the common law, in the Board's preliminary view subject to comments, as set forth in greater detail below.

D. Proposal To Define ''Essential Terms and Conditions of Employment'' To Generally Include Wages, Benefits, and Other Compensation; Hours of Work and Scheduling; Hiring and Discharge; Discipline; Workplace Health and Safety; Supervision; Assignment; and Work Rules and Directions Governing the Manner, Means, or Methods of Work Performance

Pursuant to proposed § 103.40(d), ''essential terms and conditions of employment'' will ''generally include, but are not limited to: wages, benefits, and other compensation; hours of work and scheduling; hiring and discharge; discipline; workplace health and safety; supervision; assignment; and work rules and directions governing the manner, means, or methods of work performance.'' The Board believes, subject to comments, that this definition is consistent with the broad, inclusive approach to defining the set of essential terms and conditions of employment the Board took prior to the 2020 Rule, with court approval. See, *e.g., Aldworth Co.,* 338 NLRB 137, 139 (2002) (''The relevant facts involved in th[e] determination [of shared or co-determined essential terms and conditions of employment] extend to nearly every aspect of employees' terms and conditions of employment and must be given weight commensurate with their significance to employees' work life.''), enfd. sub nom. *Dunkin' Donuts Mid-Atlantic Distribution Center* v. *NLRB,* 363 F.3d 437 (D.C. Cir. 2004).

The Board believes, subject to comments, that in most workplaces, the proposed rule offers a set of useful

[29] See *Joint Employer Status Under the National Labor Relations Act,* 85 FR 11184, 11235 (Feb. 26, 2020).

[30] *TLI, Inc.,* 271 NLRB 798 (1984); *Laerco Transportation,* 269 NLRB 324 (1984). See also *AM Property Holding Corp.,* 350 NLRB 998 (2007), enfd. in relevant part sub nom. *Service Employees International Union, Local 32BJ* v. *NLRB,* 647 F.3d 435 (2d Cir. 2011); *Airborne Express,* 338 NLRB 597 (2002); *Flagstaff Medical Center,* 357 NLRB 659 (2011).

benchmarks for identifying essential terms and conditions of employment. In addition, both the Act and the common law offer support for generally treating these terms and conditions of employment as essential. Proposed § 103.40(d) includes ''wages, benefits, and other compensation'' and ''hours of work and scheduling.'' [31] The structure and text of the Act provide significant support for anticipating that in most employment relationships these terms and conditions of employment will be considered ''essential.'' Section 8(d), defining the duty to bargain, refers to ''wages, hours, and other terms and conditions of employment.'' 29 U.S.C. 158(d). And, section 9(a) refers to a chosen union as the exclusive representative of employees ''for the purposes of collective bargaining in respect to rates of pay, wages, hours of employment, or other conditions of employment.'' 29 U.S.C. 159(a).

Section 2 and section 220 of the *Restatement (Second) of Agency*—which the courts have acknowledged as persuasive authority for construing the common-law definition of ''employer''—provide further guidance that the Board believes, subject to comments, warrants treating additional terms and conditions of employment as essential. As set forth above, section 2 of the *Restatement* emphasizes the importance of a putative employer's control of the ''physical conduct'' of an employee ''in the performance of the service'' to the employer. It is the Board's view, subject to comments, that section 2 justifies in most cases treating discipline, workplace health and safety, supervision, assignment, and certain work rules and directions as essential terms and conditions of employment.[32] Section 220 of the *Restatement* likewise supports the usual inclusion of other work rules and directions related to determining the manner, means, or methods of work performance as essential terms and conditions of employment, as it emphasizes the ''extent of control'' an employer ''may exercise over the details of the work'' in identifying what distinguishes an employee from an independent contractor. And, section 220 supports including hiring and discharge as essential terms and conditions of employment, as that section treats employment tenure and the ''length of time for which the person is employed'' as relevant.

The Board proposes an inclusive approach to defining the set of essential terms and conditions of employment to ensure that the joint-employer standard can encompass changing circumstances in the workplace over time, as well as the particularities of certain industries or occupations. Thus, while the proposed rule identifies terms and conditions that would generally be considered essential, the Board anticipates that comments will permit it to refine the list of essential terms and conditions of employment. The Board observes that, over time and through its adjudicatory processes, the Board's case law has developed a non-exhaustive list of ''mandatory subjects'' of collective bargaining, *i.e.* subjects that implicate wages, hours and other terms and conditions of employment as delineated by sections 9(a), 8(a)(5) and 8(d) of the Act.[33] The Board has found mandatory subjects of bargaining to include, *inter alia:* overtime pay; [34] paid vacations; [35] the provision of group health insurance plans; [36] the scheduling of employee breaks; [37] paid lunch periods; [38] employee parking; [39] grievance [40] and arbitration [41] procedures; work rules; [42] employee dress codes; [43] health and safety issues; [44] and workplace meal prices.[45]

The shortcomings of the 2020 Rule's exhaustive list of essential terms and conditions of employment (which did not include workplace health and safety) were revealed during the COVID–19 pandemic. This experience has persuaded the Board, subject to comments, that other similarly unforeseen circumstances may arise in the future and so the joint-employer standard should not adopt an exhaustive list of essential terms and conditions of employment in given workplaces, but instead leave some flexibility for the Board in future adjudication under a final rule. Proposed § 103.40(d) likewise aims to ensure that the Board's approach to defining essential terms and conditions of employment is not needlessly overinclusive. For example, the Board is inclined to believe that, while workplace health and safety likely constitutes an essential condition of employment in healthcare, mining, and construction industry workplaces, there may be other workplaces in which health and safety concerns are less acute. We note, as well, that because the proposed rule requires the existence of a common-law employment relationship between a joint employer and particular employees, a joint employer necessarily will control those terms and conditions of employment sufficient to establish an employment relationship, regardless of which terms and conditions it does *not* control. The Board invites comment on all aspects of its approach to essential terms and conditions of employment, including the specific terms and conditions of employment it should (or should not) generally consider ''essential.'' [46]

[31] We note that § 103.40(b) of the 2020 Rule also included ''wages, benefits, [and] hours of work'' as essential terms and conditions of employment. See 85 FR 11235.

[32] Sec. 2 of the *Restatement (Second of Agency)* provides further support for proposed Sec. 103.40(d)'s inclusion of ''hours of work and scheduling'' as typically included on the list of essential terms and conditions of employment.

We note that § 103.40(b) of the 2020 Rule also treated several of these terms and conditions of employment as essential, including ''hiring, discharge, discipline, supervision, and direction.'' See 85 FR 11235.

[33] *NLRB* v. *Wooster Div. of Borg-Warner Corp.,* 356 U.S. 342, 349 (1958).

[34] *Am. Ambulance,* 255 NLRB 417, 418–19 (1981), enfd. without opinion 692 F.2d 762 (9th Cir. 1982).

[35] *Jimmy-Richard Co.,* 210 NLRB 802, 808 (1974), enfd. 527 F.2d 803 (D.C. Cir. 1975).

[36] *W.W. Cross & Co.,* 77 NLRB 1162, 1163 (1948), enfd. 174 F.2d 875 (1st Cir. 1949).

[37] *El Paso Elec. Co.,* 355 NLRB 428, 451 (2010), enfd 681 F.3d 651 (5th Cir. 2012).

[38] *Van Dorn Mach. Co.,* 286 NLRB 1233, 1233–1234, 1234 fn. 5 (1987), enfd. 881 F.2d 302 (6th Cir. 1989).

[39] *United Parcel Serv.,* 336 NLRB 1134, 1134 (2001).

[40] *Healthcare Workers Union, Loc. 250 (Alta Bates Med. Ctr.),* 321 NLRB 382, 384 (1996).

[41] *NLRB* v. *Ind. Stave Co., Diversified Indus. Div.,* 591 F.2d 443, 446 (8th Cir. 1979), enfg. as modified 233 NLRB 1202 (1977).

[42] *The Toledo Blade Co., Inc.,* 343 NLRB 385, 387 (2004).

[43] *Medco Health Sols. of Las Vegas, Inc.,* 357 NLRB 170, 172 (2011), enfd. in rel. part 701 F.3d 710 (D.C. Cir. 2012).

[44] *NLRB* v. *Am. Nat. Can Co., Foster-Forbes Glass Div.,* 924 F.2d 518, 524 (4th Cir. 1991), enfg. 293 NLRB 901, 904 (1989).

[45] *Ford Motor Co.,* 230 NLRB 716, 718 (1977), enfd. 571 F.2d 993 (7th Cir. 1978), affd. 441 U.S. 488 (1979).

[46] In particular, the Board seeks comment on the following questions. As mentioned above, the starting point for the proposed rule is the Act, which specifically references wages, hours, and other terms and conditions of employment. Should the proposed list of essential terms and conditions of employment solely include those terms and conditions of employment that are referenced in the statute? What terms and conditions of employment are essential to the existence of a common-law employment relationship? Is the Board's proposed inclusive approach to defining essential terms and conditions of employment appropriate? If so, how should the Board generally approach the task of identifying the essential terms and conditions?

We disagree with our dissenting colleagues' contention that the pending litigation challenging the 2020 Rule's exclusion of health and safety matters from the rule's exhaustive list of essential terms and conditions of employment in any way forecloses our preliminary view that, moving forward, an inclusive approach to defining essential terms and conditions of employment would better serve the policies of the Act.

E. Proposal to Specify That Whether an Employer Possesses the Authority To Control or Exercises the Power To Control One or More of the Employees' Terms and Conditions of Employment Is Determined Under Common-Law Agency Principles and That Evidence of Reserved or Indirect Control Is Sufficient To Establish Status as a Joint Employer

Proposed § 103.40(e) provides that common-law agency principles govern the determination of whether an employer possesses the authority to control or exercises the power to control one or more of the essential terms and conditions of employment of the employees at issue. As discussed above, the Board acknowledges that ''Congress has tasked the courts, and not the Board, with defining the common-law scope of 'employer' '' and that ''the common-law lines identified by the judiciary'' thus delineate the boundaries of the ''policy expertise that the Board brings to bear'' on the question of whether a business entity is a joint employer of another employer's employees under the Act. *BFI* v. *NLRB,* 911 F.3d at 1208–1209. Accordingly, in defining the types of control that will be sufficient to establish joint-employer status under the Act, the Board looks for guidance from the judiciary, including primary articulations of relevant principles by judges applying the common law, as well as secondary compendiums, reports, and restatements of these common law decisions, focusing ''first and foremost [on] the 'established' common-law definitions at the time Congress enacted the National Labor Relations Act in 1935 and the Taft-Hartley Amendments in 1947.'' Id. at 1209 (citations omitted).

Subject to comments, the Board believes that the policies of the Act, together with the expansive common-law employer-employee relationship defined by the judiciary, make it appropriate for the Board to give determinative weight to the existence of a putative joint employer's authority to control the essential terms and conditions of employment, whether or not such control is exercised, and without regard to whether any exercise of such control is direct or indirect, such as through an intermediary.

1. Reserved Control

First, long before the 1935 enactment of the Act, the Supreme Court recognized and applied a common-law rule that ''the relation of master and servant exists whenever the employer *retains the right* to direct the manner in which the business shall be done, as well as the result to be accomplished, or, in other words, 'not only what shall be done, but how it shall be done.' '' *Singer Mfg. Co.* v. *Rahn,* 132 U.S. 518, 523 (1889) (emphasis added) (quoting *Railroad Co.* v. *Hanning,* 82 U.S. 649, 657 (1872)). The Court in *Singer* affirmed the holding below that a worker was an employee [47] of a company because the Court concluded that the company had contractually reserved such control over the performance of the work that it ''might, if it saw fit, instruct [the worker] what route to take, or even what speed to drive.'' Id. at 523. In reaching this conclusion, the Court relied solely on the parties' contract, and did not discuss whether or in what manner the company had ever actually exercised any control over the terms and conditions under which the worker performed his work. In other words, the Court found a common-law employer-employee relationship based on contractually reserved control without reference to whether or how that control was exercised.[48]

Between the Court's decision in *Singer* and the relevant congressional enactments of the NLRA in 1935 and the Taft-Hartley amendments in 1947, Federal courts of appeals and State high courts consistently followed the Supreme Court in emphasizing the primacy of the right of control over whether or how it was exercised in decisions that turned on the existence of a common-law employer-employee relationship. For example, in 1934, the Supreme Court of Missouri examined whether a worker was an ''employee'' of two companies under a State workmen's compensation statute—the terms of which the court construed ''in the sense in which they were understood at common law''—and affirmed that ''the essential question is not what the companies did when the work was being done, but whether they had a right to assert or exercise control.'' [49] And, in 1945, the Court of Appeals for the District of Columbia Circuit explained that, in distinguishing employees from independent contractors, ''it is the right to control, not control or supervision itself, which is most important.'' [50]

[47] As discussed above, a ''servant'' is an employee. See, *e.g.,* 30 C.J.S. *Employer—Employee* sec. 1 (2022) (''The terms 'servant' and 'employee' are interchangeable.'').

[48] See also *Chicago Rock Island & Pac. Ry. Co.* v. *Bond,* 240 U.S. 449, 456 (1916) (worker was not employee of railroad company where contract provided ''company *reserves and holds no control* over [worker] in the doing of such work other than as to the results to be accomplished,'' and Court found company ''did not *retain the right* to direct the manner in which the business should be done, as well as the results to be accomplished, or, in other words, did not *retain control* not only of what should be done, but how it should be done.'') (emphasis added); *Little* v. *Hackett,* 116 U.S. 366, 376 (1886) (''[I]t is this *right to control* the conduct of the agent which is the foundation of the doctrine that the master is to be affected by the acts of his servant.'') (emphasis added) (quoting *Bennet* v. *New Jersey R.R. & Transp. Co.,* 36 N.J.L. 225 (N.J. 1873)).

[49] *Maltz* v. *Jackoway-Katz Cap Co.,* 82 SW2d 909, 912, 918 (Mo. 1934). See also *McDermott's Case,* 186 NE 231, 232–233 (Mass. 1933) (''One may be a servant though far away from the master, or so much more skilled than the master that actual direction and control would be folly, for it is the right to control, rather than the exercise of it that is the test.''); *Larson* v. *Independent School Dist No. 11J of King Hill,* 22 P.2d 299, 301 (Idaho 1933) (''It is not necessary that control be exercised, if the right of control exists.''); *Gordon* v. *S.M. Byers Motor Car Co.,* 164 A. 334, 335–336 (Pa. 1932) (''The control of the work reserved in the employer which makes the employee a mere servant . . . means a power of control, not necessarily the exercise of the power.'') (internal quotation and citation omitted); *Brothers* v. *State Industrial Accident Commission,* 12 P.2d 302, 304 (Or. 1932) (''[T]he true test of the relationship of employer and employee is not the actual exercise of control, but the right to exercise control.'') (internal quotation and citation omitted); *Murrays Case,* 154 A. 352, 354 (Me. 1931) (''Authorities are numerous and uniform that the vital test is to be found in the fact that the employer has or not retained power of control or superintendence over the employee or contractor. The test of the relationship is the right to control. It is not the fact of actual interference with the control, but the right to interfere that makes the difference between an independent contractor and a servant or agent. There is no conflict as to this general rule'') (internal quotation and citation omitted); *Van Watermeullen* v. *Industrial Commission,* 174 NE 846, 847–848 (Ill. 1931) (''One of the principal factors which determine whether a worker is an employee or an independent worker is the matter of the right to control the manner of doing the work, not the actual exercise of that right.''); *Norwood Hospital* v. *Brown,* 122 So. 411, 413 (Ala. 1929) (''[T]he ultimate question . . . is not whether the employer actually exercised control, but whether it had a right to control.'').

[50] *Grace* v. *Magruder,* 148 F.2d 679, 681 (D.C. Cir. 1945). See also *Industrial Commission* v. *Meddock,* 180 P.2d 580, 584 (Ariz. 1947) (''It is the right to control rather than the fact that the employer does control that determines the status of the parties, and this right to control is, in turn, tested by those standards applicable to the facts at hand.''); *D.M. Rose & Co.* v. *Snyder,* 206 SW 2d 897, 904 (Tenn. 1947) (internal quotations and citations omitted) (''[the] right of control is the distinguishing mark which differentiates the relation of master and servant from that of employer and independent contractor. . . . Wherever the defendant has had such right of control, irrespective of whether he exercised it or not, he has been held to be the responsible principal or master.''); *Green Valley Coop. Dairy Co.* v. *Industrial Comm'n,* 27 NW 2d 454, 457 (Wis. 1947) (citation omitted) (''It is quite immaterial whether the right to control is exercised by the master so long as he has the right to exercise such control.''); *Bobik* v. *Industrial Commission,* 64 NE 2d, 829, (Ohio 1946) (''[I]t is not, however, the actual exercise of the right by interfering with the work but rather the right to control which constitutes the test.''); *Cimorelli* v. *New York Cent. R. Co.,* 148 F.2d 575, 578 (6th Cir. 1945) (''The fact of actual interference or exercise of control by the employer is not material. If the existence of the right or authority to interfere or control appears, the contractor cannot be independent.''); *Dunmire* v. *Fitzgerald,* 37 A.2d 596, 599 (Pa. 1944) (in determining ''who was the controlling master of the

Unsurprisingly, early twentieth century secondary authority similarly distills from the cases a common-law rule under which the right of control establishes the existence of the common-law employer-employee relationship, without regard to whether or how such control is exercised. For example, in 1922, an American Law Report (A.L.R.) annotation states as black-letter law that:

In every case which turns upon the nature of the relationship between the employer and the person employed, the essential question to be determined is *not whether the former actually exercised control* over the details of the work, *but whether he had a right to exercise that control.*[51]

And, as stated above, the first Restatement of Agency, published in 1933, defines ''master,'' and ''servant,'' thus:

(1) A master is a principal who employs another to perform service in his affairs and who controls *or has the right to control* the physical conduct of the other in the performance of the service.

(2) A servant is a person employed by a master to perform service in his affairs whose physical conduct in the performance of the service is controlled *or is subject to the right of control* by the master.[52]

Finally, the first edition of *American Jurisprudence,* published between 1936 and 1948, states that ''the really essential element of the [employer-employee] relationship is *the right of control*—the right of one person, the master, to order and control another, the servant, in the performance of work by the latter, and *the right to direct* the manner in which the work shall be done,'' and ''[t]he test of the employer-employee relation is *the right of the employer to exercise control* of the details and method of performing the work.'' [53]

The Board believes, subject to comments and based on consultation of this and other judicial authority, that when Congress enacted the NLRA in 1935 and the Taft-Hartley Amendments in 1947, the existence of a putative employer's reserved authority to control the details of the terms and conditions under which work was performed sufficed to establish a common-law employer-employee relationship without regard to whether or in what manner such control was exercised.

From 1947 to today, innumerable judicial decisions and secondary authorities examining the common-law employer-employee relationship have continued to emphasize the primacy of the putative employer's authority to control, without regard to whether or in what manner that control has been exercised. For example, in 2014, the Supreme Court of California affirmed that ''what matters under the common law is not how much control a hirer *exercises,* but how much control the hirer retains the *right* to exercise.'' [54] As

borrowed employe[e], ... The criterion is not whether the borrowing employer in fact exercised control, but whether he had the right to exercise it.''); *Bush* v. *Wilson & Co.,* 138 P.2d 457, 461 (Kan. 1943) (''[W]hether a person is an employee of another depends upon whether the person who is claimed to be an employer had a right to control the manner in which the work was done. It has been pointed out many times that this means not actually the exercise of control, but does mean the right to control.''); *Ross* v. *Schneider,* 27 SE 2d 154, 157 (Va. 1943) (quoting *Murray's Case,* 154 A. 352, 354 (Me. 1931)) (''Authorities are numerous and uniform that the vital test is to be found in the fact that the employer has or not retained power of control or superintendence over the employee or contractor. 'The test of the relationship is the right to control. It is not the fact of actual interference with the control, but the right to interfere that makes the difference between an independent contractor and a servant or agent.' *Tuttle* v. *Embury-Martin Lumber Co.,* [158 NW 875, 879 (Mich. 1916)].''); *Jones* v. *Goodson,* 121 F.2d 176, 179 (10th Cir. 1941) (''the legal relationship of employer and employee . . . exists when the person for whom services are performed has the right to control and direct . . . the details and means by which [the service] is accomplished. . . . it is not necessary that the employer actually direct or control the manner in which the services are performed; it is sufficient if he has the right to do so.''); *S.A. Gerrard Co.* v. *Industrial Accident Commission,* 110 P.2d 377 (Cal. 1941) (''the right to control, rather than the amount of control which was exercised, is the determinative factor.'').

[51] *General discussion of the nature of the relationship of employer and independent contractor,* 19 A.L.R. 226 at sec. 7 & fn. 1 (1922) (emphasis added) (citations omitted). A 1931 A.L.R. annotation similarly reports that ''[i]t is not the fact of actual interference or exercise of control by the employer which renders one a servant rather than an independent contractor, but the existence of the right or authority to interfere or control.'' *Tests in determining whether one is an independent contractor,* 75 A.L.R. 725 (1931).

Other, earlier secondary authority was also consistent with this view. For example, the second edition of *The American & English Encyclopedia of Law,* published over several years spanning the turn of the century, explains that ''[t]he relation of master and servant exists where the employer has *the right* to select the employee; *the power* to remove and discharge him; and *the right* to direct both what work shall be done and the way and manner in which it shall be done.'' 20 The American & English Encyclopedia of Law 12 *Master and Servant* (2d ed. 1902) (emphasis added) (citations omitted). Likewise, in 1907, the *Cyclopedia of Law and Procedure* defines ''master,'' inter alia, as ''[o]ne who not only prescribes the end, but directs, *or at any time may direct,* the means and methods of doing the work.'' 26 Cyclopedia of Law and Procedure 966 fn. 2 *Master and Servant* (1907) (emphasis added) (citations omitted). The 1925 first edition of *Corpus Juris* echoes the same definitions set forth in the *Cyclopedia,* and additionally notes state high court common-law authority holding that ''*where the master has the right of control, it is not necessary that he actually exercise such control.*'' 39 C.J. Master and Servant sec. 1 Definitions 33 fn. 8 (1st ed. 1925) (emphasis added) (quoting *Tucker* v. *Cooper,* 158 P. 181 (Cal. 1916)).

[52] Restatement (First) of Agency sec. 2 (Am. Law Inst. 1933) (emphasis added). See also id. at sec. 220 (''A servant is a person employed to perform a service for another in his affairs and who, with respect to his physical conduct in the performance of the service, is subject to the other's control *or right to control.*'') (emphasis added). As noted above, the District of Columbia Circuit observed in *BFI* v. *NLRB,* 911 F.3d at 1211, that ''the 'right to control' runs like a *leitmotif* through the Restatement (Second) of Agency,'' which, though published in 1958, is relevantly similar to the first restatement.

[53] 35 Am. Jur. *Master and Servant* sec. 3 (1st ed. 1941) (emphasis added).

[54] *Ayala* v. *Antelope Valley Newspapers, Inc.,* 327 P.3d 165, 169, 172 (Cal. 2014); see also, *e.g., Garcia-Celestino* v. *Ruiz Harvesting, Inc.,* 898 F.3d 1110, 1121 (11th Cir. 2018) (''We emphasize that 'it is the *right* to control, not the actual exercise of control that is significant.'''); *Mallory* v. *Brigham Young Univ.,* 332 P.3d 922, 928–929 (Utah 2014) (''If the principal has the right to control the agent's method and manner of performance, that agent is a servant whether or not the right is specifically exercised.''); *Shatto* v. *McLeod Regional Medical Center,* 753 SE2d 416, 419, 420 (S.C. 2013) (''While evidence of actual control exerted by a putative employer is evidence of an employment relationship, the critical inquiry is whether there exists the *right and authority* to control and direct the particular work or undertaking.''); *Anthony* v. *Okie Dokie Inc.,* 976 A.2d 901, 906 (DC 2009) (quoting *Safeway Stores Inc.* v. *Kelly,* 448 A.2d 856, 860 (DC 1982)) (''The determinative factor 'is whether the employer has the *right* to control and direct the servant in the performance of his work and the manner in which the work is to be done . . . and not the actual exercise of control or supervision.' ''); *Universal Am-Can Ltd. V. WCAB,* 762 A.2d 328, 332–333 (Pa. 2000) (''[I]t is the existence of the *right* to control that is significant, irrespective of whether the control is actually exercised.''); *Reed* v. *Glyn,* 724 A.2d 464, 466 (Vt. 1998) (''It is to be observed that actual interference with the work is unnecessary—it is the right to interfere that determines.''); *JFC Temps, Inc.* v. *W.C.A.B. (Lindsay),* 620 A.2d 862, 864–865 (Pa. 1996) (''The law governing the ''borrowed'' employee is well-established. . . . The entity possessing the right to control the manner of the performance of the servant's work is the employer, irrespective of whether the control is actually exercised.''); *Harris* v. *Miller,* 438 SE 2d 731, 735 (N.C. 1994) (''The traditional test of liability under the borrowed servant rule [provides that] a servant is the employe (sic) of the person who has the *right* of controlling the manner of his performance of the work, irrespective of whether he actually *exercises* that control or not.'') (internal quotation and citation omitted); *Beddia* v. *Goodin,* 957 F.2d 254, 257 (6th Cir. 1992) (''The test is whether the employer retained control, or the right to control, the modes and manner of doing the work contracted for. *It is not necessary that the control ever be exercised.*''); *Ex parte Curry,* 607 S.2d 230, 232 (Ala. 1992) (''In the last analysis, it is the reserved right of control rather than its actual exercise that provides the answer.''); *ARA Leisure Services, Inc. v NLRB,* 782 F.2d 456, 460 (4th Cir. 1986) (''It is the right to control, rather than the actual exercise of control, that is significant.''); *NLRB* v. *Associated Diamond Cabs, Inc.,* 702 F.2d 912, 920 (11th Cir. 1983) (''[I]t is the *right* to control, not the actual exercise of control, that is significant.''); *Glenmar Cinestate Inc.* v. *Farrell,* 292 SE2d 366, 369 (Va. 1982) (''It is not the fact of actual interference with the control, but the right to interfere, that makes the difference between an independent contractor and a servant or agent.''); *Baird* v. *Sickler,* 433 NE 2d 593, 594–595 (Ohio 1982) (''For the relationship to exist, it is unnecessary that such right of control be exercised; it is sufficient that the right merely exists.''); *Seafarers Local 777 (Yellow Cab)* v. *NLRB,* 603 F.2d 862, 874 (D.C. Cir. 1978) (quoting *Williams* v. *U.S.,* 126 F.2d 129, 132 (7th Cir. 1942)) (''[I]t is the right

Continued

noted above, the *Restatement (Second) of Agency* relevantly echoes the First Restatement's emphasis on the right of control.[55] *Corpus Juris Secundum* provides that ''[a]n employee/servant is a type of agent whose physical conduct is controlled *or is subject to the right to control* by the master; the servant's principal, who controls *or has the right to control* the physical conduct of the servant, is called the master.'' [56] And, the second edition of *American Jurisprudence* provides that ''the principal test of an employment relationship is whether the alleged employer has *the right to control* the manner and means of accomplishing the result desired.'' [57] Based on its examination of this and other judicial and secondary authority, the Board agrees with the District of Columbia Circuit that ''for what it is worth [the common-law rule in 1935 and 1947] is still the common-law rule today.'' [58] The Board also notes that, as set forth in greater detail above, this view is in keeping with the Board's prior treatment of reserved control in the period following the *Greyhound* decision and before the Board began imposing additional control-related restrictions in *TLI/Laerco* and their progeny.

Finally, because the facts of many cases do not require distinguishing between contractually reserved and actually exercised control, many judicial decisions and other authorities spanning the last century have articulated versions of the common-law test that do *not* expressly include this distinction. But the Board is not aware of any common-law judicial decision or other common-law authority directly supporting the proposition that, given the existence of a putative employer's contractually reserved authority to control, further evidence of direct and immediate exercise of that control is necessary to establish a common-law employer-employee relationship. For these reasons, the Board believes, subject to comments, that the judicially defined common-law boundaries on the Board's exercise of its policy expertise cannot justify the adoption of a joint-employer standard that requires a showing of actual exercise of direct and immediate control in order to establish that an entity is a joint employer of another entity's employees, as current § 103.40 improperly requires.

2. Indirect Control or Control Exercised Through an Intermediary

The Board believes, subject to comments, that evidence that an employer has actually exercised such control over essential terms and conditions, whether directly or indirectly, such as through an intermediary, necessarily also suffices to establish the existence of a joint-employer relationship. As the District of Columbia Circuit has recognized, ''[t]he common law . . . permits consideration of those forms of indirect control that play a relevant part in determining the essential terms and conditions of employment.'' *BFI* v. *NLRB,* 911 F.3d at 1199–1200. In addition, the District of Columbia Circuit has explained that the definition of ''employer'' set forth in section 2(2) of the Act ''textually indicates that the statute looks at all probative indicia of employer status, whether exercised 'directly or indirectly''' and therefore that the Act ''expressly recognizes that agents acting 'indirectly' on behalf of an employer could also count as employers.'' Id. at 1216.

Judicial decisions and secondary authorities addressing the common-law employer-employee relationship confirm that indirect control, including control exercised through an intermediary, is relevant to the existence of an employment relationship. The *Restatement (Second) of Agency* explicitly recognized the significance of indirect control, both in providing that ''the control or right to control needed to establish the relation of master and servant may be very attenuated'' and in discussing the subservant doctrine, which deals with cases in which one employer's control may be exercised indirectly, while a second entity directly controls employees.[59] As the District of Columbia Circuit explained in *BFI,* ''the common law has never countenanced the use of intermediaries or controlled third parties to avoid the creation of a master-servant relationship.'' [60]

Consistent with these longstanding common-law principles, the Board believes, subject to comments, that evidence showing that a putative joint employer wields indirect control over the essential terms and conditions of employment of another employer's employees is relevant to the joint-employer inquiry. Ignoring relevant evidence of indirect control over essential terms and conditions of employment would, in the words of the District of Columbia Circuit, ''allow manipulated form to flout reality,'' [61] contrary to the teachings of the common law. Under the proposed rule, for example, evidence that a putative joint employer communicates work assignments and directives to another entity's managers or exercises ongoing oversight to ensure that job tasks are performed properly may demonstrate the type of indirect control over essential terms and conditions of employment that is necessary to establish a joint-employer relationship. The Board welcomes comment on this and other forms of indirect control that should be considered probative (or not probative) of joint-employer status.

F. Proposal To Clarify That Evidence of Control Over Matters That Are Immaterial to the Existence of an Employment Relationship or That Do Not Bear on Employees' Essential Terms and Conditions of Employment Is Not Relevant to the Joint-Employer Inquiry

Proposed § 103.40(f) incorporates the District of Columbia Circuit's teaching in *BFI* that an employer's control over matters that are immaterial to the existence of an employment relationship under established common-law agency principles, or that otherwise do not bear on the employees' essential terms and conditions of employment, is not relevant to the joint-employer inquiry.[62] In addition, the proposed rule responds to the District of Columbia Circuit's criticism that the *BFI* Board did not sufficiently ''distinguish between indirect control that the common law of

and not the exercise of control which is the determining element.''); *Combined Insurance Co. of America* v. *Sinclair,* 584 P.2d 1034, 1042 (Wyo. 1978) (''The base determining factor is whether [putative employer] retained [t]he right of control of the manner that [putative employee] operated his vehicle and not whether such control was in fact exercised.''); *NLRB* v. *Deaton Inc.,* 502 F.2d 1221, 1225 (5th Cir. 1974) (''It is the right and not the exercise of control which is the determining element''); *Dovell* v. *Arundel Supply Corp.,* 361 F.2d 543, 545 (D.C. Cir. 1966) (quoting *Grace* v. *Magruder,* 148 F.2d 679, 681 (D.C. Cir. 1945)) (''[I]t is the right to control, not control or supervision itself, which is most important.''); *United Ins. Co. of America* v. *NLRB,* 304 F.2d 86, 89 (7th Cir. 1962) (''[I]t is the right and not the exercise of control which is the determining element.''); *Cohen* v. *Best Made Mfg. Co.,* 169 A.2d 10, 11–12 (R.I. 1961) (''The final test is the right of the employer to exercise power of control rather than the actual exercise of such power.''); *Fardig* v. *Reynolds,* 348 P.2d 661, 663 (Wash. 1960) (''It is well settled in this state that . . . [it] is not the actual exercise of the right of interference with the work, but the right to control, which constitutes the test.'').

[55] See Restatement (Second) of Agency secs. 2, 220 (Am. Law Inst. 1958).

[56] 30 C.J.S. *Employer—Employee* sec. 1 (2022) (emphasis added) (citations omitted).

[57] 27 Am. Jur. 2d. *Employment Relationship* sec. 1 (2022) (emphasis added) (citations omitted).

[58] *BFI* v. *NLRB,* 911 F.3d at 1210 & fn. 6.

[59] *Restatement (Second) of Agency* sections 5(2), comments e, f, and illustration 6; 220(1), comment d; 226, comment a (1958).

[60] 911 F.3d at 1217 (citing *Nicholson* v. *Atchison, T. & S. F. Ry. Co.,* 147 P. 1123, 1126 (Kan. 1915) (use of a ''branch company'' as a ''mere instrumentality'' ''did not break the relation of master and servant existing between the plaintiff and the [putative master]'').

[61] Id. at 1219.

[62] *BFI,* 911 F.3d at 1222–1223.

agency considers intrinsic to ordinary third-party contracting relationships, and indirect control over the essential terms and conditions of employment.'' *BFI,* 911 F.3d at 1222–1223. In remanding the case to the Board, the court identified as key the ''common-law principle that a joint employer's control—whether direct or indirect, exercised or reserved—must bear on the 'essential terms and conditions of employment' . . . and not on the routine components of a company-to-company contract.'' Id. at 1221 (citation omitted).

The Board's proposed rule does not purport to exhaustively detail the universe of business arrangements that bear on the existence of a common-law employer-employee relationship. However, the Board agrees with the *BFI* Board and the District of Columbia Circuit that contractual terms limited to ''dictat[ing] the results of a contracted service,'' that aim ''to control or protect [the employer's] own property,'' [63] or to ''set the objective, basic ground rules, and expectations for a third-party contractor'' [64] will generally not be relevant to the inquiry (assuming those terms do not otherwise affect the employees' essential terms and conditions of employment). In addition, the Board agrees that ''routine components of a company-to-company contract,'' like a ''very generalized cap on contract costs,'' or an ''advance description of the tasks to be performed under the contract,'' will generally not be material to the existence of an employment relationship under common-law agency principles.[65] The Board specifically seeks public comment regarding this portion of its proposed rule and invites commenters to address which ''routine components of a company-to-company contract'' the Board should not consider relevant to the joint-employer analysis. In addition, the Board invites comment regarding which contractual controls reserved by a putative joint employer over another entity's employees should establish that the putative joint employer is also a common-law employer of the other entity's employees.

G. Proposal To Clarify That a Party Asserting Joint-Employer Status Has the Burden of Establishing That Relationship by a Preponderance of the Evidence

Proposed § 103.40(g) confirms, in keeping with *BFI,* 362 NLRB at 1616, that the party asserting that an employer is a joint employer of particular employees has the burden of establishing that relationship by a preponderance of the evidence.

H. Proposal To Explain That the Provisions of the Rule Are Intended To Be Severable

Proposed § 103.40(h) explains that the Board intends the provisions of the rule to be severable in the event any provision of the rule is held to be unlawful. The Board's preliminary view is that proposed § 103.40(a), (b), and (c), which address the common-law employment relationship, may be severable from the other provisions of the proposed rule, which address statutory issues that are informed by the common law. The Board specifically invites public comment on its preliminary view regarding the severability of the provisions of the rule.

V. Conclusion

The Board welcomes public comment on all aspects of its proposed rule. In particular, the Board seeks input from employees, unions, and employers with experience in workplaces in which multiple entities possess or exercise some control over a particular group of employees' working conditions.

Although the Board has offered proposed rule text that would rescind the 2020 Rule and replace it with a new rule setting forth the joint-employer standard, the Board is also specifically interested in commenters' responses to the following questions. Should the Board solely rescind the 2020 joint-employer rule and not replace it with a new rule? If so, how could the Board address the issue that the prior legal standard (*BFI* 2015) was denied enforcement in part by the District of Columbia Circuit? In the alternative, should the Board amend the 2020 Rule, and if so, should the rule be amended in the manner set forth in this NPRM? Are there any reliance interests related to the 2020 Rule, and if so, how should the Board assess those interests?

As stated above, comments regarding this proposed rule must be received by the Board on or before November 7, 2022. Comments replying to comments submitted during the initial comment period must be received by the Board on or before November 21, 2022.

Our dissenting colleagues were part of the Board that issued the 2020 Rule at a time when the Board consisted of a three-member quorum without any dissenting views.[66] As discussed above, the 2020 Rule displaced *BFI,* which had returned to the Board's traditional joint-employer analysis after a period during which the Board applied a more restrictive standard that we preliminarily believe was not supported by the text or purposes of the Act, by earlier Board or court precedent, or by the common law. Our dissenting colleagues express many of the same criticisms of the Board's traditional standard, as embodied in *BFI* and the proposed rule, that they expressed in the now-vacated decision in *Hy-Brand Industrial Contractors,*[67] and in the 2020 Rule.[68] We have expressed our preliminary view that the Act's purpose of promoting effective collective bargaining is better served by the Board's traditional standard than by the overly restrictive standard embodied in the 2020 Rule.[69] We look forward to receiving and reviewing the public's comments and, afterward, considering these issues afresh with the good-faith participation of all members of the Board.

VI. Dissenting View of Members Kaplan and Ring

Two-and-a-half years ago, the Board issued a final rule (''the 2020 Rule'') setting forth the standard for determining, under the National Labor Relations Act (''NLRA'' or ''the Act''), whether two entities constitute a joint employer of employees directly

[63] *BFI,* supra, 362 NLRB at 1614.

[64] *BFI,* supra, 911 F.3d at 1220.

[65] Id. The Board believes, subject to comments, that certain forms of so-called ''cost-plus'' contracting arrangements bear on employees' essential terms and conditions of employment. See, *e.g., Dunkin' Donuts Mid-Atlantic Distribution Center* v. *NLRB,* 363 F.3d 437, 441 (D.C. Cir. 2004) (one entity ''determined [another entity's] employee wage and benefit rates'' by ''specifying, in the parties' 'cost-plus' lease agreement, the rates it would reimburse [that entity].''). However, because such contractual arrangements may reveal varying degrees of indirect control over the wages of another entity's employees, ''[a] characterization of the transaction as a 'cost plus' contract is not necessarily determinative of the question as to the relationship of the parties thereto.'' 35 Am. Jur. *Master and Servant* sec. 5 (1st ed. 1941). As a result, the proper categorization of such arrangements may be a matter best left to development through case-by-case adjudication. See id. (where parties have entered into a cost-plus contract, ''some of the authorities have held the parties to be employer and contractor, and others have held them to be master and servant.'').

[66] As mentioned above, then-Member McFerran dissented from the 2018 NPRM that resulted in the 2020 Rule before her prior term expired on December 19, 2019. She was reappointed August 10, 2020, after the publication of the 2020 Rule.

[67] 365 NLRB No. 156 (2017), vacated by 366 NLRB No. 26 (2018).

[68] Member Kaplan was a member of the panel majority that reversed *BFI* in *Hy-Brand* before a different Board panel vacated that decision.

[69] Contrary to our dissenting colleague's suggestion, the proposed rule would only require a putative joint employer to bargain over those terms and conditions of employment which it possesses the authority to control or over which it exercises the power to control.

employed by only one of them.[70] There, after thoroughly considering tens of thousands of public comments and carefully analyzing the legal landscape, the Board adopted a comprehensive joint-employer standard that is consistent with common-law agency principles and provides clear guidance to regulated parties. The 2020 Rule was an immense undertaking, requiring thousands of personnel hours to complete. Today, however, with their Notice of Proposed Rulemaking (''NPRM''), the majority sets in motion a project to do it all over again. Worse, the rule they propose would be clearly inferior to the 2020 Rule, it would be contrary to the very common-law principles they so insistently emphasize, and it would fail to pass muster under the Administrative Procedure Act.

Our colleagues offer no valid justification for launching a second resource-intensive joint-employer rulemaking. They do not purport to rely on any experience under the 2020 Rule. Indeed, they cannot do so, since the Board has yet to apply it in a single case. Nor do they rely on any court precedent postdating the 2020 Rule's publication or on any factual developments, much less any seismic shift in American workplaces. The majority's stated purpose for this new rulemaking is to ''explicitly ground the joint-employer standard in common-law agency principles and provide relevant guidance to parties covered by the Act regarding their rights and responsibilities under the Act.'' But the 2020 Rule already achieves both these objectives and does so far better than the rule the majority proposes. Indeed, the proposed rule fails to achieve either of its stated aims. It neither articulates the common-law agency principles that appropriately bear on determining joint-employer status under the NLRA nor provides any real guidance to the regulated community. Instead, it simply purports to expand joint-employer status to the outermost limits of the common law (while actually going beyond those limits) and leaves everything else to case-by-case adjudication.

The universally accepted general formulation of the joint-employer standard—embodied in the 2020 Rule—is that an employer may be considered a joint employer of a separate employer's employees only if the two employers ''share or codetermine the employees' essential terms and conditions of employment.'' See § 103.40 of the Board's Rules and Regulations; see also *Browning-Ferris Industries of California, Inc.* v. *NLRB,* 911 F.3d 1195, 1201 (D.C. Cir. 2018); *NLRB* v. *Browning-Ferris Industries of Pennsylvania, Inc.,* 691 F.2d 1117, 1123 (3d Cir. 1982), enfg. 259 NLRB 148 (1981). To establish that this ''share or codetermine'' standard has been met, the Board's longstanding rule was that a putative joint employer's control over employment matters must be direct and immediate. See, *e.g., TLI, Inc.,* 271 NLRB 798, 798–799 (1984), enfd. mem. sub nom. *General Teamsters Local Union No. 326* v. *NLRB,* 772 F.2d 894 (3d Cir. 1985); *Laerco Transportation,* 269 NLRB 324 (1984). Indirect control, or an unexercised contractual reservation of a right to control, was insufficient.

This standard, which had been applied for at least 30 years, was eliminated by a divided Board in *Browning-Ferris Industries of California, Inc., d/b/a BFI Newby Island Recyclery,* 362 NLRB 1599 (2015) (*BFI*).[71] Under *BFI,* one company could be deemed a joint employer of another company's employees based *exclusively* on either a *never-exercised* contractual reservation of right to control one or more essential terms and conditions of employment or on its *indirect* control of or influence over such terms and conditions, provided the evidence satisfied a second analytical step, namely, that ''the putative joint employer possesses sufficient control over employees' essential terms and conditions of employment to permit meaningful bargaining.'' *BFI,* 362 NLRB at 1600.

The United States Court of Appeals for the District of Columbia Circuit denied enforcement of the Board's decision in *BFI.* The D.C. Circuit held that while the common law supported the Board's holding that indirect control and a contractually reserved right to control are relevant to the joint-employer inquiry, the *BFI* Board had ''overshot the common-law mark'' by failing to distinguish evidence of indirect control that bears on workers' essential terms and conditions of employment from evidence that simply documents the routine parameters of company-to-company contracting. *Browning-Ferris Industries of California, Inc.* v. *NLRB,* 911 F.3d at 1216. The court also faulted the Board for failing to ''meaningfully apply'' the second step of its standard. Id. at 1221–1222. Finally, and importantly, the court did not affirm *BFI*'s holding that indirect control, or a contractually reserved right to control, can establish joint-employer status absent direct and immediate control. It left those issues undecided. Id. at 1213, 1218.

In formulating the 2020 Rule, the Board heeded the D.C. Circuit's guidance. It announced a joint-employer standard that is firmly grounded in common-law agency principles. It recognized that indirect control and a contractually reserved right to control are probative of joint-employer status. But, addressing the issues the D.C. Circuit left unaddressed, it also recognized that making either one *dispositive* of joint-employer status, absent evidence of direct and immediate control over one or more essential terms and conditions of employment, would contravene the common law and ill serve the purposes and policies of the Act. Accordingly, the 2020 Rule specified that to establish that an entity shares or codetermines the essential terms and conditions of another employer's employees, the entity must possess and exercise such substantial direct and immediate control over one or more essential terms or conditions of their employment as would warrant finding that the entity meaningfully affects matters relating to the employment relationship with those employees. Evidence of the entity's indirect control over essential terms and conditions of employment of another employer's employees, the entity's contractually reserved but never exercised authority over the essential terms and conditions of employment of another employer's employees, or the entity's control over mandatory subjects of bargaining other than the essential terms and conditions of employment is probative of joint-employer status, but only to the extent it supplements and reinforces evidence of the entity's possession or exercise of direct and immediate control over a particular essential term and condition of employment. 29 CFR 103.40(a). The 2020 rule also specified in detail how a joint-employer determination is to be made, enumerating the specific factors that would be considered and how those factors would be applied. This included defining a closed set of ''essential terms and conditions of employment,'' specifying how ''direct and immediate control'' would be determined with respect to each of them, and defining all other key terms used in the rule. See 29 CFR 103.40(b)–(f). Thus, the 2020 Rule aligns with the common law and the D.C. Circuit's 2018 decision and provides a self-contained, comprehensive standard for

[70] Joint Employer Status Under the National Labor Relations Act, 85 FR 11184 (Feb. 26, 2020) (codified at 29 CFR 103.40).

[71] Review granted in part and remanded 911 F.3d 1195 (D.C. Cir. 2018).

determining whether a joint-employer relationship exists.

The proposed rule would eliminate all the 2020 Rule's detailed guidance regarding conduct that constitutes direct and immediate control of each essential term and condition of employment. In its place, the proposed rule simply incorporates by reference the entire body of common-law agency principles. As a result, unions, employers, and employees would find no guidance in the rule itself. Instead, they would have to go searching for guidance in the common law to determine whether a joint-employer relationship exists.

Worse, the proposed rule also radically expands the circumstances in which joint-employer status can be found, going well beyond common-law limits and anything contemplated by the Board's decision in *BFI.* As discussed below, the proposed rule makes a never-exercised contractual reservation of right to control, or indirect control of or influence over a single term or condition of employment deemed ''essential,'' *determinative* of joint-employer status. *BFI* did not.[72] In addition, rather than respond to the D.C. Circuit's criticism of the *BFI* Board's failure to meaningfully apply the second step of its announced standard, the proposed rule simply abandons that step altogether, embracing the unsupported and wholly unreasonable assumption that where an entity possesses nothing more than a never-exercised right of control, any bargaining by that entity ''will necessarily be meaningful.'' In addition, the proposed rule substitutes an open-ended, non-exclusive list of essential terms and conditions of employment for the closed list set forth in the 2020 Rule. As explained below, this open-ended list renders the proposed rule impermissibly vague and therefore arbitrary and capricious. For all these reasons, we respectfully dissent.

Background and the 2020 Rule

Section 2(2) of the National Labor Relations Act defines an ''employer'' to include ''any person acting as an agent of an employer, directly or indirectly.'' 29 U.S.C. 152(2). In determining whether an employment relationship exists between an entity and employees directly employed by a separate employer, common-law agency principles are controlling.[73] The Board will find that two separate entities are joint employers of employees directly employed by only one of them if the evidence shows that they share or codetermine those matters governing the employees' essential terms and conditions of employment.[74]

The Board, with court approval, long held that a determination that two or more entities do share or codetermine such matters requires proof that a putative joint employer has actually exercised substantial direct and immediate control over one or more essential terms and conditions of employment of another entity's employees. See *Summit Express, Inc.,* 350 NLRB 592, 592 fn. 3 (2007) (finding that the General Counsel failed to prove direct and immediate control and therefore dismissing joint-employer allegation); *Airborne Express,* 338 NLRB 597, 597 fn. 1 (2002) (holding that ''the essential element'' in a joint-employer analysis ''is whether a putative joint employer's control over employment matters is direct and immediate'') (citing *TLI, Inc.,* 271 NLRB at 798–799); *Laerco Transportation,* 269 NLRB at 324 (dismissing joint-employer allegation where user employer's supervision of supplied employees was limited and routine); see also *NLRB* v. *CNN America, Inc.,* 865 F.3d 740, 748–751 (D.C. Cir. 2017) (finding that the Board erred by failing to adhere to its ''direct and immediate control'' standard); *SEIU Local 32BJ* v. *NLRB,* 647 F.3d 435, 442–443 (2d Cir. 2011) ('''An essential element' of any joint employer determination is 'sufficient evidence of immediate control over the employees.' '') (quoting *Clinton's Ditch Co-op Co.* v. *NLRB,* 778 F.2d 132, 138 (2d Cir. 1985)). Under this precedent, an entity's unexercised contractual reservation of a right to control or indirect control/influence was insufficient to establish joint-employer status.

In 2015, a divided Board significantly lowered the bar for proving a joint-employer relationship in *BFI,* supra, 362 NLRB at 1599. There, a Board majority eliminated the requirement of proof that a putative joint employer had actually exercised direct and immediate control over essential terms and conditions of employment. Id. at 1613–1614. The *BFI* majority held that a joint-employer relationship could be based solely on an unexercised contractual reservation of right to control and/or indirect control. In other words, the *BFI* majority expanded the joint-employer doctrine to potentially include in the collective-bargaining process an employer's independent business partner that has an indirect or potential impact on the employees' essential terms and conditions of employment, even where the business partner has not itself actually established those essential employment terms or collaborated with the undisputed employer in setting them.

The defining feature of the Board's *BFI* standard was its elimination of the preexisting requirement of proof that a putative joint employer actually exercised substantial direct and immediate control over the essential terms and conditions of another company's workers. Contrary to our colleagues' claims that the D.C. Circuit ''broadly uph[e]ld[ ] the Board's *BFI* joint-employer standard,'' the court did not uphold its defining feature. It expressly left unaddressed whether indirect control or contractually-reserved-but-unexercised authority could, standing alone, establish a joint-employer relationship.[75]

After canvassing common-law agency principles, including those identified in the Restatements of Agency, the D.C. Circuit did ''uphold as fully consistent with the common law the [*BFI*] Board's determination that both reserved authority to control and indirect control *can be relevant factors* in the joint-employer analysis.'' 911 F.3d at 1222 (emphasis added). In short, the court held that contractually reserved control and indirect control can contribute to a joint-employer finding without addressing whether those factors could independently establish a joint-employer relationship.

The court in *Browning-Ferris Industries of California* v. *NLRB* made several other important points that subsequently informed the 2020 Rule. First, the court made clear that the common law sets the outer limit of a permissible joint-employer standard

[72] See *BFI,* 362 NLRB at 1614 (''The right to control . . . is *probative* of joint-employer status, as is the actual exercise of control, whether direct or indirect'' (emphasis added).).

[73] *NLRB* v. *United Insurance Co. of America,* 390 U.S. 254, 256 (1968).

[74] *CNN America, Inc.,* 361 NLRB 439, 441 (2014) (quoting *TLI, Inc.,* 271 NLRB at 798), enf. denied in part 865 F.3d 740 (D.C. Cir. 2017). The ''share or codetermine'' standard was first stated by the United States Court of Appeals for the Third Circuit in *NLRB* v. *Browning-Ferris Industries of Pennsylvania, Inc.,* 691 F.2d at 1123. As the D.C. Circuit observed in its 2018 decision, after the Third Circuit formulated the ''share or codetermine'' standard, the Board and the courts began coalescing around it. *Browning-Ferris Industries of California, Inc.* v. *NLRB,* 911 F.3d at 1201.

[75] 911 F.3d at 1213 (''[B]ecause the Board relied on evidence that Browning-Ferris both had a 'right to control' and had 'exercised that control,' this case does not present the question whether the reserved right to control, divorced from any actual exercise of that authority, could alone establish a joint-employer relationship.'') (internal citation omitted); 911 F.3d at 1218 (''[W]hether indirect control can be 'dispositive' is not at issue in this case because the Board's decision turned on its finding that Browning-Ferris exercised control 'both directly and indirectly.' '').

under the Act, without suggesting in any way that the standard must or should be coextensive with that outer limit.

> The policy expertise that the Board brings to bear on applying the National Labor Relations Act to joint employers *is bounded by* the common-law's definition of a joint employer. The Board's rulemaking, in other words, *must color within the common-law lines* identified by the judiciary.

Id. at 1208 (emphasis added). Hence, while it is clear that the Board is precluded from adopting a more expansive joint-employer doctrine than the common law permits, it may adopt a narrower standard that promotes the Act's policies. This is a point that was recognized by the Board majority in *BFI* itself. *BFI,* 362 NLRB at 1613 (''The common-law definition of an employment relationship establishes the outer limits of a permissible joint-employer standard under the Act.''). Indeed, the Board, with court approval, has long made policy choices not to exercise the full extent of its jurisdiction, including as to particular classes of employment relationships.[76]

Second, the D.C. Circuit made clear that, under the common law, the independent-contractor standard, with its emphasis on the right to control, is different from the joint-employer standard:

> [T]he independent-contractor and joint-employer tests ask different questions. The independent-contractor test considers who, if anyone, controls the worker other than the worker herself. The joint-employer test, by contrast, asks how many employers control individuals who are unquestionably superintendent.

911 F.3d at 1214. In this regard, the court explained that ''a rigid focus on independent-contractor analysis omits the vital second step in joint-employer cases, which asks, once control over the workers is found, *who* is exercising that control, *when,* and *how*.'' Id. at 1215 (emphasis in original). To rephrase, the vital second step of a common-law joint-employer analysis does indeed focus on the exercise of control.

Third, the D.C. Circuit held that the *BFI* Board's treatment of the indirect-control factor contravened the common law. Id. at 1221. Specifically, the court concluded that the *BFI* Board had ''overshot the common-law mark'' by failing to distinguish evidence of indirect control that bears on workers' essential terms and conditions of employment from evidence that simply documents the routine parameters of company-to-company contracting. Id. at 1216. The court explained that, for example, it would be inappropriate to give any weight in a joint-employer analysis to the fact that Browning-Ferris had controlled the basic contours of a contracted-for service, such as by requiring four lines' worth of employee sorters plus supporting screen cleaners and housekeepers. Id. at 1220–2221.

Fourth, the court held that the Board had erred by failing to meaningfully apply the second step of its two-step standard: ''whether the putative joint employer possesses sufficient control over employees' essential terms and conditions of employment to permit meaningful collective bargaining.'' On this point, the court rebuked the Board for ''never delineat[ing] what terms and conditions of employment are 'essential' '' and for adopting an ''inclusive'' and ''non-exhaustive'' approach to the meaning of ''essential terms.'' Id. at 1221–1222. The court also faulted the Board for failing to clarify what ''meaningful collective bargaining'' might require in the parties' arrangement. The court remanded the case to the Board for further proceedings consistent with the court's opinion.[77]

The Board's 2020 Rule is within the boundaries set by common-law agency principles as defined by the D.C. Circuit's 2018 *BFI* decision and furthers the Act's policy of promoting meaningful collective bargaining. The 2020 Rule appropriately accounts for the ''vital second step in joint-employer cases'' identified by the court in *BFI:* once control over the workers is found, determining ''*who* is exercising that control, *when,* and *how.*'' Id. at 1215. Under the 2020 Rule, an entity can be deemed a joint employer of another company's employees only if it possesses and actually exercises substantial direct and immediate control over a broad-but-exhaustive list of essential terms and conditions of employment.

The 2020 Rule does not turn a blind eye to reserved control or indirect control. It expressly provides that those forms of control are ''probative of joint-employer status.'' See § 103.40(a) of the Board's Rules and Regulations. Specifically, each may serve to supplement and reinforce evidence the putative joint employer either possesses or has exercised substantial direct and immediate control over workers' essential terms. Plainly, the fact that an entity has a contractual reservation of a right to control is relevant to establishing possession of control. Further, both reserved control and indirect control are relevant to whether the control possessed and exercised is substantial. 85 FR 11186. However, standing alone, reserved and indirect control cannot establish that one company is the joint employer of another's employees. See § 103.40(a) of the Board's Rules and Regulations. The 2020 Rule requires proof that a putative joint employer played an active role, either alone or in collaboration with an undisputed employer, in setting employees' essential terms. The D.C. Circuit left this issue open for the Board to resolve, and the Board appropriately did so in the 2020 Rule.

In promulgating the 2020 Rule, the Board also made clear that it did not intend to permit an entity to immunize itself from joint-employer status by implementing its control through an intermediary. ''Direct and immediate control exercised through an intermediary remains direct and immediate.'' 85 FR 11209. This, too, is consistent with the D.C. Circuit's guidance. See *Browning-Ferris* v. *NLRB,* 911 F.3d at 1217 (''[T]he common law has never countenanced the use of intermediaries or controlled third parties to avoid the creation of a master-servant relationship.'').

The 2020 Rule, unlike our colleagues' proposed rule, appropriately recognizes that the determination of joint-employer status cannot be divorced from the practical consequences of finding that an entity *is* a joint employer. The Board

[76] See *Northwestern University,* 362 NLRB 1350, 1352 (2015) (declining to assert jurisdiction over Northwestern University football players who receive grant-in-aid scholarships, even assuming they are statutory employees, due to the nature and structure of the NCAA Division I Football Bowl Subdivision); *Brevard Achievement Center,* 342 NLRB 982, 983–985 (2004) (declining to exercise jurisdiction over disabled workers whose relationship with an employer is ''primarily rehabilitative'' as opposed to ''typically industrial'' because ''Congress did not intend that the Act govern'' the former); *Brown University, 342 NLRB 483, 493 (2004) (dismissing representation petition based on the* ''*belief that the imposition of collective bargaining on graduate students would improperly intrude into the educational process and would be inconsistent with the purposes and policies of the Act*''*), overruled on policy grounds by Columbia University, 364 NLRB No. 90 (2016); Siemons Mailing Service,* 122 NLRB 81 (1959) (describing Board's discretionary commerce standard).

[77] On remand, the Board found that any retroactive application of a refined standard would be manifestly unjust. The Board therefore dismissed the complaint and amended the certification of representative to remove BFI as a joint employer. *Browning-Ferris Industries of California, Inc. d/b/a BFI Newby Island Recyclery,* 369 NLRB No. 139, slip op. at 1 (2020). Thereafter, a divided Board denied the union's motion for reconsideration. *Browning-Ferris Industries of California, Inc. d/b/a BFI Newby Island Recyclery,* 370 NLRB No. 86 (2021).

On further review, the D.C. Circuit found the Board's retroactivity analysis erroneous, granted the union's petition for review, and vacated the Board's order dismissing the complaint and amending the certification of representative. *Sanitary Truck Drivers & Helpers Local 350, International Brotherhood of Teamsters* v. *NLRB,* --- F.4th ----, 2022 WL 3008026 (D.C. Cir. July 29, 2022).

explained that the 2020 Rule promoted the Act's policies by imposing bargaining obligations only on those employer entities that actually control essential working conditions and by establishing a fairly bright-line rule to guide regulated parties. In that rule, it was stated that the Board believes a standard that requires an entity to possess and exercise substantial direct and immediate control over essential terms and conditions of employment is consistent with the purposes and policies of the Act . . . . The Act's purpose of promoting collective bargaining is best served by a joint-employer standard that places at the bargaining table only those entities that control terms and conditions that are most material to collective bargaining. Moreover, a less demanding standard would unjustly subject innocent parties to liability for others' unfair labor practices and coercion in others' labor disputes. A fuzzier standard with no bright lines would make it difficult for the Board to distinguish between arm's-length contracting parties and genuine joint employers. Accordingly, preserving the element of direct and immediate control over essential terms and conditions draws a discernible and predictable line, providing ''certainty beforehand'' for the regulated community. 85 FR 11205.

A primary benefit of the 2020 Rule is the clear guidance that it provides to regulated parties. Not only does it clearly identify the general types of control that will render one company the joint employer of another's workers, it also provides specific examples with respect to each essential employment term. For example, with respect to ''wages,'' the 2020 Rule provides that an employer exercises direct and immediate control if it determines the wage rate paid to another employer's individual employees or job classifications, but not if it enters into a cost-plus contract with another company. Further, with respect to the essential term of ''direction,'' the 2020 Rule provides that an entity exercises direct and immediate control by assigning particular employees their individual work schedules, positions, and tasks, but not if it merely sets the schedule for completing a project or describes the work to be accomplished on a project. The 2020 Rule provides similar examples for each of the other six ''essential'' terms. And the 2020 Rule makes clear that like reserved and indirect control over essential terms, control over non-essential mandatory subjects of bargaining can be probative of joint-employer status but is insufficient, standing alone, to establish a joint-employer relationship.

Reasons for Our Dissent

We dissent from the majority's decision to engage in rulemaking in this area at this time because, for the reasons stated above, there is no valid justification for doing so, particularly a mere two-and-a-half years after the 2020 Rule was promulgated. We further dissent from the majority's NPRM because the proposed rule is fundamentally flawed and inconsistent with the common law and the policies of the Act for the reasons stated below. The proposed rule is sufficiently flawed that a decision to adopt it would be arbitrary and capricious. For the same reasons, any revised rule that could be permissibly based on it would be arbitrary and capricious as well.

A. The Proposed Rule Is Arbitrary and Capricious Because It Fails To Provide Meaningful Guidance

The choice between rulemaking and adjudication is left to the Agency's informed discretion in the first instance.[78] In either circumstance, however, the Administrative Procedure Act (APA), 5 U.S.C. 551 *et seq.,* establishes standards that Federal agencies must follow. Specifically, the APA prohibits administrative agencies from acting arbitrarily and capriciously. In this regard, the Supreme Court has explained that the APA requires the agency to ''provide reasoned explanation for its action . . . . An agency may not, for example, depart from a prior policy *sub silentio* . . . . And of course the agency must show that there are good reasons for the new policy.'' *FCC* v. *Fox Television Stations, Inc.,* 556 U.S. 502, 515 (2009) (internal citation omitted). More recently, the Supreme Court succinctly held that ''[t]he APA's arbitrary-and-capricious standard requires that agency action be reasonable and reasonably explained.'' *FCC* v. *Prometheus Radio Project,* ____ U.S. ____, 141 S. Ct. 1150, 1158 (2021). The proposed rule fails this test.

The majority justifies their decision to engage in rulemaking here by claiming that the proposed rule will, among other things, establish ''a definite, readily available standard [that] will assist employers and labor organizations in complying with the Act'' and ''reduce uncertainty and litigation over the basic parameters of joint-employer status'' compared to determining joint-employer status through adjudication. But the proposed rule fails to achieve these goals. It offers no greater certainty or predictability than adjudication because it expressly contemplates that joint-employer status will be determined through adjudication under the common law, not under the provisions of the proposed rule, in most if not all cases. In this respect, it will also provide markedly less guidance to parties than does the 2020 Rule.

Absent any rule whatsoever, joint-employer status would be determined through case-by-case adjudication applying the common law of agency.[79] Rather than specify how the common-law standard will be applied in determining joint-employer status, however, the proposed rule simply incorporates it by reference in no fewer than three places. Section 103.40(a) of the proposed rule provides that ''an employer, as defined by section 2(2) of the National Labor Relations Act (the Act), is an employer of particular employees, as defined by section 2(3) of the Act, if the employer has an employment relationship with those employees under common-law agency principles.'' Section 103.40(b) of the proposed rule provides that ''[w]hether an employer possesses the authority to control or exercises the power to control one or more of the employees' terms and conditions of employment is determined under common-law agency principles.'' And § 103.40(f) of the proposed rule provides that ''[e]vidence of an employer's control over matters that are immaterial to the existence of an employment relationship under common-law agency principles or control over matters that do not bear on the employees' essential terms and conditions of employment is not relevant to the determination of whether the employer is a joint employer.'' Determinations of joint-employer status under each of these provisions will require adjudication under the common law, since the proposed rule by its terms

[78] *NLRB* v. *Bell Aerospace Co.,* 416 U.S. 267, 294 (1974) (''[T]he choice between rulemaking and adjudication lies in the first instance within the Board's discretion.''); *SEC* v. *Chenery Corp.,* 332 U.S. 194, 203 (1947) (''[T]he choice made between proceeding by general rule or by individual, ad hoc litigation is one that lies primarily in the informed discretion of the administrative agency.'').

[79] See *NLRB* v. *United Insurance Co. of America,* 390 U.S. at 256 (holding that the Board must ''apply general agency principles in distinguishing between employees and independent contractors under the Act''); *Browning-Ferris Industries of California* v. *NLRB,* 911 F.3d at 1214–1215 (''[E]mployee-or-independent-contractor cases can still be instructive in the joint-employer inquiry to the extent that they elaborate on the nature and extent of control necessary to establish a common-law employment relationship. Beyond that, a rigid focus on independent-contractor analysis omits the vital second step in joint-employer cases, which asks, once control over the workers is found, *who* is exercising that control, *when,* and *how.*'') (emphasis in original).

provides no other guidance. This is precisely how the determinations would be made if there were no rule at all.[80]

Moreover, the proposed rule incorporates ''common-law agency principles'' but offers no guidance whatsoever as to the meaning of that term. Does the proposed rule incorporate the Restatement of Agency? If so, which of the three Restatements is being incorporated? Do ''common-law agency principles'' include court decisions applying the common law? If so, which ones? Does a decision by a single court count, even if most other courts disagree? The proposed rule does not answer or even acknowledge any of these questions, much less provide a reasonable explanation for failing to do so. See *FCC* v. *Prometheus Radio Project,* 141 S. Ct. at 1158 (''The APA's arbitrary-and-capricious standard requires that agency action be reasonable and reasonably explained.'').

Another weakness in the proposed rule is the uncertainty it would inject into the identification of ''essential'' terms and conditions of employment. Where the 2020 Rule provided an exhaustive list, the proposed rule takes a ''broad, inclusive'' (*i.e.,* vague) approach. The text of the proposed regulation provides a non-exhaustive list of ''essential'' subjects without providing any guidance on how regulated parties (or the Board) could determine whether an unlisted subject is ''essential.'' The proposed rule compounds that uncertainty by suggesting that whether a particular subject is ''essential'' may depend on the particular industry involved, and further, that the category of ''essential'' terms may change over the course of time.

In *Browning-Ferris Industries of California, Inc.* v. *NLRB,* the D.C. Circuit faulted the *BFI* Board for failing to delineate what terms and conditions are ''essential'' to make collective bargaining ''meaningful'' and instead simply declaring that it would adhere to an '' 'inclusive' and 'non-exhaustive' approach.'' 911 F.3d at 1221–1222 (citation omitted). In remanding the case to the Board, the D.C. Circuit articulated its trust that, before finding a joint-employer relationship, the Board ''would not neglect to . . . explain which terms and conditions are 'essential' to permit 'meaningful collective bargaining,' '' id. at 1222—referring, in that last phrase, to the second step of the *BFI* standard.[81] Our colleagues' response? They keep *BFI*'s ''inclusive'' and ''non-exhaustive'' approach to ''essential'' terms and conditions, but they evade—for the time being—the task of furnishing the explanation the D.C. Circuit requires by tossing out the second step of the *BFI* standard altogether and declaring that ''any required bargaining under the new standard will necessarily be meaningful.'' Whether this solution has legs remains to be seen. Although the D.C. Circuit did not expressly endorse *BFI*'s second step, presumably the court would not have instructed the Board to explain that step more fully on remand if it deemed it superfluous to begin with.

The proposed rule is a step backward from the 2020 Rule in all these respects. As noted above, the 2020 Rule specified the factors to be considered in making a joint-employer determination and explained how they relate to each other. This permitted parties to determine whether a joint-employer relationship would be found based on the text of the rule itself, without any need to resort to Restatements of Agency, precedent applying the common law, or any other source to make that determination because the 2020 Rule itself reflected the boundaries established by the common law. It also specified the terms or conditions of employment that would be considered essential in determining joint-employer status. For all these reasons, the 2020 Rule indisputably provides parties with greater certainty and predictability than they would have if joint-employer status were decided by adjudication. The proposed rule, on the other hand, does not.

While administrative agencies have the authority to revise or amend previously promulgated rules, the APA requires the agency to ''provide reasoned explanation for its action . . . . [and] show that there are good reasons for the new policy.'' *FCC* v. *Fox Television Stations, Inc.,* 556 U.S. at 515 (internal citation omitted). Here, our colleagues fail to acknowledge that their proposed rule provides less guidance for the regulated community than the 2020 Rule. Nor have they shown that there are ''good reasons'' for replacing a clear, well-defined, and comprehensive rule with one that simply sets employers, employees, and unions adrift in a sea of common-law agency precedent, just as if there were no joint-employer rule at all. For this reason as well, the proposed rule is arbitrary and capricious. Id.

B. The Proposed Rule Is Contrary to the Common Law

The drastic changes our colleagues propose making to existing law also do not find support in the common-law standards they claim to endorse. They assert that the Act's policies ''make it appropriate for the Board to give determinative weight to the existence of a putative joint employer's authority to control the essential terms and conditions of employment, whether or not such control is exercised, and without regard to whether any exercise of such control is direct or indirect.'' However, they fail to cite a body of court precedent holding that a joint-employer relationship—whether under the common law or in the specific context of the National Labor Relations Act—may be based solely on a never-exercised contractual reservation of right to control or on indirect control of or impact on employees' essential working conditions.

Contrary to our colleagues' suggestion, *Greyhound Corp.,* 153 NLRB 1488 (1965), does not support their view that a joint-employer relationship may be based exclusively on a never-exercised contractual reservation of a right to control and/or indirect control. In that case, the Board found that Greyhound was a joint employer of its cleaning contractor's employees based in part on Greyhound's actual exercise of substantial direct and immediate control over the employees' essential terms and conditions of employment. Specifically, the Board relied on the fact that Greyhound had actually engaged in ''detailed supervision'' of the employees on a day-to-day basis regarding the manner and means of their performance. Id. at 1496. Also, the Board relied on the fact that Greyhound had actually prompted the discharge of one of the contractor's employees whom Greyhound had felt was unsatisfactory. Id. at 1491 fn. 8. To be sure, the Board also gave some weight to provisions in the business contract between Greyhound and the contractor. That contract granted Greyhound the right to specify the ''exact manner and means'' through which the employees' work would be accomplished, control their wages, set their schedules, and assign employees to perform the work. Id. at 1495–1496. But the Board specifically stated that ''[t]he joint employer finding herein is premised on the common control *exercised* by Greyhound and [the cleaning contractor] over the employees.'' Id. at 1492 (emphasis

[80] This naturally invites the question, why is the majority proposing a new rule to replace the 2020 Rule rather than simply rescinding the 2020 Rule? We suspect the answer is that rescinding the 2020 Rule without replacing it with a new rule would effectively reinstate *BFI,* which the majority departs from in key respects.

[81] See *BFI,* 362 NLRB at 1600 (''If this common-law employment relationship exists, the inquiry then turns to whether the putative joint employer possesses sufficient control over employees' essential terms and conditions of employment to permit meaningful collective bargaining.'').

added). And the Board explained that Greyhound had ''reserved to itself, both as a matter of express contractual agreement *and in actual practice,* rights over these employees which are consistent with its status as their employer along with [the cleaning contractor].'' Id. at 1495 (emphasis added). In short, *Greyhound* supports the 2020 Rule, not the proposed rule.[82]

In an earlier case related to *Greyhound,* the Supreme Court held that a Federal district court lacked subject-matter jurisdiction to enjoin the Board from conducting a representation election based on the plaintiff's challenge to the Board's joint-employer determination in the representation proceeding. *Boire* v. *Greyhound Corp.,* 376 U.S. 473 (1964). While the Court there did not rule directly on the joint-employer standard, it observed that the Board had found Greyhound and the cleaning contractor constituted a joint employer ''because they had exercised common control over the employees.'' Id. at 475. The Court further stated that ''whether Greyhound possessed sufficient indicia of control to be an 'employer' is essentially a factual issue.'' Id. at 481. Accordingly, *Boire* v. *Greyhound* offers no support for the proposed rule.

The majority's proposed rule also finds no support in *NLRB* v. *Browning-Ferris Industries of Pennsylvania, Inc.,* 691 F.2d at 1117. There, the Third Circuit set forth the ''correct standard'' as follows: ''[W]here two or more employers *exert significant control* over the same employees—where from the evidence it can be shown that they share or co-determine those matters governing essential terms and conditions of employment—they constitute 'joint employers' within the meaning of the NLRA.'' Id. at 1124 (emphasis added).[83] Applying that standard, the court found that the operator of a refuse site (BFI) was a joint employer of drivers directly employed and supplied by its trucking contractors. The court relied on BFI's actual exercise of substantial direct and immediate control over the drivers' essential terms and conditions of employment. Specifically, BFI possessed and exercised the right to hire and fire the drivers at issue. Id. at 1120, 1124. Also, BFI and the trucking contractors ''together determined the drivers' compensation and shared in the day to day supervision of the drivers.'' Id. at 1125. On that record, the Third Circuit found that substantial evidence ''support[ed] the Board's finding that BFI *exerted significant control* over the work of the drivers,'' and it therefore affirmed the Board's joint-employer conclusion. Id. at 1125 (emphasis added). The Third Circuit did not hint, much less hold, that an entity shares or codetermines matters governing essential terms and conditions of employment of a separate employer's employees without having actually exercised control over those terms and conditions—on its own or in collaboration with the undisputed employer—by hiring, discharging, disciplining, supervising, or directing them or by setting their wages, benefits, or hours of work.

Our colleagues also mistakenly rely on independent-contractor-or-employee cases to support their proposed drastic changes to the Board's joint-employer standard. To be sure, the courts have stated that a worker is an employee, not an independent contractor, if an employer *possesses* a ''right to control'' her manner and means of performance, regardless of whether that right is exercised. In determining whether an employer possesses a ''right to control'' in that context, courts consider a variety of factors, which the Supreme Court summarized in *Community for Creative Non-Violence* v. *Reid,* 490 U.S. 730 (1989).[84] But, as referenced above, the D.C. Circuit explained in *Browning-Ferris* v. *NLRB* that the common-law independent-contractor standard and joint-employer standard are different because the joint-employer standard has a crucial second step, which asks, who is exercising control, when, and how. 911 F.3d at 1215. As the court explained, ''using the independent-contractor test exclusively to answer the joint-employer question would be rather like using a hammer to drive in a screw: it only roughly assists the task because the hammer is designed for a different purpose.'' Id. Our colleagues' proposed rule simply disregards the second step of the common-law joint-employer standard identified by the D.C. Circuit. It would eliminate any requirement of actual exercise of control and thus render immaterial ''how'' any control is exercised (directly or indirectly). Therefore, the proposed rule is inconsistent with the common law for this reason as well.

C. The Proposed Rule Misleadingly Claims To Return to the BFI Standard

Our colleagues say that they are proposing ''to rescind [the 2020 Rule] and replace it with a new rule that incorporates the *BFI* standard.'' This is not so. The majority's proposed rule ventures into territory the *BFI* Board steered clear of. It would not merely return the Board to the *BFI* standard but would implement a standard considerably more extreme than *BFI.* As shown below, the proposed rule's expansions of joint-employer status are contrary to the common law and the policies of the Act.

[82] The majority misleadingly claims that ''[f]or nearly two decades after *Greyhound,* the Board treated the right to control employees' work and their terms and conditions of employment as determinative in the joint-employer analysis.'' To support that assertion, the majority cites a number of decisions in which the Board and reviewing courts found ''probative'' (*i.e.,* relevant) a company's unexercised contractual reservation of right to control and/or its indirect control over essential terms and conditions of employment. But, in nearly every one of those cases, the Board also relied in part on an entity's actual exercise of direct and immediate control and did not state or imply that a joint-employer finding would have been appropriate absent that exercise of control. See, *e.g., Lowery Trucking Co.,* 177 NLRB 13, 15 (1969) (finding that freight company was joint employer of drivers supplied by trucking company based in part on actual exercise of detailed supervision, participation in the hiring process, discharge of two drivers, and discipline of a third), enfd. sub nom. *Ace-Alkire Freight Lines* v. *NLRB,* 431 F.2d 280 (8th Cir. 1970). Our research revealed only two cases in which the Board apparently based a joint-employer finding exclusively on an unexercised contractual reservation of right to control essential employment terms: *Jewel Tea Co.,* 162 NLRB 508 (1966), and *Value Village,* 161 NLRB 603 (1966). However, in each case, the Board failed to offer any rationale for *why* an unexercised reservation of right, standing alone, could establish joint-employer status under the Act. In that regard, those two opinions were conclusory. Two conclusory decisions do not establish a traditional approach. Moreover, our research uncovered no cases in which the Board or a court based a joint-employer finding solely on *indirect* control.

[83] To be sure, the proposed rule incorporates the ''share or codetermine'' standard in proposed § 103.40(b). However, in § 103.40(c), it defines the ''share or codetermine'' standard to include indirect control of, and possession of a never-exercised authority to control, any essential term or condition of employment. This is not how the standard has been understood or applied historically. Indeed, it is contrary to the understanding of the court that first formulated the ''share or codetermine'' standard, the Third Circuit, which equated it with a shared ''exert[ion]'' of ''significant control'' over a group of employees. *NLRB* v. *Browning-Ferris Industries of Pennsylvania,* 691 F.2d at 1194. Our colleagues' definition of the ''share or codetermine'' standard, so at variance with how that standard has been understood, reminds us of a dialogue between Humpty Dumpty and Alice in chapter 6 of Lewis Carroll's *Through the Looking Glass:* ''When I use a word,'' Humpty Dumpty said in a rather scornful tone, ''it means just what I choose it to mean—neither more nor less.'' ''The question is,'' said Alice, ''whether you can make words mean so many different things.'' ''The question is,'' said Humpty Dumpty, ''which is to be master—that's all.''

[84] The so-called ''*Reid* factors,'' which are culled from the Federal common law of agency, include (1) the skill required; (2) the source of the instrumentalities and tools; (3) the location of the work; (4) the duration of the relationship between the parties; (5) whether the hiring party has the right to assign additional projects to the hired party; (6) the extent of the hired party's discretion over when and how long to work; (7) the method of payment; (8) the hired party's role in hiring and paying assistants; (9) whether the work is part of the regular business of the hiring party; (10) whether the hiring party is in business; (11) the provision of employee benefits; and (12) the tax treatment of the hired party. Id. at 751–752.

First, although the *BFI* majority opened the door to finding joint-employer status, on the facts of a particular case, based solely on indirect control or a never-exercised reserved right to control,[85] they stopped short of declaring these *dispositive* of joint-employer status as a matter of law.[86] Our colleagues' proposed rule does not. Section 103.40(b) of the proposed rule provides that employers are joint employers if they ''share or codetermine those matters governing employees' essential terms and conditions of employment,'' and § 103.40(c) states that ''[t]o 'share or codetermine those matters governing employees' essential terms and conditions of employment' *means* for an employer to possess the authority to control (whether directly, indirectly, or both), or to exercise the power to control (whether directly, indirectly, or both), one or more of the employees' essential terms and conditions of employment'' (emphasis added). And if that isn't clear enough, § 103.40(e) of the proposed rule states: ''Possessing the authority to control *is sufficient* to establish status as a joint employer, regardless of whether control is exercised. Exercising the power to control indirectly *is sufficient* to establish status as a joint employer, regardless of whether the power is exercised directly'' (emphasis added).

The proposed rule also abandons *BFI*'s second step, which required proof that ''the putative joint employer possesses sufficient control over employees' essential terms and conditions of employment to permit meaningful collective bargaining.'' 362 NLRB at 1600. Our colleagues thus repudiate the *BFI* Board's view that in some cases, a putative joint employer's degree of control over the terms and conditions of employment of another employer's employees will be insufficient to warrant placing the putative joint employer at the bargaining table, and accordingly that it would be contrary to the policies of the Act to find a joint-employer relationship in those circumstances. 362 NLRB at 1610–1611, 1614. Instead, our colleagues simply assert that where ''a putative joint employer possesses the authority to control or exercises the power to control employees' essential terms and conditions of employment, any required bargaining under the new standard will necessarily be meaningful.'' The majority offers no support whatsoever for this step. They simply declare that it must be so.

The majority's omission of *BFI*'s ''meaningful collective bargaining'' inquiry contradicts the D.C. Circuit's decision in *Browning-Ferris Industries of California, Inc.* v. *NLRB,* supra. There, the D.C. Circuit faulted the Board for failing to apply the second step of the *BFI* standard and declared that the Board must explain how a putative joint-employer's control would result in ''meaningful collective bargaining'' before it could find a joint-employer relationship. Presumably, the court would not have remanded for that purpose if the inquiry were unnecessary to the joint-employer determination.

In our view, the majority's assumption that any bargaining required under their newly-fashioned standard will necessarily be meaningful is also patently unreasonable. It bears emphasis that joint-employer bargaining requires separate entities to bargain together. Such bargaining will be unworkable unless those entities' interests are sufficiently aligned to permit them to bargain together, rather than against, each other. Moreover, it makes no sense to force an entity to participate in collective bargaining where its influence over the terms and conditions of employment of another employer's employees is too attenuated to make its participation meaningful, and it is unfair to impose unfair labor practice liability on that entity if it fails or refuses to do so. Nevertheless, the proposed rule would require just that, even where a putative joint employer has never exercised a reserved right to control any one term or condition of employment our colleagues would deem essential—including where that employment term has never before been so deemed but is discovered to be essential in the case itself.[87] It is unlikely, to say the least, that bargaining on the basis of so tenuous a relationship will be either meaningful or productive.

It is difficult to imagine a better recipe for injecting chaos into the practice and procedure of collective bargaining that the majority claims to promote. This is contrary to the national labor policy that *Congress* established, which aims to ''achiev[e] industrial peace by promoting *stable* collective-bargaining relationships.'' *Auciello Iron Works, Inc.* v. *NLRB,* 517 U.S. 781, 790 (1996) (emphasis added).[88] Moreover, collective bargaining was intended by Congress to be a process that could conceivably produce agreements. See, *e.g., NLRB* v. *Insurance Agents' International Union,* 361 U.S. 477, 485 (1960) (Congress intended collective bargaining to be ''a process that look[s] to the ordering of the parties' industrial relationship through the formation of a contract.''); *H.J. Heinz Co.* v. *NLRB,* 311 U.S. 514, 523 (1941) (The object of collective bargaining under the Act is ''an agreement between employer and employees as to wages, hours and working conditions.''). There is nothing stable about the collective-bargaining relationships the proposed rule would create, nor is there any likelihood that those relationships would result in an agreement.

D. The Proposed Rule Is Not Required To Address Health and Safety Matters

Contrary to the majority's wholly unsupported suggestion, the 2020 Rule does not turn a blind eye to a putative joint employer's control over health and safety matters. To be sure, the 2020 Rule does require that an entity possess and exercise direct and immediate control over one or more essential terms or conditions of employment, as defined by the Rule, before joint-employer status may be found, and health and safety matters are not one of those essential terms and conditions of employment. As noted above, however, the 2020 Rule also specifically states that ''the entity's control over mandatory subjects of bargaining other than the essential terms and conditions of employment is probative of joint-employer status, but only to the extent it supplements and reinforces evidence of the entity's possession or exercise of direct and

[85] See *BFI,* 362 NLRB at 1613–1614 (''We will no longer require that a joint employer not only possess the authority to control employees' terms and conditions of employment, but must also exercise that authority, and do so directly, immediately, and not in a 'limited and routine' manner.'').

[86] See *BFI,* 362 NLRB at 1614 (''The right to control . . . is *probative* of joint-employer status, as is the actual exercise of control, whether direct or indirect'' (emphasis added).).

[87] See § 103.40(d) of the proposed rule: '' 'Essential terms and conditions of employment' will generally include, *but are not limited to:* wages, benefits, and other compensation; hours of work and scheduling; hiring and discharge; discipline; workplace health and safety; supervision; assignment; and work rules and directions governing the manner, means, or methods of work performance'' (emphasis added). Holding a party liable under sec. 8(a)(5) of the Act for failing to bargain, where the violation is premised on a finding that the party is a joint employer based on a contractually reserved right to control an employment term *never before deemed essential* would surely abrogate that party's due process rights. Yet that is an outcome the proposed rule evidently countenances. And if the Board were to adopt a recent position advocated by the General Counsel, the affirmative remedy for that violation might not be limited to an order to bargain. See *ArrMaz Products, Inc.,* 12–CA–294086 (arguing that the Board should order the employer to ''make the bargaining-unit employees whole for the lost opportunity to engage in collective bargaining,'' overruling *Ex-Cell-O Corp.,* 185 NLRB 107 (1970)).

[88] See also *Colgate-Palmolive-Peet Co.* v. *NLRB,* 338 U.S. 355, 362 (1949) (''To achieve stability of labor relations was the primary objective of Congress in enacting the National Labor Relations Act.'').

immediate control over a particular essential term and condition of employment.'' As such, control over health and safety matters is relevant to joint-employer status under the 2020 Rule.

We therefore emphatically reject the majority's unsupported assertion that ''[t]he shortcomings of the 2020 Rule's exhaustive list of essential terms and conditions of employment (which did not include workplace health and safety) were revealed during the COVID–19 pandemic.'' While the proposed rule cites no source for this claim, it is a matter of public record that this is one of the allegations in the complaint filed by the Service Employees International Union in their pending lawsuit to invalidate the 2020 Rule.[89] It is the obligation of the Board to defend against that lawsuit, not to effectively support it by publicly endorsing the plaintiff's allegations.

There is, moreover, no merit to this reckless charge. Not one example has been cited in which a union's inability to bargain with a putative joint employer of employees it represents has adversely affected any employee's health or safety for any reason, much less because of the COVID–19 pandemic. Nor is it at all evident why a union would be unable to secure needed health and safety measures, including protections against COVID–19, through bargaining with the entity that is the undisputed employer of the employees it represents without also including a putative joint employer, much less that the differences between the 2020 Rule and the proposed rule would make any difference in this regard.

Among other things, the unlikely scenario posited by the majority would involve an undisputed employer that contracted away its control over its employees' health and safety despite its established legal obligation to provide a safe workplace and the liability that it would incur if it breached that duty.[90] Even in that implausible scenario, the differences between the 2020 Rule and the proposed rule would be material only if the putative joint employer controlled health and safety but none of the essential terms and conditions of employment specified in the 2020 Rule. Our colleagues offer no reason to believe that this situation has ever occurred.

Conclusion

For all these reasons, we dissent from this Notice of Proposed Rulemaking to rescind and replace the 2020 Rule. We would leave the 2020 Rule in place and move the U.S. District Court for the District of Columbia to lift the stay on the SEIU's challenge to it. We would defend the 2020 Rule, and we are confident that it would be upheld by the courts as within the boundaries set by common-law agency principles. Of course, given that a second round of rulemaking will proceed, we shall consider with open minds all public comments, any developments brought to our attention, and the considered views of our colleagues.

VI. Regulatory Procedures

Regulatory Flexibility Act

A. Initial Regulatory Flexibility Analysis

The Regulatory Flexibility Act of 1980 (''RFA''), 5 U.S.C. 601, *et seq.,* requires agencies to ''review rules to assess and take appropriate account of the potential impact on small businesses, small governmental jurisdictions, and small organizations, as provided by the [RFA].'' [91]

It requires agencies promulgating proposed rules to prepare an Initial Regulatory Flexibility Analysis (''IRFA'') and to develop alternatives wherever possible, when drafting regulations that will have a significant impact on a substantial number of small entities. However, an agency is not required to prepare an IRFA for a proposed rule if the agency head certifies that, if promulgated, the rule will not have a significant economic impact on a substantial number of small entities.[92] The RFA does not define either ''significant economic impact'' or ''substantial number of small entities.'' [93] Additionally, ''[i]n the absence of statutory specificity, what is 'significant' will vary depending on the economics of the industry or sector to be regulated. The agency is in the best position to gauge the small entity impacts of its regulations.'' [94]

Although the Board believes that it is unlikely that the proposed rule will have a significant economic impact on a substantial number of small entities, it seeks public input on this hypothesis and has prepared an IRFA to provide the public the fullest opportunity to comment on the proposed rule. An IRFA describes why an action is being proposed; the objectives and legal basis for the proposed rule; the number of small entities to which the proposed rule would apply; any projected reporting, recordkeeping, or other compliance requirements of the proposed rule; any overlapping, duplicative, or conflicting Federal rules; and any significant alternatives to the proposed rule that would accomplish the stated objectives, consistent with applicable statutes, and that would minimize any significant adverse economic impacts of the proposed rule on small entities.[95] Descriptions of this proposed rule, its purpose, objectives, and legal basis are contained earlier in the Summary and Supplemental Information sections and are not repeated here.

As with the Board's 2020 Rule on Joint Employer Status under the Act, we assume that the costs of compliance for most small entities will be minimal. We assume for purposes of this analysis all small employers and small entity labor unions will incur a low cost of compliance with the rule, related to reviewing and understanding the substantive changes to the joint-employer standard. The Board welcomes comments from the public that will shed light on potential compliance costs unknown to the Board or on any other part of this IRFA.

B. Description and Estimate of Number of Small Entities to Which the Rule Applies

In order to evaluate the impact of the proposed rule, the Board first identified the entire universe of businesses that could be impacted by a change in the joint-employer standard. According to the United States Census Bureau, there were 6,102,412 business firms with employees in 2019.[96] Of those, the

[89] See *Service Employees International Union* v. *NLRB,* Case No. 21–cv–2443 (D.D.C.). The complaint in that case, like the NPRM here, alleges that the 2020 Rule ''arbitrarily and capriciously excludes health and safety matters from the set of employment conditions over which an entity that exercises control must bargain. The latter error is particularly egregious in the context of the global COVID–19 pandemic.'' (On January 6, 2022, the court granted a joint motion filed by the SEIU and the Board to stay Case No. 21–cv–2443 in light of the Board's stated intent to engage in a second rulemaking on the joint-employer standard.)

[90] See, *e.g.,* 29 U.S.C. 654, which states that each employer shall furnish to each of his employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees and shall comply with occupational safety and health standards promulgated under this chapter.

[91] E.O. 13272, sec. 1, 67 FR 53461 (''Proper Consideration of Small Entities in Agency Rulemaking'').

[92] 5 U.S.C. 605(b).

[93] 5 U.S.C. 601.

[94] Small Business Administration Office of Advocacy, ''A Guide for Government Agencies: How to Comply with the Regulatory Flexibility Act'' (''SBA Guide'') at 18, *https://www.sba.gov/sites/default/files/advocacy/How-to-Comply-with-the-RFA-WEB.pdf.*

[95] 5 U.S.C. 603(b).

[96] U.S. Department of Commerce, Bureau of Census, 2019 Statistics of U.S. Businesses (''SUSB'') Annual Data Tables by Enterprise Employment Size, *https://www.census.gov/data/tables/2019/*

Continued

Census Bureau estimates that about 6,081,544 were firms with fewer than 500 employees.[97] While this proposed rule does not apply to employers that do not meet the Board's jurisdictional requirements, the Board does not have the data to determine the number of excluded entities.[98] Accordingly, the Board assumes for purposes of this analysis that all of the 6,081,544 small business firms could be impacted by the proposed rule and will incur the one-time compliance cost of reading and familiarizing themselves with the text of the new rule.[99]

The Board also recognizes that businesses that are involved in the exchange of employees or operational control, or labor unions that represent employees at such businesses, may have a particular interest in the rule and are most likely to incur the compliance costs discussed herein. Therefore, as it did in its 2018 IRFA, the Board is emphasizing the relevance of the rule to entities in the following five categories: (1) contractors/subcontractors; (2) temporary help service suppliers; (3) temporary help service users; (4) franchisees; and (5) labor unions.[100]

(1) Businesses that enter contracts or subcontracts to receive a wide range of services that may satisfy primary business objectives or solve discrete problems that they are not qualified to address often share workspaces and control over workers, rendering their relationships potentially subject to application of the Board's joint-employer standard. The Board does not have the means to identify precisely how many businesses are impacted by contracting and subcontracting within the U.S. or how many contractors and subcontractors would be small businesses as defined by the SBA. In its 2018 IRFA, the Board solicited input on the number of contractors and subcontractors that qualify as small businesses but received no responsive comments.[101]

(2) Temporary help service providers (NAICS #561320) are primarily engaged in supplying workers to supplement a client-employer's workforce. To be defined as a small business temporary help service supplier by the SBA, the entity must generate receipts of less than $30 million annually.[102] In 2017, there were 14,343 temporary service supplier firms in the U.S.[103] Of these temporary service supplier firms, 13,384 had receipts of $29,999,999 or less. Therefore, according to SBA standards, 93.3% of all temporary help service supplier firms are small businesses.

(3) Entities that use temporary help services in order to staff their businesses are widespread throughout many types of industries. The Census Bureau's 2020 Annual Business Survey revealed that of the 2,687,205 respondent firms with paid employees, 94,930 of those firms obtained staffing from temporary help services in that calendar year.[104] This survey provides the only gauge of employers that obtain staffing from temporary help services and the Board is without the means to estimate what portion of those are small businesses as defined by the NAICS. For purposes of this IRFA, the Board assumes that all 94,930 users of temporary services are small businesses.

(4) Franchising is a method of distributing products or services in which a franchisor lends its trademark or trade name and a business system to a franchisee, which pays a royalty and often an initial fee for the right to conduct business under the franchisor's name and system.[105] Franchisors generally exercise some operational control over their franchisees, which potentially renders the relationship subject to application of the Board's joint-employer standard. The Board does not have the means to identify precisely how many franchisees operate within the U.S., or how many are small businesses as defined by the SBA. The Census Bureau's 2020 Annual Business Survey revealed that, of the 130,492 firms that operated a portion of their business as a franchise, 125,989 had fewer than 500 paid employees.[106] Based on this available data and the fact that the 500-employee threshold is commonly used to describe the universe of small employers, we assume that 125,989 (96.5% of total) are small businesses.

(5) Labor unions, as defined by the NLRA, are entities ''in which employees participate and which exist for the

econ/susb/2019-susb-annual.html (from downloaded Excel Table entitled ''U.S. & States, 6-digit NAICS'' found at *https://www2.census.gov/programs-surveys/susb/tables/2019/us_state_6digitnaics_2019.xlsx*. ''Establishments'' refer to single location entities—an individual ''firm'' can have one or more establishments in its network. The Board has used firm level data for this IRFA because establishment data is not available for certain types of employers discussed below. Census Bureau definitions of ''establishment'' and ''firm'' can be found at *https://www.census.gov/programs-surveys/susb/about/glossary.html.*

[97] The Census Bureau does not specifically define small business, but does break down its data into firms with 500 or more employees and those with fewer than 500 employees. *See* U.S Department of Commerce, Bureau of Census, 2019 SUSB Annual Data Tables by Enterprise Employment Size, *https://www.census.gov/data/tables/2019/econ/susb/2019-susb-annual.html* (from downloaded Excel Table entitled ''U.S. & States, 6-digit NAICS'') found at *https://www2.census.gov/programs-surveys/susb/tables/2019/us_state_6digitnaics_2019.xlsx*. Consequently, the 500-employee threshold is commonly used to describe the universe of small employers. For defining small businesses among specific industries, the standards are defined by the North American Industry Classification System (NAICS), which we set forth below.

[98] Pursuant to 29 U.S.C. 152(6) and (7), the Board has statutory jurisdiction over private sector employers whose activity in interstate commerce exceeds a minimal level. *NLRB* v. *Fainblatt,* 306 U.S. 601, 606–07 (1939). To this end, the Board has adopted monetary standards for the assertion of jurisdiction that are based on the volume and character of the business of the employer. In general, the Board asserts jurisdiction over employers in the retail business industry if they have a gross annual volume of business of $500,000 or more. *Carolina Supplies & Cement Co.,* 122 NLRB 88 (1959). But shopping center and office building retailers have a lower threshold of $100,000 per year. *Carol Management Corp.,* 133 NLRB 1126 (1961). The Board asserts jurisdiction over non-retailers generally where the value of goods and services purchased from entities in other states is at least $50,000. *Siemons Mailing Service,* 122 NLRB 81 (1959).

The following employers are excluded from the NLRB's jurisdiction by statute: Federal, State and local governments, including public schools, libraries, and parks, Federal Reserve banks, and wholly-owned government corporations, 29 U.S.C. 152(2); employers that employ only agricultural laborers, those engaged in farming operations that cultivate or harvest agricultural commodities, or prepare commodities for delivery, 29 U.S.C. 153(3); and employers subject to the Railway Labor Act, such as interstate railroads and airlines, 29 U.S.C. 152(2).

[99] The Board welcomes comments from the public regarding particularized direct costs that exist in these or any other sector.

[100] Comments received in response to the 2018 IRFA did not reveal any other categories of small entities that would likely take special interest in a change in the standard for determining joint-employer status under the Act or indicate that there is a unique burden for entities in these categories. 85 FR 11234.

[101] 83 FR 46694 fn. 56; 85 FR 11234.

[102] 13 CFR 121.201.

[103] The Census Bureau only provides data about receipts in years ending in 2 or 7, so the 2017 data is the most recent available information regarding receipts. See U.S Department of Commerce, Bureau of Census, 2017 SUSB Annual Data Tables by Establishment Industry, NAICS classification #561320, *https://www2.census.gov/programs-surveys/susb/tables/2017/us_6digitnaics_rcptsize_2017.xlsx.*

[104] U.S. Department of Commerce, Bureau of Census, 2020 Annual Business Survey—Characteristics of Businesses, *https://www.census.gov/data/tables/2020/econ/abs/2020-abs-characteristics-of-businesses.html* (from downloaded Excel Table entitled ''Type(s) of Workers Employed by Sector, Sex, Ethnicity, Race, and Veteran Status,'' found at *https://data.census.gov/cedsci/table?q=ab1900%2a&tid=ABSCB2019.AB1900CSCB01&hidePreview=true&nkd=QDESC~B20*).

[105] See International Franchising Establishments FAQs, found at *https://www.franchise.org/faqs-about-franchising.*

[106] U.S. Department of Commerce, Bureau of Census, 2020 Annual Business Survey—Characteristics of Businesses, *https://www.census.gov/data/tables/2020/econ/abs/2020-abs-characteristics-of-businesses.html* (from downloaded Excel Table entitled ''Businesses Operated as a Franchise by Sex, Ethnicity, Race, Veteran Status, and Employment Size of Firm,'' found at *https://data.census.gov/cedsci/table?q=ab1900%2a&tid=ABSCB2019.AB1900CSCB04&hidePreview=true&nkd=QDESC~B06*).

purpose . . . of dealing with employers concerning grievances, labor disputes, wages, rates of pay, hours of employment, or conditions of work.'' [107] By defining which employers are joint employers under the NLRA, the proposed rule impacts labor unions generally, and more directly may affect those labor unions that organize the specific business sectors discussed above. The SBA's ''small business'' standard for ''Labor Unions and Similar Labor Organizations'' (NAICS #813930) is $14.5 million in annual receipts.[108] In 2017, there were 13,137 labor union firms in the U.S.[109] Of these firms, at least 12,875 labor union firms (98% of total) had receipts of under $10 million and are definitely small businesses according to SBA standards. Since the Board cannot determine how many of the 89 labor union firms with receipts between $10,000,000 and $14,999,999 fall below the $14.5 million annual receipt threshold, it will assume that these are all small businesses as defined by the SBA. For the purposes of the IRFA, the Board assumes that 12,964 labor union firms (98.7% of total) are small businesses.

Based on the foregoing, the Board assumes there are 13,384 temporary help supplier firms, 94,930 temporary help user firms, 125,989 franchise firms, and 12,964 union firms that are small businesses. Therefore, among these four categories of employers that are likely most interested in the proposed rule, 247,267 business firms are assumed to be small businesses as defined by the SBA.[110] We believe that these small businesses, and small businesses regularly engaged in contracting/subcontracting, have a general interest in the rule and would be most likely impacted by the one-time compliance cost of reviewing and understanding the rule, as described below. But employers will only be significantly impacted when they are alleged to be a joint employer in a Board proceeding. Given our historic filing data, this number is very small relative to the number of small entities in these five categories.

A review of the Board's representation petitions and unfair labor practice (ULP) charges provides a basis for estimating the frequency that the joint-employer issue comes before the NLRB. During the four-year period between January 1, 2018 and December 31, 2021, 75,343 representation and unfair labor practice cases were initiated with the Agency. In 772 of those filings, the representation petition or ULP charge asserted a joint-employer relationship between at least two employers.[111] Accounting for repetitively alleged joint-employer relationships in these filings, we identified 467 separate joint-employer relationships involving an estimated 934 employers.[112] Accordingly, the joint-employer standard most directly impacted approximately .015% of all 6,102,412 business firms (including both large and small businesses) over the four-year period.

C. Recordkeeping, Reporting, and Other Compliance Costs

The RFA requires the Agency to determine the amount of ''reporting, recordkeeping and other compliance requirements'' imposed on small entities.[113] The United States Court of Appeals for the District of Columbia Circuit has explained that this provision requires an agency to consider direct burdens that compliance with a new regulation will likely impose on small entities.[114]

At the outset, it is critical to understand that entities may lawfully choose to associate as joint employers under Federal law. Joint-employer status under the NLRA is relevant only to apportioning liability and bargaining obligations as a result of NLRB unfair labor practice and representation cases, not to whether such liabilities and obligations exist in the first instance. While entities may choose to rearrange their business relationships to minimize risk of joint-employer status, they may also choose not to. Accordingly, because the proposed rule would not make any form of business arrangement unlawful, it appears to impose no direct compliance costs other than those for reading and understanding the rule.

We therefore believe that the proposed rule imposes no capital costs for equipment needed to meet the regulatory requirements; no direct costs of modifying existing processes and procedures to comply with the proposed rule; no lost sales and profits directly resulting from the proposed rule; no changes in market competition as a direct result of the proposed rule and its impact on small entities or specific submarkets of small entities; no extra costs associated with the payment of taxes or fees associated with the proposed rule; and no direct costs of hiring employees dedicated to compliance with regulatory requirements.[115] And, like the current rule, the proposed rule does not impose any new information collection or reporting requirements on small entities.

For the purposes of this IRFA, the Board assumes that small entities, with particular emphasis on those small entities in the five categories with special interest in the proposed rule, will be interested in reviewing the rule to understand the restored common-law joint-employer standard. We estimate that a human resources or labor relations specialist at a small employer who undertook to become generally familiar with the proposed changes may take at most one hour to read the text of the rule and the supplementary information published in the **Federal Register**.[116] It is also possible that a small employer may wish to consult with an attorney, which we estimated to require one hour as well.[117] Using the Bureau of Labor Statistics' estimated wage and benefit costs, we have

[107] 29 U.S.C. 152(5).

[108] 13 CFR 121.201.

[109] See U.S Department of Commerce, Bureau of Census, 2017 SUSB Annual Data Tables by Establishment Industry, NAICS classification #722513, *https://www2.census.gov/programs-surveys/susb/tables/2017/us_6digitnaics_rcptsize_2017.xlsx.*

[110] Comments received in response to the 2018 IRFA did not reveal any other categories of small entities that would likely take special interest in a change in the standard for determining joint-employer status under the Act or that there was a unique burden for entities in these subcategories. 85 FR 11234.

[111] This includes initial representation case petitions (RC petitions) and unfair labor practice charges (CA cases) filed against employers.

[112] Since a joint-employer relationship requires at least two employers, we have estimated the number of employers by multiplying the number of asserted joint-employer relationships by two. Some of these filings assert more than two joint employers; but, on the other hand, some of the same employers are named multiple times in these filings. Additionally, this number is certainly inflated because the data does not reveal those cases where a joint-employer relationship exists but the parties' joint-employer status is not in dispute.

[113] See 5 U.S.C. 603(b)(4), 604(a)(4).

[114] See *Mid-Tex Elec. Co-op* v. *FERC,* 773 F.2d 327, 342 (D.C. Cir. 1985) (''[I]t is clear that Congress envisioned that the relevant 'economic impact' was the impact of compliance with the proposed rule on regulated small entities.'').

[115] See SBA Guide at 37.

[116] Data from the Bureau of Labor Statistics indicates that employers are more likely to have a human resources specialist (BLS #13–1071) than to have a labor relations specialist (BLS #13–1075). Compare Occupational Employment and Wages, May 2021, 13–1075 Labor Relations Specialists, found at *https://www.bls.gov/oes/current/oes131075.htm,* with Occupational Employment and Wages, May 2021, 13–1071 Human Resources Specialists, found at *https://www.bls.gov/oes/current/oes131071.htm.*

[117] The Board believes that an experienced labor relations specialist or labor relations attorney would not expend more than an hour to read and understand the rule. The proposed rule returns to the pre-2020 Rule standard and incorporates the common-law definition of ''employer'' that already applies in most jurisdictions throughout the nation. We believe most employers are already knowledgeable with these standards if relevant to their businesses, as are labor relations attorneys.

assessed these labor costs to be between $147.24 and $151.51.[118]

Labor unions would also review the rule, similarly incurring an hour of legal fees. ($99.64, see fn. 118.) Like labor compliance professionals or employer labor-management attorneys, union counsels would only require one hour of legal time because they would already be familiar with the pre-2020 standard for determining joint-employer status under the Act and common-law principles.

The Board is not inclined to find the estimated $151.51 cost to small employers and the estimated $99.64 cost to small labor unions for review to be significant within the meaning of the RFA. In making this finding, one important indicator is the cost of compliance in relation to the revenue of the entity or the percentage of profits affected.[119] Other criteria to be considered are the following:

—Whether the rule will cause long-term insolvency, *i.e.,* regulatory costs that may reduce the ability of the firm to make future capital investment, thereby severely harming its competitive ability, particularly against larger firms;
—Whether the cost of the proposed regulation will (a) eliminate more than 10 percent of the businesses' profits; (b) exceed one percent of the gross revenues of the entities in a particular sector, or (c) exceed five percent of the labor costs of the entities in the sector.[120]

The minimal cost to read and understand the rule will not generate any such significant economic impacts.

Since the only quantifiable impact that we have identified is the $151.51 or $99.64 that may be incurred in reviewing and understanding the rule, we do not believe, subject to comments, that the proposed rule will have a significant economic impact on a substantial number of small entities.

D. Duplicate, Overlapping, or Conflicting Federal Rules

The Board has not identified any Federal rules that conflict with the proposed rule. It welcomes comments that suggest any potential conflicts not noted in this section.

E. Alternatives Considered

Pursuant to 5 U.S.C. 603(c), agencies are directed to look at ''any significant alternatives to the proposed rule which accomplish the stated objectives of applicable statutes and which minimize any significant economic impact of the proposed rule on small entities.'' The SBA has described this step as ''[t]he keystone of the IRFA,'' because ''[a]nalyzing alternatives establishes a process for the agency to evaluate proposals that achieve the regulatory goals efficiently and effectively without unduly burdening small entities, erecting barriers to competition, or stifling innovation.'' [121] The Board considered two primary alternatives to the proposed rules.

First, the Board considered taking no action. As explained in section II above, the Board believes, subject to comments, that the 2020 Rule wrongly departs from the common-law definition of employer. The Board is additionally concerned that the 2020 Rule does not adequately reflect important background legal principles and the Act's public policy of ''encouraging the practice and procedure of collective bargaining'' and maximizing employees' ''full freedom of association, self-organization, and designation of representatives of their own choosing, for the purpose of negotiating the terms and conditions of their employment or other mutual aid or protection.'' [122] Thus, for the reasons stated in Sections II and III above, the Board believes it necessary to revisit the 2020 Rule. Consequently, we reject maintaining the status quo.

Second, the Board considered creating exemptions for certain small entities, but is inclined to believe, subject to comments, that doing so would be both contrary to judicial precedent and impracticable. As noted previously, the Supreme Court and District of Columbia Circuit have explained that common-law agency principles apply when construing statutes, like the Act, whose terms are otherwise undefined in statute.[123] The Board is therefore bound to assess the employment relationship under common-law rules and is inclined to believe that the Act and judicial precedent would not provide strong support for the development of exceptions to longstanding common-law principles solely for small entities.[124] Moreover, even if the Act would permit such an exemption, the Board believes that exception would swallow the rule, given that such a large percentage of employers and unions would be exempt under the SBA definitions. We further agree with the observations regarding a small-entity exemption that the Board made in the 2020 Rule, which are equally applicable now, that as this rule often applies to relationships involving a small entity (such as a franchisee) and a large enterprise (such as a franchisor), exemptions for small businesses would decrease the application of the rule to larger businesses as well, potentially undermining the policy behind this rule. Additionally, given the very small quantifiable cost of compliance, it is possible that the burden on a small business of determining whether it fell within a particular exempt category might exceed the burden of compliance. Congress gave the Board very broad jurisdiction, with no suggestion that it wanted to limit coverage of any part of the Act to only larger employers.[125] As the Supreme Court has noted, ''[t]he [NLRA] is federal legislation, administered by a national agency, intended to solve a national problem on a national scale.'' [126]

85 FR 11235. We therefore rejected a small entity exemption as an effective alternative to the proposed rule. The Board welcomes comments on other alternatives to consider that would reduce the regulatory burden on small entities while carrying out the mission of the Act in conformance with the statutory language and judicial precedent.

Paperwork Reduction Act

The NLRB is an agency within the meaning of the Paperwork Reduction Act (PRA). 44 U.S.C. 3502(1) and (5). This Act creates rules for agencies when they solicit a ''collection of information,'' 44 U.S.C. 3507, which is defined as ''the obtaining, causing to be obtained, soliciting, or requiring the

[118] For wage figures, see May 2021 National Occupancy Employment and Wage Estimates, found at *https://www.bls.gov/oes/current/oes_nat.htm.* The Board has been administratively informed that BLS estimates that fringe benefits are approximately equal to 40 percent of hourly wages. Thus, to calculate total average hourly earnings, BLS multiplies average hourly wages by 1.4. In May 2021, average hourly wages for labor relations specialists (BLS #13–1075) were $37.05. The same figure for a lawyer (BLS #23–1011) is $71.17. Accordingly, the Board multiplied each of those wage figures by 1.4 and added them to arrive at its estimate.

[119] See SBA Guide at 18.

[120] Id. at 19.

[121] Id. at 37.

[122] 29 U.S.C. 151.

[123] See fn. 27, supra, and accompanying text (citing *NLRB* v. *Town & Country Electric, Inc.,* 516 U.S. 85, 92–95 (1995)); *BFI,* 911 F.3d at 1206.

[124] Although it does not have the ability to quantify a specific number, the Board notes again that it has declined jurisdiction over employers whose activity in commerce does not exceed a minimal level. See fn. 98, supra. That declination of jurisdiction should exclude many small employers from the reach of the proposed rule. Many other small entities are excluded by the NLRA's terms, which protect only concerted activities engaged in between two or more statutory employees; thus, businesses with zero or one statutory employee are unaffected by the proposed rule.

[125] However, there are standards that prevent the Board from asserting authority over entities that fall below certain jurisdictional thresholds. This means that extremely small entities outside of the Board's jurisdiction will not be affected by the proposed rule. See 29 CFR 104.204.

[126] *NLRB* v. *Nat. Gas Util. Dist. of Hawkins Cty., Tenn.,* 402 U.S. 600, 603–04 (1971) (quotation omitted).

disclosure to third parties or the public, of facts or opinions by or for an agency, regardless of form or format.'' 44 U.S.C. 3502(3)(A). The PRA only applies when such collections are ''conducted or sponsored by those agencies.'' 5 CFR 1320.4(a).

The proposed rule does not involve a collection of information within the meaning of the PRA; rather, it adopts a judicially approved standard for determining joint-employer status under the Act. Outside of administrative proceedings (discussed below), the proposed rule does not require any entity to disclose information to the NLRB, other government agencies, third parties, or the public.

The only circumstance in which the proposed rule could be construed to involve disclosures of information to the Agency, third parties, or the public is when an entity's status as a joint employer has been alleged in the course of the Board's administrative proceedings. However, the PRA provides that collections of information related to ''an administrative action or investigation involving an agency against specific individuals or entities'' are exempt from coverage. 44 U.S.C. 3518(c)(1)(B)(ii). A representation proceeding under section 9 of the Act, as well as an investigation into an unfair labor practice under section 10 of the Act, are administrative actions covered by this exemption.[127] The Board's decisions in these proceedings are binding on and thereby alter the legal rights of the parties to the proceedings and thus are sufficiently ''against'' the specific parties to trigger this exemption.[128]

For the foregoing reasons, the proposed rule does not contain information collection requirements that require approval by the Office of Management and Budget under the PRA.

List of Subjects in 29 CFR Part 103

Colleges and universities, Election procedures, Health facilities, Jurisdictional standards, Labor management relations, Music, Remedial orders, Sports.

[127] See Representation—Case Procedures, 79 FR 74307, 74468–74469 (Dec. 15, 2014).

[128] Legislative history indicates Congress wrote this exception to broadly cover many types of administrative action, not just those involving ''agency proceedings of a prosecutorial nature.'' *See* S. REP. 96–930 at 56, *as reprinted in* 1980 U.S.C.C.A.N. 6241, 6296. For the reasons more fully explained by the Board in prior rulemaking, 79 FR 74307, 74468–69 (2015), representation proceedings, although not qualifying as adjudications governed by the Administrative Procedure Act, 5 U.S.C. 552b(c)(1), are nonetheless exempt from the PRA under 44 U.S.C. 3518(c)(1)(B)(ii).

The Proposed Rule

For the reasons discussed in the preamble, the Board proposes to amend 29 CFR part 103 as follows:

PART 103—OTHER RULES

■ 1. The authority citation for part 103 continues to read as follows:

Authority: 29 U.S.C. 156, in accordance with the procedure set forth in 5 U.S.C. 553.

Subpart D—Joint Employers

■ 2. Revise § 103.40 to read as follows:

§ 103.40 Joint Employers.

(a) An employer, as defined by section 2(2) of the National Labor Relations Act (the Act), is an employer of particular employees, as defined by section 2(3) of the Act, if the employer has an employment relationship with those employees under common-law agency principles.

(b) For all purposes under the Act, two or more employers of the same particular employees are joint employers of those employees if the employers share or codetermine those matters governing employees' essential terms and conditions of employment.

(c) To ''share or codetermine those matters governing employees' essential terms and conditions of employment'' means for an employer to possess the authority to control (whether directly, indirectly, or both), or to exercise the power to control (whether directly, indirectly, or both), one or more of the employees' essential terms and conditions of employment.

(d) ''Essential terms and conditions of employment'' will generally include, but are not limited to: wages, benefits, and other compensation; hours of work and scheduling; hiring and discharge; discipline; workplace health and safety; supervision; assignment; and work rules and directions governing the manner, means, or methods of work performance.

(e) Whether an employer possesses the authority to control or exercises the power to control one or more of the employees' terms and conditions of employment is determined under common-law agency principles. Possessing the authority to control is sufficient to establish status as a joint employer, regardless of whether control is exercised. Exercising the power to control indirectly is sufficient to establish status as a joint employer, regardless of whether the power is exercised directly. Control exercised through an intermediary person or entity is sufficient to establish status as a joint employer.

(f) Evidence of an employer's control over matters that are immaterial to the existence of an employment relationship under common-law agency principles or control over matters that do not bear on the employees' essential terms and conditions of employment is not relevant to the determination of whether the employer is a joint employer.

(g) A party asserting that an employer is a joint employer of particular employees has the burden of establishing, by a preponderance of the evidence, that the entity meets the requirements set forth in paragraphs (a) through (f) of this section.

(h) The provisions of this section are intended to be severable. If any paragraph of this section is held to be unlawful, the remaining paragraphs of this section not deemed unlawful shall remain in effect to the fullest extent permitted by law.

Dated: August 31, 2022.

Roxanne L. Rothschild,

Executive Secretary.

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DEPARTMENT OF HOMELAND SECURITY

48 CFR Parts 3049 and 3052

[Docket No. DHS–2022–0046]

RIN 1601–AB08

Homeland Security Acquisition Regulation (HSAR); United States Coast Guard Contract Termination Policy (HSAR Case 2020–001)

AGENCY: Office of the Chief Procurement Officer, Department of Homeland Security (DHS).

ACTION: Proposed rule.

SUMMARY: DHS is proposing to amend the Homeland Security Acquisition Regulation (HSAR) to add a new subpart and new contract clause to establish contract termination policy for the United States Coast Guard (USCG) and amend a clause to address the applicability of USCG's contract termination policy to commercial items.

DATES: Interested parties should submit written comments to one of the addresses shown below on or before November 7, 2022, to be considered in the formation of the final rule.

ADDRESSES: Submit comments identified by HSAR Case 2020–001, Contract Termination Policy for the United States Coast Guard, using any of the following methods:

• *Regulations.gov: https://www.regulations.gov.*

Submit comments via the Federal eRulemaking portal by entering ''HSAR Case 2020–001'' under the heading ''Enter Keyword or ID'' and selecting ''Search.'' Select the link ''Submit a Comment'' that corresponds with ''HSAR Case 2020–001.'' Follow the instructions provided at the ''Submit a Comment'' screen. Please include your name, company name (if any), and ''HSAR Case 2020–001'' on your attached document.

Comments received generally will be posted without change to *https://www.regulations.gov,* including any personal information provided. To confirm receipt of your comment(s), please check *www.regulations.gov,* approximately two to three days after submission to verify posting. The Department is not accepting mailed comments at this time.

FOR FURTHER INFORMATION CONTACT: Ms. Linda Stivaletti-Petty, Procurement Analyst, DHS, Office of the Chief Procurement Officer, Acquisition Policy and Legislation at (202) 447–5639 or email *HSAR@hq.dhs.gov.* When using email, include HSAR Case 2020–001 in the ''Subject'' line.

SUPPLEMENTARY INFORMATION:

I. Background

The Federal Acquisition Regulations (FAR), found in 48 CFR part 1, is a uniform regulation regarding the acquisition of goods and services for Federal Government agencies. 48 CFR part 12, ''Acquisition of Commercial Products and Commercial Services,'' deals with the acquisition of commercial items, while part 49 discusses the termination of contracts or solicitations. Under 48 CFR 49.101 contracts or solicitations may be terminated, either for convenience or default, only when it is in the government's interest. The use of a termination provision depends on the contract type such as a supply contract, service contract, construction contract, research and development contract and the method of payment, *i.e.,* fixed price or cost type.[1]

Section 3523 of the John S. McCain National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2019 (Pub. L. 115–232)(14 U.S.C. 1155(a)) requires that before terminating a procurement or acquisition contract with a total value of more than $1,000,000, the Commandant of the Coast Guard shall notify each vendor under such contract and require the vendor to maintain all work product related to the contract until the earlier of— (A) not less than 1 year after the date of the notification; or (B) the date the Commandant notifies the vendor that maintenance of such work product is no longer required.[2]

Specifically, 14 U.S.C. 1155(b) defines ''work product'' to mean: (1) tangible and intangible items and information produced or possessed as a result of a contract and (2) includes—(A) any completed end items; (B) any uncompleted end items; and (C) any property in the contractor's possession in which the United States Government has an interest. Section 1155(c) establishes a penalty such that any vendor that fails to maintain the work product is liable to the United States for a civil penalty of not more than $25,000 for each day on which the work product is unavailable.

Department of Homeland Security (DHS) is proposing to add a new subpart regarding contract termination policy for the United States Coast Guard (USCG) in the Homeland Security Acquisition Regulation (HSAR)[3] to ensure all USCG contractors and subcontractors comply with contract termination policy.

II. Proposed Changes

This rule proposes to amend the HSAR to:

Add new subpart 3049.90 Contract Termination (USCG) to part 3049 Termination of Contracts. This new subpart would consist of two sections, section 3049.9001 Policy (USCG) and section 3049.9002 Contract Clause (USCG). The proposed addition of this subpart and sections would align the USCG's contract termination regulatory requirements with 14 U.S.C. 1155. HSAR 3049.9001 Policy (USCG) would incorporate the provisions laid out in 14 U.S.C. 1155(a), regarding the termination of contracts and maintenance of all work product related to contracts. The proposed policy would require that before terminating a contract with a value of more than $1,000,000, the Commandant of the Coast Guard shall notify the contractor and the contractor shall be required to maintain all work product related to the contract until the earlier of—(1) not less than 1 year after the date of the notification; or (2) the date the Commandant notifies the vendor that maintenance of such work product is no longer required. The proposed definition of ''Work Product'' is also taken from 14 U.S.C. 1155. This proposed new subpart would state that a contractor that fails to maintain a work product is liable to the United States for a civil penalty of not more than $25,000 for each day on which such work product is unavailable. This subpart would require the USCG to insert this contract termination policy in all contracts, including contracts for commercial items, with a total value of more than $1,000,000. These proposed revisions to the HSAR are necessary to ensure USCG contractors understand their roles and responsibilities to maintain work product in the event of a termination, as required by 14 U.S.C. 1155.

This proposal would add a new HSAR clause, ''3052.249–90 Contract Termination (USCG),'' that would implement 3049.9001 Policy (USCG). This clause would be required in all USCG solicitations and contracts, including contracts for commercial items, with a total value of more than $1,000,000.

This proposed rule would also amend HSAR clause 3052.212–70 ''Contract Terms and Conditions Applicable to DHS Acquisition of Commercial Items'' to add HSAR clause 3052.249–90 ''Contract Termination (USCG) that would implement 3049.9–9001 Policy (USCG)''. This clause would be required in all USCG solicitations and contracts, including contracts for commercial items, with a total value of more than $1,000,000.

III. Applicability to Commercial Item Acquisitions, Including Commercially Available Off-the-Shelf (COTS) Items, and Acquisitions Below the Simplified Acquisition Threshold (SAT)

Section 3523 of the NDAA also provides for a civil penalty and does not limit the application of the requirements of the statute to non-commercial contracts. Consistent with 41 U.S.C. 1905, 1906, and 1907, the DHS Chief Procurement Officer has determined that section 3523 of the NDAA does apply to the acquisition of commercial items, including COTS items. Because 41 U.S.C. 3523 states it applies to contracts with a total value of more than $1,000,000, the requirements of the statute do not apply to contracts below the SAT.

[1] *See* 48 CFR 49.5.

[2] This section of the NDAA was originally codified at 14 U.S.C. 657. However, section 108(b) of the Frank LoBiondo Coast Guard Authorization Act of 2018 (Pub. L. 115–282) subsequently redesignated § 657 as 14 U.S.C. 1155.

[3] The HSAR is issued for Departmental guidance according to the policy cited in the FAR at 48 CFR 1.301. The HSAR establishes uniform DHS policies and procedures for all acquisition activities within the DHS and is issued by the Chief Procurement Officer who is the DHS Senior Procurement Executive. The HSAR is located at 48 CFR Chapter 30.

IV. Executive Orders 12866 and 13563

Executive Orders 12866 (Regulatory Planning and Review) and 13563 (Improving Regulation and Regulatory Review) 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 (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Executive Order 13563 emphasizes the importance of quantifying costs and benefits, reducing costs, harmonizing rules, and promoting flexibility.

The Office of Management and Budget (OMB) has not designated this proposed rule a significant regulatory action under section 3(f) of Executive Order 12866. Accordingly, OMB has not reviewed it. A regulatory analysis (RA) follows.

Table 1 presents a summary of impacts of the proposed rule.

TABLE 1—SUMMARY OF IMPACTS OF THE NPRM

Category	Summary
Applicability	Addition of contract termination and notification requirements for the Coast Guard in Chapter 30 of the HSAR for contracts that are terminated by the Coast Guard, this would apply to new contracts, including contracts for commercial items of more than $1 million.
Affected Population	Contractors and subcontractors whose contracts are terminated by the Coast Guard. Approximately 2 contracts annually.
Costs	There are no new costs of the proposed rule as its proposed requirements already exist in other regulations and statutes.
Unquantified Benefits	The proposed rule would provide consistency between existing statutes and regulations for contractors and subcontractors whose contracts are terminated by the Coast Guard.

The Federal Government seeks contractual work with the general public when it wishes to purchase, rent, lease, or otherwise obtain supplies or services from non-Federal sources. The FAR defines this process as ''contracting.'' [4] This proposed rule would revise the HSAR to require Coast Guard to insert termination and notification requirements into its new contracts (this rulemaking would not apply to existing Coast Guard contracts), including contracts for commercial items, with a total value of more than $1 million.

The Coast Guard incorporates contract termination clauses in accordance with the FAR, the HSAR, the Homeland Security Acquisition Manual (HSAM), and the Coast Guard Acquisition Procedures (CGAP) into contracts as applicable and using this clause when deemed necessary for the Coast Guard to exercise its right to do so.

Based on our analysis, we do not estimate that this proposed rule would impose any new requirements or regulatory costs on contractors and subcontractors who perform contractual work, with a total value of more than $1 million, for the Federal Government. Our analysis also shows that the Federal Government would not incur any new regulatory costs as a result of this proposed rule. We present a summary of the estimated impacts of the proposed rule in Table 2.

TABLE 2—PROPOSED CHANGES AND THE ESTIMATED IMPACTS

HSAR part or subpart affected	Description of proposed change	Basis for no cost impact
3049	Removes the term ''Reserved'' in the Homeland Security Acquisition Regulation (HSAR). Adds terms to the HSAR: —''Part 3049'' to Termination of Contracts. —''Subpart 3049.90 Contract Termination (USCG)''. —''3049.9001 Policy (USCG)''. —''3049.9002 Contract Clause (USCG)'', part and subpart titles.	Administrative,[5] we do not estimate a cost for this item because it contains the insertion of the text, with no requirements, in part 3049 of the HSAR.
3049.90	Adds term ''Contract Termination (USCG)''—subpart title, to the HSAR.	Administrative, we do not estimate a cost for this item because it contains the insertion of text, with no requirements, in part 3049 of the HSAR.
3049.9001	Adds term ''Policy (USCG)''—title, to the HSAR	Administrative, we do not estimate a cost for this item because it contains the insertion of text, with no requirements, in part 3049 of the HSAR.
3049.9001(a)	Adds paragraph (a) to the HSAR and would implement requirements of 14 U.S.C. 1155, which provides contract termination policy for procurement or acquisition contracts, including commercial contracts greater than $1 million.	We do not estimate a cost for this regulatory provision because the FAR, Title 48 of the CFR, currently requires the Federal Government to include similar language in applicable Federal contracts. Termination and notification requirements are addressed in subpart 49.1 of the FAR. The statutory language for contract termination is currently in 14 U.S.C. 1155(a)(1) for all contracts, including commercial contracts, with a total value of more than $1 million.

[4] Readers should reference the FAR for a full definition of the term ''contracting''.

TABLE 2—PROPOSED CHANGES AND THE ESTIMATED IMPACTS—Continued

HSAR part or subpart affected	Description of proposed change	Basis for no cost impact
3049.9001(b)	Adds paragraph (b) to the HSAR, ''Notification''—title. Paragraph would implement requirements of 14 U.S.C. 1155, which states the Commandant of the Coast Guard must notify the contractor before terminating a procurement or acquisition contract of greater than $1 million and the contractor must maintain work product as specified in the Code.	We do not estimate a cost for this regulatory provision because subpart 49.1 of the FAR currently contains notification requirements for the Federal Government. The statutory language for notification of contract termination is currently in 14 U.S.C. 1155(a)(1) for procurement or acquisition contracts of more than $1 million (14 U.S.C. 1155(b) defines work product). Maintaining of records is required by section 4.7 of the FAR. The Federal Government is currently required to include similar language in applicable Federal contracts.
3049.9001(c)	Adds paragraph (c) ''Work Product Defined''—title, to the HSAR.	Administrative—we do not estimate a cost for the addition of this regulatory provision because there is no requirement, 14 U.S.C. 1155 currently contains the definition of the term ''work product''.
3049.9001(d)	Adds paragraph (d) ''Penalty''—title, to the HSAR	We do not estimate a cost for this provision because 14 U.S.C. 1155 currently contains the statutory language for ''penalty''. This item has not been levied for past Coast Guard contracts since the statute was enacted in 2019.
3049.9001(e)	Adds paragraph (e) to the HSAR, which states the substance of the clause shall be inserted by the contractor in contracts and subcontracts and for commercial items with a total value of more than $1 million.	We do not estimate a cost for this provision because subpart 49.5 of the FAR requires the contracting officer to insert similar language in applicable contracts. The relevant clauses are in subpart 52.249–1 through 10 of the FAR.
3049.9002	Adds the term ''Contract Clause (USCG)''-title, to the HSAR; states Coast Guard contracting officers shall insert the clause at 3052.249–90 in all solicitations and contracts, including commercial items with a total value of more than $1 million.	Administrative—we do not estimate a cost for the addition of the title to this subpart of the HSAR. We do not estimate a cost for this regulatory provision itself because the contracting officer of the Coast Guard currently inserts similar language in applicable contracts, including contracts for commercial items, with a total value of more than $1 million.
3052	In subpart 3052.2 of the HSAR, ''Texts of Provisions and Clauses'', adds term ''3052.249–90 Contract Termination (USCG)''.	Administrative—we do not estimate a cost for this item because it includes the insertion of the regulatory text, with no requirements, in part 3052 of the HSAR.
3052.249–90	—Adds text ''Contract Termination (USCG)''—title, to part 3052 of the HSAR. —Adds sentence to part 3052 of the HSAR, ''As prescribed in the USCG guidance at (HSAR) 48 CFR 3049.9002, insert the following clause:''. —Adds text ''Contract Termination (USCG) (Month 2022)'' and paragraphs (a) through (e) to part 3052 of the HSAR.	Administrative—we do not estimate a cost for the insertion of the regulatory text that would be added to part 3052 of the HSAR. We do not estimate costs for the regulatory text in paragraphs (a) through (e) of this subpart because the requirements are currently contained in 49.5 of the FAR. The statutory language currently exists in 14 U.S.C. 1155. The requirements are also in 3049.9001(a) through (e).
3052.212–70	Adds term ''3052.249–90 Contract Termination (USCG)'' to the HSAR.	Administrative—we do not estimate a cost for this item because it contains the insertion of the regulatory text, with no requirements, in part 3052 of the HSAR.

Affected Population

The affected population of this proposed rule is a contractor (if a contractor enters into a contract with a subcontractor, the subcontractor would be counted as part of the main or primary contract) whose contract is terminated by the Coast Guard; this would apply only to a contract, including a commercial contract, with a total value of more than $1 million.

DHS and the Coast Guard worked collaboratively to provide the information for this regulatory analysis. The Coast Guard collected acquisition data from the Coast Guard's Office of Procurement Policy and Oversight to obtain the population or the number of contracts it has acquired over the past 11 years. We used the Federal Procurement Data System-Next Generation (FPDS–NG) database to collect the acquisition data.[6] The Coast Guard acquired a total of 7,228 contracts, including commercial items, with a total value of more than $1 million, from fiscal year 2010 (FY 2010) through fiscal year 2020 (FY 2020), which ended on September 30, 2020. Included in this number are an unknown number of subcontracts. For accounting purposes, the Coast Guard counts the main contract or the contract it awards as the primary contract, along with subcontracts, if applicable, as 1 contract.[7] During this period of time, the Coast Guard terminated 25 contracts with a value of more than $1 million, or an average of about 2.3 contracts a year.

Of the 7,228 total contracts, the Coast Guard awarded contracts to 3,947 small businesses.[8] Out of the 25 contracts,

[5] We use the term ''administrative'' to mean proposed editorial changes or proposed changes to the regulatory text that contain no regulatory requirements or impacts to the affected population of the proposed rule. The provisions we identified as ''administrative'' in Table 2 do not have quantifiable costs, cost savings, or benefits associated with them. See Table 1 for the unquantified benefits of the proposed rule.

[6] The Federal Government retains data on Federal procurements through the FPDS–NG. Readers can reference the FPDS–NG website for information on the procurement of Federal contracts at: *https://www.gsa.gov/tools-overview/buying-and-selling-tools/federal-procurement-data-system.*

[7] A fiscal year in the Federal Government is the period of time from October 1 in one calendar year to September 30 of the following calendar year. It is the accounting period when Federal agencies submit budget requests to the Office of Management and Budget (OMB) for planning and operational purposes. The data we collected are through fiscal year 2020; the Coast Guard generally awards contracts, through its budget and acquisition process, in the preceding fiscal year for the following fiscal year.

[8] When a small business wishes to obtain a Federal contract, it can do so by ''self-certification'' on the Small Business Administration's (SBA) website before it registers for contract opportunities with the Federal Government. Readers can learn more about this process using the General Services Administration's (GSA) website at: *https://www.gsa.gov/small-business#gsa-now.* A small

including commercial contracts, with a value of more than $1 million, that the Coast Guard terminated during this period of time, 8 of them were associated with small businesses. This is an average of less than 1 small business contract termination a year (we discuss the impacts to small entities in Section IV, ''Regulatory Flexibility Act'', of this ''Regulatory Analysis'').

Cost Analysis of the Proposed Rule

This proposed rule would not impose any new regulatory costs on contractors, subcontractor, and the Federal Government because the requirements of this proposed rule currently exist in the FAR and in the statute (see 48 CFR chapter 1). We explain our reasoning below for each regulatory provision of this proposed rule. However, the FAR does not contain the penalty clause that exists in 14 U.S.C. 1155 that we would implement in section 3049.9001, paragraph (d).

We do not estimate a cost for the items we identified as ''administrative'' in Table 2 because they would contain the addition of the regulatory text in the HSAR. This includes adding part, subpart, and section titles to the HSAR. This would cover part 3049, subpart 3049.90 (with sections 3049.9001 and 3049.9002), part 3052, and 3052.212–70 of the HSAR (see Table 2).

Subpart 3049.90 of the HSAR would contain the contract termination policy and notification of termination requirements for the Coast Guard.

Section 3049.9001 would implement the requirements of the NDAA. Paragraph (a) would implement the current statutory language in 14 U.S.C. 1155(a)(1), which provides the contract termination policy for Coast Guard contracts, including contracts for commercial items, with a total value of more than $1 million. Additionally, subpart 49.1 (49.101) of the FAR currently provides the authority for Federal agencies and more specifically contracting officers to terminate contracts ''. . . for the convenience of the Government, or for default . . .''. Because the proposed rule would add the statutory language, which supplements the existing regulatory requirement for contract termination of subpart 49.1 of the FAR, we do not estimate a cost for this proposed change.

Paragraph (b) of section 3049.9001 would contain the notification requirement for the Commandant of the Coast Guard to notify the contractor before terminating a contract, including contracts for commercial items, with a total value of more than $1 million, and for the contractor to maintain all work product related to the contract until the earlier of—

(1) Not less than 1 year after the date of notification; or

(2) The date the Commandant notifies the vendor that maintenance of such work product is no longer required.

Title 14 U.S.C. 1155(a)(1), currently provides the statutory authority for the Commandant of the Coast Guard to notify the contractor before terminating a procurement or acquisition contract with a total value of more than $1 million. It also states the contractor must maintain all work product related to the contract as we previously mentioned. Subpart 49.1, specifically section 49.102 of the FAR currently contains the regulatory requirement that Federal contracting officers notify the contractor before terminating a contract for convenience or default. Title 14 U.S.C. 1155 does not specify the method of notification; however, the FAR states it must be by written notice or it ''may be expedited by means of electronic communication capable of providing confirmation of receipt by the contractor''. It has been the past (and current) practice of the Coast Guard to notify contractors of contract termination by electronic means and for the contractor to reply by electronic means; therefore, this is not a new requirement and it would not impose any new costs on the contractor and the Coast Guard for this method of notification. Because the proposed rule would add the statutory language for the notification of contract termination, which section 49.102 of the FAR allows by electronic means, we do not estimate a cost for this proposed change (the statutory language for this provision also exists in 14 U.S.C. 1155).

We also do not estimate a cost for the requirement of the contractor to maintain all work product related to the contract because 14 U.S.C. 1155(b) statutorily requires the contractor to perform this function for the timeframe specified in the statute. Furthermore, subpart 4.7 [specifically sections 4.703(a) through (d)] of the FAR requires a contractor to retain records for the time specified in these regulations (readers should refer to subpart 4.7 of the FAR for contractor records retention).

Additionally, this is not a new Information Collection Request (ICR) nor would it amend an existing ICR under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501).[9] The proposed rule would add the statutory language, codified in 14 U.S.C. 1155, to this subpart and paragraph of the HSAR and would ensure the contractor maintains the work product for the timeframes specified in the statute. Lastly, because the Coast Guard terminated an average of about 2 contracts a year over the past 11 years, this number does not exceed the threshold of 10 or more persons for a collection of information as defined in Title 5 part 1320 of the CFR.[10]

Paragraph (c) of 3049.9001 would contain the definition of the term ''work product'' and would be titled ''Work Product Defined.'' We classify this as an administrative provision without a regulatory requirement. We do not estimate a cost for this provision because this proposed rule would add this definition to the HSAR, which is codified in the statute in 14 U.S.C. 1155.

Paragraph (d) of 3049.9001 would add the penalty a contractor would incur if it fails to maintain the work product defined in paragraph (c) of this section. The Coast Guard does not believe it is likely it will levy this penalty in the future because for the contracts that it has terminated, the Coast Guard has generally been able to access the maintained work product when necessary. Because this regulatory language is codified in the statute in 14 U.S.C. 1155, we do not estimate a cost for this proposed change to the HSAR.

Paragraph (e) of 3049.9001 would contain the requirement for the contractor to insert the substance of the clause into contracts and subcontracts, including contracts and for commercial items with a total value of more than $1 million. Subpart 49.5 (''Contract Termination Clauses'') of the FAR requires contracting officers to insert the substance of the clause into solicitations and contracts as specified in the statute. As a result, we classify this regulatory language and addition to the HSAR as an administrative item; therefore, we do not estimate a cost for this proposed change.

business is one that meets SBA's size standards based upon the North American Industry Classification System (NAICS). Readers can reference SBA's table of size standards and the NAICS codes at: *https://www.sba.gov/document/support-table-size-standards.* For more information on NAICS codes, readers should reference the U.S. Census Bureau's website at: *https://www.census.gov/naics/.* Small businesses may also obtain Federal contracts through GSA's ''One Acquisition Solution for Integrated Services'' (OASIS) Small Business (OASIS SB) contracts, see: *https://www.gsa.gov/buying-selling/products-services/professional-services/buy-services/oasis-and-oasis-small-business.*

[9] Readers should reference the PRA for further information at: *https://www.govinfo.gov/content/pkg/PLAW-104publ13/html/PLAW-104publ13.htm.*

[10] Readers should reference the CFR for a full definition of the term ''collection of information'' and for further information on controlling paperwork burdens on the public at: *https://www.govinfo.gov/content/pkg/CFR-2010-title5-vol3/xml/CFR-2010-title5-vol3-part1320.xml.*

The proposed rule would add section 3049.9002, ''Contract Clause (USCG''), to subpart 3049.90 of the HSAR. It states Coast Guard contracting officers shall insert the clause at 3052.249–90, ''Contract Termination (USCG)'', in all solicitations and contracts, including contracts for commercial items, with a total value of more than $1 million. Similar to the proposed paragraph (e) of subpart 3049.9001, the contracting officer of the Coast Guard is required in subpart 49.5 of the FAR to insert this language into all solicitations and contracts.[11] As a result, we classify this regulatory language and addition to the HSAR as an administrative item; therefore, we do not estimate a cost for this proposed change.

Lastly, the proposed rule would add section 3052.249–90, ''Contract Termination (USCG)'', to the HSAR. We classify this proposed change as an administrative item, which would add the regulatory language with the same requirements that would be contained in section 3049.9001, paragraphs (a) through (e) of HSAR. As a result, we do not estimate a cost for this proposed change.

Benefit Analysis of the Proposed Rule

The primary benefit of this proposed rule is to provide contractors and subcontractors, a consistent regulatory environment between the U.S.C., the FAR, and the HSAR, in the event the Federal Government terminates a contract, including contracts for commercial items, with a total value of more than $1 million. The regulatory consistency also includes the notification of termination to a contractor by the Commandant of the Coast Guard. The HSAR would contain the requirement of the U.S.C. for the contractor to maintain the work product specified and the penalty to be levied against a contractor for not maintaining the work product as defined in the statute.

Alternatives of the Proposed Rule

DHS considered two alternatives to this proposed rule. Neither alternative would align the HSAR with the statutory requirements of 14 U.S.C. 1155, nor would they provide the consistent regulatory environment of the chosen alternative.

1. *No Action Alternative.* We rejected this alternative because the HSAR would not align with the relevant statute, which contain the statutory requirements for contract termination and notification for the Coast Guard, specifically, the National Defense Authorization Act (NDAA) for Fiscal Year 2019 (Pub. L. 115–232), 14 U.S.C. 1155, and subpart 49.5 of the FAR.[12] The statutory requirements are applicable to contracts, including contracts for commercial items, with a total value of more than $1 million. The HSAR would also not contain the requirement for the contractor to maintain the work product as defined in the U.S.C. Lastly, the HSAR would not contain the penalty specified in the U.S.C. levied against a contractor for not maintaining the work product.

2. Issue a policy letter referencing the FAR and the U.S.C. for contract termination policy and notification for the Coast Guard. We rejected this alternative because the a policy letter would not revise the HSAR and thus it would not contain the requirements found in 14 U.S.C. 1155. A policy letter would merely provide guidance for contractors regarding the Coast Guard's contract termination policy, including the penalty clause, and notification procedures for requirements that currently exist in the relevant statutes and regulations. There would be no costs associated with this alternative.

V. Regulatory Flexibility Act

Under the Regulatory Flexibility Act, 5 U.S.C. 601 612, we have considered whether this proposed rule would have a significant economic impact on a substantial number of small entities. 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.

This proposed rule would not impose any new requirements or costs on small entities. This proposed rule would insert the Coast Guard's termination policy and the notification of termination procedures for contracts, including contracts for commercial items, with a total value of more than $1 million, into DHS' HSAR. The requirements for contract termination and notification are currently in subpart 49.5 of the FAR and 14 U.S.C. 1155.

The Coast Guard collected data on contracts it terminated over the past 11 years, including contracts for commercial items, with a total value of more than $1 million. Over this period of time, the Coast Guard terminated 8 contracts (or less than 1 a year on average) awarded to small businesses that met this total dollar value. Although these 8 companies registered as a ''small business'' with the SBA in order to obtain a contract with the Federal Government as a small business, we researched these companies to determine the type of small entity that they are in order to correctly classify them in this Regulatory Flexibility Act (RFA) analysis. This is necessary because a ''small business'' is one type of small entity as stated previously in this section.

We obtained the NAICS codes from the FPDS–NG for all 8 companies. We found company-specific information on 6 of the 8 companies by using the publicly-available online database of businesses in the United States, ReferenceUSAgov (we did not find revenue or employee information for 2 companies, and assumed they were small).[13] Nevertheless, based on each company's NAICS code, and using SBA's table of size standards for each NAICS code, we found all of the 8 companies, who had contracts with a total value of more than $1 million that were terminated by the Coast Guard, to be small businesses, and not governmental jurisdictions or not-for-profit organizations that are independently owned and operated and are not dominant in their fields.

As noted above, that the Coast Guard terminated an average of less than 1 contract a year (over the past 11 years) that was associated with a small entity and that the proposed rule would not impose any new requirements or costs on small entities. Therefore, DHS certifies under 5 U.S.C. 605(b) that this proposed rule would not have a significant economic impact on a substantial number of small entities.

If you think that your business, organization, or governmental jurisdiction qualifies as a small entity and that this proposed rule would have a significant economic impact on it, please submit a comment to the docket at the address listed in the **ADDRESSES** section of this preamble. In your comment, explain why you think it qualifies and how and to what degree this proposed rule would economically affect it.

[11] The proposed rule includes all Coast Guard contracts. The Coast Guard, however, issues primarily fixed-price contracts or firm fixed-price contracts. The FAR defines fixed-price contracts as types of contracts that ''. . . provide for a firm price or, in appropriate cases, an adjustable price . . . the contracting officer shall use firm fixed-price or fixed price with economic price adjustment contracts when acquiring commercial items, except as provided in 12.207(b)''. Readers should refer to the FAR for information about other types of contracts.

[12] For further information, readers should reference the NDAA for fiscal year 2019 at: *https://www.congress.gov/115/bills/hr5515/BILLS-115hr5515enr.pdf.*

[13] Readers can access the database at: *https://www.referenceusagov.com/Home/Home.*

VI. Paperwork Reduction Act

The Paperwork Reduction Act of 1995 (44 U.S.C. 3501 3520) requires agencies to consider the impact of paperwork and other information collection burdens imposed on the public. According to the 1995 amendments to the Paperwork Reduction Act, an agency may not collect or sponsor the collection of information, nor may it impose an information collection requirement unless it displays a currently valid Office of Management and Budget (OMB) control number. As defined in 5 CFR 1320.3(c), ''collection of information'' comprises reporting, recordkeeping, monitoring, posting, labeling, and other similar actions.

DHS has determined that there would be no new requirement for information collection associated with this proposed rule. This proposed rule would not change the burden in the collections currently approved by OMB under OMB Control Numbers, 1600–0002, ''Various Contract Related Forms that will be Included in the Homeland Security Acquisition Regulation'', 1600–0003, ''Post-Contract Award Information'', and 1600–0005, ''Solicitation of Proposal Information for Award of Public Contracts''. There are no Coast Guard Information Collection Requests (ICRs) associated with non-Federal contracts.

List of Subjects in 48 CFR Parts 3049 and 3052

Government procurement.

Paul Courtney,

Chief Procurement Officer, Department of Homeland Security.

Therefore, DHS proposes to amend 48 CFR parts 3049 and 3052 as follows:

PART 3049—TERMINATION OF CONTRACTS

■ 1. The authority citation for part 3049 is revised to read as follows:

Authority: 14 U.S.C. 1155.

■ 2. Add subpart 3049.90 to read as follows:

Subpart 3049.90 Contract Termination (USCG)

3049.9001 Policy (USCG).

(a) This section implements 14 U.S.C. 1155 and provides the policy for the USCG to use for contract terminations. This contract termination policy applies to USCG contract terminations, including contracts for commercial items, with a total value of more than $1,000,000.

(b) *Notification.* Before terminating a contract with a total value of more than $1,000,000, the Commandant of the Coast Guard shall notify the contractor and the contractor shall be required to maintain all work product related to the contract until the earlier of—

(1) not less than 1 year after the date of the notification; or

(2) the date the Commandant notifies the vendor that maintenance of such work product is no longer required.

(c) *Work Product Defined.* The term ''work product''—

(1) means tangible and intangible items and information produced or possessed as a result of a contract referred to in subsection (b); and

(2) includes—

(i) any completed end items;

(ii) any uncompleted end items; and

(iii) any property in the Contractor's possession in which the United States Government has an interest.

(d) *Penalty.* A Contractor that fails to maintain work product as required under subsection (b) is liable to the United States for a civil penalty of not more than $25,000 for each day on which such work product is unavailable.

(e) The Contractor shall insert the substance of this clause in contracts and subcontracts, including contracts and for commercial items, with a total value of more than $1,000,000.

3049.9002 Contract clause (USCG).

USCG contracting officers shall insert the clause at 3052.249–90, Contract Termination (USCG), in all solicitations and contracts, including contracts for commercial items, with a total value of more than $1,000,000.

PART 3052—SOLICITATION PROVISIONS AND CONTRACT CLAUSES

■ 3. The authority citation for part 3052 is revised to read as follows:

Authority: 5 U.S.C. 301–302, 14 U.S.C. 1155, 41 U.S.C. 1303, 41 U.S.C. 1707, 41 U.S.C. 1702, and 48 CFR subpart 1.3.

■ 4. Add § 3052.249–90 to read as follows:

§ 3052.249–90 Contract Termination (USCG).

As prescribed in the USCG guidance at (HSAR) 48 CFR 3049.9002, insert the following clause:

Contract Termination (USCG) (Month 2022)

(a) This contract is subject to Section 3523 of the John S. McCain National Defense Authorization Act for Fiscal Year 2019 (Pub. L. 115–232), 14 U.S.C. 1155, pertaining to contract terminations for the United States Coast Guard (USCG).

(b) *Notification.* As required by 14 U.S.C. 1155(b), before terminating a contract with a total value of more than $1,000,000, the Commandant of the Coast Guard shall notify the contractor and the contractor shall be required to maintain all work product related to the contract until the earlier of—

(1) not less than 1 year after the date of the notification; or

(2) the date the Commandant notifies the vendor that maintenance of such work product is no longer required.

(c) *Work Product Defined.* In this clause the term ''work product''—

(1) means tangible and intangible items and information produced or possessed as a result of a contract referred to in subsection (b); and

(2) includes—

(i) any completed end items;

(ii) any uncompleted end items; and

(iii) any property in the Contractor's possession in which the United States Government has an interest.

(d) *Penalty.* A Contractor that fails to maintain work product as required under subsection (b) is liable to the United States for a civil penalty of not more than $25,000 for each day on which such work product is unavailable.

(e) The Contractor shall insert the substance of this clause in contracts and subcontracts, including contracts for commercial items, with a total value of more than $1,000,000.

(End of clause)

§ 3052.212–70 Contract Terms and Conditions Applicable to DHS Acquisition of Commercial Items. [Amended]

■ 5. In § 3052.212–70, add the text ''_HSAR 3052.249–90 Contract Termination (USCG)'' at the end of the section, after the text ''_3052.247–72 F.o.B. Destination Only.'' and before the text ''(End of clause)''.

[FR Doc. 2022–18814 Filed 9–6–22; 8:45 am]

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Notices

Federal Register
Vol. 87, No. 172
Wednesday, September 7, 2022

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 AGRICULTURE

Food Safety and Inspection Service

[Docket No. FSIS–2022–0020]

Notice of Request To Renew an Approved Information Collection: Import Inspection Application and Application for the Return of Exported Products to the United States

AGENCY: Food Safety and Inspection Service, USDA.

ACTION: Notice and request for comments.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995 and Office of Management and Budget (OMB) regulations, the Food Safety and Inspection Service (FSIS) is announcing its intention to renew the approved information collection regarding import inspection applications. The approval for this information collection will expire on December 31, 2022. FSIS is making no changes to the information collection.

DATES: Submit comments on or before November 7, 2022.

ADDRESSES: FSIS invites interested persons to submit comments on this **Federal Register** notice. Comments may be submitted by one of the following methods:

- *Federal eRulemaking Portal:* This website provides commenters the ability to type short comments directly into the comment field on the web page or to attach a file for lengthier comments. Go to *https://www.regulations.gov*. Follow the on-line instructions at that site for submitting comments.
- *Mail:* Send to Docket Clerk, U.S. Department of Agriculture, Food Safety and Inspection Service, 1400 Independence Avenue SW, Mailstop 3758, Washington, DC 20250–3700.
- *Hand- or Courier-Delivered Submittals:* Deliver to 1400 Independence Avenue SW, Washington, DC 20250–3700.

Instructions: All items submitted by mail or electronic mail must include the Agency name and docket number FSIS–2022–0020. Comments received in response to this docket will be made available for public inspection and posted without change, including any personal information, to *https://www.regulations.gov*.

Docket: For access to background documents or comments received, call (202) 205–0495 to schedule a time to visit the FSIS Docket Room at 1400 Independence Avenue SW, Washington, DC 20250–3700.

FOR FURTHER INFORMATION CONTACT: Gina Kouba, Office of Policy and Program Development, Food Safety and Inspection Service, USDA, 1400 Independence Avenue SW, Mailstop 3758, South Building, Washington, DC 20250–3700; (202) 720–5627.

SUPPLEMENTARY INFORMATION:

Title: Import Inspection Application and Application for the Return of Exported Products to the United States.

OMB Number: 0583–0159.

Type of Request: Request to renew an approved information collection.

Abstract: FSIS has been delegated the authority to exercise the functions of the Secretary (7 CFR 2.18, 2.53), as specified in the Federal Meat Inspection Act (FMIA) (21 U.S.C. 601, *et seq.*), the Poultry Products Inspection Act (PPIA) (21 U.S.C. 451, *et seq.*), and the Egg Products Inspection Act (EPIA) (21 U.S.C. 1031, *et seq.*). These statutes mandate that FSIS protect the public by verifying that meat, poultry, and egg products are safe, wholesome, unadulterated, and properly labeled and packaged.

FSIS is requesting a renewal of the approved information collection regarding import inspection applications. The approval for this information collection will expire on December 31, 2022. FSIS is making no changes to the information collection.

For each consignment of product exported to the United States, FSIS requires the government of the exporting country to provide a Foreign Inspection Certificate. On the Foreign Inspection Certificate, FSIS requires the date; the foreign country of export and the producing foreign establishment number; the species used to produce the product; the source country and foreign establishment number for amenable source materials, if they originate from a country other than the exporting country; the product's description, including the process category, the product category, and the product group; the name and address of the consignor or exporter; the name and address of the consignee or importer; the number of units and the shipping or identification marks on the units; the net weight of each lot and; any additional information the Administrator requests to determine whether the product is eligible to be imported into the U.S.

FSIS also requires an *Import Inspection Application* (FSIS Form 9540–1), which is completed by an applicant, usually an importer or customs broker. The information required on FSIS Form 9540–1, which is similar to that required on the foreign inspection certificate, may be submitted electronically or via paper application. If there is any discrepancy in importer or consignee information between the Import Inspection Application and the Foreign Inspection Certificate, FSIS would rely on the information provided on the Import Inspection Application. For any product-based information, the foreign inspection certificate information, which is certified by an official of the foreign government, would take precedence over information provided on the Import Inspection Application.

For importers and brokers participating in the Partner Government Agency (PGA) Message Set, the information on FSIS Form 9540–1 is submitted electronically. FSIS would rely on any importer or consignee information electronically transferred from the U.S. Customs and Border Protection's (CBP) Automated Commercial Environment (ACE) to the FSIS Public Health Information System (PHIS) Import Component. Applicants that do not file this information electronically can submit paper applications (FSIS Form 9540–1) to FSIS inspection personnel at an official import inspection establishment. The applicant is required to submit the FSIS Form 9540–1 in advance of the shipment's arrival, but no later than when the entry is filed with CBP (9 CFR 327.5, 381.198, 557.5, 590.920).

Return of Exported Products to the United States

When product inspected and passed by FSIS is exported, but then returned to this country, the owner, broker, or agent of the product (the applicant) arranges for the product's entry and notifies FSIS. In accordance with 9 CFR 327.17, 381.209, 557.17, and 590.965, exported product returned to this country is exempt from FSIS import inspection requirements upon notification to and approval from the Agency's Recall Management and Technical Analysis Division (RMTAD). RMTAD may require, however, that returned product be re-inspected at a federally-inspected facility for food safety and food defense determinations.

As part of this process, an applicant completes the FSIS Form 9010–1, *Application for the Return of Exported Products to the United States.* The purpose of the form is to allow RMTAD to decide whether re-inspection of the returned product is needed and to notify the appropriate FSIS office where to perform the re-inspection of the product, if necessary. If FSIS inspection program personnel determine that the product is safe and not adulterated or misbranded, the product may be released into domestic commerce.

FSIS has made the following estimates based upon an information collection assessment:

Estimate of burden: The public reporting burden for this collection of information is estimated to average .202 hours per response.

Estimated total number of respondents: 939.

Estimated annual number of responses: 244,354.

Estimated Total Annual Burden on Respondents: 49,385 hours.

All responses to this notice will be summarized and included in the request for OMB approval. All comments will also become a matter of public record. Copies of this information collection assessment can be obtained from Gina Kouba, Office of Policy and Program Development, Food Safety and Inspection Service, USDA, 1400 Independence Avenue SW, Mailstop 3758, South Building, Washington, DC 20250–3700; (202) 720–5627.

Comments are invited on: (a) whether the proposed collection of information is necessary for the proper performance of FSIS' functions, including whether the information will have practical utility; (b) the accuracy of FSIS' estimate of the burden of the proposed collection of information, including the validity of the method and assumptions used; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques, or other forms of information technology. Comments may be sent to both FSIS, at the addresses provided above, and the Desk Officer for Agriculture, Office of Information and Regulatory Affairs, Office of Management and Budget (OMB), Washington, DC 20253.

Additional Public Notification

Public awareness of all segments of rulemaking and policy development is important. Consequently, FSIS will announce this **Federal Register** publication on-line through the FSIS web page located at: *https://www.fsis.usda.gov/federal-register.*

FSIS will also announce and provide a link to this **Federal Register** publication through the FSIS *Constituent Update,* which is used to provide information regarding FSIS policies, procedures, regulations, **Federal Register** notices, FSIS public meetings, and other types of information that could affect or would be of interest to our constituents and stakeholders. The *Constituent Update* is available on the FSIS web page. Through the web page, FSIS can provide information to a much broader, more diverse audience. In addition, FSIS offers an email subscription service which provides automatic and customized access to selected food safety news and information. This service is available at: *https://www.fsis.usda.gov/subscribe.* Options range from recalls to export information, regulations, directives, and notices. Customers can add or delete subscriptions themselves and have the option to password protect their accounts.

USDA Non-Discrimination Statement

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, religion, sex, gender identity (including gender expression), sexual orientation, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident.

Persons with disabilities who require alternative means of communication for program information (*e.g.,* Braille, large print, audiotape, American Sign Language, etc.) should contact the responsible Agency or USDA's TARGET Center at (202) 720–2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877–8339. Additionally, program information may be made available in languages other than English.

To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, AD–3027, found online at *https://www.usda.gov/oascr/how-to-file-a-program-discrimination-complaint* and at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632–9992.

Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue SW, Washington, DC 20250–9410; (2) fax: (202) 690–7442; or (3) email: *program.intake@usda.gov.*

USDA is an equal opportunity provider, employer, and lender.

Paul Kiecker,

Administrator.

[FR Doc. 2022–19240 Filed 9–6–22; 8:45 am]

BILLING CODE 3410–DM–P

COMMISSION ON CIVIL RIGHTS

Notice of Public Meeting of the Puerto Rico Advisory Committee

AGENCY: Commission on Civil Rights.

ACTION: Announcement of meeting.

SUMMARY: Notice is hereby given, pursuant to the provisions of the rules and regulations of the U.S. Commission on Civil Rights (Commission), and the Federal Advisory Committee Act (FACA), that a meeting of the Puerto Rico Advisory Committee to the Commission will convene by virtual web conference on Wednesday, September 28, 2022, at 1 p.m. (AT). The purpose is to for project planning.

DATES: September 28, 2022, Wednesday, at 1 p.m. (AT):

- To join by web conference, use Zoom link: *https://tinyurl.com/2up7szbd*, password, if needed: USCCR–PR
- To join by phone only, dial 1–551–285–1373; Meeting ID: 161 246 7105#

FOR FURTHER INFORMATION CONTACT: Victoria Moreno at *vmoreno@usccr.gov* or by phone at 434–515–0204.

SUPPLEMENTARY INFORMATION: This meeting will be held in Spanish with English interpretation available for participants joining via Zoom, with the exception of call-in users. This meeting is available to the public through the Zoom link above. If joining only via phone, callers can expect to incur charges for calls they initiate over wireless lines, and the Commission will not refund any incurred charges. Individuals who are deaf, deafblind and hard of hearing may also follow the proceedings by first calling the Federal Relay Service at 1–800–877–8339 and providing the Service with the call-in number found through registering at the web link provided above for the meeting.

Members of the public are entitled to make comments during the open period at the end of the meeting. Members of the public may also submit written comments; the comments must be received in the Regional Programs Unit within 30 days following the respective meeting. Written comments may be emailed to Victoria Moreno at *vmoreno@usccr.gov.* All written comments received will be available to the public.

Persons who desire additional information may contact the Regional Programs Unit at (202) 809–9618. Records and documents discussed during the meeting will be available for public viewing as they become available at the *www.facadatabase.gov.* Persons interested in the work of this advisory committee are advised to go to the Commission's website, *www.usccr.gov,* or to contact the Regional Programs Unit at the above phone number or email address.

Agenda: Wednesday, September 28, 2022; 1 p.m. (AT)

1. Welcome & Roll Call
2. Committee Discussion and Project Planning
3. Next Steps
4. Public Comment
5. Other Business
6. Adjourn

Dated: September 1, 2022.

David Mussatt,

Supervisory Chief, Regional Programs Unit.

[FR Doc. 2022–19268 Filed 9–6–22; 8:45 am]

BILLING CODE P

DEPARTMENT OF COMMERCE

International Trade Administration

North American Free Trade Agreement (NAFTA), Article 1904; Binational Panel Review: Notice of Completion of Panel Review

AGENCY: United States Section, NAFTA Secretariat, International Trade Administration, Department of Commerce.

ACTION: Notice of completion of Panel Review.

SUMMARY: In accordance with the NAFTA *Rules of Procedure for Article 1904 Binational Panel Reviews,* the Panel Review of *Ammonium Sulphate from the United States of America (Secretariat File Number: MEX–USA–2015–1904–01)* was completed and the panelists were discharged from their duties effective September 1, 2022.

FOR FURTHER INFORMATION CONTACT: Vidya Desai, United States Secretary, NAFTA Secretariat, Room 2061, 1401 Constitution Avenue NW, Washington, DC 20230, 202–482–5438.

SUPPLEMENTARY INFORMATION: Article 1904 of NAFTA provides a dispute settlement mechanism for binational panel reviews of trade remedy determinations issued by the Government of the United States, the Government of Canada, and the Government of Mexico. On July 19, 2022, the NAFTA Binational Panel issued an Order affirming the Secretaria de Economia's Fourth Determination on Remand. Accordingly, the Notice of Completion of Panel Review is being issued pursuant to Rule 78 of the NAFTA *Rules of Procedure for Article 1904 Binational Panel Reviews.* For the complete NAFTA *Rules of Procedure for Article 1904 Binational Panel Reviews,* please see *https://can-mex-usa-sec.org/secretariat/agreement-accord-acuerdo/nafta-alena-tlcan/rules-regles-reglas/index.aspx?lang=eng.*

Dated: September 1, 2022.

Vidya Desai,

U.S. Secretary, NAFTA Secretariat.

[FR Doc. 2022–19237 Filed 9–6–22; 8:45 am]

BILLING CODE 3510–GT–P

DEPARTMENT OF COMMERCE

International Trade Administration

[A–570–124; C–570–125]

Certain Vertical Shaft Engines Between 99cc and Up to 225cc, and Parts Thereof, From the People's Republic of China: Affirmative Preliminary Determination of Circumvention of the Antidumping and Countervailing Duty Orders

AGENCY: Enforcement and Compliance, International Trade Administration, Department of Commerce.

SUMMARY: The U.S. Department of Commerce (Commerce) preliminarily determines that vertical shaft engines with displacements between 60cc and up to 99cc produced in the People's Republic of China (China) and exported to the United States, are circumventing the antidumping duty (AD) and countervailing duty (CVD) orders on certain vertical shaft engines between 99cc and up to 225cc, and parts thereof (small vertical engines), from China. Interested parties are invited to comment on these preliminary results.

DATES: Applicable September 7, 2022.

FOR FURTHER INFORMATION CONTACT: Benjamin A. Luberda, AD/CVD Operations, Enforcement and Compliance, International Trade Administration, U.S. Department of Commerce, 1401 Constitution Avenue NW, Washington, DC 20230; telephone: (202) 482–2185.

SUPPLEMENTARY INFORMATION:

Background

On May 4, 2021, the Department of Commerce (Commerce) published AD and CVD orders on small vertical engines from China.[1] On September 17, 2021, in response to a request from Briggs & Stratton, LLC (the petitioner),[2] Commerce initiated a circumvention inquiry to determine whether imports of engines with displacements between 60cc and up to 99cc produced in China and exported to the United States are ''altered in form or appearance in minor respects'' from in-scope merchandise such that they should be considered subject to the *Orders.*[3] For a complete

[1] *See Certain Vertical Shaft Engines Between 99cc and Up to 225cc, and Parts Thereof from the People's Republic of China: Antidumping and Countervailing Duty Orders,* 86 FR 23675 (May 4, 2021) (*Orders*).

[2] See Petitioner's Letter, ''Request for Anti-Circumvention Inquiry Pursuant to Section 781(c) and/or Section 781(d) of the Tariff Act of 1930,'' dated July 30, 2021.

[3] *See Certain Vertical Shaft Engines Between 99cc and up to 225cc, and Parts Thereof, from the People's Republic of China: Initiation of Anti-*

description of events that followed initiation of this inquiry, *see* the Preliminary Decision Memorandum.[4]

Scope of the Orders

The merchandise subject to the *Orders* is small vertical engines from China. For a complete description of the scope of the *Orders, see* the Preliminary Decision Memorandum.

Scope of the Circumvention Inquiry

This circumvention inquiry covers small vertical engines with displacements between 60cc and up to 99cc produced in China and exported to the United States.

Statutory and Regulatory Framework

Section 781(c) of the Tariff Act of 1930, as amended (the Act), provides that Commerce may find circumvention of an AD or CVD order when merchandise of the same class or kind as subject merchandise has been ''altered in form or appearance in minor respects . . . whether or not included in the same tariff classification.'' Section 781(c)(2) of the Act provides an exception that ''{p}aragraph 1 shall not apply with respect to altered merchandise if the administering authority determines that it would be unnecessary to consider the altered merchandise within the scope of the {order}.''

While the Act is silent as to what factors to consider in determining whether alterations are properly considered ''minor,'' the legislative history of this provision indicates that there are certain factors that should be considered before reaching a circumvention determination. In conducting a circumvention inquiry under section 781(c) of the Act, Commerce has generally relied upon ''such criteria as the overall physical characteristics of the merchandise, the expectations of the ultimate users, the use of the merchandise, the channels of marketing and the cost of any modification relative to the total value of the imported products.'' [5] Concerning the allegation of minor alteration under section 781(c) of the Act and 19 CFR 351.225(i), Commerce examines such factors as: (1) overall physical characteristics; (2) expectations of ultimate users; (3) use of merchandise; (4) channels of marketing; and (5) cost of any modification relative to the value of the imported products.[6] Each inquiry is highly dependent on the facts on the record and must be analyzed in light of those specific facts.[7] Thus, along with the five factors enumerated above, Commerce may also consider the circumstances under which the products enter the United States, including, but not limited to, the timing of the entries and the quantity of merchandise entered during the circumvention review period.[8]

Preliminary Determination

We preliminarily determine that small vertical engines with displacements between 60cc and up to 99cc and engines with displacements of 99cc up to 225cc are not dissimilar in terms of overall physical characteristics of the merchandise, the expectations of the ultimate users, the use of the merchandise, channels of marketing, and the timing and circumstances under which the Zongshen Companies exported the engines with displacements between 60cc and up to 99cc.[9] Because we find that the merchandise subject to this inquiry is not dissimilar to subject merchandise, we preliminarily determine that the engines at issue constitute merchandise ''altered in form or appearance in minor respects'' from in-scope merchandise, within the meaning of section 781(c)(1) of the Act. Also, we preliminarily determine that the affirmative circumvention finding should be applied on a countrywide basis.

For a full description of the methodology underlying our conclusions, *see* the Preliminary Decision Memorandum. 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 *http://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.* A list of the topics discussed in the Preliminary Decision Memorandum is attached at the appendix to this notice.

Suspension of Liquidation

In accordance with 19 CFR 351.225(l)(2), we will direct U.S. Customs and Border Protection (CBP) to suspend liquidation of small vertical engines between 60cc and up to 99cc produced in China and exported to the United States that are entered, or withdrawn from warehouse, for consumption on or after September 17, 2021 (*i.e.,* the date of the initiation of this inquiry).[10] Pursuant to 19 CFR 351.225(l)(2), we will also instruct CBP to require cash deposits of estimated duties equal to the AD and CVD rates in effect for small vertical engines for each unliquidated entry of small vertical engines between 60cc and up to 99cc produced in China and exported to the United States that are entered, or withdrawn from warehouse, for consumption on or after September 17, 2021. The suspension of liquidation instructions will remain in effect until further notice.

Public Comment

Interested parties are invited to comment on this preliminary determination of circumvention and may submit case briefs and/or written comments within 14 days of the

Circumvention Inquiry of Antidumping and Countervailing Duty Orders—60cc up to 99cc Engines; 86 FR 51866 (September 17, 2021) (*Initiation Notice*), and accompanying Issues and Decision Memorandum.

[4] *See* Memorandum, ''Preliminary Decision Memorandum for the Circumvention Inquiry,'' dated concurrently with, and hereby adopted by, this notice (Preliminary Decision Memorandum).

[5] *See Carbon and Certain Alloy Steel Wire Rod from Mexico: Initiation of Anti-Circumvention Inquiry of Antidumping Duty Order,* 83 FR 5405 (February 7, 2018) (citing S. Rep. No. 71, 100th Cong., 1st Sess. 100 (1987)).

[6] *Id.; see also Deacero S.A. de C.V.* v. *United States,* 817 F.3d 1332 (Fed. Cir. 2016).

[7] *See, e.g., Certain Uncoated Paper from Australia, Brazil, the People's Republic of China, Indonesia, and Portugal: Affirmative Preliminary Determination of Circumvention of the Antidumping and Countervailing Duty Orders,* 82 FR 26778 (June 9, 2017), and accompanying Preliminary Decision Memorandum, at ''IV. Statutory and Regulatory Framework.''

[8] *Id.; see also, e.g., Affirmative Preliminary Determination of Circumvention of the Antidumping Duty Order on Certain Cut-to-Length Steel Plate from the People's Republic of China,* 74 FR 33991, 33992–93 (July 14, 2009); *Brass Sheet and Strip from West Germany; Negative Preliminary Determination of Circumvention of Antidumping Duty Order,* 55 FR 32655 (August 10, 1990), unchanged in *Brass Sheet and Strip from Germany; Negative Final Determination of Circumvention of Antidumping Duty Order,* 56 FR 65884 (December 19, 1991); and *Small Diameter Graphite Electrodes from the People's Republic of China: Initiation of Anticircumvention Inquiry,* 77 FR 37873 (June 25, 2012).

[9] In the less-than-fair-value investigation, Commerce found that Chongqing Zongshen General Power Machine Co., Ltd.; Chongqing Dajiang Power Equipment Co., Ltd.; and Chongqing Zongshen Power Machinery Co., Ltd. (collectively, the Zongshen Companies) should be treated as a single entity. *See Certain Vertical Shaft Engines Between 99cc and Up to 225cc, and Parts Thereof, from the People's Republic of China: Preliminary Affirmative Determination of Sales at Less Than Fair Value, and Preliminary Affirmative Determination of Critical Circumstances, in Part,* 85 FR 66932 (October 21, 2020), unchanged in *Certain Vertical Shaft Engines Between 99cc and Up To 225cc, and Parts Thereof, from the People's Republic of China: Final Affirmative Determination of Sales at Less Than Fair Value and Final Affirmative Determination of Critical Circumstances in Part,* 86 FR 14077 (March 12, 2021). Absent information to the contrary, we continue to treat the Zongshen Companies as a single entity for the purposes of this inquiry.

[10] *See Initiation Notice.*

publication of this notice.[11] Rebuttal briefs, limited to issues raised in the case briefs, may be filed no later than seven days after the date on which the case briefs are due.[12] Parties who submit case briefs of rebuttal briefs in this inquiry 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.[13] Case and rebuttal briefs should be filed electronically via ACCESS.[14] Note that Commerce has modified certain of its requirements for serving documents containing business proprietary information, until further notice.[15]

Pursuant to 19 CFR 351.310(c), interested parties who wish to request a hearing must submit a written request to the Assistant Secretary for Enforcement and Compliance, filed electronically and received successfully in its entirety via ACCESS by 5:00 p.m. Eastern Time within 14 days after the date of publication of this notice.[16] Hearing requests should contain: (1) the party's name, address, and telephone number; (2) the number of participants; and (3) a list of issues to be discussed. Issues raised in the hearing will be limited to issues raised in the briefs. If a request for a hearing is made, parties will be notified of the date and time for the hearing at a later date.

Postponement of Final Determination

Section 781(f) of the Act provides that, to the maximum extent practicable, Commerce shall make its circumvention determinations within 300 days from the date of initiation of the inquiry. On July 14, 2022, we extended the final determination until August 25, 2022.[17] We determine that it is not practicable to make a final determination in this circumvention inquiry by the current deadline of August 25, 2022, because Commerce will require additional time to review and analyze case and rebuttal briefs. Therefore, we are extending the time period for issuing the final determination in this inquiry by 103 days, to December 6, 2022.

[11] Commerce is exercising its discretion, under 19 CFR 351.309(c)(1)(ii), to alter the time limit for filing of case briefs.

[12] Commerce is exercising its discretion, under 19 CFR 351.309(d)(1), to alter the time limit for filing of rebuttal briefs.

[13] *See* 19 CFR 351.309(c)(2) and (d)(2).

[14] *See* 19 CFR 351.303.

[15] *See Temporary Rule Modifying AD/CVD Service Requirements Due to COVID–19; Extension of Effective Period,* 85 FR 41363 (July 10, 2020).

[16] *See* 19 CFR 351.310(c).

[17] *See* Memorandum, ''Extension of Anti-Circumvention Final Determination,'' dated July 14, 2022.

Notification to Interested Parties

This affirmative preliminary circumvention determination is in accordance with section 781(c) of the Act and 19 CFR 351.225(i).

Dated: August 25, 2022.

Lisa W. Wang,

Assistant Secretary for Enforcement and Compliance.

Appendix

List of Topics Discussed in the Preliminary Decision Memorandum

[FR Doc. 2022–19310 Filed 9–6–22; 8:45 am]

BILLING CODE 3510–DS–P

DEPARTMENT OF COMMERCE

International Trade Administration

United States Investment Advisory Council; Meeting

AGENCY: SelectUSA, International Trade Administration, U.S. Department of Commerce.

ACTION: Notice of an open meeting.

SUMMARY: In accordance with the Federal Advisory Committee Act (FACA), this notice announces, the United States Investment Advisory Council (IAC) will hold a public meeting on September 29, 2022. In August 2022, U.S. Secretary of Commerce Gina M. Raimondo appointed a new cohort of members who will serve two-year terms. Members will meet for the first time to hear from Federal government officials on the importance of foreign direct investment (FDI) in the United States and discuss programs and policies to promote and retain such investments across the country.

DATES: Thursday, September 29, 2022, 10:30 a.m.–12 p.m. ET.

ADDRESSES: The meeting will be held in-person and virtually. Please note that pre-clearance is required both to attend the meeting in person and to make a statement during the public comment portion of the meeting. Please limit comments to five minutes or less and submit a brief statement summarizing your comments to: *IAC@trade.gov* or United States Investment Advisory Council, U.S. Department of Commerce, 1401 Constitution Avenue NW, Room 30011, Washington, DC 20230. The deadline for members of the public to register, including requests to make comments during the meeting and for auxiliary aids, or to submit written comments for dissemination prior to the meeting is 5:00 p.m. ET on September 22, 2022. Members of the public are encouraged to submit registration requests and written comments via email to ensure timely receipt.

FOR FURTHER INFORMATION CONTACT: Rachel David, United States Investment Advisory Council, Room 30011, 1401 Constitution Avenue NW, Washington, DC 20230, email: *IAC@trade.gov.*

SUPPLEMENTARY INFORMATION: The IAC was established under the discretionary authority of the Secretary of Commerce (Secretary) and in accordance with the Federal Advisory Committee Act (5 U.S.C. app.).

The IAC advises the Secretary on matters relating to the promotion and retention of foreign direct investment in the United States. At the inaugural meeting, the newly appointed IAC members will introduce themselves and will discuss the subcommittee topics and appointments. In previous years, the IAC subcommittees have included economic competitiveness, workforce development, and strategic communications. The agenda may change to accommodate IAC business. The final agenda will be posted on the Department of Commerce website for the IAC at: *https://www.trade.gov/selectusa-investment-advisory-council,* at least one week in advance of the meeting.

Public Participation: The meeting will be open to the public and will be accessible to people with disabilities. All guests are required to register in advance by the deadline identified under the **DATES** caption. Requests for auxiliary aids must be submitted by the registration deadline. Last minute requests will be accepted but may be impossible to fill. There will be fifteen (15) minutes allotted for oral comments from members of the public joining the meeting. To accommodate as many speakers as possible, the time for public comments may be limited to three (3) minutes per person. Individuals wishing to reserve speaking time during the meeting must submit a request at the time of registration, as well as the name and address of the proposed speaker and a brief statement summarizing the comments. If the number of registrants

requesting to make statements is greater than can be reasonably accommodated during the meeting, the International Trade Administration may conduct a lottery to determine the speakers.

Speakers are requested to submit a written copy of their prepared remarks by 5:00 p.m. ET on September 22, 2022, for inclusion in the meeting records and for circulation to the Members of the IAC.

In addition, any member of the public may submit pertinent written comments concerning the Council's affairs at any time before or after the meeting. Comments may be submitted to Rachel David at the contact information indicated above. To be considered during the meeting, comments must be received no later than 5:00 p.m. ET on September 22, 2022, to ensure transmission to the IAC members prior to the meeting. Comments received after that date and time will be distributed to the members but may not be considered during the meeting.

Comments and statements will be posted on the IAC website (*https://www.trade.gov/selectusa-investment-advisory-council*) without change, including any business or personal information provided such as it includes names, addresses, email addresses, or telephone numbers. All comments and statements received, including attachments and other supporting materials, are part of the public record and subject to public disclosure. You should submit only information that you wish to make publicly available.

Copies of the meeting minutes will be available within 90 days of the meeting date.

Dated: September 1, 2022.

Jasjit Singh Kalra,

Executive Director, SelectUSA.

[FR Doc. 2022–19314 Filed 9–6–22; 8:45 am]

BILLING CODE 3510–DR–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

Final Management Plan for the Rookery Bay National Estuarine Research Reserve

AGENCY: Office for Coastal Management, National Ocean Service, National Oceanic and Atmospheric Administration (NOAA), Department of Commerce.

ACTION: Notice of approval of the revised management plan Rookery Bay National Estuarine Research Reserve.

SUMMARY: Notice is hereby given that the Office for Coastal Management, National Ocean Service, National Oceanic and Atmospheric Administration, U.S. Department of Commerce approves the revised management plan for the Rookery Bay National Estuarine Research Reserve in Florida. In accordance with applicable Federal regulations, the Florida Department of Environmental Protection revised the Rookery Bay Reserve's management plan, which replaces the plan previously approved in 2012.

ADDRESSES: The approved Rookery Bay Reserve management plan can be downloaded or viewed at *http://publicfiles.dep.state.fl.us/DSL/OES/Management_Plans/October_2022_MPlans/RookeryBayNERR_Draft_MP.pdf.* These documents are also available by sending a written request to Matt Chasse of NOAA's Office for Coastal Management, by email at *matt.chasse@noaa.gov.*

FOR FURTHER INFORMATION CONTACT: Matt Chasse of NOAA's Office for Coastal Management, by email at *matt.chasse@noaa.gov,* phone at 240–628–5417.

SUPPLEMENTARY INFORMATION: Pursuant to 15 CFR 921.33(c), a State must revise the management plan for a research reserve at least every five years. Changes to a reserve's management plan may be made only after receiving written approval from NOAA. NOAA approves changes to management plans via notice in the **Federal Register**. On March 14, 2022, NOAA issued a notice in the **Federal Register** announcing a thirty-day public comment period for the proposed revision of the management plan for the Rookery Bay National Estuarine Research Reserve (87 FR 14254). Responses to written and oral comments received, and an explanation of how comments were incorporated into the final versions of the revised management plans, are available in appendix C of the final plan.

The revised management plan outlines the reserve's strategic goals and objectives; administrative structure; programs for conducting research and monitoring, education, and training; resource protection, restoration, volunteer, and communications plans; prescribed fire and invasive species plans; consideration for future land acquisition; and facility development to support reserve operations.

The Rookery Bay revised management plan focuses on building upon past successes and accomplishments. Research and monitoring will focus on habitat mapping, wildlife communities, resource management and restoration, coastal change and resilience, and ecosystem services. Reserve education programming will focus on informed community and individual action as related to ecosystems, human connections, resilience, and outreach. The reserve is also planning on enhancing the use of technology in education programming and on building a robust interpretation program with volunteer staff. Coastal training will continue offering programs to professional audiences and conduct an updated needs assessment. The plan also includes the reserve monitoring the health of fish and bird communities, invasive species control efforts, and the use of prescribed fire as a management tool. In addition, the reserve is expecting to expand its strategic partnership with Florida International University.

Furthermore, no reserve boundary or acreage changes are incorporated into the revised management plan.

NOAA reviewed the environmental impacts of the Rookery Bay revised management plans and determined that these actions are categorically-excluded from further analysis under the National Environmental Policy Act, consistent with NOAA Administrative Order 216–6.

Authority: 16 U.S.C. 1451 *et seq.;* 15 CFR 921.33.

Keelin S. Kuipers,

Deputy Director, Office for Coastal Management, National Ocean Service, National Oceanic and Atmospheric Administration.

[FR Doc. 2022–19255 Filed 9–6–22; 8:45 am]

BILLING CODE 3510–NK–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

[RTID 0648–XC333]

New England Fishery Management Council; Public Meeting

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Notice of a public meeting.

SUMMARY: The New England Fishery Management Council (Council, NEFMC) will hold a four-day hybrid meeting with both in-person and remote participation to consider actions affecting New England fisheries in the exclusive economic zone (EEZ). The Council continues to follow all public safety measures related to COVID–19 and intends to do so for this meeting.

DATES: The meeting will be held on Monday, Tuesday, Wednesday, and Thursday, September 26, 27, 28, and 29, 2022, beginning at 1 p.m. on Monday, 9 a.m. on Tuesday, 8:30 a.m. on Wednesday, and 9 a.m. on Thursday.

ADDRESSES:

Meeting address: The meeting will be held at the Beauport Hotel, 55 Commercial Street, Gloucester, MA 01930; telephone (978) 282–0008; online at *https://www.beauporthotel.com*. Join the webinar at *https://attendee.gotowebinar.com/register/7374448002191175695.*

Council address: New England Fishery Management Council, 50 Water Street, Mill 2, Newburyport, MA 01950; telephone: (978) 465–0492; *www.nefmc.org.*

FOR FURTHER INFORMATION CONTACT: Thomas A. Nies, Executive Director, New England Fishery Management Council; telephone: (978) 465–0492, ext. 113.

SUPPLEMENTARY INFORMATION:

Agenda

Monday, September 26, 2022

After brief announcements, the Greater Atlantic Regional Fisheries Office (GARFO) Regional Administrator will swear in new and reappointed Council members. Then, the Council will hold its annual election of officers before receiving reports on recent activities from its Chair and Executive Director, the GARFO Regional Administrator, the Northeast Fisheries Science Center (NEFSC) Director, the NOAA Office of General Counsel, the Mid-Atlantic Fishery Management Council liaison, staff from the Atlantic States Marine Fisheries Commission (ASMFC), and representatives from the U.S. Coast Guard, NOAA's Office of Law Enforcement, the Northwest Atlantic Fisheries Organization (NAFO), the NMFS Highly Migratory Species Advisory Panel, and the South Atlantic Council's Dolphin/Wahoo Committee. Next, the Council will receive a report on the Northeast Trawl Advisory Panel's (NTAP) recent meetings. As the last item of business for the day, the Council will engage in a discussion on East Coast Climate Change Scenario Planning. The Council will examine the four scenarios developed during a June workshop and two August deepening webinars before discussing next steps for developing Council recommendations to inform the 2023 summit for this initiative.

Tuesday, September 27, 2022

The Council will begin the second day of its meeting with a NOAA presentation on the revised management plan for the Stellwagen Bank National Marine Sanctuary. Next, the Council will receive information on the Northeast Canyons and Seamounts Marine National Monument entailing a GARFO update and consult with the Council on: (1) the NOAA Fisheries process for drafting regulatory actions to formally close fishing within the boundaries of the Northeast Canyons and Seamounts Marine National Monument; and (2) the updated timeline for U.S. Fish and Wildlife Service/NMFS public scoping sessions for the draft Monument Management Plan. The Council then will address the proposed Hudson Canyon National Marine Sanctuary and discuss: (1) the NOAA scoping process to consider designating a national marine sanctuary in the Hudson Canyon area; (2) a NOAA letter seeking input on Council involvement in preparing draft regulations for the proposed sanctuary; and (3) next steps for developing a response. Following the conclusion of these items, the Council will receive a presentation on the Scallop Survey Working Group's final report.

After the lunch break, the Council will continue with the Scallop Committee report and cover two items. First, the Council will receive an update on Framework Adjustment 36 to the Atlantic Sea Scallop Fishery Management Plan (FMP) entailing: (1) a preliminary overview of 2022 surveys; and (2) a progress report on work being done to develop specifications for the 2023 fishing year, default specifications for the 2024 fishing year, and other measures. The Council then will devote the remainder of the day to discussing issues related to scallop leasing. The Council first will receive a summary of all oral and written comments collected during the scoping process for this issue and then decide whether to take the next step and initiate an amendment to the Scallop FMP to further consider leasing alternatives for the limited access component of the fishery. At the conclusion of this discussion, the Council will adjourn for the day.

Wednesday, September 28, 2022

The Council will lead off the third day of its meeting in closed session to discuss internal administrative matters regarding policies for preventing harassment of Council staff and all other Council process participants. Once the Council enters into the open session of the meeting, it first will receive a presentation from the Northeast Fisheries Science Center on the peer reviewed results from the Atlantic Herring and Southern New England/Mid-Atlantic Winter Flounder Management Track Stock Assessments. This will be followed by another NEFSC presentation on the peer reviewed results for the American Plaice Research Track Assessment. Next, the Council will receive a backgrounder by staff on the Transboundary Management Guidance Committee (TMGC) and the process used for managing shared U.S./Canada resources on Georges Bank. The U.S. Co-Chair of the Transboundary Resources Assessment Committee (TRAC) will provide a presentation on 2022 assessments results and related updates for Eastern Georges Bank cod, Eastern Georges Bank haddock, and Georges Bank yellowtail flounder. The Scientific and Statistical Committee (SSC) Chair will provide: (1) the SSC's recommendations on the overfishing limits (OFLs) and acceptable biological catches (ABCs) for Georges Bank yellowtail flounder for fishing years 2023 and 2024; (2) input on Gulf of Maine cod rebuilding approaches; (3) recommendations on Georges Bank cod ABCs for 2023 and 2024; and (4) OFLs and ABCs for Southern New England/Mid-Atlantic winter flounder for 2023, 2024, and 2025. The Council then will review and approve the TMGC's recommendations for 2023–24 total allowable catches (TACs) for shared U.S./Canada resources on Georges Bank.

Following the lunch break, the Council will take up the Groundfish Committee report, which will cover progress on Framework Adjustment 65 to the Groundfish FMP. The framework includes: (1) 2023–24 TACs for U.S./Canada shared resources on Georges Bank; (2) 2023–24 specifications for Georges Bank cod and Georges Bank yellowtail flounder; (3) 2023–25 specifications for 14 additional groundfish stocks; (4) revised rebuilding plans for Gulf of Maine cod and Southern New England/Mid-Atlantic winter flounder; (5) additional measures to promote stock rebuilding; and (6) groundfish ABC control rule revisions. The Council then will hear the Atlantic Herring Committee report. First, the Council will receive the SSC's recommendations for OFLs and ABCs for Atlantic herring for fishing years 2023, 2024, and 2025 before taking final action on 2023–25 specifications for the fishery. Second, the Council will discuss Framework Adjustment 7 to the Atlantic Herring FMP, which was initiated to develop measures to protect adult spawning herring on Georges

Bank. The Council may consider a change in its herring priorities to discontinue work on this action. Following herring, the Council will take up the Habitat Committee report, which will cover four items: (1) a discussion and possible initiation of a framework adjustment to facilitate offshore Atlantic salmon aquaculture; (2) a GAFRO update on the three-year review of the Dedicated Habitat Research Areas (DHRAs) contained in the Council's Omnibus Essential Fish Habitat Amendment 2; (3) a discussion of the utility of an exempted fishing permit study for management of fishing gear impacts in the Great South Channel Habitat Management Area; and (4) offshore energy and habitat-related work updates, including a Bureau of Ocean Energy Management Gulf of Maine wind update, as well as progress reports on other work. The Council then will adjourn for the day.

Thursday, September 29, 2022

The Council will lead off the fourth day of its meeting with a presentation from the Northeast Fisheries Science Center's Fishery Monitoring and Research Division. The report will cover: (1) the status of ongoing responsibilities within the division; (2) updates on at-sea monitoring and observer program activities, funding status, and coverage rates; and (3) a cooperative research update. The Council then will cover two monkfish items. First, it will receive a presentation on the final Monkfish Fishery Performance Report. This will be followed by a progress report on Framework Adjustment 13 to the Monkfish FMP, which contains 2023–25 fishery specifications and other measures. The Council then will take up the Ecosystem-Based Fishery Management (EBFM) Committee report, which will include updates on: (1) planning for EBFM informational outreach workshops; (2) contractor work to develop and conduct a prototype management strategy evaluation (MSE) for EBFM and the Georges Bank example Fishery Ecosystem Plan (eFEP); and (3) discussions with NOAA Fisheries on National Standard 1's application to the Council's eFEP catch management framework. The Council then will receive the 2022 Northeast Skate Complex Annual Monitoring Report covering the 2021 skate fishing year, as well as an overview of the Skate Plan Development Team's work to improve methods for catch accounting, specification setting, and in-season quota monitoring.

Following the lunch break, members of the public will have the opportunity to speak during an open comment period on issues that relate to Council business but are not included on the published agenda for this meeting. The Council asks the public to limit remarks to 3–5 minutes. These comments will be received both in person and through the webinar. A guide for how to publicly comment through the webinar is available on the Council website at *https://s3.amazonaws.com/nefmc.org/NEFMC-meeting-remote-participation_generic.pdf.* Next, NMFS will provide a presentation on proposed regulatory changes to reduce vessel strikes to North Atlantic right whales, and the Council will have an opportunity to provide comments. The Northeast Fisheries Science Center will provide a presentation on the ''Draft Ropeless Fishing Roadmap: A Strategy to Develop On-Demand Fishing,'' which is intended to help reduce the risk of right whale entanglements with fishing gear. The Council will have an opportunity to provide feedback. The next presentation will be on NOAA's National Saltwater Recreational Fisheries Policy. The Council will consider whether to submit comments on this updated policy. The Council then will hold its initial discussion on 2023 Council Priorities before closing out the meeting with other business.

Although non-emergency issues not contained on this agenda may come before the 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 Fishery Conservation and Management 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 (see **ADDRESSES**) at least 5 days prior to the meeting date.

Authority: 16 U.S.C. 1801 *et seq.*

Dated: August 31, 2022.

Rey Israel Marquez,

Acting Deputy Director, Office of Sustainable Fisheries, National Marine Fisheries Service.

[FR Doc. 2022–19235 Filed 9–6–22; 8:45 am]

BILLING CODE 3510–22–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

Interagency Marine Debris Coordinating Committee Meeting

AGENCY: National Ocean Service (NOS), National Oceanic and Atmospheric Administration (NOAA), Department of Commerce (DOC).

ACTION: Notice of open meeting.

SUMMARY: Notice is hereby given of a virtual public meeting of the Interagency Marine Debris Coordinating Committee (IMDCC). IMDCC members will discuss Federal marine debris activities, with a particular emphasis on the topics identified in the section on *Matters to Be Considered.*

DATES: The virtual public meeting will be held on September 29, 2022, from 10 a.m. to 11 a.m. Eastern Time (ET).

ADDRESSES: The meeting will be held virtually using Adobe Connect. You can connect to the meeting using the website or phone number provided:

Meeting link: https://noaaorr.adobeconnect.com/imdcc/.

Phone: +1 866–399–2601; PIN: 8663992601.

Attendance will be limited to the first 100 individuals to join the virtual meeting room. Refer to the IMDCC website at *https://marinedebris.noaa.gov/IMDCC* for the most up-to-date information on how to participate and on the agenda.

FOR FURTHER INFORMATION CONTACT: Ya'el Seid-Green, Executive Secretariat, IMDCC, Marine Debris Program; Phone 240–533–0399; Email *yael.seid-green@noaa.gov* or visit the IMDCC website at *https://marinedebris.noaa.gov/IMDCC.*

SUPPLEMENTARY INFORMATION: IMDCC is a multi-agency body responsible for coordinating a comprehensive program of marine debris research and activities among Federal agencies, in cooperation and coordination with non-governmental organizations, industry, academia, States, Tribes, and other nations, as appropriate. Representatives meet to share information, assess and promote best management practices, and coordinate the Federal Government's efforts to address marine debris.

The Marine Debris Act establishes the IMDCC (33 U.S.C. 1954). The IMDCC submits biennial progress reports to Congress with updates on activities, achievements, strategies, and recommendations. NOAA serves as the Chairperson of the IMDCC.

The meeting will be open to public attendance on September 29, 2022, from

10 a.m. to 11 a.m. ET. There will not be a public comment period. The meeting will not be recorded.

Matters To Be Considered

The open meeting will include a presentation from the NOAA Marine Debris Program on abandoned and derelict vessels. The agenda topics described are subject to change. The latest version of the agenda will be posted at *https://marinedebris.noaa.gov/IMDCC.*

Special Accommodations

The meeting is accessible to people with disabilities. Closed captioning will be available. Requests for other auxiliary aids should be directed to Ya'el Seid-Green, Executive Secretariat at *yael.seid-green@noaa.gov* or 240–533–0399 by September 22, 2022.

Scott Lundgren,

Director, Office of Response and Restoration, National Ocean Service, National Oceanic and Atmospheric Administration.

[FR Doc. 2022–19254 Filed 9–6–22; 8:45 am]

BILLING CODE 3510–NK–P

COMMODITY FUTURES TRADING COMMISSION

Market Risk Advisory Committee

AGENCY: Commodity Futures Trading Commission.

ACTION: Notice of meeting.

SUMMARY: The Commodity Futures Trading Commission (CFTC) announces that on September 28, 2022, from approximately 9:30 a.m. to 12:30 p.m. (Eastern Daylight Time), the Market Risk Advisory Committee (MRAC or Committee) will hold an in-person public meeting at the CFTC's Washington, DC headquarters with options for the public to attend virtually. At this meeting, the MRAC will address refining the Committee's agenda and topics of discussion on a forward-looking basis, developments in the digital asset markets and the unique risks of such markets, investor and customer protection in markets with increasing retail participation, the importance of climate-related market risk, and market structure developments, including a possible vote to reestablish the Market Structure subcommittee and a discussion of issues that should be addressed by that subcommittee.

DATES: The meeting will be held on September 28, 2022, from approximately 9:30 a.m. to 12:30 p.m. (Eastern Daylight Time). Please note that the meeting may end early if the MRAC has completed its business. Members of the public who wish to submit written statements in connection with the meeting should submit them by October 5, 2022.

ADDRESSES: The meeting will take place in the Conference Center at the CFTC's headquarters, Three Lafayette Centre, 1155 21st Street NW, Washington, DC 20581 subject to CFTC facility health protocols in place at that time. You may submit public comments, identified by ''Market Risk Advisory Committee,'' through the CFTC website at *https://comments.cftc.gov.* Follow the instructions for submitting comments through the Comments Online process on the website. If you are unable to submit comments online, contact Bruce Fekrat, Designated Federal Officer or Marilee Dahlman, Alternate Designated Federal Officer, via the contact information listed in the **FOR FURTHER INFORMATION CONTACT** section of this notice, to discuss alternate means of submitting your comments. Any statements submitted in connection with the committee meeting will be made available to the public, including publication on the CFTC website, *https://www.cftc.gov.*

FOR FURTHER INFORMATION CONTACT: Bruce Fekrat, MRAC Designated Federal Officer, Commodity Futures Trading Commission, Three Lafayette Centre, 1155 21st Street NW, Washington, DC 20581; (202) 418–5690; or Marilee Dahlman, MRAC Alternate Designated Federal Officer, Commodity Futures Trading Commission, Three Lafayette Centre, 1155 21st Street NW, Washington, DC; (202) 247–6544.

SUPPLEMENTARY INFORMATION: The meeting will be open to the public. Seating for the public may be limited due to the CDC's COVID–19 Community Level, which may require facilitating physical distancing to avoid overcrowding and additional restrictions. Members of the public may listen to the meeting by telephone by calling a domestic or international number to connect to a live, listen-only audio feed. Call-in participants should be prepared to provide their first name, last name, and affiliation.

Telephone: Dial (for higher quality, dial a number based on your current location): US: +1 669 254 5252 or +1 646 828 7666 or +1 669 216 1590 or +1 551 285 1373 or 833 568 8864 (Toll Free) or 833 435 1820 (Toll Free).

International Numbers: Will be posted on the CFTC's website, *https://www.cftc.gov,* on the page for the meeting, under Related Links.

Webinar ID: 160 382 3651.

Pass Code/Pin Code: 282509.

The meeting will also be open to the public via webcast on the *https://www.cftc.gov* website. The meeting agenda may change to accommodate other MRAC priorities. For agenda updates, please visit the MRAC committee site at: *https://www.cftc.gov/About/CFTCCommittees/MarketRiskAdvisoryCommittee/mrac_meetings.html.*

All written submissions provided to the CFTC in any form will also be published on the CFTC's website. Persons requiring special accommodations to attend the meeting because of a disability should notify one of the individuals listed in the **FOR FURTHER INFORMATION CONTACT** section of this notice.

(Authority: 5 U.S.C. app. 2 section 10(a)(2).)

Dated: August 31, 2022.

Christopher Kirkpatrick,

Secretary of the Commission.

[FR Doc. 2022–19230 Filed 9–6–22; 8:45 am]

BILLING CODE 6351–01–P

DEPARTMENT OF DEFENSE

Defense Acquisition Regulations System

[Docket Number DARS–2022–0018; OMB Control Number 0704–0441]

Information Collection Requirement; Defense Federal Acquisition Regulation Supplement (DFARS); Quality Assurance

AGENCY: Defense Acquisition Regulations System, Department of Defense (DoD).

ACTION: Notice.

SUMMARY: The Defense Acquisition Regulations System has submitted to OMB for clearance the following proposal for collection of information under the provisions of the Paperwork Reduction Act.

DATES: Consideration will be given to all comments received by October 7, 2022.

SUPPLEMENTARY INFORMATION:

Title and OMB Number: Defense Federal Acquisition Regulation Supplement (DFARS) Part 246, Quality Assurance, and related clauses at 252.246; OMB Control Number 0704–0441.

Affected Public: Businesses or other for-profit and not-for-profit institutions.

Respondent's Obligation: Required to obtain or retain benefits.

Frequency: On occasion.

Type of Request: Extension of a currently approved collection.

Number of Respondents: 34,842.

Annual Responses: 122,024.

Annual Burden Hours: 2,075,685 (includes 39,075 reporting hours and 2,036,610 recordkeeping hours).

Needs and Uses: The information collections under OMB Control Number 0704–0441 pertain to all information that offerors or contractors must submit related to DFARS contract quality assurance programs.

a. 252.246–7003, Notification of Potential Safety Issues. Contracting officers require timely notification of potential safety defects so that (1) systems and equipment likely affected by the situation can be readily identified, and (2) appropriate engineering investigation and follow-on actions can be taken to establish and mitigate risk.

b. 252.246–7005, Notice of Warranty Tracking of Serialized Items. The information provided by offerors under this solicitation provision alerts contracting officers in those cases where the offeror is proposing to provide a warranty for an individual contract line item for which DoD has not specified a warranty in the solicitation. The warranty notice will permit the Government to recognize and utilize any warranty after contract award.

c. 252.246–7006, Warranty Tracking of Serialized Items. The information provided by contractors allows DoD to track warranties for item unique identification (IUID) required items in the IUID registry to obtain maximum utility of warranties provided on contracted items. The identification and enforcement of warranties is essential to the effectiveness and efficiency of DoD's material readiness. Providing visibility and accountability of warranty data associated with acquired goods, from the identification of the requirement to the expiration date of the warranted item, significantly enhances DoD's ability to take full advantage of warranties, resulting in—

(1) Reduced costs;

(2) Ability to recognize benefits included at no additional cost;

(3) Ability to compare performance against Government-specified warranties; and

(4) Identification of sufficient durations for warranties for specific goods.

d. 252.246–7008, Sources of Electronic Parts. The contracting officer uses the information to ensure that the contractor performs the traceability of parts, additional inspection, testing, and authentication required when an electronic part is not obtained from a trusted supplier. The Government may also use this information to more actively perform acceptance.

Comments and recommendations on the proposed information collection should be sent to Ms. Susan Minson, DoD Desk Officer, at *Oira_submission@omb.eop.gov.* Please identify the proposed information collection by DoD Desk Officer and the Docket ID number and title of the information collection.

You may also submit comments, identified by docket number and title, by the following method: Federal eRulemaking Portal: *https://www.regulations.gov.* Follow the instructions for submitting comments.

DoD Clearance Officer: Ms. Angela Duncan. Requests for copies of the information collection proposal should be sent to Ms. Duncan at *whs.mc-alex.esd.mbx.dd-dod-information-collections@mail.mil.*

Jennifer D. Johnson,

Editor/Publisher, Defense Acquisition Regulations System.

[FR Doc. 2022–19284 Filed 9–6–22; 8:45 am]

BILLING CODE 5001–06–P

DEPARTMENT OF DEFENSE

Defense Acquisition Regulations System

[Docket Number DARS–2022–0017; OMB Control Number 0704–0549]

Information Collection Requirements; Defense Federal Acquisition Regulation Supplement; Contractors Performing Private Security Functions Outside the United States

AGENCY: Defense Acquisition Regulations System, Department of Defense (DoD).

ACTION: Notice.

SUMMARY: The Defense Acquisition Regulations System has submitted to OMB for clearance the following proposal for collection of information under the provisions of the Paperwork Reduction Act.

DATES: Consideration will be given to all comments received by October 7, 2022.

SUPPLEMENTARY INFORMATION:

Title and OMB Number: Defense Federal Acquisition Regulation Supplement (DFARS) Part 225, Foreign Acquisition, and Defense Contractors Performing Private Security Functions Outside the United States; OMB Control Number 0704–0549.

Affected Public: Businesses entities.

Respondent's Obligation: Required to obtain or retain benefits.

Type of Request: Revision of a currently approved collection.

Reporting Frequency: On Occasion.

Number of Respondents: 10.

Responses per Respondent: 4.

Annual Responses: 40.

Average Burden per Response: 0.5 hours.

Annual Burden Hours: 20.

Needs and Uses: Geographic combatant commanders are required by statute to establish procedures and assign responsibilities for ensuring that contractors and contractor personnel report certain security incidents when performing private security functions in covered operational areas. The clause at DFARS 252.225–7039, Defense Contractors Performing Private Security Functions Outside the United States, requires contractors and subcontractors performing private security functions in designated operational areas outside the United States to comply with 32 CFR part 159 and any orders, directives, and instructions contained in the contract on reporting the following types of incidents to the geographic combatant commander if and when they occur:

(a) A weapon is discharged by personnel performing private security functions.

(b) Personnel performing private security functions are attacked, killed, or injured.

(c) Persons are killed or injured or property is destroyed as a result of conduct by contractor personnel.

(d) A weapon is discharged against personnel performing private security functions or personnel performing such functions believe a weapon was so discharged.

(e) Active, non-lethal countermeasures (other than the discharge of a weapon) are employed by personnel performing private security functions in response to a perceived immediate threat.

Comments and recommendations on the proposed information collection should be sent to Ms. Susan Minson, DoD Desk Officer, at *Oira_submission@omb.eop.gov.* Please identify the proposed information collection by DoD Desk Officer and the Docket ID number and title of the information collection.

You may also submit comments, identified by docket number and title, by the following method: Federal eRulemaking Portal: *https://www.regulations.gov.* Follow the instructions for submitting comments.

DoD Clearance Officer: Ms. Angela Duncan. Requests for copies of the information collection proposal should be sent to Ms. Duncan at *whs.mc-*

alex.esd.mbx.dd-dod-information-collections@mail.mil.

Jennifer D. Johnson,

Editor/Publisher, Defense Acquisition Regulations System.

[FR Doc. 2022–19285 Filed 9–6–22; 8:45 am]

BILLING CODE 5001–06–P

DEPARTMENT OF DEFENSE

Defense Acquisition Regulations System

[Docket Number DARS–2022–0021]

Information Collection Requirement; Defense Federal Acquisition Regulation Supplement; Rights in Technical Data and Computer Software (OMB Control Number 0704–0369)

AGENCY: Defense Acquisition Regulations System; Department of Defense (DoD).

ACTION: Notice and request for comments regarding a proposed extension of an approved information collection requirement.

SUMMARY: In compliance with the Paperwork Reduction Act of 1995, DoD announces the proposed extension of a public information collection requirement and seeks public comment on the provisions thereof. DoD invites comments on: whether the proposed collection of information is necessary for the proper performance of the functions of DoD, including whether the information will have practical utility; the accuracy of the estimate of the burden of the proposed information collection; ways to enhance the quality, utility, and clarity of the information to be collected; and ways to minimize the burden of the information collection on respondents, including the use of automated collection techniques or other forms of information technology. The Office of Management and Budget (OMB) has approved this information collection for use under Control Number 0704–0369 through December 31, 2022. DoD proposes that OMB approve an extension of the information collection requirement, to expire three years after the approval date.

DATES: DoD will consider all comments received by November 7, 2022.

ADDRESSES: You may submit comments, identified by OMB Control Number 0704–0369, using any of the following methods:

○ *Federal eRulemaking Portal: https://www.regulations.gov.* Follow the instructions for submitting comments.

○ *Email: osd.dfars@mail.mil.* Include OMB Control Number 0704–0369 in the subject line of the message.

Comments received generally will be posted without change to *http://www.regulations.gov,* including any personal information provided.

FOR FURTHER INFORMATION CONTACT: Mr. David Johnson, at 202–913–5764.

SUPPLEMENTARY INFORMATION:

Title and OMB Number: Defense Federal Acquisition Regulation Supplement (DFARS) Subpart 227.71, Rights in Technical Data, and Subpart 227.72, Rights in Computer Software and Computer Software Documentation, and related provisions and clauses; OMB Control Number 0704–0369.

Affected Public: Businesses or other for-profit and not-for-profit institutions.

Respondent's Obligation: Required to obtain or retain benefits.

Reporting Frequency: On occasion.

Type of Request: Extension of a currently approved collection.

Number of Respondents: 75,250.

Responses per Respondent: 13, approximately.

Annual Responses: 959,602.

Average Burden per Response: 1 hour, approximately.

Annual Response Burden Hours: 904,574.

Annual Recordkeeping Burden Hours: 90,600.

Total Annual Burden Hours: 995,174.

Needs and Uses: DFARS subparts 227.71 and 227.72 prescribe the use of solicitation provisions and contract clauses containing information collection requirements that are associated with rights in technical data and computer software. DoD needs this information to implement 10 U.S.C. 2320, Rights in technical data, and 10 U.S.C. 2321, Validation of proprietary data restrictions. DoD uses the information to recognize and protect contractor rights in technical data and computer software that are associated with privately funded development; and to ensure that technical data delivered under a contract are complete and accurate and satisfy contract requirements.

DoD uses the following DFARS provisions and clauses in solicitations and contracts to require offerors and contractors to identify and mark data or software requiring protection from unauthorized use, release, or disclosure in accordance with 10 U.S.C. 2320:

252.227–7013, Rights in Technical Data—Noncommercial Items.

252.227–7014, Rights in Noncommercial Computer Software and Noncommercial Computer Software Documentation.

252.227–7017, Identification and Assertion of Use, Release, or Disclosure Restrictions.

252.227–7018, Rights in Noncommercial Technical Data and Computer Software—Small Business Innovation Research (SBIR) Program.

In accordance with 10 U.S.C. 2320(a)(2)(D), DoD may disclose limited rights data to persons outside the Government, or allow those persons to use data with use, release, or disclosure restrictions, if the recipient agrees not to further release, disclose, or use the data. Therefore, the clause at DFARS 252.227–7013, Rights in Technical Data—Noncommercial Items, requires the contractor to identify and mark data or software that it provides with limited rights.

In accordance with 10 U.S.C. 2321(b), contractors and subcontractors at any tier must be prepared to furnish written justification for any asserted restriction on the Government's rights to use or release data. The following DFARS clauses require contractors and subcontractors to maintain adequate records and procedures to justify any asserted restrictions:

252.227–7019, Validation of Asserted Restrictions—Computer Software.

252.227–7037, Validation of Restrictive Markings on Technical Data.

In accordance with 10 U.S.C. 2320, DoD must protect the rights of contractors that have developed items, components, or processes exclusively at private expense. Therefore, the clause at DFARS 252.227–7025, Limitations on the Use or Disclosure of Government-Furnished Information Marked with Restrictive Legends, requires a contractor or subcontractor to submit a use and nondisclosure agreement when it obtains data from the Government to which the Government has less than unlimited rights. In addition, DFARS 227.7103–7, Use and nondisclosure agreement, requires intended recipients of technical data or computer software delivered to the Government with restrictions on use, modification, reproduction, release, performance, display, or disclosure, to sign the use and nondisclosure agreement at 227.7103–7(c) prior to release or disclosure of the data, unless the recipient is a Government contractor that requires access to a third party's data or software for the performance of a Government contract that contains the clause at 252.227–7025, Limitations on Use or Disclosure of Government-Furnished Information Marked with Restrictive Legends. According to 10 U.S.C. 2320(a)(2)(D), DoD may disclose limited rights data to persons outside the Government, or allow those persons

to use limited rights data, if the recipient agrees not to further use, release, or disclose the data.

The provision at DFARS 252.227–7028, Technical Data or Computer Software Previously Delivered to the Government, requires an offeror to identify any technical data or computer software that it previously delivered, or will deliver, under any Government contract. DoD needs this information to avoid paying for rights in technical data or computer software that the Government already owns.

Jennifer D. Johnson,

Editor/Publisher, Defense Acquisition Regulations System.

[FR Doc. 2022–19283 Filed 9–6–22; 8:45 am]

BILLING CODE 5001–06–P

DEPARTMENT OF ENERGY

Request for Information on Grid Resilience and Innovation Partnerships Program

AGENCY: Grid Deployment Office, U.S. Department of Energy.

ACTION: Request for information.

SUMMARY: The U.S. Department of Energy (DOE or the Department) invites public comment on its request for information (RFI) on DOE's implementation strategy for the Grid Resilience and Innovation Partnerships (GRIP) program, including on the competitive solicitation process, draft funding opportunity announcement (FOA) language, prioritization of topics and projects, and selection criteria.

DATES: Responses to the RFI must be received by no later than 5 p.m. EDT on October 14, 2022.

ADDRESSES: Interested parties are to submit questions, comments, and responses to the Department's RFI to the following email address: *GDORFI@hq.doe.gov.* Include ''Grid Resilience and Innovation Partnerships Program'' in the subject line of the email. Responses must be provided as a Microsoft Word (.docx) or PDF attachment to the email, and no more than 20 pages in length, 12-point font, 1-inch margins. It is recommended that attachments with file sizes exceeding 25MB be compressed (*i.e.,* zipped) to ensure message delivery. Only electronic responses will be accepted. For ease of replying and to aid categorization of your responses, please copy and paste the RFI questions, including the question numbering, and use them as a template for your response. Respondents may answer as many or as few questions as they wish. The Grid Resilience and Innovation Partnerships (GRIP) program RFI is available at: *https://www.fedconnect.net/fedconnect/?doc=DE-FOA-0002827&agency=DOE.* The Draft Funding Opportunity Announcement (FOA) for FY22 and FY23 GRIP funding is available at: *https://www.fedconnect.net/fedconnect/?doc=DE-FOA-0002740&agency=DOE.*

FOR FURTHER INFORMATION CONTACT: Please contact: Dylan Reed, (202) 586–3185, *GDORFI@hq.doe.gov.*

SUPPLEMENTARY INFORMATION: The Infrastructure Investment and Jobs Act (IIJA) (Pub. L. 117–58) approximately $10.5 billion for the five-year period encompassing FY22 through FY26, to prevent outages and enhance the resilience of the electric grid, deploy technologies to enhance grid flexibility, and to demonstrate innovative approaches to power sector infrastructure resilience and reliability. Together, DOE refers to these programs as the GRIP program.

The purpose of this RFI is to solicit feedback from industry, academia, research laboratories, government agencies, State and local officials, labor unions, Tribes, community-based organizations (CBOs), and other stakeholders on issues related to the GRIP program.

To help inform DOE's implementation of the IIJA provisions referenced previously, this RFI seeks input on the following categories:

1. DOE's implementation strategy and approach for the GRIP program, both overall and for each of the individual topic areas.

2. DOE's approach to Community Benefits including engagement, quality jobs, Diversity, Equity, Inclusion and Accessibility (DEIA), and Justice40.

3. Build America, Buy America requirements.

This is solely a request for information and is not a funding opportunity announcement. DOE is not accepting applications at this time and will not reimburse any of respondents' costs in preparing a response.

The complete GRIP program RFI can be found at: *https://www.fedconnect.net/fedconnect/?doc=DE-FOA-0002827&agency=DOE.*

The Draft FOA for FY22 and FY23 GRIP Funding can be found at: *https://www.fedconnect.net/fedconnect/?doc=DE-FOA-0002740&agency=DOE.*

Proprietary Information

Because information received in response to this RFI may be used to structure future programs and formula grant allocations and/or otherwise be made available to the public, respondents are strongly advised NOT to include any information in their responses that might be considered business sensitive, proprietary, or otherwise confidential. If, however, a respondent chooses to submit business sensitive, proprietary, or otherwise confidential information, it must be clearly and conspicuously marked as such in the response. Responses containing confidential, proprietary, or privileged information must be conspicuously marked as described below. Failure to comply with these marking requirements may result in the disclosure of the unmarked information under the Freedom of Information Act or otherwise. The U.S. Federal Government is not liable for the disclosure or use of unmarked information and may use or disclose such information for any purpose.

Confidential, Commercial, and Financial Information. Consistent with 10 CFR 1004.11, DOE requires that 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 Commercial and Financial Information'' 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. The copy containing confidential commercial and financial information must include a cover sheet marked as follows identifying the specific pages containing confidential, proprietary, or privileged information: ''Notice of Restriction on Disclosure and Use of Data: Pages [list applicable pages] of this response may contain confidential, commercial, or financial information that is exempt from public disclosure.'' The Government may use or disclose any information that is not appropriately marked or otherwise restricted, regardless of source. In addition, (1) the header and footer of every page that contains confidential, proprietary, or privileged information must be marked as follows: ''Contains Confidential, Commercial, or Financial Information Exempt from Public Disclosure'' and (2) every line and paragraph containing proprietary, privileged, or trade secret information must be clearly marked with [[double brackets]] or highlighting.

Signing Authority

This document of the Department of Energy was signed on September 1, 2022, by Maria D. Robinson, Director of the Grid Deployment Office, 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 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 on publication in the **Federal Register**.

Signed in Washington, DC, on September 1, 2022.

Treena V. Garrett,

Federal Register Liaison Officer, U.S. Department of Energy.

[FR Doc. 2022–19308 Filed 9–6–22; 8:45 am]

BILLING CODE 6450–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Project No. 2275–050]

Public Service Company of Colorado; Notice of Application for Amendment of License, Soliciting Comments, Motions To Intervene, and Protests

Take notice that the following hydroelectric application has been filed with the Commission and is available for public inspection:

a. *Type of Proceeding:* Application for non-capacity amendment of license.

b. *Project No.:* 2275–050.

c. *Date Filed:* January 28, 2022.

d. *Licensee:* Public Service Company of Colorado.

e. *Name of Project:* Salida Hydroelectric Project.

f. *Location:* The Salida Hydroelectric Project is located on the South Arkansas River and Fooses Creek, approximately 6 miles west of the town of Poncha Springs in Chaffee County, Colorado. The project partially occupies federal land managed by the U.S. Forest Service within the Pike-San Isabel National Forests.

g. *Filed Pursuant to:* Federal Power Act, 16 U.S.C. 791a–825r.

h. *Licensee Contact:* Christine Johnson, (303) 294–2224, *christine.johnston@xcelenergy.com.*

i. *FERC Contact:* Rebecca Martin, (202) 502–6012, *Rebecca.martin@ferc.gov.*

j. *Deadline for filing comments, interventions, and protests:* September 30, 2022.

The Commission strongly encourages electronic filing. Please file comments, motions to intervene, and protests using the Commission's eFiling system at *http://www.ferc.gov/docs-filing/efiling.asp.* Commenters can submit brief comments up to 6,000 characters, without prior registration, using the eComment system at *http://www.ferc.gov/docs-filing/ecomment.asp.* You must include your name and contact information at the end of your comments. For assistance, please contact FERC Online Support at *FERCOnlineSupport@ferc.gov,* (866) 208–3676 (toll free), or (202) 502–8659 (TTY). In lieu of electronic filing, you may submit a paper copy. Submissions sent via the U.S. Postal Service must be addressed to: Kimberly D. Bose, Secretary, Federal Energy Regulatory Commission, 888 First Street NE, Room 1A, Washington, DC 20426. Submissions sent via any other carrier must be addressed to: Kimberly D. Bose, Secretary, Federal Energy Regulatory Commission, 12225 Wilkins Avenue, Rockville, Maryland 20852. The first page of any filing should include docket number P–2275–050. Comments emailed to Commission staff are not considered part of the Commission record.

The Commission's Rules of Practice and Procedure require all intervenors filing documents with the Commission to serve a copy of that document on each person whose name appears on the official service list for the project. Further, if an intervenor files comments or documents with the Commission relating to the merits of an issue that may affect the responsibilities of a particular resource agency, they must also serve a copy of the document on that resource agency.

k. *Description of Request:* The Salida Project consists of two developments, Salida No. 1 and Salida No. 2. The licensee has determined that the Salida No.1 development is no longer economical. The licensee proposes to amend the existing license for the project to decommission the Salida No. 1 development by removing the Garfield and Fooses dams and reservoirs, pipeline, penstock, powerhouse, and substation.

l. *Locations of the Application:* This filing may be viewed on the Commission's website at *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. You may also register online at *http://www.ferc.gov/docs-filing/esubscription.asp* to be notified via email of new filings and issuances related to this or other pending projects. For assistance, call 1–866–208–3676 or email *FERCOnlineSupport@ferc.gov,* for TTY, call (202) 502–8659. Agencies may obtain copies of the application directly from the applicant.

m. Individuals desiring to be included on the Commission's mailing list should so indicate by writing to the Secretary of the Commission.

n. *Comments, Protests, or Motions to Intervene:* Anyone may submit comments, a protest, or a motion to intervene in accordance with the requirements of Rules of Practice and Procedure, 18 CFR 385.210, .211, .214, respectively. In determining the appropriate action to take, the Commission will consider all protests or other comments filed, but only those who file a motion to intervene in accordance with the Commission's Rules may become a party to the proceeding. Any comments, protests, or motions to intervene must be received on or before the specified comment date for the particular application.

o. *Filing and Service of Documents:* Any filing must (1) bear in all capital letters the title ''COMMENTS'', ''PROTEST'', or ''MOTION TO INTERVENE'' as applicable; (2) set forth in the heading the name of the applicant and the project number of the application to which the filing responds; (3) furnish the name, address, and telephone number of the person commenting, protesting or intervening; and (4) otherwise comply with the requirements of 18 CFR 385.2001 through 385.2005. All comments, motions to intervene, or protests must set forth their evidentiary basis. Any filing made by an intervenor must be accompanied by proof of service on all persons listed in the service list prepared by the Commission in this proceeding, in accordance with 18 CFR 385.2010.

Dated: August 31, 2022.

Kimberly D. Bose,

Secretary.

[FR Doc. 2022–19252 Filed 9–6–22; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. IC22–34–000]

Commission Information Collection Activities (FERC–550), Comment Request Extension

AGENCY: Federal Energy Regulatory Commission, Department of Energy.

ACTION: Comment request.

SUMMARY: In compliance with the requirements of the Paperwork Reduction Act of 1995, the Federal Energy Regulatory Commission (Commission or FERC) is soliciting public comment on the currently approved information collection, FERC–550 (Oil Pipeline Rates—Tariff Filings and Depreciation Studies).

DATES: Comments on the collection of information are due November 7, 2022.

ADDRESSES: Send written comments on FERC–550 (IC22–34–000) to the Commission. You may submit copies of your comments by one of the following methods:

Electronic filing through *https://www.ferc.gov,* is preferred.

- *Electronic Filing:* Documents must be filed in acceptable native applications and print-to-PDF, but not in scanned or picture format.
- For those unable to file electronically, comments may be filed by USPS mail or by hand (including courier) delivery.

○ *Mail via U.S. Postal Service Only Addressed to:* Federal Energy Regulatory Commission, Secretary of the Commission, 888 First Street NE, Washington, DC 20426.

○ *Hand (including courier) delivery to:* Federal Energy Regulatory Commission, 12225 Wilkins Avenue, Rockville, MD 20852.

Instructions: FERC submissions must be formatted and filed in accordance with submission guidelines at: *https://www.ferc.gov.* For user assistance, contact FERC Online Support by email at *ferconlinesupport@ferc.gov,* or by phone at: (866) 208–3676 (toll-free).

Docket: Users interested in receiving automatic notification of activity in this docket or in viewing/downloading comments and issuances in this docket may do so at *https://www.ferc.gov/ferc-online/overview.*

FOR FURTHER INFORMATION CONTACT: Ellen Brown may be reached by email at *DataClearance@FERC.gov,* telephone at (202) 502–8663.

SUPPLEMENTARY INFORMATION:

Title: FERC–550, Oil Pipeline Rates—Tariff Filings and Depreciation Studies.

OMB Control No.: 1902–0089.

Type of Request: Three-year extension of the FERC–550 information collection requirements with no revisions to the collection, but with adjustments in the burden estimates.

Abstract: FERC–550 is required to assist the Commission in implementing the duties and powers that were vested on October 1, 1977, in the Interstate Commerce Commission (49 U;S.C. 60502). The Commission's regulatory jurisdiction over oil pipelines includes:

- Regulation of rates and practices of oil pipeline companies engaged in interstate transportation;
- Establishment of equal service conditions to provide shippers with equal access to pipeline transportation; and
- Establishment of reasonable rates for transporting petroleum and petroleum products by pipeline.

Oil Pipeline Tariffs and Rates

The filing requirements for oil pipeline tariffs and rates [1] put in place by the FERC–550 data collection provide the Commission with the information it needs to analyze proposed tariffs, rates, fares, and charges of oil pipelines and other carriers in connection with the transportation of crude oil and petroleum products. Specifically, these filings typically include indexing, market-based rates, or initial rate filings. The Commission uses this information to determine whether the proposed tariffs and rates are just and reasonable.

The Commission's regulations at 18 CFR parts 341 through 348 provide that letters of transmittal must describe the filings and explain any changes to the carrier's rates, rules, terms or conditions of service; state if a waiver is being requested, and specify the statute, section, regulation, policy, or order requested to be waived; and identify the tariffs supplemental numbers, or tariff sections and the proposed effective date of the tariff publication. The letter of transmittal must certify that the filing has been sent to each subscriber of the tariff publication. A carrier may file to amend or modify a tariff contained in a tariff filing at any time during the pendency of the filing. Carriers must cancel tariffs when the service or transportation movement is terminated. If the service in connection with the tariff is no longer in interstate commerce, the tariff publication must state so. Whenever the tariff of a carrier on file with the Commission is to be adopted by another carrier as a result of an acquisition, merger, or name change, the succeeding company must file with the Commission, and post within 30 days after such succession, the tariff, or portion thereof, that has been adopted in the electronic format required by *§ 341.1* bearing the name of the successor company.

Oil Pipeline Depreciation Studies

The Commission's regulation at 18 CFR 347.1 provides that oil pipelines must file material to support requests for newly established or changed property account depreciation studies. It requires an applicant to file electronically, and the transmittal letter must give a general description of the change in depreciation rates, certify that the transmittal also has been sent to each shipper and to each subscriber, and state if there are no subscribers. The proposed depreciation rates being established must be used until they are either accepted or modified by the Commission. Rates in effect at the time of the proposed revision must continue to be used until the proposed revised rates are approved or modified by the Commission. The oil pipeline must provide information in sufficient detail to fully explain and justify the proposed rates. Modifications, additions, and deletions to data elements should be made to reflect the individual circumstances of the carrier's properties and operations.

Type of Respondent: Oil Pipelines.

Estimate of Annual Burden: [2] The burden related to this collection now includes a new line item, Depreciation Studies, which is currently approved by OMB under the FERC collection FERC–550 (1902–0089), but historically was combined with other requirements outlined in 18 CFR parts 341 through 348. Depreciation studies are required if an oil pipeline seeks to modify the depreciation rates they have in their existing tariffs. Since these filings are submitted only for pipelines seeking modification, and are more rare (<10% of filings) than other reporting requirements such as indexing. Staff is correcting the estimates by adding a new line item specific to depreciation studies. Based on recent experience with this collection, staff estimates that 22 respondents will file a depreciation study each year. By separating depreciation studies from tariff filings, this adjustment will allocate 880 total

[1] 18 CFR parts 341 through 348.

[2] ''Burden'' is the total time, effort, or financial resources expended by persons to generate, maintain, retain, or disclose or provide information to or for a Federal agency. For further explanation of what is included in the information collection burden, refer to 5 CFR 1320.3.

burden hours to the depreciation studies line item now being added.

In another adjustment, the number of hours for Oil Rates and Tariff Filings will decrease from 7.8 hours to 7 hours per respondent due to the hour allocation going to the second line (Depreciation Studies) in the table below. Additionally, since the previous renewal, the number of respondents to Oil Rates and Tariff filings also increased from 219 to 258 based on the number of filings received by the Commission. The overall revised burden estimates result to an increase to 280 (+61) respondents, 796 (+86) responses, and 6,298 hours (+760).

The Commission estimates the annual public reporting burden and cost [3] for the FERC–550 information collection as follows:

FERC–550: OIL PIPELINE RATES—TARIFF FILINGS AND DEPRECIATION STUDIES

	Number of respondents	Annual number of responses per respondent	Total number of responses [4]	Average burden hrs. & cost ($) per response	Total annual burden hours & total annual cost ($)	Cost per respondent ($)
	(1)	(2)	(1) * (2) = (3)	(4)	(3) * (4) = (5)	(5) ÷ (1)
Oil Rates and Tariff Filings.	258	3	774	7 hrs.; $637	5,418 hrs.; $493,038	$1,911
Depreciation [5] Studies.	22	1	22	40 hrs.; $3,640	880 hrs.; $80,080	$3,640
Total	280	.....	796	.....	6,298 hrs.; $573,118	.....

[4] This figure is rounded.

[5] Depreciation Studies previously was included under Oil Rates and Tariff Filings in the OMB inventory under OMB Control No. 1902–0089. However, for a more accurate estimate of burden a new row was added for Depreciation Studies (18 CFR 347.1). This new row will properly account for the differences in burden hours and type of filing with the Oil Rates and Tariff filings (18 CFR parts 341 through 348).

Comments: Comments are invited on: (1) whether the collection of information is necessary for the proper performance of the functions of the Commission, including whether the information will have practical utility; (2) the accuracy of the agency's estimate of the burden and cost of the collection of information, including the validity of the methodology and assumptions used; (3) ways to enhance the quality, utility and clarity of the information collection; and (4) ways to minimize the burden of the collection of information on those who are to respond, including the use of automated collection techniques or other forms of information technology.

Dated: August 31, 2022.

Kimberly D. Bose,

Secretary.

[FR Doc. 2022–19251 Filed 9–6–22; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

Empire District Electric Company; Notice of Waiver Period for Water Quality Certification Application

On August 26, 2022, Empire District Electric Company submitted to the Federal Energy Regulatory Commission (Commission) a copy of its application for a Clean Water Act section 401(a)(1) water quality certification filed with the Missouri Department of Natural Resources (Missouri DNR), in conjunction with the above captioned project. Pursuant to 40 CFR 121.6 and section [4.34(b)(5), 5.23(b), 153.4, or 157.22] of the Commission's regulations,[1] we hereby notify the Missouri DNR of the following:

Date of Receipt of the Certification Request: July 28, 2022

Reasonable Period of Time to Act on the Certification Request: One year (July 28, 2023).

If Missouri DNR fails or refuses to act on the water quality certification request on or before the above date, then the agency certifying authority is deemed waived pursuant to section 401(a)(1) of the Clean Water Act, 33 U.S.C. 1341(a)(1).

Dated: August 31, 2022.

Kimberly D. Bose,

Secretary.

[FR Doc. 2022–19250 Filed 9–6–22; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. RM98–1–000]

Records Governing Off-the-Record Communications

This constitutes notice, in accordance with 18 CFR 385.2201(b), of the receipt of prohibited and exempt off-the-record communications.

Order No. 607 (64 FR 51222, September 22, 1999) requires Commission decisional employees, who make or receive a prohibited or exempt off-the-record communication relevant to the merits of a contested proceeding, to deliver to the Secretary of the Commission, a copy of the communication, if written, or a summary of the substance of any oral communication.

Prohibited communications are included in a public, non-decisional file associated with, but not a part of, the decisional record of the proceeding. Unless the Commission determines that the prohibited communication and any responses thereto should become a part of the decisional record, the prohibited off-the-record communication will not be considered by the Commission in reaching its decision. Parties to a proceeding may seek the opportunity to respond to any facts or contentions made in a prohibited off-the-record

[3] The Commission staff thinks that the hourly cost (for wages and benefits) for industry staff completing the FERC–550 is similar to the cost of FERC employees. FERC staff estimates that industry costs for salary plus benefits are similar to Commission costs. The cost figure is the FY2022 FERC average annual salary plus benefits ($188,992/year or $91/hour).

[1] 18 CFR [4.34(b)(5)/5.23(b)/153.4/157.22].

communication and may request that the Commission place the prohibited communication and responses thereto in the decisional record. The Commission will grant such a request only when it determines that fairness so requires. Any person identified below as having made a prohibited off-the-record communication shall serve the document on all parties listed on the official service list for the applicable proceeding in accordance with Rule 2010, 18 CFR 385.2010.

Exempt off-the-record communications are included in the decisional record of the proceeding, unless the communication was with a cooperating agency as described by 40 CFR 1501.6, made under 18 CFR 385.2201(e)(1)(v).

The following is a list of off-the-record communications recently received by the Secretary of the Commission. The communications listed are grouped by docket numbers in ascending order. These filings are available for electronic review at the Commission in the Public Reference Room or may be viewed on the Commission's website at *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. For assistance, please contact FERC Online Support at *FERCOnlineSupport@ferc.gov* or toll free at (866) 208–3676, or for TTY, contact (202) 502–8659.

Docket Nos.	File date	Presenter or requester
Prohibited:		
1. CP21–57–000	8/26/2022	FERC Staff.[1]
Exempt:		
1. CP16–116–000	8/23/2022	U.S. Congress.[2]
CP16–454–000		
CP16–455–000		

[1] Emailed comments dated 8/25/2022 from Cory Alperstein.
[2] Congressmen Dan Crenshaw and Michael C. Burgess.

Dated: August 31, 2022.

Debbie-Anne A. Reese,

Deputy Secretary.

[FR Doc. 2022–19245 Filed 9–6–22; 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 Pipeline Rate and Refund Report filings:

Filings Instituting Proceedings

Docket Numbers: PR22–59–000.
Applicants: EasTrans, LLC.
Description: § 284.123(g) Rate Filing: EasTrans SOC 6.0.0 to be effective 9/1/2022.
Filed Date: 8/30/22.
Accession Number: 20220830–5055.
Comment Date: 5 p.m. ET 9/20/22.
284.123(g) Protests Due: 5 p.m. ET 10/31/22.

Docket Numbers: PR22–60–000.
Applicants: DCP Guadalupe Pipeline, LLC.
Description: § 284.123(g) Rate Filing: DCP Guadalupe SOC 8.0.0 to be effective 9/1/2022.
Filed Date: 8/30/22.
Accession Number: 20220830–5056.
Comment Date: 5 p.m. ET 9/20/22.
284.123(g) Protests Due: 5 p.m. ET 10/31/22.

Docket Numbers: RP22–1160–000.
Applicants: Northwest Pipeline LLC.
Description: § 4(d) Rate Filing: 2022 Winter Fuel Filing to be effective 10/1/2022.
Filed Date: 8/30/22.
Accession Number: 20220830–5041.
Comment Date: 5 p.m. ET 9/12/22.

Docket Numbers: RP22–1161–000.
Applicants: LA Storage, LLC.
Description: § 4(d) Rate Filing: LA Storage, LLC—Tariff Updates and Houskeeping Revisions to be effective 10/1/2022.
Filed Date: 8/30/22.
Accession Number: 20220830–5060.
Comment Date: 5 p.m. ET 9/12/22.

Docket Numbers: RP22–1162–000.
Applicants: Natural Gas Pipeline Company of America LLC.
Description: § 4(d) Rate Filing: Negotiated Rate Agreement Filing-Mercuria Energy America, LLC to be effective 9/1/2022.
Filed Date: 8/30/22.
Accession Number: 20220830–5084.
Comment Date: 5 p.m. ET 9/12/22

Docket Numbers: RP22–1163–000.
Applicants: Algonquin Gas Transmission, LLC.
Description: § 4(d) Rate Filing: Negotiated Rates—Con Ed to NE 809165 to be effective 9/1/2022.
Filed Date: 8/30/22.
Accession Number: 20220830–5092.
Comment Date: 5 p.m. ET 9/12/22.

Docket Numbers: RP22–1164–000.
Applicants: Texas Eastern Transmission, LP.
Description: § 4(d) Rate Filing: Negotiated Rates—Con Ed to Direct En 8978154 to be effective 9/1/2022.
Filed Date: 8/30/22.
Accession Number: 20220830–5112.
Comment Date: 5 p.m. ET 9/12/22.

Docket Numbers: RP22–1165–000.
Applicants: Adelphia Gateway, LLC.
Description: § 4(d) Rate Filing: Adelphia Non-Conforming and NRA filing August 30, 2022 to be effective 9/1/2022.
Filed Date: 8/30/22.
Accession Number: 20220830–5122.
Comment Date: 5 p.m. ET 9/12/22.

Docket Numbers: RP22–1166–000.
Applicants: Alliance Pipeline L.P.
Description: § 4(d) Rate Filing: Negotiated Rates—Various Sept 1 2022 Releases to be effective 9/1/2022.
Filed Date: 8/31/22.
Accession Number: 20220831–5014.
Comment Date: 5 p.m. ET 9/12/22.

Docket Numbers: RP22–1167–000.
Applicants: Eastern Gas Transmission and Storage, Inc.
Description: § 4(d) Rate Filing: EGTS—August 31, 2022 Negotiated Rate Agreements to be effective 10/1/2022.
Filed Date: 8/31/22.
Accession Number: 20220831–5015.
Comment Date: 5 p.m. ET 9/12/22.

Docket Numbers: RP22–1168–000.
Applicants: Equitrans, L.P.
Description: § 4(d) Rate Filing: Non-Conforming Negotiated Rate Agreements—10/1/2022 to be effective 10/1/2022.
Filed Date: 8/31/22.
Accession Number: 20220831–5016.
Comment Date: 5 p.m. ET 9/12/22.

Docket Numbers: RP22–1169–000.
Applicants: MoGas Pipeline LLC.
Description: § 4(d) Rate Filing: MoGas Pipeline Annual Fuel Tracker Filing to be effective 10/1/2022.
Filed Date: 8/31/22.
Accession Number: 20220831–5017.
Comment Date: 5 p.m. ET 9/12/22.

Docket Numbers: RP22–1170–000.
Applicants: MountainWest Pipeline, LLC.

Description: § 4(d) Rate Filing: PAL1 Contracting Procedures to be effective 10/1/2022.

Filed Date: 8/31/22.

Accession Number: 20220831–5019.

Comment Date: 5 p.m. ET 9/12/22.

Docket Numbers: RP22–1171–000.

Applicants: Florida Gas Transmission Company, LLC.

Description: § 4(d) Rate Filing: Fuel Filing on 8–31–22 to be effective 10/1/2022.

Filed Date: 8/31/22.

Accession Number: 20220831–5024.

Comment Date: 5 p.m. ET 9/12/22.

Docket Numbers: RP22–1173–000.

Applicants: Cove Point LNG, LP.

Description: Compliance filing: Cove Point—2022 Revenue Crediting Report to be effective N/A.

Filed Date: 8/31/22.

Accession Number: 20220831–5027.

Comment Date: 5 p.m. ET 9/12/22.

Docket Numbers: RP22–1174–000.

Applicants: WBI Energy Transmission, Inc.

Description: § 4(d) Rate Filing: Semi-Annual Fuel and Electric Power Adjustment to be effective 10/1/2022.

Filed Date: 8/31/22.

Accession Number: 20220831–5028.

Comment Date: 5 p.m. ET 9/12/22.

Any person desiring to intervene or protest in any of the above proceedings must file in accordance with Rules 211 and 214 of the Commission's Regulations (18 CFR 385.211 and 385.214) 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.

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.

Dated: August 31, 2022.

Debbie-Anne A. Reese,

Deputy Secretary.

[FR Doc. 2022–19246 Filed 9–6–22; 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 electric corporate filings:

Docket Numbers: EC22–115–000.

Applicants: MN8 Energy LLC.

Description: Joint Application for Authorization Under Section 203 of the Federal Power Act of MN8 Energy LLC, et al.

Filed Date: 8/30/22.

Accession Number: 20220830–5151.

Comment Date: 5 p.m. ET 9/20/22.

Take notice that the Commission received the following Complaints and Compliance filings in EL Dockets:

Docket Numbers: EL22–85–000.

Applicants: PJM Interconnection, L.L.C.

Description: ISO/RTO § 206 Filing: Section 206 Filing to Resolve Ambiguous Use of Designated Entity to be effective N/A.

Filed Date: 8/26/22.

Accession Number: 20220826–5142.

Comment Date: 5 p.m. ET 9/15/22.

Docket Numbers: EL22–86–000; QF03–76–004.

Applicants: Boyd, Michael E., Californians for Renewable Energy, Inc. (CARE), Michael E. Boyd, Doug Macmillan, William and Shona Leroy, Carmela and Rigoberto Garnica, and Charles Adams v. California Public Utilities Commission (CPUC).

Description: Californians for Renewable Energy Inc.(CARE), et al. submit Petition for Enforcement Pursuant to Section 210(H) of the Public Utility Regulatory Policies Act of 1978.

Filed Date: 8/26/22.

Accession Number: 20220826–5170.

Comment Date: 5 p.m. ET 9/16/22.

Take notice that the Commission received the following electric rate filings:

Docket Numbers: ER10–1186–013; ER10–1329–013; ER11–2731–006; ER11–3097–014; ER12–421–006; ER13–738–010.

Applicants: DTE Electric Company, Heritage Garden Wind Farm I, LLC, DTE Energy Trading, Inc., Heritage Stoney Corners Wind Farm I, LLC, St. Paul Cogeneration, LLC, DTE Energy Supply, LLC.

Description: Notice of Change in Status of DTE Energy Supply, LLC, et al.

Filed Date: 8/30/22.

Accession Number: 20220830–5150.

Comment Date: 5 p.m. ET 9/20/22.

Docket Numbers: ER10–2437–018.

Applicants: Arizona Public Service Company.

Description: Supplement to July 29, 2022 Notice of Change in Status of Arizona Public Service Company.

Filed Date: 8/30/22.

Accession Number: 20220830–5147.

Comment Date: 5 p.m. ET 9/20/22.

Docket Numbers: ER20–1977–002.

Applicants: Versant Power.

Description: Compliance filing: Offer of Settlement (ER20–1977-) to be effective N/A.

Filed Date: 8/31/22.

Accession Number: 20220831–5095.

Comment Date: 5 p.m. ET 9/21/22.

Docket Numbers: ER22–2747–000.

Applicants: WSPP Inc.

Description: § 205(d) Rate Filing: List of Members Update 2022 to be effective 8/26/2022.

Filed Date: 8/30/22.

Accession Number: 20220830–5120.

Comment Date: 5 p.m. ET 9/20/22.

Docket Numbers: ER22–2748–000.

Applicants: SunZia Transmission LLC.

Description: Petition for Waivers and Blanket Authorization under Section 204 of SunZia Transmission LLC.

Filed Date: 8/30/22.

Accession Number: 20220830–5146.

Comment Date: 5 p.m. ET 9/20/22.

Docket Numbers: ER22–2749–000.

Applicants: Southwest Power Pool, Inc.

Description: § 205(d) Rate Filing: Revisions to Add Surety Bonds as a Form of Financial Security to be effective 11/1/2022.

Filed Date: 8/31/22.

Accession Number: 20220831–5046.

Comment Date: 5 p.m. ET 9/21/22.

Docket Numbers: ER22–2750–000.

Applicants: Basin Electric Power Cooperative.

Description: Initial rate filing: Submission of Service Agreement Nos. 108 and 109 to be effective 8/31/2022.

Filed Date: 8/31/22.

Accession Number: 20220831–5081.

Comment Date: 5 p.m. ET 9/21/22.

Docket Numbers: ER22–2751–000.

Applicants: Mid-Atlantic Interstate Transmission, LLC, PJM Interconnection, L.L.C.

Description: § 205(d) Rate Filing: Mid-Atlantic Interstate Transmission, LLC submits tariff filing per 35.13(a)(2)(iii: MAIT submits Eight ECSAs, SA Nos. 6413–6420 to be effective 10/31/2022.

Filed Date: 8/31/22.

Accession Number: 20220831–5087.

Comment Date: 5 p.m. ET 9/21/22.

Docket Numbers: ER22–2752–000.

Applicants: Mid-Atlantic Interstate Transmission, LLC, PJM Interconnection, L.L.C.

Description: § 205(d) Rate Filing: Mid-Atlantic Interstate Transmission, LLC

submits tariff filing per 35.13(a)(2)(iii: MAIT submits Eight ECSAs, SA Nos. 6483–6488, 6490 and 6491 to be effective 10/31/2022.

Filed Date: 8/31/22.

Accession Number: 20220831–5088.

Comment Date: 5 p.m. ET 9/21/22.

Docket Numbers: ER22–2753–000.

Applicants: NorthWestern Corporation.

Description: § 205(d) Rate Filing: RS No. 329—LGIA between Colstrip Transmission Owners and GB Energy Park LLC to be effective 8/22/2022.

Filed Date: 8/31/22.

Accession Number: 20220831–5121.

Comment Date: 5 p.m. ET 9/21/22.

Docket Numbers: ER22–2754–000.

Applicants: Duke Energy Florida, LLC.

Description: § 205(d) Rate Filing: DEF–SECI Reimbursement Agreement RS No. 354 to be effective 10/31/2022.

Filed Date: 8/31/22.

Accession Number: 20220831–5127.

Comment Date: 5 p.m. ET 9/21/22.

Docket Numbers: ER22–2755–000.

Applicants: PJM Interconnection, L.L.C.

Description: § 205(d) Rate Filing: Original ISA, SA No. 6575-Queue No. AD1–152; Cancellation of IISA, SA No. 6215 to be effective 8/2/2022.

Filed Date: 8/31/22.

Accession Number: 20220831–5132.

Comment Date: 5 p.m. ET 9/21/22.

Docket Numbers: ER22–2756–000.

Applicants: Invenergy Nelson LLC.

Description: Initial rate filing: Filing of Assignment, Co-Tenancy, and Shared Facilities Agreement to be effective 10/31/2022.

Accession Number: 20220831–5136.

Comment Date: 5 p.m. ET 9/21/22.

Docket Numbers: ER22–2757–000.

Applicants: Invenergy Nelson Expansion LLC.

Description: Initial rate filing: Filing of Assignment, Co-Tenancy, and Shared Facilities Agreement to be effective 10/31/2022.

Filed Date: 8/31/22.

Accession Number: 20220831–5137.

Comment Date: 5 p.m. ET 9/21/22.

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 or protest in any of the above proceedings must file in accordance with Rules 211 and 214 of the Commission's Regulations (18 CFR 385.211 and 385.214) 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.

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.

Dated: August 31, 2022.

Debbie-Anne A. Reese,

Deputy Secretary.

[FR Doc. 2022–19247 Filed 9–6–22; 8:45 am]

BILLING CODE 6717–01–P

ENVIRONMENTAL PROTECTION AGENCY

[EPA–HQ–OECA–2017–0640; FRL–10158–01–OECA]

Proposed Information Collection Request; Comment Request; Recordkeeping Requirements for Producers of Pesticides and Pesticide Devices Under 40 CFR Part 169; EPA ICR Number 0143.13, OMB Control Number 2070–0028

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: The Environmental Protection Agency is planning to submit an information collection request (ICR), ''Recordkeeping Requirements for Producers, of Pesticides and Pesticide Devices under 40 CFR part 169'' (EPA ICR No. 0143.13, OMB Control No. 2070–0028) to the Office of Management and Budget (OMB) for review and approval in accordance with the Paperwork Reduction Act. Before doing so, EPA is soliciting public comments on specific aspects of the proposed information collection as described below. This is a proposed extension of the ICR, which is currently approved through November 30, 2022. An Agency 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.

DATES: Comments must be submitted on or before November 7, 2022.

ADDRESSES: Submit your comments, referencing Docket ID No. EPA Docket ID No. EPA–HQ–OECA–2017–0640, online using *www.regulations.gov* (our preferred method), or by mail to: EPA Docket Center, Environmental Protection Agency, Mail Code 28221T, 1200 Pennsylvania Ave. NW, Washington, DC 20460.

EPA's policy is that all comments received will be included in the public docket without change including any personal information provided unless the comment includes profanity, threats, information claimed to be Confidential Business Information (CBI) or other information whose disclosure is restricted by statute.

FOR FURTHER INFORMATION CONTACT: Michelle Yaras, Office of Compliance, Monitoring, Assistance, and Media Programs Division, Pesticides, Waste & Toxics Branch (2227A), Environmental Protection Agency, 1200 Pennsylvania Ave. NW, Washington, DC 20460; telephone number: 202–564–4153; email address: *yaras.michelle@epa.gov.*

SUPPLEMENTARY INFORMATION: Supporting documents which explain in detail the information that the EPA will be collecting are available in the public docket for this ICR. The docket can be viewed online at *www.regulations.gov* or in person at the EPA Docket Center, WJC West, Room 3334, 1301 Constitution Ave. NW, Washington, DC. The telephone number for the Docket Center is 202–566–1744. For additional information about EPA's public docket, visit *http://www.epa.gov/dockets.*

Pursuant to section 3506(c)(2)(A) of the PRA, EPA is soliciting comments and information to enable it to: (i) 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; (ii) 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; (iii) enhance the quality, utility, and clarity of the information to be collected; and (iv) 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. EPA will consider the comments received and amend the ICR as appropriate. The final ICR package will then be submitted to OMB for review and approval. At that time, EPA will issue another **Federal Register** document to announce the submission of the ICR to OMB and the opportunity to submit additional comments to OMB.

Abstract: Producers of pesticides and pesticide devices must maintain certain records with respect to their operations and make such records available for inspection and copying as specified in section 8 of the Federal Insecticide, Fungicide, and Rodenticide Act (FIFRA) and in regulations at 40 CFR part 169.

This information collection is mandatory under 40 CFR part 169. It is used by the Agency to determine compliance with FIFRA. The information is used by EPA Regional pesticide enforcement and compliance staffs, the Office of Enforcement and Compliance Assurance (OECA), and the Office of Pesticide Programs (OPP) within the Office of Chemical Safety and Pollution Prevention (OCSPP), as well as the U.S. Department of Agriculture (USDA), the Food and Drug Administration (FDA), and other Federal agencies, States under Cooperative Enforcement Agreements, and the public. An agency 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.

Form numbers: None.

Respondents/affected entities: Producers of pesticides and pesticide devices for sale or distribution in or exported to the United States.

Respondent's obligation to respond: Mandatory (40 CFR part 169).

Estimated number of respondents: 19,027 (total).

Frequency of response: Annual.

Total estimated burden: 15,078 hours (per year). Burden is defined at 5 CFR 1320.03(b).

Total estimated cost: $372,721 (per year). There are no annualized capital or O&M costs associated with this ICR since all equipment associated with this ICR is present as part of ordinary business practices.

Changes in estimates: There is a decrease of 42,054 hours in the total estimated respondent burden compared with the ICR currently approved by OMB. This decrease of 42,054 hours is a result of our reassessment of the assumptions used to estimate the burden of this ICR. Adjustments resulted from corrections of clerical or computational errors in the previous ICR renewal supporting statement. Further adjustments to the burden estimates resulted from (1) adjustments in the salary computation for industry to reflect current wage scales, (2) adjustments for inflation, and (3) adjustment to the number of respondents.

Elizabeth Vizard,

Acting Director, Office of Compliance/MAMPD.

[FR Doc. 2022–19236 Filed 9–6–22; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[FRL–10152–01–R10]

Proposed Reissuance of NPDES General Permit for Federal Aquaculture Facilities and Aquaculture Facilities Located in Indian Country in Washington (WAG130000)

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice of proposed reissuance of NPDES General Permit and request for public comment.

SUMMARY: The Director of the Water Division, Environmental Protection Agency (EPA) Region 10, proposes to reissue the National Pollutant Discharge Elimination System (NPDES) General Permit for Federal Aquaculture Facilities and Aquaculture Facilities Located in Indian Country in Washington (draft general permit). As proposed, eligible facilities include Concentrated Aquatic Animal Production (CAAP) facilities, non-CAAP facilities, aquaculture research facilities, and dam fish passage facilities. Currently, there are 32 facilities covered under the existing administratively continued general permit. Existing aquaculture facilities may request authorization to discharge under the general permit by submitting a Notice of Intent (NOI) no more than ninety (90) days following the effective date of the draft general permit. New facilities that begin operations after the effective date of the draft general permit must submit a NOI at least 180 days prior to initiation of operations. Upon receipt, EPA will review the NOI to ensure that all permit requirements are met. If determined appropriate by EPA, a discharger will be granted coverage under the general permit upon the date that EPA provides written notification. EPA is accepting public comments on the draft general permit.

DATES: Comments must be received by November 7, 2022.

ADDRESSES: Comments and requests regarding the draft general permit must be submitted to *epar10wd-npdes@epa.gov* with the subject line: Public Comments on WAG130000.

FOR FURTHER INFORMATION CONTACT: Permit documents may be found on the EPA Region 10 website at: *https://www.epa.gov/npdes-permits/npdes-general-permit-federal-aquaculture-facilities-and-aquaculture-facilities-located.*

Copies of the draft general permit and fact sheet are also available upon request. Requests may be made to Audrey Washington at (206) 553–0523. Requests may also be electronically mailed to: *washington.audrey@epa.gov.*

SUPPLEMENTARY INFORMATION: Please see the draft general permit and fact sheet.

Other Legal Requirements

This action is not a significant regulatory action and was therefore not submitted to the Office of Management and Budget (OMB) for review.

In accordance with National Environmental Policy Act (NEPA), an Environmental Assessment (EA) and associated Finding of No Significant Impact (FONSI) for a proposed facility at Cassimer Bar that would be covered under this general permit are available for review and comment along with this general permit.

Compliance with Endangered Species Act, Essential Fish Habitat, Paperwork Reduction Act, and other requirements are discussed in the fact sheet to the proposed permit.

Daniel D. Opalski,

Director, Water Division, Region 10.

[FR Doc. 2022–19261 Filed 9–6–22; 8:45 am]

BILLING CODE 6560–50–P

FEDERAL COMMUNICATIONS COMMISSION

[OMB 3060–0649, OMB 3060–0980, OMB 3060–1065; FR ID 103257]

Information Collections Being Reviewed by the Federal Communications Commission Under Delegated Authority

AGENCY: Federal Communications Commission.

ACTION: Notice and request for comments.

SUMMARY: As part of its continuing effort to reduce paperwork burdens, and as required by the Paperwork Reduction Act of 1995 (PRA), the Federal Communications Commission (FCC or Commission) invites the general public and other Federal agencies to take this opportunity to comment on the following information collection. Comments are requested concerning: whether the proposed collection of information is necessary for the proper performance of the functions of the Commission, including whether the information shall have practical utility; the accuracy of the Commission's burden estimate; ways to enhance the quality, utility, and clarity of the information collected; ways to minimize the burden of the collection of information on the respondents, including the use of automated

collection techniques or other forms of information technology; and ways to further reduce the information collection burden on small business concerns with fewer than 25 employees. The FCC may not conduct or sponsor a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. No person shall be subject to any penalty for failing to comply with a collection of information subject to the PRA that does not display a valid OMB control number.

DATES: Written PRA comments should be submitted on or before November 7, 2022. If you anticipate that you will be submitting comments but find it difficult to do so within the period of time allowed by this notice, you should advise the contact listed below as soon as possible.

ADDRESSES: Direct all PRA comments to Cathy Williams, FCC, via email to *PRA@fcc.gov* and to *Cathy.Williams@fcc.gov.*

FOR FURTHER INFORMATION CONTACT: For additional information about the information collection, contact Cathy Williams at (202) 418–2918.

SUPPLEMENTARY INFORMATION:

OMB Control Number: 3060–0649.

Title: Section 76.1601, Deletion or Repositioning of Broadcast Signals; Section 76.1617, Initial Must-Carry Notice; Section 76.1607, Principal Headend.

Form Number: Not applicable.

Type of Review: Extension of a currently approved collection.

Respondents: Business or other for-profit entities; Not for profit institutions.

Number of Respondents/Responses: 3,300 respondents; 3,950 responses.

Estimated Hours per Response: 0.5 hours–1 hour.

Frequency of Response: On occasion reporting requirement, Third party disclosure requirement.

Total Annual Burden: 2,050 hours.

Total Annual Cost: No cost.

Obligation to Respond: Required to obtain or retain benefits. The statutory authority for this information collection is contained in section 4(i) of the Communications Act of 1934, as amended.

Needs and Uses: The information collection requirements listed below are covered under this information collection are as follows: 47 CFR 76.1601 requires that a cable operator shall provide written notice to any broadcast television station at least 30 days prior to either deleting from carriage or repositioning that station. Such notification shall also be provided to subscribers of the cable system.

47 CFR 76.1607 states that a cable operator shall provide written notice by certified mail to all stations carried on its system pursuant to the must-carry rules at least 60 days prior to any change in the designation of its principal headend.

47 CFR 76.1617(a) states within 60 days of activation of a cable system, a cable operator must notify all qualified Non-Commercial Education (NCE) stations of its designated principal headend by certified mail.

47 CFR 76.1617(b) states within 60 days of activation of a cable system, a cable operator must notify all local commercial and Non-Commercial Education (NCE) stations that may not be entitled to carriage because they either fail to meet the standards for delivery of a good quality signal to the cable system's principal headend, or may cause an increased copyright liability to the cable system.

47 CFR 76.1617(c) states within 60 days of activation of a cable system, a cable operator must send by certified mail a copy of a list of all broadcast television stations carried by its system and their channel positions to all local commercial and noncommercial television stations, including those not designated as must-carry stations and those not carried on the system.

OMB Control Number: 3060–0980.

Title: Implementation of the Satellite Home Viewer Improvement Act of 1999: Local Broadcast Signal Carriage Issues and Retransmission Consent Issues, 47 CFR 76.66.

Form Number: Not applicable.

Type of Review: Extension of a currently approved collection.

Respondents: Business or other for-profit entities.

Number of Respondents and Responses: 3,410 respondents; 4,388 responses.

Estimated Time per Response: 0.5 hour to 5 hours.

Frequency of Response: Third party disclosure requirement; On occasion reporting requirement; Once every three years reporting requirement; Recordkeeping requirement.

Obligation to Respond: Required to obtain or retain benefits. The statutory authority for this collection is contained in 47 U.S.C. 325, 338, 339 and 340.

Total Annual Burden: 3,576 hours.

Total Annual Cost: $24,000.

Needs and Uses: Television broadcast stations and satellite carriers will use the information collected under this collection to determine what stations must be carried by satellite carriers. The Commission will use information collected in order to ensure compliance with its satellite television broadcast carriage rules.

OMB Control Number: 3060–1065.

Title: Section 25.701 of the Commission's Rules, Direct Broadcast Satellite Public Interest Obligations.

Form Number: N/A.

Type of Review: Extension of a currently approved collection.

Respondents: Business or other for-profit entities.

Number of Respondents and Responses: 2 respondents; 2 responses.

Estimated Time per Response: 1–10 hours.

Frequency of Response: Recordkeeping requirement; on occasion reporting requirement; one time reporting requirement; annual reporting requirement; Third party disclosure requirement.

Obligation to Respond: Required to obtain or retain benefits. The statutory authority which covers this information collection is contained in Section 335 of the Communications Act of 1934, as amended.

Total Annual Burden: 49 hours.

Total Annual Cost: No cost.

Needs and Uses: The political broadcasting reporting, recordkeeping requirement, and third-party disclosure requirements in this information collection will be used by the public to assess money expended and time allotted to a political candidate and by the Commission to ensure that equal access is afforded to other qualified candidates. The Commission will use the children's programming recordkeeping burden to verify compliance with the commercial limits established in 47 CFR 25.701(e), and by the public to assess the DBS provider's compliance with the commercial limits. The carriage election contact information will be used by broadcasters to notify DBS providers when their carriage election changes from retransmission consent to must carry, or vice versa.

Federal Communications Commission.

Katura Jackson,

Federal Register Liaison Officer.

[FR Doc. 2022–19224 Filed 9–6–22; 8:45 am]

BILLING CODE 6712–01–P

FEDERAL COMMUNICATIONS COMMISSION

[OMB 3060–0316, OMB 3060–0360, OMB 3060–0653, OMB 3060–0750 and OMB 3060–0754; FR ID 103153]

Information Collections Being Submitted for Review and Approval to Office of Management and Budget

AGENCY: Federal Communications Commission.

ACTION: Notice and request for comments.

SUMMARY: As part of its continuing effort to reduce paperwork burdens, as required by the Paperwork Reduction Act (PRA) of 1995, the Federal Communications Commission (FCC or the Commission) invites the general public and other Federal Agencies to take this opportunity to comment on the following information collection. Pursuant to the Small Business Paperwork Relief Act of 2002, the FCC seeks specific comment on how it can further reduce the information collection burden for small business concerns with fewer than 25 employees.

DATES: Written comments and recommendations for the proposed information collection should be submitted on or before October 7, 2022.

ADDRESSES: Comments should be sent 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. Your comment must be submitted into *www.reginfo.gov* per the above instructions for it to be considered. In addition to submitting in *www.reginfo.gov* also send a copy of your comment on the proposed information collection to Cathy Williams, FCC, via email to *PRA@fcc.gov* and to *Cathy.Williams@fcc.gov.* Include in the comments the OMB control number as shown in the **SUPPLEMENTARY INFORMATION** below.

FOR FURTHER INFORMATION CONTACT: For additional information or copies of the information collection, contact Cathy Williams at (202) 418–2918. To view a copy of this information collection request (ICR) submitted to OMB: (1) go to the web page *http://www.reginfo.gov/public/do/PRAMain,* (2) look for the section of the web page called ''Currently Under Review,'' (3) click on the downward-pointing arrow in the ''Select Agency'' box below the ''Currently Under Review'' heading, (4) select ''Federal Communications Commission'' from the list of agencies presented in the ''Select Agency'' box, (5) click the ''Submit'' button to the right of the ''Select Agency'' box, (6) when the list of FCC ICRs currently under review appears, look for the Title of this ICR and then click on the ICR Reference Number. A copy of the FCC submission to OMB will be displayed.

SUPPLEMENTARY INFORMATION: The Commission may not conduct or sponsor a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. No person shall be subject to any penalty for failing to comply with a collection of information subject to the PRA that does not display a valid OMB control number.

As part of its continuing effort to reduce paperwork burdens, as required by the Paperwork Reduction Act (PRA) of 1995 (44 U.S.C. 3501–3520), the FCC invited the general public and other Federal Agencies to take this opportunity to comment on the following information collection. Comments are requested concerning: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the Commission, including whether the information shall have practical utility; (b) the accuracy of the Commission's burden estimates; (c) ways to enhance the quality, utility, and clarity of the information collected; and (d) ways to minimize the burden of the collection of information on the respondents, including the use of automated collection techniques or other forms of information technology. Pursuant to the Small Business Paperwork Relief Act of 2002, Public Law 107–198, see 44 U.S.C. 3506(c)(4), the FCC seeks specific comment on how it might ''further reduce the information collection burden for small business concerns with fewer than 25 employees.''

OMB Control Number: 3060–0316.

Title: 47 CFR 76.5, Definitions, 76.1700, Records to Be Maintained Locally by Cable System Operators; 76.1702, Equal Employment Opportunity; 76.1703, Commercial Records on Children's Programs; 76.1707, Leased Access; 76.1711, Emergency Alert System (EAS) Tests and Activation.

Form Number: N/A.

Type of Review: Extension of a currently approved collection.

Respondents: Business or other for-profit entities.

Number of Respondents and Responses: 3,000 respondents; 3,000 responses.

Estimated Time per Response: 14 hours.

Frequency of Response: Recordkeeping requirements.

Obligation to Respond: Required to obtain or retain benefits. The statutory authority for this information collection is contained in sections 151, 152, 153, 154, 301, 302, 302a, 303, 303a, 307, 308, 309, 312, 315, 317, 325, 339, 340, 341, 503, 521, 522, 531, 532, 534, 535, 536, 537, 543, 544, 544a, 545, 548, 549, 552, 554, 556, 558, 560, 561, 571, 572, 573 of the Communications Act of 1934, as amended.

Total Annual Burden: 42,000 hours.

Total Annual Cost: None.

Needs and Uses: The Commission is seeking Office of Management and Budget (OMB) approval for the extension of a currently approved collection. The information collection requirements for this information collection are as follows: 47 CFR 76.1700 requires cable system operators to place the public inspection file materials required to be retained by the following rules in the online public file hosted by the Commission, with the exception of existing political file material which cable systems may continue to retain in their local public file until the end of the retention period: Sections 76.1701 (political file), 76.1702 (EEO), 76.1703 (commercial records for children's programming), 76.1705 (performance tests—channels delivered); 76.1707 (leased access); and 76.1709 (availability of signals), 76.1710 (operator interests in video programming), 76.1715 (sponsorship identification), and 76.630 (compatibility with consumer electronics equipment. Cable systems with fewer than 5,000 subscribers may continue to retain their political file locally and are not required to upload new political file material to the online public file until March 1, 2018. In addition, cable systems may elect to retain the material required by Section 76.1708 (principal headend) locally rather than placing this material in the online public file.

47 CFR 76.1700(b) requires cable system operators to make the records required to be retained by the following rules available to local franchising authorities: Sections 76.1704 (proof-of-performance test data) and 76.1713 (complaint resolution).

47 CFR 76.1700(c) requires cable system operators to make the records required to be retained by the following rules available to the Commission: Sections 76.1704 (proof-of-performance test data), 76.1706 (signal leakage logs and repair records), 76.1711 (emergency alert system and activations), 76.1713 (complaint resolution), and 76.1716 (subscriber records).

47 CFR 76.1700(d) exempts cable television systems having fewer than 1,000 subscribers from the online public file and the public inspection requirements contained in 47 CFR 76.1701 (political file); 76.1702 (equal employment opportunity); 76.1703 (commercial records for children's programming); 76.1704 (proof-of-performance test data); 76.1706 (signal leakage logs and repair records); and 76.1715 (sponsorship identifications).

47 CFR 76.1700(e) requires that public file material that continues to be

retained at the system be retained in a public inspection file maintained at the office which the system operator maintains for the ordinary collection of subscriber charges, resolution of subscriber complaints, and other business or at any accessible place in the community served by the system unit(s) (such as a public registry for documents or an attorney's office). Public files must be available for public inspection during regular business hours.

47 CFR 76.1700(f) requires cable systems to provide a link to the public inspection file hosted on the Commission's website from the home page of its own website, if the system has a website, and provide contact information on its website for a system representative who can assist any person with disabilities with issues related to the content of the public files. A system also is required to include in the online public file the address of the system's local public file, if the system retains documents in the local file that are not available in the Commission's online file, and the name, phone number, and email address of the system's designated contact for questions about the public file. In addition, a system must provide on the online public file a list of the five digit ZIP codes served by the system.

47 CFR 76.1700(g) requires that cable operators make any material in the public inspection file that is not also available in the Commission's online file available for machine reproduction upon request made in person, provided the requesting party shall pay the reasonable cost of reproduction. Requests for machine copies must be fulfilled at a location specified by the system operator, within a reasonable period of time, which in no event shall be longer than seven days. The system operator is not required to honor requests made by mail but may do so if it chooses.

47 CFR 76.1702(a) requires that every employment unit with six or more full-time employees shall maintain for public inspection a file containing copies of all EEO program annual reports filed with the Commission and the equal employment opportunity program information described in 47 CFR 76.1702(b). These materials shall be placed in the Commission's online public inspection file for each cable system associated with the employment unit. These materials must be placed in the Commission's online public inspection file annually by the date that the unit's EEO program annual report is due to be filed and shall be retained for a period of five years. A headquarters employment unit file and a file containing a consolidated set of all documents pertaining to the other employment units of a multichannel video programming distributor that operates multiple units shall be maintained in the Commission's online public file for every cable system associated with the headquarters employment unit.

47 CFR 76.1702(b) requires that the following equal employment opportunity program information shall be included annually in the unit's public file, and on the unit's website, if it has one, at the time of the filing of its FCC Form 396–C: (1) A list of all full-time vacancies filled by the multichannel video programming distributor employment unit during the preceding year, identified by job title; (2) For each such vacancy, the recruitment source(s) utilized to fill the vacancy (including, if applicable, organizations entitled to notification, which should be separately identified), identified by name, address, contact person and telephone number; (3) The recruitment source that referred the hiree for each full-time vacancy during the preceding year; (4) Data reflecting the total number of persons interviewed for full-time vacancies during the preceding year and the total number of interviewees referred by each recruitment source utilized in connection with such vacancies; and (5) A list and brief description of the initiatives undertaken during the preceding year, if applicable.

47 CFR 76.1703 requires that cable operations airing children's programming must maintain records sufficient to verify compliance with 47 CFR 76.225 and make such records available to the public. Such records must be maintained for a period sufficient to cover the limitation period specified in 47 U.S.C. 503(b)(6)(B). Cable television operators must file their certifications of compliance with the commercial limits in children's programming annually within 30 days after the end of the calendar year.

47 CFR 76.1707 requires that if a cable operator adopts and enforces a written policy regarding indecent leased access programming pursuant to § 76.701, such a policy will be considered published pursuant to that rule by inclusion of the written policy in the operator's public inspection file.

47 CFR 76.1711 requires that records be kept of each test and activation of the Emergency Alert System (EAS) procedures pursuant to the requirement of 47 CFR part 11 and the EAS Operating Handbook. These records shall be kept for three years.

47 CFR 76.5 describes certain terms covered in the cable industry.

OMB Control No.: 3060–0360.

Title: Section 80.409, Station Logs (Maritime Services).

Form No.: N/A.

Type of Review: Extension of a currently approved collection.

Respondents: Business or other for-profit entities, not-for-profit institutions, and state, local and tribal government.

Number of Respondents: 19,919 respondents; 19,919 responses.

Estimated Time per Response: 27.3–95 hours.

Frequency of Response: Recordkeeping requirement.

Obligation to Respond: Required to obtain or retain benefits. The statutory authority for this collection is contained in 47 U.S.C. 151–155, 301–609.

Total Annual Burden: 559,901 hours.

Annual Cost Burden: No cost.

Needs and Uses: The Commission will submit this extension (no change in the recordkeeping requirement) to the OMB after this 60-day comment period to obtain the full three-year clearance from them. The information collection requirements are as follows:

Section 80.409(c), Public Coast Station Logs: This requirement is necessary to document the operation and public correspondence of public coast radio telegraph, public coast radiotelephone stations, and Alaska public-fixed stations, including the logging of distress and safety calls where applicable. Entries must be made giving details of all work performed which may affect the proper operation of the station. Logs must be retained by the licensee for a period of two years from the date of entry, and, where applicable, for such additional periods such as logs relating to a distress situation or disaster must be retained for three years from the date of entry in the log. If the Commission has notified the licensee of an investigation, the related logs must be retained until the licensee is specifically authorized in writing to destroy them. Logs relating to any claim or complaint of which the station licensee has notice must be retained until the claim or complaint has been satisfied or barred by statute limiting the time for filing suits upon such claims.

Section 80.409(d), Ship Radiotelegraph Logs: Logs of ship stations which are compulsorily equipped for radiotelegraphy and operating in the band 90 to 535 kHz must contain specific information in log entries according to this subsection.

Section 80.409(e), Ship Radiotelephone Logs: Logs of ship stations which are compulsorily equipped for radiotelephony must

contain specific information in applicable log entries and the time of their occurrence.

The recordkeeping requirements contained in section 80.409 is necessary to document the operation and public correspondence service of public coast radiotelegraph, public coast radiotelephone stations and Alaska-public fixed stations, ship radiotelegraph, ship radiotelephone and applicable radiotelephone including the logging of distress and safety calls where applicable.

OMB Control Number: 3060–0653.

Title: Sections 64.703(b) and (c), Consumer Information—Posting by Aggregators.

Form No.: N/A.

Type of Review: Extension of a currently approved collection.

Respondents: Business or other for-profit entities.

Number of Respondents: 56,075 respondents; 5,339,038 responses.

Estimated Time per Response: .017 hours (1 minute) to 3 hours.

Frequency of Response: On occasion reporting requirements; Third party disclosure.

Obligation to Respond: Required to obtain or retain benefits. The statutory authority for this information collection is found at section 226 [47 U.S.C. 226] Telephone Operator Services codified at 47 CFR 64.703(b) Consumer Information.

Total Annual Burden: 174,401 hours.

Total Annual Cost: $1,558,212.

Needs and Uses: The information collection requirements included under this OMB Control Number 3060–0653, requires aggregators (providers of telephones to the public or to transient users of their premises) under 47 U.S.C. 226(c)(1)(A), 47 CFR 64.703(b) of the Commission's rules, to post in writing, on or near such phones, information about the pre-subscribed operator services, rates, carrier access, and the FCC address to which consumers may direct complaints.

Section 64.703(c) of the Commission's rules requires the posted consumer information to be added when an aggregator has changed the pre-subscribed operator service provider (OSP) no later than 30 days following such change. Consumers will use this information to determine whether they wish to use the services of the identified OSP.

OMB Control Number: 3060–0750.

Title: 47 CFR 73.671, Educational and Informational Programming for Children; 47 CFR 73.673, Public Information Initiatives Regarding Educational and informational Programming for Children.

Form Number: N/A.

Type of Review: Extension of a currently approved collection.

Respondents: Business or other for-profit entities.

Number of Respondents and Responses: 1,756 respondents; 1,116,816 responses.

Estimated Time per Response: 0.017–0.084 hours.

Frequency of Response: Third-party disclosure requirements.

Obligation to Respond: Required to obtain or retain benefits. The statutory authority for this collection is contained in Sections 154(i), 303, and 336 of the Communications Act of 1934, as amended.

Total Annual Burden: 57,105 hours.

Total Annual Cost: None.

Needs and Uses: The Commission is seeking Office of Management and Budget (OMB) approval for the extension of a currently approved collection. The information collection requirements for this information collection are as follows:

Pursuant to 47 CFR 73.671(c)(5), each commercial television broadcast station must identify programming as specifically designed to educate and inform children by the display on the television screen throughout the program of the symbol E/I. This requirement is intended to assist parents in identifying educational and informational programming for their children. Noncommercial television broadcast stations are no longer required to identify Core Programming by displaying the E/I symbol throughout the program.

Pursuant to 47 CFR 73.671(e), each television broadcast station that preempts an episode of a regularly scheduled weekly Core Program on its primary stream will be permitted to count the episode toward the Core Programming processing guidelines if it reschedules the episode on its primary stream in accordance with the requirements of 47 CFR 73.671(e). Similarly, each television broadcast station that preempts an episode of a regularly scheduled weekly Core Program on a multicast stream will be permitted to count the episode toward the Core Programming processing guidelines if it reschedules the episode on the multicast stream in accordance with the requirements of 47 CFR 73.671(e). Among other requirements, the station must make an on-air notification of the schedule change during the same time slot as the preempted episode. The on-air notification must include the alternate date and time when the program will air.

Pursuant to 47 CFR 73.673, each commercial television broadcast station licensee must provide information identifying programming specifically designed to educate and inform children to publishers of program guides. This requirement is intended to improve the information available to parents regarding programming specifically designed for children's educational and informational needs. Commercial television broadcast station licensees are no longer required to provide program guide publishers an indication of the age group for which the programming is intended.

OMB Control Number: 3060–0754.

Title: FCC Form 2100, Application for Media Bureau Audio and Video Service Authorization, Schedule H.

Form Number: FCC Form 2100, Schedule H.

Type of Review: Extension of a currently approved collection.

Respondents: Business or other for profit entities.

Number of Respondents: 1,756 respondents; 1,756 responses.

Estimated Time per Response: 10 hours.

Frequency of Response: Recordkeeping requirement: Annual reporting requirement.

Obligation to Respond: Required to obtain or retain benefits. Statutory authority for this collection of information is contained in Sections 154(i) and 303 of the Communications Act of 1934, as amended.

Total Annual Burden: 17,560 hours.

Total Annual Cost: $1,053,600.

Needs and Uses: The Commission is seeking Office of Management and Budget (OMB) approval for the extension of a currently approved collection. Commercial full-power and Class A television broadcast stations are required to file FCC Form 2100, Schedule H (formerly FCC Form 398) (Children's Television Programming Report) within 30 days after the end of each calendar year. FCC Form 2100, Schedule H is a standardized form that: (a) Provides a consistent format for reporting the children's educational television programming aired by licensees to meet their obligation under the Children's Television Act of 1990 (CTA), and (b) facilitates efforts by the public and the FCC to monitor compliance with the CTA.

Commercial full-power and Class A television stations are required to complete FCC Form 2100, Schedule H within 30 days after the end of each calendar year and file the form with the Commission. The Commission places the form in the station's online public inspection file maintained on the

Commission's database (*www.fcc.gov*). Stations use FCC Form 2100, Schedule H to report, among other things, the Core Programming (*i.e.,* children's educational and informational programming) the station aired the previous calendar year. FCC Form 2100, Schedule H also includes a ''Preemption Report'' that must be completed for each Core Program that was preempted during the year. This ''Preemption Report'' requests information on the reason for the preemption, the date of each preemption, the reason for the preemption and, if the program was rescheduled, the date and time the program was re-aired.

Federal Communications Commission.

Katura Jackson,

Federal Register Liaison Officer.

[FR Doc. 2022–19223 Filed 9–6–22; 8:45 am]

BILLING CODE 6712–01–P

GENERAL SERVICES ADMINISTRATION

[Notice-MRB–2022–03; Docket No. 2022–02; Sequence No. 20]

GSA Acquisition Policy Federal Advisory Committee; Notification of Upcoming Web-Based Public Meeting

AGENCY: Office of Government-wide Policy, General Services Administration (GSA).

ACTION: Notice.

SUMMARY: GSA is providing notice of the first meeting of the GSA Acquisition Policy Federal Advisory Committee (hereinafter ''the Committee'' or ''the GAP FAC'') in accordance with the requirements of the Federal Advisory Committee Act. This meeting will be open to the public. Information on attending and providing written public comment is under the **SUPPLEMENTARY INFORMATION** section.

DATES: The GSA Acquisition Policy Federal Advisory Committee will hold a web-based open public meeting on September 22, 2022, from 1 p.m. to 4 p.m. Eastern Daylight Time (EDT).

ADDRESSES: The meeting will be accessible via webcast. Registrants will receive the webcast information before the meeting.

FOR FURTHER INFORMATION CONTACT: Boris Arratia, Designated Federal Officer, Office of Government-wide Policy, 703–795–0816, or email: *boris.arratia@gsa.gov*; or Stephanie Hardison, Office of Government-wide Policy, 202–258–6823, or email: *stephanie.hardison@gsa.gov*. Additional *information about* 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 Administrator of GSA established the GSA Acquisition Policy Federal Advisory Committee) as a discretionary advisory committee under agency authority in accordance with the provisions of the Federal Advisory Committee Act (FACA), as amended (5 U.S.C. App 2).

As America's buyer, GSA is uniquely positioned to enable a modern, accessible, and streamlined acquisition ecosystem and a robust marketplace connecting buyers to the suppliers and businesses that meet their mission needs. The GAP FAC will assist GSA in this endeavor through expert advice on a broad range of innovative solutions to acquisition policy, workforce, and industry partnership challenges.

The GAP FAC will serve as an advisory body to GSA's Administrator on how GSA can use its acquisition tools and authorities to target the highest priority Federal acquisition challenges. The GAP FAC will advise GSA's Administrator on emerging acquisition issues, challenges, and opportunities to support its role as America's buyer.

The initial focus for the GAP FAC will be on driving regulatory, policy, and process changes required to embed climate and sustainability considerations in Federal acquisition. This includes examining and recommending steps GSA can take to support its workforce and industry partners in ensuring climate and sustainability issues are fully considered in the acquisition process.

Purpose of the Meeting

The purpose of this meeting is to provide introductions, discuss the Committee charge, and begin the Committee's work.

Meeting Agenda

- Opening remarks
- GAP FAC Member Introductions
- GAP FAC Charter, Purpose & Goals
- Subcommittee Establishment Discussion
- Summary and Next Steps
- Closing Remarks and Adjourn

Meeting Registration

The meeting is open to the public. The meeting will be accessible by webcast. Registration is required for web viewing. To register, go to: *https://www.eventbrite.com/e/412111505607* Online registration closes at 5:00 p.m. EDT September 21, 2022. All registrants will be asked to provide their name, affiliation, phone number, and email address. After registration, individuals will receive webcast access information via email.

Public Comment

Written public comments are being accepted throughout the life of the Committee. Written comments can be sent to *gapfac@gsa.gov*. For comments specific to this public meeting, submit the comment via email by September 21, 2022 with the meeting date in the subject line. Comments submitted after this date will still be provided to the Committee members, but please be advised that Committee members may not have adequate time to consider the comments prior to the meeting.

Special Accommodations

For information on services for individuals with disabilities, or to request accommodation of a disability, please contact the Designated Federal Officer at least 10 business days prior to the meeting to give GSA as much time as possible to process the request. Closed captioning and live ASL interpreter services will be available.

Krystal Brumfield,

Associate Administrator, Office of Government-wide Policy, General Services Administration.

[FR Doc. 2022–19330 Filed 9–6–22; 8:45 am]

BILLING CODE 6820–61–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Meeting of the Community Preventive Services Task Force (CPSTF)

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

ACTION: Notice of meeting.

SUMMARY: The Centers for Disease Control and Prevention (CDC) within the Department of Health and Human Services (HHS) announces the next meeting of the Community Preventive Services Task Force (CPSTF) on October 19–20, 2022.

DATES: The meeting will be held on Wednesday, October 19, 2022, from 10:00 a.m. to 6:00 p.m. EDT, and Thursday, October 20, 2022, from 10:00 a.m. to 6:00 p.m. EDT.

ADDRESSES: The meeting will be available to the public via web conference.

FOR FURTHER INFORMATION CONTACT: Arielle Arnold, Office of the Associate Director for Policy and Strategy; Centers for Disease Control and Prevention, 1600 Clifton Road NE, MS H21–10, Atlanta, GA 30329. Telephone: (404)498–4512; Email: *CPSTF@cdc.gov*.

SUPPLEMENTARY INFORMATION:

Meeting Accessibility: The Community Preventive Services Task Force (CPSTF) meeting will be shown via web conference. CDC will send web conference information to registrants upon receipt of their registration. All meeting attendees must register by October 12, 2022 to receive the web conference information for meeting. CDC will email web conference information from the *CPSTF@cdc.gov* mailbox.

To register for the meeting, individuals should send an email to *CPSTF@cdc.gov* and include the following information: name, title, organization name, organization address, phone, and email.

Public Comment: Individuals who would like to make public comments during the October meeting must state their desire to do so with their registration and provide their name and organizational affiliation and the topic to be addressed (if known). The requestor will receive instructions for the public comment process for this meeting after the request is received. A public comment period follows the CPSTF's discussion of each systematic review and will be limited, up to three minutes per person. Public comments will become part of the meeting summary.

Background on the CPSTF: The CPSTF is an independent, nonfederal panel whose members are appointed by the CDC Director. CPSTF members represent a broad range of research, practice, and policy expertise in prevention, wellness, health promotion, and public health. The CPSTF was convened in 1996 by HHS to identify community preventive programs, services, and policies that increase health, longevity, save lives and dollars, and improve Americans' quality of life. CDC is mandated to provide ongoing administrative, research, and technical support for the operations of the CPSTF. During its meetings, the CPSTF considers the findings of systematic reviews of existing research and practice-based evidence and issues recommendations. CPSTF recommendations are not mandates for compliance or spending. Instead, they provide information about evidence-based options that decision makers and affected community members can consider when they are determining what best meets the specific needs, preferences, available resources, and constraints of their jurisdictions and constituents. The CPSTF's recommendations, along with the systematic reviews of the evidence on which they are based, are compiled on the Community Guide website (*www.thecommunityguide.org*).

Matters proposed for discussion: The agenda will consist of deliberation on systematic reviews of literature and is open to the public. Topics will include Mental Health; Nutrition, Physical Activity, and Obesity; Social Determinants of Health; and Substance Use. Information regarding the start and end times for each day, and any updates to agenda topics, will be available on the Community Guide website (*www.thecommunityguide.org*) closer to the date of the meeting.

The meeting agenda is subject to change without notice.

Angela K. Oliver,

Executive Secretary, Centers for Disease Control and Prevention.

[FR Doc. 2022–19215 Filed 9–6–22; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day–22–1283; Docket No. CDC–2022–0102]

Proposed Data Collection Submitted for Public Comment and Recommendations

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

ACTION: Notice with comment period.

SUMMARY: The Centers for Disease Control and Prevention (CDC), as part of its continuing effort to reduce public burden and maximize the utility of government information, invites the general public and other federal agencies the opportunity to comment on a continuing information collection, as required by the Paperwork Reduction Act of 1995. This notice invites comment on a proposed information collection project titled Monitoring and Reporting for the Overdose Data to Action (OD2A) Co-Operative Agreement. Information will be collected to provide data to CDC for program monitoring and budget tracking, to improve timely CDC-recipient communications, and to inform technical assistance and guidance documents produced by CDC to support program implementation among funded jurisdictions.

DATES: CDC must receive written comments on or before November 7, 2022.

ADDRESSES: You may submit comments, identified by Docket No. CDC–2022–0102 by either of the following methods:

- *Federal eRulemaking Portal: www.regulations.gov*. Follow the instructions for submitting comments.
- *Mail:* Jeffrey M. Zirger, Information Collection Review Office, Centers for Disease Control and Prevention, 1600 Clifton Road, NE, MS H21–8, Atlanta, Georgia 30329.

Instructions: All submissions received must include the agency name and Docket Number. CDC will post, without change, all relevant comments to *www.regulations.gov*.

Please note: Submit all comments through the Federal eRulemaking portal (*www.regulations.gov*) or by U.S. mail to the address listed above.

FOR FURTHER INFORMATION CONTACT: To request more information on the proposed project or to obtain a copy of the information collection plan and instruments, contact Jeffrey M. Zirger, Information Collection Review Office, Centers for Disease Control and Prevention, 1600 Clifton Road NE, MS H21–8, Atlanta, Georgia 30329; Telephone: 404–639–7570; Email: *omb@cdc.gov*.

SUPPLEMENTARY INFORMATION: Under the Paperwork Reduction Act of 1995 (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. In addition, the PRA also requires federal agencies to provide a 60-day notice in the **Federal Register** concerning each proposed collection of information, including each new proposed collection, each proposed extension of existing collection of information, and each reinstatement of previously approved information collection before submitting the collection to the OMB for approval. To comply with this requirement, we are publishing this notice of a proposed data collection as described below.

The OMB is particularly interested in comments that will help:

1. 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;

2. 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;

3. Enhance the quality, utility, and clarity of the information to be collected;

4. 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 submissions of responses; and

5. Assess information collection costs.

Proposed Project

Monitoring and Reporting for the Overdose Data to Action (OD2A) Co-Operative Agreement (OMB Control No. 0920–1283, Exp. 1/31/2023)—Revision—National Center for Injury Prevention and Control (NCIPC), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

The Centers for Disease Control and Prevention (CDC) National Center for Injury Prevention and Control (NCIPC) seeks OMB approval for the Revision of this previously approved Information Collection Request (ICR) (OMB Control No. 0920–1283, Exp. 1/31/2023) to continue collecting information from jurisdictions funded under the Overdose Data to Action (OD2A) funding opportunity.

Drug overdose deaths in the United States increased by 18% per year from 2014 to 2016. Opioid overdose deaths have increased fivefold from 1999 to 2016 and in 2017, there were more than 47,000 deaths attributed to opioids. While the opioid overdose epidemic worsens in scope and magnitude, it is also becoming more complex. The complex and changing nature of the opioid overdose epidemic highlights the need for an interdisciplinary, comprehensive, and cohesive public health approach.

The purpose of the OD2A is to support funded jurisdictions in obtaining high quality, complete, and timelier data on opioid prescribing and overdoses, and to use those data to inform prevention and response efforts. The intent is to ensure that funded jurisdictions are well equipped to do rigorous work under both components, and to ensure that these components are linked and implemented as part of a system. This Revision request is also intended to initiate collection of new information from jurisdictions (which include states and Washington, DC) funded under the OD2A in States, as well as to collect new information from jurisdictions (which include U.S. Territories, cities, and counties) funded under the OD2A Limiting Overdose through Collaborative Actions in Localities.

This information is being collected to provide crucial data to CDC for program monitoring and budget tracking, to improve timely CDC-recipient communications, and to inform technical assistance and guidance documents produced by CDC to support program implementation among funded jurisdictions. Ultimately, the information feedback loop created by these information collection tools is designed to help jurisdictions decrease fatal and nonfatal overdoses. It will also provide CDC with the capacity to respond in a timely manner to requests for information about the program from the Department of Health and Human Services (HHS), the White House, Congress, and other sources.

CDC requests OMB approval for an estimated 1,075 annual burden hours. There are no costs to respondents other than their time to participate.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondent	Form name	Number of respondents	Total number of responses per respondent	Average burden per response (in hours)	Total burden hours (in hours)
OD2A-funded state, territory, county, and city health departments.	OD2A Evaluation and Performance Measuring Plan Template.	22	1	4	88
	OD2A Organizational Capacity Assessment Tool.	22	1	1	22
	OD2A Activity Progress Report and Work Plan.	22	1	2	44
OD2A–S-funded state and District of Columbia health departments.	OD2A–S Activity Progress Report and Work Plan—Initial population.	51	1	11	561
OD2A–LOCAL-funded territory, county, and city health departments.	OD2A–LOCAL Activity Progress Report and Work Plan.	40	1	9	360
Total					1,075

Jeffrey M. Zirger,

Lead, Information Collection Review Office, Office of Scientific Integrity, Office of Science, Centers for Disease Control and Prevention.

[FR Doc. 2022–19216 Filed 9–6–22; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifiers: CMS–10824, CMS–R–131 and CMS–10556]

Agency Information Collection Activities: Proposed Collection; Comment Request

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

ACTION: Notice.

SUMMARY: The Centers for Medicare & Medicaid Services (CMS) is announcing an opportunity for the public to comment on CMS' intention to collect information from the public. Under the Paperwork Reduction Act of 1995 (the PRA), federal agencies are required to publish notice in the **Federal Register** concerning each proposed collection of information (including each proposed extension or reinstatement of an existing collection of information) and to allow 60 days for public comment on the proposed action. Interested persons are invited to send comments regarding our burden estimates or any other aspect of this collection of information, including the necessity and utility of the proposed information collection for the proper performance of the agency's functions, the accuracy of the estimated burden, ways to enhance the quality, utility, and clarity of the information to be collected, and the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

DATES: Comments must be received by November 7, 2022.

ADDRESSES: When commenting, please reference the document identifier or OMB control number. To be assured consideration, comments and recommendations must be submitted in any one of the following ways:

1. *Electronically.* You may send your comments electronically to *http://www.regulations.gov.* Follow the instructions for ''Comment or Submission'' or ''More Search Options'' to find the information collection document(s) that are accepting comments.

2. *By regular mail.* You may mail written comments to the following address: CMS, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development, Attention: Document Identifier/OMB Control Number: _____, Room C4–26–05, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

To obtain copies of a supporting statement and any related forms for the proposed collection(s) summarized in this notice, you may make your request using one of following:

1. Access CMS' website address at website address at *https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing.*

FOR FURTHER INFORMATION CONTACT: William N. Parham at (410) 786–4669.

SUPPLEMENTARY INFORMATION:

Contents

This notice sets out a summary of the use and burden associated with the following information collections. More detailed information can be found in each collection's supporting statement and associated materials (see **ADDRESSES**).

CMS–10824 Annual Notice of Chance and Evidence of Coverage for Applicable Integrated Plans in States that Require Integrated Materials

CMS–R–131 Advance Beneficiary Notice of Noncoverage (ABN)

CMS–10556 Medical Necessity and Contract Amendments Under Mental Health Parity

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. The term ''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 requires federal agencies to publish a 60-day notice in the **Federal Register** concerning each proposed collection of information, including each proposed extension or reinstatement of an existing collection of information, before submitting the collection to OMB for approval. To comply with this requirement, CMS is publishing this notice.

Information Collection

1. *Type of Information Collection Request:* Revision of a previously approved collection; *Title of Information Collection:* Annual Notice of Change and Evidence of Coverage for Applicable Integrated Plans in States that Require Integrated Materials; *Use:* CMS requires AIPs to use the approved standardized documents to ensure that correct information is disclosed to current and potential enrollees. Additionally, CMS requires AIPs to submit the completed ANOC and EOC documents to CMS. CMS stores the completed templates. New and current enrollees can review the ANOC and EOC upon receipt to find plan benefits, premiums and cost sharing for the coming year to be in a better position to make informed and educated plan selections. CMS does not require new and current enrollees to review the documents or use them in any way.

MA organizations with AIPs in States that require these integrated documents upload ANOC and EOC documents into the Health Plan Management System (HPMS) to ensure accuracy and regulatory compliance. Section 422.111(h)(2)(ii) requires that, the ANOC/EOC be available on the website and 422.111(d)(2) requires that the plan send the ANOC to the enrollee in hard copy format, upon request. Section 423.128(d)(2) requires that Part D sponsors post the ANOC and EOC documents on their website and send the ANOC only to enrollees electronically or in hard copy. *Form Number:* CMS–10824 (OMB control number: 0938–New); *Frequency:* Annually; *Affected Public:* Private Sector; Businesses or other for-profits; *Number of Respondents:* 47; *Total Annual Responses:* 47; *Total Annual Hours:* 564. (For policy questions regarding this collection contact Julie Jones at 630–337–5863.)

2. *Type of Information Collection Request:* Extension of a previously approved collection; *Title of Information Collection:* Advance Beneficiary Notice of Noncoverage (ABN); *Use:* The use of the written Advance Beneficiary Notice of Non-coverage (ABN) is to inform Medicare beneficiaries of their liability under specific conditions. This has been available since the ''limitation on liability'' provisions in section 1879 of the Social Security Act (the Act) were enacted in 1972 (Pub. L. 92–603).

The ABNs are not given every time items and services are delivered. Rather, ABNs are given only when a physician, provider, practitioner, or supplier anticipates that Medicare will not provide payment in specific cases. An ABN may be given, and the beneficiary may subsequently choose not to receive the item or service. An ABN may also be issued because of other applicable statutory requirements other than § 1862(a)(1) such as when a beneficiary wants to obtain an item from a supplier who has not met Medicare supplier number requirements, as listed in section 1834(j)(1) of the Act or when statutory requirements for issuance specific to HHAs are applicable. *Form Number:* CMS–R–131 (OMB control number: 0938–0566); *Frequency:*

Occasionally; *Affected Public:* Private Sector; Businesses or other for-profits, Not-for-profits institutions; *Number of Respondents:* 1,701,558; *Total Annual Responses:* 323,947,630; *Total Annual Hours:* 37,794,970. (For policy questions regarding this collection contact Jennifer McCormick at 410–786–2852.)

3. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Medical Necessity and Contract Amendments Under Mental Health Parity; *Use:* Upon request, regulated entities must provide a medical necessity disclosure. Receiving this information will enable potential and current enrollees to make more educated decisions given the choices available to them through their plans and may result in better treatment of their mental health or substance use disorder (MH/SUD) conditions. States use the information collected and reported as part of its contracting process with managed care entities, as well as its compliance oversight role. In states where a Medicaid Managed Care Organization (MCO) is responsible for providing the full scope of medical/surgical and MH/SUD services to beneficiaries, the state will review the parity analysis provided by the MCO to confirm that the MCO benefits are in compliance. CMS uses the information collected and reported in an oversight role of State Medicaid managed care programs. *Form Number:* CMS–10556 (OMB control number: 0938–1280); *Frequency:* Once and occasionally; *Affected Public:* Individuals and households, the Private sector, and State, Local, or Tribal Governments; *Number of Respondents:* 71,104,769; *Total Annual Responses:* 426,628; *Total Annual Hours:* 71,294. (For policy questions regarding this collection contact Matthew Rodriguez at 303–844–4724.)

Dated: September 1, 2022.

William N. Parham, III,

Director, Paperwork Reduction Staff, Office of Strategic Operations and Regulatory Affairs.

[FR Doc. 2022–19316 Filed 9–6–22; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifiers CMS–10328]

Agency Information Collection Activities: Submission for OMB Review; Comment Request

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

ACTION: Notice.

SUMMARY: The Centers for Medicare & Medicaid Services (CMS) is announcing an opportunity for the public to comment on CMS' intention to collect information from the public. 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 or reinstatement of an existing collection of information, and to allow a second opportunity for public comment on the notice. Interested persons are invited to send comments regarding the burden estimate or any other aspect of this collection of information, including the necessity and utility of the proposed information collection for the proper performance of the agency's functions, the accuracy of the estimated burden, ways to enhance the quality, utility, and clarity of the information to be collected, and the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

DATES: Comments on the collection(s) of information must be received by the OMB desk officer by October 7, 2022.

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.

To obtain copies of a supporting statement and any related forms for the proposed collection(s) summarized in this notice, you may make your request using one of following:

1. Access CMS' website address at website address at: *https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing.*

FOR FURTHER INFORMATION CONTACT: William Parham at (410) 786–4669.

SUPPLEMENTARY INFORMATION: Under the Paperwork Reduction Act of 1995 (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. The term ''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 publish a 30-day notice in the **Federal Register** concerning each proposed collection of information, including each proposed extension or reinstatement of an existing collection of information, before submitting the collection to OMB for approval. To comply with this requirement, CMS is publishing this notice that summarizes the following proposed collection(s) of information for public comment:

1. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Medicare Self-Referral Disclosure Protocol; *Use:* Section 6409 of the ACA requires the Secretary to establish a voluntary self-disclosure process that allows providers of services and suppliers to self-disclose actual or potential violations of section 1877 of the Act.

The SRDP is a voluntary self-disclosure process that allows providers of services and suppliers to disclose actual or potential violations of section 1877 of the Act. For purposes of the SRDP, a person submitting a disclosure to the SRDP will be referred to as a ''disclosing party.'' CMS analyzes the disclosed conduct to determine compliance with section 1877 of the Act and the application of the exceptions to the physician self-referral prohibition.

Specifically, under the proposal a physician practice disclosing group practice noncompliance will submit an SRDP form consisting of the following components: (1) the SRDP Disclosure Form, (2) a single Group Practice Information Form covering all the physicians in the practice who made prohibited referrals to the practice, and (3) a Financial Analysis Worksheet. All other entities will continue to submit disclosures using the SRDP Disclosure Form, separate Physician Information Forms for each physician covered in the self-disclosure, and a Financial Analysis Worksheet. *Form Number:* CMS–10328 (OMB control number: 0938–1106);

Frequency: Yearly; *Affected Public:* Private Sector (Business or other for-profits, Not-for-Profit Institutions); *Number of Respondents:* 100; *Total Annual Responses:* 200; *Total Annual Hours:* 5,000. (For policy questions regarding this collection contact Matthew Edgar at 410–786–0698.)

Dated: September 1, 2022.

William N. Parham, III,

Director, Paperwork Reduction Staff, Office of Strategic Operations and Regulatory Affairs.

[FR Doc. 2022–19323 Filed 9–6–22; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Submission for Office of Management and Budget (OMB) Review; Sexual Risk Avoidance Education Performance Analysis Study—Extension (OMB #0970–0536)

AGENCY: Office of Planning, Research, and Evaluation (OPRE), Administration for Children and Families (ACF), U.S. Department of Health and Human Services (HHS).

ACTION: Request for public comment.

SUMMARY: OPRE and the Family and Youth Services Bureau (FYSB) request an extension without changes to a currently approved information collection activity as part of the Sexual Risk Avoidance Education Performance Analysis Study (SRAE PAS) (OMB Control No. 0970–0536; expiration date October 31, 2022). The goal of the study is to collect, analyze, and report on performance measures data for the SRAE program.

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: The purpose of the SRAE program is to educate youth on how to voluntarily refrain from nonmarital sexual activity and prevent other youth risk behaviors. The requested extension will allow ACF to continue to collect the performance measures from SRAE grantees. Data will continue to be used to determine if the SRAE grantees are meeting performance benchmarks related to their program's mission and priorities. The program office will continue to use the data to provide technical assistance to grantees and for its own reporting purposes.

Respondents: Departmental SRAE (DSRAE), State SRAE (SSRAE), and Competitive SRAE (CSRAE) grantees, their sub recipients, and program participants.

ANNUAL BURDEN ESTIMATES

Instrument	Number of respondents (total over request period)	Number of responses per respondent (total over request period)	Average burden per response (in hours)	Total burden (in hours)	Annual burden (in hours)
(1) Participant Entry Survey					
DSRAE participants	378,390	1	0.1333	50,439	16,813
SSRAE participants	952,899	1	0.1333	127,021	42,340
CSRAE participants	60,408	1	0.1333	8,052	2,684
(2) Participant Exit Survey					
DSRAE participants	302,712	1	0.1667	50,462	16,821
SSRAE participants	762,319	1	0.1667	127,079	42,360
CSRAE participants	48,326	1	0.1667	8,056	2,685
(3) Performance reporting data entry form: grantees					
DSRAE grantees	119	6	16	11,424	3,808
SSRAE grantees	39	6	16	3,744	1,248
CSRAE grantees	34	6	16	3,264	1,088
(4) Performance reporting data entry form: subrecipients					
DSRAE subrecipients	252	6	13	19,656	6,552
SSRAE subrecipients	426	6	13	33,228	11,076
CSRAE subrecipients	63	6	13	4,914	1,638

Estimated Total Annual Burden Hours: 149,113.

Authority: 42 U.S.C 1310.

Mary B. Jones,

ACF/OPRE Certifying Officer.

[FR Doc. 2022–19256 Filed 9–6–22; 8:45 am]

BILLING CODE 4184–83–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Submission for OMB Review; Sexual Risk Avoidance Education National Evaluation: Nationwide Study of the National Descriptive Study (New Collection)

AGENCY: Office of Planning, Research and Evaluation, Administration for Children and Families, HHS.

ACTION: Request for public comments.

SUMMARY: The Office of Planning, Research and Evaluation (OPRE), Administration for Children and Families (ACF), U.S. Department of Health and Human Services (HHS), proposes survey and focus group data collection activities for the Sexual Risk Avoidance Education National Evaluation (SRAENE) Nationwide Study (NWS) of the National Descriptive Study (NDS).

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: OPRE/ACF/HHS proposes to conduct the NWS, a sub-study under the NDS of the SRAENE, to learn about Sexual Risk Avoidance Education (SRAE) program implementation experiences and outcomes of the SRAE grant program. The NWS builds on the Early Implementation Study, the first sub-study of the NDS, which was designed to tell the story about SRAE grant program plans (OMB Control #0970–0530). The NWS, which responds to Congress's reauthorization in February 2018 of title V, section 510 of the Social Security Act (Pub. L. 115–123), extended by the CARES ACT of 2020 (Pub. L. 116–136), will use a mixed-methods approach of surveys and focus groups to tell the story of the SRAE grant program, collecting detailed information on grantee program implementation experiences from grant recipients, SRAE program providers and facilitators, and youth program recipients. The NWS will also make use of extant data from grant-recipient performance measures on program outputs and outcomes. Combined with data on program implementation, the NWS will examine associations between implementation, outputs, and outcomes. The survey and focus group data are key to fully understanding program implementation experiences from all levels that bring the SRAE programs to youth-from grant administrators to program supervisors to the facilitators who interact directly with the youth themselves.

The study is being undertaken by ACF and its contractor Mathematica. The study research questions driving the need for data collection are as follows:

1. What are grant recipients' and providers' experiences with delivering SRAE curricular content? What are youth's experiences with receiving the SRAE curricular content?

2. How did grant recipients and providers interpret, understand, and address the A to F topics in the SRAE legislation?

3. Are some features of implementation more strongly associated with youth outcomes than others?

4. What provider characteristics are associated with a greater number of youth served and with youth outcomes?

To support these efforts, ACF proposes the following data collection activities: (1) a web-based survey of all grant recipient Directors who are not also providers, (2) a web-based survey of all SRAE program providers, (3) a web-based survey of all SRAE program facilitators, and (4) in-person (or virtual if necessary) focus groups with youth recipients of SRAE programming across five geographic regions of the United States.

Respondents: Respondents to the surveys will be SRAE program grant Directors, SRAE program providers, and SRAE program facilitators. Focus group participants will be youth recipients of SRAE programming. The focus group participants will be recruited from middle and high school across five U.S. Geographic regions: West, Midwest, Southwest, Southeast, and Northeast.

ANNUAL BURDEN ESTIMATES

Instrument	Number of respondents (total over request period)	Number of responses per respondent (total over request period)	Avg. burden per response (in hours)	Total/annual burden (in hours)
(1) NWS Grantee Survey	40	1	.17	7
(2) NWS Provider Survey	500	1	.75	375
(3) NWS Facilitator Survey	1,600	1	.75	1,200
(4) SRAE Program Youth Focus Group Discussion Guide	200	1	* .83	166
Estimated Total Annual Burden Hours:				1,748

* Average burden per response includes 5 minutes to complete the consent and assent forms.

Authority: The Title V Competitive SRAE Program was authorized and funded by section 510 of the Social Security Act (42 U.S.C. 710), as amended by section 50502 of the Bipartisan Budget Act of 2018 (Public Law 115–123) and extended by the CARES Act of 2020 (Public Law 116–136).

See *https://www.ssa.gov/OP_Home/ssact/title05/0510.htm.*

Mary B. Jones,

ACF/OPRE Certifying Officer.

[FR Doc. 2022–19231 Filed 9–6–22; 8:45 am]

BILLING CODE 4184–83–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. FDA–2020–N–2029]

Proposal To Withdraw Approval of MAKENA; Hearing; Correction

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice of hearing; correction.

SUMMARY: The Food and Drug Administration (FDA) is correcting a notice entitled ''Proposal To Withdraw Approval of MAKENA; Hearing'' that appeared in the **Federal Register** of August 17, 2022. The document announced the hearing on the Center for Drug Evaluation and Research's proposal to withdraw approval of MAKENA (hydroxyprogesterone caproate injection, 250 milligrams per milliliter, once weekly), new drug application 021945, held by Covis Pharma Group/Covis Pharma GmbH. The document was published with an incorrect deadline. This document corrects that error.

FOR FURTHER INFORMATION CONTACT: Rachael Vieder Linowes, Office of Scientific Integrity, Food and Drug Administration, 10903 New Hampshire Ave., Bldg. 1, Rm. 4206, Silver Spring, MD 20993, 240–402–5931, *rachael.linowes@fda.hhs.gov.*

SUPPLEMENTARY INFORMATION: In the **Federal Register** of August 17, 2022 (87 FR 50626), in FR Doc. 2022–17715, on page 50628, the following correction is made:

1. On page 50628, in the last paragraph of the second column, in the first sentence, ''September 6, 2022'' is corrected to ''September 14, 2022.''

Dated: September 1, 2022.

Lauren K. Roth,

Associate Commissioner for Policy.

[FR Doc. 2022–19293 Filed 9–6–22; 8:45 am]

BILLING CODE 4164–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. FDA–2018–N–1262]

Issuance of Priority Review Voucher; Rare Pediatric Disease Product

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing the issuance of a priority review voucher to the sponsor of a rare pediatric disease product application. The Federal Food, Drug, and Cosmetic Act (FD&C Act), as amended by the Food and Drug Administration Safety and Innovation Act (FDASIA), authorizes FDA to award priority review vouchers to sponsors of approved rare pediatric disease product applications that meet certain criteria. FDA is required to publish notice of the award of the priority review voucher. FDA has determined that ZTALMY (ganaxolone), manufactured by Marinus Pharmaceuticals, Inc., meets the criteria for a priority review voucher.

FOR FURTHER INFORMATION CONTACT: Cathryn Lee, Center for Drug Evaluation and Research, Food and Drug Administration, 10903 New Hampshire Ave., Silver Spring, MD 20993–0002, 301–796–1394, email: *Cathryn.Lee@fda.hhs.gov.*

SUPPLEMENTARY INFORMATION: FDA is announcing the issuance of a priority review voucher to the sponsor of an approved rare pediatric disease product application. Under section 529 of the FD&C Act (21 U.S.C. 360ff), which was added by FDASIA, FDA will award priority review vouchers to sponsors of approved rare pediatric disease product applications that meet certain criteria. FDA has determined that ZTALMY (ganaxolone), manufactured by Marinus Pharmaceuticals, Inc., meets the criteria for a priority review voucher. ZTALMY (ganaxolone) is indicated to treat seizures associated with cyclin-dependent kinase-like 5 (CDKL5) deficiency disorder in patients 2 years of age and older.

For further information about the Rare Pediatric Disease Priority Review Voucher Program and for a link to the full text of section 529 of the FD&C Act, go to *https://www.fda.gov/ForIndustry/DevelopingProductsforRareDiseasesConditions/RarePediatricDiseasePriorityVoucherProgram/default.htm.* For further information about ZTALMY (ganaxolone), go to the ''Drugs@FDA'' website at *https://www.accessdata.fda.gov/scripts/cder/daf/.*

Dated: August 31, 2022.

Lauren K. Roth,

Associate Commissioner for Policy.

[FR Doc. 2022–19276 Filed 9–6–22; 8:45 am]

BILLING CODE 4164–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Solicitation of Nominations for Membership To Serve on the Advisory Commission on Childhood Vaccines

AGENCY: Health Resources and Services Administration (HRSA), Department of Health and Human Services (HHS).

ACTION: Request for nominations.

SUMMARY: HRSA is seeking nominations of qualified candidates for consideration for appointment as members of the Advisory Commission on Childhood Vaccines (ACCV). The ACCV advises the Secretary of HHS (Secretary) on issues related to implementation of the National Vaccine Injury Compensation Program (VICP). HRSA is seeking nominations of qualified candidates to fill vacancies on the ACCV.

DATES: Written nominations for membership on the ACCV will be received on a continuous basis.

ADDRESSES: Nomination packages must be submitted to the Director, Division of Injury Compensation Programs, Health Systems Bureau, HRSA, 5600 Fishers Lane, Room 08N146B, Rockville, Maryland 20857. Candidates can submit electronic nomination packages by email to Pita Gomez at *ACCV@hrsa.gov.*

FOR FURTHER INFORMATION CONTACT: Pita Gomez, Principal Staff Liaison, Division of Injury Compensation Programs, Health Systems Bureau, HRSA at (301) 945–9386 or email at *ACCV@hrsa.gov.* A copy of the ACCV charter and list of the current membership is available on the ACCV website at *https://www.hrsa.gov/advisory-committees/vaccines/index.html.*

SUPPLEMENTARY INFORMATION: The ACCV was established by Title XXI of the Public Health Service Act (the Act) and advises the Secretary on issues related to implementation of the VICP. The ACCV meets at least four times each calendar year.

Nominations: HRSA is requesting nominations for voting members to serve as Special Government Employees (SGEs) on the ACCV to fill open positions. The Secretary appoints members with the expertise needed to fulfill the duties of the ACCV. The

membership requirements are set forth in section 2119 of the National Childhood Vaccine Injury Act.

The ACCV consists of nine voting members appointed by the Secretary as follows: (1) Three health professionals, who are not employees of the U.S. government, and who have expertise in the health care of children, the epidemiology, etiology, and prevention of childhood diseases, and the adverse reactions associated with vaccines, of whom at least two shall be pediatricians; (2) three members from the general public, of whom at least two shall be legal representatives (parents or guardians) of children who have suffered a vaccine-related injury or death; and (3) three attorneys, of whom at least one shall be an attorney whose specialty includes representation of persons who have suffered a vaccine-related injury or death, and of whom one shall be an attorney whose specialty includes representation of vaccine manufacturers. In addition, the Director of the National Institutes of Health, the Assistant Secretary for Health, the Director of the Centers for Disease Control and Prevention, and the Commissioner of the Food and Drug Administration (or the designees of such officials) serve as non-voting ex officio members.

HHS will consider nominations of all qualified individuals with a view to ensure that the ACCV includes the areas of subject matter expertise noted above. As indicated above, at least two of the three ACCV members of the general public must be legal representatives (parents or guardians) of children who have suffered a vaccine-related injury or death. Because those members must be the legal representatives of children who have suffered a vaccine-related injury or death, to be considered for appointment to the ACCV in that category, there must have been a finding (*i.e.,* a decision) by the U.S. Court of Federal Claims or a civil court that a VICP-covered vaccine caused, or was presumed to have caused, the represented child's injury or death. Additionally, based on a recommendation made by the ACCV, the Secretary will consider having a health professional with expertise in obstetrics as one of the members of the general public. Interested applicants may self-nominate or be nominated by another individual or organization.

Individuals selected for appointment to the Committee will be invited to serve for up to 3 years. Members are appointed as SGEs and receive a stipend and reimbursement for per diem and travel expenses incurred for attending ACCV meetings and/or conducting other business on behalf of the ACCV, as authorized by 5 U.S.C. 5703 for persons employed intermittently in government service.

The following information must be included in the package of materials submitted for each individual nominated for consideration: (1) a letter of nomination stating the name, affiliation, and contact information for the nominee, the basis for the nomination (*i.e.,* what specific attributes, perspectives, and/or skills does the individual possess that would benefit the workings of the ACCV) and the nominee's field(s) of expertise; (2) the name, address, daytime telephone number, and email address at which the nominator can be contacted; and (3) a current copy of the nominee's curriculum vitae. The individual being nominated or the person/organization recommending the candidate may submit nomination packages directly to HRSA, which will collect and retain nomination packages to create a pool of possible future ACCV voting members. When a vacancy occurs, HRSA and HHS will review nomination packages from the appropriate category and nominees may be contacted at that time.

HHS endeavors to ensure that the membership of the ACCV is fairly balanced in terms of points of view represented and that individuals from a broad representation of geographic areas, gender, and ethnic and minority groups, as well as individuals with disabilities, are considered for membership. Appointments shall be made without discrimination on the basis of race, age, ethnicity, national origin, gender, disability, sexual orientation, or cultural, religious, or socioeconomic status.

Individuals who are selected to be considered for appointment will be required to provide detailed information regarding their financial holdings, consultancies, and research grants or contracts. Disclosure of this information is required for HRSA ethics officials to determine whether there is a potential conflict of interest between the SGE's public duties as a member of the ACCV and their private interests, including an appearance of a loss of impartiality as defined by federal laws and regulations, and to identify any required remedial action needed to address the potential conflict.

Authority: Under the authorities that established the ACCV, the Federal Advisory Committee Act of October 6, 1972, (Pub. L. 92–463) and section 2119 of the National Childhood Vaccine Injury Act (Pub. L. 99–660, as amended), HRSA is requesting nominations for voting members of the ACCV.

Maria G. Button,

Director, Executive Secretariat.

[FR Doc. 2022–19242 Filed 9–6–22; 8:45 am]

BILLING CODE 4165–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

Findings of Research Misconduct

AGENCY: Office of the Secretary, HHS.

ACTION: Notice.

SUMMARY: Findings of research misconduct have been made against Ritankar Majumdar, Ph.D. (Respondent), who was a postdoctoral fellow in the intramural program of the Laboratory of Cellular and Molecular Biology (CMB), Center for Cancer Research (CCR), National Cancer Institute (NCI), National Institutes of Health (NIH). Respondent engaged in research misconduct in research supported by U.S. Public Health Service (PHS) funds, specifically the NCI Intramural Research Program. The administrative actions, including supervision for a period of three (3) years, were implemented beginning on August 15, 2022, and are detailed below.

FOR FURTHER INFORMATION CONTACT: Wanda K. Jones, Dr.P.H., Acting Director, Office of Research Integrity, 1101 Wootton Parkway, Suite 240, Rockville, MD 20852, (240) 453–8200.

SUPPLEMENTARY INFORMATION: Notice is hereby given that the Office of Research Integrity (ORI) has taken final action in the following case:

Ritankar Majumdar, Ph.D., National Institutes of Health: Based on the report of an investigation conducted by NIH and analysis conducted by ORI in its oversight review, ORI found that Dr. Ritankar Majumdar, former postdoctoral fellow in the intramural program of the Laboratory of CMB, CCR, NCI, NIH, engaged in research misconduct in research supported by PHS funds, specifically the NCI Intramural Research Program.

ORI found that Respondent engaged in research misconduct by knowingly or recklessly falsifying and/or fabricating data in the following one (1) published paper, one (1) manuscript, three (3) PHS grant applications, and fifteen (15) presentations:

- Exosomes Mediate LTB4 Release during Neutrophil Chemotaxis. *PloS Biol.* 2016 Jan 7; 14(1):e1002336; doi: 10.1371/journal.pbio.1002336 (hereafter referred to as ''*PloS Biol* 2016'').

Retraction in: *PLoS Biol.* 2021 Jul 7;19(7):e3001320; doi: 10.1371/journal.pbio.3001320.

• Biogenesis of Leukotriene B4-Containing Exosomes at the Nuclear Envelope. Manuscript accepted for publication in *Nature Cell Biology* in 2019 and withdrawn (hereafter referred to as the ''*NCB* manuscript'').

• R01 AI145072–01, ''Signal relay during directed cell migration,'' submitted to the National Institute of Allergy and Infectious Diseases (NIAID), NIH, on 06/04/2018.

• R01 AI145072–01A1, ''Signal relay during directed cell migration,'' submitted to NIAID, NIH, on 04/16/2019.

• R01 AI152517–01, ''Signal relay during directed cell migration,'' submitted to NIAID, NIH, on 08/16/2019, funded from 07/10/2020–6/30/2025.

• LTB4-synthesizing enzymes aggregate on nuclear lipid rafts that bud exosomes to mediate signal relay during neutrophil chemotaxis. Poster Presentation at the University of Maryland (UMD) in 2016 (hereafter referred to as the ''UMD 2016 presentation'').

• Exosome secretion as an effective mechanism of LTB4-mediated signal relay in migrating neutrophils. Oral presentation at the American Society for Exosomes and Microvesicles (ASEM) on 10/17/2015 (hereafter referred to as the ''ASEM 2015 presentation'').

• Chemotactic gradient amplification through the release of extracellular vesicles during eukaryotic chemotaxis. Oral presentation at Collective Dynamics in Microorganisms and Cellular Systems (CDMCS) on 05/25/2016 (hereafter referred to as the ''CDMCS 2016 presentation'').

• Signal Relay is Mediated by Exosome Release during Dictyostelium and Neutrophil Chemotaxis. Oral presentation at International CIM (Cells in Motion) Symposium 2015 on 09/14/2015 (hereafter referred to as the ''CIM 2015 presentation'').

• Do ESCRTS DR(ea)M of nuclear MVBs? Interplay of ESCRT Dependent and Independent processes in Exosome Biogenesis during Relay of Chemotactic Signals in Neutrophils. Poster presentation at Directed Cell Migration Gordon Research Conference (GRC) from 01/22/2017–01/27/2017 (hereafter referred to as the ''GRC 2017 presentation'').

• Nuclear Lipid Microdomains as a Novel Niche for Exosome Biogenesis: Interplay of ESCRT Dependent and Independent Processes During Relay of Chemotactic Signals in Neutrophils OR Do ESCRTs DR(ea)M of nuclear MVBs? Oral presentation at Directed Cell Migration Gordon Research Seminar (GRS) on 01/21/2017 (GRS2017.pptx) (hereafter referred to as the ''GRS 2017 presentation'').

• Lab Meeting on 02/13/15 (hereafter referred to as ''Lab Meeting 02/13/15'').

• Lab Meeting in August 2015 (hereafter referred to as ''Lab Meeting 08/2015'').

• Lab Meeting on October 7, 2016 (hereafter referred to as ''Lab Meeting 10/07/2016'').

• Lab Meeting in July 2016 (hereafter referred to as ''Lab Meeting 07/2016'').

• A series of fortunate events. Lab Meeting in December 2016 (hereafter referred to as ''Lab Meeting 12/2016'').

• Lab Meeting on November 4, 2015 (hereafter referred to as ''Lab Meeting 11/04/2015'').

• Exosome secretion as an effective mechanism of LTB4 mediated signal relay in migrating neutrophils. LCMB Presentation in 2015 (hereafter referred to as ''LCMB 2015 presentation V1'').

• Exosome secretion as an effective mechanism of LTB4 mediated signal relay in migrating neutrophils. LCMB Presentation in 2015 (hereafter referred to as ''LCMB 2015 presentation V2'').

• Extracellular Vesicles mediate signal relay during Chemotaxis. LCMB Seminar in 2014 (hereafter referred to as ''LCMB 2014 seminar'').

• Data compilation for LCMB Seminar in 2016 (hereafter referred to as ''LCMB 2016 seminar data 1'').

• A series of fortunate events: Do ESCRTs DR(ea)M of nuclear MVBs? Oral presentation at LCMB in 2016 (hereafter referred to as ''LCMB 2016 seminar data 2'').

Specifically, ORI found that:

• Respondent knowingly or recklessly falsified and/or fabricated electron microscopic (EM) image data for the formation of multivesicular bodies (MVBs) in migrating primary neutrophils following chemoattractant activation by:

—adding and/or removing 5-lipoxygenase (5–LO) immunogold signal and/or cell organelle membranes and/or subcellular vesicles in:

➢ *NCB* manuscript:

—Figure 1B, also included in:
- Figure 4C in R01 AI145072–01
- Figure 3B in R01 AI145072–01A1
- Slide 8 in Lab Meeting 10/07/2016
- Slide 2 in Lab Meeting 12/2016
- Column 2, Row 1 in GRC 2017 presentation 1

—Figures 1C and 1D

—Figure 7D, also included in:
- Slide 14 in Lab Meeting 10/07/2016
- Slide 3 in Lab Meeting 12/2016
- Column 2 Row 4 in GRC 2017 presentation 1

➢ *PloS Biology* 2016:

—Figure 2A, also included in:
- Figure 11 in UMD 2016 presentation

—Figure 2B, also included in:
- Slide 20 in LCMB 2015 presentation V1
- Slide 20 in LCMB 2015 presentation V2

—Figure 2C, also included in:
- Slide 20 in LCMB 2015 presentation V1
- Slide 22 in LCMB 2015 presentation V2
- Slide 6 in GRS 2017 presentation 2

—Figure 2Giii, also included in:
- Figure 3 in R01 AI145072–01
- Figure 2 in R01 AI145072–01A1
- Figure 2 in R01 AI152517–01
- Slide 20 in Lab Meeting 08/2015
- Slide 5 in Lab Meeting 07/2016
- Slide 17 in Lab Meeting 11/04/2015
- Slide 18 in LCMB 2015 presentation V1
- Slide 68 in LCMB 2015 presentation V2
- Slides 7 and 13 in LCMB 2016 seminar data 1
- Slides 6 and 12 in LCMB 2016 seminar data 2
- Figure 1b in UMD 2016 presentation
- Slide 16 in ASEM 2015 presentation
- Slide 32 in CDMCS 2016 presentation
- Slide 46 in CIM 2015 presentation
- Column 1, Row 4 in GRC 2017 presentation 1
- Slides 10 and 12 in GRS 2017 presentation 2

➢ R01 AI145072–01A1:

—Figure 3D, also included in:
- Figure 3D in R01 AI152517–01
- Figure 4Diii in AI145072–01
- Slide 4 in Lab Meeting 12/2016

—presenting EM images from the same source and falsely relabeling them to represent different experimental results in:

➢ Figures 1A and 7D in the *NCB* manuscript

➢ Figures 2A and 2D in *PloS Biology* 2016

• Respondent knowingly or recklessly falsified and/or fabricated immunoblot image data for chemoattractant activation of MVBs in migrating primary neutrophils in:

—Supplemental Figure 2B of the *NCB* manuscript:

➢ by copying the panel representing ''5–LO'' in Figure 1C in *PloS Biology* 2016, and flipping, re-sizing, and relabeling it to represent ''Flotillin''

➢ by copying the panel representing

''5–LO'' in the second row of the left column in Slide 9 in Lab Meeting 02/13/15 and rotating, resizing, and relabeling to represent ''Laminin''

• Respondent knowingly or recklessly falsified and/or fabricated time-lapse confocal microscopic image data for nuclear envelope vesicle formation by falsely presenting still images in reverse order from the original movies in the *NCB* manuscript:

—Supplemental Movie S1
—Figure 2A, also included in:
➢ Figure 4 in R01 AI145072–01A1
➢ Slide 8 in Lab Meeting 07/2016
➢ Figure 11 in UMD 2016 presentation
➢ Slide 38 in LCMB 2016 seminar data 1

Dr. Majumdar entered into a Voluntary Settlement Agreement (Agreement) and voluntarily agreed to the following:

(1) Respondent will have his research supervised for a period of three (3) years beginning on August 15, 2022 (the ''Supervision Period''). Prior to the submission of an application for PHS support for a research project on which Respondent's participation is proposed and prior to Respondent's participation in any capacity in PHS-supported research, Respondent will submit a plan for supervision of Respondent's duties to ORI for approval. The supervision plan must be designed to ensure the integrity of Respondent's research. Respondent will not participate in any PHS-supported research until such a supervision plan is approved by ORI. Respondent will comply with the agreed-upon supervision plan.

(2) The requirements for Respondent's supervision plan are as follows:

i. A committee of 2–3 senior faculty members at the institution who are familiar with Respondent's field of research, but not including Respondent's supervisor or collaborators, will provide oversight and guidance for a period of three (3) years from the effective date of the Agreement. The committee will review primary data from Respondent's laboratory on a quarterly basis and submit a report to ORI at six (6) month intervals setting forth the committee meeting dates and Respondent's compliance with appropriate research standards and confirming the integrity of Respondent's research.

ii. The committee will conduct an advance review of each application for PHS funds, or report, manuscript, or abstract involving PHS-supported research in which Respondent is involved. The review will include a discussion with Respondent of the primary data represented in those documents and will include a certification to ORI that the data presented in the proposed application, report, manuscript, or abstract are supported by the research record.

(3) During the Supervision Period, Respondent will ensure that any institution employing him submits, in conjunction with each application for PHS funds, or report, manuscript, or abstract involving PHS-supported research in which Respondent is involved, a certification to ORI that the data provided by Respondent are based on actual experiments or are otherwise legitimately derived and that the data, procedures, and methodology are accurately reported and not plagiarized in the application, report, manuscript, or abstract.

(4) If no supervision plan is provided to ORI, Respondent will provide certification to ORI at the conclusion of the Supervision Period that his participation was not proposed on a research project for which an application for PHS support was submitted and that he has not participated in any capacity in PHS-supported research.

(5) During the Supervision Period, Respondent will exclude himself voluntarily from serving in any advisory or consultant capacity to PHS including, but not limited to, service on any PHS advisory committee, board, and/or peer review committee.

Dated: September 1, 2022.

Wanda K. Jones,

Acting Director, Office of Research Integrity, Office of the Assistant Secretary for Health.

[FR Doc. 2022–19263 Filed 9–6–22; 8:45 am]

BILLING CODE 4150–31–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Cancer Institute; Notice of Closed Meetings

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended, notice is hereby given of the following meetings.

The meetings 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 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 grant applications and contract proposals, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Cancer Institute Special Emphasis Panel; Cancer Epidemiology Cohort Studies.

Date: October 13, 2022.

Time: 12:00 p.m. to 5:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Cancer Institute at Shady Grove, 9609 Medical Center Drive, Room 7W254, Rockville, Maryland 20850 (Telephone Conference Call).

Contact Person: Susan Lynn Spence, Ph.D., Scientific Review Officer, Research Technology and Contract Review Branch, Division of Extramural Activities, National Cancer Institute, NIH, 9609 Medical Center Drive, Room 7W254, Rockville, Maryland 20850, 240–620–0819, *susan.spence@nih.gov.*

Name of Committee: National Cancer Institute Special Emphasis Panel; Technologies for Global Health.

Date: October 14, 2022.

Time: 9:00 a.m. to 5:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Cancer Institute at Shady Grove, 9609 Medical Center Drive, Room 7W608, Rockville, Maryland 20850 (Telephone Conference Call).

Contact Person: Nadeem Khan, Ph.D., Scientific Review Officer, Research Technology and Contract Review Branch, Division of Extramural Activities, National Cancer Institute, NIH, 9609 Medical Center Drive, Room 7W608, Rockville, Maryland 20850, 240–276–5856, *nadeem.khan@nih.gov.*

Name of Committee: National Cancer Institute Special Emphasis Panel; SEP–4: NCI Clinical and Translational Cancer Research.

Date: October 18, 2022.

Time: 9:30 a.m. to 6:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Cancer Institute at Shady Grove, 9609 Medical Center Drive, Room 7W640, Rockville, Maryland 20850 (Telephone Conference Call).

Contact Person: Saejeong J. Kim, Ph.D., Scientific Review Officer, Special Review Branch, Division of Extramural Activities, National Cancer Institute, NIH, 9609 Medical Center Drive, Room 7W640 Rockville, Maryland 20850, 240–276–7684, *saejeong.kim@nih.gov.*

Name of Committee: National Cancer Institute Special Emphasis Panel; Therapeutics for Pediatric and Rare Cancers.

Date: October 20, 2022.

Time: 10:00 a.m. to 5:00 p.m.

Agenda: To review and evaluate contract proposals.

Place: National Cancer Institute at Shady Grove, 9609 Medical Center Drive, Room 7W608, Rockville, Maryland 20850 (Telephone Conference Call).

Contact Person: Nadeem Khan, Ph.D., Scientific Review Officer, Research Technology and Contract Review Branch,

Division of Extramural Activities, National Cancer Institute, NIH, 9609 Medical Center Drive, Room 7W608, Rockville, Maryland 20850, 240–276–5856 *nadeem.khan@nih.gov.*

Name of Committee: National Cancer Institute Special Emphasis Panel; SEP–7: NCI Clinical and Translational Cancer Research.

Date: October 26, 2022.

Time: 9:00 a.m. to 5:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Cancer Institute at Shady Grove, 9609 Medical Center Drive, Room 7W104, Rockville, Maryland 20850 (Telephone Conference Call).

Contact Person: Robert F. Gahl, Ph.D., Scientific Review Officer, Special Review Branch, Division of Extramural Activities, National Cancer Institute, NIH, 9606 Medical Center Drive, Room 7W104, Rockville, Maryland 20850, 240–276–7869, *robert.gahl@nih.gov.*

Name of Committee: National Cancer Institute Special Emphasis Panel; Assay Validation of High-Quality Biomarkers and Use of PLCO.

Date: October 26, 2022.

Time: 12:00 p.m. to 5:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Cancer Institute at Shady Grove, 9609 Medical Center Drive, Room 7W254, Rockville, Maryland 20850 (Telephone Conference Call).

Contact Person: Susan Lynn Spence, Ph.D., Scientific Review Officer, Research Technology and Contract Review Branch, Division of Extramural Activities, National Cancer Institute, NIH, 9609 Medical Center Drive, Room 7W254, Rockville, Maryland 20850, 240–620–0819, *susan.spence@nih.gov.*

Name of Committee: National Cancer Institute Special Emphasis Panel; SEP–9: NCI Clinical and Translational Cancer Research.

Date: October 27, 2022.

Time: 9:00 a.m. to 6:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Cancer Institute at Shady Grove, 9609 Medical Center Drive, Room 7W634, Rockville, Maryland 20850 (Telephone Conference Call).

Contact Person: Michael E. Lindquist, Ph.D., Scientific Review Officer, Research Programs Review Branch, Division of Extramural Activities, National Cancer Institute, NIH, 9609 Medical Center Drive, Room 7W634, Rockville, Maryland 20850, *mike.lindquist@nih.gov.*

Name of Committee: National Cancer Institute Special Emphasis Panel; Technologies for Pediatric and Rare Cancers.

Date: October 27, 2022.

Time: 11:00 a.m. to 4:00 p.m.

Agenda: To review and evaluate contract proposals.

Place: National Cancer Institute at Shady Grove, 9609 Medical Center Drive, Room 7W102, Rockville, Maryland 20850 (Telephone Conference Call).

Contact Person: Shakeel Ahmad, Ph.D., Branch Chief, Research Technology and Contract Review Branch, Division of Extramural Activities, National Cancer Institute, NIH, 9609 Medical Center Drive, Room 7W102 Rockville, Maryland 20850, 240–276–6442, *ahmads@mail.nih.gov.*

Name of Committee: National Cancer Institute Special Emphasis Panel; Innovative Molecular and Cellular Analysis Technologies.

Date: November 3–4, 2022.

Time: 9:30 a.m. to 4:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Cancer Institute at Shady Grove, 9609 Medical Center Drive, Room 7W238, Rockville, Maryland 20850 (Telephone Conference Call).

Contact Person: Jeffrey E. DeClue, Ph.D., Scientific Review Officer, Research Technology and Contract Review Branch, Division of Extramural Activities, National Cancer Institute, NIH, 9609 Medical Center Drive, Room 7W238 Rockville, Maryland 20850, 240–276–6371, *decluej@mail.nih.gov.*

Name of Committee: National Cancer Institute Special Emphasis Panel; SEP–6: NCI Clinical and Translational Cancer Research.

Date: November 10, 2022.

Time: 9:00 a.m. to 5:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Cancer Institute at Shady Grove, 9609 Medical Center Drive, Room 7W608, Rockville, Maryland 20850 (Telephone Conference Call).

Contact Person: Nadeem Khan, Ph.D., Scientific Review Officer, Research Technology and Contract Review Branch, Division of Extramural Activities, National Cancer Institute, NIH, 9609 Medical Center Drive, Room 7W608, Rockville, Maryland 20850, 240–276–5856, *nadeem.khan@nih.gov.*

Name of Committee: National Cancer Institute Special Emphasis Panel; SEP–1 NCI Clinical and Translational Cancer Research.

Date: November 17, 2022.

Time: 9:00 a.m. to 6:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Cancer Institute at Shady Grove, 9609 Medical Center Drive, Room 7W244, Rockville, Maryland 20850 (Telephone Conference Call).

Contact Person: John Paul Cairns, Ph.D., Scientific Review Officer, Research Programs Review Branch, Division of Extramural Activities, National Cancer Institute, NIH, 9609 Medical Center Drive, Room 7W244, Rockville, Maryland 20850, 301–461–0303, *paul.cairns@nih.gov.*

Name of Committee: National Cancer Institute Special Emphasis Panel; SBIR Phase IIB Bridge Toward Commercialization.

Date: November 17, 2022.

Time: 11:00 a.m. to 6:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Cancer Institute at Shady Grove, 9609 Medical Center Drive, Room 7W246, Rockville, Maryland 20850 (Telephone Conference Call).

Contact Person: Jun Fang, Ph.D., Scientific Review Officer, Research Technology and Contract Review Branch, Division of Extramural Activities, National Cancer Institute, NIH, 9609 Medical Center Drive, Room 7W246, Rockville, Maryland 20850, 240–276–5460, *jfang@mail.nih.gov.*

Name of Committee: National Cancer Institute Special Emphasis Panel; SEP–10: NCI Clinical and Translational Cancer Research.

Date: December 7, 2022.

Time: 9:00 a.m. to 6:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Cancer Institute at Shady Grove, 9609 Medical Center Drive, Room 7W120, Rockville, Maryland 20850 (Telephone Conference Call).

Contact Person: Majed M. Hamawy, Ph.D., Scientific Review Officer, Research Programs Review Branch, Division of Extramural Activities, National Cancer Institute, NIH, 9609 Medical Center Drive, Room 7W120, Rockville, Maryland 20850, 240–276–6457, *mh101v@nih.gov.*

(Catalogue of Federal Domestic Assistance Program Nos. 93.392, Cancer Construction; 93.393, Cancer Cause and Prevention Research; 93.394, Cancer Detection and Diagnosis Research; 93.395, Cancer Treatment Research; 93.396, Cancer Biology Research; 93.397, Cancer Centers Support; 93.398, Cancer Research Manpower; 93.399, Cancer Control, National Institutes of Health, HHS).

Dated: September 1, 2022.

Melanie J. Pantoja,

Program Analyst, Office of Federal Advisory Committee Policy.

[FR Doc. 2022–19274 Filed 9–6–22; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Center for Scientific Review; Notice of Closed Meetings

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended, notice is hereby given of the following meetings.

The meetings 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: Risk, Prevention and Health Behavior Integrated Review Group; Biobehavioral Medicine and Health Outcomes Study Section.

Date: October 3–4, 2022.

Time: 10:00 a.m. to 8:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892 (Virtual Meeting).

Contact Person: Mark A. Vosvick, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 3110, Bethesda, MD 20892, (301) 402–4128, *mark.vosvick@nih.gov.*

Name of Committee: Oncology 1—Basic Translational Integrated Review Group; Cancer Cell Biology Study Section.

Date: October 6–7, 2022.

Time: 8:00 a.m. to 7:30 p.m.

Agenda: To review and evaluate grant applications.

Place: Hilton Alexandria Old Town, 1767 King Street, Alexandria, VA 22314.

Contact Person: Charles Morrow, MD, Ph.D., Scientific Review Officer, Center for Scientific Review National Institutes of Health, 6701 Rockledge Drive, Room 6202, MSC 7804, Bethesda, MD 20892, 301–408–9850, *morrowcs@csr.nih.gov.*

Name of Committee: Surgical Sciences, Biomedical Imaging and Bioengineering Integrated Review Group; Surgery, Anesthesiology and Trauma Study Section.

Date: October 6–7, 2022.

Time: 9:30 a.m. to 7:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892 (Virtual Meeting).

Contact Person: Weihua Luo, MD, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 5114, MSC 7854, Bethesda, MD 20892, (301) 435–1170, *luow@csr.nih.gov.*

Name of Committee: Biobehavioral and Behavioral Processes Integrated Review Group; Language and Communication Study Section.

Date: October 6–7, 2022.

Time: 10:00 a.m. to 8:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892 (Virtual Meeting).

Contact Person: Rochelle Francine Hentges, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 1000C, Bethesda, MD 20892, (301) 402–8720, *hentgesrf@mail.nih.gov.*

Name of Committee: Infectious Diseases and Immunology A Integrated Review Group; Bacterial Pathogenesis Study Section.

Date: October 12–13, 2022.

Time: 10:00 a.m. to 7:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892 (Virtual Meeting).

Contact Person: Susan Daum, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 3202, Bethesda, MD 20892, 301–827–7233, *susan.boyle-vavra@nih.gov.*

Name of Committee: Molecular, Cellular and Developmental Neuroscience Integrated Review Group; Molecular and Cellular Neuropharmacology Study Section.

Date: October 13–14, 2022.

Time: 9:00 a.m. to 8:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892 (Virtual Meeting).

Contact Person: Vanessa S. Boyce, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Rm. 4185, MSC 7850, Bethesda, MD 20892, (301) 402–3726, *boycevs@csr.nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; PAR–22–079: High-End Instrumentation (HEI) Grant Program.

Date: October 18, 2022.

Time: 9:00 a.m. to 8:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892 (Virtual Meeting).

Contact Person: Krystyna H. Szymczyk, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD 20892, (301) 480–4198, *szymczykk@csr.nih.gov.*

(Catalogue of Federal Domestic Assistance Program Nos. 93.306, Comparative Medicine; 93.333, Clinical Research, 93.306, 93.333, 93.337, 93.393–93.396, 93.837–93.844, 93.846–93.878, 93.892, 93.893, National Institutes of Health, HHS)

Dated: August 31, 2022.

David W. Freeman,

Program Analyst, Office of Federal Advisory Committee Policy.

[FR Doc. 2022–19214 Filed 9–6–22; 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 10(d) 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; Development and Optimization of Next-Generation Immunological Assays to Support Influenza Clinical Studies and Trials (UH2/UH3 Clinical Trial Not Allowed).

Date: September 30, 2022.

Time: 9:00 a.m. to 12:00 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 3E70A, Rockville, MD 20892, (Virtual Meeting).

Contact Person: Annie Walker-Abbey, 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 3E70A, Rockville, MD 20852, 240–627–3390, *aabbey@niaid.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: September 1, 2022.

Tyeshia M. Roberson-Curtis,

Program Analyst, Office of Federal Advisory Committee Policy.

[FR Doc. 2022–19241 Filed 9–6–22; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute for Environment Health Sciences, Amended Notice of Meeting

Notice is hereby given of a change in the meeting of the National Advisory Environmental Health Sciences Council, September 13–14, 2022, Virtual Meeting, which was published in the **Federal Register** on August 09, 2022, V 87 No. 152, Pages 48491–48492, FR Doc No. 2022–17034.

Meeting is being amended to change the closed session and open session on September 13, 2022 to:

Name of Committee: National Advisory Environmental Health Sciences Council.

Date: September 13–14, 2022.

Closed: September 13, 2022, 10:00 a.m. to 11:30 a.m.

Agenda: To review and evaluate grant applications.

Place: Division of Extramural Research and Training, National Institute of Environmental Health Sciences, Durham, NC 27709 (Virtual Meeting).

Open: September 13, 2022, 11:45 a.m. to 5:15 p.m.

Agenda: Discussion of program policies and issues/Council Discussion.

Place: Division of Extramural Research and Training, National Institute of Environmental Health Sciences, Durham, NC 27709, *https://www.niehs.nih.gov/news/webcasts/* (Virtual Meeting).

Dated: August 31, 2022.

David W. Freeman,

Program Analyst, Office of Federal Advisory Committee Policy.

[FR Doc. 2022–19213 Filed 9–6–22; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Center for Scientific Review; Notice of Closed Meetings

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended, notice is hereby given of the following meetings.

The meetings 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: Bioengineering Sciences & Technologies Integrated Review Group; Instrumentation and Systems Development Study Section.

Date: October 4–5, 2022.

Time: 6:30 a.m. to 6:00 p.m.

Agenda: To review and evaluate grant applications.

Place: Doubletree Hotel Bethesda (Formerly Holiday Inn Select), 8120 Wisconsin Avenue, Bethesda, MD 20814.

Contact Person: Kee Forbes, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 5148, MSC 7806, Bethesda, MD 20892, 301–272–4865, *pyonkh2@csr.nih.gov.*

Name of Committee: Bioengineering Sciences & Technologies Integrated Review Group; Nanotechnology Study Section.

Date: October 6–7, 2022.

Time: 9:30 a.m. to 9:30 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892 (Virtual Meeting).

Contact Person: Joseph Thomas Peterson, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 4118, MSC 7814, Bethesda, MD 20892, 301–408–9694, *petersonjt@csr.nih.gov.*

(Catalogue of Federal Domestic Assistance Program Nos. 93.306, Comparative Medicine; 93.333, Clinical Research, 93.306, 93.333, 93.337, 93.393–93.396, 93.837–93.844, 93.846–93.878, 93.892, 93.893, National Institutes of Health, HHS)

Dated: August 31, 2022.

Miguelina Perez,

Program Analyst, Office of Federal Advisory Committee Policy.

[FR Doc. 2022–19211 Filed 9–6–22; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Center for Scientific Review; Notice of Closed Meetings

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended, notice is hereby given of the following meetings.

The meetings 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: Brain Disorders and Clinical Neuroscience Integrated Review Group; Clinical Neuroimmunology and Brain Tumors Study Section.

Date: October 6–7, 2022.

Time: 9:00 a.m. to 7:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD 20892 (Virtual Meeting).

Contact Person: Aleksey Gregory Kazantsev, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 5201, Bethesda, MD 20817, 301–435–1042, *aleksey.kazantsev@nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel; PAR Panel: Biomedical Imaging and Metabolism Instrumentation S10 Grant Programs.

Date: October 6–7, 2022.

Time: 10:00 a.m. to 8:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892 (Virtual Meeting).

Contact Person: ZHENG Li, Ph.D., Scientific Review Officer, The Center for Scientific Review, The National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD 20892, 301–594–3385, *zheng.li3@nih.gov.*

Name of Committee: Oncology 2—Translational Clinical Integrated Review Group; Clinical Oncology Study Section.

Date: October 17–18, 2022.

Time: 8:00 a.m. to 6:00 p.m.

Agenda: To review and evaluate grant applications.

Place: Canopy by Hilton, 940 Rose Avenue, North Bethesda, MD 20852.

Contact Person: Laura Asnaghi, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institute of Health, 6701 Rockville Drive, Room 6200, MSC 7804, Bethesda, MD 20892, (301) 443–1196, *laura.asnaghi@nih.gov.*

Name of Committee: Cardiovascular and Respiratory Sciences Integrated Review Group; Lung Injury, Repair, and Remodeling Study Section.

Date: October 17–18, 2022.

Time: 8:00 a.m. to 6:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892 (Virtual Meeting).

Contact Person: Ghenima Dirami, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 4122, MSC 7814, Bethesda, MD 20892, 240–498–7546, *diramig@csr.nih.gov.*

Name of Committee: Biobehavioral and Behavioral Processes Integrated Review Group; Motor Function, Speech and Rehabilitation Study Section.

Date: October 17–18, 2022.

Time: 9:00 a.m. to 8:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892 (Virtual Meeting).

Contact Person: Biao Tian, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 3166, MSC 7848, Bethesda, MD 20892, (301) 402–4411, *tianbi@csr.nih.gov.*

Name of Committee: Cell Biology Integrated Review Group; Biology and Development of the Eye Study Section.

Date: October 17–18, 2022.

Time: 10:00 a.m. to 7:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892 (Virtual Meeting).

Contact Person: Kevin Czaplinski, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6901 Rockledge Drive, Bethesda, MD 20892, (301) 480–9139, *czaplinskik2@csr.nih.gov.*

Name of Committee: Bioengineering Sciences & Technologies Integrated Review Group; Modeling and Analysis of Biological Systems Study Section.

Date: October 18–19, 2022.

Time: 10:00 a.m. to 8:30 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892 (Virtual Meeting).

Contact Person: Zarana Patel, Ph.D., Scientific Review Officer, The Center for Scientific Review, The National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD 20892, 301–496–9295, *zarana.patel@nih.gov.*

(Catalogue of Federal Domestic Assistance Program Nos. 93.306, Comparative Medicine; 93.333, Clinical Research, 93.306, 93.333, 93.337, 93.393–93.396, 93.837–93.844, 93.846–93.878, 93.892, 93.893, National Institutes of Health, HHS)

Dated: August 31, 2022.

Miguelina Perez,

Program Analyst, Office of Federal Advisory Committee Policy.

[FR Doc. 2022–19210 Filed 9–6–22; 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 10(d) 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; Cognitive Impairment and Decision Making.

Date: October 5, 2022.

Time: 12:00 p.m. to 1:30 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, National Institute on Aging, Gateway Building, 7201 Wisconsin Avenue, Bethesda, MD 20892 (Virtual Meeting).

Contact Person: Kimberly Firth, Ph.D., National Institutes of Health, National Institute on Aging, Gateway Building, 7201 Wisconsin Avenue, Suite 2C212, Bethesda, MD 20892, 301–402–7702, *firthkm@mail.nih.gov.*

Information is also available on the Institute's/Center's home page: *www.nia.nih.gov/,* where an agenda and any additional information for the meeting will be posted when available.

(Catalogue of Federal Domestic Assistance Program Nos. 93.866, Aging Research, National Institutes of Health, HHS)

Dated: August 31, 2022.

Miguelina Perez,

Program Analyst, Office of Federal Advisory Committee Policy.

[FR Doc. 2022–19208 Filed 9–6–22; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute on Alcohol Abuse and Alcoholism; Notice of Closed Meetings

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended, notice is hereby given of the following meetings.

The meetings 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 Alcohol Abuse and Alcoholism Initial Review Group; Biomedical Research Study Section.

Date: October 21, 2022.

Time: 9:00 a.m. to 5:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, National Institute on Alcohol Abuse and Alcoholism, 6700B Rockledge Drive, Bethesda, MD 20892 (Virtual Meeting).

Contact Person: Philippe Marmillot, Ph.D., Scientific Review Officer, Extramural Project Review Branch, National Institute on Alcohol Abuse and Alcoholism, 6700B Rockledge Drive, Room 2118, MSC 6902, Bethesda, MD 20892, 301–443–2861, *marmillotp@mail.nih.gov.*

Name of Committee: National Institute on Alcohol Abuse and Alcoholism Initial Review Group; Epidemiology, Prevention and Behavior Research Study Section.

Date: October 25, 2022.

Time: 9:30 a.m. to 5:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, National Institute on Alcohol Abuse and Alcoholism, 6700B Rockledge Drive, Bethesda, MD 20892 (Virtual Meeting).

Contact Person: Anna Ghambaryan, M.D., Ph.D., Scientific Review Officer, Extramural Project Review Branch, National Institute on Alcohol Abuse and Alcoholism, 6700B Rockledge Drive, Room 2120, MSC 6902, Bethesda, MD 20892, 301–443–4032, *anna.ghambaryan@nih.gov.*

(Catalogue of Federal Domestic Assistance Program Nos. 93.271, Alcohol Research Career Development Awards for Scientists and Clinicians; 93.272, Alcohol National Research Service Awards for Research Training; 93.273, Alcohol Research Programs; 93.891, Alcohol Research Center Grants; 93.701, ARRA Related Biomedical Research and Research Support Awards., National Institutes of Health, HHS)

Dated: September 1, 2022.

Melanie J. Pantoja,

Program Analyst, Office of Federal Advisory Committee Policy.

[FR Doc. 2022–19266 Filed 9–6–22; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute on Drug Abuse; Notice of Closed Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended, notice is hereby given of a meeting of the Board of Scientific Counselors, NIDA.

The meeting will be closed to the public as indicated below in accordance with the provisions set forth in sections 552b(c)(6), Title 5 U.S.C., as amended for the review, discussion, and evaluation of individual grant applications conducted by the National Institute on Drug Abuse, including consideration of personnel qualifications and performance, and the competence of individual investigators, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: Board of Scientific Counselors, NIDA.

Date: October 25–26, 2022.

Closed: 8:30 a.m. to 5:30 p.m.

Agenda: To review and evaluate personnel qualifications and performance, and competence of individual investigators.

Place: National Institute on Drug Abuse, NIH, Biomedical Research Center, 251 Bayview Boulevard, Baltimore, MD 21224 (Virtual Meeting).

Contact Person: Deon M. Harvey, Ph.D., Management Analyst, Office of the Scientific Director, National Institute on Drug Abuse, 251 Bayview Boulevard, Room 04A314, Baltimore, MD 21224, (443) 740–2466, *deon.harvey@nih.gov.*

(Catalogue of Federal Domestic Assistance Program Nos. 93.277, Drug Abuse Scientist Development Award for Clinicians, Scientist Development Awards, and Research Scientist Awards; 93.278, Drug Abuse National Research Service Awards for Research Training; 93.279, Drug Abuse and Addiction Research Programs, National Institutes of Health, HHS)

Dated: September 1, 2022.

Tyeshia M. Roberson-Curtis,

Program Analyst, Office of Federal Advisory Committee Policy.

[FR Doc. 2022–19243 Filed 9–6–22; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of Diabetes and Digestive and Kidney Diseases; Notice of Closed Meeting

Pursuant to section 10(d) 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 Diabetes and Digestive and Kidney Diseases Special Emphasis Panel; RC2: High Impact, Interdisciplinary Science in NIDDK Research Areas.

Date: September 29, 2022.

Time: 1:00 p.m. to 3:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, Two Democracy Plaza, 6707 Democracy Boulevard, Bethesda, MD 20892 (Video Meeting).

Contact Person: Cheryl Nordstrom, Ph.D., MPH, Scientific Review Officer, NIDDK/Scientific Review Branch, National Institutes of Health, 6707 Democracy Blvd., Room 7013, Bethesda, MD 20892, 301–402–6711, *cheryl.nordstrom@nih.gov.*

(Catalogue of Federal Domestic Assistance Program Nos. 93.847, Diabetes, Endocrinology and Metabolic Research; 93.848, Digestive Diseases and Nutrition Research; 93.849, Kidney Diseases, Urology and Hematology Research, National Institutes of Health, HHS)

Dated: August 31, 2022.

Miguelina Perez,

Program Analyst, Office of Federal Advisory Committee Policy.

[FR Doc. 2022–19209 Filed 9–6–22; 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 10(d) 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; Resources to Advance Pediatrics and HIV Prevention Science (RAPPS) (N01).

Date: September 29, 2022.

Time: 11:00 a.m. to 4:00 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 3G33, Rockville, MD 20892 (Virtual Meeting).

Contact Person: Poonam Pegu, 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 3G33, Rockville, MD 20852, 240–292–0719, *poonam.pegu@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: September 1, 2022.

Tyeshia M. Roberson-Curtis,

Program Analyst, Office of Federal Advisory Committee Policy.

[FR Doc. 2022–19244 Filed 9–6–22; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Human Genome Research Institute; Amended Notice of Meeting

Notice is hereby given of a change in the meeting of the National Advisory Council for Human Genome Research, September 19, 2022, 09:00 a.m. to September 20, 2022, 04:00 p.m., NHGRI, 6700B Rockledge Drive, Bethesda, MD 20892 which was published in the **Federal Register** on August 12, 2022, 87 FR 49873.

This notice is being amended to remove the visitor testing requirement for entering NIH facilities due to CDC updates published August 11, 2022, regarding screening testing. The meeting is partially Closed to the public.

Dated: August 31, 2022.

Miguelina Perez,

Program Analyst, Office of Federal Advisory Committee Policy.

[FR Doc. 2022–19212 Filed 9–6–22; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HOMELAND SECURITY

[Docket No. CISA–2022–0007]

Notice of President's National Infrastructure Advisory Council Meeting

AGENCY: Cybersecurity and Infrastructure Security Agency (CISA), Department of Homeland Security (DHS).

ACTION: Notice of Federal Advisory Committee Act (FACA) meeting; request for comments.

SUMMARY: CISA is publishing this notice to announce the following President's National Infrastructure Advisory Council (NIAC) meeting. This meeting will be partially closed to the public.

DATES:

Meeting Registration: Registration is required to attend the meeting and must be received no later than 5:00 p.m. Eastern Time (ET) on September 19, 2022. For more information on how to participate, please contact *NIAC@cisa.dhs.gov.*

Speaker Registration: Registration to speak during the meeting's public comment period must be received no later than 5:00 p.m. ET on September 19, 2022.

Written Comments: Written comments must be received no later than 5:00 p.m. ET on September 19, 2022.

Meeting Date: The NIAC will meet on September 26, 2022, from 1:00 p.m. to 5:00 p.m. ET. The meeting may close early if the council has completed its business.

ADDRESSES: The National Infrastructure Advisory Council's open session will be held in-person at 1650 Pennsylvania Ave. NW, Washington, DC; however, members of the public may participate via teleconference only. Requests to

participate will be accepted and processed in the order in which they are received. For access to the conference call bridge, information on services for individuals with disabilities, or to request special assistance, please email *NIAC@cisa.dhs.gov* by 5:00 p.m. ET on September 19, 2022. The NIAC is committed to ensuring all participants have equal access regardless of disability status. If you require a reasonable accommodation due to a disability to fully participate, please contact Celinda Moening at *NIAC@cisa.dhs.gov* as soon as possible.

Comments: The council will consider public comments on issues as listed in the **SUPPLEMENTARY INFORMATION** section below. Associated materials for potential discussions during the meeting will be available for review at *https://www.cisa.gov/niac* by September 23, 2022. Comments should be submitted by 5:00 p.m. ET on September 19, 2022 and must be identified by Docket Number CISA–2022–0007. Comments may be submitted by one of the following methods:

- *Federal eRulemaking Portal: www.regulations.gov.* Please follow the instructions for submitting written comments.
- *Email: NIAC@cisa.dhs.gov.* Include the Docket Number CISA–2022–0007 in the subject line of the email.

Instructions: All submissions received must include the words ''Department of Homeland Security'' and the Docket Number for this action. Comments received will be posted without alteration to *www.regulations.gov,* including any personal information provided. You may wish to read the Privacy & Security Notice which is available via a link on the homepage of *www.regulations.gov.*

Docket: For access to the docket and comments received by the National Infrastructure Advisory Council, please go to *www.regulations.gov* and enter docket number CISA–2022–0007.

A public comment period will take place from 4:30 p.m. to 4:40 p.m. Speakers who wish to participate in the public comment period must email *NIAC@cisa.dhs.gov* to register. Speakers should limit their comments to 3 minutes and will speak in order of registration. Please note that the public comment period may end before the time indicated, depending on the number of speakers who register to participate.

FOR FURTHER INFORMATION CONTACT: Celinda Moening, *NIAC@cisa.dhs.gov.*

SUPPLEMENTARY INFORMATION: The NIAC is established under section 10 of E.O. 13231 issued on October 16, 2001, continued and amended under the authority of E.O. 14048, dated September 30, 2021. Notice of this meeting is given under the Federal Advisory Committee Act (FACA), 5 U.S.C. appendix (Pub. L. 92–463). The NIAC provides the President, through the Secretary of Homeland Security, advice on the security and resilience of the Nation's critical infrastructure sectors.

Agenda: The National Infrastructure Advisory Council will meet in an open session on Monday, September 26, 2022 from 3:00 p.m. to 5:00 p.m. ET to discuss NIAC activities. The open session will include: (1) a period for public comment; (2) a discussion on *The Infrastructure Investment and Jobs Act*/Bipartisan Infrastructure Law; and (3) a roundtable discussion on potential study topics and subcommittees.

The council will meet in a closed session from 1:00 p.m. to 2:30 p.m. ET during which time senior Government intelligence officials will provide a classified threat briefing concerning threats to the Nation's critical infrastructure and engage NIAC members in follow-on discussions.

Basis for Closure: In accordance with section 10(d) of FACA and 5 U.S.C. 552b(c)(1), *The Government in the Sunshine Act,* it has been determined that a portion of the agenda requires closure, as the disclosure of the classified information that will be discussed would not be in the public interest.

The agenda item includes a classified threat briefing and discussion, at which time senior Government intelligence officials will discuss information concerning threats to the Nation's critical Infrastructure with NIAC members. This briefing is anticipated to be classified at the secret level. Public disclosure of these threats, as well as vulnerabilities and mitigations, is a risk to the Nation's infrastructure security posture as adversaries could use this information to do harm. Therefore, this portion of the meeting is required to be closed pursuant to section 10(d) of FACA and 5 U.S.C. 552b(c)(1).

Dated: August 31, 2022.

Celinda E. Moening,

Alternate Designated Federal Officer, National Infrastructure Advisory Council, Cybersecurity and Infrastructure Security Agency, Department of Homeland Security.

[FR Doc. 2022–19228 Filed 9–6–22; 8:45 am]

BILLING CODE 9110–9P–P

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

[Docket No. FR–7060–N–06]

60-Day Notice of Proposed Information Collection: Capital Needs Assessment of Public Housing; OMB Control No.: 2528–XXXX

AGENCY: Office of the Policy Development and Research, HUD.

ACTION: Notice.

SUMMARY: HUD is seeking approval from the Office of Management and Budget (OMB) for the information collection described below. In accordance with the Paperwork Reduction Act, HUD is requesting comment from all interested parties on the proposed collection of information. The purpose of this notice is to allow for 60 days of public comment.

DATES: *Comments Due Date:* November 7, 2022.

ADDRESSES: Interested persons are invited to submit comments regarding this proposal. Comments should refer to the proposal by name and/or OMB Control Number and should be sent to: Anna P. Guido, Reports Management Officer, REE, Department of Housing and Urban Development, 451 7th Street SW, Room 8210 Washington, DC 20410–5000; telephone 202–402–5535 (this is not a toll-free number) or email at *Anna.P.Guido@hud.gov* for a copy of the proposed forms or other available information. Persons with hearing or speech impairments may access this number through TTY by calling the toll-free Federal Relay Service at (800) 877–8339.

FOR FURTHER INFORMATION CONTACT: Anna P. Guido, Reports Management Officer, REE, Department of Housing and Urban Development, 451 7th Street SW, Washington, DC 20410–5000; email Anna P. Guido at *Anna.P.Guido@hud.gov* or telephone 202–402–5535 (this is not a toll-free number). Persons with hearing or speech impairments may access this number through TTY by calling the toll-free Federal Relay Service at (800) 877–8339. Copies of available documents submitted to OMB may be obtained from Ms. Guido.

SUPPLEMENTARY INFORMATION: This notice informs the public that HUD is seeking approval from OMB for the information collection described in section A.

A. Overview of Information Collection

Title of Information Collection: Capital Needs Assessment of Public Housing.

OMB Approval Number: Pending.

Type of Request: New collection.

Form Number: N/A.

Description of the Need for the Information and Proposed Use: The Office of Policy Development and Research at the U.S. Department of Housing and Urban Development (HUD) is proposing the collection of information for the *Capital Needs Assessment of Public Housing.*

Public housing serves the housing needs of low- and very-low-income households, including needy families, the elderly, and the disabled. In the United States, public housing is owned and managed by public housing authorities (PHAs), which are units of state and local government. Public housing is nonetheless heavily subsidized and regulated by HUD's Office of Public and Indian Housing through the Operating Fund, Capital Fund, and other means. The capital needs of public housing have a direct bearing on HUD's Capital Fund budget and its support to PHAs for using alternative means of financing to meet those needs.

The number of public housing developments and units in the United States and the number of PHAs that own and manage public housing developments and units have changed over time. According to the most recent HUD data, there are 2,780 PHAs that own and manage 940,330 units in 6,523 public housing developments.

The public housing Capital Fund provides funds for the capital and management activities of PHAs as authorized under section 9 of the Housing Act of 1937 (42 U.S.C. 1437g) (the Act). Capital needs are defined by section 9(d)(1) of the Act, as codified at 24 CFR part 905, with section 200 listing eligible activities. These activities include, among others, the development, financing, and modernization of public housing, vacancy reduction, nonroutine maintenance, and planned code compliance. This work is intended to bring each PHA's projects up to applicable modernization and energy conservation standards.

This **Federal Register** Notice provides an opportunity to comment on the information collection for the capital needs assessment (CNA) of public housing.

After OMB approval of the Paperwork Reduction Act package, HUD and its contractor will administer a web-based survey to a sample of approximately 300 PHAs to collect data on their CNA estimates, their practices to arrive at those estimates, and their use of those estimates.

After analyzing the data from the first survey of PHAs, HUD and its contractor will administer a second web-based survey of another 500 PHAs. This survey will ask many of the same questions as the first survey.

Both surveys will provide data that, when combined with HUD's other data sources, will be used to estimate the capital needs of public housing following an iterative and duplicable approach.

Both surveys also include questions about the processes that PHAs use to assess their capital needs. Based on responses to those questions, the study will assess PHAs' processes to see how they compare to in-person data collection methods used in previous CNAs and industry best practices.

The purpose of this assessment is to better understand if a non-inspection-based approach can yield reliable and valid results that are comparable to those in the past studies, if not better.

Respondents: PHA officials and staff participating in capital needs assessments.

Estimated Number of Respondents: This information collection will affect approximately 800 respondents. This includes (1) an initial survey of 300 PHAs and (2) a second survey of 500 PHAs.

Estimated Time per Response: Each PHA survey is expected to take 30 minutes.

Frequency of Response: 1 time for all surveys.

Estimated Total Annual Burden Hours: 400 hours for all surveys.

Estimated Total Annual Cost: 15,212 for all surveys.

Respondent's Obligation: PHA staff members.

Legal Authority: The collection of information is conducted under title 12, United States Code, section 1701z and section 3507 of the Paperwork Reduction Act of 1995, 44, U.S.C., 35, as amended.

Information collection	Number of respondents	Frequency of response	Responses per annum	Burden hour per response	Annual burden hours	Hourly cost per response	Cost
PHA survey 1	300	1	1	0.5	150	$38.03	$5,704.50
PHA survey 2	500	1	1	0.5	250	38.03	9,507.50
Total	800				400		15,212.00

Source: Table B–3. Average hourly and weekly earnings of all employees on private nonfarm payrolls by industry sector, seasonally adjusted. U.S. Bureau of Labor Statistics. January 2022(P) for all business and professional services. *https://www.bls.gov/news.release/empsit.t19.htm*.

To arrive at the dollar cost of the estimated response burden, we have used preliminary estimates from the U.S. Bureau of Labor Statistics on average hourly earnings in January 2022. For PHA staff, we use the estimate for professional and business services ($38.03).

B. Solicitation of Public Comment

This notice solicits comments from members of the public and affected parties concerning the collection of information described in Section A on the following:

(1) 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;

(2) The accuracy of the agency'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 those who are to respond, including the use of appropriate automated collection techniques or other forms of information technology, *e.g.,* permitting electronic submission of responses.

HUD encourages interested parties to submit comment in response to these questions

C. Authority

Section 3507 of the Paperwork Reduction Act of 1995, 44 U.S.C. chapter 35 and title 42 U.S.C. 5424 note, title 13 U.S.C. 8(b), and title 12, U.S.C., section 1701z–1.

Todd M. Richardson,

General Deputy Assistant Secretary for Policy Development and Research.

[FR Doc. 2022–19262 Filed 9–6–22; 8:45 am]

BILLING CODE 4210–67–P

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

[Docket No. FR–7057–N–01]

60-Day Notice of Proposed Information Collection: Office of Lead Hazard Control and Healthy Homes Grant Programs, Data Collection and Progress Reporting, OMB Control No.: 2539–0008

AGENCY: Office of Lead Hazard Control and Healthy Homes, HUD.

ACTION: Notice.

SUMMARY: HUD is seeking approval from the Office of Management and Budget (OMB) for renewal of the information collection described below. In accordance with the Paperwork Reduction Act, HUD is requesting comment from all interested parties on the proposed collection of information. The purpose of this notice is to allow for 60 days of public comment.

DATES: *Comments Due Date:* November 7, 2022.

ADDRESSES: Interested persons are invited to submit comments regarding this proposal. Comments should refer to the proposal by name and/or OMB Control Number and should be sent to: Anna P. Guido, Reports Management Officer, REE, Department of Housing and Urban Development, 451 7th Street SW, Room 4176, Washington, DC 20410–5000; telephone 202–402–5535 (this is not a toll-free number) or email at *Anna.P.Guido@hud.gov* for a copy of the proposed forms or other available information. Persons with hearing or speech impairments may access this number through TTY by calling the toll-free Federal Relay Service at (800) 877–8339.

FOR FURTHER INFORMATION CONTACT: Anna P. Guido, Reports Management Officer, REE, Department of Housing and Urban Development, 451 7th Street SW, Washington, DC 20410; email Anna P. Guido at *Anna.P.Guido@hud.gov* or telephone 202–402–5535. This is not a toll-free number. Persons with hearing or speech impairments may access this number through TTY by calling the toll-free Federal Relay Service at (800) 877–8339. Copies of available documents submitted to OMB may be obtained from Ms. Guido.

SUPPLEMENTARY INFORMATION: This notice informs the public that HUD is seeking approval from OMB for renewal of the information collection described in Section A.

A. Overview of Information Collection

Title of Information Collection: Office of Lead Hazard Control and Healthy Homes Grant Programs Data Collection and Progress Reporting.

OMB Approval Number: 2539–0008.

Type of Request: Extension with some changes due to program changes.

Form Number: HUD 96006 (electronic equivalent).

Description of the need for the information and proposed use: Collect data on the progress of grantees' programs.

Respondents: Grantees of the Office of Lead Hazard Control and Healthy Homes.

The revised hour burden estimates are presented in the table below. All respondents' expenses are covered by grant funds.

Information collection	Number of respondents	Frequency of response	Responses per annum	Burden hour per response	Annual burden hours	Hourly cost per response	Annual cost
Total	700	Quarterly	4	12	33,600	none	None.

B. Solicitation of Public Comment

This notice is soliciting comments from members of the public and affected parties concerning the collection of information described in Section A on the following:

(1) 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;

(2) The accuracy of the agency'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 those who are to respond; including through the use of appropriate automated collection techniques or other forms of information technology, *e.g.,* permitting electronic submission of responses.

HUD encourages interested parties to submit comments in response to these questions.

C. Authority

Section 3507 of the Paperwork Reduction Act of 1995, 44 U.S.C. chapter 35.

The Senior Advisor to the Director for the Office of Lead Hazard Control and Healthy Homes, Warren Friedman, having reviewed and approved this document, is delegating the authority to electronically sign this document to submitter, Nacheshia Foxx, who is the Federal Register Liaison for HUD, for purposes of publication in the **Federal Register**.

Nacheshia Foxx,

Federal Register Liaison, Department of Housing and Urban Development.

[FR Doc. 2022–19218 Filed 9–6–22; 8:45 am]

BILLING CODE 4210–67–P

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

[Docket No. FR–7056–N–21]

60-Day Notice of Proposed Information Collection: Congregate Housing Services Program, OMB Control No.: 2502–0485

AGENCY: Office of the Assistant Secretary for Housing-Federal Housing Commissioner, HUD.

ACTION: Notice.

SUMMARY: HUD is seeking approval from the Office of Management and Budget (OMB) for the information collection described below. In accordance with the Paperwork Reduction Act, HUD is requesting comment from all interested parties on the proposed collection of information. The purpose of this notice is to allow for 60 days of public comment.

DATES: *Comments Due Date:* November 7, 2022.

ADDRESSES: Interested persons are invited to submit comments regarding this proposal. Comments should refer to the proposal by name and/or OMB Control Number and should be sent to: Colette Pollard, Reports Management Officer, Office of Policy Development and Research, REE, Department of Housing and Urban Development, 451 7th Street SW, Room 4176, Washington, DC 20410–5000; telephone 202–402–3400 (this is not a toll-free number) or email at *Colette.Pollard@hud.gov* for a copy of the proposed forms or other available information. Persons with hearing or speech impairments may access this number through TTY by calling the toll-free Federal Relay Service at (800) 877–8339.

FOR FURTHER INFORMATION CONTACT: Colette Pollard, Reports Management Officer, REE, Department of Housing and Urban Development, 451 7th Street SW, Washington, DC 20410; email Colette Pollard at *Colette.Pollard@hud.gov* or telephone 202–402–3400. This is not a toll-free number. Persons with hearing or speech impairments may access this number through TTY by calling the toll-free Federal Relay Service at (800) 877–8339.

Copies of available documents submitted to OMB may be obtained from Ms. Pollard.

SUPPLEMENTARY INFORMATION: This notice informs the public that HUD is seeking approval from OMB for the information collection described in Section A.

A. Overview of Information Collection

Title of Information Collection: Congregate Housing Services Program.

OMB Approval Number: 2502–0485.

Type of Request: Revision of a currently approved collection.

Form Number: SF–424, SF–425, HUD–90006, HUD–90198, HUD–91180–A, 91178–A.

Description of the need for the information and proposed use: Completion of the Annual Report by grantees provides HUD with essential information about whom the grant is serving and what sort of services the beneficiaries receive using grant funds.

The Summary Budget and the Annual Program Budget make up the budget of the grantee's annual extension request. Together the forms provide itemized expenses for anticipated program costs and a matrix of budgeted yearly costs. The budget forms show the services funded through the grant and demonstrate how matching funds, participant fees, and grant funds will be used in tandem to operate the grant program. Field staff approve the annual budget and request annual extension funds according to the budget. Field staff can also determine if grantees are meeting statutory and regulatory requirements through the evaluation of this budget.

HUD will use the Payment Voucher to monitor use of grant funds for eligible activities over the term of the grant. The Grantee may similarly use the Payment Voucher to track and record their requests for payment reimbursement for grant-funded activities.

Respondents: Non-profit institutions.

Estimated Number of Respondents: 49.

Estimated Number of Responses: 392.

Frequency of Response: Semi-annually to annually.

Average Hours per Response: 2.

Total Estimated Burdens: 612.5.

B. Solicitation of Public Comment

This notice is soliciting comments from members of the public and affected parties concerning the collection of information described in Section A on the following:

(1) 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;

(2) The accuracy of the agency'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 those who are to respond; including through the use of appropriate automated collection techniques or other forms of information technology, *e.g.,* permitting electronic submission of responses.

HUD encourages interested parties to submit comment in response to these questions.

C. Authority

Section 3507 of the Paperwork Reduction Act of 1995, 44 U.S.C. chapter 35.

Nathan Shultz,

Acting Chief of Staff, Office of Assistant Secretary for Housing—Federal Housing Commissioner.

[FR Doc. 2022–19219 Filed 9–6–22; 8:45 am]

BILLING CODE 4210–67–P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[LLNMF010000 L13100000.PP0000 223L1109AF]

Notice of Public Meeting, Northern New Mexico Resource Advisory Council, New Mexico

AGENCY: Bureau of Land Management, Interior.

ACTION: Notice of meeting.

SUMMARY: In accordance with the Federal Land Policy and Management Act of 1976, as amended, and the Federal Advisory Committee Act of 1972, the U.S. Department of the Interior, Bureau of Land Management's (BLM) Northern New Mexico Resource Advisory Council (RAC) will meet on December 1–2, 2022.

DATES: The Northern New Mexico RAC will meet as follows:

- The Northern New Mexico RAC will host a field tour for proposed target shooting areas near Santa Fe, New Mexico, on Thursday, December 1, 2022, from 9 a.m. to 4 p.m. Mountain Daylight Time. All attendees planning to join the field tour should meet at the BLM New Mexico State Office.
- The Northern New Mexico RAC will host an in-person meeting, with a virtual participation option, on Friday, December 2, 2022, from 8 a.m. to 4 p.m. Mountain Daylight Time at the BLM New Mexico State Office.

The field tour and meeting are open to the public.

ADDRESSES: Field tour attendees should meet at the BLM New Mexico State Office, 301 Dinosaur Trail, Santa Fe, New Mexico 87508 at 9 a.m. on Thursday, December 1, 2022. In person meeting attendees should meet at 8 a.m. on Friday, December 2, 2022, at the BLM New Mexico State Office.

The virtual meeting will be available on the Zoom Webinar platform. The public can register for this meeting by visiting: *https://blm.zoomgov.com/j/1615896397?pwd=RjhkRG41T2RTRXBJaGRhWk5POWxnUT09.*

Written comments pertaining to the meeting may be filed in advance of the meeting using the BLM address listed in the **FOR FURTHER INFORMATION CONTACT** section of this notice. Please include ''RAC Comment'' in your submission.

FOR FURTHER INFORMATION CONTACT: Jillian Aragon, BLM Farmington District Office, 6251 College Boulevard, Suite A, Farmington, New Mexico 87402; (505) 564–7722. Individuals 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 chartered 12-member Northern New Mexico RAC advises the Secretary of the Interior, through the BLM, on a variety of planning and management issues associated with public land management in its area of jurisdiction.

Planned meeting agenda items includes member training; nomination for Chair and Vice-Chair; Federal Land Recreation Enhancement Act fee proposals for the U.S. Forest Service's Carson, Cibola, and Santa Fe National Forests; updates from the BLM Farmington, Taos, and Rio Puerco Field Offices; and a public comment session. The agenda is subject to change and will be posted two weeks in advance of the meeting on the RAC's web page at *https://www.blm.gov/get-involved/*

resource-advisory-council/near-you/new-mexico/northern-rac.

All Northern New Mexico RAC field tours and meetings are open to the public.

All attendees for the field trip will be responsible for their own transportation and meals. Members of the public wishing to attend the field trip should notify the person listed in the **FOR FURTHER INFORMATION CONTACT** section of this notice at least two weeks in advance so that the agency can ensure compliance with Federal and State of New Mexico large group guidance.

Public Comment Procedures

The BLM welcomes comments from all interested parties. There will be a half-hour public comment period during the December 2 meeting starting at 3 p.m. for any interested members of the public who wish to address the Northern New Mexico RAC. Depending on the number of persons wishing to speak, the time for individual comments may be limited. 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 us in your comment to withhold your personal identifying information from public review, we cannot guarantee that we will be able to do so.

Meeting Accessibility/Special Accommodations: 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 (see **FOR FURTHER INFORMATION CONTACT**) section of this notice at least seven (7) business days prior to the meeting to give the Department of the Interior sufficient time to process your request. All reasonable accommodation requests are managed on a case-by-case basis.

Detailed meeting minutes for the Northern New Mexico RAC will be maintained in the Farmington District Office listed in the **FOR FURTHER INFORMATION CONTACT** section of this notice. The meeting minutes will be available for public inspection and reproduction during regular business hours within 90 days following the meeting. Minutes will also be posted on the RAC's web page at: *https://www.blm.gov/get-involved/resource-advisory-council/near-you/new-mexico/northern-rac.*

Authority: 43 CFR 1784.4–1.

Alfred M. Elser,

BLM Farmington District Manager.

[FR Doc. 2022–19253 Filed 9–6–22; 8:45 am]

BILLING CODE 4331–23–P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[LLORW00000.L11600000.DF0000. LXSSH1080000.223L1109AF; HAG22–0023]

Notice of Public Meetings for the San Juan Islands National Monument Advisory Committee, Washington

AGENCY: Bureau of Land Management, Interior.

ACTION: Notice of public meetings.

SUMMARY: In accordance with the Federal Land Policy and Management Act and the Federal Advisory Committee Act of 1972, the U.S. Department of the Interior, Bureau of Land Management's (BLM) San Juan Islands National Monument Advisory Committee (MAC) will meet as follows.

DATES: The MAC will hold virtual public meetings on Thursday, Oct. 6, and Wednesday, Dec. 7, 2022. The meetings will be held via Zoom from 9 a.m. to 3 p.m. Public comment periods will be held from 1:30 p.m. until 2:30 p.m. during each meeting.

ADDRESSES: The Zoom meeting information and instructions will be posted on the Monument Advisory Committee's web page at *https://www.blm.gov/get-involved/resource-advisory-council/near-you/oregon-washington/san-juan-islands-mac* 1 month prior to each meeting and on the press release that will be issued 1week prior to each meeting.

The public may send written comments to the MAC at the BLM Spokane District, Attn. MAC, 1103 N Fancher, Spokane Valley, WA 99212, or via email to *jeffclark@blm.gov.*

FOR FURTHER INFORMATION CONTACT: Jeff Clark, Spokane District Public Affairs Officer, 1103 N Fancher, Spokane Valley, WA 99212; telephone: (509) 536–1297; or email: *jeffclark@blm.gov.* Individuals 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 San Juan Islands MAC is comprised of 12 members representing a wide array of interests, including recreation and tourism, tribal interests, cultural and heritage, education and interpretation, wildlife and ecology, local government, the public at large, and private landowners. All MAC meetings are open to the public.

The October meeting will begin with a welcome to new MAC members. After introductions, the members will spend time reviewing the Resource Management Plan (RMP) for the San Juan Islands National Monument. Discussion and review will continue until a working lunch at noon. The next topic will be to consider opportunities for the MAC to support implementation of the RMP. At 1:30 p.m. members of the public will have the opportunity to make comments to the MAC during a 1-hour public comment period. Depending on the number of persons wishing to comment, the length of comments may be limited. The meeting will adjourn no later than 3 p.m. The December meeting will also begin at 9 a.m. with welcomes and introductions. After introductions, the members will spend time reviewing possible implementation projects the MAC can assist with and clarifying items from the BLM. This discussion/review will continue through a working lunch at noon. The next topic will be to consider opportunities for the MAC to support implementation of the RMP when the record of decision is signed. At 1:30 p.m. members of the public will have the opportunity to make comments to the MAC during a 1-hour public comment period. Depending on the number of persons wishing to comment, the length of comments may be limited. The meeting will adjourn no later than 3 p.m.

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 us in your comment to withhold your personal identifying information from public review, we cannot guarantee that we will be able to do so.

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 Department of the Interior sufficient time to process your request. All

reasonable accommodation requests are managed on a case-by-case basis.

(Authority: 43 CFR 1784.4–2)

Kurt Pindel,

Spokane District Manager.

[FR Doc. 2022–19319 Filed 9–6–22; 8:45 am]

BILLING CODE 4310–33–P

INTERNATIONAL TRADE COMMISSION

[Investigation Nos. 701–TA–678 and 731–TA–1584 (Final)]

Barium Chloride From India; Scheduling of the Final Phase of Countervailing Duty and Antidumping Duty Investigations

AGENCY: United States International Trade Commission.

ACTION: Notice.

SUMMARY: The Commission hereby gives notice of the scheduling of the final phase of countervailing and antidumping duty investigation Nos. 701–TA–678 and 731–TA–1584 (Final) pursuant to the Tariff Act of 1930 (''the Act'') to determine whether an industry in the United States is materially injured or threatened with material injury, or the establishment of an industry in the United States is materially retarded, by reason of imports of barium chloride from India, provided for in subheading 2827.39.45 of the Harmonized Tariff Schedule of the United States. The Department of Commerce (''Commerce'') has preliminarily determined imports of barium chloride from India to be subsidized. In addition, Commerce has made a preliminary negative determination of sales at less-than-fair value in the antidumping duty investigation of barium chloride from India.

DATED: August 17, 2022.

FOR FURTHER INFORMATION CONTACT: Alejandro Orozco ((202) 205–3177), Office of Investigations, U.S. International Trade Commission, 500 E Street SW, Washington, DC 20436. Hearing-impaired persons can obtain information on this matter by contacting the Commission's TDD terminal on 202–205–1810. Persons with mobility impairments who will need special assistance in gaining access to the Commission should contact the Office of the Secretary at 202–205–2000. General information concerning the Commission may also be obtained by accessing its internet server (*https://www.usitc.gov*). The public record for these investigations may be viewed on the Commission's electronic docket (EDIS) at *https://edis.usitc.gov.*

SUPPLEMENTARY INFORMATION:

Scope.—For purposes of these investigations, Commerce has defined the subject merchandise as ''barium chloride, a chemical compound having the formulas $BaCl_2$ or $BaCl_2$-$2H_2O$, currently classifiable under subheading 2827.39.4500 of the Harmonized Tariff Schedule of the United States (HTSUS).'' [1]

Background.—The final phase of these investigations is being scheduled pursuant to sections 705(b) and 731(b) of the Tariff Act of 1930 (19 U.S.C. 1671d(b) and 1673d(b)), as a result of an affirmative preliminary determination by Commerce that certain benefits which constitute subsidies within the meaning of § 703 of the Act (19 U.S.C. 1671b) are being provided to manufacturers, producers, or exporters in India of barium chloride.[2] The investigations were requested in petitions filed on January 12, 2022, by Chemical Products Corp., Cartersville, Georgia.

For further information concerning the conduct of this phase of the investigations, hearing procedures, and rules of general application, consult the Commission's Rules of Practice and Procedure, part 201, subparts A and B (19 CFR part 201), and part 207, subparts A and C (19 CFR part 207).

Participation in the investigations and public service list.—Persons, including industrial users of the subject merchandise and, if the merchandise is sold at the retail level, representative consumer organizations, wishing to participate in the final phase of these investigations as parties must file an entry of appearance with the Secretary to the Commission, as provided in § 201.11 of the Commission's rules, no later than 21 days prior to the hearing date specified in this notice. A party that filed a notice of appearance during the preliminary phase of the investigations need not file an additional notice of appearance during this final phase. The Secretary will maintain a public service list containing the names and addresses of all persons, or their representatives, who are parties to the investigations.

Please note the Secretary's Office will accept only electronic filings during this time. Filings must be made through the Commission's Electronic Document Information System (EDIS, *https://edis.usitc.gov*). No in-person paper-based filings or paper copies of any electronic filings will be accepted until further notice.

Limited disclosure of business proprietary information (BPI) under an administrative protective order (APO) and BPI service list.—Pursuant to § 207.7(a) of the Commission's rules, the Secretary will make BPI gathered in the final phase of these investigations available to authorized applicants under the APO issued in the investigations, provided that the application is made no later than 21 days prior to the hearing date specified in this notice. Authorized applicants must represent interested parties, as defined by 19 U.S.C. 1677(9), who are parties to the investigations. A party granted access to BPI in the preliminary phase of the investigations need not reapply for such access. A separate service list will be maintained by the Secretary for those parties authorized to receive BPI under the APO.

Staff report.—The prehearing staff report in the final phase of these investigations will be placed in the nonpublic record on December 16, 2022, and a public version will be issued thereafter, pursuant to § 207.22 of the Commission's rules.

Hearing.—The Commission will hold a hearing in connection with the final phase of these investigations beginning at 9:30 a.m. on January 5, 2023. Information about the place and form of the hearing, including about how to participate in and/or view the hearing, will be posted on the Commission's website at *https://www.usitc.gov/calendarpad/calendar.html.* Interested parties should check the Commission's website periodically for updates. Requests to appear at the hearing should be filed in writing with the Secretary to the Commission on or before December 28, 2022. Any requests to appear as a witness via videoconference must be included with your request to appear. Requests to appear via videoconference must include a statement explaining why the witness cannot appear in person; the Chairman, or other person designated to conduct the investigation, may in their discretion for good cause shown, grant such a request. Requests to appear as remote witness due to illness or a positive COVID–19 test result may be submitted by 3 p.m. the business day prior to the hearing.

A nonparty who has testimony that may aid the Commission's deliberations may request permission to present a short statement at the hearing. All parties and nonparties desiring to

[1] For Commerce's complete scope, please see 87 FR 50602, August 17, 2022.

[2] While Commerce has preliminarily determined that imports of barium chloride from India are not being and are not likely to be sold in the United States at less than fair value, the Commission is continuing its investigative activities pursuant to Commission rule 207.21(c).

appear at the hearing and make oral presentations should attend a prehearing conference to be held at 9:30 a.m. on December 30, 2022. Oral testimony and written materials to be submitted at the public hearing are governed by sections 201.6(b)(2), 201.13(f), and 207.24 of the Commission's rules. Parties must submit any request to present a portion of their hearing testimony *in camera* no later than 7 business days prior to the date of the hearing.

Written submissions.—Each party who is an interested party shall submit a prehearing brief to the Commission. Prehearing briefs must conform with the provisions of § 207.23 of the Commission's rules; the deadline for filing is December 27, 2022. Parties may also file written testimony in connection with their presentation at the hearing, as provided in § 207.24 of the Commission's rules, and posthearing briefs, which must conform with the provisions of § 207.25 of the Commission's rules. The deadline for filing posthearing briefs is January 11, 2023. In addition, any person who has not entered an appearance as a party to the investigations may submit a written statement of information pertinent to the subject of the investigations, including statements of support or opposition to the petition, on or before January 11, 2023. On January 25, 2023, the Commission will make available to parties all information on which they have not had an opportunity to comment. Parties may submit final comments on this information on or before January 27, 2023, but such final comments must not contain new factual information and must otherwise comply with § 207.30 of the Commission's rules. All written submissions must conform with the provisions of § 201.8 of the Commission's rules; any submissions that contain BPI must also conform with the requirements of §§ 201.6, 207.3, and 207.7 of the Commission's rules. The Commission's *Handbook on Filing Procedures,* available on the Commission's website at *https://www.usitc.gov/documents/handbook_on_filing_procedures.pdf,* elaborates upon the Commission's procedures with respect to filings.

Additional written submissions to the Commission, including requests pursuant to § 201.12 of the Commission's rules, shall not be accepted unless good cause is shown for accepting such submissions, or unless the submission is pursuant to a specific request by a Commissioner or Commission staff.

In accordance with §§ 201.16(c) and 207.3 of the Commission's rules, each document filed by a party to the investigations must be served on all other parties to the investigations (as identified by either the public or BPI service list), and a certificate of service must be timely filed. The Secretary will not accept a document for filing without a certificate of service.

Authority: These investigations are being conducted under authority of title VII of the Tariff Act of 1930; this notice is published pursuant to § 207.21 of the Commission's rules.

By order of the Commission.

Issued: August 25, 2022.

Katherine Hiner,

Acting Secretary to the Commission.

[FR Doc. 2022–19315 Filed 9–6–22; 8:45 am]

BILLING CODE 7020–02–P

DEPARTMENT OF LABOR

Employee Benefits Security Administration

[Application No. D–12022]

Z–RIN 1210 ZA07

Comment Period Extension and Hearing Notice for Proposed Amendment to Prohibited Transaction Class Exemption 84–14 (the QPAM Exemption)

AGENCY: Employee Benefits Security Administration, U.S. Department of Labor.

ACTION: Notice of extension of comment period; hearing notice and subsequent reopening of comment period.

SUMMARY: The Department of Labor (the Department) is extending the comment period for a proposed amendment to prohibited transaction class exemption 84–14 (the Proposed QPAM Amendment). Additionally, the Department of Labor's Employee Benefits Security Administration (EBSA) will hold a virtual public hearing regarding the Proposed QPAM Amendment. EBSA welcomes comments and requests to testify at the hearing from the general public. As discussed in the **DATES** section below, the Department also will reopen the comment period for the Proposed QPAM Amendment in connection with the hearing.

DATES: Written comments on the Proposed QPAM Amendment and requests to testify at the hearing must be submitted to the Department on or before October 11, 2022. The public hearing will be held on November 17, 2022, and November 18, 2022 (if necessary), via WebEx beginning at 9 a.m. EST. The Department will reopen the comment period for the Proposed QPAM Amendment for a supplemental comment period beginning on the hearing date (November 17, 2022) and publish a **Federal Register** notice announcing that the hearing transcript is available on EBSA's web page and when the supplemental comment period ends.

ADDRESSES: Please submit all written comments and requests to testify at the hearing to the Office of Exemption Determinations through the Federal eRulemaking Portal at *www.regulations.gov* using Docket ID number: EBSA–2022–0008. Instructions are provided at the end of this notice.

FOR FURTHER INFORMATION CONTACT: Erin Scott Hesse, Office of Exemption Determinations, Employee Benefits Security Administration, U.S. Department of Labor. Telephone: (202) 693–8546 (this is not a toll-free number).

SUPPLEMENTARY INFORMATION:

Background

The Department published the Proposed QPAM Amendment on July 27, 2022, with a 60-day comment period that is scheduled to expire on September 26, 2022. Since the publication of the Proposed QPAM Amendment, the Department received a request from interested persons for the Department to extend its comment period for at least an additional 60 days. After carefully considering the extension request, the Department has decided that it is appropriate to extend the initial comment period for an additional 15 days until October 11, 2022 (a total of 75 days) to provide interested parties with additional time to prepare and submit comments, as well as to provide a supplemental comment period following a public hearing.

Hearing and Supplementary Comment Period

On its own motion, the Department also has decided to hold a virtual public hearing to provide an opportunity for all interested parties to testify on material information and issues regarding the Proposed QPAM Amendment. The hearing will be held via WebEx on November 17, 2022, and November 18, 2022 (if necessary), beginning at 9 a.m. EDT and will be transcribed. Registration information to access and view the hearing will be available on EBSA's website: *www.dol.gov/agencies/ebsa*.

The Department will reopen the comment period on the Proposed QPAM

amendment for a supplemental comment period beginning on the hearing date (November 17, 2022) and closing approximately 14 days after the Department publishes the hearing transcript on EBSA's web page. The Department will publish a **Federal Register** notice announcing that the hearing transcript is available on EBSA's web page and when the supplemental comment period will close. Due to the time required to process and publish the hearing transcript, the supplemental comment period should provide interested parties with at least 30 additional days to comment on the Proposed QPAM Amendment.

Requests To Testify at the Hearing

Individuals and organizations interested in testifying at the public hearing must submit a written request to testify and a summary of their testimony by October 11, 2022. Requests to testify must include:

(1) the name, title, organization, address, email address, and telephone number of the individual who would testify;

(2) if applicable, the name of the organization(s) whose views would be represented;

(3) the date of the requestor's written comment on the Rule (if applicable); and

(4) a concise summary of the testimony that would be presented.

Any requestors with disabilities requiring special accommodations for their testimony should contact Erin Scott Hesse at (202) 693–8546 after submitting their request (this is not a toll-free number).

The Department will organize the hearing into several moderated panels. Each individual or organization will be given 10 minutes to testify and should be prepared to answer questions regarding the testimony. EBSA will post an agenda containing the panel compositions and presentation times on *www.dol.gov/agencies/ebsa* no later than November 15, 2022.

EBSA may limit the number of presenters based on how many testimony requests it receives. In that event, EBSA will ensure that the broadest array of viewpoints on all aspects of the Proposed QPAM Amendment is represented and will include in the public record all testimony summaries it receives.

Instructions for Submitting Comments and Requests To Testify

All written comments and requests to testify at the hearing should be sent to the Office of Exemption Determinations through the Federal eRulemaking Portal at *www.regulations.gov* using Docket ID number: EBSA–2022–0008 on or before October 11, 2022. Individuals and Organizations are encouraged to submit all comments and requests to testify electronically and not to follow such submission with paper copies. Comments and requests to testify will also be available to the public, without charge, online at *www.regulations.gov,* at Docket ID number: EBSA–2022–0008 and *www.dol.gov/agencies/ebsa.* They also will be available for public inspection in the Public Disclosure Room of the Employee Benefits Security Administration, U.S. Department of Labor, Room N–1513, 200 Constitution Avenue NW, Washington, DC 20210; however, the Public Disclosure Room may be closed for all or a portion of the comment period due to circumstances surrounding the COVID–19 pandemic caused by the novel coronavirus.

Warning to Commenters and Requestors: All comments, requests to testify, and testimony summaries will be included in the public record without change and will be made available online at *www.regulations.gov,* including any personal information provided, unless the comment, request to testify, or testimony summary includes information claimed to be confidential or other information whose disclosure is restricted by statute. If you submit a comment, request to testify, or testimony summary, the Employee Benefits Security Administration (EBSA) recommends that you include your name and other contact information, but DO NOT submit information that you consider to be confidential, or otherwise protected (such as Social Security number or an unlisted phone number), or confidential business information that you do not want publicly disclosed on your comment, request to testify, or testimony summary. However, if EBSA cannot read your comment, request to testify, or testimony summary due to technical difficulties and cannot contact you for clarification, EBSA might not be able to consider your comment or schedule you to testify. Additionally, the *www.regulations.gov* website is an ''anonymous access'' system, which means EBSA will not know your identity or contact information unless you provide it. If you send an email directly to EBSA without going through *www.regulations.gov,* your email address will be automatically captured and included as part of the comment that is placed in the public record and made available on the internet.

Customer Service Information: Individuals interested in obtaining information from the Department concerning ERISA and employee benefit plans may call the Employee Benefits Security Administration's Toll-Free Hotline, at 1–866–444–3272 or visit EBSA's website (*www.dol.gov/agencies/ebsa*).

Signed at Washington, DC, this 1st day of September, 2022.

Ali Khawar,

Acting Assistant Secretary, Employee Benefits Security Administration, U.S. Department of Labor.

[FR Doc. 2022–19317 Filed 9–6–22; 8:45 am]

BILLING CODE 4510–29–P

MILLENNIUM CHALLENGE CORPORATION

[MCC FR 22–10]

Millennium Challenge Corporation Candidate Country Report for Fiscal Year 2023

AGENCY: Millennium Challenge Corporation.

ACTION: Notice.

SUMMARY: The Millennium Challenge Act of 2003 requires the Millennium Challenge Corporation to publish a report that identifies countries that are ''candidate countries'' for Millennium Challenge Account assistance during fiscal year 2023. The report is set forth in full below.

(Authority: 22 U.S.C. 7707(a))

Dated: September 1, 2022.

Thomas G. Hohenthaner,

Acting VP/General Counsel and Corporate Secretary.

Millennium Challenge Corporation Candidate Country Report for Fiscal Year 2023

Summary

This report to Congress is provided in accordance with section 608(a) of the Millennium Challenge Act of 2003, as amended, 22 U.S.C. 7701, 7707(a) (the Act).

The Act authorizes the provision of assistance for global development through the Millennium Challenge Corporation (MCC) for countries that enter into a Millennium Challenge Compact with the United States to support policies and programs that advance the progress of such countries to achieve lasting economic growth and poverty reduction. The Act requires MCC to take a number of steps in selecting countries with which MCC will seek to enter into a compact, including determining the countries that will be eligible countries for fiscal year

(FY) 2023 based on (a) a country's demonstrated commitment to (i) just and democratic governance, (ii) economic freedom, and (iii) investments in its people, (b) the opportunity to reduce poverty and generate economic growth in the country, and (c) the availability of funds to MCC. These steps include the submission to the congressional committees specified in the Act and publication in the **Federal Register** of reports on the following:

- The countries that are ''candidate countries'' for FY 2023 based on their per capita income levels and their eligibility to receive assistance under U.S. law and countries that would be candidate countries but for specified legal prohibitions on assistance (section 608(a) of the Act);
- The criteria and methodology that the MCC Board of Directors (the Board) will use to measure and evaluate the relative policy performance of the ''candidate countries'' consistent with the requirements of subsections (a) and (b) of section 607 of the Act in order to determine ''eligible countries'' from among the ''candidate countries'' (section 608(b) of the Act); and
- The list of countries determined by the Board to be ''eligible countries'' for FY 2023, identification of such countries with which the Board will seek to enter into compacts, and a justification for such eligibility determination and selection for compact negotiation (section 608(d) of the Act).

This report is the first of three required reports listed above.

Candidate Countries for FY 2023

The Act requires the identification of all countries that are candidate countries for purposes of eligibility for MCC compact assistance for FY 2023 and the identification of all countries that would be candidate countries for purposes of eligibility for MCC compact assistance but for specified legal prohibitions on assistance. Under sections 606(a) and (b) of the Act, candidate countries must qualify as low income or lower middle income countries as defined in the Act.

Specifically, a country will be a candidate country in the low income category for FY 2023 if it

- has a per capita income that is not greater than the World Bank's lower middle income country threshold for such fiscal year ($4,255 gross national income per capita for FY 2023);
- is among the 75 countries identified by the World Bank as having the lowest per capita income; and
- is not ineligible to receive United States economic assistance under part I of the Foreign Assistance Act of 1961, as amended (the Foreign Assistance Act), by reason of the application of the Foreign Assistance Act or any other provision of law.

A country will be a candidate country in the lower middle income category for FY 2023 if it

- has a per capita income that is not greater than the World Bank's lower middle income country threshold for such fiscal year ($4,255 gross national income per capita for FY 2023);
- is not among the 75 countries identified by the World Bank as having the lowest per capita income; and
- is not ineligible to receive United States economic assistance under part I of the Foreign Assistance Act by reason of the application of the Foreign Assistance Act or any other provision of law.

Under section 606(c) of the Act as applied for FY 2023, a country with per capita income changes from FY 2022 to FY 2023 such that the country would be reclassified from the low income category to the lower middle income category or vice versa will retain its income status in its former category for FY 2023 and two subsequent fiscal years (FY 2024 and FY 2025). A country that has transitioned to the upper middle income category does not qualify as a candidate country.

Pursuant to section 606(d) of the Act, the Board identified the following countries as candidate countries under the Act for FY 2023. In so doing, the Board referred to the prohibitions on assistance to countries for FY 2022 under the Department of State, Foreign Operations, and Related Programs Appropriations Act, 2022 (FY 2022 SFOAA) contained in Division K of the Consolidated Appropriations Act, 2022 (Pub.L. 117–103).

Candidate Countries: Low Income Category

1. Afghanistan
2. Angola
3. Bangladesh
4. Benin
5. Bhutan
6. Bolivia
7. Burundi
8. Cabo Verde
9. Cameroon
10. Central African Republic
11. Chad
12. Comoros
13. Congo, Democratic Republic of the
14. Congo, Republic of the
15. Côte d'Ivoire
16. Djibouti
17. Egypt
18. El Salvador
19. Gambia, The
20. Ghana
21. Guinea
22. Guinea-Bissau
23. Honduras
24. India
25. Kenya
26. Kiribati
27. Kyrgyzstan
28. Laos
29. Lebanon
30. Lesotho
31. Liberia
32. Madagascar
33. Malawi
34. Mauritania
35. Micronesia, Federated States of
36. Mongolia
37. Morocco
38. Mozambique
39. Nepal
40. Niger
41. Nigeria
42. Pakistan
43. Papua New Guinea
44. Philippines
45. Rwanda
46. Sao Tome and Principe
47. Senegal
48. Sierra Leone
49. Solomon Islands
50. Somalia
51. Tajikistan
52. Tanzania
53. Timor-Leste
54. Togo
55. Tunisia
56. Uganda
57. Ukraine
58. Uzbekistan
59. Vanuatu
60. Vietnam
61. Yemen
62. Zambia

Candidate Countries: Lower Middle Income Category

1. Algeria
2. Eswatini
3. Indonesia
4. Samoa

Countries That Would Be Candidate Countries but for Legal Provisions That Prohibit Assistance

Countries that would be considered candidate countries for purposes of eligibility for MCC compact assistance for FY 2023 but are ineligible to receive United States economic assistance under part I of the Foreign Assistance Act by reason of the application of any provision of the Foreign Assistance Act or any other provision of law are listed below. This list is based on legal prohibitions against economic assistance that apply as of July 22, 2022.

Prohibited Countries: Low Income Category

- Burkina Faso is ineligible to receive foreign assistance due to concerns

relative to its record on human rights and pursuant to the military coup restriction in section 7008 of the FY 2022 SFOAA.

- Burma is ineligible to receive foreign assistance due to concerns relative to its record on human rights and pursuant to the military coup restriction in section 7008 of the FY 2022 SFOAA.
- Cambodia is ineligible to receive foreign assistance pursuant to section 7043(b)(2) of the FY 2022 SFOAA, which restricts (with limited exceptions) assistance to the Government of Cambodia unless the Secretary of State certifies that the Government of Cambodia is taking effective steps to strengthen regional security and stability and respect the rights and responsibilities enshrined in the Constitution of the Kingdom of Cambodia.
- Eritrea is ineligible to receive foreign assistance due to its human rights record and its status as a Tier 3 country under the Trafficking Victims Protection Act of 2000 (22 U.S.C. 7101 *et seq.*).
- Ethiopia is ineligible to receive foreign assistance due to its human rights record.
- Haiti is ineligible to receive foreign assistance unless the Secretary of State provides a certification pursuant to section 7045(c)(1) of the FY 2022 SFOAA.
- Iran is ineligible to receive foreign assistance, including due to its status as a Tier 3 country under the Trafficking Victims Protection Act of 2000 (22 U.S.C. 7101 *et seq.*).
- Korea, North of is ineligible to receive foreign assistance, including due to its status as a Tier 3 country under the Trafficking Victims Protection Act of 2000 (22 U.S.C. 7101 *et seq.*).
- Mali is ineligible to receive foreign assistance pursuant to the military coup restriction in section 7008 of the FY 2022 SFOAA.
- Nicaragua is ineligible to receive foreign assistance, including due to its status as a Tier 3 country under the Trafficking Victims Protection Act of 2000 (22 U.S.C. 7101 *et seq.*).
- South Sudan is ineligible to receive foreign assistance pursuant to section 7042(h)(2) of the FY 2022 SFOAA due to its human rights record.
- Sudan is ineligible to receive foreign assistance including due to the military coup restriction in section 7008 of the FY 2022 SFOAA.
- Syria is ineligible to receive foreign assistance, including due to its status as a Tier 3 country under the Trafficking Victims Protection Act of 2000 (22 U.S.C. 7101 *et seq.*).
- Zimbabwe is ineligible to receive foreign assistance, including pursuant to section 7042(j)(2) of the FY 2021 SFOAA, which prohibits (with limited exceptions) assistance for the central government of Zimbabwe unless the Secretary of State certifies and reports to Congress that the rule of law has been restored, including respect for ownership and title to property, and freedoms of expression, association, and assembly.

Prohibited Countries: Lower Middle Income Category

- Sri Lanka is ineligible to receive foreign assistance pursuant to section 7044(e)(2) of the FY 2022 SFOAA, which restricts (with limited exceptions) assistance for the central government unless the Secretary makes certain certifications regarding actions taken by the Government of Sri Lanka and reports to the Committees on Appropriations.

Countries identified above as candidate countries, as well as countries that would be considered candidate countries but for the applicability of legal provisions that prohibit U.S. economic assistance, may be the subject of future statutory restrictions or determinations, or changed country circumstances, that affect their legal eligibility for assistance under part I of the Foreign Assistance Act by reason of application of the Foreign Assistance Act or any other provision of law for FY 2023.

[FR Doc. 2022–19267 Filed 9–6–22; 8:45 am]

BILLING CODE 9211–03–P

NATIONAL FOUNDATION ON THE ARTS AND THE HUMANITIES

National Endowment for the Humanities

Extension of a Currently Approved Collection; 30-Day Comment Request; Generic Clearance for the Collection of Qualitative Feedback on Agency Service Delivery

AGENCY: National Endowment for the Humanities, National Foundation on the Arts and the Humanities.

ACTION: Notice; request for comments.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995, the National Endowment for the Humanities (NEH) has requested that the Office of Management and Budget renew its generic clearance for the collection of qualitative feedback on agency service delivery. This generic clearance fast-tracks the process for NEH to seek feedback from the public, through surveys and similar feedback instruments, regarding NEH services and programs. The public may obtain copies of this Generic Information Collection Request (ICR), with applicable supporting documentation, by visiting *www.reginfo.gov.*

DATES: Please submit comments by October 7, 2022.

ADDRESSES: Submit written comments to the Office of Information and Regulatory Affairs, Office of Management and Budget, 725 17th Street NW, Washington, DC 20503, Attn: Desk Officer for the National Endowment for the Humanities; or by email to *oira_submission@omb.eop.gov;* or by fax to (202) 395–6974.

FOR FURTHER INFORMATION CONTACT: Samuel Roth, Attorney-Advisor, Office of the General Counsel, National Endowment for the Humanities, 400 7th Street SW, Room 4060, Washington, DC 20506; (202) 606–8322; *gencounsel@neh.gov.*

SUPPLEMENTARY INFORMATION: NEH first published notice of its intent to seek OMB approval for this ICR in the **Federal Register** of June 30, 2022 (87 FR 39132) and allowed 60 days for public comment. The agency did not receive any public comments. The purpose of this notice is to allow an additional 30 days for public comment.

Overview of This Information Collection

Type of Review: Extension of a currently approved collection.

Title: Generic Clearance for the Collection of Qualitative Feedback on Agency Service Delivery.

OMB Control Number: 3136–0140.

Abstract: NEH is seeking to renew its generic clearance for the collection of qualitative feedback on agency service delivery. This information collection enables NEH to obtain qualitative customer and stakeholder feedback in an efficient, timely manner, in accordance with the Administration's commitment to improving the Federal Government's customer experience and service delivery. Qualitative feedback includes information that provides useful insights on perceptions and opinions, as opposed to statistical surveys that yield quantitative results that can be generalized to the population of study.

There is no change in the method, substance, or estimated burden of the proposed collection of information.

Affected Public: Individuals and Households, Businesses and Organizations, State, Local or Tribal Governments.

Frequency of Collection: On occasion.

Estimated Annual Number of Respondents: 10,000.

Estimated Average Time per Response: 15 minutes.

Estimated Total Annual Burden Hours: 2,500 hours.

Request for Comments

The public is invited to comment on all aspects of this ICR including: (a) whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on those who are to respond, including through the use of automated collection techniques or other forms of information technology.

Dated: August 31, 2022.

Samuel Roth,

Attorney-Advisor, National Endowment for the Humanities.

[FR Doc. 2022–19147 Filed 9–6–22; 8:45 am]

BILLING CODE 7536–01–P

NUCLEAR REGULATORY COMMISSION

[NRC–2022–0028]

Information Collection: NRC Form 850, Request for Contractor Assignment(s)

AGENCY: Nuclear Regulatory Commission.

ACTION: Renewal of existing information collection; request for comment.

SUMMARY: The U.S. Nuclear Regulatory Commission (NRC) invites public comment on the renewal of Office of Management and Budget (OMB) approval for an existing collection of information. The information collection is entitled, ''NRC Form 850, Request for Contractor Assignment(s).''

DATES: Submit comments by November 7, 2022. 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:

- *Federal Rulemaking Website:* Go to *https://www.regulations.gov* and search for Docket ID NRC–2022–0028. 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(s) listed in the **FOR FURTHER INFORMATION CONTACT** section of this document.
- *Mail comments to:* David C. Cullison, Office of the Chief Information Officer, Mail Stop: T–6 A10M, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001.

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: David C. Cullison, Office of the Chief Information Officer, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001; telephone: 301–415–2084; email: *Infocollects.Resource@nrc.gov.*

SUPPLEMENTARY INFORMATION:

I. Obtaining Information and Submitting Comments

A. Obtaining Information

Please refer to Docket ID NRC–2022–0028 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–2022–0028.
- *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, 301–415–4737, or by email to *PDR.Resource@nrc.gov.* The supporting statement and NRC Form 850 are available in ADAMS under Accession Nos. ML22192A094 and ML22210A127.
- *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.
- *NRC's Clearance Officer:* A copy of the collection of information and related instructions may be obtained without charge by contacting the NRC's Clearance Officer, David C. Cullison, Office of the Chief Information Officer, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001; telephone: 301–415–2084; email: *Infocollects.Resource@nrc.gov.*

B. Submitting Comments

The NRC encourages electronic comment submission through the Federal rulemaking website (*https://www.regulations.gov*). Please include Docket ID NRC–2022–0028, in your comment submission.

The NRC cautions you not to include identifying or contact information in comment submissions that you do not want to be publicly disclosed in your comment submission. All comment submissions are posted at *https://www.regulations.gov* and entered into ADAMS. Comment submissions are not routinely edited to remove identifying or contact information.

If you are requesting or aggregating comments from other persons for submission to the OMB, 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 comment submissions are not routinely edited to remove such information before making the comment submissions available to the public or entering the comment into ADAMS.

II. Background

In accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. chapter 35), the NRC is requesting public comment on its intention to request the OMB's approval for the information collection summarized below.

1. *The title of the information collection:* NRC Form 850, Request for Contractor Assignment(s).
2. *OMB approval number:* 3150–0218.
3. *Type of submission:* Extension.
4. *The form number, if applicable:* NRC Form 850.
5. *How often the collection is required or requested:* On occasion.
6. *Who will be required or asked to respond:* NRC contractors, subcontractors and other individuals who are not NRC employees.
7. *The estimated number of annual responses:* 500.
8. *The estimated number of annual respondents:* 500.
9. *The estimated number of hours needed annually to comply with the information collection requirement or request:* 85.
10. *Abstract:* NRC Form 850 is completed by NRC contractors,

subcontractors, licensee employees, employees of other government agencies, and other individuals who are not NRC employees who require an NRC access authorization.

III. Specific Requests for Comments

The NRC is seeking comments that address the following questions:

1. Is the proposed collection of information necessary for the NRC to properly perform its functions? Does the information have practical utility?

2. Is the estimate of the burden of the information collection accurate?

3. Is there a way to enhance the quality, utility, and clarity of the information to be collected?

4. How can the burden of the information collection on respondents be minimized, including the use of automated collection techniques or other forms of information technology?

Dated: September 1, 2022.

For the Nuclear Regulatory Commission.

David C. Cullison,

NRC Clearance Officer, Office of the Chief Information Officer.

[FR Doc. 2022–19258 Filed 9–6–22; 8:45 am]

BILLING CODE 7590–01–P

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–95646; File No. SR–NYSEAMER–2022–36]

Self-Regulatory Organizations; NYSE American, LLC.; Notice of Filing and Immediate Effectiveness of Proposed Rule Change To Adopt New Rules 997NY, 997.1NY, 997.2NY and 997.3NY and Delete Paragraph (d) to Rule 957NY

August 31, 2022.

Pursuant to Section 19(b)(1) [1] of the Securities Exchange Act of 1934 (''Act'') [2] and Rule 19b–4 thereunder,[3] notice is hereby given that, on August 23, 2022, NYSE American, LLC (''NYSE American'' or the ''Exchange'') filed with the Securities and Exchange Commission (the ''Commission'') the proposed rule change as described in Items I and II, below, which Items have been prepared by the self-regulatory organization. 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] 15 U.S.C. 78a.

[3] 17 CFR 240.19b–4.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The Exchange proposes to adopt new Rules 997NY, 997.1NY, 997.2NY and 997.3NY regarding certain position transfers, including off-floor transfers. The Exchange also proposes to delete paragraph (d) to Rule 957NY (Reporting Duties). The proposed rule change is available on the Exchange's website at *www.nyse.com,* at the principal office of the Exchange, 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 self-regulatory organization 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 those 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 parts of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and the Statutory Basis for, the Proposed Rule Change

1. Purpose

The purpose of this rule change is to adopt new Rules 997NY, 997.1NY, 997.2NY, and 997.3NY regarding certain position transfers, including off-floor transfers as described herein. The proposed rules are substantively identical to rules on other options exchanges and would align the Exchange's rules with that of its competitors.[4] This proposal would benefit investors by reducing the administrative burden of determining whether their transfers comply with multiple sets of options exchange rules. In addition, the Exchange proposes to delete paragraph (d) to Rule 957NY (Reporting Duties) for reason set forth below.

Proposed Rule 997NY: Transactions Off the Exchange

Rules 19c–1 and 19c–3 under the Securities Exchange Act of 1934 (the ''Act'') describe rule provisions that each national securities change must include in its Rules regarding the ability of members to engage in transactions off an exchange. While the Exchange's rules, stated policies, and practices are consistent with these provisions of the Act, the Exchange Rules do not currently include these provisions. Therefore, the proposed rule change adopts these provisions in new Rule 997NY, ''Transactions Off the Exchange,'' in accordance with Rules 19c–1 and 19c–3 under the Act. Proposed Rule 997NY is also substantively identical to the off-floor transactions rule of another options exchange and thus would align Exchange rules with those of its competitors.[5]

Proposed Rule 997NY(a) provides that except as otherwise provided by this proposed Rule, no ATP Holder [6] acting as principal or agent may effect transactions in any class of option contracts listed on the Exchange for a premium in excess of $1.00 other than (1) on the Exchange, (2) on another exchange on which such option contracts are listed and traded, or (3) in the over-the-counter market if the stock underlying the option class, or in the case of an index option, if all the component stocks of an index underlying the option class, was a National Market System security under SEC Rule 600 at the time the Exchange commenced trading in that option class, unless that ATP Holder has first attempted to execute the transaction on the floor of the Exchange and has reasonably ascertained that it may be executed at a better price off the floor.

Proposed Rule 997NY(b) provides that, notwithstanding the provisions of paragraph (a) of this proposed Rule, an ATP Holder acting as agent may execute a customer's order off the Exchange floor with any other person (except when such ATP Holder also is acting as agent for such other person in such transaction) for the purchase or sale of an option contract listed on the Exchange.

Proposed Rule 997NY(c) provides that for each transaction in which an ATP Holder acting as principal or agent executes any purchase or sale of an option contract listed on the Exchange other than on the Exchange or on another exchange on which such option contracts are listed and traded, a record

[4] *See, e.g.,* Cboe Options Exchange, Inc. (''Cboe'') Rule 5.12 (Transactions Off the Exchange); Cboe Rule 6.7 (Off-Floor Transfer of Positions); Cboe Rule 6.8 (Off-Floor RWA Transfers); and NYSE Arca Rule 6.78A–O (In-Kind Exchange of Options Positions and ETF Shares and UIT Units) and Cboe Rule 6.9 (same).

[5] *See* Cboe Rule 5.12 (Transactions Off the Exchange).

[6] An ''ATP Holder'' is a natural person, sole proprietorship, partnership, corporation, limited liability company or other organization, in good standing, that has been issued an ATP [American Trading Permit] by the Exchange. *See* Rule 900.2NY(5).

of such transaction shall be maintained by such ATP Holder and shall be available for inspection by the Exchange for a period of one year. Such record shall include the circumstances under which the transaction was executed in conformity with this Rule.

Proposed Rule 997NY(d) provides that no rule, stated policy, or practice of the Exchange may prohibit or condition, or be construed to prohibit or condition, or otherwise limit, directly or indirectly, the ability of any ATP Holder acting as agent to effect any transaction otherwise than on the Exchange with another person (except when such ATP Holder also is acting as agent for such other person in such transaction) in any equity security listed on the Exchange or to which unlisted trading privileges on the Exchange have been extended.

Proposed Rule 997NY(e) provides that no rule, stated policy, or practice of the Exchange may prohibit or condition, or be construed to prohibit, condition, or otherwise limit, directly or indirectly, the ability of any ATP Holder to effect any transaction otherwise than on the Exchange in any reported security listed and registered on the Exchange or as to which unlisted trading privileges on the Exchange have been extended (other than a put option or call option issued by Options Clearing Corporates or OCC) which is not a covered security.[7]

Proposed Rule 997.1NY: Off-Floor Transfer of Positions

The Exchange proposes to adopt new Rule 997.1NY titled ''Off-Floor Transfer of Positions,'' to provide a process by which ATP Holders may transfer option positions between accounts, individuals, or entities in limited circumstances without first exposing the order on the Exchange. This rule would also permit off-floor transfers upon the occurrence of significant, non-recurring events. Proposed Rule 997.1NY is substantively identical to the rules of other option exchanges regarding permissible off-floor transfers of options positions and would align Exchange rules with those of its competitors.[8]

Proposed Rule 997.1NY(a) provides that, notwithstanding proposed Rule 997NY (described above), existing positions in options listed on the Exchange of an ATP Holder, or non-ATP Holder, that are to be transferred on, from, or to the books of a Clearing Member [9] may be transferred off the Exchange (an ''off-floor transfer'') if the off-floor transfer involves one or more of the following events:

- an adjustment or transfer in connection with the correction of a bona fide error in the recording of a transaction or the transferring of a position to another account, provided that the original trade documentation confirms the error;
- the transfer of positions from one account to another account where no change in ownership is involved (*i.e.,* accounts of the same Person (as defined in Rule 15)),[10] provided the accounts are not in separate aggregation units or otherwise subject to information barrier or account segregation requirements;
- the consolidation of accounts where no change in ownership is involved;
- a merger, acquisition, consolidation, or similar non-recurring transaction for a Person;
- the dissolution of a joint account in which the remaining ATP Holder assumes the positions of the joint account;
- the dissolution of a corporation or partnership in which a former nominee of the corporation or partnership assumes the positions;
- positions transferred as part of an ATP Holder's capital contribution to a new joint account, partnership, or corporation;
- the donation of positions to a not-for-profit corporation;
- the transfer of positions to a minor under the Uniform Gifts to Minors Act; or
- the transfer of positions through operation of law from death, bankruptcy, or otherwise.

The proposed rule change makes clear that the transferred positions must be on, from, or to the books of a Clearing Member. The proposed rule change states that existing positions of an ATP Holder or a non-ATP Holder may be subject to an off-floor transfer, except under specified circumstances in which a transfer may only be effected for positions of an ATP Holder.[11] The Exchange notes off-floor transfers of positions in Exchange listed options may also be subject to applicable laws, rules, and regulations, including rules of other self-regulatory organizations.[12] Except as explicitly provided in proposed Rule 997.1NY, the proposed rule change is not intended to exempt off-floor position transfers from any other applicable rules or regulations, and proposed paragraph (h) to Rule 997.1NY makes this clear.

Proposed Rule 997.1NY(b) provides that no position may net against another position (''netting''), and no position transfer may result in preferential margin or haircut treatment, unless otherwise permitted by proposed paragraph (f) (described below). Netting occurs when long positions and short positions in the same series ''offset'' against each other, leaving no position, or a reduced position. For example, if an ATP Holder wanted to transfer 100 long calls to another account that contained short calls of the same options series as well as other positions, even if the off-floor transfer is permitted pursuant to one of the permissible events listed in proposed Rule 997.1NY(a)(1)–(10), the ATP Holder could not transfer the offsetting series, as they would net against each other and close the positions.

Proposed Rule 997.1NY(c) provides that the transfer price, to the extent it is consistent with applicable laws, rules, and regulations, including rules of other self-regulatory organizations, and tax and accounting rules and regulations, at which an off-floor transfer may be effected is either: (1) the original trade prices of the positions that appear on the books of the trading Clearing Member, in which case the records of the off-floor transfer must indicate the original trade dates for the positions; provided, transfers to correct bona fide errors pursuant to proposed subparagraph (a)(1) must be transferred at the correct original trade prices; (2) mark-to-market prices of the positions at the close of trading on the transfer date; (3) mark-to-market prices of the positions at the close of trading on the trade date prior to the transfer date; [13] or (4) the then-current market price of the positions at the time the transfer is effected. Proposed Rule 997.1NY(c) provides market participants that effect off-floor transfers with flexibility to

[7] The ''Options Clearing Corporation'' or ''OCC'' refers to The Options Clearing Corporation, a subsidiary of the Participating Exchanges. *See* Rule 900.2NY(55). The term ''Participating Exchanges'' refers to any national securities exchange that has qualified for participation in the OCC pursuant to the provisions of the Rules of the Options Clearing Corporation. *See* Rule 900.2NY(61).

[8] *See* Cboe Rule 6.7 (Off-Floor Transfer of Positions). *See also* Nasdaq ISE LLC (''ISE'') Options 6, Section 5 (Transfer of Positions); Miami Options Exchange (''MIAX'') Rule 1326 (Transfer of Positions). As noted below, regarding the ''presidential'' exemption, Cboe Rule 6.7(f) does not explicitly include the Chief Executive Officer, which reference is included in ISE Options 6, Section 5(f); MIAX Rule 1326(f).

[9] A ''Clearing Member'' refers to an ATP Holder that has been admitted to membership in the OCC pursuant to the provisions of the Rules of the OCC. *See* Rule 900.2NY(11).

[10] A ''Person'' refers to a natural person, corporation, partnership, association, joint stock company, trust, fund, or any organized group of persons whether incorporated or not. *See* Rule 15. The proposed transfers may only occur between the same individual or legal entity.

[11] *See* proposed Rule 997.1NY(a)(5) and (7).

[12] *See* proposed Rule 997.1NY(h).

[13] For example, for a transfer that occurs on a Tuesday, the transfer price may be based on the closing market price on Monday.

select a transfer price based on the circumstances of the transfer and their business. However, for corrections of bona fide errors, because those transfers are necessary to correct processing errors that occurred at the time of the transaction, those off-floor transfers would occur at the original transaction price, as the purpose of the transfer is to create the originally intended result of the transaction.

Proposed Rule 997.1NY(d) requires an ATP Holder and its Clearing Member(s) (to the extent the ATP Holder is not self-clearing) to submit to the Exchange, in a manner determined by the Exchange, written notice prior to effecting an off-floor transfer from or to the account(s) of an ATP Holder(s).[14] Per proposed Rule 997.1NY(d)(1), the proposed notice must indicate: the Exchange-listed options positions to be transferred; the nature of the transaction; the enumerated provision(s) under proposed Rule 997.1NY(a) pursuant to which the positions are being transferred; the name of the counterparty(ies); the anticipated transfer date; the method for determining the transfer price; and any other information requested by the Exchange. The proposed notice is designed to ensure that the Exchange is made aware of all transfers so that the Exchange can monitor and review such transfers (including the records that must be retained pursuant to proposed Rule 997.1NY(e) (described below) to determine whether they are effected in accordance with the Exchange rules. Additionally, the Exchange believes that requiring notice from the ATP Holder(s) and its Clearing Member(s) would ensure that both parties are in agreement with respect to the terms of the transfer. In light of the notice requirement contained in proposed Rule 997.1NY(d), the Exchange proposes to make a conforming change by deleting paragraph (d) to Rule 957NY, which similarly requires ATP Holders to report to the Exchange any off-floor transactions, and to hold paragraph (d) as Reserved.[15]

Per proposed Rule 997.1NY(d)(2), however, receipt of prior notice of an off-floor transfer would not constitute a determination by the Exchange that such transfer was effected or reported in conformity with the requirements of proposed Rule 997.1NY. As such, notwithstanding submission of written notice to the Exchange, ATP Holder and Clearing Members that effect off-floor transfers that do not conform to the requirements of the proposed Rule would be subject to appropriate disciplinary action in accordance with the Exchange rules.

Similarly, proposed Rule 997.1NY(e) requires that each party to an off-floor transfer generate and retain records of the information provided in the written notice to the Exchange (pursuant to proposed subparagraph (d)(1)), as well as information regarding the actual Exchange-listed options that are ultimately transferred, the actual transfer date, and the actual transfer price (and the original trade dates, if applicable), and any other information the Exchange may request the ATP Holder or Clearing Member to provide.

Proposed 997.1NY(f) provides exemptions to the prohibition against off-floor transfers, as approved by the Exchange's President or Chief Executive Officer (or his or her designee(s)).[16] Specifically, this provision is in addition to the exemptions (to Rule 997NY) set forth in proposed Rule 997.1NY(a)(1)–(10). The Exchange proposes that the Exchange President or Chief Executive Officer (or his or her designee(s)) may grant an exemption from the requirement of this proposed Rule, on his or her own motion or upon application of the ATP Holder (with respect to the ATP Holder's positions) or a Clearing Member (with respect to positions carried and cleared by the Clearing Members). The President, the Chief Executive Officer, or his or her designee(s), may permit an off-floor transfer if necessary or appropriate for the maintenance of a fair and orderly market and the protection of investors and is in the public interest, including due to unusual or extraordinary circumstances. For example, an exemption may be granted if the market value of the Person's positions would be compromised by having to comply with the requirement to trade on the Exchange pursuant to the normal auction process or when, in the judgment of the President, the Chief Executive Officer, or his or her designee(s), market conditions make trading on the Exchange impractical.

The Exchange proposes to state that the off-floor transfer procedure set forth in Rule 997.1NY is intended to facilitate non-routine, nonrecurring movements of positions, except for transfers between accounts of the same Person pursuant to proposed subparagraph (a)(2), and is not to be used repeatedly or routinely in circumvention of the normal auction market process.[17]

Lastly, proposed paragraph (h) provides that the off-floor transfer procedure set forth in proposed Rule 997.1NY is only applicable to positions in options listed on the Exchange; that off-floor transfers of positions in Exchange-listed options may also be subject to applicable laws, rules, and regulations, including rules of other self-regulatory organizations; and that off-floor transfers of non-Exchange listed options and other financial instruments are not governed by this proposed Rule 997.1NY.

Proposed Rule 997.2NY: Off-Floor RWA Transfers

The Exchange proposes to adopt Rule 997.2NY titled ''Off-Floor RWA Transfers,'' to facilitate the reduction of risk-weighted assets (''RWA'') attributable to open options positions. This proposal is substantively identical to rules on other options exchanges and would align the Exchanges rules with that of its competitors.[18]

SEC Rule 15c3–1 (Net Capital Requirements for Brokers or Dealers) (''Net Capital Rules'') requires registered broker-dealers, unless otherwise excepted, to maintain certain specified minimum levels of capital.[19] The Net Capital Rules are designed to protect securities customers, counterparties, and creditors by requiring that broker-dealers have sufficient liquid resources on hand, at all times, to meet their financial obligations. Notably, hedged positions, including offsetting futures and options contract positions, result in

[14] This notice provision applies only to transfers involving an ATP Holder's positions and not to positions of non-ATP Holders, as the latter parties are not subject to Exchange rules. In addition, no notice would be required to effect transfers to correct bona fide errors pursuant to proposed subparagraph (a)(1) or transfers of positions from one account to another where no change in ownership is involved pursuant to proposed paragraph (a)(2) of Rule 997.1NY.

[15] *See* Rule 957.NY(d) (providing that ''[f]or each transaction in which an ATP Holder participates off-board (off a participating Exchange) in any option pertaining to an underlying security which is currently approved for Exchange options transactions, such ATP Holder shall report the transaction to the Exchange in a form and manner prescribed by the Exchange. (With the identity of participants removed, such transaction may be made public by the Exchange.)'').

[16] *See* ISE Options 6, Section 5(f); MIAX Rule 1326(f). The Exchange notes that, unlike the rules of ISE and MIAX, which refer to ''senior level designees,'' the Exchange proposes to instead reference ''designees,'' which omits the potentially ambiguous ''senior'' qualifier. The Exchange believes this distinction does not alter the or impede the authority granted in the proposed provision and is consistent with other Exchange rules that provide for delegated authority. *See, e.g.,* Rule 975NY(k)(3)(A) (proving that the appeals panel to review Obvious Errors or Catastrophic Errors be comprised, in part of, the Exchange Chief Regulatory Officer (''CRO''), or a *designee* of the CRO).

[17] *See* proposed Rule 997.1NY(g).

[18] *See, e.g.,* Cboe Rule 6.8 (Off-Floor RWA Transfers); ISE Options 6, Section 6 (Off-Exchange RWA Transfers).

[19] 17 CFR 240.15c3–1.

certain net capital requirement reductions under the Net Capital Rules.[20]

Subject to certain exceptions, Clearing Members are subject to the Net Capital Rules.[21] However, a subset of Clearing Members are subsidiaries of U.S. bank holding companies, which, due to their affiliations with their parent U.S.-bank holding companies, must comply with additional bank regulatory capital requirements pursuant to rulemaking required under the Dodd-Frank Wall Street Reform and Consumer Protection Act.[22] Pursuant to this mandate, the Board of Governors of the Federal Reserve System, the Office of the Comptroller of the Currency, and the Federal Deposit Insurance Corporation have approved a regulatory capital framework for subsidiaries of U.S. bank holding company clearing firms.[23] Generally, these rules, among other things, impose higher minimum capital and higher asset risk weights than were previously mandated for Clearing Members that are subsidiaries of U.S. bank holding companies under the Net Capital Rules. Furthermore, the new rules do not fully permit deductions for hedged securities or offsetting options positions.[24] Rather, capital charges under these standards are, in large part, based on the aggregate notional value of short positions regardless of offsets. As a result, in general, Clearing Members that are subsidiaries of U.S. bank holding companies must hold substantially more bank regulatory capital than would otherwise be required under the Net Capital Rules.

The Exchange is concerned with the ability of Market Makers to provide liquidity in their appointed classes. The Exchange believes that permitting market participants to efficiently transfer existing options positions through an off-floor transfer process would likely have a beneficial effect on continued liquidity in the options market without adversely affecting market quality. Liquidity in the listed options market is critically important. The Exchange believes that the proposed rule change provides market participants with an efficient mechanism to transfer their open options positions from one clearing account to another clearing account and thereby increase liquidity in the listed options market. The Exchange currently has no mechanism that firms may use to transfer positions between clearing accounts without having to effect a transaction with another party and close a position.

Proposed Rule 997.2NY provides that, notwithstanding Rule 997NY (described above), existing positions in options listed on the Exchange of an ATP Holder or non-ATP Holder (including an affiliate of an ATP Holder) may be transferred on, from, or to the books of a Clearing Member off the Exchange if the transfer establishes a net reduction of RWA attributable to those options positions (an ''RWA Transfer''). Proposed paragraph (a) to Rule 997.2NY provides examples of two transfers that would be deemed to establish a net reduction of RWA, and thus qualify as a permissible RWA Transfer:

- A transfer of options positions from Clearing Member A to Clearing Member B that net (offset) with positions held at Clearing Member B, and thus closes all or part of those positions (as demonstrated in the example below); [25] and
- A transfer of options positions from a bank-affiliated Clearing Member to a non-bank-affiliated Clearing Member.[26]

These transfers would not result in a change in ownership, as they must occur between accounts of the same ''Person,'' as defined in Rule 15, per proposed Rule 997.2NY(e).[27] In other words, RWA Transfers may only occur between the same individual or legal entity. These are merely transfers from one clearing account to another, both of which are attributable to the same individual or legal entity. A market participant effecting an RWA Transfer is analogous to an individual transferring funds from a checking account to a savings account, or from an account at one bank to an account at another bank—the money still belongs to the same person, who is just holding it in a different account for personal financial reasons.

For example, Market Maker A clears transactions on the Exchange into an account it has with Clearing Member X, which is affiliated with a U.S-bank holding company. Market Maker A opens a clearing account with Clearing Member Y, which is not affiliated with a U.S.-bank holding company. Clearing Member X has informed Market Maker A that its open positions may not exceed a certain amount at the end of a calendar month, or it will be subject to restrictions on new positions it may open the following month. On August 28, Market Maker A reviews the open positions in its Clearing Member X clearing account and determines it must reduce its open positions to satisfy Clearing Member X's requirements by the end of August. It determines that transferring out 1,000 short calls in class ABC will sufficiently reduce the RWA capital requirements in the account with Clearing Member X to avoid additional position limits in September. Market Maker A wants to retain the positions in accordance with its risk profile. Pursuant to the proposed rule change, on August 31, Market Maker A transfers 1,000 short calls in class ABC to its clearing account with Clearing Member Y. As a result, Market Maker A can continue to provide the same level of liquidity in class ABC during September as it did in previous months.

An ATP Holder must ''give up'' a Clearing Member for each transaction it effects on the Exchange, which identifies the Clearing Member through which the transaction will clear.[28] An ATP Holder that has the ability to change the give up for a transaction within a specified period of time.[29] Additionally, an ATP Holder may change the Clearing Member for a specific transaction.[30] The transfer of

[20] In addition, the Net Capital Rules permit various offsets under which a percentage of an option position's gain at any one valuation point is allowed to offset another position's loss at the same valuation point (*e.g.,* vertical spreads).

[21] In the event federal regulators modify bank capital requirements in the future, the Exchange will reevaluate the proposed rule change at that time to determine whether any corresponding changes to the proposed rule are appropriate.

[22] H.R. 4173 (amending section 3(a) of the Act) (15 U.S.C. 78c(a))).

[23] 12 CFR 50; 79 FR 61440 (Liquidity Coverage Ratio: Liquidity Risk Measurement Standards).

[24] Many options strategies, including relatively simple strategies often used by retail customers and more sophisticated strategies used by broker-dealers, are risk limited strategies or options spread strategies that employ offsets or hedges to achieve certain investment outcomes. Such strategies typically involve the purchase and sale of multiple options (and may be coupled with purchases or sales of the underlying securities), executed simultaneously as part of the same strategy. In many cases, the potential market exposure of these strategies is limited and defined.

[25] This transfer would establish a net reduction of RWA attributable to the transferring Person, because there would be fewer open positions and thus fewer assets subject to Net Capital Rules.

[26] This transfer would establish a net reduction of RWA attributable to the transferring Person, because the non-bank-affiliated Clearing Member would not be subject to Net Capital Rules, as described above.

[27] *See supra* note 10 (defining Person).

[28] *See* Rule 961 (Authorizing Give Up of a Clearing Member) (providing process for an ATP Holder (other than a Market Maker) to indicate each of its transactions any OCC number of a Clearing Member through which a transaction will be cleared (*i.e.,* the give up), subject to the criteria set forth in the rule).

[29] *See* Rule 961(g)(1) (providing that, ''[i]f the ATP Holder has the ability through an Exchange system to do so, the ATP Holder may change the give up on the trade to another Clearing Member for whom they are an Authorized ATP Holder or to its Guarantor.''; which ability ''will end at the Trade Date Cutoff Time.'').

[30] The Clearing Member Trade Assignment (''CMTA'') process at OCC facilitates the transfer of option trades/positions from one OCC clearing

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positions from an account with one clearing firm to the account of another clearing firm pursuant to the proposed rule change has a similar result as changing a give up or CMTA, as it results in a position that resulted from a transaction moving from the account of one clearing firm to another, just at a different time and in a different manner.[31]

In the above example, if Market Maker A had initially given up Clearing Member Y rather than Clearing Member X on the transactions that resulted in the 1,000 long calls in class ABC, or had changed the give-up or CMTA to Clearing Member Y pursuant to Rule 961 the ultimate result would have been the same. There are a variety of reasons why firms give up or CMTA transactions to certain clearing firms (and not to non-bank affiliate clearing firms) at the time of a transaction, and the proposed rule change provides firms with a mechanism to achieve the same result at a later time.

Proposed paragraph (b) to Rule 997.2NY provides that RWA Transfers may occur on a routine, recurring basis. As noted in the example above, clearing firms may impose restrictions on the amount of open positions. Permitting transfers on a routine, recurring basis will provide market participants with the flexibility to comply with these restrictions when necessary to avoid position limits on future options activity. Additionally, proposed paragraph (f) to Rule 997.2NY provides that no prior written notice to the Exchange is required for RWA Transfers. Because of the potential routine basis on which RWA Transfers may occur, and because of the need for flexibility to comply with the restrictions described above, the Exchange believes such requirement may interfere with the ability of ATP Holders to comply with any Clearing Member restrictions describe above, and may be burdensome to provide notice for these routine transfers.

Proposed Rule 997.2NY(c) provides that RWA Transfers may result in the netting of positions. Netting occurs when long positions and short positions in the same series ''offset'' against each other, leaving no or a reduced position. For example, if there were 100 long calls in one account, and 100 short calls of the same option series were added to that account, the positions would offset, leaving no open positions. Firms may maintain different clearing accounts for a variety of reasons, such as the structure of their businesses, the manner in which they trade, their risk management procedures, and for capital purposes. While there are times when a firm may not want to close out open positions to reduce RWA, there are other times when a firm may determine it is appropriate to close out positions to accomplish a reduction in RWA.

In the example above, suppose after making the RWA Transfer described above, Market Maker A effects a transaction on September 25 that results in 1,000 long calls in class ABC, which clears into its account with Clearing Member X. If Market Maker A had not effected its RWA Transfer in August, the 1,000 long calls would have offset against the 1,000 short calls, eliminating both positions and thus any RWA capital requirements associated with them. At the end of August, Market Maker A did not want to close out the 1,000 short calls when it made its RWA Transfer. However, given changed circumstances in September, Market Maker A has determined it no longer wants to hold those positions. The proposed rule change would permit Market Maker A to effect an RWA Transfer of the 1,000 short calls from its account with Clearing Member Y to its account with Clearing Member X (or vice versa), which results in elimination of those positions (and a reduction in RWA associated with them). As noted above, such netting would have occurred if Market Maker A cleared the September transaction directly into its account with Clearing Member Y, or had not effected an RWA Transfer in August. Netting provides market participants with appropriate flexibility to conduct their businesses as they see fit while having the ability to reduce RWA capital requirements when necessary.

Proposed Rule 997.2NY(d) provides that RWA Transfers may not result in preferential margin or haircut treatment. Finally, per proposed Rule 997.2NY(g), RWA Transfers may only be effected for options listed on the Exchange, as transfers of non-Exchange listed options and other financial instruments are not governed by proposed Rule 997.2NY, and will be subject to applicable laws, rules, and regulations, including rules of other self-regulatory organizations (including OCC).[32]

Proposed Rule 997.3NY: In-Kind Exchange of Options Positions and ETF Shares and UIT Units

The Exchange proposes to adopt Rule 997.3NY regarding in-kind exchanges of options positions and exchange-traded fund (''Fund'') shares and unit investment trust (''UIT'') interests. As discussed further below, the ability to effect ''in kind'' transfers is a key component of the operational structure of a Fund and a UIT. Currently, in general, Funds and UITs can effect in-kind transfers with respect to equity securities and fixed-income securities. The in-kind process is the means by which assets may be added to or removed from Funds and UITs. The proposed rule change is substantively identical to rules on other options exchanges and would align the Exchanges rules with that of its competitors.[33]

Proposed Rule 997.3NY would add a circumstance under which off-floor transfers of options positions would be permitted to occur, in addition to the circumstances in proposed Rules 997.1NY and 997.2NY. Specifically, Rule 997.3NY would allow positions in options listed on the Exchange to be transferred off the Exchange by an ATP Holder in connection with transactions (a) to purchase or redeem ''creation units'' of Fund Shares between an ''authorized participant'' [34] and the issuer [35] of such Fund Shares [36] or (b) to create or redeem units of a UIT between

member to another in an automated fashion. Changing a CMTA for a specific transaction would allocate the trade to a different OCC clearing member than the one initially identified on the trade.

[31] The transferred positions will continue to be subject to OCC rules, as they will continue to be held in an account of an OCC member.

[32] All RWA Transfers will be subject to all recordkeeping requirements applicable to ATP Holders and Clearing Members under the Act, such as Rule 17a–3 and 17a–4.

[33] *See* NYSE Arca Rule 6.78A–O and Cboe Options Rule 6.9 (except that the Cboe rule does not include a notice provision related to the transfers that is contained in Rule 6.78A–O(b) and proposed Rule 997.2NY(b)). *See also* Securities and Exchange Act Release No. 90552 (December 2, 2020), 85 FR 79049 (December 8, 2020) (SR–NYSEArca–2020–102) (immediately effective filing to adopt Rule 6.78A–O to allow in-kind exchange of options positions and ETF Shares and UIT Units).

[34] The Exchange is proposing that, for purposes of proposed Rule 997.3NY, the term ''authorized participant'' would be defined as an entity that has a written agreement with the issuer of Fund Shares or one of its service providers, which allows the authorized participant to place orders for the purchase and redemption of creation units (*i.e.,* specified numbers of Fund Shares). *See* proposed Rule 997.3NY(a)(1). While an authorized participant may be an ATP Holder and directly effect transactions in options on the Exchange, an authorized participant that is not an ATP Holder may effect transactions in options on the Exchange through an ATP Holder on its behalf.

[35] The Exchange proposes that, for purposes of proposed Rule 997.3NY, any issuer of Fund Shares would be registered with the Commission as an open-end management investment company under the Investment Company Act of 1940 (the ''1940 Act''). See proposed Rule 997.3NY(a)(2).

[36] A Fund Share is a share or other security traded on a national securities exchange and defined as an NMS stock, as set forth in in Rule 600(b)(47) of Regulation NMS, which includes open-end management investment companies registered with the Commission. *See* Rule 915, Commentary .06.

a broker-dealer and the issuer [37] of such UIT units, which transfers would occur at the price used to calculate the net asset value (''NAV'') of such Fund Shares or UIT units, respectively. Allowing the Exchange to permit off-floor transfers of options positions in connection with the creation and redemption process would enable the Exchange to compete with other options exchanges that allow such transfers.

However, the Exchange believes it is appropriate to include in proposed Rule 997.3NY(b) the requirement that ATP Holders that engage in such transfers ''must, upon request of the Exchange, provide to the Exchange information relating to the transfers in a form and manner prescribed by the Exchange.'' The Exchange notes that this proposed provision is identical to the notice provision in NYSE Arca Rule 6.78A–O(b), and, like that provision, would help ensure that ATP Holders keep accurate books and records relating to such transfers for review by the Exchange, which is to the benefit of all market participants.

The Exchange's proposal mirrors other exchange rules in that applies solely in the context of transfers of options positions effected in connection with transactions to purchase or redeem creation units of Fund Shares between Funds and authorized participants,[38] and units of UITs between UITs and sponsors. Other than the transfers covered by the proposed rule, transactions involving options, whether held by a Fund or an authorized participant, or a UIT or a sponsor would be fully subject to all applicable Exchange trading rules.

2. Statutory Basis

The Exchange believes that its proposal is consistent with Section 6(b) of the Act,[39] in general, and furthers the objectives of Section 6(b)(5) of the Act,[40] in particular, because it is 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 and because it is not designed to permit unfair discrimination between customers, issuers, brokers, or dealers. As a general matter, the proposed rules are substantively identical to rules on other options exchanges and would align the Exchanges rules with that of its competitors. As such, this proposal would benefit investors by reducing the administrative burden of determining whether their off-floor transfers comply with multiple sets of options exchange rules.

Proposed Rule 997NY: Transactions Off the Exchange

In particular, the Exchange believes proposed Rule 997NY is consistent with the Act, because it adopts provisions in the Rules specifically required by Rules 19c–1 and 19c–3 under the Act, setting forth the Exchange's general prohibition against off-floor transfers. The proposed rule change will add transparency to the Exchange rules, which would benefit investors. In addition, as noted herein, proposed Rule 997NY is substantively identical to the rules of at least one other options exchange and would therefore allow the Exchange to compete on equal footing.

Proposed Rule 997.1NY: Off-Floor Transfer of Positions

The Exchange believes that permitting off-floor transfers in very limited circumstances would allow ATP Holders to accomplish certain goals efficiently. Proposed Rule 997.1NY is also substantively identical to the rules of other options exchanges and, consistent with those rules, the proposed rule permits non-recurring off-floor transfers in situations involving dissolutions of entities or accounts, for purposes of donations, mergers or by operation of law. As noted above for example, an ATP Holder that is undergoing a structural change and a one-time movement of positions may require a transfer of positions or an ATP Holder that is leaving a firm that will no longer be in business may require a transfer of positions to another firm. Also, an ATP Holder may require a transfer of positions to make a capital contribution. The above-referenced circumstances are non-recurring situations where the transferor continues to maintain some ownership interest or manage the positions transferred. By contrast, repeated or routine transfers between entities or accounts—even if there is no change in beneficial ownership as a result of the transfer—is inconsistent with the purposes for which the proposed rule will be adopted. Accordingly, such activity would not be permitted under the proposed rule. The proposed rule change would provide market participants that experience these limited, non-recurring events with an efficient and effective means to transfer positions in these situations. The Exchange believes the proposed rule change regarding permissible transfer prices would provide market participants with flexibility to determine the price appropriate for their business, which maintain cost bases in accordance with normal accounting practices and removes impediments to a free and open market.

The proposed rule change which requires notice and maintenance of records would ensure the Exchange is able to review off-floor transfers for compliance with the Exchange rules, which prevents fraudulent and manipulative acts and practices. The requirement to retain records is consistent with the requirements of Rule 17a–3 and 17a–4 under the Act.

Similar to the rules of other options exchanges, the Exchange would permit a presidential exemption.[41] The Exchange believes that this exemption is consistent with the Act because the Exchange's Chief Executive Officer or President (or his or her designee(s)) would consider an exemption in very limited circumstances (*i.e.,* to facilitate non-routine, nonrecurring movements of positions not designed to circumvent the normal auction market process). Proposed Rule 997.1NY(f) specifically provides that the Exchange's Chief Executive Officer or President (or his or her designee(s)) may in his or her judgment allow an off-floor transfer if it is necessary or appropriate for the maintenance of a fair and orderly market and the protection of investors and is in the public interest, including due to unusual or extraordinary circumstances such as the market value of the Person's positions will be comprised by having to comply with the requirement to trade on the Exchange pursuant to the normal auction process or, when in the judgment of the President, Chief Executive Officer, or his or her designee(s), market conditions

[37] The Exchange proposes that, for purposes of proposed Rule 997.3NY, any issuer of UIT units would be a trust registered with the Commission as a unit investment trust under the 1940 Act. See proposed Rule 997.3NY(a)(3).

[38] *See supra* note 34. The term ''authorized participant'' is specific and narrowly defined. As noted in the Investment Company Act Release No. 33140 (June 28, 2018), 83 FR 37332 (July 31, 2018) (the ''Proposed ETF Rule Release''), the requirement that only authorized participants of a Fund may purchase creation units from (or sell creation units to) a Fund ''is designed to preserve an orderly creation unit issuance and redemption process between [Funds] and authorized participants.'' Furthermore, an ''orderly creation unit issuance and redemption process is of central importance to the arbitrage mechanism.'' *See* Proposed ETF Rule Release at 83 FR 37348.

[39] 15 U.S.C. 78f(b).

[40] 15 U.S.C. 78f(b)(5).

[41] *See* ISE Options 6, Section 5(f); MIAX Rule 1326(f). *See also* Cboe Rule 6.8(f).

make trading on the Exchange impractical. These standards within paragraph (f) of the proposed rule are intended to provide guidance concerning the use of this exemption to the benefit of investors and the investing public for the maintenance of a fair and orderly market and the protection of investors and is in the public interest.

Finally, the Exchange believes the conforming change to delete paragraph (d) to Rule 957NY in light of the comparable notice requirement in proposed Rule 997.1NY(d) would reduce redundancy, add clarity, transparency and internal consistent to Exchange rules.

Proposed Rule 997.2NY: Off-Floor RWA Transfers

The Exchange believes proposed Rule 997.2NY to permit RWA Transfers, which is substantially the same as the rules of other options markets, would remove impediments to and perfect the mechanism of a free and open market and a national market system by providing liquidity in the listed options market. The Exchange believes providing market participants with an efficient process to reduce RWA capital requirements attributable to open positions in clearing accounts with U.S. bank-affiliated clearing firms may contribute to additional liquidity in the listed options market, which, in general, protects investors and the public interest.

The proposal to permit RWA Transfers to occur on a routine, recurring basis and result in netting, also provides market participants with sufficient flexibility to reduce RWA capital requirements at times necessary to comply with requirements imposed on them by clearing firms. This would permit market participants to respond to then-current market conditions, including volatility and increased volume, by reducing the RWA capital requirements associated with any new positions they may open while those conditions exist. Given the additional capital that may become available to market participants as a result of the RWA Transfers, market participants would be able to continue to provide liquidity to the market, even during periods of increased volume and volatility, which liquidity ultimately benefits investors. It is not possible for market participants to predict what market conditions will exist at a specific time, and when volatility will occur. The proposed rule change to permit routine, recurring RWA Transfers (without any required prior written notice) would provide market participants with the ability to respond to these conditions whenever they occur. Permitting such transfers on a routine, recurring basis will provide market participants with the flexibility to comply with applicable restrictions when necessary to avoid position limits on future options activity. In addition, with respect to netting, as discussed above, firms may maintain different clearing accounts for a variety of reasons, such as the structure of their businesses, the manner in which they trade, their risk management procedures, and for capital purposes. Netting may otherwise occur with respect to a firm's positions if it structured its clearing accounts differently, such as by using a universal account. Therefore, the proposed rule change will permit netting while allowing firms to continue to maintain different clearing accounts in a manner consistent with their businesses.

The Exchange recognizes the numerous benefits of executing options transactions on exchanges, including price transparency, potential price improvement, and a clearing guarantee. However, the Exchange believes it is appropriate to permit RWA Transfers to occur off the Exchange, as these benefits are inapplicable to RWA Transfers, which are narrow in scope and intended to achieve a limited beneficial purpose. RWA Transfers are not intended to be a competitive trading tool. There is no need for price discovery or improvement, as the purpose of the transfer is to reduce RWA asset capital requirements attributable to a market participants' positions. Unlike trades on an exchange, the price at which an RWA Transfers occurs is immaterial—the resulting reduction in RWA is the critical part of the transfer. RWA Transfers will result in no change in ownership, and thus they do not constitute trades with a counterparty (and thus eliminating the need for a counterparty guarantee). The transactions that resulted in the open positions to be transferred as an RWA Transfer were already guaranteed by a Clearing Member, and the positions will continue to be subject to OCC rules, as they will continue to be held in an account with a Clearing Member. The narrow scope of the proposed rule change and the limited, beneficial purpose of RWA Transfers make allowing RWA Transfers to occur off the floor appropriate and important to support the provision of liquidity in the listed options market.

The proposed rule change does not unfairly discriminate against market participants, as all ATP Holders and non-ATP Holders with open positions in options listed on the Exchange may use the proposed off-floor transfer process to reduce the RWA capital requirements of Clearing Members. Finally, this proposed rule change would align Exchange rules with those of other options exchanges, thereby allowing the Exchange to compete on equal footing.

Proposed Rule 997.3NY: In-Kind Exchange of Options Positions and ETF Shares and UIT Units

The Exchange believes proposed Rule 997.3NY to permit off-floor transfers in connection with the in-kind Fund and UIT creation and redemption process would promote just and equitable principles of trade as it would permit Funds and UITs that invest in options traded on the Exchange to utilize the in-kind creation and redemption process that is available for Funds and UITs that invest in equities and fixed-income securities.

The Exchange believes it is appropriate to require ATP Holders that engage in off-floor transfers as provided in proposed Rule 997.3NY(b) to keep records of such transactions such that this information could be shared with the Exchange upon request. The Exchange believes this provision, which is identical to NYSE Arca Rule 6.78A–O(b), would prevent fraudulent and manipulative acts and practices, to promote just and equitable principles of trade because the provision would help ensure that ATP Holders keep accurate books and records relating to such transfers for review by the Exchange, which is to the benefit of all market participants. Finally, this proposed rule change would align Exchange rules with those of other options exchanges, thereby allowing the Exchange to compete on equal footing.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange believes that the proposal would not impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of Section 6(b)(8) of the Act.[42] The proposed rules are not intended to be competitive trading tools, but rather to set forth the general prohibition against off-floor transactions and to facilitate certain off-floor transactions in limited circumstances that meet the enumerated criteria.

The Exchange does not believe the proposed rule change regarding off-floor position transfers set forth in the proposed rules would impose an undue burden on intra-market competition as

[42] 15 U.S.C. 78f(b)(8).

the transfer procedure(s) may be utilized by any ATP Holder and the rule would apply uniformly to all ATP Holders. Use of each off-floor transfer procedure is voluntary and all ATP Holders may use each such procedure to transfer positions as long as the criteria in the proposed rule are satisfied.

The Exchange does not believe the proposed rule change will impose an undue burden on inter-market competition. As indicated above, it is intended to provide an additional clearly delineated and limited circumstance in which options positions can be transferred off an exchange (as well as to set forth the general prohibition against such transfers). Additionally, as discussed above, the proposed rule change is substantively identical to the rules of other options exchanges and would allow the Exchange to compete on equal footing. Moreover, the Exchange believes having similar rules related to off-floor position transfers to those of other options exchanges will reduce the administrative burden on market participants of determining whether their transfers comply with multiple sets of rules.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

No written comments were solicited or received with respect to the proposed rule change.

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[43] and Rule 19b–4(f)(6) thereunder.[44] 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 and Rule 19b–4(f)(6)(iii) thereunder.[45]

[43] 15 U.S.C. 78s(b)(3)(A)(iii).

[44] 17 CFR 240.19b–4(f)(6).

[45] 15 U.S.C. 78s(b)(3)(A)(iii). Rule 19b–4(f)(6)(iii) requires a self-regulatory organization to give the Commission written notice of its intent to file 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 Commission notes that the Exchange satisfied this requirement.

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) of the Act[46] 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 (*http://www.sec.gov/rules/sro.shtml*); or
- Send an email to *rule-comments@sec.gov*. Please include File Number SR–NYSEAMER–2022–36 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–NYSEAMER–2022–36. 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 (*http://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 10:00 a.m. and 3:00 p.m. Copies of the filing also will be available for inspection and copying at the principal office of the Exchange. All comments received will be posted without change. Persons submitting comments are cautioned that we do not redact or edit personal identifying information from comment submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–NYSEAMER–2022–36 and should be submitted on or before September 28, 2022.

[46] 15 U.S.C. 78s(b)(2)(B).

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[47]

J. Matthew DeLesDernier,

Deputy Secretary.

[FR Doc. 2022–19226 Filed 9–6–22; 8:45 am]

BILLING CODE 8011–01–P

[47] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–95644; File No. SR–NYSEARCA–2022–55]

Self-Regulatory Organizations; NYSE Arca, Inc.; Notice of Filing and Immediate Effectiveness of Proposed Rule Change To Modify Rule 6.78–O and Adopt New Rules Related Thereto and Delete Paragraph (d) to Rule 6.69–O

August 31, 2022.

Pursuant to Section 19(b)(1)[1] of the Securities Exchange Act of 1934 (''Act'')[2] and Rule 19b–4 thereunder,[3] notice is hereby given that, on August 23, 2022, NYSE Arca, Inc. (''NYSE Arca'' or the ''Exchange'') filed with the Securities and Exchange Commission (the ''Commission'') the proposed rule change as described in Items I and II, below, which Items have been prepared by the self-regulatory organization. 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 modify Rule 6.78–O and to adopt new rules related thereto regarding certain position transfers, including off-floor transfers. The Exchange also proposes to delete paragraph (d) to Rule 6.69–O (Reporting Duties). The proposed rule change is available on the Exchange's

[1] 15 U.S.C. 78s(b)(1).

[2] 15 U.S.C. 78a.

[3] 17 CFR 240.19b–4.

website at *www.nyse.com,* at the principal office of the Exchange, 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 self-regulatory organization 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 those 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 parts of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and the Statutory Basis for, the Proposed Rule Change

1. Purpose

The purpose of this rule change is to modify Rule 6.78–O and to adopt new rules related thereto regarding certain position transfers, including off-floor transfers as described herein. As discussed herein, the proposed rules are substantively identical to rules on other options exchanges and would align the Exchanges rules with that of its competitors, thus reducing market participants' administrative burden of determining whether their transfers comply with multiple sets of options exchange rules.[4] The Exchange also proposes to delete paragraph (d) to Rule 6.69–O (Reporting Duties) for reason set forth below.

Rule 6.78–O sets forth the general rule that transactions of option contracts listed on the Exchange for a premium in excess of $1.00 must be effected on the floor of the Exchange or on another exchange.[5] Notwithstanding this prohibition, the Exchange permits certain types of position transfers to be effected off the floor.[6] In addition, Rule 6.78–O(e) sets forth a procedure for an ''on-floor'' transfer of positions and Rule 6.78–O(f) authorizes the Exchange's Chief Executive Officer to grant exemptions to (e) of the Rule.

The Exchange proposes to delete current Rule 6.78–O in its entirety and replace it with proposed Rules 6.78–O and 6.78A–O, the text of which rules are substantively identical to Cboe Options Exchange, Inc. (''Cboe'') Rules 5.12 (Transactions Off the Exchange) and Rule 6.7 (Off-Floor Transfer of Positions). As such, the proposed rules would align Exchange rules with those of its competitors.[7] The Exchange believes having similar rules related to off-floor transfer positions to those of other options exchanges would reduce the administrative burden on market participants of determining whether their off-floor transfers comply with multiple sets of rules. The proposed Rules would apply to all Exchange rules and, as such, the Exchange is not proposing to carry forward current Commentary .03, which specifies Exchange rules to which it applies.[8]

Proposed Rule 6.78–O: Transactions Off the Exchange

Proposed Rule 6.78–O(a) provides that except as otherwise provided by this proposed Rule, no OTP Holders or OTP Firm [9] acting as principal or agent may effect transactions in any class of option contracts listed on the Exchange for a premium in excess of $1.00 other than (1) on the Exchange, (2) on another exchange on which such option contracts are listed and traded, or (3) in the over-the-counter market if the stock underlying the option class, or in the case of an index option, if all the component stocks of an index underlying the option class, was a National Market System security under SEC Rule 600 at the time the Exchange commenced trading in that option class, unless that OTP Holder or OTP Firm has first attempted to execute the transaction on the floor of the Exchange and has reasonably ascertained that it may be executed at a better price off the floor.[10] Proposed Rule 6.78–O(a) is substantially the same as current Rule 6.78–O(a) and (b), regarding off-floor transfer requirements for an OTP Holder or OTP Firm acting as principal or agent, respectively, except that it updates references to SEC rules.[11] Proposed Rule 6.78–O(a)(1)–(3), insofar as it clarifies the securities to which the proposed Rule applies, obviates the need for current Commentary .01 to Rule 6.78–O.[12]

Proposed Rule 6.78–O(b) provides that, notwithstanding the provisions of paragraph (a) of this proposed Rule, an OTP Holder or OTP Firm acting as agent may execute a customer's order off the Exchange floor with any other person (except when such OTP Holder or OTP Firm also is acting as agent for such other person in such transaction) for the purchase or sale of an option contract listed on the Exchange.[13]

Proposed Rule 6.78–O(c) provides that for each transaction in which an OTP Holder or OTP Firm acting as principal or agent executes any purchase or sale of an option contract listed on the Exchange other than on the Exchange or on another exchange on which such option contracts are listed and traded, a record of such transaction shall be maintained by such OTP Holder or OTP Firm and shall be available for inspection by the Exchange for a period of one year. Such record shall include the circumstances under which the transaction was executed in conformity with this Rule.[14]

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[4] *See, e.g.,* Cboe Options Exchange, Inc. (''Cboe'') Rule 5.12 (Transactions Off the Exchange); Cboe Rule 6.7 (Off-Floor Transfer of Positions); Cboe Rule 6.8 (Off-Floor RWA Transfers); and NYSE Arca Rule 6.78A–O (In-Kind Exchange of Options Positions and ETF Shares and UIT Units) and Cboe Rule 6.9 (same).

[5] *See* Rule 6.78–O(a)–(b). Rule 6.78–O(c) requires that OTP Holders or OTP Firms that effect off-floor transfers keep records of such transactions.

[6] *See* Rule 6.78–O(d)(1) (setting forth specific events under which off-floor transfers are permitted). The Exchange notes that new Rule 6.78A–O will address enumerated exceptions to the general prohibition against off-floor transfers (as set forth in proposed Rule 6.78–O).

[7] *See, e.g.,* Cboe Rule 5.12 (Transactions Off the Exchange) and Rule 6.7 (Off-Floor Transfer of Positions).

[8] *See* Rule 6.78–O, Commentary .03 (providing that ''[t]o the extent applicable, all other Exchange rules, including Rule 6.49–O, Solicited Transactions, will apply to the transfer procedure set forth in subsections (d) through (f). The following Rules do not apply to transfer procedures: 6.71–O (Meaning of Premium Bids and Offers); 6.74–O (Bids and Offers in Relation to Units of Trading); 6.75–O (Priority of Bids and Offers); 6.76–O (Priority of Split Price Transactions); and 6.47–O (''Crossing'' Orders and Stock/Option, SSF/Option Orders)'').

[9] An ''OTP Holder'' is a natural person, in good standing, who has been issued an OTP, or has been named as a Nominee. See Rule 1.1. An ''OTP Firm'' is a sole proprietorship, partnership, corporation, limited liability company or other organization in good standing who holds an OTP or upon whom an individual OTP Holder has conferred trading privileges on the Exchange's Trading Facilities pursuant to and in compliance with Exchange rules. *See id.*

[10] *See* Cboe Rule 5.12(a).

[11] *See* Rules 6.78–O(a) and (b) (setting forth the requirements for OTP Holders or OTP Firms acting for their own account or as agent, respectively, to effect off-board transactions (or off a participating exchange) ''involving any purchase or sale of an option for a premium in excess of $1.00 covering the same underlying security and having the same exercise price and expiration date as a series of options currently open for trading on the Exchange,'' including ensuring such transactions could not be executed at a better price on an exchange).

[12] *See* Rule 6.78–O, Commentary .01 (providing that ''[p]aragraphs (a) and (b) above shall not apply to option transactions executed (i) on the Exchange, (ii) on another exchange, or (iii) through the facilities of NASDAQ, if the security underlying the option class was a National Market System ('NMS') Tier 1 security under Securities and Exchange Commission Rule 11Aa2–1(b)(1) at the time the Exchange commenced trading in that option class'').

[13] *See* Cboe Rule 5.12(b).

[14] *See* Cboe Rule 5.12(c). Proposed Rule 6.78–O(c) is substantially the same as current Rule 6.78–O(c) regarding recording-keeping requirements for OTP Holders or OTP Firms effecting off-floor transfers.

Proposed Rule 6.78–O(d) provides that no rule, stated policy, or practice of the Exchange may prohibit or condition, or be construed to prohibit or condition, or otherwise limit, directly or indirectly, the ability of any OTP Holder or OTP Firm acting as agent to effect any transaction otherwise than on the Exchange with another person (except when such OTP Holder or OTP Firm also is acting as agent for such other person in such transaction) in any equity security listed on the Exchange or to which unlisted trading privileges on the Exchange have been extended.[15]

Proposed Rule 6.78–O(e) provides that no rule, stated policy, or practice of the Exchange may prohibit or condition, or be construed to prohibit, condition, or otherwise limit, directly or indirectly, the ability of any OTP Holder or OTP Firm to effect any transaction otherwise than on the Exchange in any reported security listed and registered on the Exchange or as to which unlisted trading privileges on the Exchange have been extended (other than a put option or call option issued by Options Clearing Corporates or OCC) which is not a covered security.[16]

Proposed Rule 6.78A–O: Off-Floor Transfer of Positions

Rule 6.78–O specifies the circumstances under which OTP Holder and OTP Firms may effect transfers of positions, both on and off the trading floor, notwithstanding the general prohibition against off-floor transfers (discussed above).[17] The Exchange proposes to adopt new Rule 6.78A–O, titled ''Off-Floor Transfer of Positions,'' which would set forth the permissible reasons for and procedures related to off-floor position transfers, but would not include the provisions related to on-floor position transfers. Proposed Rule 6.78A–O is substantively identical to the rules of other option exchanges regarding permissible off-floor transfers of options positions and would align Exchange rules with those of its competitors.[18]

First, the on-floor position transfer procedure set forth in Rule 6.78–O(e) and (f) was designed to help OTP Holders and OTP Firms with a need to transfer positions in bulk as part of a sale or disposition of all or substantially all of its assets or options positions to obtain the best possible price for the positions while also ensuring that other OTP Holders and OTP Firms had an adequate opportunity to make bids and offers on the positions being transferred.[19] In addition, the ''on-floor'' position transfer procedure could be used by OTP Holders and OTP Firms that, for reasons other than a forced liquidation, such as an extended vacation, wished to liquidate their entire, or nearly their entire, open positions in a single set of transactions, subject to certain restrictions.[20] Currently, because OTP Holders have been largely consolidated in the hands of firms rather than individuals, such transfers are, for the most part unnecessary; if an individual takes an extended vacation, another member of the firm handles the firm's book. Accordingly, the Exchange believes that the on-floor transfer of positions procedure no longer serves the uses for which it was originally adopted. Moreover, the process—which is only used on a limited basis—is nonetheless administratively burdensome on the Exchange. Further, other options exchange with a trading floor and a transfer of positions rule do not offer an on-floor transfer procedure.[21]

Current Rule 6.78–O(d) lists the circumstances in which OTP Holders or OTP Firms may transfer their positions off the floor. The circumstances currently listed include: (i) the dissolution of a joint account in which the remaining OTP Holder or OTP Firm assumes the positions of the joint account; (ii) the dissolution of a corporation or partnership in which a former nominee of the corporation or partnership assumes the positions; (iii) positions transferred as part of an OTP Holder's or OTP Firm's capital contribution to a new joint account, partnership, or corporation; (iv) the donation of positions to a not-for-profit corporation; (v) the transfer of positions to a minor under the Uniform Gifts to Minors Act; (vi) a merger or acquisition resulting in continuity of ownership or management; or (vii) consolidation of accounts within an OTP Holder or OTP Firm (the ''current Exchange-permitted off-floor transfers''). As set forth below, the Exchange proposes to carry forward the current Exchange-permitted off-floor transfers into proposed Rule 6.78A–O and to add three new permissible circumstances.[22]

Proposed Rule 6.78A–O(a) would provide that, notwithstanding proposed Rule 6.78–O (described above), existing positions in options listed on the Exchange of an OTP Holder or OTP Firm, or non-OTP Holder or OTP Firm, that are to be transferred on, from, or to the books of a Clearing Member[23] may be transferred off the Exchange (an ''off-floor transfer) if the transfer involves one or more of the events listed in proposed Rule 6.78–O(a)(1)–(10).[24] The proposed Rule makes clear that Rule 6.78A–O does not apply to products other than options listed on the Exchange, consistent with the Exchange's other trading rules.[25] It also clarifies that an OTP Holder or OTP Firm or Clearing Member must be on at least one side of the off-floor transfer. The proposed rule change also clarifies that transferred positions must be on, from, or to the books of a Clearing Member. The proposed rule change also

[15] *See* Cboe Rule 5.12(d).

[16] *See* Cboe Rule 5.12(e). The ''Options Clearing Corporation'' or ''OCC'' refers to The Options Clearing Corporation, a subsidiary of the Participating Exchanges. *See* Rule 900.2NY(55). The term ''Participating Exchanges'' refers to any national securities exchange that has qualified for participation in the OCC pursuant to the provisions of the Rules of the Options Clearing Corporation. *See* Rule 900.2NY(61).

[17] *See* Rule 6.78–O(d) (which enumerates circumstances under which off-floor position transfers may occur) and Rule 6.78–O(e) and (f) (which sets forth the procedure or permissible positions transfers on the floor of the exchange or on another options exchange).

[18] *See* Cboe Rule 6.7 (Off-Floor Transfer of Positions). *See also* Nasdaq ISE, LLC (''ISE'') Options 6, Section 5 (Transfer of Positions); Miami Options Exchange (''MIAX'') Rule 1326 (Transfer of Positions). As noted below, regarding the ''presidential'' exemption, Cboe Rule 6.7(f) does not explicitly include the Chief Executive Office, which reference is included in ISE Options 6, Section 5(f); MIAX Rule 1326(f).

[19] *See* Rule 6.78–O(e)(1).

[20] *See* Rule 6.78–O, Commentary .04. Among other restrictions, repeated and frequent use of the on-floor procedure in Rule 6.78–O by an OTP Holder/OTP Firm is not permitted. The Exchange proposes to include text from current Commentary .04 that provides that the on-floor transfer procedure is not to be used repeatedly or routinely in circumvention of the normal auction market process in proposed Rule 6.78A–O, as that provision applies to both the current on-floor and off-floor position transfer procedures. *See* proposed Rule 6.78A–O(g) (discussed herein).

[21] *See, e.g.,* Cboe Rule 5.12 (Transactions Off the Exchange) and Rule 6.7 (Off-Floor Transfer of Positions); ISE Options 6, Section 5 (Transfer of Positions).

[22] *See* proposed Rule 6.78A–O(a). Because proposed Rule 6.78A–O (Off-Floor Transfer of Positions) would replace current Rule 6.78A–O (In-Kind Exchange of Options Positions and ETF Shares and UIT Units), the Exchange proposes the non-substantive conforming change to re-number current Rule 6.78A–O as Rule 6.78C–O. The Exchange is not making any substantive changes to the text of proposed Rule 6.78C–O and believes the proposed change would add clarity, transparency and internal consistent to Exchange rules making them easier to navigate and comprehend.

[23] A ''Clearing Member'' refers to an OTP Firm or OTP Holder that has been admitted to membership in the OCC pursuant to the provisions of the Rules of the OCC. *See* Rule 1.1.

[24] It is possible for positions transfers to occur between two Non-OTP Holders or OTP Firms. For example, one Non-OTP Holder may transfer positions on the books of a Clearing Member to another Non-OTP Holder pursuant to the proposed rule.

[25] Proposed paragraph (h) to Rule 6.78A–O also clarifies that the off-floor transfer procedure only applies to positions in options listed on the Exchange, and that transfers of non-Exchange-listed options and other financial instruments are not governed by Rule 6.78A–O.

clarifies that existing positions of an OTP Holder or OTP Firm or a non-OTP Holder or OTP Firm may be subject to an off-floor transfer, except under specified circumstances in which a transfer may only be effected for positions of an OTP Holder or OTP Firm.[26] As such the proposed changes, in addition to aligning with the rules of another options exchange (*i.e.,* Cboe Rule 6.7), would add clarity and transparency to Exchange rules.

The Exchange notes that off-floor transfers of positions in Exchange-listed options may also be subject to applicable laws, rules, and regulations, including rules of other self-regulatory organizations.[27] Except as explicitly provided in the proposed rule text, the proposed rule change is not intended to exempt off-floor position transfers from any other applicable rules or regulations, and proposed paragraph (h) makes this clear in the rule.

Proposed Rule 6.78A–O(a)(1)–(10) carries over the seven current Exchange-permitted off-floor transfers and adds three more such permissible off-floor transfers as follows:

• Proposed Rule 6.78A–O(a)(1) permits an off-floor transfer to occur if it is an adjustment or transfer in connection with the correction of a bona fide error in the recording of a transaction or the transferring of a position to another account, provided that the original trade documentation confirms the error.[28]

• Proposed Rule 6.78A–O(a)(2) permits an off-floor transfer if it is a transfer of positions from one account to another account where there is no change in ownership involved (*i.e.,* the accounts are for the same Person [29]) provided the accounts are not in separate aggregation units or otherwise subject to information barrier or account segregation requirements.[30] The proposed rule change provides market participants with flexibility to maintain positions in accounts used for the same trading purpose in a manner consistent with their businesses. Such transfers are not intended to be transactions among different market participants, as there would be no change in ownership permitted under the provision, and would also not permit transfers among different trading units for which accounts are otherwise required to be maintained separately.[31] The Exchange is not proposing to carry forward current Commentary .02 as this information contained therein is obviated by proposed Rule 6.78A–O(a)(2).[32]

• Proposed Rule 6.78A–O(a)(10) permits an off-floor transfer if it is a transfer of positions through operation of law from death, bankruptcy, or otherwise.[33] This proposed provision is consistent with applicable laws, rules, and regulations that legally require transfers in certain circumstances. This proposed rule change is consistent with the purposes of other circumstances in the current rule, such as the transfer of positions to a minor or dissolution of a corporation.[34]

The Exchange notes that proposed 6.78A–O(a)(3)–(9) carry forward the current Exchange-permitted off-floor transfer circumstances set forth in Rule 6.78–O(d)(1)(i)–(vii), without substantive differences.[35] The Exchange believes the new events set forth in proposed Rule 6.78A–O have similar purposes as the (now carried forward) current Exchange-permitted off-floor transfers set forth in current Rule 6.78–O(d)(1), which is to permit market participants to move positions from one account to another and to permit transfers upon the occurrence of significant, non-recurring events.[36] As noted above, the proposed rule change is consistent with rules of other self-regulatory organizations.

Proposed Rule 6.78A–O(b) sets forth certain restrictions on permissible off-floor transfers relating to netting of open positions and to margin and haircut treatment, unless otherwise permitted by proposed paragraph (f) (described below). Proposed Rule 6.78A–O(b) is designed to align and harmonize Rule 6.78A–O(b) with the rules of other options exchanges relating to off-floor transfers.[37] As proposed, no position may net against another position (''netting''), and no position transfer may result in preferential margin or haircut treatment. Netting occurs when long positions and short positions in the same series ''offset'' against each other, leaving no position, or a reduced position. For example, if an OTP Holder or OTP Firm wanted to transfer 100 long calls to another account that contained short calls of the same options series as well as other positions, even if the off-floor transfer is permitted pursuant to one of the permissible events listed in proposed Rule 6.78A–O(a)(1)–(10), the OTP Holder or OTP Firm could not transfer the offsetting series, as they would net against each other and close the positions.

Proposed Rule 6.78A–O(c) provides that the transfer price, to the extent it is consistent with applicable laws, rules, and regulations, including rules of other self-regulatory organizations, and tax and accounting rules and regulations, at which an off-floor transfer may be effected is either: (1) the original trade prices of the positions that appear on the books of the trading Clearing Member, in which case the records of the off-floor transfer must indicate the original trade dates for the positions; provided, transfers to correct bona fide errors pursuant to proposed subparagraph (a)(1) must be transferred at the correct original trade prices; (2) mark-to-market prices of the positions at the close of trading on the transfer date; (3) mark-to-market prices of the positions at the close of trading on the trade date prior to the transfer date; [38] or (4) the then-current market price of the positions at the time the transfer is effected. Proposed Rule 6.78A–O(c) provides market participants that effect off-floor transfers with flexibility to select a transfer price based on the circumstances of the transfer and their business. However, for corrections of bona fide errors, because those transfers are necessary to correct processing errors that occurred at the time of the transaction, those off-floor transfers would occur at the original transaction price, as the purpose of the transfer is

[26] *See* proposed Rule 6.78A–O(a)(5) and (7).

[27] *See* proposed Rule 6.78A–O(h).

[28] *See* Cboe Rule 6.7(a)(1).

[29] A ''Person'' refers to a natural person, corporation, partnership, association, joint stock company, trust, fund, or any organized group of persons whether incorporated or not. *See* Rule 1.1. The proposed transfers may only occur between the same individual or legal entity.

[30] *See* Cboe Rule 6.7(a)(2).

[31] Various rules (for example, Regulation SHO in certain circumstances) require accounts to be maintained separately, and the proposed rule change is consistent with those rules.

[32] *See* Commentary .02 to Rule 6.78–O (providing that ''[a]cquisitions and dissolutions in which all or substantially all of the assets of one OTP Holder or OTP Firm are acquired by another or, where there remains no continuity of ownership or management are examples of situations that normally would be required to be subjected to the transfer process set forth in subsections (e) and (f). This list is not meant to be exhaustive, however, and there may be other situations in which there is a discontinuation of ownership or management of the positions that may require that the positions be brought to the floor for transfer. Questions on whether a transfer should be brought to the floor may be directed to the Exchange's Options Surveillance Department'').

[33] *See* Cboe Rule 6.7(a)(10). This proposed provision is consistent with applicable laws, rules, and regulations that legally require transfers in certain circumstances. This proposed rule change is consistent with the purposes of other circumstances in the current rule, such as the transfer of positions to a minor or dissolution of a corporation. *See, e.g.,* proposed Rule 6.78A–O(a)(6) and (9), respectively.

[34] *See, e.g.,* proposed Rule 6.78A–O(a)(6) and (9), respectively.

[35] *See* Cboe Rule 6.7(a)(3)–(9).

[36] *See* Rule 6.78A–O(g).

[37] *See, e.g.,* Cboe Rule 6.7(b).

[38] For example, for a transfer that occurs on a Tuesday, the transfer price may be based on the closing market price on Monday.

to create the originally intended result of the transaction.

Proposed Rule 6.78A–O(d) requires an OTP Holder or OTP Firm and its Clearing Member(s) (to the extent the OTP Holder or OTP Firm is not self-clearing) to submit to the Exchange, in a manner determined by the Exchange, written notice prior to effecting an off-floor transfer from or to the account(s) of an OTP Holder or OTP Firm(s).[39] Per proposed Rule 6.78–O(d)(1), the proposed notice must indicate: the Exchange-listed options positions to be transferred; the nature of the transaction; the enumerated provision(s) under proposed Rule 6.78A–O(a) pursuant to which the positions are being transferred; the name of the counterparty(ies); the anticipated transfer date; the method for determining the transfer price; and any other information requested by the Exchange. The proposed notice is designed to ensure that the Exchange is made aware of all transfers so that the Exchange can monitor and review such transfers (including the records that must be retained pursuant to proposed Rule 6.78A–O(e) (described below) to determine whether they are effected in accordance with the Exchange rules. Additionally, the Exchange believes that requiring notice from the OTP Holder or OTP Firm(s) and its Clearing Member(s) would ensure that both parties are in agreement with respect to the terms of the transfer. In light of the notice requirement contained in proposed Rule 6.78A–O (d), the Exchange proposes to make a conforming change by deleting paragraph (d) to Rule 6.69–O, which similarly requires OTP Holders and OTP Firms to report to the Exchange any off-floor transactions, and to hold paragraph (d) as Reserved.[40]

Per proposed Rule 6.78A–O(d)(2), however, receipt of prior notice of an off-floor transfer would not constitute a determination by the Exchange that such transfer was effected or reported in conformity with the requirements of proposed Rule 6.78A–O. As such, notwithstanding submission of written notice to the Exchange, OTP Holder or OTP Firm and Clearing Members that effect off-floor transfers that do not conform to the requirements of the proposed Rule would be subject to appropriate disciplinary action in accordance with the Exchange rules.

Similarly, proposed Rule 6.78A–O(e) requires that each party to an off-floor transfer generate and retain records of the information provided in the written notice to the Exchange (pursuant to proposed subparagraph (d)(1)), as well as information regarding the actual Exchange-listed options that are ultimately transferred, the actual transfer date, and the actual transfer price (and the original trade dates, if applicable), and any other information the Exchange may request the OTP Holder or OTP Firm or Clearing Member to provide.

Proposed 6.78A–O(f) provides exemptions to the prohibition against off-floor transfers, as approved by the Exchange's President or Chief Executive Officer (or his or her designee(s)).[41] Specifically, this provision is in addition to the exemptions (to Rule 6.78–O) set forth in proposed Rule 6.78A–O(a)(1)–(10). The Exchange proposes that the Exchange President or Chief Executive Officer (or his or her designee(s)) may grant an exemption from the requirement of this proposed Rule, on his or her own motion or upon application of the OTP Holder or OTP Firm (with respect to the OTP Holder or OTP Firm's positions) or a Clearing Member (with respect to positions carried and cleared by the Clearing Members). The President, the Chief Executive Officer, or his or her designee(s), may permit an off-floor transfer if necessary or appropriate for the maintenance of a fair and orderly market and the protection of investors and is in the public interest, including due to unusual or extraordinary circumstances. For example, an exemption may be granted if the market value of the Person's positions would be compromised by having to comply with the requirement to trade on the Exchange pursuant to the normal auction process or when, in the judgment of the President, the Chief Executive Officer, or his or her designee(s), market conditions make trading on the Exchange impractical.

The Exchange proposes to state that the off-floor transfer procedure set forth in Rule 6.78A–O is intended to facilitate non-routine, nonrecurring movements of positions, except for transfers between accounts of the same Person pursuant to proposed subparagraph (a)(2), and is not to be used repeatedly or routinely in circumvention of the normal auction market process.[42]

Lastly, proposed paragraph (h) provides that the off-floor transfer procedure set forth in proposed Rule 6.78A–O is only applicable to positions in options listed on the Exchange; that off-floor transfers of positions in Exchange-listed options may also be subject to applicable laws, rules, and regulations, including rules of other self-regulatory organizations; and that off-floor transfers of non-Exchange listed options and other financial instruments are not governed by this proposed Rule 6.78A–O.

Proposed Rule 6.78B–O: Off-Floor RWA Transfers

The Exchange proposes to adopt Rule 6.78B–O titled ''Off-Floor RWA Transfers,'' to facilitate the reduction of risk-weighted assets (''RWA'') attributable to open options positions. This proposal is substantively identical to rules on other options exchanges and would align the Exchanges rules with that of its competitors.[43]

SEC Rule 15c3–1 (Net Capital Requirements for Brokers or Dealers) (''Net Capital Rules'') requires registered broker-dealers, unless otherwise excepted, to maintain certain specified minimum levels of capital.[44] The Net Capital Rules are designed to protect securities customers, counterparties, and creditors by requiring that broker-dealers have sufficient liquid resources on hand, at all times, to meet their financial obligations. Notably, hedged positions, including offsetting futures and options contract positions, result in certain net capital requirement reductions under the Net Capital Rules.[45]

[39] This notice provision applies only to transfers involving an OTP Holder's or OTP Firm's positions and not to positions of non-OTP Holders or non-OTP Firms, as the latter parties are not subject to Exchange rules. In addition, no notice would be required to effect transfers to correct bona fide errors pursuant to proposed subparagraph (a)(1) or transfers of positions from one account to another where no change in ownership is involved pursuant to proposed paragraph (a)(2) of Rule 6.78A–O.

[40] *See* Rule 6.69–O(d) (providing that ''[f]or each transaction in which an OTP Holder or OTP Firm participates off-board (off a participating Exchange) in any option pertaining to an underlying security which is currently approved for Exchange options transactions, such OTP Holder or OTP Firm shall report the transaction to the Exchange in a form and manner prescribed by the Exchange. (With the identity of participants removed, such transaction may be made public by the Exchange.)'').

[41] *See* ISE Options 6, Section 5(f); MIAX Rule 1326(f). The Exchange notes that, unlike the rules of ISE and MIAX, which refer to ''senior level designees,'' the Exchange proposes to instead reference ''designees,'' which omits the potentially ambiguous ''senior'' qualifier. The Exchange believes this distinction does not alter the or impede the authority granted in the proposed provision and is consistent with other Exchange rules that provide for delegated authority. *See, e.g.,* Rule 6.87–O(k)(3)(A) (proving that the appeals panel to review Obvious Errors or Catastrophic Errors be comprised, in part of, the Exchange Chief Regulatory Officer (''CRO''), or a *designee* of the CRO).

[42] *See* proposed Rule 6.78A–O(g).

[43] *See, e.g.,* Cboe Rule 6.8 (Off-Floor RWA Transfers); ISE Options 6, Section 6 (Off-Exchange RWA Transfers).

[44] 17 CFR 240.15c3–1.

[45] In addition, the Net Capital Rules permit various offsets under which a percentage of an option position's gain at any one valuation point is

Continued

Subject to certain exceptions, Clearing Members are subject to the Net Capital Rules.[46] However, a subset of Clearing Members are subsidiaries of U.S. bank holding companies, which, due to their affiliations with their parent U.S.-bank holding companies, must comply with additional bank regulatory capital requirements pursuant to rulemaking required under the Dodd-Frank Wall Street Reform and Consumer Protection Act.[47] Pursuant to this mandate, the Board of Governors of the Federal Reserve System, the Office of the Comptroller of the Currency, and the Federal Deposit Insurance Corporation have approved a regulatory capital framework for subsidiaries of U.S. bank holding company clearing firms.[48] Generally, these rules, among other things, impose higher minimum capital and higher asset risk weights than were previously mandated for Clearing Members that are subsidiaries of U.S. bank holding companies under the Net Capital Rules. Furthermore, the new rules do not fully permit deductions for hedged securities or offsetting options positions.[49] Rather, capital charges under these standards are, in large part, based on the aggregate notional value of short positions regardless of offsets. As a result, in general, Clearing Members that are subsidiaries of U.S. bank holding companies must hold substantially more bank regulatory capital than would otherwise be required under the Net Capital Rules.

The Exchange is concerned with the ability of Market Makers to provide liquidity in their appointed classes. The Exchange believes that permitting market participants to efficiently transfer existing options positions through an off-floor transfer process would likely have a beneficial effect on continued liquidity in the options market without adversely affecting market quality. Liquidity in the listed options market is critically important. The Exchange believes that the proposed rule change provides market participants with an efficient mechanism to transfer their open options positions from one clearing account to another clearing account and thereby increase liquidity in the listed options market. The Exchange currently has no mechanism that firms may use to transfer positions between clearing accounts without having to effect a transaction with another party and close a position.

Proposed Rule 6.78B–O provides that, notwithstanding Rule 6.78–O (described above), existing positions in options listed on the Exchange of an OTP Holder or OTP Firm or non-OTP Holder or OTP Firm (including an affiliate of an OTP Holder or OTP Firm) may be transferred on, from, or to the books of a Clearing Member off the Exchange if the transfer establishes a net reduction of RWA attributable to those options positions (an ''RWA Transfer''). Proposed paragraph (a) to Rule 997.2NY provides examples of two transfers that would be deemed to establish a net reduction of RWA, and thus qualify as a permissible RWA Transfer:

- A transfer of options positions from Clearing Member A to Clearing Member B that net (offset) with positions held at Clearing Member B, and thus closes all or part of those positions (as demonstrated in the example below);[50] and
- A transfer of options positions from a bank-affiliated Clearing Member to a non-bank-affiliated Clearing Member.[51]

These transfers would not result in a change in ownership, as they must occur between accounts of the same ''Person,'' as defined in Rule 1.1, per proposed Rule 6.78B–O(e).[52] In other words, RWA Transfers may only occur between the same individual or legal entity. These are merely transfers from one clearing account to another, both of which are attributable to the same individual or legal entity. A market participant effecting an RWA Transfer is analogous to an individual transferring funds from a checking account to a savings account, or from an account at one bank to an account at another bank—the money still belongs to the same person, who is just holding it in a different account for personal financial reasons.

For example, Market Maker A clears transactions on the Exchange into an account it has with Clearing Member X, which is affiliated with a U.S-bank holding company. Market Maker A opens a clearing account with Clearing Member Y, which is not affiliated with a U.S.-bank holding company. Clearing Member X has informed Market Maker A that its open positions may not exceed a certain amount at the end of a calendar month, or it will be subject to restrictions on new positions it may open the following month. On August 28, Market Maker A reviews the open positions in its Clearing Member X clearing account and determines it must reduce its open positions to satisfy Clearing Member X's requirements by the end of August. It determines that transferring out 1,000 short calls in class ABC will sufficiently reduce the RWA capital requirements in the account with Clearing Member X to avoid additional position limits in September. Market Maker A wants to retain the positions in accordance with its risk profile. Pursuant to the proposed rule change, on August 31, Market Maker A transfers 1,000 short calls in class ABC to its clearing account with Clearing Member Y. As a result, Market Maker A can continue to provide the same level of liquidity in class ABC during September as it did in previous months.

An OTP Holder or OTP Firm must ''give up'' a Clearing Member for each transaction it effects on the Exchange, which identifies the Clearing Member through which the transaction will clear.[53] An OTP Holder or OTP Firm that has the ability to change the give up for a transaction within a specified period of time.[54] Additionally, an OTP Holder or OTP Firm may change the Clearing Member for a specific transaction.[55] The transfer of positions from an account with one clearing firm

allowed to offset another position's loss at the same valuation point (*e.g.,* vertical spreads).

[46] In the event federal regulators modify bank capital requirements in the future, the Exchange will reevaluate the proposed rule change at that time to determine whether any corresponding changes to the proposed rule are appropriate.

[47] H.R. 4173 (amending section 3(a) of the Act) (15 U.S.C. 78c(a))).

[48] 12 CFR 50; 79 FR 61440 (Liquidity Coverage Ratio: Liquidity Risk Measurement Standards).

[49] Many options strategies, including relatively simple strategies often used by retail customers and more sophisticated strategies used by broker-dealers, are risk limited strategies or options spread strategies that employ offsets or hedges to achieve certain investment outcomes. Such strategies typically involve the purchase and sale of multiple options (and may be coupled with purchases or sales of the underlying securities), executed simultaneously as part of the same strategy. In many cases, the potential market exposure of these strategies is limited and defined.

[50] This transfer would establish a net reduction of RWA attributable to the transferring Person, because there would be fewer open positions and thus fewer assets subject to Net Capital Rules.

[51] This transfer would establish a net reduction of RWA attributable to the transferring Person, because the non-bank-affiliated Clearing Member would not be subject to Net Capital Rules, as described above.

[52] *See supra* note 29 (defining Person).

[53] *See* Rule 6.15–O (Authorizing Give Up of a Clearing Member) (providing process for an OTP Holder or OTP Firm (other than a Market Maker) to indicate each of its transactions any OCC number of a Clearing Member through which a transaction will be cleared (*i.e.,* the give up), subject to the criteria set forth in the rule).

[54] *See* Rule 6.15–O(g)(1) (providing that, ''[i]f the executing OTP Holder or OTP Firm has the ability through an Exchange system to do so, the OTP Holder or OTP Firm may change the give up on the trade to another Clearing Member for whom they are an Authorized OTP or to its Guarantor,'' which ability ''will end at the Trade Date Cutoff Time.'').

[55] The Clearing Member Trade Assignment (''CMTA'') process at OCC facilitates the transfer of option trades/positions from one OCC clearing member to another in an automated fashion. Changing a CMTA for a specific transaction would allocate the trade to a different OCC clearing member than the one initially identified on the trade.

to the account of another clearing firm pursuant to the proposed rule change has a similar result as changing a give up or CMTA, as it results in a position that resulted from a transaction moving from the account of one clearing firm to another, just at a different time and in a different manner.[56]

In the above example, if Market Maker A had initially given up Clearing Member Y rather than Clearing Member X on the transactions that resulted in the 1,000 long calls in class ABC, or had changed the give-up or CMTA to Clearing Member Y pursuant to Rule 6.15–O the ultimate result would have been the same. There are a variety of reasons why firms give up or CMTA transactions to certain clearing firms (and not to non-bank affiliate clearing firms) at the time of a transaction, and the proposed rule change provides firms with a mechanism to achieve the same result at a later time.

Proposed paragraph (b) to Rule 6.78B–O provides that RWA Transfers may occur on a routine, recurring basis. As noted in the example above, clearing firms may impose restrictions on the amount of open positions. Permitting transfers on a routine, recurring basis will provide market participants with the flexibility to comply with these restrictions when necessary to avoid position limits on future options activity. Additionally, proposed paragraph (f) to Rule 6.78B–O provides that no prior written notice to the Exchange is required for RWA Transfers. Because of the potential routine basis on which RWA Transfers may occur, and because of the need for flexibility to comply with the restrictions described above, the Exchange believes such requirement may interfere with the ability of OTP Holders or OTP Firms to comply with any Clearing Member restrictions describe above, and may be burdensome to provide notice for these routine transfers.

Proposed Rule 6.78B–O(c) provides that RWA Transfers may result in the netting of positions. Netting occurs when long positions and short positions in the same series ''offset'' against each other, leaving no or a reduced position. For example, if there were 100 long calls in one account, and 100 short calls of the same option series were added to that account, the positions would offset, leaving no open positions. Firms may maintain different clearing accounts for a variety of reasons, such as the structure of their businesses, the manner in which they trade, their risk management procedures, and for capital purposes. While there are times when a firm may not want to close out open positions to reduce RWA, there are other times when a firm may determine it is appropriate to close out positions to accomplish a reduction in RWA.

In the example above, suppose after making the RWA Transfer described above, Market Maker A effects a transaction on September 25 that results in 1,000 long calls in class ABC, which clears into its account with Clearing Member X. If Market Maker A had not effected its RWA Transfer in August, the 1,000 long calls would have offset against the 1,000 short calls, eliminating both positions and thus any RWA capital requirements associated with them. At the end of August, Market Maker A did not want to close out the 1,000 short calls when it made its RWA Transfer. However, given changed circumstances in September, Market Maker A has determined it no longer wants to hold those positions. The proposed rule change would permit Market Maker A to effect an RWA Transfer of the 1,000 short calls from its account with Clearing Member Y to its account with Clearing Member X (or vice versa), which results in elimination of those positions (and a reduction in RWA associated with them). As noted above, such netting would have occurred if Market Maker A cleared the September transaction directly into its account with Clearing Member Y, or had not effected an RWA Transfer in August. Netting provides market participants with appropriate flexibility to conduct their businesses as they see fit while having the ability to reduce RWA capital requirements when necessary.

Proposed Rule 6.78B–O(d) provides that RWA Transfers may not result in preferential margin or haircut treatment. Finally, per proposed Rule 6.78B–O(g), RWA Transfers may only be effected for options listed on the Exchange, as transfers of non-Exchange listed options and other financial instruments are not governed by proposed Rule 6.78B–O, and such transfers will be subject to applicable laws, rules, and regulations, including rules of other self-regulatory organizations (including OCC).[57]

2. Statutory Basis

The Exchange believes that its proposal is consistent with Section 6(b) of the Act,[58] in general, and furthers the objectives of Section 6(b)(5) of the Act,[59] in particular, because it is 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 and because it is not designed to permit unfair discrimination between customers, issuers, brokers, or dealers. As a general matter, the proposed rules are substantively identical to rules on other options exchanges and would align the Exchanges rules with that of its competitors. As such, this proposal would benefit investors by reducing the administrative burden of determining whether their off-floor transfers comply with multiple sets of options exchange rules.

Proposed Rule 6.78–O: Transactions Off the Exchange

In particular, the Exchange believes proposed Rule 6.78–O is consistent with the Act, because it adopts and streamlines text that is substantially similar to the current rule, with updated reference to SEC rules and that also aligns Exchange rules with those of its competitors. In addition, as noted herein, proposed Rule 6.78–O is substantively identical to the rules of at least one other options exchange and would therefore allow the Exchange to compete on equal footing. Moreover, proposed Rule 6.78–O is consistent with the Act, because it adopts provisions in the Rules specifically required by Rules 19c–1 and 19c–3 under the Act, setting forth the Exchange's general prohibition against off-floor transfers.

Proposed Rule 6.78A–O: Off-Floor Transfer of Positions

Proposed Rule 6.78A–O adopts and streamlines text that is substantially similar to the current rule, with additional permissible off-floor transfers that align with permissible transfers on other options exchanges. The Exchange believes that permitting off-floor transfers in very limited circumstances would allow OTP Holders or OTP Firms to accomplish certain goals efficiently. Proposed Rule 6.78A–O is also substantively identical to the rules of other options exchanges and, consistent with those rules, the proposed rule permits non-recurring off-floor transfers

[56] The transferred positions will continue to be subject to OCC rules, as they will continue to be held in an account of an OCC member.

[57] All RWA Transfers will be subject to all recordkeeping requirements applicable to OTP Holders or OTP Firms and Clearing Members under the Act, such as Rule 17a–3 and 17a–4.

[58] 15 U.S.C. 78f(b).

[59] 15 U.S.C. 78f(b)(5).

in situations involving dissolutions of entities or accounts, for purposes of donations, mergers or by operation of law. As noted above for example, an OTP Holder or OTP Firm that is undergoing a structural change and a one-time movement of positions may require a transfer of positions or an OTP Holder or OTP Firm that is leaving a firm that will no longer be in business may require a transfer of positions to another firm. Also, an OTP Holder or OTP Firm may require a transfer of positions to make a capital contribution. The above-referenced circumstances are non-recurring situations where the transferor continues to maintain some ownership interest or manage the positions transferred. By contrast, repeated or routine transfers between entities or accounts—even if there is no change in beneficial ownership as a result of the transfer—is inconsistent with the purposes for which the proposed rule will be adopted. Accordingly, such activity should not be permitted under the proposed rule.

The proposed rule change would provide market participants that experience these limited, non-recurring events with an efficient and effective means to transfer positions in these situations. The Exchange believes the proposed rule change regarding permissible transfer prices would provide market participants with flexibility to determine the price appropriate for their business, which maintain cost bases in accordance with normal accounting practices and removes impediments to a free and open market.

The proposed rule change which requires notice and maintenance of records would ensure the Exchange is able to review off-floor transfers for compliance with the Exchange rules, which prevents fraudulent and manipulative acts and practices. The requirement to retain records is consistent with the requirements of Rule 17a–3 and 17a–4 under the Act. In addition, the Exchange believes the conforming change to delete paragraph (d) to Rule 6.69–O in light of the comparable notice requirement in proposed Rule 6.78A–O(d) would reduce redundancy, add clarity, transparency and internal consistent to Exchange rules.

Similar to the rules of other options exchanges, the Exchange would permit a presidential exemption.[60] The Exchange believes that this exemption is consistent with the Act because the Exchange's Chief Executive Officer or President (or his or her designee(s)) would consider an exemption in very limited circumstances (*i.e.,* to facilitate non-routine, nonrecurring movements of positions not designed to circumvent the normal auction market process). Proposed Rule 6.78–OA(f) specifically provides that the Exchange's Chief Executive Officer or President (or his or her designee(s)) may in his or her judgment allow an off-floor transfer if it is necessary or appropriate for the maintenance of a fair and orderly market and the protection of investors and is in the public interest, including due to unusual or extraordinary circumstances such as the market value of the Person's positions will be comprised by having to comply with the requirement to trade on the Exchange pursuant to the normal auction process or, when in the judgment of the President, Chief Executive Officer, or his or her designee(s), market conditions make trading on the Exchange impractical. These standards within paragraph (f) of the proposed rule are intended to provide guidance concerning the use of this exemption to the benefit of investors and the investing public for the maintenance of a fair and orderly market and the protection of investors and is in the public interest.

Finally, the Exchange notes that the proposed non-substantive conforming change to update current Rule 6.78A–O to 6.78C–O (In-Kind Exchange of Options Positions and ETF Shares and UIT Units) would benefit investors and the investing public because it would add clarity, transparency and internal consistency to Exchange rules making them easier to navigate and comprehend.[61]

The Exchange believes having similar rules related to off-floor transfer positions to those of other options exchanges would reduce the administrative burden on market participants of determining whether their off-floor transfers comply with multiple sets of rules.

Proposed Rule 6.78B–O: Off-Floor RWA Transfers

The Exchange believes proposed Rule 6.78B–O to permit RWA Transfers, which is substantially the same as the rules of other options markets, would remove impediments to and perfect the mechanism of a free and open market and a national market system by providing liquidity in the listed options market. The Exchange believes providing market participants with an efficient process to reduce RWA capital requirements attributable to open positions in clearing accounts with U.S. bank-affiliated clearing firms may contribute to additional liquidity in the listed options market, which, in general, protects investors and the public interest.

The proposal to permit RWA Transfers to occur on a routine, recurring basis and result in netting, also provides market participants with sufficient flexibility to reduce RWA capital requirements at times necessary to comply with requirements imposed on them by clearing firms. This would permit market participants to respond to then-current market conditions, including volatility and increased volume, by reducing the RWA capital requirements associated with any new positions they may open while those conditions exist. Given the additional capital that may become available to market participants as a result of the RWA Transfers, market participants would be able to continue to provide liquidity to the market, even during periods of increased volume and volatility, which liquidity ultimately benefits investors. It is not possible for market participants to predict what market conditions will exist at a specific time, and when volatility will occur. The proposed rule change to permit routine, recurring RWA Transfers (without any required prior written notice) would provide market participants with the ability to respond to these conditions whenever they occur. Permitting such transfers on a routine, recurring basis will provide market participants with the flexibility to comply with applicable restrictions when necessary to avoid position limits on future options activity. In addition, with respect to netting, as discussed above, firms may maintain different clearing accounts for a variety of reasons, such as the structure of their businesses, the manner in which they trade, their risk management procedures, and for capital purposes. Netting may otherwise occur with respect to a firm's positions if it structured its clearing accounts differently, such as by using a universal account. Therefore, the proposed rule change will permit netting while allowing firms to continue to maintain different clearing accounts in a manner consistent with their businesses.

The Exchange recognizes the numerous benefits of executing options transactions on exchanges, including price transparency, potential price improvement, and a clearing guarantee. However, the Exchange believes it is

[60] *See* ISE Options 6, Section 5(f); MIAX Rule 1326(f). *See also* Cboe Rule 6.8(f).

[61] *See supra* note 22 (regarding conforming change to renumber current Rule 6.78A–O to proposed Rule 6.78C–O).

appropriate to permit RWA Transfers to occur off the Exchange, as these benefits are inapplicable to RWA Transfers which are narrow in scope and are intended to achieve a limited beneficial purpose. RWA Transfers are not intended to be a competitive trading tool. There is no need for price discovery or improvement, as the purpose of the transfer is to reduce RWA asset capital requirements attributable to a market participants' positions. Unlike trades on an exchange, the price at which an RWA Transfers occurs is immaterial—the resulting reduction in RWA is the critical part of the transfer. RWA Transfers will result in no change in ownership, and thus they do not constitute trades with a counterparty (and thus eliminating the need for a counterparty guarantee). The transactions that resulted in the open positions to be transferred as an RWA Transfer were already guaranteed by a Clearing Member, and the positions will continue to be subject to OCC rules, as they will continue to be held in an account with a Clearing Member. The narrow scope of the proposed rule change and the limited, beneficial purpose of RWA Transfers make allowing RWA Transfers to occur off the floor appropriate and important to support the provision of liquidity in the listed options market. The proposed rule change does not unfairly discriminate against market participants, as all OTP Holders/Firms and non-OTP Holders/Firms with open positions in options listed on the Exchange may use the proposed off-floor transfer process to reduce the RWA capital requirements of Clearing Members. Finally, this proposed rule change would align Exchange rules with those of other options exchanges, thereby allowing the Exchange to compete on equal footing.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange believes that the proposal will not impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of Section 6(b)(8) of the Act.[62] The proposed rules are not intended to be a competitive trading tools, but rather to set forth the general prohibition against off-floor transactions and to facilitate certain off-floor transactions in limited circumstances that meet the enumerated criteria.

The Exchange does not believe the proposed rule change regarding off-floor position transfers set forth in the proposed rules would impose an undue burden on intra-market competition as the transfer procedure(s) may be utilized by any OTP Holders/Firms and the rule will apply uniformly to all OTP Holders or OTP Firms. Use of each off-floor transfer procedure is voluntary, and all OTP Holders or OTP Firms may use each such procedure to transfer positions as long as the criteria in the proposed rule are satisfied.

The Exchange does not believe the proposed rule change will impose an undue burden on inter-market competition. As indicated above, it is intended to provide an additional clearly delineated and limited circumstance in which options positions can be transferred off an exchange (as well as to set forth the general prohibition against such transfers). Additionally, as discussed above, the proposed rule change is substantively identical to the rules of other options exchanges and would allow the Exchange to compete on equal footing. Moreover, the Exchange believes having similar rules related to off-floor position transfers to those of other options exchanges will reduce the administrative burden on market participants of determining whether their transfers comply with multiple sets of rules.

Finally, the Exchange notes that the proposed non-substantive conforming change to update current Rule 6.78A–O to 6.78C–O (In-Kind Exchange of Options Positions and ETF Shares and UIT Units) would benefit investors and the investing public because it would add clarity, transparency and internal consistency to Exchange rules making them easier to navigate and comprehend.[63]

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

No written comments were solicited or received with respect to the proposed rule change.

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[64] and Rule 19b–4(f)(6) thereunder.[65] 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 and Rule 19b–4(f)(6)(iii) thereunder.[66]

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) of the Act[67] 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 (*http://www.sec.gov/rules/sro.shtml*); or
- Send an email to *rule-comments@sec.gov.* Please include File Number SR–NYSEARCA–2022–55 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–NYSEARCA–2022–55. 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 (*http://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent

[62] 15 U.S.C. 78f(b)(8).

[63] *See supra* note 22 (regarding conforming change to renumber current Rule 6.78A–O to proposed Rule 6.78C–O).

[64] 15 U.S.C. 78s(b)(3)(A)(iii).

[65] 17 CFR 240.19b–4(f)(6).

[66] 15 U.S.C. 78s(b)(3)(A)(iii). Rule 19b–4(f)(6)(iii) requires a self-regulatory organization to give the Commission written notice of its intent to file 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 Commission notes that the Exchange satisfied this requirement.

[67] 15 U.S.C. 78s(b)(2)(B).

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 10:00 a.m. and 3:00 p.m. Copies of the filing also will be available for inspection and copying at the principal office of the Exchange. All comments received will be posted without change. Persons submitting comments are cautioned that we do not redact or edit personal identifying information from comment submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–NYSEARCA–2022–55 and should be submitted on or before September 28, 2022.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[68]

J. Matthew DeLesDernier,

Deputy Secretary.

[FR Doc. 2022–19227 Filed 9–6–22; 8:45 am]

BILLING CODE 8011–01–P

SECURITIES AND EXCHANGE COMMISSION

Sunshine Act Meetings

TIME AND DATE: 2:00 p.m. on Thursday, September 8, 2022.

PLACE: The meeting will be held via remote means and/or at the Commission's headquarters, 100 F Street NE, Washington, DC 20549.

STATUS: This meeting will be closed to the public.

MATTERS TO BE CONSIDERED: Commissioners, Counsel to the Commissioners, the Secretary to the Commission, and recording secretaries will attend the closed meeting. Certain staff members who have an interest in the matters also may be present.

In the event that the time, date, or location of this meeting changes, an announcement of the change, along with the new time, date, and/or place of the meeting will be posted on the Commission's website at *https://www.sec.gov.*

The General Counsel of the Commission, or his designee, has certified that, in his opinion, one or more of the exemptions set forth in 5 U.S.C. 552b(c)(3), (5), (6), (7), (8), 9(B) and (10) and 17 CFR 200.402(a)(3), (a)(5), (a)(6), (a)(7), (a)(8), (a)(9)(ii) and (a)(10), permit consideration of the scheduled matters at the closed meeting.

The subject matter of the closed meeting will consist of the following topics:

Institution and settlement of injunctive actions;

Institution and settlement of administrative proceedings;

Resolution of litigation claims; and

Other matters relating to examinations and enforcement proceedings.

At times, changes in Commission priorities require alterations in the scheduling of meeting agenda items that may consist of adjudicatory, examination, litigation, or regulatory matters.

CONTACT PERSON FOR MORE INFORMATION: For further information; please contact Vanessa A. Countryman from the Office of the Secretary at (202) 551–5400.

(*Authority:* 5 U.S.C. 552b.)

Dated: September 1, 2022.

Vanessa A. Countryman,

Secretary.

[FR Doc. 2022–19345 Filed 9–2–22; 11:15 am]

BILLING CODE 8011–01–P

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–95651; File No. 10–239]

In the Matter of the Application of 24X National Exchange LLC for Registration as a National Securities Exchange; Order Instituting Proceedings To Determine Whether To Grant or Deny an Application for Registration as a National Securities Exchange Under Section 6 of the Securities Exchange Act of 1934

September 1, 2022.

I. Introduction

On March 25, 2022, 24X National Exchange LLC (''24X'' or ''Exchange'') filed with the Securities and Exchange Commission (''Commission'') a Form 1 application under the Securities Exchange Act of 1934 (''Act''), seeking registration as a national securities exchange under Section 6 of the Act.[1] Notice of the application was published for comment in the **Federal Register** on June 6, 2022.[2] The Commission received three comments on the application.[3] As discussed further below, the commenters stated that 24X's application does not include sufficient information about several aspects of its proposed operation.[4] One commenter stated that the application ''does not meet the legal and administrative requirements'' under the Act.[5] Another commenter questioned whether ''24X has the necessary structure and checks in place to protect investors and ensure a fair and orderly market'' and stated that certain elements of 24X's proposal were not sufficiently described and that additional information was required to evaluate the proposal.[6] This commenter stated that 24X ''contemplates trading concepts that have not been tested within the U.S. equities markets'' and that the application raises a number of questions ''including how its new exchange will interact with the current trading ecosystem.'' [7] Another commenter stated that the 24X Form 1 should not be approved because the regulatory infrastructure necessary to support its proposed trading system does not yet exist.[8]

Section 19(a)(1) of the Act [9] requires the Commission, within ninety days of the date of publication of notice of an application for registration as a national securities exchange, or such longer period as to which the applicant consents, to, by order, grant such registration [10] or institute proceedings to determine whether such registration should be denied.[11] This order is instituting proceedings under Section 19(a)(1)(B) of the Act [12] to determine whether 24X's application for registration as a national securities exchange should be granted or denied, and provides notice of the grounds for denial under consideration by the Commission, as set forth below.

[68] 17 CFR 200.30–3(a)(12).

[1] 15 U.S.C. 78f.

[2] *See* Securities Exchange Act Release No. 95007 (May 31, 2022), 87 FR 34333 (''Notice'').

[3] *See* letters from Brian Hyndman, President and Chief Executive Officer, Blue Ocean ATS, LLC, dated July 21, 2022 (''Blue Ocean Letter''); Eun Ah Choi, Senior Vice President, The Nasdaq Stock Market LLC, dated July 21, 2022 (''Nasdaq Letter''); and Hope Jarkowski, General Counsel, NYSE Group, dated July 29, 2022 (''NYSE Letter'') to Vanessa A. Countryman, Secretary, Commission. The public comment file for 24X's Form 1 application (File No. 10–239) is available on the Commission's website at: *https://www.sec.gov/comments/10-239/10-239.htm.*

[4] *See* Blue Ocean Letter at 2–6, Nasdaq Letter at 2–5 and NYSE Letter at 2–4.

[5] *See* Blue Ocean Letter at 6.

[6] *See* Nasdaq Letter at 5.

[7] *Id.*

[8] *See* NYSE Letter at 4.

[9] 15 U.S.C. 78s(a)(1).

[10] 15 U.S.C. 78s(a)(1)(A).

[11] 15 U.S.C. 78a(a)(1)(B).

[12] 15 U.S.C. 78s(a)(1)(B).

II. Description of 24X's Proposed Trading System

According to 24X's Form 1, 24X proposes to operate a fully automated electronic trading platform for the trading of listed NMS stocks pursuant to unlisted trading privileges (''UTP'').[13] 24X would not maintain a physical trading floor.[14] Liquidity would be derived from quotes as well as orders to buy and orders to sell submitted to 24X electronically by exchange members [15] from remote locations.[16] The Exchange proposes to operate an electronic limit order book with a continuous matching function. Orders resting on the book would be ranked in price/time priority.[17] 24X proposes to accept market orders, limit orders and pegged orders with various modifiers and time-in-force instructions.[18] Orders may be submitted in round lots, mixed lots or odd-lots.[19] One novel feature of 24X's proposal is that it proposes to allow the unit of trading of an order to be 1/1,000th of a share.[20] 24X proposes to report executions to the appropriate consolidated transaction reporting system ''to the extent required by the Act and the rules and regulations thereunder.'' [21]

24X proposes a retail order program.[22] Pursuant to this program, retail orders [23] submitted by retail organization members [24] would be eligible to receive price improvement from retail market makers.[25] Pursuant to proposed 24X Rule 11.21(d)(2), retail market makers would be required to provide continuous two-sided quotes of at least 100 shares during ''Regular Trading Hours.'' [26]

As discussed further below, one novel feature of 24X's proposed trading rules is that 24X proposes to allow trading in NMS stocks 24 hours a day, 7 days per week, 365 days a year.[27] 24X has proposed specific rules to govern trading during regular trading hours [28] as well as trading outside of regular trading hours.[29]

III. Proceedings To Determine Whether To Grant or Deny the Application and Grounds for Potential Denial Under Consideration

As required by Section 19(a)(1)(B) of the Act,[30] the Commission is hereby providing notice of grounds for denial under consideration, as set forth below. Institution of such proceedings is appropriate at this time in view of the issues raised by the application. Institution of proceedings does not indicate that the Commission has reached any conclusions with respect to any of the issues involved.

Under Section 19(a)(1) of the Act, the Commission shall grant an application for registration as a national securities exchange if the Commission finds that the requirements of the Act and the rules and regulations thereunder with respect to the applicant are satisfied. The Commission shall deny such application for registration if it does not make such a finding.[31] Under Section 6(b) of the Act, an exchange shall not be registered as a national securities exchange unless the Commission determines that it has satisfied the relevant requirements of the Act.[32] In particular, Section 6(b)(1) of the Act requires that the Commission find that an exchange is so organized and has the capacity to carry out the purposes of the Act.[33] In addition, under Section 6(b)(3) of the Act, the Commission must find that the rules of the exchange assure a fair representation of its members in the selection of its directors and administration of its affairs and provide that one or more directors shall be representative of issuers and investors and not be associated with a member of the exchange, broker or dealer.[34] Section 6(b)(5) of the Act requires that the rules of the exchange be designed, among other things, to prevent fraudulent and manipulative acts and practices, 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 mechanisms of a free and open market and a national market system, and in general to protect investors and the public interest.[35] Finally, under Section 6(b)(8) of the Act, the Commission must find that the rules of the exchange do not impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of Act.[36]

The Commission is particularly interested in commenters' views as to whether 24X has provided sufficient information in its Form 1 to support a finding that the proposal is consistent with the requirements of the Act and the rules and regulations thereunder.[37]

In addition, the Commission is particularly interested in commenters' views as to whether the proposed rules relating to the corporate structure of 24X, as described in more detail below, would ensure that 24X is so organized and has the capacity to carry out the purposes of the Act and assure a fair representation of its members in the selection of its directors and administration of its affairs.

The Commission also is particularly interested in commenters' views as to whether 24X's proposed rules that would extensively expand the hours of trading in NMS stocks, as described in more detail below, are designed to prevent fraudulent and manipulative acts and practices, promote just and equitable principles of trade, foster cooperation and coordination with persons engaged in regulating, clearing, settling, processing information with respect to, and facilitating transactions in securities, remove impediments to and perfect the mechanisms of a free

[13] *See* Exhibit E of 24X's Form 1 at 1, 4.

[14] *Id.* at 1.

[15] 24X proposes to have one class of membership open to registered broker-dealers. *See* proposed 24X Rule 2.3 (stating that, ''any registered broker or dealer that is and remains a member of a national securities association registered under Section 15A(a) of the Act or a member of another national securities exchange registered under Section 6(a) of the Act shall be eligible to be, and to remain, a Member.'').

[16] *See* Exhibit E of 24X's Form 1 at 1.

[17] Proposed 24X Rule 11.8(a).

[18] Proposed 24X Rule 11.7. *See also* Exhibit B–1 of 24X's Form 1.

[19] Proposed 24X Rule 11.6(q). *See also* Exhibit E–1 of 24X's Form 1 at 4.

[20] Proposed 24X Rule 11.6(q).

[21] Proposed 24X Rule 11.11(a); *see also* Exhibit E to 24X Form 1 at 10 (stating that 24X intends to join the CTA and Nasdaq UTP Plans).

[22] Proposed 24X Rules 11.17–11.21.

[23] *See* proposed 24X Rule 11.17(a)(2) for the proposed definition of ''retail order.''

[24] *See* proposed 24X Rule 11.17(a)(1) for the proposed definition of ''retail organization member.''

[25] *See* proposed 24X Rule 11.18 for the proposed registration requirements for retail market makers.

[26] The term ''Regular Trading Hours'' is not defined in the proposed 24X rule book. *See* Exhibit B–1 to the 24X Form 1.

[27] *See* proposed 24X Rule 11.1 (describing the hours of trading and trading days for 24X).

[28] Regulation NMS Rule 600(b)(77) defines ''regular trading hours'' as ''the time between 9:30 a.m. and 4:00 p.m. Eastern Time . . .'' As described further below, 24X proposes to define four different trading sessions. *See* proposed 24X Rules 1.5(b), defining the ''24X Market Session''; 1.5(k) defining the ''Core Market Session''; 1.5(v) defining the ''Post-market Session''; and 1.5(w) defining the ''Pre-Market Session.''

[29] *See e.g.,* proposed 24X Rule 11.16 (describing what orders are eligible for execution outside of regular trading hours).

[30] 15 U.S.C. 78s(a)(1)(B).

[31] 15 U.S.C. 78s(a)(1).

[32] 15 U.S.C. 78f.

[33] 15 U.S.C. 78f(b)(1).

[34] 15 U.S.C. 78f(b)(3).

[35] 15 U.S.C. 78f(b)(5).

[36] 15 U.S.C. 78f(b)(8).

[37] 15 U.S.C. 78s(a)(1). *See also* NYSE Letter at 2 (''the application falls short in providing sufficient information upon which to assess how such innovations could function consistent either with the Act . . .''); Nasdaq Letter at 2; and Blue Ocean Letter at 2.

and open market and a national market system, and in general protect investors and the public interest.

Further, the Commission is particularly interested in commenters' views as to whether 24X's proposed rules to allow orders to be submitted in fractional shares are designed to foster cooperation and coordination with persons engaged in regulating, clearing, settling, processing information with respect to, and facilitating transactions in securities, remove impediments to and perfect the mechanisms of a free and open market and a national market system.

Additionally, the Commission is particularly interested in commenters' views as to whether 24X's proposal to locate a ''mirrored'' primary platform in London would result in 24X being so organized and have the capacity to be able to carry out the purposes of the Act and whether 24X's rules relating to the mirrored platform are designed to foster cooperation and coordination with persons engaged in regulating, clearing, settling, processing information with respect to, and facilitating transactions in securities, and to remove impediments to and perfect the mechanisms of a free and open market and a national market system.

A. Corporate Governance

1. 24X

24X is wholly-owned by its direct parent company, 24X US Holdings LLC (''US Holdings''), which in turn is wholly-owned by 24X Bermuda Holdings LLC (''Bermuda Holdings'').[38] 24X is a Delaware limited liability company whose sole member is US Holdings.[39] The proposed business and affairs of 24X will be managed under the direction of a Board that is proposed to have at a minimum six Directors once 24X commences operations as a national securities exchange.[40] As proposed, the 24X Board would consist of

- one Director who is the Chief Executive Officer of the Company;
- at minimum three ''Independent Directors'' [41]; and
- the number of ''Membership Representative Directors'' [42] which shall be at least twenty percent of the Board, provided that if twenty percent of the Directors then serving on the Board is not a whole number, such minimum number of ''Representative Directors'' [43] shall be rounded up to the next whole number.

The 24X LLC Agreement also provides for ''Public Directors'' [44] although none are proposed to serve on the 24X Board.

The proposed Nominating Committee of 24X would nominate candidates for election to the 24X Board.[45] For positions on the 24X Board requiring persons who qualify as Member Representative Directors, the proposed Nominating Committee would nominate only those persons whose names have been approved and submitted by the ''Member Nominating Committee.'' [46] Nominees to the 24X Board from both the proposed Nominating Committee and the proposed Member Nominating Committee would be elected on an annual basis by vote of U.S. Holdings.[47]

In the past, the Commission has stated that ensuring that at least 20% of an exchange's governing board is comprised of directors that are chosen and elected by the exchange's members helps to ensure the fair representation of members in the selection of directors and the administration of an exchange as required by Section 6(b)(3) of the Act.[48] The Commission has stated that this requirement helps to ensure that members have a voice in an exchange's self-regulatory program, and that an exchange is administered in a way that is equitable to all those who trade on its market or through its facilities.[49] The Commission also has stated that a process whereby exchange members can directly nominate candidates for directors for an exchange board via a petition process also helps to ensure the fair representation of members, consistent with Section 6(b)(3) of the Act.[50]

The Commission is considering whether the overall composition of the 24X Board, including the specific categories of Directors as defined in the 24X LLC Agreement, would enable 24X to be so organized and have the capacity to carry out the purposes of the Act consistent with Section 6(b)(1) of the Act [51]. As proposed, there are categories of Directors that are not defined in the 24X LLC Agreement.[52] In addition, the Commission is considering whether the 24X Board composition fulfills the statutory requirement that one or more directors on the 24X Board is representative of issuers and investors and not associated with a member of the exchange, broker or dealer.[53] The Commission also is considering whether

[38] *See* Exhibits A and C of 24X's Form 1.

[39] *See* Exhibit A–2 of 24X's Form 1 at 1.

[40] *See* Exhibit A–2 of 24X's Form 1 at 6.

[41] ''Independent Directors'' are proposed to be defined as a ''Director who has no material relationship with the Company or any affiliate of the Company, or any Exchange Member or any affiliate of any such Exchange Member; provided, however, that an individual who otherwise qualifies as an Independent Director shall not be disqualified from serving in such capacity solely because such Director is a Director of the Company or an affiliate thereof.'' *See* Exhibit A–2 of 24X's Form 1 at 2.

[42] ''Member Representative Director'' is proposed to be defined as a Director ''who has been elected or appointed to the Board from time to time in accordance with this Agreement after having been nominated by the Member Nominating Committee. A Member Representative Director must be an officer, director, employee, or agent of an Exchange Member.'' *See* Exhibit A–2 of 24X's Form 1 at 3.

[43] ''Representative Directors'' are not defined in the Limited Liability Company Agreement of 24X National Exchange LLC (''24X LLC Agreement'').

[44] *See* Exhibit A–2 of 24X's Form 1 at 7. ''Public Directors'' are not defined in the 24X LLC Agreement.

[45] *See* Exhibit A–2 of 24X's Form 1 at 9. According to the proposed Nominating Committee Charter, the Nominating Committee shall consist of at least three members, or such greater number as determined by the Board, each of whom shall be an ''Independent Director,'' as such term is proposed to be defined in the Limited Liability Company Agreement of the Exchange. *See* Exhibit J–4 of 24X's Form 1 at 1.

[46] The ''Member Nominating Committee'' is defined to mean ''the Member Nominating Committee elected pursuant to [the 24X Limited Liability Company Agreement].'' *See* Exhibit A–2 of 24X's Form 1 at 1. According to the Member Nominating Committee Charter, the Member Nominating Committee shall consist of at least three members, or such greater number as determined by the Board, two of whom shall be a Member Representative Director and one of whom shall be an 'Independent Director,' as such term is defined in the Limited Liability Company Agreement of the Exchange.'' *See* Exhibit J–3 of 24X's Form 1 at 1.

[47] *See* Exhibit A–2 of 24X's Form 1 at 9.

[48] Securities Exchange Act Release No. 88806 (May 4, 2020), 85 FR 27451 (May 8, 2020) (File No. 10–237) (order granting registration of MEMX LLC) (''MEMX Order'') at 27452. *See also* 15 U.S.C. 78f(b)(3).

[49] *See, e.g.,* MEMX Order, *supra* note 48 at 27452; Securities Exchange Act Release Nos. 85828 (May 10, 2019), 84 FR 21841 (May 15, 2019) (File No. 10–234) (order granting registration of Long Term Stock Exchange, Inc.) (''LTSE Order'') at 21843; 79543 (December 13, 2016), 81 FR 92901, 92903 (December 20, 2016) (File No. 10–227) (order granting registration of MIAX PEARL, LLC) (''MIAX PEARL Order'') at 92903. *See also* Securities Exchange Act Release Nos. 68341 (December 3, 2012), 77 FR 73065, 73067 (December 7, 2012) (File No. 10–207) (order granting the registration of Miami International Securities Exchange, LLC); 58375 (August 18, 2008), 73 FR 49498, 49501 (August 21, 2008) (File No. 10–182) (order granting the registration of BATS Exchange, Inc.); and 53128 (January 13, 2006), 71 FR 3550, 3553 (January 23, 2006) (File No. 10–131) (granting the exchange registration of Nasdaq Stock Market, Inc.) (''Nasdaq Order'').

[50] *See e.g.,* MEMX Order, *supra* note 48, at 27452; LTSE Order, *supra* note 49, at 21843; and MIAX PEARL Order, *supra* note 49, at 92903.

[51] 15 U.S.C. 78f(b)(1).

[52] *See supra* notes 43 and 44.

[53] 15 U.S.C. 78f(b)(3). The Commission has approved in the past an exchange board composition that requires that the number of ''Non-Industry Directors'' equal or exceed the number of ''Industry Directors'' and directors that represent the exchange's members. With respect to this compositional requirement, the Commission stated that this requirement supports an exchange's ability to protect the public interest. *See e.g.,* MEMX Order, *supra* note 48, at 27452; LTSE Order, *supra* note 49, at 21843; MIAX PEARL Order, *supra* note 49, at 92903.

the proposed process for nominating candidates for the Member Representative Directors positions on the 24X Board is consistent with the Section 6(b)(3) of the Act in light of the fact that 24X does not propose a process that would permit 24X Members to directly nominate such Member Representative Directors for election to the 24X Board.[54]

2. US Holdings, Bermuda Holdings and Regulation of 24X

US Holdings is a Delaware limited liability company whose sole member is Bermuda Holdings.[55] As proposed, U.S. Holdings would be managed by, and all decisions on behalf of US Holdings would be made by, Bermuda Holdings.[56] Generally, the members of Bermuda Holdings include holders of ''Preferred Units'' [57] (which are further divided into ''Series A Units'' and ''Series Seed Units''),[58] ''Common Units'' [59] and ''Non-Voting Units''.[60] Members with voting rights, or ''Voting Units,'' include Common Units and Preferred Units except Series Seed-2 Units, which are a sub-category of Series Seed Units.[61] Each Voting Unit shall have one vote.[62]

If 24X's application for registration as a national securities exchange is granted, 24X would have all of the attendant regulatory obligations of a national securities exchange under the Act. In particular, 24X would be responsible for the operation and regulation of its exchange and the regulation of its members. Therefore, the Commission is considering whether US Holdings' and Bermuda Holdings' activities with respect to the operation of 24X are consistent with, and do not interfere with, 24X's self-regulatory obligations.[63] In making this determination previously, the Commission has considered whether the governing documents of an exchange's parent company are designed to facilitate the ability of the exchange to fulfill its regulatory obligations and their impact on Commission oversight of the exchange.[64] For the reasons discussed below, the Commission is considering whether US Holdings and Bermuda Holdings are organized in such a way as to enable 24X to fulfill its statutory obligations as a national securities exchange under Section 6(b) of the Act.[65]

Ownership Structure: Voting and Ownership Concentration Limits. The Commission is considering whether the corporate documents of 24X's holding companies, which are US Holdings and Bermuda Holdings, contain ownership and voting provisions that are designed to prevent the holding companies, or any party to the holding companies, from exercising undue control over the operation of 24X, and to ensure that 24X and the Commission are able to carry out their regulatory obligations under the Act.[66]

For example, among other things, the Commission has approved applications for registration as a national securities exchange where the governing documents of the holding companies of the exchange provide that for so long as the holding companies shall control, directly or indirectly, the exchange, no person, either alone or together with its related persons will be permitted to beneficially own, directly or indirectly, of record or beneficially, more than 40% of the holding company.[67] The Commission stated that such ownership concentration provisions are consistent with the Act because they are designed to prevent any party holding an interest in the holding companies from exercising undue control over the operation of the exchange and to ensure that the exchange and the Commission are able to carry out their regulatory obligations under the Act.[68] The Commission has approved provisions setting ownership limitations for all national securities exchanges.[69]

The Commission also has approved more restrictive conditions for broker-dealer members of an exchange applicant; specifically, the Commission has approved requirements for holding companies of exchanges that prohibit a broker-dealer member of the exchange from beneficially owning, directly or indirectly, either alone or together with their related persons, more than 20% of voting interest in the exchange applicant.[70] The Commission stated that such ownership limitations on broker-dealer members of an exchange applicant are appropriate because they are designed to address the conflicts of interest that might result from a member of a national securities exchange owning

[54] *See* LTSE Order, *supra* note 49, at 21843 (stating that, among other things, the means by which member representatives will be chosen will help ensure fair representation of members in selection of directors and administration of LTSE, and is therefore consistent with Section 6(b)(3) of the Act).

[55] *See* Exhibit C–12 and C–13 of 24X's Form 1 at 1.

[56] *See* Exhibit C–13 of 24X's Form 1 at 2. Bermuda Holdings is a limited liability company formed under the laws of Bermuda. *See* Exhibit C–1 and C–2 of 24X's Form 1 at 1.

[57] ''Preferred Units'' are defined to mean ''Series A Units and the Series Seed Units.'' *See* Exhibit C–2 of 24X's Form 1 at 7.

[58] *See* Exhibit C–2 of 24X's Form 1.

[59] ''Common Units'' are defined to mean ''[u]nits of common membership interests of the Company, or any other ownership interests of the Company into which such units are reclassified, reconstituted or exchanged.'' *See* Exhibit C–2 of 24X's Form 1 at 5.

[60] ''Non-voting Units'' are defined to mean ''units of non-voting membership interests of the Company, or any other ownership interests of the Company into which such units are reclassified, reconstituted or exchanged. *See* Exhibit C–2 of 24X's Form 1 at 7.

[61] *See* Exhibit C–2 of 24X's Form 1 at 11.

[62] *Id.*

[63] *See* 15 U.S.C. 78f(b)(1). *See also* Nasdaq Order, *supra* note 49, at 3552.

[64] *See e.g.,* MEMX Order, *supra* note 48, at 27453; LTSE Order, *supra* note 49, at 21843; MIAX Pearl Order, *supra* note 49, at 73069; and Nasdaq Order, *supra* note 49, at 3552.

[65] 15 U.S.C. 78f(b).

[66] In some cases, an exchange applicant has been owned by more than one holding company. For purposes of this discussion regarding 24X, the Commission shall refer to ''holding companies'' when referring to an entity or entities that own an exchange.

[67] *See e.g.,* MEMX Order, *supra* note 48, at 27453; LTSE Order, *supra* note 49, at 21844; and MIAX Pearl Order, *supra* note 49, at 92905. *See also* MEMX Holdings LLC Agreement, Article III, Section 3.5(a)(1); LTSE Group Inc. Certificate, Article IX, subparagraph (A)(2)(b)(i)(A); Miami Holdings Certificate, Article NINTH (b)(i)(A). The Commission also has approved registration where a related provision also requires the exchange to redeem any voting interest that was sold, transferred or otherwise disposed of that was above the ownership concentration limitation. *See e.g.,* MEMX Order, *supra* note 48 at 27453; LTSE Order, *supra* note 49, at 21844; and MIAX Pearl Order, *supra* note 49, at 92905. *See also* MEMX Holdings LLC Agreement, Article III, Section 3.7(c); LTSE Group Inc. Certificate, Article IX, subparagraph (a)(2)(e); Miami Holdings Certificate, Article Ninth (e).

[68] *See e.g.,* MEMX Order, *supra* note 48, at 27455; LTSE Order, *supra* note 49, at 21845; and MIAX PEARL Order, *supra* note 49, at 92906.

[69] *See, e.g.,* Securities Exchange Act Release Nos. 76998 (January 29, 2016), 81 FR 6066, 6070–71 (February 4, 2016) (File No. 10–221) (order granting the exchange registration of ISE Mercury, LLC); 70050 (July 26, 2013), 78 FR 46622, 46627 (August 1, 2013) (File No. 10–209) (order granting the exchange registration of Topaz Exchange LLC (nka ISE Gemini, LLC); 68341 (December 3, 2012), 77 FR 73065, 73070 (December 7, 2012) (File No. 10–207) (order granting the exchange registration of Miami International Securities Exchange LLC); 58375 (August 18, 2008), 73 FR 49498, 49500 (August 21, 2008) (File No. 10–182) (order granting the exchange registration of BATS Exchange, Inc.) (''BATS Order''). *See also supra* notes 67–68; Securities Exchange Act Release Nos. 62158 (May 24, 2010), 75 FR 30082 (May 28, 2010) (CBOE–2008–88) (CBOE Demutualization Approval Order); 53963 (June 8, 2006), 71 FR 34660 (June 15, 2006) (SR–NSX–2006–03) (NSX Demutualization Order); 51149 (February 8, 2005), 70 FR 7531 (February 14, 2005) (SR–CHX–2004–26) (CHX Demutualization Order); and 49098 (January 16, 2004), 69 FR 3974 (January 27, 2004) (SR–Phlx–2003–73) (Phlx Demutualization Order).

[70] *See e.g.,* MEMX Order, *supra* note 48, at 27453; LTSE Order, *supra* note 49, at 21844; and MIAX Pearl Order, *supra* note 49, at 92905. *See also* MEMX Holdings LLC Agreement, Article III, Section 3.5(a)(2); LTSE Group Inc. Certificate, Article IX, subparagraph (A)(2)(b)(i)(B); Miami Holdings Certificate, Article NINTH (b)(i)(B).

interests in the exchange.[71] The Commission also has previously stated that a member's ownership interest in an entity that controls an exchange could become so large as to cast doubt on whether the exchange may fairly and objectively exercise its self-regulatory responsibilities with respect to such member.[72] The Commission stated that such requirements are designed to minimize the potential that a person or entity can improperly interfere with or restrict the ability of the exchange to effectively carry out its regulatory oversight responsibilities under the Act.[73] The Commission has approved provisions setting membership ownership limitations for all national securities exchanges.[74]

In addition, the Commission has previously approved voting limitations in the corporate documents of the holding companies of exchanges that provide that no person, alone or together with its related persons, may, directly, indirectly, or pursuant to any agreement, vote or cause the voting of voting interest in the exchange, or give any consent or proxy with respect to voting units in the exchange representing more than 20% of the voting power of the exchange.[75] Similar to the ownership concentration limits, the Commission stated that such voting concentration limits are a way to minimize the potential that a person or entity can improperly interfere with or restrict the ability of the exchange to effectively carry out its regulatory oversight responsibilities under the Act through the exercise of voting power.[76] The Commission has approved provisions setting voting limitations for all national securities exchanges.[77]

The Commission is considering whether the Limited Liability Company Agreement of 24X US Holdings LLC and the Amended and Restated Limited Liability Company Agreement of 24X Bermuda Holdings LLC, as proposed, contain provisions that help ensure that 24X is so organized and has capacity to carry out the purposes of Section 6(b)(1) of the Act. As proposed, there are no ownership or voting concentration limits in either the Limited Liability Company Agreement of 24X US Holdings LLC or in the Amended and Restated Limited Liability Company Agreement of 24X Bermuda Holdings LLC. [78] Therefore, the Commission is considering whether 24X is so organized and has capacity to carry out the purposes of Section 6(b)(1) of the Act without undue influence by US Holdings and Bermuda Holdings. Further, the Commission is considering whether 24X retains a sufficient degree of independence to effectively carry out its regulatory obligations under the Act. Similarly, because 24X does not propose to include any ownership or voting limitations on 24X members that might have or acquire an ownership interest in US Holdings and Bermuda Holdings, the Commission is considering whether the Limited Liability Company Agreement of 24X US Holdings LLC and the Amended and Restated Limited Liability Company Agreement of 24X Bermuda Holdings LLC contain mechanisms to ensure that should a member of 24X own Voting Units, such ownership would not interfere with 24X's ability to be so organized and have the capacity to carry out the purposes of Section 6(b)(1) of the Act without undue influence by such member.

Regulatory Independence of 24X and Oversight of 24X. In order to be granted registration as a national securities exchange, 24X must be able to carry out its regulatory responsibilities under, and operate in a manner consistent with, the Act. This requires 24X to have the ability to carry out its regulatory function independently, and to be organized and operate in a fashion consistent with, the Act, particularly with Section 6(b)(1) of the Act, which requires, in part, an exchange to be so organized and have the capacity to carry out the purposes of the Act.[79] Although neither US Holdings nor Bermuda Holdings would themselves carry out 24X's regulatory functions or be directly overseen by the Commission, as direct and indirect owners of 24X, the activities and actions of US Holdings and Bermuda Holdings with respect to the operation of 24X must be consistent with, and must not interfere with, 24X's regulatory obligations as a national securities exchange. Therefore, the Commission is considering whether the corporate documents of US Holdings and Bermuda Holdings contain provisions that are designed to help maintain the independence of the regulatory function of 24X and oversight of 24X by the Commission.

The Commission has granted the registration of national securities exchanges that have holding company structures.[80] As part of the Commission's analysis of a holding company structure proposed by an exchange, the Commission has considered and approved provisions in the exchange's holding companies' corporate documents that are designed to help ensure that the holding companies of an exchange will enable the exchange to operate in a way that facilitates the exchange's ability to carry out its regulatory function independently, and to be organized and operate in a fashion that is consistent with the Act, particularly with Section 6(b)(1) of the Act, which requires, in part, an exchange to be so organized and have the capacity to carry out the purposes of the Act.[81] Such provisions generally address: [82]

[71] *See* MEMX Order, *supra* note 48, at 27455; LTSE Order, *supra* note 49, at 21845; and MIAX PEARL Order, *supra* note 49, at 92906.

[72] *Id.* The Commission has further stated that a member that is a controlling shareholder of an exchange could seek to exercise that controlling influence by directing the exchange to refrain from, or the exchange may hesitate to, diligently monitor and conduct surveillance of the member's conduct or diligently enforce the exchange's rules and the federal securities laws with respect to conduct by the member that violates such provisions. *Id.*

[73] *See* MEMX Order, *supra* note 48, at 27456; LTSE Order, *supra* note 49, at 21845; and MIAX PEARL Order, *supra* note 49, at 92906.

[74] *See supra* notes 69–73.

[75] *See e.g.,* MEMX Order, *supra* note 48, at 27454; LTSE Order, *supra* note 49, at 21844; MIAX Pearl Order, *supra* note 49, at 92905. *See also* MEMX Holdings LLC Agreement, Article III, Section 3.5(a)(iii); LTSEG Certificate, Article IX, subparagraph (A)(2)(b)(i)(C); Miami Holdings Certificate, Article NINTH (b)(i)(C). Such provisions also applied to any voting agreement, plan, or other arrangement, where the effect of such agreement, plan, or other arrangement would be to enable any person, either alone or together with its related persons, to vote, possess the right to vote, or cause the voting of voting interest in the exchange that would represent more than 20% of the voting power of the then issued and outstanding voting interest in the exchange. *See* MEMX Holdings LLC Agreement, Article III, Section 3.5(a)(iii); LTSEG Certificate, Article IX, subparagraph (A)(2)(b)(i)(C).

[76] *See* MEMX Order, *supra* note 48, at 27456; LTSE Order, *supra* note 49, at 21845; and MIAX PEARL Order, *supra* note 49, at 92906. The Commission also has approved the ability of an exchange to waive the ownership and voting concentration limits under certain circumstances. *See e.g.,* MEMX Order, *supra* note 48, at 27454; LTSE Order, *supra* note 49, at 21844; and MIAX PEARL Order, *supra* note 49, at 92905 MEMX Holdings LLC Agreement, Article III, Section 3.5(b)(ii); LTSEG Certificate, Article IX, subparagraph (A)(2)(b)(ii)(B); Miami Holdings Certificate, Article NINTH (b)(ii)(B).

[77] *See supra* notes 69, 75–76 .

[78] As proposed, Schedule A to the Amended and Restated Limited Liability Company Agreement of 24X Bermuda Holdings LLC indicates two members, Dmitri Galinov and Point72 Ventures Investments, LLC, own 44.76% and 20.09%, respectively, of Bermuda Holdings. *See* Schedule A to Exhibit C–2 of 24X's Form 1. However, Exhibit K of 24X's Form 1 also indicates that Dmitri Galinov and Point72 Ventures Investments, LLC own 35.58% and 15.97% of Bermuda Holdings, respectively.

[79] 15 U.S.C. 78f(b)(1).

[80] *See e.g., supra* note 69.

[81] 15 U.S.C. 78f(b)(1).

[82] The Commission has approved provisions addressing regulatory independence for all exchanges. *See, e.g.,* Securities Exchange Act Release Nos. 76998 (January 29, 2016), 81 FR 6066, 6071–72 (February 4, 2016) (File No. 10–221) (order granting the exchange registration of ISE Mercury, LLC); 70050 (July 26, 2013), 78 FR 46622, 46627–29 (August 1, 2013) (File No. 10–209) (order

Giving Due Regard to a National Securities Exchange's Self-Regulatory Obligations. A commitment that requires the directors, officers, employees and agents of exchange holding companies to give due regard to the preservation of the independence of the self-regulatory function of the exchange and its obligations to investors and the general public.[83]

Compliance with Federal Securities Laws. A provision that requires exchange holding companies and their officers, directors, employees, and agents to comply with the federal securities laws and the rules and regulations promulgated thereunder and agree to cooperate with the Commission and the exchange in respect of the Commission's oversight responsibilities.[84]

Submission of Jurisdiction. A provision that requires exchange holding companies and their officers, directors, employees, and agents to submit to the jurisdiction of the U.S. federal courts, the Commission, and the exchange, for purposes of any suit, action or proceeding arising out of, or relating to, the exchange's activities.[85]

Books and Records of a National Securities Exchange Reflecting Confidential Information. A provision that requires all books and records of an exchange reflecting confidential information pertaining to the self-regulatory function of the exchange to be retained in confidence by the exchange and its personnel, directors, officers, employees, and agents, and will not be used by the exchange for any non-regulatory purposes and shall not be made available to any person other than to personnel of the Commission, or to other personnel under specified conditions.[86] Similar provisions regarding the treatment of confidential information pertaining to the self-regulatory function of the exchange apply to the holding companies of an exchange, including the directors, officers, employees, and agents of the holding companies.[87]

Books and Records of the Holding Companies. A provision that requires the books and records of exchange holding companies to be maintained in the United States and, to the extent they are related to the operation or administration of the exchange, the holding companies' books and records will be subject at all times to inspection and copying by the Commission and the exchange,[88] and to the extent they are related to the operation or administration of the exchange, the books, records, premises, officers, directors, employees, and agents of the holding companies will be deemed to be the books, records, premises, officers, directors, employees, and agents of exchange, for purposes of, and subject to oversight pursuant to, the Act.[89]

Consent to Provisions by Holding Company Officers, Directors, Employees and Agents. A provision that requires exchange holding companies to take reasonable steps necessary to cause its officers, directors, employees, and agents, prior to accepting a position with the holding companies to consent in writing to the applicability of the provisions discussed above, with respect to their activities related to the exchange.[90]

Changes to Holding Company Constituting Documents to be Filed with the Commission. A provision that requires exchange holding companies' corporate documents to provide that so long as the holding companies control the exchange, any changes to the holding companies' constituting documents must be submitted to the exchange governing board for approval, and, if such change is required to be filed with the Commission pursuant to Section 19(b) of the Act and the rules and regulations thereunder, such change shall not be effective until filed with and effective by operation of law, or filed with and approved by the Commission.[91]

The Commission is considering whether US Holdings and Bermuda Holdings are proposed to be organized in a way that would help maintain the independence of the regulatory function of 24X and foster the oversight of the exchange by the Commission. 24X has not adopted any of these provisions in the Amended and Restated Limited Liability Company Agreement of 24X Bermuda Holdings LLC.[92] Therefore, the Commission is considering whether the structure of 24X and its parent companies, US Holdings and Bermuda Holdings, help to ensure the independence of 24X's regulatory function. Further, the Commission is considering whether the structure of 24X and its parent companies helps to ensure that 24X can carry out its regulatory responsibilities under, and operate in a manner consistent with, the Act. Specifically, the Commission is considering whether the proposed structure is consistent with Section 6(b)(1), which requires, in part, that an exchange to be so organized and have

granting the exchange registration of Topaz Exchange LLC (nka ISE Gemini, LLC); 68341 (December 3, 2012), 77 FR 73065, 73070–71 (December 7, 2012) (File No. 10–207) (order granting the exchange registration of Miami International Securities Exchange LLC); 58375 (August 18, 2008), 73 FR 49498, 49498–99(August 21, 2008) (File No. 10–182) (order granting the exchange registration of BATS Exchange, Inc.) (''BATS Order''). *See also infra* notes 83–91; Securities Exchange Act Release Nos. 62158 (May 24, 2010), 75 FR 30082 (May 28, 2010) (CBOE–2008–88) (CBOE Demutualization Approval Order); 53963 (June 8, 2006), 71 FR 34660 (June 15, 2006) (SR–NSX–2006–03) (NSX Demutualization Order); 51149 (February 8, 2005).

[83] *See e.g.,* MEMX Order, *supra* note 48, at 27456; LTSE Order, *supra* note 49, at 21845; and MIAX Pearl Order, *supra* note 49, at 92906. *See also* MEMX Holdings LLC Agreement, Article III, Section 3.5(a)(iii); LTSE Group Inc. Bylaws, Article X, Section 10.1; Miami Holdings Bylaws, Article VII, Section 1.

[84] *See e.g.,* MEMX Order, *supra* note 48, at 27456; LTSE Order, *supra* note 49, at 21845–21856; and MIAX Pearl Order, *supra* note 49, at 92906. *See also* MEMX Holdings LLC Agreement, Article XI, Section 11.3(h); LTSE Group Inc. Bylaws, Article X, Section 10.4; Miami Holdings Bylaws, Article VII, Section 4. The holding companies also must take reasonable steps necessary to cause its officers, directors, employees and agents to so cooperate. *Id.*

[85] *See e.g.,* MEMX Order, *supra* note 48, at 27456; LTSE Order, *supra* note 49, at 21846; and MIAX Pearl Order, *supra* note 49, at 92906. *See also* MEMX Holdings LLC Agreement, Article XV, Section 15.12(b); LTSE Group Inc. Bylaws, Article X, Section 10.5; Miami Holdings Bylaws, Article VII, Section 5.

[86] *See e.g.,* MEMX Order, *supra* note 48, at 27456; LTSE Order, *supra* note 49, at 21846; and MIAX Pearl Order, *supra* note 49, at 92906. *See also* Second Amended and Restated Limited Liability Company Agreement of MEMX LLC, Article XIII, Section 13.1; LTSE, Inc. Bylaws, Article XI, Section 11.4; MIAX Pearl Bylaws, Article X, Section 10.4.

[87] *See e.g.,* MEMX Order, *supra* note 48, at 27456; LTSE Order, *supra* note 49, at 21846; and MIAX Pearl Order, *supra* note 49, at 92906. *See also* MEMX Holdings LLC Agreement, Article XII, Section 12.2(c); LTSE Group Inc. Bylaws, Article X, Section 10.2; Miami Holdings Bylaws, Article VII, Section 2.

[88] *See e.g.,* MEMX Order, *supra* note 48 at 27456; LTSE Order, *supra* note 49, at 21846; and MIAX Pearl Order, *supra* note 49, at 92906–92907. *See also* MEMX Holdings LLC Agreement, Article XII, Section 12.2(a) and (b); LTSE Group Inc. Bylaws, Article X, Section 10.3; Miami Holdings Bylaws, Article VII, Section 3.

[89] *See e.g.,* MEMX Order, *supra* note 48, at 27456; LTSE Order, *supra* note 49, at 21846; and MIAX Pearl Order, *supra* note 49, at 92907. *See also* MEMX Holdings LLC Agreement, Article XII, Section 12.2(b); LTSE Group Inc. Bylaws, Article X, Section 10.3; Miami Holdings Bylaws, Article VII, Section 3.

[90] *See e.g.,* MEMX Order, *supra* note 48, at 27456–27457; LTSE Order, *supra* note 49, at 21846; and MIAX Pearl Order, *supra* note 49, at 92907. *See also* MEMX Holdings LLC Agreement, Article XIII, Section 8.18(b); LTSE Group Inc. Bylaws, Article X, Section 10.6; Miami Holdings Bylaws, Article VII, Section 6.

[91] *See e.g.,* MEMX Order, *supra* note 48, at 27457; LTSE Order, *supra* note 49, at 21846; and MIAX Pearl Order, *supra* note 49, at 92907. *See also* MEMX Holdings LLC Agreement, Article XV, Section 15.9(a); LTSEG Certificate, Article IX, Section (A)1 and LTSEG Bylaws, Article IX; Miami Holdings Certificate, Article VIII and Miami Holdings By-Laws, Article XII, Section 1. This requirement is critical as it helps to ensure Commission oversight and approval, as appropriate, for any changes to an exchange holding company corporate documents.

[92] *See* Amended and Restated Limited Liability Company Agreement of 24X Bermuda Holdings LLC and the Limited Liability Company Agreement of 24X US Holdings LLC.

the capacity to carry out the purposes of the Act.[93]

B. 24X Trading Sessions

24X proposes to offer significantly expanded trading outside of regular trading hours for NMS stocks by operating a national securities exchange 24 hours a day, seven days a week, 365 days a year, including holidays.[94] 24X proposes to offer four trading sessions—a ''Core Market Session'' that corresponds with regular trading hours of 9:30 a.m. to 4:00 p.m. Eastern time; a ''Post-Market Session'' that would run from 4:00 p.m. to 8:00 p.m. Eastern time on each U.S. business day; a ''Pre-Market Session'' that would run from 4:00 a.m. to 9:30 a.m. Eastern time on each U.S. business day; and a ''24X Market Session'' that would run from 8:00 p.m. to 4:00 a.m. Eastern time on each U.S. business day, and any time that falls on weekends and holidays.[95] While several exchanges offer a pre-market trading session starting as early as 4:00 a.m. Eastern time on each U.S. business day,[96] and most exchanges offer a post-close trading session until 8:00 p.m. Eastern time on each business day,[97] the Commission has not previously considered the potential issues arising from an exchange application that expands the trading hours for continuous trading as 24X proposes.

1. Exchange Trading Hours

24X refers to the proposed Core Market Session, Pre-Market Session and Post-Market Session collectively in its proposed rules as ''Exchange Trading Hours.'' [98] 24X proposes to permit orders to be entered, canceled, modified, executed on or routed away from the Exchange during Exchange Trading Hours.[99] Orders outstanding at 7:59:59 p.m. Eastern Time each business day would be automatically cancelled.[100] 24X proposes to permit trading in fractional shares in round lots, odd lots, or mixed lots.[101] Market Orders [102] and pegged orders [103] would be accepted only during the Core Market Session, while limit orders would be accepted during Exchange Trading Hours and the 24X Market Session, as discussed below.[104]

2. 24X Market Session

24X proposes to apply some, but not all, of its rules that would apply during Exchange Trading Hours to trading that would occur during the 24X Market Session.[105] For example, market orders [106] and pegged orders [107] would be prohibited from the 24X Market Session. Limit orders,[108] which would be allowed during the 24X Market Session, would be required to have one of the following time-in-force (''TIF'') instructions: immediate or cancel (''IOC''),[109] fill-or-kill (''FOK'') [110] or Day+.[111] In addition, the proposed rules would permit orders to be entered, canceled, modified or executed on the Exchange, but not routed away, during the 24X Market Session.[112] While the proposed rules would impose continuous two-sided quoting obligation on retail market makers during ''Regular Trading Hours,'' [113] the proposed rules would establish no analogous market making obligation during the 24X Market Session.

While 24X proposes to join the CTA/CQ and UTP Plans, the 24X proposal does not address how real-time consolidated dissemination of quotation information and transaction reporting could be available during the 24X Market Session because currently, the CTA/CQ and UTP Plans do not operate during the times that cover the proposed 24X Market Session. One commenter stated that the exclusive SIPs do not operate during the 24X Market Session and that therefore the national best bid or offer (''NBBO'') would not be disseminated.[114] This commenter asked the Commission to ''consider the potential risks related to the lack of transparency, including the risk to investors associated with trading during the 24X Trading Session, without a real-time NBBO and if 24X's proprietary feeds are the only displayed liquidity.'' [115] Another commenter stated that it was unclear how 24X could offer after-hours trading in the absence of real time reporting or operation of the securities information processors (''SIPs'') and that such trading would likely be inconsistent with Regulation NMS Rule 601.[116]

The proposed 24X Market Session rules relating to risk and volatility moderators would also differ from those applicable during Exchange Trading Hours. While 24X would participate in the Plan to Address Extraordinary Market Volatility (''LULD Plan'') [117] during the Core Market Session,[118] the LULD Plan currently is not effective during the times that 24X proposes to operate the 24X Market Session. Consequently, during the 24X Market Session, 24X proposes that the Reference Price of a given security would be defined as either the last sale price prior to the start of the 24X Market Session or the primary market's most recent closing price when opening on a quote.[119] Under 24X's proposal, five minutes after the start of the 24X Market Session, the Reference Price would be required to be updated every 30 seconds to reflect the average price of the security over the last preceding five minute period of the 24X Market Session, but only if the new Reference Price would be at least 1% above or below the existing Reference Price.[120] 24X also proposes to include certain price bands during the 24X Market Session (''24X Price Band(s)''). Under the proposal, the 24X Price Bands are calculated for a given security by multiplying the Reference Price by an applicable Percentage Parameter, which is then added to the Reference Price to calculate the Upper 24X Price Band and

[93] 15 U.S.C. 78f(b)(1).

[94] Proposed 24X Rule 11.1.

[95] Proposed 24X Rule 11.1(a).

[96] *See, e.g.,* NYSE Arca, Inc., Cboe EDGX Exchange, Inc. and The Nasdaq Stock Market LLC.

[97] *See, e.g.,* NYSE Arca, Inc., NYSE American LLC, NYSE Chicago, Inc., NYSE National, Inc., Cboe BZX Exchange, Inc., Cboe BYX Exchange, Inc., Cboe EDGA Exchange, Inc., Cboe EDGX Exchange, Inc., and The Nasdaq Stock Market LLC.

[98] Proposed 24X Rule 11.1(a)(1).

[99] Proposed 24X Rule 11.1(b).

[100] Proposed 24X Rule 11.1(d).

[101] *See* Proposed 24X Rule 11.6(q) and Exhibit E of 24X's Form 1 at 4.

[102] Proposed 24X Rule 11.7(a)(4).

[103] Proposed 24X Rule 11.7(c)(4).

[104] Proposed 24X Rule 11.7(b)(6).

[105] *See, e.g.,* Proposed 24X Rule 11.16.

[106] Proposed 24X Rules 11.7(a)(5) and 11.16(b)(1).

[107] Proposed 24X Rules 11.7(c)(5) and 11.16(b)(2).

[108] Proposed 24X Rule 11.7(b)(7).

[109] Proposed 24X Rule 11.6(o)(1). IOC is defined as an instruction the User may attach to an order stating the order is to be executed in whole or in part as soon as such order is received. The portion not executed immediately on the Exchange or another trading center (pursuant to proposed Rule 11.10) is treated as cancelled and is not posted to the 24X Book.

[110] Proposed 24X Rule 11.6(o)(3). FOK is defined as an instruction the User may attach to an order stating that the order is to be executed in its entirety as soon as it is received and, if not so executed, cancelled. An order with a FOK instruction is not eligible for routing away pursuant to proposed Rule 11.10.

[111] Proposed 24X Rule 11.6(o)(4). Day+ is defined as an instruction the User may attach to an order stating that an order to buy or sell is designated for execution starting with the beginning of the 24X Market Session and, if not executed, expires at the end of the Post-Market Session.

[112] Proposed 24X Rules 11.1(c) and 11.10.

[113] *See supra* note 26.

[114] *See* Nasdaq Letter at 2.

[115] *See* Nasdaq Letter at 2. This commenter also stated that it did ''not believe that the Application has adequately explained how 24X's new exchange will interact with, and be integrated into, the national market system.''

[116] *See* NYSE Letter at 3.

[117] *See* Securities Exchange Act Release No. 85623 (April 11, 2019), 84 FR 16086 (April 17, 2019) (Order Approving the Eighteenth Amendment to the National Market System Plan to Address Extraordinary Market Volatility).

[118] Proposed 24X Rule 11.15(e)(2).

[119] Proposed 24X Rules 11.14(c)(3) and 11.15(f).

[120] *Id.*

subtracted from the Reference Price to calculate the Lower 24X Price Band.[121] If an order entered during the 24X Market Session falls outside of the 24X Price Bands, 24X proposes to identify three distinct Members that have at least 100 shares in the relevant security priced at the applicable end of the 24X Price Bands and consult with these Members as to whether the 24X Price Bands should be adjusted.[122] In the event that 24X is unable to find such Members, or 24X and the Members determine that the 24X Price Bands should not change, the order that triggered the review will be represented at the Upper 24X Price Band or Lower 24X Price Band, as appropriate.[123] One commenter expressed concern with the proposed 24X volatility monitors, stating that it is not clear how well the mechanism would work, especially during periods of extreme market volatility or material newsworthy events.[124] Commenters also raised concerns about how 24X would implement regulatory trading halts and pauses.[125]

24X's proposal to provide for continuous trading on an exchange outside of regular trading hours raises a number of issues, many of which have been considered previously in the context of pre-market and post-market trading sessions. In particular, these include the need for heightened disclosures and consolidated last sale and quotation information in the after-hours market, as well as the associated increased trading risks of after-hours trading, including, among other things, greater price volatility, reduced liquidity, wider spreads, and fewer investor protections, have been raised before.[126] As other exchanges have proposed expanded trading hours to include pre-market and post-market sessions, the Commission has approved such expansion where certain safeguards were implemented to mitigate these concerns.[127] Such safeguards include, among other things, specific disclosures to investors of heightened risks of after-hours trading,[128] establishing risk and volatility moderators and a corresponding expansion of the operational hours of the SIPs,[129] to help ensure the availability of consolidated last sale and quotation information.

The Commission is considering whether the 24X proposal to operate as an exchange that permits continuous trading is consistent with Section 6(b)(5) of the Act, which requires, among other things, that the rules of an exchange be designed to prevent fraudulent and manipulative acts and practices, promote just and equitable principles of trade, foster cooperation and coordination with persons engaged in regulating, clearing, settling, processing information with respect to, and facilitating transactions in securities, remove impediments to and perfect the mechanisms of a free and open market and a national market system, and in general protect investors and the public interest, particularly given the lack of transparency during the 24X Market Session. Specifically, the SIPs currently do not operate during the hours the 24X Market Session is proposed to occur and therefore quotation and last sale information, including the calculation of an NBBO, would not be available during the 24X Market Session. The Commission is evaluating whether the absence of consolidated market information during the 24X Market Session is consistent with Section 6(b)(5) of the Act.[130] The Commission is considering whether 24X's proposed investor disclosures,[131] which mirror those made available by other exchanges,[132] are sufficient to highlight the what appear to be unique risks associated with continuous trading during the 24X Market Session. Specifically, the Commission is evaluating whether these disclosures, currently used for exchange pre-market and post-market trading sessions, sufficiently inform investors of the greater potential risks associated with the significantly expanded after-hours trading that 24X proposes for its 24X Market Session.

Next, the Commission is considering whether the rules proposed by 24X to address certain risks associated with trading during the 24X Market Session are consistent with the Act. First, certain mechanisms that address volatility in individual symbols and the equities market as a whole are not available during the after-hours sessions.[133] The Commission is considering whether the 24X proposed risk and volatility moderators are consistent with Section 6(b)(5) of the Act. Second, 24X proposes to impose on its members certain requirements governing risk management controls and supervisory procedures[134] that are

[121] Proposed 24X Rule 11.15(f).

[122] *Id.*

[123] *Id.*

[124] *See* Blue Ocean Letter at 4. The commenter also stated that 24X's proposal is silent on the actual mechanics for initiating and ending trading halts and does not explain how clearance and settlement of trades made before or during a halt would occur. *See id.* Further, the commenter states that no explanation is given as to how corporate actions would be treated. *See id.,* at 5.

[125] *See* Blue Ocean Letter at 4 and Nasdaq Letter at 4 (''the Application does not sufficiently explain how 24X will coordinate with primary listing exchanges to implement regulatory trading halts and pauses during the entirety of the 24X Trading Session'').

[126] *See, e.g.,* Special Study: Electronic Communication Networks and Afterhours Trading, Division of Market Regulation, Commission (June 2000), *https://www.sec.gov/news/studies/ecnafter.htm;* Investor Bulletin: After-Hours Trading, Office of Investor Education and Advocacy, Commission (May 2011), *https://www.sec.gov/files/afterhourtrading.pdf; and Investor Publications, Commission,* After-Hours Trading: Understanding the Risks *(Nov. 8, 2008), https://www.sec.gov/reportspubs/investor-publications/investorpubsafterhourshtm.html.* Investor Bulletin: Extended Hours Trading (June 6, 2022) Extended-Hours Trading: Investor Bulletin | Ivestor.gov. Staff reports, Investor Bulletins, and other staff documents (including those cited herein) represent the views of Commission staff and are not a rule, regulation, or statement of the Commission. The Commission has neither approved nor disapproved the content of these documents and, like all staff statements, they have no legal force or effect, do not alter or amend applicable law, and create no new or additional obligations for any person. The Commission has expressed no view regarding the analysis, findings, or conclusions contained herein.

[127] *See, e.g.,* Securities and Exchange Act Nos. 77607 (April 13, 2016) 81 FR 23032 (April 19, 2016) (Order Approving Proposed Rule Change, as Modified by Amendment No. 1 Thereto, To Adopt an Early Trading Session and Three New Time-In-Force Instructions), at 23034; 42003 (October 13, 1999) 64 FR 56554 (October 20, 1999) (Notice of Filing and Order Granting Accelerated Approval of Proposed Rule Change and Amendment No. 1 by National Association of Securities Dealers, Inc. Relating to the Extension of Certain Nasdaq Services and Facilities Until 6:30 p.m. Eastern Time); 42004 (October 13, 1999) 64 FR 56548 (October 20,1999) (Notice of Filing of Proposed Rule Change and Amendment Nos. 1 and 2 and Order Granting Accelerated Approval of Proposed Rules Change and Amendment Nos. 1 and 2 by the Chicago Stock Exchange Relating to the Implementation of an Extended Hours Trading Session).

[128] *See, e.g.,* FINRA Rule 2265, Investors Exchange Rule 3.290, Nasdaq Section 20.

[129] The SIPs, which collect, consolidate and disseminate consolidated data, including the NBBO, in the equity market are currently governed by (1) the Consolidated Tape Association Plan (''CTA Plan''), (2) the Consolidated Quotation Plan (''CQ Plan''), and (3) the Joint Self-Regulatory Organization Plan Governing the Collection, Consolidation, and Dissemination of Quotation and Transaction Information for Nasdaq-Listed Securities Traded on Exchanges on an Unlisted Trading Privileges Basis (''UTP Plan'').

[130] One commenter states that 24X has not sufficiently analyzed how the Exchange would comply with certain Commission rules and interact with other exchanges when the SIPs are not operating. *See* Nasdaq Letter at 2. The commenter ''encouraged'' the Commission to consider the potential risks resulting from the absence of a real-time NBBO. *See id.* Further, the commenter states that the 24X proposal would not allow for technical changes that typically take place during pauses in the trading day. *See id.,* at 3.

[131] Proposed 24X Rule 3.21.

[132] *See supra* note 128.

[133] Specifically, Limit Up—Limit Down trading pauses and market wide circuit breakers are unavailable during after-hours trading.

[134] *See* Proposed 24X Rule 11.10(g). The Market Access Rule, Rule 15c3–5, referred to in proposed

Continued

similar to requirements imposed by other exchanges.[135] The Commission is evaluating whether such proposed risk management controls and supervisory procedures, which appear to be based on requirements that were established for the current trading hours and environment are sufficient during the 24X Market Session or whether additional mechanisms would be needed. The Commission is also considering how the relevant clearing agencies for equities, the National Securities Clearing Corporation (''NSCC'') and the Depository Trust Company, would address any potential credit, market, and liquidity risks associated with trades submitted by the Exchange when the markets, banks, Fedwire, and any providers of settlement services are closed for business.[136] The Commission is considering whether the 24X proposal would permit risk to be managed in a manner consistent with the requirements of Section 6(b)(5) of the Act that an exchange's rules be designed to prevent fraudulent and manipulative acts and practices, promote just and equitable principles of trade, foster cooperation and coordination with persons engaged in regulating, clearing, settling, processing information with respect to, and facilitating transactions in securities, remove impediments to and perfect the mechanisms of a free and open market and a national market system, and, in general protect investors and the public interest.

Further, the Commission is considering other issues raised by commenters about 24X's proposal to substantially extend exchange trading hours. Commenters raise concerns about whether 24X's proposal is consistent with the requirements of Section 6(b)(5) of the Act that an exchange's rules be designed to prevent fraudulent and manipulative acts and practices, promote just and equitable principles of trade, foster cooperation and coordination with persons engaged in regulating, clearing, settling, processing information with respect to, and facilitating transactions in securities, remove impediments to and perfect the mechanisms of a free and open market and a national market system, and, in general protect investors and the public interest. Specifically, commenters raised concerns about the effect of 24X's proposal on market-wide surveillance.[137] These commenters stated that the 24X proposal does not sufficiently detail how 24X will coordinate with primary listing exchanges to surveil securities during the 24X Market Session or how market surveillance will work generally.[138]

In addition, commenters stated that 24X has not sufficiently explained how 24X will comply with relevant Commission rules in light of 24X's novel features.[139] Specifically, one commenter states that the 24X proposal does not explain how 24X intends to comply with Regulation NMS Rules 602, 603, 610 and 611 and Regulation SHO generally.[140] The commenter also stated that the 24X's proposed routing relationship with Instinet is not adequately described, especially in light of the 24X Market session when other exchanges are closed.[141]

A commenter stated that listed companies often release material information outside of core market hours and that primary listing exchanges typically require companies to notify their primary listing exchanges prior to the release of such information to allow the exchange to determine whether a trading halt is necessary.[142] The commenter suggested the Commission consider the effect the 24X Market Session would have on the disclosure of material information and the volatility in securities outside of core hours trading hours when material information is released.[143]

A commenter stated that the 24X proposal does not address how 24X will handle the elimination of natural trading pauses when corporate actions, such as stock splits, dividends, mergers and SPAC combinations typically occur at the end of the trading day.[144] The commenter also stated that the 24X proposal does not adequately explain how 24X will pause trading to allow for critical exchange, industry, and systems tests that are typically performed when the exchange is not operating.[145]

1. Fractional Shares

24X proposes to permit orders to be submitted in round lots, mixed lots or odd-lots. Orders are proposed to be submitted in as small as 1/1,000th of a share.[146] 24X's proposal does not describe how trading in fractional shares would occur. Trading in fractional shares on an exchange raises issues relating to trade reporting,[147] custody, clearance [148] and settlement, and quote display. The Commission is considering whether 24X's proposal to accept orders and offer trading in fractional shares in units as small as 1/1,000th of a share is designed to foster cooperation and coordination with persons engaged in regulating, clearing, settling, processing information with respect to, and facilitating transactions in securities, 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, consistent with Section 6(b)(5) of the Act.

Three commenters raised concerns over 24X's proposal to allow for trading in fractional shares. Three commenters stated that 24X's proposal does not sufficiently explain how trading in fractional shares would function.[149] One commenter stated that it is unclear from 24X's proposal how trading in fractional shares will comply with certain relevant

24X Rule 11.10(g), requires broker-dealers with market access to, among other things, establish, document, and maintain a system of risk management controls and supervisory procedures reasonably designed to manage financial, regulatory, and other risks of this business activity. 17 CFR 240.15c3–5.

[135] *See, e.g.,* Cboe Rule 5.36(f); CboeEDGX Rules 21.9(f); Nasdaq Rule 4757(b); Nasdaq BX Rule 4758(c); MEMX Rule 11.11(g).

[136] Three commenters raised concerns relating to 24X's ability to clear and settle trades after-hours. *See* Nasdaq Letter at 3 (stating that US equities clearance and settlement does not operate on a 24/7 basis); NYSE Letter at 2–4 (stating that 24X does not describe any procedures or process for NSCC to clear trades during the 24X market session); and Blue Ocean Letter at 4 (stating that 24X has not addressed the daily settlement of trades with NSCC when NSCC and its constituent members are typically closed). One commenter also questioned whether 24X would be able to clear trades on a continuous net settlement system as proposed under its Rule 11.2 because NSCC is not open for business on weekends. *Id.*

[137] *See* Nasdaq Letter at 4–5. *See also* Blue Ocean Letter at 5–6.

[138] *See id.* One commenter states that 24X's proposal would be the first occurrence of a national securities exchange that utilizes unlisted trading privileges to operate outside the trading hours of the primary listing exchange. *See* Nasdaq Letter at 3.

[139] *See* Nasdaq Letter at 3. *See also* Blue Ocean Letter at 3 and 5.

[140] *See* Blue Ocean Letter at 3 and 5.

[141] *See* Blue Ocean Letter at 3 (stating that it is ''critical'' for the Commission and other market participants to be able to understand and evaluate how routing of orders will be administered when other markets are closed).

[142] *See* Nasdaq Letter at 4.

[143] *See id.*

[144] *See id.* Specifically, the commenter referenced corporate actions including stock splits, dividends, and mergers that typically take effect at the end of the trading day.

[145] *See id.* Specifically, the commenter references tests such as general customer testing, disaster recovery tests, industry-wide business continuity tests.

[146] *See supra* note 101.

[147] *See* Nasdaq Letter at 3. (''the SIPs do not currently allow for the reporting of fractional shares'').

[148] *See* Nasdaq Letter at 3 and NYSE Letter at 3.

[149] *See* Blue Ocean Letter at 3. *See also* NYSE Letter at 2 and Nasdaq Letter at 3. The commenters state that important information including minimum trade size and how fractional trading would interact with other Exchanges is not addressed.

Commission rules.[150] Two commenters also stated that the 24X proposal has not adequately described how fractional share trading would operate in connection with the SIPs,[151] or how fractional shares would clear, settle, and route to other markets that do not allow fractional share trading.[152] One commenter stated that because 24X's proposed rules require all transactions to be cleared using a continuous net settlement system, and because NSCC is not available for either after-hours trading or trading in fractional shares, 24X will not be able to provide after-hours trading and trading in fractional shares while also complying with its own rules regarding clearing and settlement.[153] Therefore, the commenter states that if 24X were approved as a national securities exchange, it would immediately be in violation of Section 19(g) of the Act.[154]

C. Sufficiency of Exhibits—Regulatory Funding

1. Exhibit I

To help ensure that 24X has and would continue to have adequate funding to be able to meet its responsibilities under the Act, 24X represents that, if the Commission approves 24X's application for registration as a national securities exchange, US Holdings, as the controlling owner of the membership interests in the Exchange, would allocate sufficient assets to 24X to enable 24X's operation.[155] Specifically, 24X represents that the US Holdings will make a cash contribution to 24X of $5,000,000, ''in addition to any previously-provided in-kind contributions, such as legal, regulatory, and infrastructure-related services.'' [156] 24X also represents that such cash and in-kind contributions from the US Holdings will be adequate to operate 24X, including the regulation of the Exchange, and that 24X and the US Holdings have entered into an agreement that requires the US Holdings to provide adequate funding for the Exchange's operations, including the regulation of the Exchange.[157] 24X represents this agreement provides that (1) the Exchange shall receive all fees, including regulatory fees and trading fees, payable by the Exchange's members, as well as any funds received from any applicable market data fees and tape revenue, and (2) US Holdings will provide the Exchange with cash, cash equivalents, securities or other sufficiently liquid instruments sufficient to help ensure that the Exchange's financial resources (calculated as assets in excess of liabilities) remain greater than $5 million.[158]

Further, any revenues received by the Exchange from fees derived from its regulatory function or regulatory fines will not be used for non-regulatory purposes or distributed to the US Holdings, but rather, shall be applied to fund the legal and regulatory operations of the Exchange (including surveillance and enforcement activities), or, as the case may be, shall be used to pay restitution and disgorgement of funds intended for customers (except in the event of liquidation of the Exchange, which case US Holdings will be entitled to the distribution of the remaining assets of the Exchange).[159]

The Commission is considering whether 24X has satisfied the requirements to file certain exhibits included in 24X's Form 1. In its Form 1 application, 24X states that it is not filing audited financial statements for itself as the applicant, as required under Exhibit I, because ''24X National Exchange LLC has been formed but has not commenced operations and does not yet have audited financial statements for any fiscal year.'' [160] Further, in the Exhibit I, 24X represents that US Holdings ''shall make prior to the launch of the Exchange, through its U.S. bank account, a cash contribution to the Exchange of $5 million, in addition to any previously provided in-kind contributions, such as legal, regulatory, and infrastructure-related services.'' [161] However, as discussed further below, 24X has not explained or otherwise shown how the financial statements filed for the US Holdings under Exhibit D reflect that US Holdings has or will have sufficient funds to provide 24X with such cash contributions.

2. Exhibit D

Exhibit D requires that the applicant file unconsolidated financial statements for each subsidiary or affiliate for the latest fiscal year. Such financial statements must include a balance sheet and income statement ''with such footnotes and other disclosures as are necessary to avoid rendering the financial statements misleading.'' In the US Holdings balance sheet filed under Exhibit D, total assets are reported as negative $439.[162] It is unclear as to what this number signifies, as assets generally cannot be below $0. Further, this negative $439 is not reflected in the financial statements of other subsidiaries. The financial statements filed by 24X do not include accompanying footnotes or disclosures that explain these discrepancies. Moreover, while in Exhibit I 24X states that US Holdings ''shall make prior to the launch of the Exchange, through its U.S. bank account, a cash contribution to the Exchange of $5 million, in addition to any previously provided in-kind contributions, such as legal, regulatory, and infrastructure-related services,'' [163] the Commission is considering whether the financial statements filed for US Holdings under Exhibit D show US Holdings has the financial resources to make a $5 million U.S. Dollar cash infusion, as 24X states, such that the Exchange would be organized and have the capacity to carry out the purposes of the Act, including the ability to enforce compliance by its members, and persons associated with its members, with the federal securities laws and rules thereunder and the rules of the exchange.

In addition, the Commission is considering whether the financial statements for the US Holdings filed under Exhibit D for the Form 1 show that US Holdings would be able to provide the financial support that 24X describes in its Form 1. In its Form 1 application, 24X states that it is not filing audited financial statements for itself as applicant, as required under Exhibit I, because ''24X National Exchange LLC has been formed but has not commenced operations and does not yet have audited financial statements for any fiscal year.'' [164] Moreover, 24X further states that, ''[i]f the Commission approves the Exchange's Form 1 Application for Registration as a national securities exchange, 24X US

[150] *See* Nasdaq Letter at 3. The commenter specifically states that 24X has not explained how fractional share trading is consistent with Rules 602, 603, 610, and 611 of Regulation NMS.

[151] *See id.* The commenter stated that 24X has not analyzed the potential costs of technical enhancements to the exclusive SIPs. *See also* NYSE Letter at 2–4 (stating that 24X is silent on whether it intends to report to the SIP in fractional quantities or if it would round to a whole share. Further, the commenter states that certain studies have found that rounding up fractional shares to a whole can distort reported market volumes).

[152] *See* Nasdaq Letter at 3.

[153] *See* NYSE Letter at 2–3.

[154] *Id.* This commenter also states that it is unclear how fractional share quotations would be incorporated into any potential odd-lot quotation reporting, should odd-lot quotations reporting be expanded in the future.

[155] *See* Exhibit I of 24X's Form 1.

[156] *Id.*

[157] *Id.*

[158] *Id.*

[159] *See* Proposed 24X Rule 15.2.

[160] *See* Exhibit I of 24X's Form 1.

[161] *Id.*

[162] *See* Exhibit D of 24X's Form 1.

[163] *See* Exhibit I of 24X's Form 1.

[164] *Id.*

Holdings LLC (''Parent''), as the controlling owner of the membership interests in the Exchange, will allocate sufficient assets to the Exchange to enable its operation.'' [165] Given the applicant's stated reliance on US Holdings for sufficient financial support to enable its operation, the Commission is considering whether the unaudited financial statements filed for the applicant's parent, US Holdings, show that the Exchange would be organized and have the capacity to carry out the purposes of the Act, including the ability to enforce compliance by its members, and persons associated with its members, with the federal securities laws and rules thereunder and the rules of the exchange.

D. Location of Exchange Trading Platform

24X proposes to locate its primary trading platform in the Equinix data center located in New York (''NY4''). 24X also proposes to locate a ''mirrored'' primary platform in London (''LD4'').[166] 24X did not describe how the LD4 platform would operate along with the platform in NY4. The Commission is considering whether the proposal is consistent with the requirements under Section 6(b)(1) of the Act, which among other things, requires the exchange to be so organized and have the capacity to be able to carry out the purposes of the Act and to comply, and to enforce compliance by its members and persons associated with its members, with provisions of the Act. The Commission also is considering whether the proposal is consistent with Section 6(b)(5) of the Act, which requires the rules of the exchange to prevent fraudulent and manipulative acts and practices, to promote just and equitable principles of trade, to foster cooperation and coordination with persons engaged with regulating, clearing, settling, processing, information with respect to and facilitating transactions in securities, to remove impediments to and perfect the mechanisms of a free and open market and a national market system.

One commenter expressed concern over this aspect of 24X's proposal.[167] The commenter stated that no other U.S. exchange operates a mirrored primary U.S. trading platform outside of the United States and stated that 24X does not explain this structure in its proposal.[168] Further, the commenter stated that the Commission should consider the proposed structure's jurisdictional and operational implications and whether such a structure ''would open the door to foreign markets to operate mirrored markets within the United States.'' [169]

IV. Request for Written Comment

The Commission requests that interested persons provide written views and data with respect to 24X's Form 1 and the questions included above or other relevant issues. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's internet comment form (*http://www.sec.gov/rules/sro.shtml*); or
- Send an email to *rule-comments@sec.gov.* Please include File Number 10–239 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 10–239. 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 (*http://www.sec.gov/rules/other.shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to 24X's Form 1 filed with the Commission, and all written communications relating to the application 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 10:00 a.m. and 3:00 p.m. All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make publicly available. All submissions should refer to File Number 10–239 and should be submitted on or before September 28, 2022.

By the Commission.

J. Matthew DeLesDernier,

Deputy Secretary.

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[165] *Id.*

[166] *See* Exhibit E–1 of 24X's Form 1 at 1.

[167] *See* Nasdaq Letter at 4.

[168] *Id.*

[169] *Id.*

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–95647; File No. SR–CBOE–2022–043]

Self-Regulatory Organizations; Cboe Exchange, Inc.; Notice of Filing and Immediate Effectiveness of a Proposed Rule Change To Amend Its Rule Relating to Minimum Market-Maker Quote Size

August 31, 2022.

Pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 (the ''Act''),[1] and Rule 19b–4 thereunder,[2] notice is hereby given that on August 25, 2022, Cboe Exchange, Inc. (the ''Exchange'' or ''Cboe Options'') filed with the Securities and Exchange Commission (the ''Commission'') the proposed rule change as described in Items I, II, and III below, which Items have been prepared by the Exchange. The Exchange filed the proposal as a ''non-controversial'' proposed rule change pursuant to Section 19(b)(3)(A)(iii) of the Act [3] and Rule 19b–4(f)(6) thereunder.[4] 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

Cboe Exchange, Inc. (the ''Exchange'' or ''Cboe Options'') proposes to amend its Rule relating to minimum Market-Maker quote size. The text of the proposed rule change is provided below.

(additions are *italicized;* deletions are [bracketed])

* * * * *

Rules of Cboe Exchange, Inc.

* * * * *

Rule 5.52. Market-Maker Quotes

(a) No change.

(b) *Size.* A Market-Maker's bid (offer) for a series must be accompanied by the minimum number of contracts determined by the Exchange on a class-by-class basis, *and if the Exchange determines on a premium basis and/or expiration basis for series with expirations (1) no more than one week, (2)*

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] 15 U.S.C. 78s(b)(3)(A)(iii).

[4] 17 CFR 240.19b–4(f)(6).

between one week and two weeks, (3) between two weeks and one month, (4) between one month and two months, (5) between two months and three months, (6) between three months and six months, (7) between six months and nine months, (8) between nine months and 15 months, and (9) 15 months or more, the minimum of which will be one contract at the price of the bid (offer) the Market-Maker is willing to buy (sell). The System rejects a Market-Maker's bid (offer) that does not meet the minimum initial quote size determined by the Exchange for that class.

[(1) For SPX, the Exchange may also determine a minimum initial quote size on a premium basis and an expiration basis for series with expirations (1) no more than one week, (2) between one week and three months, (3) between three months and six months, (4) between six months and 15 months, and (5) 15 months or more.

(2)] The obligation of Market-Makers to make competitive markets under Rule 5.51 does not preclude Trading Permit Holders in a trading crowd from discussing a request for a market that is greater than the disseminated size for that option class, for the purpose of making a single bid (offer) based upon the aggregate of individual bids (offers) by Trading Permit Holders in the trading crowd, but only when the Trading Permit Holder representing the order asks for a single bid (offer). Whenever a single bid (offer) pursuant to this paragraph is made, such bid (offer) is a firm quote, and each ICMP participating in the bid (offer) must fulfill his portion of the single bid (offer) at the single price.

* * * * *

The text of the proposed rule change is also available on the Exchange's website (*http://www.cboe.com/AboutCBOE/CBOELegalRegulatoryHome.aspx*), 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 its Rule relating to minimum Market-Maker quote size. Specifically, the Exchange proposes to amend Rule 5.52(b)[5] to permit the Exchange to determine a minimum initial quote size on a premium basis and/or an expiration basis for any option class, not just S&P 500 Index (''SPX'') options.[6] Currently, Rule 5.52 permits the Exchange to determine a minimum initial quote size on a class-by-class basis. Subparagraph (b)(1) of that rule also permits the Exchange, for SPX, to determine a minimum initial quote size on a premium and an expiration basis for series with expirations (1) no more than one week, (2) between one week and three months, (3) between three months and six months, (4) between six months and 15 months, and (5) 15 months or more.

While different classes may exhibit different trading characteristics, which make different minimum quote sizes appropriate as permitted by the current Rule, the same may be true of series with different premiums and expirations within a class to ensure the quote size is not burdensome on Market-Makers. For example, series with higher premiums or farther expirations generally have wider spreads and lower trading volumes, and positions in those series carry additional risk. These characteristics make lower minimum quote size requirements more appropriate and less burdensome on Market-Makers. This is generally true for all classes, not just SPX options.

Therefore, the Exchange proposes to permit the Exchange to determine minimum initial quote size on a premium and/or expiration basis for all classes.[7] Additionally, it proposes to amend the groupings of expirations to provide the Exchange with sufficient flexibility to determine minimum quote sizes appropriate for each class. Specifically, the proposed rule change will permit the Exchange to determine the minimum quote size for any class on a premium basis and/or expiration basis for series with expirations (1) no more than one week, (2) between one week and two weeks, (3) between two weeks and one month, (4) between one month and two months, (5) between two months and three months, (6) between three months and six months, (7) between six months and nine months, (8) between nine months and 15 months, and (9) 15 months or more.[8] To the extent the Exchange determines the minimum quote size for a class will not be on a premium and/or expiration basis, the Exchange will determine the minimum quote size for that class as it does today, which is determining a minimum quote size for all series in that class.

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.[9] Specifically, the Exchange believes the proposed rule change is consistent with the Section 6(b)(5)[10] 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 the Section 6(b)(5)[11] requirement that the rules of an exchange not be designed to permit unfair discrimination between customers, issuers, brokers, or dealers.

In particular, the Exchange believes the proposed rule change will promote just and equitable principles of trade by permitting the Exchange to impose more effective and not overly burdensome minimum size requirements on Market-Makers in all classes, which the Exchange believes will lead to continued liquidity on the Exchange, ultimately benefiting investors. The

[5] The proposed rule change moves the language from Rule 5.52(b)(1), as amended, into the main part of Rule 5.52(b). As a result, the proposed rule change deletes the numbering for subparagraph (2), as that would be the only subparagraph for Rule 5.52(b) and thus will no longer require numbering.

[6] The Exchange will announce any minimum quote size requirements for any class with sufficient advance notice in accordance with Rule 1.5.

[7] The minimum quote size must continue to be at least one contract at the price of the bid (offer) the Market-Maker is willing to buy (sell). The System rejects a Market-Maker's bid (offer) that does not meet the minimum initial quote size determined by the Exchange for that class.

[8] As noted above, Rule 5.52(b)(1) already permits the Exchange to set minimum quote sizes on a premium and expiration basis for SPX options. The proposed expiration groupings will permit the Exchange to determine minimum quote sizes for SPX options in the same manner as it does today, as it could determine the same minimum quote size for multiple expiration groupings to conform to the current expiration groupings (for example, the same minimum quote size for proposed expiration groups two through five is equivalent to having a minimum quote size equal to current expiration group two).

[9] 15 U.S.C. 78f(b).

[10] 15 U.S.C. 78f(b)(5).

[11] *Id.*

Exchange believes the proposed rule change maintains an appropriate balance of obligations and benefits. The Exchange believes it is appropriate to have authority to establish minimum quote sizes in a class on an expiration or premium basis to reflect the different trading characteristics of those series within that class. The Exchange believes these proposed changes will continue to incentivize Market-Makers to have appointments in any class in which the Exchange may impose minimum quote size requirements on a premium or expiration basis, which increases liquidity and in general protects investors.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange does not believe that the proposed rule change will impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act. The Exchange does not believe that the proposed rule change will impose any burden on intramarket competition that is not necessary or appropriate in furtherance of the Act because any minimum size requirements the Exchange imposes in a class on a premium or expiration basis will apply in the same manner to all Market-Makers with appointments in that class. The Exchange does not believe that the proposed rule change will impose any burden on intermarket competition that is not necessary or appropriate in furtherance of the Act because it relates solely to quoting obligations the Exchange imposes on Market-Makers on the Exchange. The Exchange believes the proposed rule change will maintain an appropriate balance of Market-Maker obligations and benefits and will permit the Exchange to impose more effective minimum size requirements in a class without being overly burdensome on Market-Makers given the differing trade characteristics applicable to series with different expirations and premiums.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

The Exchange neither solicited nor received comments on the proposed rule change.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Because the foregoing 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 for 30 days from the date on which it was filed, or such shorter time as the Commission may designate, it has become effective pursuant to Section 19(b)(3)(A)(iii) of the Act[12] and subparagraph (f)(6) of Rule 19b–4 thereunder.[13]

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 shall institute proceedings under Section 19(b)(2)(B)[14] 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 (*http://www.sec.gov/rules/sro.shtml*); or
- Send an email to *rule-comments@sec.gov.* Please include File Number SR–CBOE–2022–043 on the subject line.

Paper Comments

- Send paper comments in triplicate to the Secretary, Securities and Exchange Commission, 100 F Street NE, Washington, DC 20549–1090.

All submissions should refer to File Number SR–CBOE–2022–043. 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 (*http://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 10:00 a.m. and 3:00 p.m. Copies of the filing also will be available for inspection and copying at the principal office of the Exchange. All comments received will be posted without change. Persons submitting comments are cautioned that we do not redact or edit personal identifying information from comment submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number *SR–CBOE–2022–043* and should be submitted on or before September 28, 2022.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[15]

J. Matthew DeLesDernier,

Deputy Secretary.

[FR Doc. 2022–19225 Filed 9–6–22; 8:45 am]

BILLING CODE 8011–01–P

[12] 15 U.S.C. 78s(b)(3)(A)(iii).

[13] 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 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.

[14] 15 U.S.C. 78s(b)(2)(B).

[15] 17 CFR 200.30–3(a)(12).

SURFACE TRANSPORTATION BOARD

[Docket No. EP 552 (Sub-No. 26)]

Railroad Revenue Adequacy—2021 Determination

AGENCY: Surface Transportation Board.

ACTION: Notice of decision.

SUMMARY: On September 6, 2022, the Board served a decision announcing the 2021 revenue adequacy determinations for the nation's Class I railroads. Five Class I railroads (BNSF Railroad Company, CSX Transportation, Inc., Norfolk Southern Combined Railroad Subsidiaries, Soo Line Corporation, and Union Pacific Railroad Company) were found to be revenue adequate.

DATES: This decision is effective on September 6, 2022.

FOR FURTHER INFORMATION CONTACT: Pedro Ramirez, (202) 245–0333. Assistance for the hearing impaired is available through the Federal Relay Service at (800) 877–8339.

SUPPLEMENTARY INFORMATION: Under 49 U.S.C. 10704(a)(3), the Board is required to make an annual determination of railroad revenue adequacy. A railroad is

considered revenue adequate under 49 U.S.C. 10704(a) if it achieves a rate of return on net investment (ROI) equal to at least the current cost of capital for the railroad industry. For 2020, this number was determined to be 10.37% in *R.R. Cost of Capital—2021,* EP 558 (Sub-No. 25) (STB served Aug. 2, 2022). The Board then applied this revenue adequacy standard to each Class I railroad. Five Class I carriers (BNSF Railroad Company, CSX Transportation, Inc., Norfolk Southern Combined Railroad Subsidiaries, Soo Line Corporation, and Union Pacific Railroad Company) were found to be revenue adequate for 2021.

The decision in this proceeding is posted at *www.stb.gov.*

Decided: August 31, 2022.

By the Board, Board Members Fuchs, Hedlund, Oberman, Primus, and Schultz.

Jeffrey Herzig,

Clearance Clerk.

[FR Doc. 2022–19321 Filed 9–6–22; 8:45 am]

BILLING CODE 4915–01–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

[Docket No. 2013–0259]

Agency Information Collection Activities: Requests for Comments; Clearance of Renewed Approval of Information Collection: Advisory Circular: Reporting of Laser Illumination of Aircraft

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice and request for comments.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995, FAA invites public comments about our intention to request the Office of Management and Budget (OMB) approval renew information collection. Advisory Circular 70–2A provides guidance to civilian air crews on the reporting of laser illumination incidents and recommended mitigation actions to be taken in order to ensure continued safe and orderly flight operations.

DATES: Written comments should be submitted by November 1, 2022.

ADDRESSES: Please send written comments:

By Electronic Docket: www.regulations.gov (Enter docket number into search field).

By mail: Barbara Hall by email at: Barbara Hall, Federal Aviation Administration, ASP–110, 10101 Hillwood Parkway, Fort Worth, TX 76177.

FOR FURTHER INFORMATION CONTACT: Barbra Hall by email at: *Barbra.L.Hall@faa.gov;* phone: 940–594–5913.

SUPPLEMENTARY INFORMATION:

Public Comments Invited: You are asked to comment on any aspect of this information collection, including (a) Whether the proposed collection of information is necessary for FAA's performance; (b) the accuracy of the estimated burden; (c) ways for FAA to enhance the quality, utility and clarity of the information collection; and (d) ways that the burden could be minimized without reducing the quality of the collected information. The agency will summarize and/or include your comments in the request for OMB's clearance of this information collection.

OMB Control Number: 2120–0698

Title: Advisory Circular (AC): Reporting of Laser Illumination of Aircraft.

Form Numbers: Advisory Circular 70–2A, Reporting of Laser Illumination of Aircraft.

Type of Review: Renewal of an information collection.

Background: Advisory Circular 70–2A provides guidance to civilian air crews on the reporting of laser illumination incidents and recommended mitigation actions to be taken in order to ensure continued safe and orderly flight operations. Information is collected from pilots and aircrews that are affected by an unauthorized illumination by lasers. The requested reporting involves an immediate broadcast notification to Air Traffic Control (ATC) when the incident occurs, as well as a broadcast warning of the incident if the aircrew is flying in uncontrolled airspace. In addition, the AC requests that the aircrew supply a written report of the incident and send it by fax or email to the Washington Operations Control Complex (WOCC) as soon as possible.

Respondents: Approximately 1,100 pilots and crewmembers.

Frequency: Information is collected on occasion.

Estimated Average Burden per Response: 10 minutes.

Estimated Total Annual Burden: 183 hours.

Issued in Washington, DC, on September 1, 2022.

Sandra Ray,

Aviation Safety Inspector, Aviation Safety, Safety Standards, AFS–260.

[FR Doc. 2022–19318 Filed 9–6–22; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

National Highway Traffic Safety Administration

[Docket No. NHTSA–2021–0079; Notice 2]

Maserati North America, Inc., Grant of Petition for Decision of Inconsequential Noncompliance

AGENCY: National Highway Traffic Safety Administration (NHTSA), Department of Transportation (DOT).

ACTION: Grant of petition.

SUMMARY: Maserati North America, Inc., (MNA), has determined that certain model year (MY) 2014–2021 Maserati Ghibli, Quattroporte, and Levante motor vehicles do not fully comply with Federal Motor Vehicle Safety Standard (FMVSS) No. 208, *Occupant Crash Protection.* MNA filed a noncompliance report dated August 5, 2021. MNA subsequently petitioned NHTSA on August 30, 2021, and amended its petition on January 13, 2022, for a decision that the subject noncompliance is inconsequential as it relates to motor vehicle safety. This document announces the grant of MNA's petition.

FOR FURTHER INFORMATION CONTACT: Syed Rahaman, Office of Vehicle Safety Compliance, the National Highway Traffic Safety Administration (NHTSA), (202) 306–7018, *Syed.Rahaman@dot.gov.*

SUPPLEMENTARY INFORMATION:

I. Overview

MNA has determined that certain MY 2014–2021 Maserati Levante, Ghibli, and Quattroporte motor vehicles do not fully comply with paragraph S4.5.1(b)(3) of FMVSS No. 208, *Occupant Crash Protection* (49 CFR 571.208).

MNA filed a noncompliance report dated August 5, 2021, pursuant to 49 CFR part 573, *Defect and Noncompliance Responsibility and Reports.* MNA subsequently petitioned NHTSA on August 30, 2021, and amended its petition on January 13, 2022, for an exemption from the notification and remedy requirements of 49 U.S.C. Chapter 301 on the basis that this noncompliance is inconsequential as it relates to motor vehicle safety, pursuant to 49 U.S.C. 30118(d) and 30120(h) and 49 CFR part 556, *Exemption for Inconsequential Defect or Noncompliance.*

Notice of receipt of MNA's petition was published with a 30-day public comment period, on January 31, 2022, in the **Federal Register** (87 FR 4991). No comments were received. To view the

petition and all supporting documents log onto the Federal Docket Management System (FDMS) website at *https://www.regulations.gov/.* Then follow the online search instructions to locate docket number ''NHTSA–2021–0079.''

II. Vehicles Involved

Approximately 78,588 MY 2014–2021 Maserati Levante, Ghibli, and Quattroporte motor vehicles, manufactured between April 30, 2013, and July 13, 2021, are potentially involved.

III. Noncompliance

MNA explains that the subject vehicles are equipped with air bag warning labels that are affixed to the headliner, rather than either side of the sun visor, as required by S4.5.1(b)(3) of FMVSS No. 208.

IV. Rule Requirements

Paragraph S4.5.1(b)(3) of FMVSS No. 208, includes the requirements relevant to this petition. Vehicles certified to meet the requirements specified in S19, S21, or S23 on or after September 1, 2003, shall have a label permanently affixed to either side of the sun visor, at the manufacturer's option, at each front outboard seating position that is equipped with an inflatable restraint.

V. Summary of MNA's Petition

The following views and arguments presented in this section, ''V. Summary of MNA's Petition,'' are the views and arguments provided by MNA. They do not reflect the views of the Agency. MNA describes the subject noncompliance and contends that the noncompliance is inconsequential as it relates to motor vehicle safety.

MNA says that the sun visor is affixed with an air bag alert label that informs ''passengers to flip the sun visor to the down position'' to view the warning label. MNA also says that although the air bag warning label is affixed to the headliner, the label is clearly visible when the sun visor is in the down position. In its petition, MNA provides computer-aided design (CAD) illustrations of the air bag alert label and noncompliant air bag warning label.

MNA states its belief that although the air bag warning label is not positioned on the sun visor, the combination with the air bag alert label on the sun visor with the warning label on the headliner provides a prominent display as intended by FMVSS No. 208. In support of this argument, MNA cites a 2016 Notice of Proposed Rulemaking (NPRM) on Vehicle Defect Reporting Requirements [1] in which MNA says NHTSA assessed ''the suitability of the headliner for safety warning labels in Section IV, Alternatives Considered and Proposed for the Label, and finds the headliner to be an effective location for a safety warning label.'' MNA cites NHTSA as stating that it recognizes ''the headliner as an effective location for safety warning labels.'' MNA further states that NHTSA has found the headliner to be of similar benefit as the sun visor for the placement of the air bag warning label. *Id.*

MNA says it ''is not aware of any crashes, injuries, or customer complaints associated with this condition'' and that production is being updated to correct the noncompliance in future vehicles.

MNA concludes that the subject noncompliance is inconsequential as it relates to motor vehicle safety and its petition to be exempted from providing notification of the noncompliance, as required by 49 U.S.C. 30118, and a remedy for the noncompliance, as required by 49 U.S.C. 30120, should be granted.

VI. NHTSA's Analysis

In determining inconsequentiality of a noncompliance, NHTSA focuses on the safety risk to individuals who experience the type of event against which a recall would otherwise protect.[2] In general, NHTSA does not consider the absence of complaints or injuries when determining if a noncompliance is inconsequential to safety. The absence of complaints does not mean vehicle occupants have not experienced a safety issue, nor does it mean that there will not be safety issues in the future.[3]

NHTSA focuses on the consequence to an occupant who is exposed to the consequence of that noncompliance.[4] The Safety Act is preventive, and manufacturers cannot and should not wait for deaths or injuries to occur in their vehicles before they carry out a recall.[5] Indeed, the very purpose of a recall is to protect individuals from risk. *Id.*

FMVSS No. 208 S4.5.1(b)(3) requires air bag warning labels to be affixed to either side of the sun visor. The purpose of FMVSS No. 208 is to reduce the adverse effects of air bags by attracting the attention of vehicle occupants to look for the air bag warning label on the sun visor. In its petition, MNA explains that the subject vehicles are equipped with air bag warning labels that are affixed to the headliner, rather than either side of the sun visor

FMVSS No. 208 S4.5.1(c) requires an air bag alert label to be permanently affixed to the sun visor so that the label is visible when the visor is in the stowed position if the air bag warning label required by S4.5.1(b) is not visible when the sun visor is in the stowed position. The alert label must contain the content of the sun visor label as shown in Figure 6(c) of FMVSS No. 208. This requirement specifies that manufacturers, who place the label required by S4.5.1(b)(3) on the side of the visor that is hidden from the occupant when stowed, must place an air bag alert label on the visible part of the sun visor. MNA has done this and used the correct Figure 6(c) label. NHTSA believes this to be adequate notice to the occupant instructing them to ''flip visor over'' and view the full air bag warning label. In the case of the subject vehicles, the occupant would clearly see the required warning label on the headliner directly above the sun visor.

NHTSA has evaluated the merits of the inconsequential noncompliance petition submitted by MNA and has determined that this particular noncompliance is inconsequential to motor vehicle safety. NHTSA agrees with MNA that the noncompliant placement of the air bag warning label in the subject vehicles is inconsequential. Paragraph S4.5.1(b)(3) allows for placement of the air bag warning label on either side of the sun visor, including the side that is hidden from the driver when stowed. Paragraph S4.5.1(c) requires an instructional alert

[1] *See* 81 FR 85478 (November 28, 2016)

[2] *See Gen. Motors, LLC; Grant of Petition for Decision of Inconsequential Noncompliance,* 78 FR 35355 (June 12, 2013) (finding noncompliance had no effect on occupant safety because it had no effect on the proper operation of the occupant classification system and the correct deployment of an air bag); *Osram Sylvania Prods. Inc.; Grant of Petition for Decision of Inconsequential Noncompliance,* 78 FR 46000 (July 30, 2013) (finding occupant using noncompliant light source would not be exposed to significantly greater risk than occupant using similar compliant light source).

[3] *See Morgan 3 Wheeler Limited; Denial of Petition for Decision of Inconsequential Noncompliance,* 81 FR 21663, 21666 (Apr. 12, 2016); *see also United States* v. *Gen. Motors Corp.,* 565 F.2d 754, 759 (D.C. Cir. 1977) (finding defect poses an unreasonable risk when it ''results in hazards as potentially dangerous as sudden engine fire, and where there is no dispute that at least some such hazards, in this case fires, can definitely be expected to occur in the future'').

[4] *See Gen. Motors Corp.; Ruling on Petition for Determination of Inconsequential Noncompliance,* 69 FR 19897, 19900 (Apr. 14, 2004); *Cosco Inc.; Denial of Application for Decision of Inconsequential Noncompliance,* 64 FR 29408, 29409 (June 1, 1999).

[5] *See, e.g., United States* v. *Gen. Motors Corp.,* 565 F.2d 754, 759 (D.C. Cir. 1977).

label informing the occupant to flip the visor over, placing the visor in the down position, for more information. MNA explained that the label is clearly visible when the sun visor is in the down position and is displayed as intended by FMVSS No. 208.

VII. NHTSA's Decision

In consideration of the foregoing, NHTSA finds that MNA has met its burden of persuasion that the subject FMVSS No. 208 noncompliance in the affected vehicles is inconsequential to motor vehicle safety. Accordingly, MNA's petition is hereby granted and MNA is consequently exempted from the obligation of providing notification of, and a free remedy for, that noncompliance under 49 U.S.C. 30118 and 30120.

NHTSA notes that the statutory provisions (49 U.S.C. 30118(d) and 30120(h)) that permit manufacturers to file petitions for a determination of inconsequentiality allow NHTSA to exempt manufacturers only from the duties found in sections 30118 and 30120, respectively, to notify owners, purchasers, and dealers of a defect or noncompliance and to remedy the defect or noncompliance. Therefore, this decision only applies to the subject vehicles that MNA no longer controlled at the time it determined that the noncompliance existed. However, the granting of this petition does not relieve vehicle distributors and dealers of the prohibitions on the sale, offer for sale, or introduction or delivery for introduction into interstate commerce of the noncompliant vehicles under their control after MNA notified them that the subject noncompliance existed.

(Authority: 49 U.S.C. 30118, 30120: delegations of authority at 49 CFR 1.95 and 501.8)

Otto G. Matheke III,

Director, Office of Vehicle Safety Compliance.

[FR Doc. 2022–19234 Filed 9–6–22; 8:45 am]

BILLING CODE 4910–59–P

DEPARTMENT OF TRANSPORTATION

Office of the Secretary

[Docket No. OST–2022–0074]

Privacy Act of 1974; Department of Transportation, Federal Aviation Administration, DOT/FAA 811, FAA Health Information Records

AGENCY: Office of the Departmental Chief Information Officer, Office of the Secretary of Transportation, DOT.

ACTION: Notice of a modified Privacy Act system of records.

SUMMARY: In accordance with the Privacy Act of 1974, the Department of Transportation (DOT) proposes to rename, update, and reissue an existing system of records notice currently titled DOT Federal Aviation Administration (FAA) system of records DOT/FAA 811, ''Employee Health Record System.'' This system of records notice (hereafter referred to as ''Notice'') previously covered FAA employees only. FAA employee occupational health care records and Health Awareness Program records are currently covered under the Office of Personnel Management (OPM)/Government (GOVT)—10 Employee Medical File System Records SORN (80 FR 74815—November 30, 2015). The updated Notice covers the FAA's collection, use, and maintenance of non-occupational health records on federal employees, as well as FAA contractors and members of the public, such as students, interns and training and research participants, who receive emergency medical services at either the Civil Aerospace Medical Institute (CAMI) Occupational Health Clinic located at the Mike Monroney Aeronautical Center (MMAC) in Oklahoma City, OK, or the FAA Headquarters (HQ) Health Unit located in the HQ building in Washington, DC. Additionally, it covers FAA's collection of participation status (*i.e.,* eligible, ineligible) on members of the public who engage in research and training programs at the agency. Any medical records collected in the course of these research or training programs is outside the scope of this Notice. The data collected in the system is a combination of health information and Personally Identifiable Information (PII) which is used to provide proper medical care and case management.

DATES: Written comments should be submitted on or before October 7, 2022. The Department may publish an amended Systems of Records Notice in light of any comments received. This new system will be effective October 7, 2022.

ADDRESSES: You may submit comments, identified by docket number OST–2022–0074 by any of the following methods:

- *Federal e-Rulemaking Portal: http://www.regulations.gov.* Follow the instructions for submitting comments.
- *Mail:* Docket Management Facility, U.S. Department of Transportation, 1200 New Jersey Ave. SE, West Building Ground Floor, Room W12–140, Washington, DC 20590–0001.
- *Hand Delivery or Courier:* West Building Ground Floor, Room W12–140, 1200 New Jersey Ave. SE, between 9 a.m. and 5 p.m. ET, Monday through Friday, except Federal Holidays.
- *Fax:* (202) 493–2251. Instructions: You must include the agency name and docket number Docket No. OST–2022–0074. All comments received will be posted without change to *http://www.regulations.gov,* including any personal information provided.

Privacy Act: Anyone is able to search the electronic form of all comments received in any of our dockets by the name of the individual submitting the comment (or signing the comment, if submitted on behalf of an association, business, labor union, etc.). You may review the DOT's complete Privacy Act statement in the **Federal Register** published on January 17, 2008 (73 FR 3316–3317), or you may visit *https://www.transportation.gov/privacy.*

Docket: For access to the docket to read background documents or comments received, go to *http://www.regulations.gov* or to the street address listed above. Follow the online instructions for accessing the docket.

FOR FURTHER INFORMATION CONTACT: For questions, please contact Karyn Gorman, Acting Departmental Chief Privacy Officer, Privacy Office, Department of Transportation, Washington, DC 20590; *privacy@dot.gov;* or 202–366–3140.

SUPPLEMENTARY INFORMATION:

Notice Updates

This Notice update includes substantive changes to system name, system location, system manager, purpose, categories of individuals, categories of records, record source categories, routine uses of records maintained in the system, policies and practices for retrieval of records, policies and practices for retention and disposal of records, policies and practices for storage of records, and record access procedures; and non-substantive changes to administrative, technical and physical safeguards, contesting record procedures, and notification procedures. Updates also include editorial changes to simplify and clarify language, formatting, and text of the previously published Notice, to align with the requirements of Office of Management and Budget (OMB) Memoranda A–108, and to ensure consistency with other Notices issued by the Department of Transportation.

I. Background

In accordance with the Privacy Act of 1974, 5 U.S.C. 552a, the Department of Transportation (DOT)/Federal Aviation Administration (FAA) proposes to modify a DOT system of records titled

DOT/FAA 811 ''Employee Health Record System.'' This system of records notice applies to non-occupational health records the FAA collects and maintains on federal employees, as well as FAA contractors, and members of the public who receive emergency medical services. This notice also applies to medical information concerning members of public's eligibility to participate in research and training programs offered by CAMI, and their participant status within those programs. Medical information that CAMI maintains on these training and research participants is the same medical evaluation information that it maintains on those who visit the health centers for non-occupational health reasons, except that these files also include documentation of the individual's participant status in the relevant research or training program. Any medical records collected as part of FAA's research is outside the scope of this Notice. The health facilities that provide in-person care are located at the Mike Monroney Aeronautical Center (MMAC), Civil Aerospace Medicine Institute (CAMI in Oklahoma City, OK and the FAA Headquarters (HQ), Room 328, Building FOB10A, in Washington, DC The facility that provides medical evaluations for purposes of determining eligibility for research and training programs is the Mike Monroney Aeronautical Center (MMAC), Civil Aerospace Medicine Institute (CAMI) in Oklahoma City, OK. The data collected on individuals is detailed below in the Categories of Records.

The following substantive changes have been made to the Notice:

1. *System Name:* This Notice updates the system name from DOT/FAA 811 ''Employee Health Record System,'' to DOT/FAA 811 ''FAA Health Information Records System'' to describe more accurately the coverage of health records specifically collected, used, and maintained on federal employees, FAA contractors, and members of the public treated at one of the two FAA health facilities.

2. *System Location:* This Notice updates the system locations to specifically identify the addresses of the two FAA health facilities. One is located at the FAA, Civil Aerospace Medical Institute, Occupational Health Clinic, Mike Monroney Aeronautical Center, 6500 S Macarthur Blvd., Oklahoma City, OK 73169, and the other at the FAA HQ, 800 Independence Avenue SW, Room 328, Building FOB10A, Washington, DC 20591. The previous Notice only mentioned the Washington location with no specific address, and regional and center medical facilities. The FAA's regional and center medical facilities only collect occupational health records, which are covered by the Office of Personnel Management (OPM)/Government (GOVT)–10 Employee Medical File System Records. Because these regional and center medical facilities do not collect or maintain non-occupational records, the references to these previous locations are removed from this modified Notice.

3. *System Manager:* This Notice updates the system manager information for the two FAA health facilities and adds telephone numbers for each. The modified Notice removes the reference to Regional Flight Surgeon as it no longer applies given collection of only occupational health records in the regional and center medical facilities, which is covered by the OPM/GOVT–10 Notice.

4. *Purpose:* This Notice updates the purpose section to reflect the documentation of emergency care provided to federal employees, FAA contractors, and members of the public. Additionally, there is documentation of participation status of members of the public to engage in research and training programs at the FAA. The previous Notice reference of documenting the nature of the complaint or physical examination findings, treatment rendered, and case disposition will remain in this Notice while the preparation of analytical and statistical studies and reports is removed as it no longer applies.

5. *Categories of Individuals:* The previously published Notice only lists FAA employees as categories of individuals. However, the FAA health facilities provide emergency care to federal employees, as well as FAA contractors and members of the public, such as students, interns, and training and research participants. This Notice updates the categories of individuals to include these groups.

6. *Categories of Records:* This Notice updates the categories of records information referenced in the previous Notice by identifying data elements, to include PII such as: last name, social security number (SSN)/patient identifier (ID), date of birth (DOB), gender, company (if contractor), work phone and cell phone. The previous Notice listed broad categories of PII and health records; therefore, to ensure greater transparency, these changes provide more specificity to these categories and data elements collected and maintained by the FAA.

7. *Records Source:* This Notice updates the records source categories to reflect that the FAA collects data from non-FAA federal employees (*i.e.,* Department of Defense and DOT personnel), FAA contractors and members of the public, as well as FAA health facility staff, federal and private sector medical practitioners and treatment facilities (including external providers and consultants).

8. *Routine Use:* This Notice updates the routine uses to include the Department of Transportation's general routine uses applicable to this Notice as they were previously only incorporated by reference. The Office of Management and Budget (OMB) Memorandum A–108 recommends that agencies include all routine uses in one notice rather than incorporating general routine uses by reference; therefore, the Department is replacing the statement in DOT/FAA 811 that referenced the ''Statement of General Routine Uses'' with all of the general routine uses that apply to this system of records. Additionally, there are new system specific routine uses being added to this Notice. Each new external sharing of medical information is compatible with the purpose of providing the best care to those individuals needing it at the respective FAA facilities. The CAMI Health Clinic, specifically, expects to receive accreditation regarding its quality of care and will share information on appropriate patient records with assessors for this purpose. Specific portions of patient records will be shared with appropriate external providers to ensure their continuity of care. Patient consent to share their information cannot always be obtained in a timely manner, especially if incapacitated, so it is necessary to authorize sharing with external providers as needed. And, finally, in the interest of public health, any information related to communicable diseases at FAA facilities will be shared with relevant federal, state and local health authorities. Only personal information specific to the sharing will be exchanged with external sources. The new routine uses are as follows:

a. To external medical professionals and independent entities, any patient records required to support their reviews for purposes of determining medical quality assurance and safety of FAA health facilities.

b. To private or other government health care providers, portions of patient records required for consultation, referral, and continuity of care or medical contingency support.

c. To disclose information to a Federal, state, or local agency to the extent necessary to comply with laws governing reporting of communicable diseases.

d. To disclose to a requesting agency, organization, or individual minimal personal and health information concerning those individuals who are reasonably believed to have contracted an illness or been exposed to or suffered from a health hazard while visiting FAA facilities.

9. *Records Storage:* This Notice updates the policies and practices for the storage of records to reflect that records previously referenced in the Notice as stored in security files and containers, and in computer databases, are now also stored in micrographic, photographic, as well as medical recordings, such as electrocardiograph tapes, x-rays and strip charts.

10. *Records Retrieval:* This Notice updates the policies and practices for the retrieval of records to reflect that individual medical history records are retrieved by name, patient ID and date of birth.

11. *Retention and Disposal:* This Notice updates the policies and practices for retention and disposal of records section to add the following schedules: National Archives and Records Administration (NARA) General Records Schedule (GRS) 2.7, ''Employee Health and Safety Records,'' Item 070, ''Non-occupational Individual medical case files,'' which requires records to be destroyed 10 years after the most recent encounter. In addition, the previous Notice stipulated that federal employee health records would be destroyed six years after last entry; this requirement is removed from this modified Notice because the records are now maintained for ten years as referenced above. NARA, NCI–237–77–7, ''Environmental Health Record,'' Item 6, Medical Records for non-FAA employees which are destroyed five years after treatment date.

12. *Records Access:* This Notice updates the record access procedures to reflect that signatures on signed requests for records must either be notarized or accompanied by a statement made under penalty of perjury in compliance with 28 U.S.C. 1746. The FAA has determined that the sensitivity of the health information maintained in this system of records warrants this additional identity requirement.

The following non-substantive changes to the administrative, technical, and physical safeguards, contesting records procedures, and notification procedures have been made to improve the transparency and readability of the Notice:

13. *Administrative, Technical and Physical Safeguards:* This Notice updates the administrative, technical and physical safeguards to align with the requirements of OMB Memoranda A–108 and for consistency with other DOT/FAA SORNs.

14. *Contesting Records:* This Notice updates the procedures for contesting records to refer the reader to the record access procedures section rather than the ''System Manager.''

15. *Notifications:* This Notice updates the notification procedures to refer the reader to the record access procedures section rather than the ''System Manager.''

II. Privacy Act

The Privacy Act (5 U.S.C. 552a) governs the means by which the Federal Government collects, maintains, and uses personally identifiable information (PII) in a System of Records. A ''System of Records'' is a group of any records under the control of a Federal agency from which information about individuals is retrieved by name or other personal identifier. The Privacy Act requires each agency to publish in the **Federal Register** a System of Records Notice (SORN) identifying and describing each System of Records the agency maintains, including the purposes for which the agency uses PII in the system, the routine uses for which the agency discloses such information outside the agency, and how individuals to whom a Privacy Act record pertains can exercise their rights under the Privacy Act (*e.g.,* to determine if the system contains information about them and to contest inaccurate information). In accordance with 5 U.S.C. 552a(r), DOT has provided a report of this system of records to the Office of Management and Budget and to Congress.

SYSTEM NAME AND NUMBER:

DOT/FAA 811, ''FAA Health Information Records System.''

SECURITY CLASSIFICATION:

Unclassified, sensitive.

SYSTEM LOCATION:

1. Federal Aviation Administration, Mike Monroney Aeronautical Center, Civil Aerospace Medical Institute, Occupational Health Clinic, 6500 S. MacArthur Blvd., Building 13, Oklahoma City, OK 73169.

2. Federal Aviation Administration, 800 Independence Avenue SW, Room 328, Building FOB10A, Washington, DC 20591.

SYSTEM MANAGER(S):

1. *CAMI Occupational Health Clinic:* AAM–700 CAMI Clinic Manager, Federal Aviation Administration, Mike Monroney Aeronautical Center, 6500 S. MacArthur Blvd., Building 13, Oklahoma City, OK 73169; (405) 954–3711.

2. *DC Health Unit:* AAM–200 Medical Specialties Division Manager, Federal Aviation Administration, 800 Independence Avenue SW, Room 328, Building FOB10A, Washington, DC 20591; (202) 267–3535.

AUTHORITY FOR MAINTENANCE OF THE SYSTEM:

5 U.S.C. 7901.

PURPOSE(S) OF THE SYSTEM:

Records in this system of records are maintained for a variety of purposes, which include the following: Document the health facility visit(s) and/or emergency care provided, the nature of complaint, physical examination findings, treatment rendered, and case disposition. Medical evaluation records and participation status are maintained about members of the public to determine their eligibility to participate in research or training programs at the FAA.

CATEGORIES OF INDIVIDUALS COVERED BY THE SYSTEM:

Individuals covered by this system include federal employees, FAA contractors, and members of the public.

CATEGORIES OF RECORDS IN THE SYSTEM:

Information maintained includes records of emergency care visits by individuals at one of the FAA health facility locations, as well as participation status to determine eligibility for engagement in training and research programs at the FAA. Categories of records could include healthcare records such as medical history, vaccination information, full lists of medications and allergies, chronic medical problems and surgical history, medical examinations, laboratory and radiology information, hearing tests and spirometry tests for non-occupational reasons, as well as treatment plans, and participation status for engagement in research and training programs. PII elements include: full name, SSN/patient ID, date of birth, address, gender, company (if contractor), work phone, and cell phone.

RECORD SOURCE CATEGORIES:

Information contained in this system comes from a variety of sources to include the individuals to whom the records pertain, FAA health facility staff, federal and private sector medical practitioners and treatment facilities (including external providers and consultants).

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM, INCLUDING CATEGORIES OF USERS AND THE PURPOSES OF SUCH USES:

In addition to other disclosures, generally permitted under 5 U.S.C. 552a(b) of the Privacy Act, all or a portion of the records or information contained in this system may be disclosed outside DOT as a routine use pursuant to 5 U.S.C. 552a(b)(3) as follows:

System Specific Routine Use

1. To external medical professionals and independent entities, any patient records required to support their reviews for purposes of determining medical quality assurance and safety of FAA health facilities.

2. To private or other government health care providers, portions of patient records required for consultation, referral, and continuity of care or mission medical contingency support.

3. To disclose information to a Federal, state, or local agency to the extent necessary to comply with laws governing reporting of communicable diseases.

4. To disclose to a requesting agency, organization, or individual minimal personal and health information concerning those individuals who are reasonably believed to have contracted an illness or been exposed to or suffered from a health hazard while visiting FAA facilities.

Departmental Routine Uses

5. In the event that a system of records maintained by DOT to carry out its functions indicates a violation or potential violation of law, whether civil, criminal or regulatory in nature, and whether arising by general statute or particular program pursuant thereto, the relevant records in the system of records may be referred, as a routine use, to the appropriate agency, whether Federal, State, local or foreign, charged with the responsibility of investigating or prosecuting such violation or charged with enforcing or implementing the statute, or rule, regulation, or order issued pursuant thereto.

6. A record from this system of records may be disclosed, as a routine use, to a Federal, State, or local agency maintaining civil, criminal, or other relevant enforcement information or other pertinent information, such as current licenses, if necessary to obtain information relevant to a DOT decision concerning the hiring or retention of an employee, the issuance of a security clearance, the letting of a contract, or the issuance of a license, grant, or other benefit.

7. A record from this system of records may be disclosed, as a routine use, to a Federal agency, in response to its request, in connection with the hiring or retention of an employee, the issuance of a security clearance, the reporting of an investigation of an employee, the letting of a contract, or the issuance of a license, grant, or other benefit by the requesting agency, to the extent that the information is relevant and necessary to the requesting agency's decision on the matter.

8a. Routine Use for Disclosure for Use in Litigation. It shall be a routine use of the records in this system of records to disclose them to the Department of Justice or other Federal agency conducting litigation when (a) DOT, or any agency thereof, or (b) Any employee of DOT or any agency thereof, in his/her official capacity, or (c) Any employee of DOT or any agency thereof, in his/her individual capacity, where the Department of Justice has agreed to represent the employee, or (d) The United States or any agency thereof, where DOT determines that litigation is likely to affect the United States, is a party to litigation or has an interest in such litigation, and the use of such records by the Department of Justice or other Federal agency conducting the litigation is deemed by DOT to be relevant and necessary in the litigation, provided, however, that in each case, DOT determines that disclosure of the records in the litigation is a use of the information contained in the records that is compatible with the purpose for which the records were collected.

8b. Routine Use for Agency Disclosure in Other Proceedings. It shall be a routine use of records in this system to disclose them in proceedings before any court or adjudicative or administrative body before which DOT or any agency thereof, appears, when (a) DOT, or any agency thereof, or (b) Any employee of DOT or any agency thereof in his/her official capacity, or (c) Any employee of DOT or any agency thereof in his/her individual capacity where DOT has agreed to represent the employee, or (d) The United States or any agency thereof, where DOT determines that the proceeding is likely to affect the United States, is a party to the proceeding or has an interest in such proceeding, and DOT determines that use of such records is relevant and necessary in the proceeding provided, however that in each case, DOT determines that disclosure of the records in the proceeding is a use of the information contained in the records that is compatible with the purpose for which the records were collected.

9. The information contained in this system of records will be disclosed to the Office of Management and Budget, OMB, in connection with the review of private relief legislation as set forth in OMB Circular No. A–19 at any stage of the legislative coordination and clearance process as set forth in that Circular.

10. Disclosure may be made to a Congressional office from the record of an individual in response to an inquiry from the Congressional office made at the request of that individual. In such cases, however, the Congressional office does not have greater rights to records than the individual. Thus, the disclosure may be withheld from delivery to the individual where the file contains investigative or actual information or other materials, which are being used, or are expected to be used, to support prosecution or fines against the individual for violations of a statute, or of regulations of the Department based on statutory authority. No such limitations apply to records requested for Congressional oversight or legislative purposes; release is authorized under 49 CFR 10.35(9).

11. One or more records from a system of records may be disclosed routinely to the National Archives and Records Administration in records management inspections being conducted under the authority of 44 U.S.C. 2904 and 2906.

12. DOT may make available to another agency or instrumentality of any government jurisdiction, including State and local governments, listings of names from any system of records in DOT for use in law enforcement activities, either civil or criminal, or to expose fraudulent claims, regardless of the stated purpose for the collection of the information in the system of records. These enforcement activities are generally referred to as matching programs because two lists of names are checked for match using automated assistance. This routine use is advisory in nature and does not offer unrestricted access to systems of records for such law enforcement and related antifraud activities. Each request will be considered on the basis of its purpose, merits, cost effectiveness and alternatives using Instructions on reporting computer matching programs to the Office of Management and Budget, OMB, Congress, and the public, published by the Director, OMB, dated September 20, 1989.

13. It shall be a routine use of the information in any DOT system of records to provide to the Attorney General of the United States, or his/her designee, information indicating that a person meets any of the disqualifications for receipt, possession, shipment, or transport of a firearm

under the Brady Handgun Violence Prevention Act. In case of a dispute concerning the validity of the information provided by DOT to the Attorney General, or his/her designee, it shall be a routine use of the information in any DOT system of records to make any disclosures of such information to the National Background Information Check System, established by the Brady Handgun Violence Prevention Act, as may be necessary to resolve such dispute.

14a. To appropriate agencies, entities, and persons when (1) DOT suspects or has confirmed that there has been a breach of the system of records; (2) DOT has determined that as a result of the suspected or confirmed breach there is a risk of harm to individuals, DOT (including its information systems, programs, and operations), the Federal Government, or national security; and (3) the disclosure made to such agencies, entities, and persons is reasonably necessary to assist in connection with DOT's efforts to respond to the suspected or confirmed breach or to prevent, minimize, or remedy such harm.

14b. To another Federal agency or Federal entity, when DOT determines that information from this system of records is reasonably necessary to assist the recipient agency or entity in (1) responding to a suspected or confirmed breach or (2) preventing, minimizing, or remedying the risk of harm to individuals, the recipient agency or entity (including its information systems, programs, and operations), the Federal Government, or national security, resulting from a suspected or confirmed breach.

15. DOT may disclose records from this system, as a routine use, to the Office of Government Information Services for the purpose of (a) resolving disputes between FOIA requesters and Federal agencies and (b) reviewing agencies' policies, procedures, and compliance in order to recommend policy changes to Congress and the President.

16. DOT may disclose records from this system, as a routine use, to contractors and their agents, experts, consultants, and others performing or working on a contract, service, cooperative agreement, or other assignment for DOT, when necessary to accomplish an agency function related to this system of records.

17. DOT may disclose records from this system, as a routine use, to an agency, organization, or individual for the purpose of performing audit or oversight operations related to this system of records, but only such records as are necessary and relevant to the audit or oversight activity. This routine use does not apply to intra-agency sharing authorized under Section (b)(1) of the Privacy Act.

POLICIES AND PRACTICES FOR STORAGE OF RECORDS:

Records are stored in multiple formats, including paper, digital, micrographic, photographic, as well as medical recordings, such as electrocardiograph tapes, x-rays and strip charts.

POLICIES AND PRACTICES FOR RETRIEVAL OF RECORDS:

Records may be retrieved by name, SSN, patient ID and/or date of birth.

POLICIES AND PRACTICES FOR RETENTION AND DISPOSAL OF RECORDS:

Emergency medical care related health records and participation status for engagement in research and training programs are maintained according to the following schedule: GRS 2.7 ''Employee Health and Safety Records,'' Item 070, ''Non-occupational Individual medical case files,'' which requires records to be destroyed 10 years after the most recent encounter. Medical records for non-FAA employees visiting the clinic to receive first aid or emergency treatment are maintained according to NARA, NCI–237–77–7 and destroyed five years after treatment date.

ADMINISTRATIVE, TECHNICAL, AND PHYSICAL SAFEGUARDS:

Records in this system are safeguarded in accordance with applicable rules and policies, including all applicable DOT automated systems security and access policies. Strict controls have been imposed to minimize the risk of compromising the information that is being stored. Access to records in this system is limited to those individuals who have a need to know the information for the performance of their official duties and who have appropriate clearances or permissions.

RECORD ACCESS PROCEDURES:

Individuals seeking notification of whether this system of records contains information about them may contact the System Manager at the address provided in the section ''System Manager.'' When seeking records about yourself from this system of records or any other Departmental system of records your request must conform to the Privacy Act regulations set forth in 49 CFR part 10. You must sign your request and your signature must either be notarized or submitted under 28 U.S.C. 1746, a law that permits statements to be made under penalty of perjury as a substitute for notarization. If your request is seeking records pertaining to another living individual, you must include a statement from that individual certifying his/her agreement for you to access his/her records.

CONTESTING RECORD PROCEDURES:

See ''Record Access Procedures.''

NOTIFICATION PROCEDURE:

See ''Record Access Procedures.''

EXEMPTIONS CLAIMED FOR THE SYSTEM:

None.

HISTORY:

A full notice of this system of records, DOT/FAA 811 Employee Health Record System, was published in the **Federal Register** on April 11, 2000 (65 FR 19519).

Issued in Washington, DC.

Karyn Gorman,

Acting Departmental Chief Privacy Officer.

[FR Doc. 2022–19182 Filed 9–6–22; 8:45 am]

BILLING CODE P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

Proposed Collection; Comment Request for Timely Mailing Treated as Timely Filing

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice and request for comments.

SUMMARY: The Internal Revenue Service, as part of its continuing effort to reduce paperwork and respondent burden, invites the general public and other Federal agencies to take this opportunity to comment on continuing information collections, as required by the Paperwork Reduction Act of 1995. The IRS is soliciting comments concerning the timely mailing treated as timely filing.

DATES: Written comments should be received on or before November 7, 2022 to be assured of consideration.

ADDRESSES: Direct all written comments to Andres Garcia, Internal Revenue Service, Room 6526, 1111 Constitution Avenue NW, Washington, DC 20224, or by email to *pra.comments@irs.gov*. Include OMB control number 1545–1899 or Timely Mailing Treated As Timely Filing, in the subject line of the message.

FOR FURTHER INFORMATION CONTACT: Requests for additional information or copies of the form should be directed to

Kerry Dennis at (202) 317–5751, or at Internal Revenue Service, Room 6526, 1111 Constitution Avenue NW, Washington, DC 20224, or through the internet, at *Kerry.L.Dennis@irs.gov*.

SUPPLEMENTARY INFORMATION:

Title: Timely Mailing Treated As Timely Filing.

OMB Number: 1545–1899.

Regulation Project Number: T.D. 9543 and Revenue Procedure 97–19.

Abstract: This information collection contains regulations that provide guidance as to the only ways to establish prima facie evidence of delivery of documents that have a filing deadline prescribed by the internal revenue laws, absent direct proof of actual delivery. The regulations are necessary to provide greater certainty on this issue and to provide specific guidance. The regulations affect taxpayers who mail Federal tax documents to the Internal Revenue Service or the United States Tax Court. Revenue Procedure 97–19 provides the criteria that will be used by the IRS to determine whether a private delivery service qualifies as a designated Private Delivery Service under section 7502 of the Internal Revenue Code.

Current Actions: There is no change to the paperwork burden previously approved by OMB.

Type of Review: Extension of a currently approved collection.

Affected Public: Individuals or households, business or other for-profit organizations, not-for-profit institutions, farms, federal government, and state, local, or tribal government.

The estimated burden related to Revenue Procedure 97–19:

Estimated Number of Responses: 14.

Estimated Time per Response: 60 hours, 54 minutes.

Estimated Total Annual Burden Hours: 853.

The estimated related to T.D. 9543:

Estimated Number of Responses: 10,847,647.

Estimated Time per Response: 6 minutes.

Estimated Total Annual Burden Hours: 1,084,765.

Total Estimated Number of Respondents: 10,847,661.

Total Estimated Total Annual Burden Hours: 1,085,618 hours.

The following paragraph applies to all the collections of information covered by this notice.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless the collection of information displays a valid OMB control number. Books or records relating to a collection of information must be retained if their contents may become material in the administration of any internal revenue law. Generally, tax returns and tax return information are confidential, as required by 26 U.S.C. 6103.

Request for Comments: Comments submitted in response to this notice will be summarized and/or included in the request for OMB approval. All comments will become a matter of public record. Comments are invited on: (a) whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology; and (e) estimates of capital or start-up costs and costs of operation, maintenance, and purchase of services to provide information.

Approved: September 1, 2022.

Kerry L. Dennis,

Tax Analyst.

[FR Doc. 2022–19248 Filed 9–6–22; 8:45 am]

BILLING CODE 4830–01–P

DEPARTMENT OF THE TREASURY

Open Meeting of the Federal Advisory Committee on Insurance

AGENCY: Departmental Offices, U.S. Department of the Treasury.

ACTION: Notice of open meeting.

SUMMARY: This notice announces that the U.S. Department of the Treasury's Federal Advisory Committee on Insurance (FACI) will meet via videoconference on Thursday, September 29, 2022, from 1 p.m.–4:30 p.m. eastern time. The meeting is open to the public. The FACI provides non-binding recommendation and advice to the Federal Insurance Office (FIO) in the U.S. Department of Treasury.

DATES: The meeting will be held via videoconference on Thursday, September 29, 2022, from 1 p.m.–4:30 p.m. eastern time.

ADDRESSES: The Committee meeting will be held in the Cash Room, Department of the Treasury, 1500 Pennsylvania Ave. NW, Washington, DC 20220 and via videoconference. The meeting will be open to the public and the site is accessible to individuals with disabilities. Because the meeting will be held in a secured facility, members of the public who plan to attend the meeting must register online. Attendees may visit *https://events.treasury.gov/s/event-template/a2mt0000002oRYwAAM* and fill out a secure online registration form. A valid email address will be required to complete online registration.

(Note: Online registration will close on September 23rd or when capacity is reached.) The public can also attend remotely via live webcast: *www.yorkcast.com/treasury/events/2022/09/29/faci.* The webcast will also be available through the FACI's website: *https://home.treasury.gov/policy-issues/financial-markets-financial-institutions-and-fiscal-service/federal-insurance-office/federal-advisory-committee-on-insurance-faci.* Please refer to the FACI website for up-to-date information on this meeting. Requests for reasonable accommodations under section 504 of the Rehabilitation Act should be directed to Snider Page, Office of Civil Rights and Diversity, Department of the Treasury at (202) 622–0341, or *snider.page@treasury.gov.*

FOR FURTHER INFORMATION CONTACT: Jigar Gandhi, Senior Insurance Regulatory Policy Analyst, Federal Insurance Office, U.S. Department of the Treasury, 1500 Pennsylvania Ave. NW, Room 1410 MT, Washington, DC 20220, at (202) 622–3220 (this is not a toll-free number). Persons who have difficulty hearing or speaking may access this number via TTY by calling the toll-free Federal Relay Service at (800) 877–8339.

SUPPLEMENTARY INFORMATION: Notice of this meeting is provided in accordance with the Federal Advisory Committee Act (FACA), 5 U.S.C. app. 10(a)(2), through implementing regulations at 41 CFR 102–3.150.

Public Comment: Members of the public wishing to comment on the business of the FACI are invited to submit written statements by either of the following methods:

Electronic Statements

- Send electronic comments to *faci@treasury.gov.*

Paper Statements

- Send paper statements in triplicate to the Federal Advisory Committee on Insurance, U.S. Department of the Treasury, 1500 Pennsylvania Ave. NW, Room 1410 MT, Washington, DC 20220.

In general, the Department of the Treasury will make submitted comments available upon request without change, including any business or personal information provided such as names, addresses, email addresses, or

telephone numbers. Requests for public comments can be submitted via email to *faci@treasury.gov.* The Department of the Treasury will also make such statements available for public inspection and copying in the Department of the Treasury's Library, 720 Madison Place NW, Room 1020, Washington, DC 20220, on official business days between the hours of 10:00 a.m. and 5:00 p.m. Eastern Time. You can make an appointment to inspect statements by telephoning (202) 622–2000. All statements received, including attachments and other supporting materials, are part of the public record and subject to public disclosure. You should submit only information that you wish to make available publicly.

Tentative Agenda/Topics for Discussion: This will be the third FACI meeting of 2022. In this meeting, the FACI will discuss topics related to climate-related financial risk and the insurance sector, cyber insurance developments, and international insurance issues. The FACI will also receive status updates from each of its subcommittees and from FIO on its activities, as well as consider any new business.

Dated: September 1, 2022.

Steven Seitz,

Director, Federal Insurance Office.

[FR Doc. 2022–19259 Filed 9–6–22; 8:45 am]

BILLING CODE 4810–AK–P

FEDERAL REGISTER

Vol. 87 Wednesday,
No. 172 September 7, 2022

Part II

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Parts 431, 435, 457, et al.
Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes; Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 431, 435, 457, and 600

[CMS–2421–P]

RIN 0938–AU00

Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: This rulemaking proposes changes to simplify the processes for eligible individuals to enroll and retain eligibility in Medicaid, the Children's Health Insurance Program (CHIP), and the Basic Health Program. This proposed rule would remove barriers and facilitate enrollment of new applicants, particularly those dually eligible for Medicare and Medicaid; align enrollment and renewal requirements for most individuals in Medicaid; establish beneficiary protections related to returned mail; create timeliness requirements for redeterminations of eligibility in Medicaid and CHIP; make transitions between programs easier; eliminate access barriers for children enrolled in CHIP by prohibiting premium lock-out periods, waiting periods, and benefit limitations; and modernize recordkeeping requirements to ensure proper documentation of eligibility and enrollment.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on November 7, 2022.

ADDRESSES: In commenting, please refer to file code CMS–2421–P.

Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to *http://www.regulations.gov*. Follow the ''Submit a comment'' instructions.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–2421–P, P.O. Box 8016, Baltimore, MD 21244–8016.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–2421–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Stephanie Bell, (410) 786–0617, *Stephanie.Bell@cms.hhs.gov*.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following website as soon as possible after they have been received: *http://www.regulations.gov*. Follow the search instructions on that website to view public comments.

I. Background

Since 1965, Medicaid has been a cornerstone of America's health care system. The program provides free or low-cost health coverage to low-income individuals and families and helps to meet the diverse health care needs of children, pregnant individuals, parents and other caretaker relatives, older adults, and people with disabilities. For 25 years, the Children's Health Insurance Program (CHIP) has served as a bridge from Medicaid to private insurance for somewhat higher-income children. As of May 2022, the most recent month for which enrollment data are available, nearly 89 million individuals were enrolled in Medicaid and CHIP.[1]

Access to health coverage expanded significantly in 2010 with enactment of the Patient Protection and Affordable Care Act (Pub. L. 111–148, enacted on March 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152, enacted on March 30, 2010), together referred to as the Affordable Care Act (ACA). The ACA expanded Medicaid eligibility to low-income adults under age 65 without regard to parenting or disability status, simplified Medicaid and CHIP enrollment processes, and established health insurance Marketplaces where individuals without access to Medicaid, CHIP, or other comprehensive coverage could purchase coverage in a Qualified Health Plan (QHP). Many individuals with household income above the Medicaid and CHIP income standards became eligible for premium tax credits and/or cost-sharing reductions to help cover the cost of the coverage. In addition, the ACA provided States with the option of establishing a Basic Health Program (BHP), which provides affordable health coverage to individuals whose household income exceeds 133 percent but does not exceed 200 percent of the Federal Poverty Level (FPL) (that is, lower income individuals who would otherwise be eligible to purchase coverage through the Marketplaces with financial subsidies). BHPs allow States to provide more affordable coverage for these individuals and to improve the continuity of care for those whose income fluctuates above and below the Medicaid and CHIP levels. To date, two States, New York and Minnesota, have established BHPs, covering over 1 million people.[2]

In addition to coverage expansion, the ACA also required the establishment of a seamless system of coverage for all insurance affordability programs (that is, Medicaid, CHIP, BHP, and the insurance affordability programs available through the Marketplaces). In accordance with sections 1943 and 2107(e)(1)(T) of the Social Security Act (the Act) and sections 1413 and 2201 of the ACA, individuals must be able to apply for, and enroll in, the program for which they qualify using a single application submitted to any program. In the March 23, 2012 **Federal Register**, CMS issued implementing regulations titled ''Medicaid program; Eligibility Changes Under the Affordable Care Act of 2010'' final rule, (77 FR 17144) (referred to hereafter as the ''2012 eligibility final rule''), and the ''Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment'' final rule titled in July 2013 (78 FR 42160) (referred to hereafter

[1] May 2022 Medicaid & CHIP Enrollment Data Highlights—*https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-chip-enrollment-data/monthly-medicaid-chip-application-eligibility-determination-and-enrollment-reports-data/index.html.*

[2] *https://www.cms.gov/files/document/health-insurance-exchanges-2022-open-enrollment-report-final.pdf.*

as the ''2013 eligibility final rule''). These regulations focused on establishing a single streamlined application, aligning financial methodologies and procedures across insurance affordability programs, and maximizing electronic verification in order to create a streamlined, coordinated, and efficient eligibility and enrollment process for eligibility determinations based on Modified Adjusted Gross Income (MAGI).

Significant progress has been made in simplifying eligibility, enrollment, and renewal processes for applicants and enrollees, as well as reducing administrative burden on State agencies administering Medicaid, CHIP, and BHP, since the promulgation of these regulations. The dynamic online applications developed by States and the Federally Facilitated Marketplaces, which ask only those questions needed to determine eligibility have reduced burden on applicants. Greater reliance on electronic verifications has reduced the need for individuals to find and submit, and for eligibility workers to review, copies of paper documentation, decreasing burden on both States and individuals and increasing program integrity. Renewals completed using electronic information available to States have increased retention of eligible individuals, while also decreasing the administrative burden on both States and enrollees.

Following a period of steady growth attributed to the ACA, enrollment in Medicaid and CHIP declined from 2017 through 2019. Evidence suggests that the economy was the primary driver of this decline. However, we also know that more restrictive State enrollment policies contribute to coverage disruptions and create churning as people lose their Medicaid or CHIP coverage and then re-enroll within a short period of time.[3] The Georgetown University Center for Children and Families estimated that 4.4 million children were uninsured in 2019, an increase from 2016 of 726,000 uninsured children. Looking at uninsurance among children by income, those with household income below 138 percent of the FPL (133 percent of the FPL is the minimum income standard that States may establish for children in Medicaid, plus a 5 percentage point disregard), the percentage of Medicaid-eligible children who did not have any health insurance coverage increased from 6.8 percent in 2016 to 7.7 percent in 2019.[4] Based on the most recently available data from the American Community Survey, children in poverty continued to experience an increase in uninsurance from 2018 through 2020 as the uninsurance rate increased by 1.6 percentage points to 9.3 percent.[5] The raw numbers represented by these percentage changes correspond to a large number of individual children who were uninsured despite having a household income low enough to be eligible for Medicaid and who may have deferred or foregone needed health care as a result.

Additionally, enrollment in Medicare Savings Programs (MSPs), through which Medicaid provides coverage of Medicare premiums and/or cost-sharing for lower income Medicare beneficiaries, has remained relatively low. The MSPs are essential to the health and economic well-being of those enrolled, promoting access to care and helping free up individuals' limited income for food, housing, and other of life's necessities. Yet a 2017 study conducted for Medicaid and CHIP Payment and Access Commission (MACPAC) estimated that only about half of eligible Medicare beneficiaries were enrolled in MSPs.[6]

The critical role of Medicaid and CHIP providing timely health care access to the most vulnerable individuals was highlighted as the Novel Coronavirus 2019 (''COVID–19'') spread across our country beginning in 2020. Medicaid and CHIP helped to provide a lifeline for those who may have lost their jobs or been exposed to COVID–19, or both, and they played a critical role in the national pandemic response. The Families First Coronavirus Response Act (Pub. L. 116–127) (FFCRA) conditioned a temporary increase in Federal Medicaid funding on State compliance with several conditions, including maintaining enrollment for beneficiaries enrolled in Medicaid through the end of the month in which the COVID–19 public health emergency (PHE) ends (''continuous enrollment condition''). Additionally, the FFCRA, along with the Coronavirus Aid, Relief, and Economic Security Act (CARES Act; Pub. L. 116–135) and the American Rescue Plan Act of 2021 (ARP; Pub. L. 117–2), also ensured Medicaid and CHIP coverage of COVID–19 testing, treatment, and vaccines, as well as vaccine administration.

The Biden-Harris Administration is committed to protecting and strengthening Medicaid and CHIP both during and following the COVID–19 PHE. On January 20, 2021, President Biden issued an Executive Order on advancing racial equity and support for underserved communities. It charged Federal agencies with identifying potential barriers that underserved communities may face to enrollment in programs like Medicaid and CHIP.[7] This was followed on January 28, 2021, by Executive Order 14009 with a specific call to strengthen Medicaid and the ACA and remove barriers to obtaining coverage for the millions of individuals who are potentially eligible but remain uninsured.[8] In April 2022, President Biden issued another Executive Order, building on progress from the first and reflecting new Medicaid and CHIP flexibilities established by the ARP. The April 5, 2022 Executive Order 14070, ''Continuing to Strengthen Americans' Access to Affordable, Quality Health Coverage'' charges Federal agencies with identifying ways to help more Americans enroll in quality health coverage.[9] It calls upon Federal agencies to examine policies and practices that make it easier for individuals to enroll in and retain coverage. Following this charge, we reviewed the improvements made to implement the ACA, examined States' successes and challenges in enrolling eligible individuals, considered the changes brought about by the COVID–19 PHE, and looked for gaps in our regulatory framework that continue to impede access to coverage.

We have learned through our experiences working with States and other stakeholders that certain policies continue to result in unnecessary administrative burden and create barriers to enrollment and retention of

[3] Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID–19 Pandemic; accessed on 8/30/21 at *https://aspe.hhs.gov/sites/default/files/private/pdf/265366/medicaid-churning-ib.pdf.*

[4] Alker, Joan and Corcoran, Alexandra. 2020. ''Children's Uninsured Rate Rises by Largest Annual Jump in More than a Decade.'' Accessed on 03/16/2022 at *https://ccf.georgetown.edu/wp-content/uploads/2020/10/ACS-Uninsured-Kids-2020_10-06-edit-3.pdf.*

[5] Katherine Keisler-Starkey and Lisa N. Bunch, U.S. Census Bureau Current Population Reports, P60–274, Health Insurance Coverage in the United States: 2020, U.S. Government Publishing Office, Washington, DC, September 2021.

[6] *Medicare Savings Program Enrollees and Eligible Non-Enrollees,* Kyle J. Caswell, Timothy A. Waidmann, The Urban Institute, June 2017: *https://www.macpac.gov/wp-content/uploads/2017/08/MSP-Enrollees-and-Eligible-Non-Enrollees.pdf.*

[7] E.O. 13985, 86 FR 7009. Accessed online on July 19, 2022 at *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/.*

[8] E.O. 14009, 86 FR 7793. Accessed online on July 19, 2022 at *https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/28/executive-order-on-strengthening-medicaid-and-the-affordable-care-act/.*

[9] E.O. 14070, 87 FR 20689. Accessed online on July 19, 2022 at *https://www.whitehouse.gov/briefing-room/presidential-actions/2022/04/05/executive-order-on-continuing-to-strengthen-americans-access-to-affordable-quality-health-coverage/.*

coverage for eligible individuals. For example:

- There are no regulations to facilitate enrollment in the MSPs. In particular, CMS does not have regulations to link enrollment in other Federal programs with the MSPs, despite the high likelihood that individuals in such programs are eligible for the MSPs. This hinders States' ability to enroll those known to be eligible. Additionally, stakeholders report that burdensome documentation requirements substantially impede eligible individuals from enrolling in the MSPs.[10]
- Individuals whose eligibility is not based on MAGI (non-MAGI individuals)—for example, those whose eligibility is based on being age 65 or older, having blindness, or having a disability—generally were not included in the enrollment simplifications established under the ACA or our implementing regulations (the 2012 and 2013 eligibility final rules), leaving such individuals at greater risk of being denied or losing coverage due to procedural reasons than their MAGI-based counterparts, even though, we believe, many are more likely to remain Medicaid eligible due to lower likelihood of changes in their income or other circumstances.
- Current regulations do not consistently provide clear timeframes for applicants and enrollees to return information needed by the State to make a determination of eligibility or for States to process and act upon information received. This may lead to unnecessary delay in processing applications and renewals, some ineligible individuals retaining coverage, and some individuals being denied increased assistance for which they have become eligible.
- Our recordkeeping regulations, which are critical to ensuring appropriate and effective oversight to identify errors in State policies and operations, were last updated in 1986 and are both outdated and lacking in needed specificity. We believe these outdated requirements have contributed to inconsistent documentation policies across States, which may have furthered the incidence of Medicaid improper payments.
- Barriers to coverage that are not permitted under any other insurance affordability program—including lock-outs for individuals terminated due to non-payment of premiums, required periods of uninsurance prior to enrollment, and annual or lifetime caps on benefits—remain a State option in separate CHIPs.

In this rulemaking, we seek to close these and other gaps, thereby streamlining Medicaid and CHIP eligibility and enrollment processes, reducing administrative burden on States and enrollees, and increasing enrollment and retention of eligible individuals. We also seek to improve the integrity of Medicaid and CHIP. Through the PERM program, the Medicaid Eligibility Quality Control (MEQC) program, and other CMS eligibility reviews, we have regular opportunities to work with States in reviewing their eligibility and enrollment processes. As a result of these reviews, and other internal program integrity efforts, States are continually making improvements to their eligibility and enrollment systems both to enhance functionality and to correct any newly identified issues. We believe the changes proposed in this rule will further these program integrity efforts, and we will continue to work closely with States throughout implementation.

Current regulations at 42 CFR 433.112 establish conditions that State eligibility and enrollment systems must meet in order to qualify for enhanced Federal matching funds. Among these conditions, § 433.112(b)(14) requires that each State system support accurate and timely processing and adjudications/eligibility determinations. As States submit proposed changes to their eligibility and enrollment systems and implement new and/or enhanced functionality, we will continue to provide them with technical assistance on the policy requirements, conduct ongoing reviews of both the State policy and State systems, and ensure that all proposed changes support more accurate and timely processing of eligibility determinations.

We will also continue to explore other opportunities for reducing the incidence of beneficiary eligibility-related improper payments, including leveraging the enhanced funding available for design, implementation, and operation of State eligibility and enrollment systems, as well as mitigation and corrective action plans that address specific State challenges. Our goal is to ensure that eligible individuals can enroll and stay enrolled without unnecessary burden and that ineligible individuals are redirected to the appropriate coverage programs as quickly as possible.

Finally, we recognize that the COVID–19 PHE and the continuous enrollment condition have disrupted routine eligibility and enrollment operations for Medicaid, CHIP, and BHP. As States look ahead toward the eventual end of the PHE and the resumption of routine operations, they are faced with providing coverage for a significantly larger pool of enrollees than they have ever had to manage in the past. From February 2020 through May 2022, enrollment in Medicaid and CHIP increased by 25.9 percent, or 18.3 million individuals, and new applications continue to be submitted. In May 2022, about 2.1 million new applications for Medicaid and CHIP were submitted to States. At the same time, many States report a shortage of eligibility workers.

CMS is actively engaged with States as they plan for initiating eligibility and enrollment work over the course of a 12-month unwinding period when the COVID–19 PHE ends (hereinafter referred to as the ''unwinding period''). A March 2022 report by the Urban Institute projected that as many as 15.8 million people could lose their Medicaid coverage when the PHE ends and the continuous enrollment requirement is no longer in effect.[11] It is a CMS priority to ensure that renewals of eligibility and transitions between coverage programs occur in an orderly process that minimizes beneficiary burden and promotes continuity of coverage.

As we consider the challenges faced by States during the unwinding period, we seek comment on reasonable implementation timelines for the provisions in this proposed rule, which would allow States to move these important protections forward without negatively impacting the resumption of routine eligibility and enrollment operations. Certain provisions designed to improve the retention of eligible individuals, such as the prospective deduction of medical expenses for medically needy individuals, agency actions on returned mail, and transitions between coverage programs, could reduce the likelihood of eligible individuals losing health coverage during unwinding. However, if implementing such provisions early would divert needed resources away

[10] In October 2020, CMS engaged with 55 stakeholders across four States to better understand experiences when applying for the MSPs. One of the main findings was that burdensome documentation requirements substantially impede eligible individuals from enrolling in the MSPs and that easing these requirements is a critical step to ensuring individuals can obtain and retain these critical benefits.

[11] Buettgens, M. and Green, A. 2022. *What will Happen to Medicaid Enrollees' Health Coverage after the Public Health Emergency*. Washington, DC: Urban Institute. Accessed on July 19, 2022 at *https://www.urban.org/research/publication/what-will-happen-medicaid-enrollees-health-coverage-after-public-health-emergency*.

from critical unwinding-related activities, then a compliance date following the unwinding period may be preferred.

We recognize that each State faces a unique set of challenges related to the unwinding period, with differing needs and opportunities. As we contemplate the timing of a final rule, we are considering adopting an effective date of 30 days following publication and a separate compliance date, which may vary by requirement, with full compliance no later than 12 months following the effective date of the final rule. This approach would provide States with immediate access to new options, like the option to establish an earlier effective date for coverage provided to individuals eligible in the QMB group. This approach also would allow States to immediately extend temporary options authorized under section 1902(e)(14)(A) of the Act as they prepare for unwinding, like the option to rely on certain third-party information to update a beneficiary's mailing address. And it would permit States with greater capacity to implement new system changes to immediately adopt simplifications like removal of the requirement to apply for other benefits as a condition of Medicaid eligibility.

At the same time, we recognize that certain changes proposed in this rule may require States to make changes to their own statute and/or regulations, as well as systems changes prior to implementation, and this process can take time. For example, if the proposed prohibition on premium lock-out periods, which delay a child's ability to re-enroll in a separate CHIP following termination of coverage due to the family's failure to pay premiums, is finalized, we would provide CHIPs that currently impose such lockout periods with the time needed to comply with the new prohibition. At the same time, by making the final rule effective 30 days following enactment, States could not newly adopt a premium lock-out period.

We seek comment on whether an effective date of 30 days following publication would be appropriate when combined with a later date for compliance for most provisions. We seek comment on the timeframe that would be most effective for compliance with each provision and whether the compliance date should vary by provision. We believe compliance with the proposed provision implementing current statutory requirements (the requirement to utilize Medicare Part D Low-Income Subsidy ''leads'' data from SSA to initiate an MSP application) should be required 30 days following publication of the final rule, because we do not have flexibility to delay what is required under the statute. New State options established under the final rule would be effective 30 days following publication, but do not require a compliance date, since States are not required to adopt optional policies. We would encourage States to come into compliance with all other new requirements as expeditiously as possible, not only because they would improve access for new applicants and improve retention of eligible enrollees, but also because they would streamline eligibility and enrollment processes and promote the overall integrity of Medicaid and CHIP. However, for proposed provisions that do not create State options and are not implementing statutory requirements, we are considering compliance dates of 90 days, 6 months, and/or 12 months following the effective date of the final rule. We seek comment on the appropriate compliance timeframe for each provision, and request that commenters explain why they believe finalizing a shorter or longer compliance timeframe is most appropriate.

II. Provisions of the Proposed Regulations

A. Facilitating Medicaid Enrollment

1. Facilitate Enrollment Through Medicare Part D Low-Income Subsidy ''Leads'' Data (§§ 435.4, 435.601, 435.911, and 435.952)

The MSPs consist of several mandatory Medicaid eligibility groups that cover Medicare Part A and/or B premiums and, in some cases, cost-sharing. State Medicaid agencies receive applications and adjudicate eligibility for full Medicaid, as well as MSP-only benefits. Currently, the MSP eligibility groups cover over 10 million low-income individuals. There are three primary MSP eligibility groups: [12] the Qualified Medicare Beneficiary (QMB) group, which pays all of an individual's Medicare Parts A and B premiums and assumes liability for most associated Medicare cost-sharing charges for people with income that does not exceed 100 percent of the FPL; the Specified Low-Income Medicare Beneficiary (SLMB) group, which pays the Part B premium for people with income that exceeds 100 percent, but is less than 120 percent, of the FPL; and the Qualifying Individuals (QI) group, which pays Part B premiums for people with income at least 120 percent but less than 135 percent of the FPL. Individuals also must meet corresponding resource criteria in order to be eligible for an MSP. The income and resource requirements for coverage under the MSPs, and the benefits to which eligible individuals are entitled, are set forth at sections 1905(p)(1) and 1902(a)(10)(E) of the Act. Among other things, section 1905(p) of the Act directs that the income and resource methodologies applied by the Social Security Administration (SSA) in determining SSI eligibility per sections 1612 and 1613 of the Act be used to determine financial eligibility for the MSPs, except that States may employ less restrictive income and/or resource methodologies than those applied in determining SSI eligibility under the authority of section 1902(r)(2) of the Act.

The MSPs are essential to the health and economic well-being of low-income Medicare enrollees, helping to free up limited income for food, housing, and other life necessities. For example, in 2022, the Part B premium is $170.10 a month, which is more than 10 percent of the income of individuals who qualify for the QI group, and an even higher percentage of income for those who qualify for the QMB or SLMB groups. Despite the importance of the MSPs, a 2017 study conducted for MACPAC estimated that only about half of eligible individuals enrolled in Medicare were also enrolled in the MSPs.[13] This means that millions of Medicare enrollees living in poverty are paying over 10 percent of their income to cover Medicare premiums alone. Complex MSP enrollment processes contribute to this low participation

[12] There is a separate and fourth MSP eligibility group generally referred to as the ''Qualified Disabled Working Individuals (QDWI) group,'' or QDWI group. As described in 1902(a)(10)(E)(ii), eligibility in the QDWI group is limited to individuals whose incomes do not exceed 200 percent of the FPL; whose resources do not exceed twice the relevant SSI resource standard (that is, for a single individual or couple); and who are eligible to enroll in Part A under section 1818A of the Act. Section 1818A of the Act permits individuals who became entitled to Part A on the basis of their receipt of Social Security disability insurance (SSDI) and who subsequently lose SSDI after returning to work (and, hence, entitlement to Part A) to enroll in Part A contingent on paying the Part A premiums. The medical assistance available to QDWIs is the coverage of the Part A premiums. The QDWI group is not included in this proposal, because the income limits of the QDWI group are significantly higher than LIS and there does not exist the flexibility to disregard resources that are available for the other MSPs.

[13] Medicare Savings Program Enrollees and Eligible Non-Enrollees, Kyle J. Caswell, Timothy A. Waidmann, The Urban Institute, June 2017: *https://www.macpac.gov/wp-content/uploads/2017/08/MSP-Enrollees-and-Eligible-Non-Enrollees.pdf.*

rate.[14] [15] In order to address the barriers to accessing MSP coverage, in 2008 Congress enacted the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, Pub. L. 110–275). MIPPA included new requirements for States to leverage the Medicare Part D Low-Income Subsidy (LIS) program to help enroll likely-eligible individuals in MSPs.

The Medicare Part D LIS program, also sometimes referred to as ''Extra Help,'' is administered by SSA and pays Medicare Part D prescription drug premiums and cost-sharing for over 13 million individuals with low income. Full premium subsidy LIS (or ''full LIS'') generally pays the Part D premiums and deductibles in full and sets co-payments for drugs at between $0 and $9.85 (in 2022) for people with incomes below 135 percent of the FPL [16] [17] who also meet certain resource criteria. To receive this benefit, individuals complete an application and submit it to SSA. Once received, SSA verifies the information provided on the LIS applications and determines eligibility. Income, resources and other eligibility criteria for the LIS program are defined at section 1860D–14 of the Act. Under section 1860D–14(a)(3)(C)(i) of the Act, income shall be determined in the manner described in section 1905(p)(1)(B) of the Act, without regard to the application of section 1902(r)(2) of the Act and except that support and maintenance furnished in kind shall not be counted as income. Section 1860D–14 of the Act provides that, for purposes of determining eligibility for the LIS program, applicants' resources be calculated ''as determined under section 1613 of the Act for the purposes of the supplemental security income (SSI) program subject to a life insurance exclusion policy.'' The SSA has also adopted several other regulatory and sub-regulatory methodological simplifications for the LIS program that deviate from SSI rules. These include the exclusion of interest and dividend income and non-liquid resources and burial funds.

The MSP and LIS programs both assist individuals with incomes below 135 percent of the FPL [18] in accessing the Medicare benefits to which they are entitled and, as illustrated above, generally use a common methodology to determine income and resource eligibility. Current regulations at 42 CFR 423.773(c) require that individuals enrolled in MSPs be automatically enrolled in LIS, but the reverse is not true, and many people enrolled in the LIS program are not enrolled in an MSP, despite likely being eligible. As mentioned above, MIPPA included several provisions to promote the enrollment of LIS applicants into the MSPs. In addition, section 112 of MIPPA amended section 1905(p)(1)(C) of the Act to increase the resource limit for the QMB, SLMB, and QI MSP eligibility groups to the same resource limit applied for full LIS established at section 1860D–14(a)(3) of the Act. The resource standard for the full LIS program and the QMB, SLMB, and QI eligibility groups for 2022 is $8,400 for a single individual and $12,600 for a couple.

Section 113 of MIPPA amended section 1144 of the Act to further eliminate barriers to enrollment in the MSP and LIS programs. Section 1144(c)(3) of the Act requires SSA to transmit data from LIS applications (''leads data'') to State Medicaid agencies. Section 1144(c)(3) of the Act also provides that the electronic transmission from SSA ''shall initiate'' an MSP application. MIPPA section 113 also added a new paragraph at section 1935(a)(4) of the Act that, beginning January 1, 2010, required States to accept leads data and ''act upon such data in the same manner and in accordance with the same deadlines as if the data constituted'' an MSP application submitted by the individual. As such, under § 435.912, States have 45 days to make an MSP eligibility determination based on the LIS data. The date of the MSP application is defined as the date of the individual's application for LIS under section 1935(a) of the Act.

Despite these statutory requirements, not all States initiate an MSP application upon receipt of leads data from SSA. CMS data reflect that over a million individuals enrolled in full LIS are not enrolled in an MSP. Given near alignment of MSP and LIS eligibility criteria, most of these individuals are likely eligible for an MSP eligibility group (See November 1, 2021 Center for Medicaid and CHIP Services Informational Bulletin, ''Opportunities to Increase Enrollment in Medicare Savings Programs'').[19]

The January 28, 2021 Executive Order on Strengthening Medicaid and the ACA directs agencies to address policies and practices that may present unnecessary barriers to individuals and families attempting to access Medicaid coverage,[20] the April 5, 2022 Executive Order on Continuing to Strengthen Americans' Access to Affordable, Quality Health Coverage charges Federal agencies with identifying ways to help more Americans enroll in quality health coverage,[21] and the December 13, 2021 Executive Order on Transforming Federal Customer Experience and Service Delivery to Rebuild Trust in Government supports streamlining State enrollment and renewal processes and removing barriers to ensure eligible individuals are automatically enrolled in and retain access to critical benefit programs.[22] As such, we have evaluated CMS's regulatory authority to reduce barriers to enrollment of eligible individuals into the MSPs. Under the authority in section 1902(a)(4) of the Act to specify ''methods of administration'' that the Secretary finds to be ''necessary for the proper administration'' of State plans, we propose several regulatory changes to promote efficient enrollment in the MSPs by maximizing State use of LIS leads data. We believe these proposals will also have a positive impact on health equity by helping to provide more low-income individuals with access to additional health coverage consistent with the January 20, 2021 Executive Order.[23]

Accepting LIS leads data as an MSP application. As noted above, under section 1935(a)(4) of the Act, SSA must

[14] Loss of Medicare-Medicaid Dual Eligible Status: Frequency, Contributing Factors, and Implications, Office of the Assistant Secretary for Planning and Evaluation, 2019. *https://aspe.hhs.gov/basic-report/loss-medicare-medicaid-dual-eligible-status-frequency-contributing-factors-and-implications.*

[15] Medicare Savings Programs: Implementation of Requirements Aimed at Increasing Enrollment, Government Accountability Office, 2012. *https://www.gao.gov/assets/gao-12-871.pdf.*

[16] Section 1860D–14 of the Act [42 U.S.C. 1395w–114].

[17] Partial premium subsidy LIS (or ''partial LIS'') generally pays for premiums on a sliding scale, from 100 percent to 25 percent paid, and sets deductibles and co-payments for drugs at a reduced level for people with income below 150 percent of the FPL who meet certain resource criteria.

[18] Section 11404 of the Inflation Reduction Act of 2022 (Pub. L. 117–169, enacted on August 16, 2022) increases the income limit for the full LIS program to income below 150 percent of the FPL and increases the resource limit to the same resource limit as applied for partial LIS program at section 1860D–14(a)(3)(E) of the Act beginning January 1, 2024.

[19] Available at *https://www.medicaid.gov/federal-policy-guidance/downloads/cib11012021.pdf.*

[20] *https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/28/executive-order-on-strengthening-medicaid-and-the-affordable-care-act/.*

[21] *https://www.whitehouse.gov/briefing-room/presidential-actions/2022/04/05/executive-order-on-continuing-to-strengthen-americans-access-to-affordable-quality-health-coverage/.*

[22] *https://www.whitehouse.gov/briefing-room/presidential-actions/2021/12/13/executive-order-on-transforming-federal-customer-experience-and-service-delivery-to-rebuild-trust-in-government/.*

[23] *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/.*

transmit the LIS leads data to States, and States must use that data to initiate an application for the MSPs. On February 18, 2010, CMS issued a State Medicaid Director Letter (SMDL #10–003), ''Medicare Improvements for Patients and Providers Act of 2008 (MIPPA),'' explaining that, ''starting January 1, 2010, the State is directed to treat the [leads] data as an application for MSP benefits, as if it had been submitted directly by the applicant.'' Additionally, the guidance explained, ''States must act on the data as an application for MSP benefits, even if the LIS application was denied by SSA.'' [24] We reiterated the 2010 guidance in 2020 through updates to the Manual for the State Payment of Medicare Premiums.[25]

In this rulemaking, we propose to codify in regulation the statutory requirements for States to maximize the use of leads data to establish eligibility for Medicaid and the MSPs. We anticipate that codifying these requirements will lead to more eligible individuals enrolling in MSPs because we believe that some States may have been unaware or unclear of the steps required to meaningfully use the leads data to streamline eligibility and enrollment in the MSPs.

Currently, all States receive leads data from SSA each business day. This data includes information on the individual's address, income, resources and household size that SSA has verified.[26] Per section 113 of MIPPA, States must accept, via secure electronic transfer, the SSA leads data and process that information to initiate an MSP application. However, we are aware that several States do not use the leads data to begin the application process. For example, upon receipt of the leads data, some States simply send the individual a letter that encloses a blank application or instructions on how to apply for the MSPs. Such practices fall short of States' statutory obligation to treat receipt of leads data as an application and to evaluate individuals' eligibility using the leads data.

We propose to add a definition of LIS leads data at § 435.4 and a new paragraph (e) to § 435.911 of the regulations to clearly delineate the steps States must take upon receipt of leads data from SSA. We propose to define LIS leads data to mean data from an individual's application for low-income subsidies under section 1860D–14 of the Act that the SSA electronically transmits to the appropriate State Medicaid agency as described in section 1144 (c)(1) of the Act. Proposed § 435.911(e)(1) requires States to accept, via secure electronic interface, the SSA LIS leads data. Proposed paragraph (e)(2) requires that States treat receipt of the leads data as an application for Medicaid and promptly and without undue delay, consistent with the timeliness standards at § 435.912, determine MSP eligibility without requiring submission of a separate application.

We recognize that State Medicaid agencies generally will need to request additional information in order to make a determination of eligibility, as some differences remain in income and resource counting methodologies between the LIS and MSPs. In addition, the leads data transmitted to the State does not include information on an individual's citizenship or immigration status, and therefore, States will need to ask individuals for their status, which must be verified in accordance with sections 1137(d), 1902(ee) or 1903(x) of the Act and §§ 435.956(a) and (b), 435.406 and 435.407, if such information is not already in the casefile and has been verified in a previous application. As such, we propose at paragraph (e)(3) of § 435.911 that States must request additional information in order to make a determination of eligibility for MSPs. We also recommend that when States request additional information from individuals, they include information on how to contact the local State Health Insurance Assistance Program (SHIP) for assistance.

However, consistent with existing regulations at §§ 435.907(e) and 435.952(c), we propose at paragraph (e)(4) of § 435.911 that States may only require that individuals provide information needed to complete an eligibility determination if information needed for such determination is not available to the agency or if information available to the agency through an electronic data match or other means is not reasonably compatible with information provided by or on behalf of the individual. Thus, under the proposed rule, States may not request that individuals attest or otherwise provide documentation to establish information contained in leads data, which SSA has already verified and confirmed for the LIS eligibility determination.

Note that a State is not in compliance with the statutory requirement in section 1935(a)(4) of the Act to initiate an application based on leads data or with the proposed regulation if it requires the individual to file a new application for MSP, since the leads data already provides much of the information that would otherwise be requested on an application. Further, as discussed in more detail below, States have the flexibility under section 1902(r)(2) of the Act to align the methodologies applied in determining MSP eligibility with the methodologies for determining eligibility for LIS. Additionally, we highly recommend completely aligning financial methodologies for determining LIS and MSP eligibility as a program integrity best practice. If a State chooses such complete alignment in financial methodologies between the LIS and MSP programs, under the proposed rule the State may not require additional financial information from an individual for whom the State has received leads data in order to make a determination of MSP eligibility.

The LIS leads data that is transferred to State agencies has been verified by the SSA. Thus, we believe that State verification of this data prior to adjudicating eligibility is duplicative and inefficient. Consistent with the Secretary's authority under section 1902(a)(4) of the Act (relating to establishment of such methods of administration as the Secretary determines ''necessary for proper and efficient administration'' of the Medicaid program) and section 1902(a)(19) of the Act (relating to simplicity of administration and the best interests of recipients), we also propose at § 435.911(e)(5) that States accept the information verified by SSA and provided through the leads data as verified, provided that the information provided through the LIS leads data supports a determination of eligibility under section 1902(a)(10)(E) of the Act.

The Computer Matching and Privacy Protection Act at 5 U.S.C. 522a(p)(1) requires States to take actions to independently verify information that SSA provides before the State may terminate, suspend, reduce, deny, or take other adverse action against an individual. Therefore, in instances in which the leads data would not support a determination of eligibility for MSPs, we propose at § 435.911(e)(7) to require that States use the attested information provided by the applicant to SSA through the LIS application process and separately verify the individual's eligibility for Medicaid in accordance with the State's verification policies.

[24] State Medicaid Director Letter, #10–003, ''Medicare Improvements for Patients and Providers Act of 2008 (MIPPA),'' page 2. Available at *https://www.medicaid.gov/federal-policy-guidance/downloads/smd10003.pdf*.

[25] Chapter 1, section 1.11.

[26] The leads data also includes information on the LIS subsidy amount and denial reasons, which States can use to immediately identify if the individual is ineligible for MSPs.

Specifically, under proposed § 435.911(e)(7), the State would be required to (1) determine whether additional information is needed to make a determination of eligibility for an MSP; (2) if additional information is needed, notify the individual that they may be eligible for assistance with their Medicare premium and/or cost sharing charges, but that additional information is needed for the agency to make a determination of such eligibility; (3) provide the individual with a minimum of 30 days to furnish any information needed by the agency to determine MSP eligibility; and (4) verify the individual's eligibility for an MSP in accordance with the State's verification plan developed in accordance with § 435.945(j). We note that, in the case of an applicant who has attested to income or assets over the applicable income or resource standard, States can, but are not required to, request additional information from the individual to confirm ineligibility for coverage.

We note that, under our proposal, States may continue to request from the individual information necessary to make an eligibility determination but that is missing from the leads data or other third-party sources. Pursuant to § 435.952(c), States may also seek information from the individual if the State has other information that is not reasonably compatible [27] with the leads data; however, we anticipate such circumstances with respect to financial eligibility will be extremely rare since SSA generally relies on the same sources for financial eligibility data also relied upon by States and the data from SSA will in most instances be the most current.

Finally, individuals eligible for the LIS program may be eligible for full Medicaid benefits, in addition to the assistance with Medicare premiums and cost-sharing available under the MSPs. Under the current regulations at § 435.911, for individuals who submit the single streamlined application used for individuals applying for Medicaid on the basis of MAGI, but who may be eligible on a basis other than MAGI, States are required to collect any additional information that is needed to make a determination on a non-MAGI basis, and to make such determination if the individual provides the needed information. Consistent with sections 1902(a)(4) and (a)(19) of the Act, we propose a similar requirement with respect to individuals whose application was initiated by receipt of LIS leads data. Specifically, under proposed § 435.911(e)(6), States would be required to collect such additional information as may be needed to determine whether such individuals are eligible for Medicaid in any other eligibility groups (that is, other than the MSPs), including other non-MAGI groups and MAGI-based groups as well. We believe this proposal would codify a pathway for efficient enrollment of LIS enrollees into both the appropriate MSP eligibility group, as well as into a full-benefit group if eligible without imposing undue administrative burdens on States. We believe this would also promote program integrity. We note that individuals can be eligible for both an MSP and an eligibility group that confers full Medicaid benefits. Therefore, the requirement under proposed § 435.911(e)(6) is in addition to the requirement to determine the individual's eligibility for an MSP.

Streamlining Methodologies. As mentioned previously, the income standard for the LIS program and the highest income standard for the MSPs is similar, the resource standard for all MSPs and the LIS is the same until January 1, 2024, and the methodologies for both programs are very closely aligned. However, the differences in income and resource methodologies prevent LIS enrollees from being seamlessly enrolled into the MSPs unless the State has elected to align the MSP methodologies with LIS methodologies by adopting certain income and resource disregards under section 1902(r)(2) of the Act.

As discussed above, the two methodologies differ slightly in that several types of income and resources that are counted in determining MSP eligibility are not counted in determining LIS eligibility.[28] States have the flexibility to achieve full alignment of the MSP and LIS methodologies. Specifically, under section 1902(r)(2) of the Act, codified in regulation at § 435.601(d), States have the option to use less restrictive income and resource methodologies in making eligibility determinations for most non-MAGI eligibility groups, including the MSPs. States can use this authority to align MSP methodologies with LIS methodologies by adopting less restrictive methodologies to disregard income and resources that are counted in determining MSP but not LIS eligibility. These include: (1) the following types of income: in-kind support and maintenance, dividend income, and interest income; and (2) the value of the following types of resources: non-liquid resources, burial funds, and life insurance. We expect that States have not maximized this opportunity due to competing priorities and the complexity of eligibility policy.

Under proposed § 435.911(e), States that adopt less restrictive MSP eligibility methodologies to completely align with the LIS methodologies would be able to use leads data to make a determination of MSP financial eligibility without requesting additional information from the individual (as noted above, information on citizenship and immigration status would still be needed), thus reducing administrative burden for the State and relieving LIS recipients of the need to navigate a complex application process.

States that have not fully aligned methodologies must continue to request the additional information needed to determine financial eligibility which is not provided through the leads data. In addition, as noted above, States must request information relating to U.S. citizenship and immigration status in order to verify such status in accordance with the State's usual processes. In accordance with § 435.406(a) and section 1137(d) of the Act, individuals must first make a declaration of U.S. citizenship or satisfactory immigration status in accordance with § 435.406(a). After the declaration is made, per regulations at § 435.956, States must attempt to electronically verify U.S. citizenship or satisfactory immigration status and, if such status cannot be promptly verified, the State must provide the individual with a reasonable opportunity period to provide documentation or other information needed to verify their status. During the reasonable opportunity period, the State must furnish benefits to individuals who otherwise meet all eligibility requirements and must itself continue efforts to verify the individual's status. These requirements apply equally to individuals being determined for eligibility in the MSPs following the State's receipt of leads data from SSA.

However, in accordance with the authority at section 1902(a)(4) of the Act to promote the administrative efficiency of the program and section 1902(a)(19) of the Act relating to simplicity of administration and the best interests of beneficiaries, we propose to add a new

[27] Under 42 CFR 435.952(c)(1), income information obtained through an electronic data match shall be considered ''reasonably compatible'' with income information provided by or on behalf of an individual if both are either above or at or below the applicable income standard or other relevant income threshold.

[28] For example, section 116 of MIPPA directs SSA not to count in-kind support and maintenance as income, and not to count the cash surrender value of life insurance policies as a resource, when determining eligibility for LIS. These statutory disregards apply only to LIS eligibility determinations and not to MSP eligibility groups.

paragraph (e) to § 435.952 to require that States adopt a number of enrollment simplification policies related to the income and resources that are counted in determining MSP, but not LIS, eligibility that would enable State agencies to use the leads data more efficiently, reduce burden on applicants and States, and increase the number of LIS enrollees successfully enrolled in the MSPs. We also anticipate these policies would have a positive health equity impact by increasing access to Medicare coverage for low-income individuals and increasing the financial security of those who successfully enroll consistent with the January 20, 2021 Executive Order.[29]

Finally, we anticipate that these enrollment simplifications will help reduce the high rate of churn that dually eligible individuals experience, largely due to administrative reasons such as providing documentation of certain income and assets to demonstrate their continued eligibility. Analysis by the Assistant Secretary for Planning and Evaluation (ASPE) for the Department of Health and Human Services in 2019 examined data from years 2007 through 2009 and found that 29.1 percent of individuals lost Medicaid eligibility for at least 1 month during the first year of transitioning to full-benefit dual eligibility and 21.1 percent lost Medicaid eligibility for at least 3 months following the transition despite dually eligible individuals' relatively stable income and assets over time.[30] Experts interviewed noted that dually eligible beneficiaries most often lost coverage because of failing to comply with administrative requirements as opposed to changes in income, assets, or functional status. In 2021, CMS performed similar analysis on data from years 2015 through 2018 and found similar results: 29.1 percent of individuals lost Medicaid eligibility for at least 1 month during the first year of transitioning to full-benefit dual eligibility and 24.1 percent lost Medicaid eligibility for at least 3 months following the transition.[31] The proposed simplifications for each source of income and resource are discussed below.

We note that our proposals would not change the income and resource rules for individuals applying for non-MAGI eligibility groups other than the MSPs. We propose simplifying income and resource policies for the MSP eligibility groups given the narrow scope of assistance available under these groups (limited to assistance with Medicare premiums and/or cost-sharing assistance), their smaller numbers of eligible and enrolled individuals relative to other non-MAGI eligibility groups, and MIPPA provisions which closely align them with the LIS program, which does not count these types of income and resources. We seek comment on extending the proposals below to all individuals seeking eligibility on a non-MAGI basis. We also seek comment on extending the proposal relating to verification of dividend and interest income to individuals seeking eligibility based on MAGI, as well as whether there are additional income or resource types to which the proposals below could be extended for all individuals.

Interest and Dividend Income. Regulations governing LIS eligibility determinations at 20 CFR 418.3350(d) exclude all interest and dividend income earned on resources owned by the applicant or their spouse. However, under the SSI income methodologies applicable to MSP determinations, States must count interest and dividend income, unless they have elected to disregard such income using the authority provided under section 1902(r)(2) of the Act and 42 CFR 435.601(d).

Based on stakeholder reports and program experience, we believe that the vast majority of individuals likely to qualify for an MSP eligibility group do not have significant interest or dividend income, whereas the requirement to timely obtain and furnish acceptable statements from financial institutions, sometimes extending back over a lengthy period of time, to document interest and dividend income earned is unduly burdensome for applicants and provides negligible program integrity value. Therefore, consistent with section 1902(a)(19) of the Act, in order to minimize undue administrative burden on applicants, we are proposing at § 435.952(e)(1)(i) and (ii) to prohibit States from requesting documentation of dividend and interest income prior to making a determination of MSP eligibility, except when the agency has information that is not reasonably compatible with the applicant's attestation. Under the proposed rule, States would be required to accept self-attestation of dividend and interest income for MSP applicants and their spouse, but would retain the option to verify such income after the individual has been enrolled (a process, currently available at State option with respect to most eligibility criteria, which we refer to as ''post-enrollment verification''), including the option to require the individual to provide documentation of interest or dividend income if electronic verification is not available.

We seek comment on the utility of post-enrollment verification and whether it results in unnecessary procedural denials of eligible individuals. If a State chooses to conduct post-enrollment verification checks, under proposed § 435.952(e)(1)(iii) it must allow individuals at least 90 calendar days to respond to requests for documentation. We seek comment on the proposal to require that States provide individuals with at least 90 calendar days to respond to requests for additional information in this situation and whether States should be required to provide, at a minimum, a shorter period of time, such as at least 30 or 60 calendar days. If a State found that an individual has income exceeding the income standard during the post-enrollment verification process, the State would take appropriate action consistent with regulations at § 435.916(d) (redesignated and revised at proposed regulations at § 435.919 in this rulemaking), including determining eligibility on other potential bases and, if not eligible on any basis, providing advance notice and fair hearing rights prior to terminating MSP coverage. Section 435.952(e)(1)(ii) clarifies that States must request documentation prior to making an initial determination to deny eligibility if they have information that is not reasonably compatible with the applicant's attestation in accordance with § 435.952(c)(2).

As discussed above, under section 1902(r)(2) of the Act, States also have the ability to disregard interest and dividend income entirely, which would bring treatment of interest and dividend income in determining eligibility for MSPs into alignment with the LIS program. We encourage States to consider adoption of such an income disregard, as it is unlikely that an applicant could have both investments large enough to generate significant interest or dividend income and resources and still satisfy the resource test for the LIS or MSP benefits.

Non-liquid resources. For LIS eligibility determinations, under 20 CFR 418.3405, SSA only counts liquid

[29] *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/*.

[30] Assistant Secretary for Planning and Evaluation (ASPE) (2019). Loss of Medicare-Medicaid dual eligible status: Frequency, contributing factors and implications. *https://aspe.hhs.gov/system/files/pdf/261716/DualLoss.pdf*.

[31] CMS completed an updated internal analysis of ASPE's study in 2021 using data from 2015–2018 that shows that dually eligible individuals continue to lose Medicaid at a high rate in their first year due to administrative reasons.

resources, which it defines as cash, financial accounts, and other financial instruments that can be converted to cash within 20 workdays. Non-liquid resources, such as an automobile, are not counted for LIS eligibility.[32] However, SSI rules in section 1613 of the Act, which apply to MSP determinations, have a broader definition of countable resources that includes non-liquid resources; for example, while SSI excludes one automobile for resource-eligibility purposes, a second automobile is countable. This can be onerous for MSP applicants because it can be difficult to timely determine, and furnish acceptable documentation of, the value of something that cannot easily be sold. Similar to interest and dividend income, consistent with section 1902(a)(19) of the Act and in order to minimize administrative burdens on individuals, we are proposing at § 435.952(e)(2)(i) to require that States accept applicants' attestation of the value of any non-liquid resources, except, as described at proposed § 435.952(e)(2)(ii), when the State has information that is not reasonably compatible with the individual's attestation. However, as with dividend and interest income, as described at proposed § 435.952(e)(2)(iii), States would retain the option to conduct post-enrollment verification, including the option to require the individual to provide documentation of non-liquid resources if electronic verification is not available, and to take appropriate action, consistent with regulations at § 435.916(d) (redesignated and revised at proposed regulations at § 435.919 in this rulemaking), if the State determines the individual greatly undervalued or failed to disclose resources. If the agency elects to conduct verifications post-enrollment, and documentation is requested, the agency must provide the individual with at least 90 calendar days from the date of the request to respond and provide any necessary information requested. As with dividend and interest income, § 435.952(e)(2)(ii) clarifies that States must request documentation prior to making an initial determination denying eligibility if they have information that is not reasonably compatible with the applicant's attestation in accordance with § 435.952(c)(2). Finally, States also may use authority at section 1902(r)(2) of the Act to disregard the value of all non-liquid resources.

Burial funds. Under section 1613(d)(1) of the Act, which applies to both LIS and MSP determinations, up to $1,500 in burial fund are to be excluded for the applicant (and an additional $1,500 for their spouse) so long as the burial fund is ''separately identifiable and has been set aside.'' The statute does not, however, prescribe how the funds must be separately identifiable. Current SSA policy allows LIS applicants to attest to having $1,500 in burial funds, which may be co-mingled with other funds in a single account (see SSA Program Operations Manual Systems [POMS] HI 03030.020 Resource Exclusions Section B.3.). However, consistent with section 1905(p)(1)(C) of the Act, which directs that SSI's resource methodologies be used to determine MSP-related resource eligibility, States typically require applicants to provide documentation that their burial funds are set aside in a separate account, as provided under SSI's burial fund-related methodology described in 20 CFR 416.1231(b). This creates a misalignment between LIS and MSP methodologies and imposes additional burdens on MSP applicants.

We propose in § 435.952(e)(3)(i) to require that States, when determining eligibility for the MSPs, allow individuals to self-attest that up to $1,500 of their resources, and up to $1,500 of their spouse's resources, are set aside as burial funds in a separate account and therefore are not countable as resources for MSP determinations. Proposed § 435.952(e)(3)(ii) clarifies that States must request documentation prior to making an initial determination of ineligibility if they have information that is not reasonably compatible with the applicant's attestation in accordance with § 435.952(c)(2). As in the proposed provision for interest and dividend income and non-liquid resources, and described at § 435.952(e)(3)(iii), States would retain the option to conduct post-enrollment verification, including obtaining documentation of resources in burial funds, and taking appropriate action, consistent with regulations at § 435.916(d) (redesignated and revised at proposed regulations at § 435.919 in this rulemaking). If the agency elects to conduct verifications post-enrollment, and documentation is requested, the agency must provide the individual with at least 90 calendar days from the date of the request to respond and provide any necessary information requested. Again, we seek comment on the 90-day response period in this situation and whether States should be required to provide, at a minimum, a shorter period of time, such as least 30 or 60 calendar days. Finally, States may also use authority at section 1902(r)(2) of the Act to disregard all or a greater amount of burial funds or to not require that the burial funds be held in a separate set-aside account.

Life Insurance Policies. Section 116 of MIPPA, codified at section 1860D–14(a)(3)(G) of the Act, eliminated the value of life insurance policies as a countable resource for LIS determinations. However, under the SSI resource methodologies described in section 1613(a) of the Act, which, as noted above, apply to MSP-related resource eligibility determinations per section 1905(p)(1)(C) of the Act, the cash surrender value of life insurance with a total face value exceeding $1,500 is countable. Term life insurance policies do not have a cash surrender value and are not a countable resource under SSI methodologies described in 20 CFR 416.1230(a). Because term life insurance is not relevant to the Medicaid eligibility determination, States are not permitted to request information about the face value of such policies.

We have received reports from advocates that obtaining documentation of a life insurance policy's cash surrender value is highly burdensome for applicants. A life insurance policy's cash surrender value depends on the market, the length of time the policyholder has paid premiums, and other factors. Further, the cash surrender value is not knowable solely from the documents a policyholder is likely to have. To obtain the current cash surrender value of a policy, an applicant generally must contact the company that has issued the policy, request a statement of the current cash surrender value and then submit that statement to the State agency once obtained. This can pose a significant hurdle to applicants, leading to denials for otherwise eligible applicants.

To reduce this burden on applicants, we encourage States to use their authority under section 1902(r)(2) of the Act to disregard a higher face value of life insurance policies or to disregard the cash surrender value of life insurance policies altogether. A few States currently disregard policies with face values of at least up to $10,000, which eliminates administrative hurdles for most individuals, while ensuring that those comparatively few applicants who own substantial policies have the value of those policies counted in their eligibility determinations.

Under proposed § 435.952(e)(4)(i), if an individual attests to having a life insurance policy with a face value

[32] The exception to this rule is that the equity value of any real property than an individual owns other than the individual's primary place of residence is counted as a resource.

below $1,500, States must accept the attested face value for purposes of making an initial eligibility determination for MSP coverage, unless the State has information that is not reasonably compatible with attested information. If the total face value of all of an individual's life insurance policies does not exceed $1,500, the cash surrender value of the individual's policies is not counted in determining MSP eligibility pursuant to sections 1613(a)(16) and 1905(p)(1)(C) of the Act. As with attested interest and dividend income, non-liquid assets, and burial funds, States would be required, as specified at proposed § 435.952(e)(4)(ii), to request additional information if they have information not reasonably compatible with the attested value prior to enrolling the individual in coverage in accordance with § 435.952(c)(2). Per current § 435.952(c)(2), the agency may accept a reasonable explanation from the applicant or require documentation.

Under proposed § 435.952(e)(4)(i)(A), if an individual attests to having a life insurance policy with a face value in excess of $1,500, consistent with current regulations at § 435.948, States may accept the attested cash surrender value. If the State has information that is not reasonably compatible with the attested value of the policy, we propose, at § 435.952(e)(4)(ii), that the State must seek additional information from the individual in accordance with § 435.952(c)(2). Per current § 435.952(c)(2), the agency may accept a reasonable explanation from the applicant or require documentation.

Per proposed § 435.952(e)(4)(iii), States would have the option to conduct post-enrollment verification for individuals enrolled based on an attested value. In conducting post-enrollment verification, if a State determines that the face value of the policy exceeds $1,500, then the State must redetermine the cash surrender value, consistent with regulations relating to changes in circumstances at § 435.916(d) (redesignated and revised at § 435.919 in this proposed rule), as described above and seek the cash surrender value on behalf of the individual consistent with § 435.952(e)(4)(iv)(A). If, in redetermining eligibility, including the cash surrender value of the policy, once obtained, the State determines the individual to be ineligible for an MSP, the State would need to consider eligibility on other potential bases and provide advance notice and fair hearing rights in accordance with part 431 subpart E of the regulations prior to terminating MSP coverage.

We also propose at § 435.952(e)(4)(iv)(A) that when documentation of the cash surrender value of a life insurance policy is required, the State must assist the individual with obtaining this information and documentation by requesting that the individual provide the name of the insurance company and policy number and authorize the State to obtain such documentation on the individual's behalf, similar to the assistance that SSA provides SSI applicants, in which SSA obtains from the applicant basic information about the policy and authorization to contact the insurer, and then confirms the cash surrender value directly with the life insurance company itself.[33] The agency may also request, but may not require, additional information from the applicant to assist the agency in obtaining documentation of the cash surrender value, such as the name of an agent. If the individual does not provide basic information about the policy and an authorization, under proposed § 435.952(e)(4)(iv)(B), the State may require that the individual provide documentation of the cash surrender value. Under proposed § 435.952(e)(4)(iv)(C), the State must provide the individual with at least 15 calendar days to provide such documentation if required pursuant to paragraph (e)(4)(i) or (ii) of this section (that is, if documentation of the cash surrender value is needed prior to the agency's making a determination of eligibility) and at least 90 calendar days if required pursuant to paragraph (e)(4)(iii) of this section (that is, post-enrollment). We note that the minimum of 15 calendar days in proposed § 435.952(e)(4)(iv)(C) for applicants to provide documentation of cash surrender value of a life insurance policy is consistent with the minimum 15 calendar days that we propose States must generally provide applicants to provide required documentation under proposed at § 435.907(d), discussed in section II.B.3 of this proposed rule. We seek comment on whether 15 calendar days or a longer minimum period, such as 20 calendar days or 30 calendar days, appropriately balances the complexity of determining and obtaining documentation of the cash surrender value with the 45-day limit for States to complete Medicaid eligibility determinations for individuals applying on a basis other than disability status under § 435.912(c)(3). The 90 calendar days proposed for individuals to obtain documentation of the cash surrender value of a life insurance policy during a post-enrollment verification process is consistent with the 90 calendar days in proposed paragraphs (e)(1)(iii), (e)(2)(iii), and (e)(3)(iii) of § 435.952.

We recognize this proposal would represent a significant change for a number of States and could present some administrative challenges to implement. However, documenting the cash surrender value of life insurance is a considerable hurdle for many applicants. Because the cash surrender value of most applicants' policies is likely very modest, the value of any life insurance policy likely will have a minimal impact on their financial eligibility for coverage, whereas obtaining documentation of the cash surrender value may pose a substantial administrative barrier to access. We believe it is in the interest of efficient administration of the program, consistent with section 1902(a)(4) of the Act, to implement a process that places fewer burdens on applicants. We also believe that States are better able to navigate obtaining such documentation when needed. We seek comment on whether the burden shifted to States under the proposed rule is appropriate, or whether an alternative approach would be preferable.

In-Kind Support and Maintenance. In-kind support and maintenance is assistance an applicant receives that is paid for by someone else, such as groceries or utilities paid for by an adult child. Section 1860D–14(a)(3)(C)(i) of the Act, added by section 116 of MIPPA, excludes in-kind support and maintenance as countable income for LIS determinations. Under SSI methodologies at 20 CFR 416.1131, which apply to MSP determinations, the value of in-kind support and maintenance, if both food and shelter are received by an applicant, is presumed to be one-third of the Federal benefit rate (FBR) ($841 per month in 2022 for a single person), unless the applicant provides documentation demonstrating a different amount. While documenting the amount of actual in-kind support and maintenance can be difficult for applicants, we do not believe it is common for applicants to attempt to rebut the one-third FBR presumption, and therefore, it is rare that applicants are faced with providing documentation of this type of income.

Under the proposed rule, States would continue to be permitted to require documentation from individuals who seek to rebut the one-third FBR presumption. However, we seek comment on if obtaining documentation to rebut the one-third presumption

[33] See SSA POMS SI 01130.300.D., Developing Life Insurance Policies at *http://policy.ssa.gov/poms.nsf/lnx/0501.130300*.

poses a barrier to eligibility and whether we should require States to accept self-attestation from individuals who seek to rebut a presumption of the amount of in-kind support and maintenance they receive subject to post-enrollment verification as discussed above. Alternatively, States can, and are encouraged to, further streamline the MSP eligibility and enrollment process for individuals with in-kind maintenance and support by disregarding in-kind support and maintenance entirely under section 1902(r)(2) of the Act.

2. Define ''Family of the Size Involved'' for the Medicare Savings Program Groups Using the Definition of ''Family Size'' in the Medicare Part D Low-Income Subsidy Program (§ 435.601)

To further facilitate alignment of methodologies used to determine eligibility for the Medicare Part D LIS and MSP groups and facilitate enrollment in the MSPs based on LIS data, we propose to amend § 435.601 (''Application of financial eligibility methodologies'') to create a new paragraph (e), in which we propose to define ''family size'' for purposes of MSP eligibility.

Each year, the U.S. Department of Health and Human Services (HHS) issues the Federal poverty guidelines (often referred to as the Federal poverty level or FPL), a measure of poverty used as an eligibility criterion by Medicaid and a number of other Federal programs. The FPL is a dollar amount that increases with the family size of an individual. For example, in 2022, in terms of annual income, the FPL is $13,590 for a single person, $18,310 for a couple, and $23,030 for a family of three.

Under section 1905(p)(2)(A) and (B) of the Act, QMB-eligible individuals have incomes that do not exceed 100 percent of the FPL ''applicable to a family of the size involved.'' Section 1905(s)(2) of the Act similarly directs that Qualified Disabled Working Individual (QDWI)-eligible individuals have incomes that do not exceed 200 percent of the FPL ''applicable to a family of the size involved.'' Section 1902(a)(10)(E)(iii) and (iv) of the Act also direct that the income standards for the SLMB and QI eligibility groups be percentages of the FPL ''applicable to a family of the size involved.'' As described above, SLMBs have incomes greater than 100 percent of the FPL and less than 120 percent of the FPL, and QIs have incomes at least equal to 120 percent of the FPL and less than 135 percent of the FPL. The statute does not define the phrase ''family of the size involved'' and CMS has historically permitted States to apply their own reasonable definition of this phrase.[34]

However, in light of the various statutory provisions to facilitate enrollment of LIS recipients into MSPs and vice versa, we believe it is appropriate to establish Federal standards governing the phrase ''family of the size involved.''

Specifically, we propose for purposes of determining eligibility for the MSP groups, consistent with our authority under section 1902(a)(4) of the Act to facilitate methods of administration that promote the proper and efficient administration of the Medicaid program, that ''family of the size involved'' be defined to include at least the individuals included in the definition of ''family size'' in the LIS program. Under § 423.772 (''Definitions'' relating to the LIS program), ''family size'' is defined to include the applicant, the applicant's spouse (if the spouse is living in the same household with the applicant), and all other individuals living in the same household who are related to the applicant and dependent on the applicant or applicant's spouse for one-half of their financial support.

By proposing that a State's definition of ''family of the size involved'' include ''at least'' the individuals described in § 423.772 for purposes of the MSP groups, States would retain flexibility to include other individuals who are not described in § 423.772. Additionally, this proposal would not affect the States' ability to adopt a different reasonable definition of the phrase for purposes of other eligibility groups. For example, in order to be eligible under section 1902(a)(10)(A)(ii)(XIII) of the Act (providing coverage for working individuals with disabilities), an individual must have income that is less than 250 percent of the FPL for a ''family of the size involved.'' States would not be required to adopt the definition at proposed § 435.601(e) for purposes of determining income eligibility for this eligibility group. We seek comment on this proposal to define ''family of the size involved'' for purposes of the MSP groups.

[34] Memorandum from Director, Center for Medicaid and State Operations, to Regional Administrator, Re: Medicaid Eligibility—Policy Governing Family Size in Determining Eligibility for Qualified Medicaid Beneficiaries and Specified Low-Income Beneficiaries. Oct. 2, 1997. Available at *https://www.medicaid.gov/sites/default/files/2019-12/medicaid-eligibilty-memo.pdf.*

3. Automatically Enroll Certain SSI Recipients Into the Qualified Medicare Beneficiaries Group (§ 435.909)

SSI is a Federal cash assistance program that serves low-income individuals who are age 65 or older, or have blindness or a disability. SSI recipients typically qualify for other Federal and State programs. For example, many SSI recipients are entitled to Medicare under 42 CFR 406.5(a) and (b). Additionally, in most States, the receipt of SSI is a mandatory basis for Medicaid eligibility pursuant to section 1902(a)(10)(A)(i)(II)(aa) of the Act, implemented at § 435.120 (''Individuals receiving SSI group,'' hereafter the ''mandatory SSI group''). Thirty-three States and the District of Columbia (DC) that cover the mandatory SSI group have an agreement with SSA under section 1634(a) of the Act under which SSA completes the determination of eligibility for the mandatory SSI group, and the Medicaid agency automatically enrolls the individual in Medicaid following a data exchange with SSA. These States commonly are referred to as ''1634 States.'' A minority of States that cover the mandatory SSI group apply the SSI program's income and resource methodologies and disability criteria but require individuals to submit a separate application to the State Medicaid agency (''criteria States'').

Eight States do not cover the mandatory SSI group. Instead, these States have elected the authority provided under section 1902(f) of the Act to apply financial methodologies and/or disability criteria more restrictive than the SSI program in determining eligibility for individuals 65 years old or older or who have blindness or a disability, subject to certain conditions. These States are referred to as ''209(b) States,'' after the provision of section 209(b) of the Social Security Act Amendments of 1972 (Pub. L. 92–603), which enacted what became codified at section 1902(f) of the Act. The eligibility group authorized by section 1902(f) of the Act is implemented at § 435.121 (''Individuals in States using more restrictive requirements for Medicaid than the SSI requirements,'' hereafter ''mandatory 209(b) State group'').

Most Medicare-eligible SSI recipients also meet the eligibility requirements for the QMB eligibility group described in sections 1902(a)(10)(E) and 1905(p) of the Act, which provides Medicaid coverage of Medicare premiums (both Part A, if applicable, and Part B) and cost- sharing (copayments, coinsurance, and deductibles).

Section 1905(p)(1) of the Act provides that, to be eligible under the QMB group, an individual must be entitled to Medicare Part A or enrolled in Medicare Part B for coverage of immunosuppressive drugs under section 1836(b) of the Act, have income that does not exceed 100 percent of the FPL for the applicable family size, and have resources that do not exceed the limits for the full-subsidy LIS program. As described at section 1860D–14(a)(3)(D) of the Act, the full-subsidy LIS resource limit is three times the SSI resource limit, adjusted annually based on changes to the Consumer Price Index.[35] (See section II.A.1. of this proposed rule for discussion of the LIS program.) The income standard for SSI (that is, SSI's maximum Federal benefit rate) is typically 74 percent of the FPL for an individual and 83 percent of the FPL for married individuals. Thus, because the income and resource standards for the QMB group exceed the income and resource standards for SSI, individuals entitled to Medicare Part A who meet the income and resource requirements for the mandatory SSI group or mandatory 209(b) group will always meet the income and resource requirements for the QMB group and be eligible for the QMB group.

Most individuals enrolled in Medicare qualify for Part A without paying a premium (premium-free Part A). SSA automatically enrolls these individuals in premium-free Part A if they are age 65 or over and receive Social Security or Railroad Retirement Board (RRB) retirement benefits under title II of the Act or are under age 65 and have received Social Security or RRB disability benefits for 24 months under title II of the Act. See 42 CFR part 406 subpart A. In 2021, approximately 2.6 million individuals (approximately one third) of SSI recipients were entitled to premium-free Part A.[36]

Under § 406.20, many individuals who are not eligible for premium-free Part A may still enroll in Part A by applying for benefits at SSA and paying a premium (''premium Part A''). In 2022, the premium for Medicare Part A was $499; however, based on prior work history, some individuals may qualify for a reduced rate of $274. Individuals who are not eligible for premium-free Part A are not automatically enrolled in premium Part A and they must enroll in Part B prior to or at the same time as they enroll in Part A. All Medicare beneficiaries must pay a monthly premium for enrollment in Part B, which is subject to an adjustment based on income. In 2022, the minimum Part B premium was $170.10.

All States currently have a buy-in agreement with the Secretary under section 1843 of the Act which requires them to pay the Part B premiums for certain Medicaid beneficiaries, including individuals enrolled in the QMB group and those receiving SSI (known as ''Part B buy-in'') as described in the Medicare regulations at § 407.42. A buy-in agreement permits States to directly enroll eligible individuals in Medicare Part B at any time of the year (without regard for Medicare enrollment periods or late enrollment penalties if applicable) and to pay the Part B premiums on the individual's behalf. In 1634 States, when SSA determines an individual eligible for both the mandatory SSI group and Medicare Part B, CMS automatically initiates Part B buy-in for the individual through a joint data exchange among CMS, the State Medicaid agency, and SSA (''buy-in data exchange'').[37] In SSI criteria and 209(b) States, SSA notifies both the State and CMS that an individual has been determined eligible for SSI and Medicare Part B; however, because such individuals must submit a separate Medicaid application for determinations of eligibility, CMS does not automatically initiate Part B buy-in. Rather, once the State determines an individual eligible for the mandatory SSI or 209(b) group, the State must initiate Part B buy-in for the individual pursuant to its buy-in agreement through its daily exchange of enrollment data with CMS. See 42 CFR 407.40(c)(4) and 407.42; CMS Manual for the State Payment of Medicare Premiums, chapter 2, section 2.5.1.

While individuals enrolled in the mandatory SSI or 209(b) group receive full Medicaid benefits, enrollment in the QMB group provides these individuals with additional protection from out-of-pocket health care costs—specifically Medicare premiums and cost-sharing charges. Moreover, Federal law prohibits all Medicare providers and suppliers, not just those participating in Medicaid, from charging QMBs for Medicare cost-sharing. Since 2018, CMS has notified Medicare providers and suppliers when an individual is enrolled in the QMB group and protected from Medicare cost-sharing liability.

Maximizing the number of Medicaid beneficiaries who are also enrolled in Medicare is not only advantageous to the individual, but it can also result in cost savings for States. As a third-party payer, Medicare pays primary to Medicaid for Medicare Part A (inpatient hospital and skilled nursing facility services) and Medicare Part B (outpatient medical care). In addition, Medicaid beneficiaries who are enrolled in both Medicare Parts A and B may join Medicare-Medicaid integrated care plans, which provide more coordinated care across the two payers and may generate savings to the State by helping beneficiaries avoid institutional placement and by providing supplemental benefits, such as dental, transportation, hearing, or other benefits that otherwise would have been covered by Medicaid.

Despite the potential benefits for Medicaid beneficiaries and State agencies, CMS data from 2022 indicates that over 500,000 or 16 percent of SSI recipients who are eligible to enroll in Medicare are not enrolled in the QMB eligibility group. We believe a major driver of eligible but unenrolled QMBs is that many States require SSI recipients to file a separate application with the State Medicaid agency in order to be evaluated for eligibility for the QMB group, even though they have been determined eligible for the mandatory SSI or 209(b) groups, and all SSI recipients who are entitled or able (with a premium) to enroll in Part A necessarily meet the requirements for QMB eligibility.

To facilitate the enrollment of SSI recipients into the QMB eligibility group we propose, consistent with section 1902(a)(4) of the Act to promote the proper and efficient administration of the Medicaid program, the January 28, 2021 Executive Order on Strengthening Medicaid and the Affordable Care Act, the April 5, 2022 Executive Order on Continuing to Strengthen Americans' Access to Affordable, Quality Health Coverage, and the December 13, 2021 *Executive Order on Transforming Federal Customer Experience and Service Delivery to Rebuild Trust in Government,* to add a new paragraph (b) at § 435.909 that generally would require States to deem an individual enrolled in the mandatory SSI or 209(b) group eligible for the QMB group the

[35] The resource limit for LIS is three times the SSI limit with yearly updates since January 1, 2010 to reflect to reflect Consumer Price Index (CPI). Note that the MSP resource test is determined without regard to the life insurance policy exclusion for Part D LIS, in accordance with section 1902(p)(1)(C).

[36] *SSI Monthly Statistics, September 2021,* Social Security Office of Retirement and Disability Policy 2021. *https://www.ssa.gov/policy/docs/statcomps/ssi_monthly/2021-09/table01.html.*

[37] States with buy-in agreements must exchange buy-in enrollment data with CMS on a daily basis under § 407.40(c)(4), and CMS also exchanges buy-in data with SSA on a daily basis. CMS collectively refers to these data exchange processes as the ''buy-in data exchange.'' See Manual for the State Payment of Medicare Premiums, chapter 2, sections 2.0 and 2.1.

month the State becomes responsible for paying the individual's Part B premiums under its buy-in agreement pursuant to § 407.47(b). We also propose technical changes to remove reserved paragraph (a) at § 435.909, redesignate § 435.909 paragraph (b) as (a) and add a new header to new § 435.909(a).

We note that under section 1902(e)(8) of the Act, QMB eligibility is effective the month following the month in which the determination of eligibility for the QMB group is made. Thus, under our proposal, QMB coverage would start the month following the month the State deems (that is, determines) an individual eligible for the QMB group and starts paying the individual's Part B premiums under the buy-in agreement. For example, if an individual is first enrolled in both the mandatory SSI or 209(b) Medicaid group and entitled to Part A in January 2025, the State would start paying the individual's Part B premiums under the buy-in agreement and deem the individual eligible for the QMB group in January 2025. The individual's QMB coverage would start February 1, 2025.

SSI Recipients Who Have Premium-Free Medicare Part A

As noted above, SSA automatically enrolls individuals who receive Social Security or RRB retirement benefits or disability benefits for 24 months into premium-free Part A. SSA data for States (including those with a 1634 agreement and those without a 1634 agreement) indicates whether an SSI recipient is entitled to premium-free Part A. As discussed above, because all SSI recipients meet the financial eligibility requirements for the QMB group, proposed § 435.909(b)(1)(i) would require all States to deem SSI recipients who are determined eligible for either the mandatory SSI group at § 435.120 or the mandatory 209(b) group at § 435.121 as eligible for the QMB group if they are entitled to premium-free Medicare Part A. Under the proposed rule, when a 1634 State (which has delegated authority to SSA to make Medicaid eligibility determinations for SSI recipients) receives from CMS the Part B buy-in enrollment for an SSI recipient who is entitled to premium-free Medicare Part A, the State would automatically enroll the individual in both the mandatory SSI group and the QMB group; such individuals would not be required to submit a separate application to the Medicaid agency to determine eligibility for the QMB group.

Criteria States and 209(b) States also obtain from CMS information that an SSI recipient is Medicare-eligible and entitled to premium-free Medicare Part A. However, in these States SSI recipients must submit a separate application to the Medicaid agency which determines eligibility for either the mandatory SSI or the 209(b) group. Under proposed § 435.909(b)(1)(i), once the State has determined an SSI recipient eligible for the mandatory SSI or the 209(b) group, the State also would start paying the Part B premiums for the individual the first month they are entitled to Part A and receiving SSI-based Medicaid and start QMB group coverage the first day of the following month.

From time to time, individuals enrolled in the mandatory SSI or 209(b) group become retroactively entitled to premium-free Medicare Part A based on a retroactive award of Social Security Disability Insurance (SSDI). Under the Medicare regulations at § 407.47(b), States generally become responsible for retroactive Part B premiums for such individuals dating back to the first month they were enrolled in the mandatory SSI or 209(b) group and eligible for Part B.[38] In an April 27, 2022 proposed rule entitled, ''Implementing Certain Provisions of the Consolidated Appropriations Act and other Revisions to Medicare Enrollment and Eligibility Rules'' (87 FR 25090) (referred to hereafter as the ''2022 Medicare eligibility and enrollment proposed rule''), we proposed adding a new paragraph (f) at § 407.47 to limit State liability for retroactive Part B premiums for full-benefit Medicaid beneficiaries, including individuals receiving SSI-based Medicaid, to a period of no greater than 36 months prior to the date of the Medicare enrollment determination. At 87 FR 25114 through 25115 of the proposed rule, we noted that this time limit would reduce burden on providers, help State Medicaid programs and the Medicare program run more efficiently, be consistent with a legal ruling in favor of States in at least one Federal court, and not harm Medicaid beneficiaries since Medicaid would have covered any medical costs the beneficiary incurred for periods in the past.

To align with that change, under § 435.909(b)(3), we propose that retroactive QMB coverage for individuals in the mandatory SSI or 209(b) group be limited to the same period for retroactive Part B premium liability proposed at § 407.47(f) in the 2022 Medicare eligibility and enrollment proposed rule. For example, if SSA determines an individual enrolled in the mandatory SSI or 209(b) group eligible for premium-free Part A in January 2025 with an effective date back to January 2023, the State would deem the individual eligible for the QMB group retroactive to January 2023. Because coverage under the QMB group begins the month after the month of the eligibility determination, QMB coverage in this example would be effective February 1, 2023. Alternatively, if SSA determines an individual enrolled in the mandatory SSI or 209(b) group eligible for premium-free Part A in January 2025 with an effective date back to January 2021, the State would deem the individual eligible for the QMB group retroactive to January 2022, with QMB coverage effective February 1, 2022. We invite comment on this limit on retroactive QMB eligibility.

Additionally, we remind States that individuals deemed eligible for Medicaid are not exempt from regularly-scheduled renewals of Medicaid eligibility in accordance with § 435.916. However, for an individual eligible under both the mandatory SSI and QMB groups, the State need only verify that the individual still receives SSI and is entitled to Medicare Part A in order to renew their eligibility in both groups. States can do this verification electronically by confirming receipt of SSI in the State Verification Exchange System or State Online Query System, and we encourage them to do so to minimize burden. When a beneficiary no longer meets the eligibility requirements for the eligibility group under which they have been receiving coverage, the State must determine eligibility on all bases before terminating eligibility.

SSI Recipients Eligible for Premium Part A

As mentioned above, individuals age 65 and over who lack the sufficient work history for premium-free Part A may qualify to pay, or have paid on their behalf, a monthly premium to receive Medicare Part A benefits.[39] To meet the requirements for premium Part A at § 406.20(b), the individual must be: age 65 or older, a U.S. resident, not otherwise entitled to Part A, entitled to Part B or in the process of enrolling in it, and a U.S. citizen or lawful permanent resident who has resided in the U.S. continuously during the 5 years immediately preceding the month they enrolled in Medicare.

[38] Individuals who are entitled to premium-free Part A are eligible to enroll in Medicare Part B under § 407.10(a)(1).

[39] Note that all individuals receiving title II benefits based on disability who have met the 24-month waiting period to enroll in Medicare are entitled to premium-free Part A.

All States must pay the Part A premium for individuals who are enrolled in the QMB eligibility group. However, States can choose one of two methods to pay the Part A premium for QMBs.[40] First, States can expand their buy-in agreement with CMS under section 1818(g) of the Act to include enrollment and payment of Part A premiums for QMBs who do not have premium-free Part A. Currently, 36 States and the District of Columbia have chosen this option. States that include payment of Part A premiums for QMBs in their buy-in agreements are called ''Part A buy-in States.'' In Part A buy-in States, individuals determined eligible for the QMB group can enroll in premium Part A at any time of the year and without regard to late enrollment penalties. Fourteen States do not include Part A in their buy-in agreements and instead pay the Part A premiums for QMBs using a group payer arrangement, which allows certain third parties (for example, States) to pay the Part A premiums for a class of beneficiaries.[41] States that use a group payer arrangement for QMBs are known as Part A ''group payer States.''

As previously noted, in order to qualify for the QMB eligibility group under section 1905(p)(1) of the Act, an individual must be entitled to hospital insurance benefits under Part A of title XVIII. Being ''entitled to'' Part A means that if an individual receives Part A-covered services, the costs of those services will be covered by Medicare. See 42 CFR 406.3. In general, an individual becomes so entitled to Part A if—(1) they are eligible for premium-free Part A based on payment of a payroll tax; or (2) are eligible to enroll in Premium Part A and do enroll (creating a Part A premium obligation). The premium payment is due for each month beginning with the first month of coverage. 42 CFR 406.32(f).

Further, section 1905(a) of the Act specifies that payments of Medicare cost-sharing for QMBs (including Part A premiums) are ''medical assistance'' for purposes of FFP, if made in the month following the month in which the individual becomes a QMB. (Per the introductory paragraph of section 1905(a) of the Act, payments for Medicare premiums and cost sharing only qualify as medical assistance in the case of Medicare cost-sharing with respect to a QMB described in section 1905(p)(1) of the Act, if provided after the month in which the individual becomes such a beneficiary). Thus, under a literal reading of the words of the statute, a State cannot claim FFP under the QMB group until the month after the month in which the individual is ''entitled to Part A,'' which requires first that a Part A premium be paid. This creates a ''catch 22'' in which low-income individuals can only be eligible for QMB coverage that makes Part A enrollment affordable if they first became liable for its premium.

This result would eviscerate the purpose of sections 1843 and 1818(g) of the Act (''buy-in statute''). Under a literal read, States with a Part A buy-in agreement could theoretically use State-only funds to pay Part A premiums the first month to allow the individual to become entitled to Part A and start QMB coverage the next month. However, in *Harris* v. *McCrae,* 448 U.S. 297 (1980), the U.S. Supreme Court held that States cannot be required to provide Medicaid using only State funds. Further, while individuals can enroll in Part A at any time of the year without regard for Medicare enrollment periods or late enrollment if the State pays their Part A premium under its buy-in agreement, this is not the case for individuals who are paying the premium themselves. Individuals who must pay the Part A premium themselves must wait until a Medicare enrollment period to enroll in Part A and may be subject to late enrollment penalties. Thus, a literal read of the statute would defeat the purpose of buy-in statute—to avoid delays in QMB enrollment by allowing QMB-eligible individuals who reside in Part A buy-in States to enroll in Part A at any time of the year, without regard to Medicare enrollment penalties.

Recognizing that a literal read of the statute would produce a result that essentially nullifies the impact of the QMB and buy-in statutory provisions, CMS instituted a policy approximately 30 years ago under which States can receive FFP for paying an individual's Part A premium the first month of entitlement, thereby triggering both Part A entitlement and QMB coverage. Under this policy, Part A buy-in States can determine an individual eligible for QMB status, and thus for their Part A premiums to be paid, if they are enrolled in Part B but not yet entitled to Part A.[42] Group payer States similarly can approve eligibility for individuals under the QMB eligibility group if SSA has determined them conditionally eligible for premium Part A, through a process known as ''conditional enrollment.'' The conditional enrollment process enables low-income individuals to apply at SSA for premium Part A on the condition that they will only be enrolled in Part A if the State determines they are eligible for the QMB group.[43] Most group payer States recognize conditional enrollment in Part A for purposes of determining QMB eligibility, but they are not required to do so.

Individuals who lack premium-free Part A are more likely to have worked in the informal economy in low wage jobs.[44] Internal analysis by CMS from 2017 found that, as compared to their QMB-eligible counterparts with premium-free Part A, QMB-eligible individuals who qualify for premium Part A tend to be poorer and more likely to be non-native English speakers. For multiple decades, the conditional enrollment policy has helped hundreds of thousands of individuals obtain essential assistance with Medicare premiums and cost-sharing by allowing States to pay the first month's premium needed to trigger Medicare Part A entitlement. Without this policy, the subsidies available under the QMB group to make Part A affordable would only be available to individuals who somehow found a way to pay the initial Part A premium (including a late enrollment penalty if applicable) themselves. We estimate that precluding coverage of Part A premium payments under the QMB group until the month after an individual has become entitled to Part A would prevent over 78,000 individuals each year from enrolling in Part A with State payment of Part A premiums.[45]

We believe that we should implement the statute in a manner that gives full effect to what we believe to be Congress' intended policy in this rare instance in which implementing the plain meaning of the words of the statute would produce a result that is at odds with this statutory purpose. In *United States* v.

[40] See chapter 1, section 1.2 of the CMS Manual for the State Payment of Medicare Premiums.

[41] See Program Operations Manual System (POMS) HI 01001.230 Group Collection-General at *http://policynet.ba.ssa.gov/poms.nsf/lnx/0601001230.*

[42] Chapter 1, section 1.10 of the CMS Manual for the State Payment of Medicare Premiums and SSA Program Operations Manual System (POMS) HI 00801.140.C Premium Part A Enrollments for Qualified Medicare Beneficiaries (QMBs)—Part A Buy-In States and Group Payer States at *http://policynet.ba.ssa.gov/poms.nsf/lnx/0600801140.*

[43] The conditional enrollment process is described in chapter 1, section 1.11 of the CMS Manual for the State Payment of Medicare Premiums and in SSA Program Operations Manual System (POMS) HI 00801.140 Premium Part A Enrollments for Qualified Medicare Beneficiaries (QMBs)—Part A Buy-In States and Group Payer States at *http://policynet.ba.ssa.gov/poms.nsf/lnx/0600801140.*

[44] *Streamlining Medicare and QMB Enrollment for New Yorkers: Medicare Part A Buy-In Analysis and Policy Recommendations,* Medicare Rights Center, February 2011. *https://www.medicarerights.org/pdf/Part-A-Buy-In-Analysis.pdf.*

[45] Based on internal CMS data from 2015–2019.

Ron Pair Enterprises, Inc., 489 U.S. 235 (1989), the U.S. Supreme Court found, ''The plain meaning of legislation should be conclusive, except in the 'rare cases [in which] the literal application of a statute will produce a result demonstrably at odds with the intentions of its drafters.' *Griffin* v. *Oceanic Contractors, Inc.,* 458 U.S. 564, 571 (1982). In such cases, the intention of the drafters, rather than the strict language, controls. *Ibid.*''

More recently, in *Donovan* v. *First Credit, Inc.,* 983 F.3d 246, 254 (6th Cir. 2020) the Sixth Circuit reformulated this concept as follows: ''Thus, the absurd-results doctrine sanctions the use of extra-textual sources to contravene statutory text only if there is no alternative and reasonable interpretation available that, consistent with legislative purpose, would avoid the absurd result.'' *See id.; In re Corrin,* 849 F.3d 653 at 657 ('When the language is ambiguous or leads to an absurd result, the court may look at the legislative history of the statute to help determine the meaning of the language.').''

We note that there is precedent, in the Medicare Part D context, for not applying the plain meaning of the words of the statute when it leads to what we believe to be an absurd result contrary to the purpose of the statute. The following language from the preamble to the January 28, 2005 final rule implementing Medicare part D explains:

> Section 1860D–1(b)(1)(C) of the Act requires CMS to auto-enroll into PDPs an individual ''who is a full benefit dual eligible individual'' who ''has failed to enroll in a prescription drug plan or an MA–PD plan.'' Although this statutory provision specifically references the statutory definition of ''full-benefit dual eligible individual'' under section 1935(c)(6) of the Act, if interpreted literally, section 1860D–1(b)(1)(C) of the Act would require CMS to auto-enroll into Part D plans only individuals receiving full-benefits under Medicaid who are already enrolled in Part D but who have ''failed to enroll in'' a Part D plan, a patently absurd result. We have an obligation to interpret the statute so as to avoid an absurd result and give full effect to the Congress' intended policy. We think it is clear that the Congress required CMS to establish an auto-enrollment process to ensure that individuals who currently receive coverage for Part D drugs under Medicaid continue to receive coverage for such drugs through enrollment in Part D beginning in 2006.[46]

For the reasons set forth above, we believe that in this case also, reading the statute literally to require an individual to pay their first month's Part A premium in order to become eligible to receive coverage of Part A premiums under the QMB group would be contrary to the fundamental purpose of the QMB statutory provisions: to enable low-income individuals to gain Medicare benefits they could not otherwise afford. A literal read of the statute is also at odds with the intent of the buy-in statute to avoid undue delays in QMB enrollment. Therefore, we propose to incorporate in the regulations our longstanding practice of providing FFP for State payments of the first month of an individual's Part A premium for individuals who are eligible for the QMB group based on conditional enrollment in Part A. This also will facilitate enrollment into the QMB group for SSI recipients who need to pay a premium to enroll in Part A.

According to internal CMS estimates, in 2022 approximately 800,000 SSI recipients were eligible for Part A by paying a premium. When an individual age 65 or older is determined eligible for SSI and Medicare Part B but lacks sufficient work history for premium-free Part A, SSA transmits the individual's record to CMS. In 1634 States, CMS automatically initiates Part B buy-in (that is, enrollment in Part B with the State paying the Part B premium); in criteria and 209(b) States, CMS alerts the State that the individual is eligible for SSI and Medicare. As described above, States must pay the Part B premiums for individuals once they are eligible for Part B and have been determined eligible for the mandatory SSI or 209(b) group under §§ 407.42 and 407.47(b). Once the SSI recipient is enrolled in Part B buy-in, CMS notifies SSA, which also updates its SSI records to reflect Part B buy-in for the individual.

As mentioned above, in Part A buy-in States, CMS considers enrollment in Part B sufficient to treat the individual as meeting the requirement that the individual be entitled to Part A for the purposes of the State's QMB eligibility determination. Because the SSI income and resource standards are below the standards for eligibility under the QMB group, individuals eligible for the mandatory SSI or 209(b) group will meet the financial eligibility requirements for the QMB group. Thus, in Part A buy-in States, when an SSI recipient who lacks sufficient work history for premium-free Part A has been determined eligible for the mandatory SSI or 209(b) group and is enrolled in Part B, the State can determine the individual eligible for the QMB eligibility group and enroll the individual in Part A buy-in.

To streamline QMB enrollment for SSI recipients who must pay a premium to enroll in Part A, we propose at § 435.909(b)(1)(ii) to require Part A buy-in States to deem those individuals who are determined eligible for the mandatory SSI or 209(b) groups as eligible for the QMB group and initiate their enrollment into Medicare Part A, pursuant to their buy-in agreement, the month they are enrolled in Part B buy-in.

As noted, in States that have a 1634 agreement with SSA, when SSA determines an individual eligible for the mandatory SSI group, SSA also notifies CMS that an individual eligible for Medicare Part B has been determined eligible for the mandatory SSI group. CMS initiates the individual's enrollment in Medicare Part B buy-in and notifies the State after doing so. In Part A buy-in States with a 1634 agreement, once the State receives the automated Part B buy-in enrollment from CMS for an SSI recipient who lacks a sufficient work history for premium-free Part A, under proposed § 435.909(b)(1)(ii) the State would enroll the individual in the mandatory SSI group, deem the individual eligible for the QMB group, and effectuate enrollment in Medicare Part A through the buy-in agreement.

As discussed above, in criteria and 209(b) States, when CMS receives information from SSA that an individual is eligible for SSI and Medicare Part B, CMS does not automatically initiate Part B enrollment, which is a prerequisite for entitlement to Part A for individuals subject to a Part A premium. In a Part A buy-in State without a 1634 agreement (that is, a criteria or 209(b) State), once the individual applies to the Medicaid agency, some States currently only determine eligibility for the mandatory SSI or 209(b) group, as applicable, and initiate Part B enrollment per their buy-in agreement. Under proposed § 435.909(b)(1)(ii), these Part A buy-in States also would be required to deem any individuals determined by the State to be eligible for the mandatory SSI or 209(b) groups as eligible for the QMB group and initiate enrollment in both Medicare Part A and Part B buy-in.

In the 14 group payer States, it is more challenging for SSI recipients to enroll in Medicare Part A and the QMB eligibility group. Unlike in Part A buy-in States, individuals determined eligible for the mandatory SSI or 209(b) group in group payer States who are enrolled in Part B pursuant to the State's buy-in agreement will not necessarily satisfy the eligibility requirement for the QMB group that the individual be entitled to Part A. Even though the State will initiate enrollment of the

[46] 70 FR 4194 at 4370 and 4371 (January 28, 2005). *https://www.govinfo.gov/content/pkg/FR-2005-01-28/pdf/05-1321.pdf.*

individual in Part B, pursuant to its buy-in agreement, it will not cover the individual's Part A premium or initiate Part A enrollment under the buy-in agreement. Instead, the individual must separately apply for premium Part A at SSA using the conditional enrollment process.

Although the conditional enrollment process provides a way for individuals to enroll in the QMB eligibility group without paying their own Part A premiums upfront, the process is administratively burdensome for both individuals and the State, and the vast majority of individuals fail to complete the process unless an eligibility worker or other application assistor provides hands on assistance through every step of the process.[47] Two other challenges currently make QMB enrollment harder for SSI recipients without premium-free Part A in group payer States. First, group payer States can only enroll individuals in premium Part A during the general Medicare enrollment period that runs from January through March each year. Second, group payer States are required to pay late enrollment penalties, if applicable, for those Medicaid beneficiaries who did not timely enroll in Medicare Part A when they first became eligible to do so.

To streamline QMB enrollment for SSI recipients without premium-free Part A in group payer States, we propose to add a State option for deeming individuals eligible for the QMB group. Specifically, proposed § 435.909(b)(2) would allow, but not require, group payer States to directly initiate Medicare Part A enrollment for individuals who are not entitled to premium-free Part A without first sending them to SSA to apply for conditional Part A enrollment. Under this proposed option, once the State has determined the individual eligible for the mandatory SSI or 209(b) group and become liable for paying their Part B premiums under the buy-in agreement pursuant to § 407.42, the State would also deem them eligible for the QMB group.

We are aware that State-specific variables can impact a State's decision to either enter into a Part A buy-in agreement or to remain a group payer State. By allowing, but not requiring, group payer States to adopt the same streamlined QMB enrollment procedures used in Part A buy-in States, we preserve the current statutory option for group payer States to operate differently than Part A buy-in States while still enabling them to modernize their processes and facilitate enrollment of these very low-income individuals into Medicare Part A and the QMB group. However, we seek comments on the administrative and fiscal impacts of our proposal and of other approaches, such as requiring group payer States to deem individuals determined eligible for the mandatory SSI or 209(b) groups as eligible for the QMB group once they have completed the conditional enrollment process at SSA.

4. Clarifying the Qualified Medicare Beneficiary Effective Date for Certain Individuals (§ 406.21)

In the above section, we seek to facilitate enrollment for SSI recipients into QMB. Here, we propose to clarify the effective date of coverage under the QMB group for individuals who must pay a premium to enroll in Part A and reside in a group payer State in order to provide individuals with protection from Medicare premiums and cost-sharing costs on the earliest possible date.

The first opportunity individuals have to enroll in premium Part A is during their initial enrollment period (IEP). For most individuals who become eligible for Medicare on or after 1966, under section 1837(d) of the Act, the IEP begins on the first day of the third month before the month the individual turns 65 and ends 7 months later.

Eligible individuals who do not enroll in premium Part A during their IEP, or who disenroll from premium Part A and wish to re-enroll, must generally do so during the general enrollment period (GEP). The GEP is established under section 1837(e) of the Act, and is the period beginning on January 1 and ending on March 31 of each year. For individuals who enroll in Medicare under the GEP in a month before January 1, 2023, Part A entitlement would begin the first of July following their enrollment, as provided in sections 1838(a)(2)(D)(i) and (ii) and (a)(3)(B)(i) and (ii) of the Act. Section 120 of the Consolidated Appropriations Act, 2021 (CAA) revised the Part A entitlement effective date for individuals who enroll during the GEP in a month beginning on or after January 1, 2023. Specifically, Part A entitlement for individuals who enroll in premium Part A during the GEP would begin with the first day of the month following the month in which they enroll.

In the 2022 Medicare eligibility and enrollment proposed rule at 87 FR 25094, we proposed to revise § 406.21(c) to implement the GEP effective dates outlined in section 120 of the CAA. Specifically, § 406.21(c)(3)(i) would require that for individuals who enroll or reenroll during a GEP prior to January 1, 2023, entitlement would begin July 1 following their enrollment, while § 406.21(c)(3)(ii) would require that for individuals who enroll or reenroll during a GEP on or after January 1, 2023, entitlement would begin on the first day of the month after the month of enrollment, consistent with section 1838(a)(2)(D)(ii) of the Act (incorporated for premium Part A beneficiaries by reference in section 1818(c) of the Act).

To align with that change, we propose to clarify the applicable effective date of QMB coverage for an individual who resides in a group payer State and enrolls in conditional Part A during the GEP. As discussed above in section II.A.3 of this preamble, in a Part A buy-in State, CMS considers enrollment in Part B sufficient to meet the requirement that an individual be entitled to Part A for the purposes of the QMB eligibility determination. However, in a group payer State, enrollment in QMB for individuals who need to pay a premium to enroll in Part A is always a two-step process. The State cannot determine individuals eligible for QMB and enroll them in Part A buy-in until SSA establishes actual or conditional Part A enrollment. With respect to QMB enrollment under a buy-in agreement under § 406.26, Medicare Part A coverage begins the first month an individual is entitled to Part A under § 406.20(b) and has QMB status. We consider a conditional Part A filing to be sufficient to fulfill the requirement for entitlement to Part A as applicable for QMB coverage.[48]

Specifically, in this rule we propose in new § 406.21(c)(5) to codify existing policy for individuals who enroll in actual or conditional Part A during the GEP. Beginning on or after January 1, 2023, the effective date of Medicare coverage for individuals who enroll in Medicare during the GEP is the month following the month of enrollment under section 1838(a)(2)(D)(1) and (a)(3)(B)(i) of the Act. For such individuals, QMB coverage starts the month premium Part A entitlement begins (if the State determines the individual has met the eligibility requirements for QMB coverage in the same month that Part A enrollment occurs), or a month later than the month of Part A entitlement (if the individual is determined eligible for QMB the month Part A entitlement begins or later).

[47] *Streamlining Medicare and QMB Enrollment for New Yorkers: Medicare Part A Buy-In Analysis and Policy Recommendations,* Medicare Rights Center, February 2011. *https://www.medicarerights.org/pdf/Part-A-Buy-In-Analysis.pdf.*

[48] See CMS Manual for the State Payment of Medicare Premiums, chapter 1, section 1.11.

This proposal would clarify that individuals who reside in group payer States and enroll in actual or conditional Part A during the GEP can obtain QMB as early as the month Part A entitlement begins.

5. Facilitate Enrollment by Allowing Medically Needy Individuals To Deduct Prospective Medical Expenses (§ 435.831)

The current medically needy income eligibility regulation at 42 CFR 435.831 permits institutionalized individuals to deduct their anticipated medical and remedial care expenses from their income. We propose to amend the regulation to allow noninstitutionalized individuals, under certain circumstances, to do the same for purposes of medically needy eligibility determinations. This proposal is designed to eliminate the institutional bias inherent in only permitting projection of the cost of care for institutionalized individuals.

Section 1902(a)(10)(C) of the Act provides States the option to extend Medicaid eligibility to ''medically needy'' individuals. Implementing regulations are codified at 42 CFR part 435, subpart D. The medically needy are individuals who have incomes too high to qualify in a categorically needy group described in section 1902(a)(10)(A) of the Act, but who have certain significant and costly health needs. Consistent with section 1902(a)(10)(C)(i)(III) of the Act and regulations at § 435.811(a), States establish a separate income standard to determine the income eligibility of medically needy individuals (referred to as the ''medically needy income level,'' or ''MNIL''). As directed by section 1903(f)(2) of the Act and § 435.831(d), a State's determination of a prospective medically needy individual's income eligibility includes the deduction of the uncovered medical and remedial expenses incurred by the individual, the individual's family members, or the individual's financially responsible relatives, from the individual's countable income. This process of deducting incurred medical and remedial expenses from an individual's countable income is referred to as a ''spenddown.''

To determine income eligibility for medically needy coverage, a State first determines an individual's countable income in accordance with § 435.831(b), including application of any disregards imposed under the methodology appropriate for the individual (for example, a $20 monthly income disregard for an individual whose Medicaid is based on SSI methodologies), or approved under the State's Medicaid plan under the authority of section 1902(r)(2) of the Act and § 435.601(d).

If the individual's remaining countable income is at or below the MNIL, they are income-eligible for the medically needy group. If the remaining countable income exceeds the MNIL, the individual will need to meet a spenddown; that is, the individual will need to reduce the amount of their income above the MNIL by the amount of their outstanding medical and remedial care expense liability, from bills the individual incurs during their current budget period, and, in some circumstances, previous to it (for example, under 42 CFR 435.831(f), bills incurred in previous budget periods that were not used to meet a spenddown because the individual had other bills that were sufficient to meet the spenddown in the previous budget periods may be used in the current budget period). As required by § 435.831(a)(1), States must choose a budget period of between 1 and 6 months to be used for medically needy individuals. The State multiplies the amount that an individual's countable income exceeds the MNIL for a single month by the number of months in the budget period. The product is the amount of medical or remedial care expenses for which the individual must document being liable—the spenddown—to establish eligibility during the budget period. Once the individual confirms having the necessary medical expense liability to the State agency, the individual is eligible for the remainder of the budget period.

For example, if an individual's countable monthly income is $1,200 in a State in which the MNIL is $700, the individual's spenddown amount, based on monthly income, would be $500 ($1,200 − $700 = $500). If the budget period elected by the State is 3 months, the State multiplies $500 by 3, and the individual's spenddown is $1,500 for the budget period. If the individual's budget period begins on January 1st, and the individual incurs unpaid medical expenses that are equal to or greater than $1,500 on February 15th, the individual will be eligible for Medicaid from February 15th through March 31st. To reestablish Medicaid eligibility in the next budget period, the individual will have to incur separate medical or remedial care expenses for $1,500. The individual will not become eligible for Medicaid again until the expenses have been incurred. This results in the individual consistently cycling on and off Medicaid, with eligibility starting at some point after the new budget period begins, causing a gap in coverage for the individual and additional administrative work for the State.

Separately, section 1902(f) of the Act and regulations at § 435.121 authorize States to apply criteria more restrictive than the SSI program criteria in determining eligibility under the mandatory eligibility group for individuals seeking Medicaid on the basis of being 65 years old or older or having blindness or disabilities, provided that they offer Medicaid to any such individual who would have been eligible under the State's 1972 Medicaid plan. (States electing this option are referred to as ''209(b) States,'' after the provision in the Social Security Amendments of 1972, Public Law 92–603, that enacted section 1902(f) of the Act). In determining whether any such individual is income-eligible, section 1902(f) of the Act and § 435.121(f)(1)(iii) also require that uncovered medical expenses incurred by the individual, the individual's family, or individual's financially responsible relatives, be deducted from countable income, and that a spenddown be calculated for individuals with income exceeding the income limit for the mandatory 209(b) State group in generally the same manner it is calculated for the medically needy.

In 1994, based on the authority granted to the Secretary under sections 1102 and 1902(a)(4) of the Act to create rules necessary for the efficient operation of the Medicaid program, and under section 1902(a)(17) of the Act to prescribe the extent to which costs of medical care may be deducted from income, we established, under § 435.831(g)(1), that States have the option to ''include medical institutional expenses (other than expenses in acute care facilities) projected to the end of the budget period at the Medicaid reimbursement rate'' in calculations [49] (59 FR 1659, January 12, 1994 referred to hereafter as the ''1994 rulemaking''). We further confirmed in the preamble to the 1994 rulemaking that 209(b) States are authorized to implement the authority established in the rule relating to the projection of medical institutional expenses.

''Projecting'' expenses means that a State includes in incurred medical expenses those costs that it anticipates an individual will incur during a budget period, which can make eligibility effective on the first day of an

[49] ''Medicaid Program; Deduction of Incurred Medical Expenses (Spenddown)'' Final Rule with Comment Period; *https://www.govinfo.gov/content/pkg/FR-1994-01-12/html/94-547.htm.*

individual's budget period, if the anticipated expenses equal or exceed the individual's spenddown. In promulgating the 1994 regulation, we reasoned that institutional services are, by their nature, constant and predictable, which supported a simplified approach for States to determine that an institutionalized individual will meet their spenddown amount each budget period. As required by regulations in § 435.831(i)(2), States must reconcile the projected amounts with the actual amounts incurred at the end of the budget period in order to confirm that the individual's incurred expenses were at least equal to the individual's spenddown.

For example, consider an individual in an institution on the first day of a month with a spenddown amount of $3,000 in a State in which the medically needy budget period is 1 month. The Medicaid rate for the facility is $4,500 ($150 daily), the private rate is $6,000 ($200 daily), and the State does not project institutional expenses. Until eligibility for Medicaid is established, the individual will be charged the private daily rate, which would mean that, in a month in which the individual does not receive any services not included in the daily rate, the individual will incur $3,000 in expenses as of the 15th of the month (3,000 ÷ 200 = 15), at which point the individual will be eligible for Medicaid, for the remainder of the month. If the individual does, however, receive any uncovered services beyond the basic services included in the daily rate, the individual would become eligible earlier in the month, although again only for the remainder of the month. The result is that the individual is consistently cycling on and off Medicaid, with an eligibility start date each budget period that is not predictable to either the institutionalized individual or State agency.

On the other hand, if the State elects to project the individual's institutional expenses under the authority of § 435.831(g)—that is, determine that the individual *will* incur the Medicaid rate of $4,500 for the month—the State can establish that the individual is eligible for Medicaid, and grant eligibility effective the first day of the month. No further eligibility-related determination is necessary. Projecting expenses can benefit both parties, by reducing administrative costs for the State and providing continuity of coverage for the beneficiary.

We explained that we considered use of the Medicaid reimbursement rate in the projection of expenses necessary to achieve the highest level of certainty that an individual will incur the liability that the regulation was permitting States to anticipate prior to the actual receipt of the services (see 59 FR 1661). For example, if a State projects the private rate for the services for an institutionalized individual, and the private rate for a particular month exceeds the individual's spenddown and the individual is consequently deemed Medicaid eligible on the first day of the month, the individual will not be charged the private rate for any of the services that month, but instead will be charged the Medicaid rate, as the provider would have to accept the Medicaid reimbursement rate for the Medicaid-covered services. If, however, the individual's spenddown amount exceeds the cost of the Medicaid rate, the individual possibly will not end up incurring in the month the expenses necessary to meet his or her spenddown. Therefore, to avoid possible erroneous grants of eligibility, we determined that the use of the Medicaid reimbursement rate in the projection of expenses was more appropriate.

The projection of expenses can have the effect of accelerating eligibility. However, only permitting projection of the cost of care for institutionalized individuals creates an inherent institutional bias. Further, we believe that there are noninstitutional services that may be similarly constant and predictable such that States could project them for individuals who must meet a spenddown to become income-eligible. Permitting projection of such noninstitutional services would reduce some of the complexity that both State agencies and individuals seeking coverage of home and community-based services (HCBS) currently experience and reduce institutional bias. Projecting noninstitutional expenses would reduce administrative costs associated with disenrolling and reenrolling individuals, as well as lead to better outcomes for individuals who would no longer cycle on and off Medicaid and experience disruptions to their continuity of care.

We propose to amend § 435.831(g) to permit States to project certain additional services that the State can determine with reasonable certainty will be constant and predictable. Similar to the explanation provided for institutional expenses in the preamble to the 1994 rule, the projection of expenses for noninstitutional services is limited to those that are reasonably certain to be received by the individual, since only the amounts for which the individual is ultimately liable can be used to reduce income. Like the reconciliation process required for projected institutional expenses, under the proposed revisions to § 435.831(g), States will have to reconcile actual noninstitutional services received with those projected at the end of budget periods to address erroneous grants of spenddown-related eligibility. Note that this proposal does not change the requirement that a State continue to apply any eligible expenses actually incurred by the individual in determining whether individuals have met the spend down amount, regardless of whether the expense was projected.

We propose to include in the regulatory language examples of specific types of expenses that we believe meet this standard, while providing additional flexibility for States to identify additional expenses that meet the criteria of being constant and predictable. Specifically, we propose to allow projection of medical or remedial expenses for the HCBS that are included in a plan of care (care plan) for an individual receiving a section 1915(i), 1915(j), or 1915(k) benefit or participating in a section 1915(c) HCBS waiver. We believe these medical and remedial expenses are generally constant and predictable because States are required to develop a care plan that identifies the services, and the frequency with which they will be received, for individuals eligible for section 1915(c), (i), (j), and (k) services, as set forth in section 1915(c)(1), (i)(1)(E) and (G), (j)(1), (5)(C), and (k)(1)(A)(i) of the Act, and §§ 441.301(b)(1)(i), 441.468(a)(1), 441.540(b)(5), 441.720, and 441.725. States could reasonably calculate, and deduct, the anticipated cost, based on the Medicaid reimbursement rate, of the services in an individual's care plan. We believe this proposal would also have the effect of eliminating the institutional bias that is fostered by the existing regulation's allowance for the projection of only institutional expenses.

The same may be true of individuals who have significant expenses related to high-cost drugs that treat a chronic condition. Pharmacies routinely keep a patient medication profile (''pharmacy profile'') for a patient, which could be used to determine which medications are for chronic conditions and which are for acute treatment. A State could, for example, use a pharmacy profile to review the 3-, 6-, or 12-month history of the prescriptions that an individual has been prescribed, and use that information to project expenses that are reasonably expected to be incurred in the current budget period.

We recognize that the projection of institutional expenses is often a straightforward calculation, as it involves only one provider, with a fixed and easily identifiable rate. By contrast, the feasibility of projecting expenses for individuals receiving section 1915(c) or (i) services or prescriptions for chronic conditions will depend on the individual's specific circumstances. For example, it is possible that a section 1915(c) participant will not receive a service that is part of their care plan during a month, or that the frequency with which the individual receives one of the services, or multiple services, in the care plan varies on a periodic basis. For such HCBS beneficiaries who need a spenddown to qualify, it may take time before a State develops a reasonable degree of certainty regarding the predictable costs the individual incurs each month. For HCBS beneficiaries whose use of services in their care plan varies greatly over the course of multiple budget periods, a State may be unable to reasonably predict the individual's service costs in a forthcoming budget period. Therefore, we propose to expressly permit States to project the expenses of section 1915(c), (j), (k) and (i) services and prescription drug services, as well as other expenses in calculating whether an individual meets their spenddown, where the State has determined that such services are constant and predictable.

For both the expenses for services expressly permitted under the examples in the proposed regulation text and for any other expenses for services that the agency has determined are reasonably constant and predictable, States would need to develop processes to evaluate the likelihood of an individual receiving the services in an upcoming budget period and the anticipated cost of the services. Discrepancies between a State's projections and the cost of services actually received inevitably will exist. Under proposed § 435.831(g)(2), States would be required to project expenses to the end of the budget period with reasonable certainty. Consistent with current regulations at § 435.831(i)(2), States would need to reconcile the projected amounts with the actual amounts incurred at the end of the budget period. Individuals who the State determines as a result of reconciliation did not actually meet their spenddown during the budget period may not have eligibility terminated retroactively. The State should use the findings made during reconciliation to prospectively determine whether the individual can be expected to incur reasonably constant and predictable expenses in the next budget period, and adjust the projection accordingly.

We invite comment to identify any other types of services that individuals may receive on a constant and predictable basis, and for which a State could project, with a degree of relative certainty, consistent costs for an individual over the course of a prospective budget period. Such services would be considered for inclusion in the regulatory text in the final rule as specific examples of services that a State can determine with reasonable certainty to be constant and predictable.

We propose to amend § 435.831 to replace the current text in paragraph (g)(2) with the proposed State option to project noninstitutional expenses. Current paragraphs (g)(2) and (3) in § 435.831 will be redesignated at paragraphs (g)(3) and (4). Note that the proposed changes to § 435.831(g) that would enable States to project reasonably certain noninstitutional expenses for medically needy individuals would also apply in projecting noninstitutional expenses in 209(b) States.

6. Application of Primacy of Electronic Verification and Reasonable Compatibility Standard for Resource Information (§§ 435.952 and 435.940)

All 50 States and the District of Columbia are required to implement an asset verification system (AVS) under section 1940 of the Act to verify certain financial resources for all individuals applying for or receiving Medicaid as an aged, blind, or disabled (ABD) individual. An AVS enables States to verify assets held in virtually any financial institution in the United States through an electronic data matching process, although not all information returned through an AVS occurs in real time; information from smaller financial institutions may take as long as 30 days or more to be returned to the Medicaid agency. In our work with States implementing the AVS requirement, many States have asked whether they are permitted to request additional documentation from applicants and beneficiaries related to resources that can be verified through the State's AVS, or if they can apply a reasonable compatibility standard for resources when resource information returned from an electronic data source is comparable to the information provided by the applicant or beneficiary.

The current regulation at § 435.952(b) provides that, if information provided by or on behalf of an individual is ''reasonably compatible'' with information obtained by the State in accordance with §§ 435.948, 435.949 or 435.956, that the State must determine or renew eligibility based on such information. Current § 435.952(c) provides that an individual must not be required to provide additional information or documentation unless information needed by the State in accordance with §§ 435.948, 435.949 or 435.956 cannot be obtained electronically or the information obtained electronically is not reasonably compatible with information provided by or on behalf of the individual. Section 435.952(c)(1) provides that States must consider income information obtained through an electronic data match to be reasonably compatible with attested income information if either both are above or both are at or below the applicable income standard or other relevant income threshold. Current § 435.952(c)(2) requires the agency to seek additional information, which may include documentation, if attested information is not reasonably compatible with information obtained through an electronic data match. However, documentation from the individual is permitted only to the extent electronic data are not available and establishing a data match would not be effective. In determining effectiveness, States must consider such factors as the administrative costs associated with establishing and using the data match compared with the administrative costs associated with relying on paper documentation, and the impact on program integrity in terms of the potential for ineligible individuals to be approved, as well as for eligible individuals to be denied coverage. We seek comment from States on potential implementation challenges, including any systems integration considerations or challenges, under this proposal which could impact the effectiveness and usefulness of such a data match.

The language of § 435.952 is written broadly to encompass all factors of eligibility, including income and resource criteria, when applicable. However, at the time § 435.952 was promulgated in the 2012 eligibility final rule, no State had implemented the AVS requirement and Federal requirements relating to verification of resources were not included in the regulations. Because § 435.952(b) and (c) apply specifically to information needed by the State to verify an individual's eligibility in accordance with §§ 435.948 (relating to income), 435.949 (relating to information received through the

Federal Data Services Hub), or 435.956 (relating to non-financial eligibility requirements), some have interpreted this requirement not to apply to verification of resources. This interpretation is not consistent with our intent. The language in § 435.952 is not specific to income. Indeed, the reasonable compatibility policies described in § 435.952(b) and (c) also apply to verification of non-financial eligibility criteria, for example, State residency which can also be verified electronically (for example, through a data match with the State's department of motor vehicles). Applying §§ 435.952(b) and (c) to resources will help streamline enrollment for individuals applying for Medicaid on a non-MAGI basis, such as on the basis of age, blindness, or disability, and decrease burden for both States and beneficiaries. If attested resource information is found to be reasonably compatible with the resource information returned from the AVS, then these resources are considered verified and no further actions from the State or from the beneficiary are needed. Therefore, we propose to revise paragraphs (b) and (c) of § 435.952 to clarify that these provisions apply also to verification of resources. Specifically, we propose to make clear that paragraphs (b) and (c) apply to any information obtained by the State—not just information obtained in accordance with § 435.948, 435.949 or 435.956. We also propose to insert the words ''and resource'' after ''income'' in paragraph (c)(1) and to delete the word ''income'' where it appears before ''standard'' and ''threshold'' to require that States consider resource information obtained through an electronic data match to be reasonably compatible with attested resource information if both are either above or at or below the applicable standard or other relevant threshold.

This proposal is intended to clarify that States are not permitted to request additional resource information from the beneficiary to determine eligibility if the resource information provided by an individual is reasonably compatible with the information received from an electronic data source, such as the AVS. If information provided by an individual is not reasonably compatible with the information received from the electronic data source, States must resolve any discrepancies per § 435.952(c)(2), which is not revised in this rulemaking.

Under the proposed regulations, resource information obtained from an electronic data source, such as an AVS, must be considered reasonably compatible with resource information provided by the applicant or beneficiary if both are either above or at or below the applicable resource standard or other applicable resource threshold. Further, while not required, States could establish a reasonable compatibility threshold, such that electronic data would be considered reasonably compatible with attested resources if the electronic data is no higher than attested resources plus the State's elected threshold amount (expressed as either a percentage or dollar amount). Some States, for example, apply a reasonable compatibility threshold of 5 or 10 percent of attested income in verifying income eligibility. States would not be required to establish the same reasonable compatibility threshold for income and resources, and may apply different reasonable compatibility thresholds for different eligibility groups, provided that the State has a reasonable rationale for doing so.

We also propose a corresponding technical change to amend § 435.940 to add section 1940 of the Act as a basis for the income and eligibility verification requirements. The proposed changes to § 435.952 in this rulemaking include resource information obtained from electronic data sources, such as an asset verification program described under section 1940 of the Act.

7. Verification of Citizenship and Identity (§ 435.407)

In 2016, we revised the Medicaid and CHIP regulations governing the verification of citizenship and identity to require States to rely primarily on electronic verification to effectuate the streamlined and coordinated approach required by the ACA to reduce burden on individuals and increase administrative efficiency. These regulatory changes were issued by CMS in a November 2016 final rule titled, ''Medicaid and Children's Health Insurance Programs: Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Other Provisions Related to Eligibility and Enrollment for Medicaid and CHIP'' (81 FR 86453, November 30, 2016) (referred to hereafter as the ''2016 eligibility and enrollment final rule''). Under the regulations, all States must first attempt to verify citizenship electronically using data from the SSA, and most States rely on a match through the Federal Data Services Hub (FDSH) for this data. In that final rule, we also streamlined and simplified the list of documents and other acceptable means of verification that can be used when citizenship cannot be verified electronically with SSA. One such alternative source of citizenship verifications, codified at § 435.407(b), is a data match with the State's (or another State's) vital statistics system. We explained in the preamble to the 2016 eligibility and enrollment final rule that if citizenship verification cannot be completed through an electronic data match with SSA, the State must attempt to verify citizenship through an electronic data match with the State's (or another State's) vital statistics system, before requesting paper documentation from the individual, if such match is available within the meaning at § 435.952(c)(2)(ii).

Under current regulation, individuals whose citizenship is verified based on any of the sources identified in § 435.407(b)—which includes, under the current regulations, a match with a State's vital statistics records or with the U.S. Department of Homeland Security (DHS) Systematic Alien Verification for Entitlements (SAVE) Program—must also provide proof of identity. The documentary evidence identified in section 1903(x)(3)(B) of the Act, codified through the 2016 eligibility and enrollment final rule at § 435.407(a), in contrast, provides ''stand-alone'' proof of citizenship; separate proof of identity is not required. Section 1903(x)(3)(B)(vi) of the Act authorizes the Secretary to specify that other documents in addition to those specified in the statute, must be accepted as stand-alone satisfactory documentation of citizenship if they determine that such documents provide both proof of United States citizenship or nationality, as well as reliable documentation of personal identity. As explained below, verification with a State's vital statistics records or SAVE, like the data match with SSA, which provides both proof of U.S. citizenship or nationality and reliable documentation of personal identity, meets this standard.

In this rule, we are proposing to further simplify the verification procedures by moving verification of citizenship with a State vital statistics agency or SAVE from paragraph (b) to paragraph (a) of § 435.407 for Medicaid, which is incorporated into CHIP regulations through existing cross-references at §§ 457.380(b)(1)(i) and 435.956(a). This change would mean that verification of birth with a State vital statistics agency or verification of citizenship with SAVE would be considered stand-alone evidence of citizenship; separate verification of identity would not be required, similar to the treatment afforded to verification of citizenship with SSA. This proposed change would reduce burden on

individuals and State Medicaid agencies and increase administrative efficiency.

Turning first to citizens whose status can be verified with DHS' SAVE Program, SAVE can provide electronic verification of U.S. citizenship for individuals who have a DHS record of naturalized or derived citizenship, usually documented with a Certificate of Naturalization or Certificate of Citizenship. Any SAVE program requestor (for example, the Medicaid or CHIP agency or other benefit granting or licensing agency) that requests verification of U.S. citizenship or immigration status through the SAVE program must provide the SAVE program with the individual's biographic information (first name, last name, and date of birth) and a personalized numeric identifier (such as an Alien Number; Form I–94, Arrival/Departure Record Number; Student and Exchange Visitor Information System (SEVIS) ID number; or unexpired foreign passport number) unique to that individual. DHS verifies identity prior to providing a SAVE program response verifying citizenship or immigration status, reviewing multiple records and in some cases requiring additional information from the requestor. If an individual's immigration status is confirmed by SAVE, the State's verification of immigration status is complete under current regulations, whereas separate proof of identity is required if SAVE confirms the individual's citizenship. Because the process followed by SAVE is identical, we do not believe that the extra step required for citizens is justified. Therefore, we propose revisions to § 435.407 to provide for comparable processes for individuals whose status is verified by SAVE, regardless of whether they are a citizen or non-citizen. Specifically, we propose to remove verification of citizenship with SAVE currently at § 435.407(b)(11) (which requires separate proof of identify) and to add such verification at proposed § 435.407(a)(8) (which would not require separate proof of identity) for Medicaid, which is incorporated into CHIP regulations through existing cross-references at §§ 457.380(b)(1)(i) and 435.956(a).

Verification of U.S. citizenship with a State vital statistics agency provides a similarly robust data matching process because a State Medicaid or CHIP agency must provide the State vital statistics agency with a minimum set of identifiable information including the name, date of birth, and Social Security Number (SSN). Some States also use additional identifiers if they are available, such as the individual's birth county, the parents' names or the mother's maiden name. Based on State feedback, CMS understands that the process and data fields used to verify citizenship with a State vital statistics agency are similar across States. Conducting a data match with specific identifiers like date of birth and SSN is the same process that could be used to provide evidence of identity, thereby making a requirement to separately verify identity redundant. Therefore, we propose revisions to § 435.407 under which verification of citizenship with a State vital statistics agency would serve as stand-alone proof of U.S. citizenship and no separate proof of identify would be required. Specifically, we propose to remove verification of citizenship with a State vital statistic's agency currently at § 435.407(b)(2) (which requires separate proof of identify) and to add such verification at proposed § 435.407(a)(7) (which would not require separate proof of identity) for Medicaid, which is incorporated into CHIP regulations through an existing cross-references at §§ 457.380(b)(1)(i) and 435.956(a). However, we recognize that different State Medicaid and CHIP agencies and vital statistics agencies may employ different processes and seek comment on what processes Medicaid and CHIP agencies use to verify citizenship with a State vital statistics agency, including what information and identifiers are used to complete verification, whether the data matching process with all State vital statistics agencies is sufficiently robust to appropriately apply this proposed change in policy to verification of citizenship in all States, or limit this change in policy only to States in which the vital statistic agency's processes are comparable to those of the SAVE program.

We note that, if citizenship cannot be verified through an electronic match with SSA, States are required to verify citizenship using an electronic match prior to requesting other forms of documentation, if such match is available and effective in accordance with § 435.952(c)(2)(ii). Inasmuch as State vital statistics agencies generally can provide electronic data matching, we are also proposing to delete the words ''at State option,'' which are included in existing § 435.407(b)(2), from proposed § 435.407(a)(7) for Medicaid, which is incorporated into CHIP regulations through an existing cross-reference at § 457.380(b)(1)(i) to § 435.956(a). Use of such match with a vital statistics agency is not voluntary if it is available and effective in accordance with § 435.952(c)(2)(ii). This proposed revision does not necessarily require a State to develop a match with its vital statistics agency. However, States that do not currently perform such electronic matches must develop that capacity if such match is available and would be effective in accordance with the standard set forth in § 435.952(c)(2)(ii). If a State already has established a match with a State vital statistics agency or it would be effective to establish such capability in accordance with the standard set forth in § 435.952(c)(2)(ii), the State must utilize such match before requesting paper documentation.

B. Promoting Enrollment and Retention of Eligible Individuals

1. Aligning Non-MAGI Enrollment and Renewal Requirements With MAGI Policies (§§ 435.907 and 435.916)

The 2012 and 2013 eligibility final rules established a number of eligibility and enrollment simplifications for MAGI-based Medicaid and CHIP beneficiaries. Among these were streamlined processes that made it easier for eligible individuals to apply and remain enrolled in Medicaid and CHIP. However, beneficiary advocates raised concerns that these simplifications have not been afforded to Medicaid beneficiaries excepted from use of MAGI-based methodologies, which is particularly problematic given that individuals over age 65 and those who are eligible based on blindness or a disability are likely to have more stable eligibility. Therefore, in this proposed rule, we propose changes to both the application and renewal requirements for MAGI-excepted applicants and beneficiaries to align with the requirements for populations based on MAGI.

Beginning with the application process, individuals must be permitted to submit the single streamlined application developed by the Secretary, or an alternative single streamlined application described at § 435.907(a)(2) of the current regulations, through all modalities specified at § 435.907(a) (online, by telephone, by mail, or in person). Although not expressly stated in the regulations, States also are expected to accept applications and supplemental forms needed for individuals to apply for coverage on a non-MAGI basis via all modalities identified in § 435.907(a). In addition, § 435.907(d) prohibits States from requiring an in-person interview as part of the application process, when determining eligibility based on MAGI, whereas States are still permitted to

require an in-person interview for MAGI-excepted applicants.

At renewal, current § 435.916(a) requires States to conduct renewals of Medicaid eligibility on an annual basis for individuals whose financial eligibility is determined using MAGI-based methodologies. However, for individuals excepted from use of the MAGI-based methodologies, § 435.916(b) of the current regulations permits States to conduct regularly-scheduled renewals more frequently (for example, every 6 months). States must renew eligibility for all Medicaid beneficiaries without requiring information from the individual if able to do so consistent with regulations at §§ 435.916(a)(2) and (b). However, when a beneficiary's eligibility cannot be renewed based on available information, States must follow a set of streamlined procedures for MAGI-based beneficiaries, which are not required for those excepted from MAGI. The procedures for requesting information from MAGI-based beneficiaries are described at § 435.916(a)(3) of the current regulations and include: (1) using a pre-populated renewal form; (2) providing the individual a minimum of 30 calendar days to sign and return the form along with any requested information; and (3) reconsidering eligibility for an individual terminated for failure to return the renewal form or other needed information if the form or other information is returned within 90 calendar days after the date of termination. The procedures for requesting information from MAGI-based beneficiaries are described at § 435.916(a)(3) of the current regulations and include: (1) using a pre-populated renewal form; (2) providing the individual a minimum of 30 calendar days to sign and return the form along with any requested information; and (3) reconsidering eligibility for an individual terminated for failure to return the renewal form or other needed information if the form or other information is returned within 90 calendar days after the date of termination. In addition, States may not require a MAGI beneficiary to complete an in-person interview as part of the renewal process under § 435.916(a)(3)(iv) of the current regulations. States may, but are not required to, adopt the procedures at § 435.916(a)(3) for individuals whose eligibility is determined on a basis other than MAGI, per § 435.916(b) of the current regulations.

While almost all States adopt at least one of the optional processes for renewals of non-MAGI beneficiaries,[50] the differences in renewal requirements for MAGI and non-MAGI beneficiaries result in a less streamlined and more burdensome process for beneficiaries who qualify for Medicaid on a non-MAGI basis, such as being age 65 or older or having blindness or a disability. As a result of these differences, individuals who are Medicaid eligible on one of these bases may be required to spend more time completing renewal paperwork if their renewal form is not prepopulated. They may be provided less time to return their renewal form and requested information, even if the individual must provide information related to additional factors of eligibility associated with non-MAGI eligibility groups as compared to MAGI eligibility groups, such as asset information.

CMS finds this to be problematic for several reasons. First, individuals who are Medicaid eligible based on being age 65 or older or having blindness or a disability are more likely to live on a fixed income and, therefore, are more likely to remain financially eligible for coverage than the non-disabled beneficiaries under age 65 who qualify for Medicaid based on MAGI.[51] We are concerned that, despite the generally greater stability of their income, and therefore, eligibility, a larger proportion of non-MAGI beneficiaries who lose coverage do so for procedural reasons. Indeed, as noted in section II.A.1. of this proposed rule, dually eligible for Medicaid and Medicare who lose Medicaid coverage within the first year of enrollment likely lose such coverage for reasons that are administrative in nature.[52] Also, individuals who are Medicaid eligible based on being age 65 or older or having blindness or disability status may experience additional barriers related to document retention, communication (for example, limited English proficiency and low health literacy), technology (for example, printing costs, access to a computer or internet) and limited access to transportation, among others. Processes that provide greater flexibility, such as reduced documentation requests and more time for returning information, can reduce these barriers.[53] [54] As a result, we believe that when States do not use available streamlined renewal procedures for this population, there is a greater risk of terminations for procedural reasons.

Using the authority provided in sections 1902(a)(4)(A) and (a)(19) of the Act to ensure the proper and efficient administration of the program and that eligibility is determined in a manner consistent with simplicity of administration and best interests of beneficiaries, we propose to revise current renewal regulations at § 435.916 to require States to apply the same renewal procedures for MAGI and non-MAGI beneficiaries. Specifically, we propose, by removing the reference in § 435.916(a)(1) to MAGI beneficiaries, to require that States conduct regularly-scheduled renewals of eligibility once, and only once, every 12 months for all Medicaid beneficiaries, including non-MAGI beneficiaries with limited exception, discussed below. We believe aligning the frequency of renewals for non-MAGI beneficiaries with the current requirement for MAGI beneficiaries is appropriate given that circumstances related to eligibility are generally more stable for non-MAGI beneficiaries and will reduce beneficiary burden, consistent with sections 1902(a)(4) and (a)(19) of the Act. In addition, we believe this proposal promotes equity across enrolled populations since non-MAGI beneficiaries, whose income tends to be more stable, would no longer be subject to more frequent requests to return renewal forms or provide documentation to verify continued eligibility than other beneficiaries. We also note that over 40 States currently conduct renewals only once every 12 months for all Medicaid beneficiaries.

[50] Kaiser Family Foundation (2019). Medicaid financial eligibility for seniors and people with disabilities: Findings from a 50-State survey, p. 19–20. *https://www.kff.org/report-section/medicaid-financial-eligibility-for-seniors-and-people-with-disabilities-findings-from-a-50-state-survey-issue-brief/*.

[51] Ku, L. & Steinmetz, E. (2013). Bridging the Gap: Continuity and Quality of Coverage in Medicaid. *https://ccf.georgetown.edu/wp-content/uploads/2013/09/GW-Continuity-Report-9-10-13.pdf*; Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services (2021). Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID–19 Pandemic. *https://aspe.hhs.gov/sites/default/files/private/pdf/265366/medicaid-churning-ib.pdf*.

[52] Assistant Secretary for Planning and Evaluation (2019). Loss of Medicare-Medicaid dual eligible status: Frequency, contributing factors and implications. *https://aspe.hhs.gov/system/files/pdf/261716/DualLoss.pdf*. CMS also recently completed an updated internal analysis of ASPE's study using data from 2015–2018 that shows that dually eligible individuals continue to lose Medicaid at a high rate in their first year due to administrative reasons.

[53] CMS Office of Burden Reduction & Health Informatics (April 2022). Navigating the Medicare Savings Program (MSP) Eligibility Experience. *https://www.cms.gov/files/document/navigating-medicare-savings-program-msp-eligibility-experience-journey-map.pdf*.

[54] CMS Office of Burden Reduction & Health Informatics (April 2022). Navigating the Medicare Savings Program (MSP) Eligibility Experience. *https://www.cms.gov/files/document/navigating-medicare-savings-program-msp-eligibility-experience-journey-map.pdf*.

We seek comment on this proposal at § 435.916(a)(1) to align the frequency of renewals for all beneficiaries, except as noted below. We are particularly interested in comments from State agencies on the administrative impact of conducting eligibility only once every 12 months for non-MAGI beneficiaries and whether or not State agencies that currently conduct renewals only once every 12 months for all Medicaid beneficiaries have experienced more stable coverage among non-MAGI beneficiaries or any program integrity concerns after shifting from a shorter renewal cycle to a 12-month renewal cycle. We are also interested in data regarding coverage losses among non-MAGI beneficiaries due to procedural reasons, such as failure to return renewal paperwork timely, versus changes to specific factors of eligibility, such as income or disability status. We are also interested in hearing from stakeholders and beneficiaries on the impact of more frequent renewals on maintaining coverage.

Section 1902(e)(8) of the Act provides an option for States to renew eligibility for QMBs described in section 1905(p)(1) of the Act more frequently than once every 12 months, but no more frequently than once every 6 months. Thus, we cannot, propose to limit renewals for QMBs to once every 12 months, and proposed § 435.916(a)(2) continues to allow States to conduct more frequent renewals of Medicaid eligibility for QMBs consistent with section 1902(e)(8) of the Act. However, States are permitted under current regulations at § 435.916(b) to conduct renewals once every 12 months for QMBs and would remain able to do so under proposed § 435.916(a)(2). We encourage States to exercise their flexibility to schedule renewals only once every 12 months for QMBs to mitigate churn and ease administrative burden on beneficiaries and States that is associated with more frequent renewals of eligibility.

Proposed § 435.916(b)(3) also requires States to adopt the renewal processes at § 435.916(a)(3) of the regulations, as revised at redesignated § 435.916(b)(2), for non-MAGI beneficiaries when a State is unable to renew eligibility for an individual based on information available to the agency. Proposed § 435.916(b)(2) and (3) would require States to provide all beneficiaries, including non-MAGI beneficiaries, whose eligibility cannot be renewed in accordance with proposed § 435.916(b)(1): (1) a renewal form that is pre-populated with information available to the agency; (2) a minimum of 30 calendar days to return the signed renewal form along with any required information; and (3) a 90-day reconsideration period for individuals terminated for failure to return their renewal form but who subsequently return their form within the reconsideration period. We believe aligning these renewal procedures would promote continuity of coverage and simplify the renewal process for non-MAGI beneficiaries in a manner that is in the best interest of beneficiaries, consistent with section 1902(a)(19) of the Act, including those in households with individuals enrolled on both a MAGI and non-MAGI basis who otherwise may be subject to more burdensome administrative requirements at renewal. In addition, we believe States will also experience reduced administrative burden associated with churn if individuals face fewer administrative barriers to maintaining coverage.

We also propose to eliminate the option States have under current regulations at §§ 435.907(d) and 435.916(b) to require an in-person interview as part of the application and renewal process for non-MAGI beneficiaries. Stakeholder feedback on the beneficiary experience navigating State application and renewal processes indicate that it can be challenging for individuals who are Medicaid eligible based on being age 65 or older or having blindness or a disability status to coordinate, prepare for, and participate in an interview and missing and/or having to reschedule an interview, particularly when the process is not flexible for the individual, can result in determinations of ineligibility and/or terminations based on procedural reasons.[55] We believe in-person interview requirements create a barrier for eligible individuals to obtain and maintain coverage without yielding any additional information than can be obtained through other modalities, particularly for individuals without access to reliable transportation or a consistent schedule.

In addition to eliminating the option to require an in-person interview, we propose to codify longstanding policy to align enrollment requirements in the best interest of all applicants. Proposed § 435.907(c)(4) codifies longstanding policy that States accept all MAGI-exempt applications and supplemental forms provided by applicants seeking coverage on a non-MAGI basis, through all the modalities listed in current regulations at § 435.907(a). Eliminating the in-person interview requirement and codifying the requirements for accepting MAGI-exempt applications and supplemental forms through all modalities would further align eligibility and enrollment procedures for MAGI and non-MAGI applicants and beneficiaries and reduce applicant and beneficiary burden, consistent with sections 1902(a)(4) and (a)(19) of the Act.

We propose removing the introductory language at the current § 435.916(b) related to the frequency of and process for renewals of eligibility for non-MAGI beneficiaries. We propose redesignating current regulations at § 435.916(b)(1) and (2) (related to the agency's option to consider blindness and disability as continuing at renewal) at proposed § 435.916(b)(3)(i) and (ii).

In addition to the policy changes proposed to align application and renewal processes for MAGI and non-MAGI populations whenever possible, we propose several additional changes to current § 435.916 to ensure that the renewal requirements are clear and consistent. We propose to redesignate current regulations at § 435.916(a)(2) (related to renewals based on information available to the agency) and § 435.916(a)(3) (related to renewals that require information from beneficiaries) to § 435.916(b)(1) and (b)(2), respectively. States will continue to be required to attempt to renew eligibility for all Medicaid beneficiaries (MAGI and non-MAGI) based on available information before requesting information from the individual, as required at current § 435.916(a)(2) and (b), and to send a renewal form to, and request information from, beneficiaries for whom the State does not have sufficient information to redetermine eligibility, and accept the renewal form through all modalities required at application at § 435.907(a). (online, by telephone, by mail, or in person). We propose to modify the header in proposed § 435.916(b)(2) from ''use of a pre-populated renewal form'' to ''renewals requiring information from the individual'' since the current regulations describe the steps States must take when conducting renewals that require information from the individual, which includes, but is not limited to, the use of pre-populated renewal forms.

At § 435.916, we also propose to revise current paragraph (a)(3)(i)(B), redesignated at proposed paragraph (b)(2)(i)(B), to clarify that the 30 calendar days that States must provide beneficiaries to return their pre-

[55] CMS Office of Burden Reduction & Health Informatics (April 2022). Navigating the Medicare Savings Program (MSP) Eligibility Experience. *https://www.cms.gov/files/document/navigating-medicare-savings-program-msp-eligibility-experience-journey-map.pdf.*

populated renewal form begins on the date the State sends the form. This would mean that beneficiaries have 30 calendar days from the date a form is postmarked or, for beneficiaries who elected to receive electronic notices, the date the electronic is sent. We believe starting the 30-day period from the date the State sends the form, instead of the date on the form, will ensure beneficiaries do not lose time to respond if the form is postmarked or sent after it is dated.

We propose clarifying revisions to current § 435.916(a)(3)(i)(B) (related to renewal form signatures), redesignated at proposed § 435.916(b)(2)(i)(B), by including a technical change to explicitly state that beneficiaries must sign their pre-populated renewal form under penalty of perjury; current regulations at § 435.916(a)(3)(i)(B) includes this requirement only by cross reference to § 435.907(f).

We propose to revise current § 435.916(a)(3)(iii) (related to timely processing of renewal forms and information returned during the reconsideration period), redesignated at proposed § 435.916(b)(2)(iii), to specify explicitly in regulation our current policy that the returned renewal form and information received during the reconsideration period serve as an application and require, via cross reference to § 435.912(c)(3) of the current regulation, that States determine eligibility within the same timeliness standards applicable to processing applications, that is, 90 calendar days for renewals based on disability status and 45 calendar days for all other renewals. Treatment of renewal forms returned during the 90-day reconsideration period as an application means that the availability of retroactive eligibility at § 435.915 can close the gap in coverage that such beneficiaries otherwise would experience. Adherence to the timeliness standards applicable to applications will ensure eligible individuals are furnished coverage with reasonable promptness, consistent with sections 1902(a)(4) and 1902(a)(8) of the Act and will minimize the likelihood that individuals will forgo needed care. As revised, proposed § 435.916(a)(3)(iii) is also consistent with guidance described in the December 4, 2020, CMCS Informational Bulletin ''Medicaid and Children's Health Insurance Program (CHIP) Renewal Requirements'' (2020 Renewal CIB) that a renewal form returned within the reconsideration period serves as an application for the purposes of adherence to timeliness standards to make determinations of eligibility.[56] [57]

We propose to redesignate and revise current regulations at § 435.916(c) and (d), related to redeterminations based on changes in circumstances, at the new proposed § 435.919. Proposed revisions to these regulations are discussed in section II.B.2. of this proposed rule.

With the redesignation of current § 435.916(c) and (d) to proposed § 435.919, we also propose to redesignate current § 435.916(e) (related to requesting only information from beneficiaries needed to renew eligibility) at proposed § 435.916(b)(2)(v). We propose to redesignate current § 435.916(f) (related to determining eligibility on all bases and transmission of data pertaining to individuals no longer eligible for Medicaid) and § 435.916(g) (relating to accessibility of renewal forms and notices) to proposed § 435.916(d) and (e), respectively. Additionally, we modify current § 435.916(f)(2), redesignated at § 435.916(d)(2) in this proposed rule, to ensure that, prior to terminating coverage for an individual determined ineligible for Medicaid, States determine eligibility for CHIP and potential eligibility for other insurance affordability programs (that is, BHP and insurance affordability programs available through the Exchanges) and transfer the individual's account in compliance with the procedures set forth in § 435.1200(e), including proposed changes described in section II.B.5. of this proposed rule. We believe requiring that these actions be completed prior to termination is necessary to limit gaps in coverage for individuals transitioning between Medicaid and other insurance affordability programs, consistent with sections 1902(a)(4) and 1902(a)(19) of the Act. We add a paragraph heading at proposed § 435.916(e) to format the provision consistent with other provisions in § 435.916.

Finally, as discussed in section II.B.3. of this proposed rule, we propose to establish time standards for States to complete renewals of eligibility in proposed § 435.912(c)(4) and add a cross reference to these proposed time standards in proposed § 435.916(c).

2. Acting on Changes in Circumstances Timeframes and Protections (§§ 435.916, 435.919, and 457.344)

Section 1902(a)(10) of the Act authorizes States to make medical assistance available under the State plan to individuals who meet certain eligibility criteria. Once an applicant has been determined eligible for coverage, Federal regulations include two basic requirements to ensure that individuals receiving medical assistance continue to be eligible. First, as described in section II.B.1. of this proposed rule, States are required to conduct regular renewals of eligibility per § 435.916(a) and (b) of the current regulations. Second, per § 435.916(c) and (d) of the current regulations, States must have a process to obtain information about changes in circumstances that may impact a beneficiary's eligibility and redetermine eligibility in between regular renewals when appropriate.

Current regulations at § 435.916(c) require that States have procedures designed to ensure that beneficiaries make timely and accurate reports of any changes in circumstances that may affect their eligibility and that such changes may be reported through any of the modes for submission of applications described in § 435.907(a). Current regulations at § 435.916(d) specify that the agency must promptly redetermine eligibility between regular renewals of eligibility whenever it receives information about a change in beneficiary circumstances that may affect eligibility, such as a change in income or the death of a beneficiary. The regulation does not define ''promptly.''

We are concerned that a number of States are not taking appropriate steps to follow up on reported or detected changes in beneficiaries' circumstances within a reasonable period of time or in a manner that promotes continuity of coverage for eligible beneficiaries. There is a potential risk to beneficiaries if a State delays processing a change in circumstances that may entitle a beneficiary to additional assistance or lower premiums or cost-sharing, as well as risk that beneficiaries may lose coverage for procedural reasons if States do follow up with a beneficiary to request additional information but do not provide sufficient time for the beneficiary to respond. Moreover, recent U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) reports, as well as CMS audits and data analyses have cited cases in which States continued to provide coverage for many months after a change impacting eligibility was identified that should have prompted a redetermination based on a change in circumstances and other instances in which States continued to make

[57] CMCS Informational Bulletin: Medicaid and Children's Health Insurance Program (CHIP) Renewal Requirements (2020). Available at *https://www.medicaid.gov/federal-policy-guidance/downloads/cib120420.pdf.*

capitated payments to managed care plans for deceased beneficiaries.[58]

Consistent with section 1902(a)(4) of the Act, to promote the proper and efficient administration of the Medicaid program, we propose to add a new § 435.919 to clearly define the responsibilities States have to act on changes in circumstances. We propose to revise and redesignate § 435.916(c) of the current regulations (related to procedures for reporting changes) to new § 435.919(a). We propose to revise and redesignate current § 435.916(d) (related to promptly acting on changes in circumstances) to proposed § 435.919(b) and (c).

Proposed § 435.919(a)(1) would specify that States must have procedures for beneficiaries to make timely and accurate reports of changes in circumstances that may affect eligibility. Proposed § 435.919(a)(2) specifies that States must accept both reported changes in circumstances that may affect eligibility and any other beneficiary reported information through the same modes for submission of application at § 435.907(a). We believe this is an important update that would ensure that beneficiaries can easily report information that supports continued enrollment in Medicaid, such as updating contact information or reporting an in-state address change, even if the information would not constitute a change in circumstances that affects eligibility.

Proposed § 435.919(b)(1) describes the steps that we believe States should be required to take in processing changes in circumstances reported by a beneficiary in between renewals of eligibility. Under the proposed regulation, States must first evaluate whether the reported change may result in ineligibility for Medicaid or a change in the amount of medical assistance for which the beneficiary is eligible (for example, a change in benefits or higher or lower premiums or cost sharing charges). If additional information is needed to determine whether the beneficiary remains eligible, the agency must redetermine eligibility based on available information, if able to do so, and if the additional information is not available to the agency, request such information from the beneficiary. When the agency requests information from the beneficiary to determine whether a change in circumstances results in coverage that is more beneficial to the individual (for example, additional benefits or lower premiums or cost sharing charges), the agency may not take adverse action if the beneficiary does not respond. In this situation, the agency would not provide the more beneficial coverage but would instead continue to provide the less beneficial coverage for which eligibility was already established. The agency must send the beneficiary written notice of this decision consistent with 42 CFR 435.917(b)(1), which must include information on the beneficiary's right to appeal their eligibility status or level of benefits and services approved.

If the reported change adversely impacts the beneficiary's eligibility for Medicaid such that termination may be necessary, the State must consider whether the beneficiary may remain eligible on any other basis, as currently required under current regulations at § 435.916(f)(1), which is redesignated at § 435.916(d)(1) in this proposed rule. If the beneficiary is determined to be ineligible for Medicaid on any basis, proposed § 435.919(b)(1), cross-referencing to proposed § 435.919(b)(4), provides that the State must provide advance notice of termination and fair hearing rights, consistent with 42 CFR part 431, subpart E of the regulations. Prior to making a determination of ineligibility, the State also must determine potential eligibility for other insurance affordability programs and transfer the individual's account, as appropriate, consistent with existing regulations at § 435.916(f)(2), redesignated at proposed § 435.916(d)(2). If the agency finds that the reported change results in other adverse action, such as higher premiums or cost sharing charges or a reduced benefit package, the State must provide advance notice of the adverse action and fair hearing rights, consistent with the requirements of 42 CFR part 431, subpart E. We note that, in accordance with 42 CFR 431.230, if the beneficiary requests a fair hearing prior to the date of action provided in the advance notice (for example, the date the individual's eligibility will be terminated), the State may not implement the adverse action until a fair hearing decision is rendered.

If a beneficiary-reported change may result in an increase in the amount of assistance a beneficiary is entitled to, for example, a reduction in premiums or cost sharing, or additional benefit, the State must verify the reported information in accordance with §§ 435.940 through 435.960 and the State's verification plan prior to granting additional coverage or assistance. Such verification may include electronic data or other information available to the agency, attested information, or documentation from the beneficiary. States may not terminate the beneficiary's coverage or take other adverse action if the individual does not respond to requests for additional information to verify the beneficiary-reported change. If the reported change has no impact on eligibility or coverage, consistent with section 1902(a)(4) and (a)(19) of the Act, we propose at § 435.919(b)(1)(iv) that the agency must acknowledge the reported change by providing the beneficiary with notice acknowledging receipt of the information and explaining that there is no impact on eligibility or coverage.

The process we are proposing for States to act on information obtained from a third party, such as information obtained through an electronic data match or from another program such as the Supplemental Nutrition Assistance Program (SNAP), is described at proposed § 435.919(b)(2). This process largely mirrors that described in proposed § 435.919(b)(1), discussed above. Under proposed § 435.919(b)(2), the agency will need to evaluate the reliability of the information obtained and, if reliable information from a third party may result in an adverse action, the State must give the beneficiary an opportunity to provide information disputing the accuracy of the third-party information in accordance with § 435.952(d). If the beneficiary does not respond with the requested information or the information provided does not establish the beneficiary's continued eligibility or entitlement to the same level of assistance, the State must: (1) provide advance notice of termination or other adverse action and fair hearing rights consistent with part 431, subpart E; and (2) before terminating the beneficiary's coverage, assess eligibility for other insurance affordability programs in accordance with proposed revisions to current § 435.916(f)(2), redesignated at § 435.916(d)(2) in this rulemaking, and transfer the individual's account, as appropriate.

If a change identified by reliable third-party data may result in an increase in the amount of coverage or assistance a beneficiary is entitled to (for example, additional benefits or lower premiums or cost sharing), States retain flexibility under the proposed rule either to act on the third-party information without additional follow up or to contact the beneficiary to determine whether the information received is accurate. However, States that choose to contact the beneficiary to verify the accuracy of information prior

[58] *https://www.lla.la.gov/PublicReports.nsf/1CDD30D9C828608286258340065E5F6/$FILE/0001ABC3.pdf* and *https://oig.hhs.gov/oas/reports/region7/71604228.pdf*; *https://oig.hhs.gov/oas/reports/region5/51800026.pdf*; *https://oig.hhs.gov/oas/reports/region4/41806220.pdf*; and *https://oig.hhs.gov/oas/reports/region5/51700008.pdf.*

to furnishing additional assistance may not terminate the beneficiary's coverage or take other adverse action if the individual does not respond to the request for information. Additionally, if States choose to contact the beneficiary and the beneficiary does not respond to the request for information, the State may act on the third-party information. If third-party information is not reliable (for example, information is older than other information available to or obtained by the State or is incomplete) or does not impact the beneficiary's eligibility, there is no requirement for the agency to take further action or to provide notice to the beneficiary. Additionally, States may not take adverse action based on unreliable information.

At § 435.919(c)(1), we propose that States provide a minimum of 30 calendar days from the date a request for information is sent, which is the date the request is postmarked or the date the notice is sent electronically if the beneficiary elected to receive electronic notices, for a beneficiary to obtain and submit information needed in order for the State to redetermine eligibility based on a change in circumstances. We believe specifying a minimum timeframe will ensure all States provide beneficiaries a reasonable time to respond to requests for information to demonstrate ongoing eligibility and mitigate churn that would otherwise occur when beneficiaries do not have sufficient time to respond to such requests. We believe the 30-day timeframe also provides beneficiaries consistency across program requirements as this aligns with the minimum timeframe MAGI beneficiaries are provided to return their renewal form in the current regulations § 435.916(a)(3)(i)(B) and proposed timeline for all beneficiaries to return their renewal form at § 435.916(a)(2)(i)(B) of this proposed rule. As discussed in section II.B.3. of this proposed rule, we propose to establish time standards for States to promptly act on changes in circumstances and standards for acting on anticipated changes in circumstances in proposed § 435.912(c)(5) and (6), and we cross reference to these proposed time standards in proposed § 435.919(c)(2).

At § 435.919(d), we propose that States provide beneficiaries whose coverage was terminated due to failure to provide information requested in accordance with proposed § 435.919(b)(1)(i) and (ii) with a 90-day reconsideration period. Under the proposal, if a beneficiary returns requested information within 90 calendar days of termination, the State would be required to redetermine the individual's eligibility without requiring a new application. While States may not require individuals to complete a new application within the reconsideration period, States may need to request additional information from the individual that is required at application, such as additional information needed to determine eligibility or a signature under penalty of perjury that information provided is accurate. Consistent with § 435.915(a) of the current regulations, retroactive coverage during the 90-day period generally would be available, including for MSP eligibility groups described in section 1902(a)(10)(ii), (iii) and (iv)[59] of the Act, to help fill any gap in coverage for eligible individuals for whom retroactive eligibility may apply. Similar to the 90-day reconsideration period provided to individuals terminated for failure to complete a regularly-scheduled renewal under § 435.916(a)(3)(iii) of the current regulations, we believe this proposed policy is important to reduce gaps in coverage as well as the administrative burden associated with churn, when beneficiaries terminated from coverage reapply within a few months thereafter, particularly beneficiaries enrolled in managed care. We propose that the application timeliness standards provided under § 435.912(c)(3) would apply to redeterminations initiated during the 90-day reconsideration period proposed at § 435.919(d). Application of the timeliness standards at § 435.912(c)(3) in this situation aligns with the proposed revision of current regulations at § 435.916(a)(3)(iii), redesignated at proposed § 435.916(b)(2)(iii), to apply the timeliness standards to redeterminations initiated during the 90-day reconsideration period afforded beneficiaries under current regulations to return renewal forms. Proposed revisions to current § 435.916(a)(3)(iii), redesignated at proposed § 435.916(b)(2)(iii), are discussed in section II.B.1. of this proposed rule.

Proposed § 435.919(e) includes the requirements in § 435.916(d)(1)(i) and (ii) of current regulation (relating to the limitation on requests for information to necessary information and the circumstances under which States may begin a new eligibility period, which is the period of time between application and renewal or regularly scheduled renewals, following a change in circumstances). We propose revisions to current § 435.916(d)(1)(i), redesignated at § 435.919(e)(1) in this proposed rule, to remove the reference to MAGI beneficiaries in order to apply the requirement that States evaluating a change in circumstances must limit requests for additional information to such change in circumstances to both MAGI and non-MAGI beneficiaries. We believe this change is necessary to ensure non-MAGI beneficiaries are not subject to a full renewal of eligibility more frequently than once every 12 months, consistent with proposed § 435.916(a). We redesignate current § 435.916(d)(1)(ii), which allows States to begin a new 12-month eligibility period if the agency has enough information to renew eligibility with respect to all eligibility criteria when processing a change in circumstances, to proposed § 435.919(e)(2). We also make technical changes to current § 435.916(d)(1)(ii), redesignated at proposed § 435.919(e)(2), to use the term ''eligibility period'' rather than ''renewal period'' and to remove the reference to the ''12-month'' eligibility period to align the length of the new eligibility period the State may begin for an individual consistent with the eligibility periods described in proposed § 435.916(a).

Finally, we propose to redesignate and modify § 435.916(d)(2), which requires that States act on anticipated changes in circumstances at the appropriate time as proposed at § 435.919(b)(3), as this provision also relates to changes in beneficiary circumstances. In proposed § 435.919(b)(3), we modify language in the current regulations at § 435.916(d)(2) to require that States act on anticipated changes at an appropriate time (instead of *the* appropriate time) and clarify that this means that the State would need to initiate a redetermination consistent with timeliness standards for processing anticipated changes in circumstances at proposed § 435.912(c)(6). While CMS does not define for each State the appropriate time to act on an anticipated change in circumstances, we expect States to begin the process early enough in order to reasonably complete the redetermination prior to the anticipated change occurring. As discussed in section II.B.3. of this proposed rule, we propose to establish timelines for States to redetermine eligibility based on anticipated changes in circumstances in proposed § 435.912(c)(6). In proposed

[59] Retroactive eligibility is not available to individuals who qualify for coverage under the QMB group described in section 1902(a)(10)(E)(i) of the Act. Per section 1902(e)(8) of the Act, coverage under the QMB group is effective the month following the month in which the QMB eligibility determination is made.

§ 435.919(c)(2), we require States to redetermine eligibility for a beneficiary with an anticipated change in circumstances within the time standards established in proposed § 435.912(c)(6). We believe including the cross reference to proposed § 435.912(c)(6) will ensure States determine the appropriate time to act based on their processes prior to the anticipated change in circumstances occurring such that the State can complete the redetermination according to the time standards in proposed § 435.912(c)(6).

With the proposed creation of § 435.919 and the proposed re-designation of § 435.916(d), with revisions, to new § 435.919(b), we also propose technical changes at §§ 435.911(c) and 435.1200(e)(1). Current § 435.911(c) applies to individuals who submit an application described in § 435.907 or whose eligibility is being renewed in accordance with § 435.916. We propose to add a new clause to extend the application of this paragraph to individuals whose eligibility is being redetermined in accordance with § 435.919. At § 435.1200(e)(1), we propose to replace the reference to § 435.916(d) with a reference to proposed § 435.919(b). Changes to § 435.1200 are discussed in further detail in section II.B.5. of this preamble. Additionally, the application of the proposed requirements of § 435.919 to CHIP is discussed in section II.E.2. of this preamble.

3. Timely Determination and Redetermination of Eligibility (§§ 435.907 and 435.912)

Several regulatory requirements, currently codified in subpart J of part 435, establish parameters to ensure that applications for coverage are not unduly burdensome and that new applicants receive a timely determination of eligibility. Other provisions protect current beneficiaries from needlessly onerous renewal requirements and ensure that States keep individuals enrolled while they review potential Medicaid eligibility on other bases. Section 435.907 of the current regulations describes the requirements for States to make available an application for Medicaid, the limitations on the information that may be requested at application, and the modalities through which individuals must be able to apply. Similarly, § 435.916 (discussed in section II.B.1. of this preamble) describes the requirements for States to conduct renewals and limitations on the information that may be requested from beneficiaries at renewal, and proposed § 435.919 (discussed in section II.B.2 of this preamble) would redesignate and revise current § 435.916(c) and (d) with respect to redeterminations based on changes in circumstances.

The requirements related to the timely determination of eligibility, including the maximum time period in which individuals are entitled to a determination of eligibility, exceptions to timeliness requirements, and considerations for States in establishing performance standards are found at § 435.912. As described at current § 435.912(c)(3), States are required to determine the eligibility of new applicants within 90 calendar days if they apply on the basis of disability and within 45 calendar days for applicants applying on all other bases. These longstanding timeframes are important for ensuring eligible applicants receive timely access to coverage. However, the current regulations do not establish standards to ensure that applicants have enough time to gather and provide additional information and documentation requested by a State in adjudicating eligibility. In addition, the timeframes provided in current § 435.912(c) expressly apply only to new applications; they do not expressly apply to redeterminations either at renewal or based on changes in circumstances.

Current regulations at § 435.930(b) require that States continue furnishing Medicaid benefits to eligible individuals, until they are found to be ineligible. Under this provision, a beneficiary may not be disenrolled if the State has not completed a redetermination of eligibility, even after the end of an individual's scheduled renewal date. This provision is critical to ensuring that eligible beneficiaries are not inappropriately terminated from coverage. However, if completing a renewal is delayed, ineligible individuals may remain inappropriately enrolled.

Ensuring the integrity of Medicaid and CHIP—both to prevent inappropriate enrollments and to protect the enrollment of eligible individuals—is an important component of CMS's work. From a program integrity perspective, both termination of coverage without an accurate determination of ineligibility and the extension of coverage beyond a beneficiary's period of eligibility would constitute an error. Through PERM, the MEQC program, and other CMS eligibility reviews, we partner with States to review their eligibility and enrollment processes and conduct case reviews to ensure that eligible individuals can enroll and stay enrolled without undue burden and that ineligible individuals are redirected to the appropriate coverage programs. Through this work, as well as our ongoing work with States prior to the COVID–19 PHE, we have become aware that in certain situations, redeterminations can remain incomplete for several months following the end of a beneficiary's eligibility period. For example, this may happen when a beneficiary does not timely return documentation or when a determination on another basis is required. While we recognize the challenges States may face in completing redeterminations by the end of a beneficiary's eligibility period or as quickly as possible when they become aware of a potential change in circumstances, it is important that States act promptly once all information and other documentation requested from the individual is received.

Consistent with sections 1902(a)(4) and (19) of the Act to ensure the proper and efficient administration of the program and that eligibility is determined in a manner consistent with simplicity of administration and best interests of beneficiaries, we propose changes to § 435.907 and § 435.912 to ensure that applicants and beneficiaries have adequate time to furnish all requested information and that States complete initial determinations and redeterminations of eligibility within a reasonable timeframe at application, at regular renewals, and following changes in circumstances.

With respect to new applicants, we propose to revise § 435.907 first to redesignate § 435.907(d) (relating to a prohibition on requiring in-person interviews) as § 435.907(d)(2). As discussed in section II.B.1 of this preamble, we also propose to revise newly redesignated paragraph (d)(2) of § 435.907 to remove the clause that states, ''for a determination of eligibility using MAGI-based income'' such that the prohibition on requiring in-person interviews applies to both the MAGI-based and non-MAGI application processes. Then we propose to establish a new paragraph (d)(1) at § 435.907, which would require that, if the State agency is unable to determine an applicant's eligibility based on the information provided on the application and verified through electronic data sources, and it must obtain additional information from the applicant, specified requirements would need to be met. This may occur, for example, if an applicant fails to complete a section of the application before signing and submitting it, or if an applicant provides information on the application that is not reasonably compatible with the

information available through electronic data sources.

Proposed § 435.907(d)(1)(i)(B) would require the agency to provide most applicants with at least 15 calendar days, from the date the request is postmarked or the electronic request is sent, to respond with the additional information. For applicants whose Medicaid eligibility is being considered on the basis of a disability, such as individuals under age 65 who may be eligible for the age and disability-related poverty level group described at section 1902(a)(10)(A)(ii)(X) of the Act, proposed § 435.907(d)(1)(i)(A) would require the agency to provide the applicant with at least 30 calendar days, from the date the request is postmarked or the electronic request is sent, to respond. Additionally, as described at proposed § 435.907(d)(1)(ii), applicants must be permitted to provide additional information through any of the modes by which an application may be submitted at current § 435.907(a). This is current policy that we are proposing to codify through this proposed rule.

As discussed in sections II.B.1 and II.B.2 of this preamble, current § 435.916(a)(3)(i)(B), redesignated at proposed § 435.916(b)(2)(i)(B), and proposed § 435.919(c)(3) would require the agency to provide current beneficiaries with at least 30 calendar days from the date the request is postmarked or the electronic request is sent to submit requested information, beginning on the date the State sends the request for additional information, which is the date the request is postmarked or the date the electronic request is sent. This is longer than the minimum timeframe of 15 calendar days that we propose for most applicants to furnish additional information or documentation. We considered establishing a 30-day requirement for all applicants, consistent with the timeframe proposed at redetermination, but we believe that a 15-day response period for most applicants is appropriate for several reasons. First, in determining eligibility for an applicant, the agency will have recently received information from the applicant (or a person acting responsibly on their behalf) who is newly seeking coverage, and we believe the applicant (or such other person) will typically be expecting a communication from the agency. By contrast, at renewal and when the agency is acting on information it has received from other sources, a beneficiary may be less likely to expect any communication from the State, and therefore, may be less prepared to respond. Second, while States are required to make eligibility effective on the date of application, or up to 3 months prior if the individual would have been eligible retroactively, applicants may be reluctant to access covered services before the eligibility determination is completed. Requiring the agency to make a final determination on applications within the maximum 45 calendar days permitted for individuals applying on a basis other than disability status while also providing the individual with at least 30 calendar days to respond to a request for additional information is unreasonable. However, to permit States more than 45 calendar days to complete applications when additional information is required also could result in eligible individuals delaying needed care. We believe that a minimum 15 calendar days strikes an appropriate balance for most applicants and we seek comment on whether States, beneficiaries, and other interested parties agree that this timeframe is appropriate.

As noted above, we are proposing that States must provide applicants applying on the basis of disability with at least 30 calendar days, from the date the request is postmarked or the electronic request is sent, to return additional information or documentation required by the agency. We believe the longer timeframe is appropriate because some individuals with disabilities may need more time to gather documentation related to their disability determination and since States have up to 90 calendar days to make a final determination of eligibility on disability-based applications, the additional time will not undermine States' ability to make a timely determination.

We are considering aligning the minimum time that States must provide all applicants to submit additional information or documentation requested by the State, as well as finalizing a longer timeframe for all applicants. Timeframes under consideration include 15 calendar days, 20 calendar days, 25 calendar days, and 30 calendar days. We are also considering a minimum requirement of 30 calendar days for all applicants, accompanied by a change to the timeliness requirements for application processing, which would establish an exception to the 45-day requirement at current § 435.912(c)(3)(ii) and provide an additional 15 calendar days for a State to complete application processing when additional information is needed. We seek comment on the appropriate minimum timeframe for applicants to submit requested information at proposed § 435.907(d) that will provide the greatest balance between ensuring that a State determines eligibility as quickly as possible and that applicants have adequate time to gather any information or documentation needed by the State to complete the determination. We also seek comment on whether the final rule should align the timeframe for all applicants or provide a longer period for individuals applying on the basis of disability, and whether a corresponding exception to the 45-day timeliness requirement at § 435.912(c)(3)(ii) should accompany a longer timeframe. In addition, we request comment on whether calendar days or business days would provide a more appropriate measure of timeliness here.

Finally, when the State agency cannot determine an applicant's eligibility for Medicaid without additional information and the agency denies eligibility because the applicant does not timely respond to a request for additional information, per current regulations at § 435.917, the State must provide the individual with notice of the agency's decision. We propose at § 435.907(d)(1)(iiii)(A) that, if the individual subsequently submits the requested information within 30 calendar days of the date the notice of ineligibility is sent (or a longer period established by the State), the State must reconsider the individual's eligibility without requiring the individual to complete and submit a new, full application. This is similar to the reconsideration periods provided at current § 435.916(a)(3)(iii) (redesignated at proposed § 435.916(b)(2)(iii) in this proposed rule) for individuals whose eligibility is terminated at their regularly-scheduled renewal and proposed § 435.919(d) for individuals whose eligibility is terminated following a change in circumstances due to failure to provide additional information requested by the agency.

To ensure that a State has adequate time to complete the determination of eligibility when requested information is submitted during the reconsideration period, we propose at § 435.907(d)(1)(iii)(B) to begin a new clock for determining timeliness. This would provide the State with an additional 45 calendar days (or 90 calendar days for disability-related determinations) to complete the eligibility determination in accordance with proposed § 435.912(c)(3), beginning on the date that the requested information is submitted. In addition, to protect the needs of applicants, the effective date of coverage would continue to be determined in accordance with the date upon which the application was submitted as described at proposed

§ 435.907(d)(1)(iii)(C). We believe this would provide the best balance for both the applicant and the State agency, by protecting the applicant's access to coverage while providing additional time for the State to complete a timely determination. We seek comment on whether the effective date of coverage should be determined in accordance with the application date or whether, consistent with the reconsideration period at renewal and the proposed reconsideration period following a change in circumstances (described in section II.B.2. of this preamble), the return of additional information would effectively constitute a new application with a new effective date of coverage.

We are proposing a 30-day reconsideration period at application, rather than a 90-day reconsideration period similar to the 90-day period proposed at redetermination, because we believe applicants will generally be expecting a communication from the State regarding the status of the submitted application and will be less likely than current beneficiaries to miss requests for additional information. We also are concerned that a longer reconsideration period for applicants would mean that a longer period of time will have elapsed between the date the applicant has attested to information provided on the application and the date a determination is ultimately made. However, recognizing that a consistent 90-day period for all reconsiderations—at application, at renewal, and following a change in circumstances—may be clearer, we seek comment on whether the length of reconsideration period at application should align with the 90-day reconsideration period currently provided at renewal and proposed for redeterminations based on changes in circumstances in this rulemaking, or whether the reconsideration period for applicants should be somewhat longer than 30 calendar days (for example, 45 calendar days or 60 calendar days) but still less than 90 calendar days.

With respect to redeterminations, we propose revisions to § 435.912 to clearly specify expectations for the maximum time States have to complete redeterminations at regular renewals, as well as when the State learns of a change in circumstances that may impact an individual's eligibility. Current § 435.912 requires States to establish timeliness and performance standards. Paragraph (a) of § 435.912 of the current regulations defines ''timeliness standards'' as the maximum period of time in which an individual is entitled to a determination of eligibility and ''performance standards'' as the overall standards for timely determinations of eligibility. Current § 435.912(b) lists the types of eligibility determinations for which States must establish standards, while § 435.912(c) sets forth criteria which the agency must account for in establishing these standards. Paragraphs (d) through (g) of current § 435.912 require the agency to inform individuals of the timeliness standards, to provide for exceptions to the timeliness standards for determining eligibility, and to document any delays in completing the required actions, as well as prohibiting the agency from using the application time standards either as a waiting period or as a reason to deny eligibility.

We propose first to revise the definition of ''timeliness standards'' in § 435.912(a) to specify that these standards must include not only the maximum time period in which every applicant is entitled to a determination of eligibility at application in accordance with § 435.907, but also the maximum period of time in which the agency must redetermine eligibility at renewal in accordance with § 435.916 and when an anticipated or known change in circumstances occurs in accordance with proposed § 435.919(b)(3). The ''performance standards'' defined in current § 435.912(a) would also be revised to clearly include standards for renewing and redetermining eligibility in a timely and efficient manner across a pool of beneficiaries. Section 435.911(c) of the regulations currently requires, in pertinent part, that agency must, promptly and without undue delay consistent with timeliness standards established under § 435.912, provide coverage to individuals who have submitted an application described in § 435.907 or whose eligibility is being renewed in accordance with § 435.916. We propose a conforming amendment to the introductory language in § 435.911(c) to include a cross reference to proposed § 435.919 to make clear that the terms of § 435.911(c) apply also to individuals whose eligibility is being redetermined following a change in circumstances.

Second, we propose to add a paragraph heading for § 435.912(b) that states, ''State plan requirements'' and expand upon the activities described in § 435.912(b) for which States would be required to establish timeliness and performance standards in their State plan. Specifically, we propose to expand the requirement in current § 435.912(b)(2) to establish timeliness and performance standards to include not only determinations of eligibility for Medicaid and assessments of potential eligibility for other insurance affordability programs, as currently required, but also final determinations of eligibility for CHIP consistent with changes proposed at § 435.1200(e) and described in section II.B.5. of this preamble. We also propose to incorporate current paragraph (b)(2) of § 435.912, which requires States to establish timeliness and performance standards for determining potential eligibility for and transferring an individual's electronic account to another insurance affordability program, into current paragraph (b)(1), such that proposed § 435.912(b)(1) would require the agency to establish performance and timeliness standards for determining Medicaid eligibility for individuals who submit an application to the Medicaid agency, as well as determining eligibility for CHIP when an individual is determined ineligible for Medicaid (in accordance with proposed changes discussed in section II.B.5. of this preamble) and determining potential eligibility for insurance affordability programs available through the Exchanges as described at proposed § 435.1200(e).

We propose to redesignate current § 435.912(b)(3) (regarding determining Medicaid eligibility for individuals transferred from other insurance affordability programs) as proposed § 435.912(b)(2) and to add new paragraphs (b)(3), (4), and (5) to § 435.912 as follows:

- Proposed § 435.912(b)(3) would require States to establish specific standards for redetermining eligibility at renewal in accordance with § 435.916;
- Proposed § 435.912(b)(4) would require the establishment of specific standards for redeterminations of eligibility related to changes in circumstances reported by a beneficiary or received from a third party as described at proposed § 435.919(b)(1) and (b)(2) respectively; and
- Proposed § 435.912(b)(5) would require the establishment of specific standards for redeterminations of eligibility at the time of an anticipated change in circumstances in accordance with proposed § 435.919(b)(3).

Third, current § 435.912(c)(1) provides that the timeliness and performance standards adopted by the agency must cover the period from the date of application, or transfer from another insurance affordability program, to the date the agency notifies the applicant of its decision or the date the agency transfers the individual to another insurance affordability program. We would revise this to specify that they also include the periods of time covered by the timeliness and performance standard adopted by the

agency for renewals and redeterminations of eligibility.

Preliminarily, we propose to redesignate the requirement at current § 435.912(c)(1) (providing that the standards for these activities cover the period from the date of application or transfer to the Medicaid agency through the date that the agency notifies the applicant of its decision or transfers the account to another insurance affordability program) as proposed § 435.912(c)(1)(i). Proposed § 435.912(c)(1)(ii) would provide that timeliness and performance standards adopted by the agency for conducting regularly-scheduled renewals must cover the period from the date that the agency initiates the steps required to renew eligibility on the basis of information available to the agency, as required under § 435.916(a)(2) (redesignated as § 435.916(b)(1) in this proposed rule), to the date that the agency sends the beneficiary notice regarding their continued eligibility for coverage, or as applicable, terminates eligibility and transfers the individual to another insurance affordability program in accordance with § 435.1200(e).

Proposed § 435.912(c)(1)(iii) would provide that timeliness and performance standards adopted by the agency for conducting redeterminations of eligibility based on a change in a beneficiary's circumstances must cover the period from the date that the agency receives information indicating a potential change in circumstances that may affect eligibility to the date that the agency sends the individual a notice regarding their continued eligibility for coverage, or as applicable, terminates eligibility and transfers the individual's electronic account to another insurance affordability program in accordance with § 435.1200(e).

Finally, proposed § 435.912(c)(1)(iv) would provide that timeliness and performance standards adopted by the agency for conducting redeterminations of eligibility based on an anticipated change in a beneficiary's circumstances must cover the period from the date the agency begins the redetermination of eligibility based on an anticipated change, as described at § 435.919(b)(3) of this subpart, to the date the agency notifies the individual of its decision or, as applicable the date the agency terminates eligibility and transfers the individual's electronic account to another insurance affordability program in accordance with § 435.1200(e). We also propose to add a heading to paragraph (c) that reads, ''Timeliness and performance standard requirements.''

Current § 435.912(c)(1) also requires States to comply with the requirements of paragraph (c)(2) (relating to criteria that States must consider in establishing their timeliness and performance standards) so as ''to promote accountability and consistency of high-quality consumer experience among States and between insurance affordability programs.'' We propose to incorporate this requirement into proposed § 435.912(c)(2) and to expand the criteria that States must take into account to reflect the broader scope of activities for which States must account for in establishing their timeliness and performance standards.

Current § 435.912(c)(2) requires that, in establishing their timeliness and performance standards, States must account for the capabilities and cost of available systems and technology, the general availability of electronic data matching and ease of connections to authoritative sources of information to determine and verify eligibility, the demonstrated performance and timeliness experience of other State Medicaid, CHIP and other insurance affordability programs, and the needs of individuals, including their preferred mode of application submission and the relative complexity of adjudicating their eligibility. Proposed revisions to § 435.912(c)(2) would add to these criteria the time needed by the agency to evaluate information obtained from electronic data sources and the time needed to provide advance notice to beneficiaries when the agency makes a determination that would result in the denial or termination of eligibility or another adverse action, since an adverse action cannot be effective until the end of the advance notice period (generally advance notice must be sent 10 days prior to the date of the action, in accordance with §§ 431.211, 431.213 and 431.214). Proposed § 435.912(c)(2) also would provide that States account for the needs of beneficiaries, as well as applicants and the complexity of their cases in establishing their timeliness and performance standards.

Paragraph (c)(3) of § 435.912 provides parameters for States in setting a standard for the timely determination of Medicaid eligibility at application and when an account transfer is received from another insurance affordability program. The parameters in current § 435.912(c)(3), of no more than 90 calendar days for determining eligibility on the basis of disability and no more than 45 calendar days for determining eligibility on all other bases, remain unchanged in this proposed rule. However, we propose several technical changes to § 435.912(c)(3), including the addition of a paragraph heading and additional references to the application and account transfer activities described in proposed paragraphs (b)(1) and (2) of this section.

We also propose to add new paragraphs (c)(4), (5), and (6) to § 435.912 to establish separate parameters within which States must establish timeliness standards for the completion of regularly scheduled renewals, redeterminations based on changes in circumstances, and redeterminations based on anticipated changes. In establishing the maximum timeframes in proposed § 435.912(c)(4) within which the agency must complete a regularly scheduled renewal, we take into account the additional time that States may need to complete a redetermination of eligibility when beneficiaries return needed information near the end of their eligibility period, as well as when the State may need to make a determination of eligibility on another basis, as required under § 435.916(f)(1) of the current regulations, redesignated at § 435.916(d)(1) in this proposed rule.

Based on our experience in working with States, we believe that once the agency has received all information needed to complete a redetermination of eligibility, 25 calendar days is ample time for the agency to process the redetermination and provide the minimum 10 days of advance notice of termination or other adverse action, if needed. Therefore, in the case of an individual whose eligibility can be renewed based on available information or who returns all needed information at least 25 calendar days or more prior to the end of the eligibility period, we propose at § 435.912(c)(4)(i) that the agency be required to complete a redetermination by the end of the eligibility period.

Recognizing that in certain cases, a State will not receive all of the information needed to redetermine eligibility until closer to the end of the eligibility period, proposed § 435.912(c)(4)(ii) would provide additional time in such cases. If information is returned before the end of the eligibility period, but with less than 25 calendar days remaining, proposed § 435.912(c)(4)(ii) would provide the agency with one additional month to complete a timely redetermination of eligibility. In such cases, the agency would be required to complete the redetermination, on the basis on which the beneficiary was last determined eligible, by no later than the end of the month following the month in which the individual's eligibility period ends.

For example, suppose a beneficiary's 12-month eligibility period is scheduled to end on March 31st, but the individual does not return all information needed to redetermine eligibility until March 20th. This is less than 25 days prior to the end of the eligibility period, so in this example, the State would need to complete the renewal by no later than April 30th (the end of the month following the month in which the individual's eligibility period ends). We seek comment on whether proposed § 435.912(c)(4)(i) and (ii) strike the right balance between maximizing completion of timely renewals and providing States with sufficient time to not only complete a renewal but also to provide advance notice of termination when necessary.

Proposed § 435.912(c)(4)(iii) addresses timelines for renewals in which eligibility must be considered on another basis. Current § 435.916(f) (redesignated at proposed § 435.916(d)) requires the agency, when it determines that an individual is no longer eligible on the basis upon which he or she has been receiving coverage, to consider eligibility on all bases prior to completing a determination of ineligibility for Medicaid. When information in the individual's case record or renewal form indicates that the beneficiary may be eligible on another basis or bases (for example, an individual determined ineligible based on MAGI may be eligible based on disability), we recognize that additional time may be required for States to obtain the additional information needed to make a determination on such other basis. Proposed § 435.912(c)(4)(iii)(B) provides the agency with 25 days to make a determination of eligibility for most beneficiaries and to send advance notice of termination if the individual is ineligible. However, if a new determination based on disability is necessary, we propose in § 435.912(c)(4)(iii)(A) a maximum of 90 days for States to complete a redetermination of eligibility on the basis of disability. The applicable time period (25 or 90 days) is measured in calendar days from the date the agency determines the individual not eligible on the basis on which he or she had been receiving coverage. We believe that a longer 90-day period is appropriate when a determination of disability is required because of the additional complexity in making a disability determination. This is consistent with the maximum 90 days provided for States making a determination of eligibility based on disability at initial application as described at current § 435.912(c)(3)(i). Regulations governing determinations of disability are found at § 435.541.

These timeliness standards for regularly scheduled renewals are cross-referenced in proposed § 435.916(c), which requires that a renewal be completed by the end of the beneficiary's eligibility period in accordance with proposed § 435.912(c)(4)(i). If an individual returns the renewal form with less than 25 calendar days remaining before the end of their eligibility period, proposed § 435.912(c)(4)(ii) would permit the State to complete the renewal by the end of the month following the month in which the individual's eligibility period ends. This would be compliant with both the renewal requirement at proposed § 435.916(c) and the timeliness requirement at proposed § 435.912(c)(4)(ii). As noted previously, when a determination of eligibility is completed after the end date of a beneficiary's eligibility period, current § 435.930(b) requires the agency to continue furnishing Medicaid to the individual while the determination of eligibility is pending. This permits the State to continue providing medical assistance to the individual until the renewal is completed, and if the individual is no longer eligible for Medicaid, it provides the State with adequate time to provide advance notice and fair hearing rights in accordance with part 431 subpart E of the regulations.

Under proposed § 435.912(c)(5), States must complete redeterminations based on changes in beneficiary circumstances reported by an individual or third party no later than the end of the month that occurs 30 calendar days from the date the State receives information indicating a potential change in circumstances, if the State has sufficient information to evaluate any potential impact and to redetermine eligibility without requesting additional information from the individual. Because most States continue coverage through the end of the month, we propose to extend the requirement to the end of the month in which the 30th day occurs. If additional information from the beneficiary is needed, we propose at § 435.912(c)(5)(ii) that States have through the end of the month that occurs 60 calendar days from the date the State receives information indicating a change in circumstances that may impact eligibility to make a redetermination of eligibility. We note that proposed § 435.919(c)(3) would require States to provide beneficiaries with at least 30 calendar days from the date the request is postmarked or the electronic request is sent to provide the information and that the State enable beneficiaries to do so through any of the modes of submission specified in § 435.907(a). This aligns with the 30 calendar days which States must provide beneficiaries to return a pre-populated renewal form and any needed documentation at renewal under current regulation at § 435.916(a)(3)(i)(B), redesignated at proposed § 435.916(b)(2)(i)(B).

Proposed § 435.912(c)(6) establishes requirements for redeterminations of eligibility based on anticipated changes in circumstances. As described in § 435.916(d)(2) (redesignated as proposed § 435.919(b)(3)), anticipated changes are events that the agency knows about in advance, like a beneficiary's birthday, and States must act on such changes at an appropriate time such that the State completes the redetermination prior to the anticipated change occurring. Thus, while CMS does not specify when a State must begin the redetermination process for an anticipated change in circumstances, under our proposal, the agency must determine the amount of time it needs to act on such changes and to begin the redetermination process with sufficient time to complete processing the redetermination prior to the change occurring. As such, we propose to apply the same basic requirements at proposed § 435.912(c)(6) for States establishing standards for redeterminations based on anticipated changes in circumstances as those described at proposed § 435.912(c)(4) for regularly scheduled renewals. At proposed § 435.912(c)(6)(i), the agency would be required to complete a redetermination of eligibility based on an anticipated change in circumstances on or before the date of the anticipated change or the last day of the month in which the anticipated change occurs.

When an individual is determined ineligible for Medicaid, States have flexibility to terminate coverage either on the date on which the individual becomes ineligible (provided that advance notice has been provided and other bases of eligibility have been considered) or at the end of the month. In States that have elected the option to continue coverage through the end of the month, the redeterminations described at proposed § 435.912(c)(4), (c)(5), and (c)(6) must be completed prior to the end of the month. In all other States, the redetermination must be completed prior to the date specified.

For example, suppose a State has a higher income standard for younger children in the eligibility group for children under age 19, and a beneficiary

whose household income exceeds the standard for children aged 6 through 18 will be turning 6 years old on October 3rd in the middle of their eligibility period. This beneficiary lives in a State that continues coverage through the end of the month in which an individual becomes ineligible. If the State receives all information needed to determine the individual's continued eligibility (in either the eligibility group for children under age 19 or another eligibility group) on or before October 6th (25 days before the end of the month in which the change occurs), then the agency would be required to complete a timely redetermination of eligibility by no later than October 31st.

If the State receives the information needed to complete a redetermination, but does not have at least 25 calendar days to process the information, then as described at proposed § 435.912(c)(6)(ii), the State would have 1 additional month to complete a timely redetermination of eligibility. Using the example above, suppose the State receives all information needed to determine the individual's eligibility on or after October 7th, then the agency would be required to complete a timely redetermination of eligibility by no later than November 30th. Proposed § 435.912(c)(6)(iii) establishes the same standards for completing a determination of another basis as that proposed at § 435.912(c)(4)(iii) for regularly scheduled renewals.

We seek comment on the amount of time provided for States to complete a redetermination of eligibility at a regularly-scheduled renewal or based on changes in circumstances at proposed § 435.912(c)(4), (c)(5), and (c)(6), whether the regulations should allow for a longer or shorter period of time, and whether the use of business days rather than calendar days would be more appropriate.

Each of the standards proposed in paragraphs (c)(3) through (6) provides for an exception to the timeliness standards, which is described in current § 435.912(e), when the agency cannot comply with the regulatory timelines due to an administrative or other emergency beyond the agency's control. States that use the timeliness exception § 435.912(e) must document the reason for delay in the case record in accordance with § 435.912(f). It is also important to note that, while the proposed timeliness standards provide maximum timeframes for completion of redeterminations at renewal or based on changes in circumstances, they do not constitute additional grace periods for States or beneficiaries to delay completion of redeterminations. States are, and will continue to be, expected to process redeterminations as expeditiously as possible, and additional time is only authorized beyond the prescribed eligibility period if a beneficiary responds to a request for information after the date required by the agency but prior to the date of termination or other adverse action identified in the beneficiary's advanced notice of termination or other adverse action.

Finally, we propose a number of technical amendments to paragraphs (d), (e), (f), and (g) of this section to clearly specify that these provisions apply to applicants and applications as well as beneficiaries and redeterminations of eligibility. Because we are specifying that the timeliness standards in section § 435.912 include both applications and redeterminations, we also propose a related change to current § 435.912(g). The current provision prohibits States from using the timeliness standards as a waiting period for new applicants or as a reason for denying eligibility because it is not determined within the required timeframe. We propose to add a new paragraph (g)(3) to § 435.912 that would prohibit States from using the timeliness standards as a reason for delaying termination of an individual's coverage or delaying an adverse action.

We propose to apply the same requirements to separate CHIPs through an existing reference to § 435.912 of the Medicaid regulations in § 457.340(d)(1). Changes to §§ 457.340(d) are discussed in further detail in section II.E.1. of this preamble.

4. Agency Action on Returned Mail (§§ 435.919 and 457.344)

Section 1902(a)(10) of the Act requires States to make medical assistance available under the State plan to individuals who meet certain eligibility criteria and provides States with the option to provide medical assistance to certain other individuals. To ensure that individuals receiving such assistance continue to meet applicable eligibility requirements, States must have a process to obtain information about changes in circumstances and redetermine eligibility when appropriate, including at annual renewal. In this rulemaking, we propose at § 435.919(f) certain actions that States must take when mail sent to a beneficiary is returned to the agency, regardless of whether the returned mail signals potential ineligibility.

The United States Postal Service (USPS) returns mail sent to beneficiary when the address used is incorrect, or the individual has moved and USPS has no record of a forwarding address, or the time-limited mail forwarding service has expired. That a beneficiary has moved does not necessarily mean the individual is no longer a State resident or ineligible on that basis. However, we are concerned that when a beneficiary's mail is returned to the agency, some States rely on that information to conclude that the individual cannot be located and terminate coverage without taking reasonable steps to ascertain the accuracy of the information received or attempting to locate the beneficiary and update their address. Additionally, if a State attempts to contact the beneficiary to verify a new in-state address received from USPS and the individual does not respond, many States continue to use the original address in the beneficiary's case record. If the new address from USPS is correct, the beneficiary has not elected to receive electronic notices, and an *ex parte* renewal based on information available to the agency is not successful, this will result in termination at the individual's regular renewal because such beneficiaries will not receive a mailed notice or renewal form and will be unable to respond as required.

We believe that returned mail may result in a significant number of beneficiaries who continue to meet all eligibility requirements being terminated from coverage, and that it is critical for States to take reasonable steps to locate beneficiaries who may have moved and to update their address prior to taking any adverse action. Therefore, consistent with section 1902(a)(4) of the Act, to promote the proper and efficient administration of the Medicaid program, and section 1902(a)(19) of the Act, to provide such safeguards as may be necessary to assure simplicity of administration and the best interests of beneficiaries, we propose adding new paragraph (f) at proposed § 435.919 to specify the steps States must take when beneficiary mail is returned to the agency.

States rely heavily on communicating with beneficiaries by mail to facilitate essential eligibility and enrollment actions, such as renewals and requests for additional information. Returned mail with an out-of-state or no forwarding address indicates a potential change in circumstance with respect to State residency, but without additional follow up by the State, the receipt of returned mail alone is not sufficient to make a definitive determination as to whether beneficiaries no longer meet State residency requirements because they have moved out of State. Returned mail with an in-state forwarding address is not an indication of a change affecting

eligibility, but it nonetheless is important for the State to confirm the accuracy of the information to ensure future ability to contact the beneficiary, for example, so that the individual can receive and return a renewal form or other information needed by the State to renew their eligibility or can receive critical program information.

Under proposed § 435.919(f), when States receive returned beneficiary mail, they must take proactive steps to verify any forwarding address provided or to otherwise locate the individual. For all returned beneficiary mail, including returned mail with an in-state, an out-of-state, or no forwarding address, we propose at §§ 435.919(f)(1) through 435.919(f)(3), that States conduct a series of data checks and outreach attempts to locate the beneficiary and verify their address. If the State is unable to locate or verify a beneficiary's address after this series of outreach attempts, proposed § 435.919(f)(4) through (f)(6) outlines required and permissible State actions based on the location of the address, if any, provided on the returned mail (that is, in-state or out-of-state). The proposed steps which States must or may take whenever beneficiary mail is returned are discussed in more detail, below.

Step 1: Check Available Data Sources for Updated Contact Information

Under proposed § 435.919(f)(1), whenever beneficiary mail is returned, the State must first check data sources available to the agency to identify any potential updated mailing address information available to the State prior to reaching out to the individual. At a minimum, a State must check for updated mailing contact information from the following sources: (1) the agency's Medicaid Enterprise System (MES); (2) the agency's contracted managed care plans, if applicable in the State; and (3) one or more other third-party data sources, discussed below.

Updated beneficiary contact information from managed care plans, enrollment brokers, claims data, and in the case of integrated eligibility systems, other State administered public benefit systems may be available in the State's MES, and for this reason we believe it is critical that States check for potential updated address information that may be in this system, as reflected at proposed § 435.919(f)(1)(i). Many States have told CMS that individuals enrolled in a managed care plan are more likely to provide their plan, which generally has more frequent contact with their beneficiaries than the State agency, with updated address information. We therefore propose at § 435.919(f)(1)(ii) that the State must obtain and check the address on file with the plan for any individual enrolled in a managed care plan. Finally, there are other third-party data sources available to State Medicaid agencies, and we propose at § 435.919(f)(1)(iii) that the State must obtain and check at least one of the following: the State agency that administers SNAP, the State agency that administers TANF, the Department of Motor Vehicles, the USPS National Change of Address (NCOA) database, and other sources specified in the State's verification plan to determine if a different and more recent address is available.

Discussed in more detail below, under proposed § 435.919(f)(2) and 435.919(g), when a State receives a forwarding address on a piece of returned mail, the State must attempt to contact the individual to verify the forwarding address and provide them with an opportunity to confirm or dispute the information.

Step 2: Conduct Outreach Using at Least Two Different Modalities

In verifying a forwarding address provided by USPS under the proposed rule, States must attempt to contact the beneficiary by both mail (at proposed § 435.919(f)(2)), as well as a modality other than mail (at proposed § 435.919(f)(3)), such as by phone, electronic notice, email, or text message. States have flexibility as to the order in which they attempt to contact the beneficiary through the different modalities.

In attempting to contact the beneficiary by U.S. mail, we propose at § 435.919(f)(2) that the State must send notices to both the current address on file, the forwarding address (if one is provided by USPS), and any address more recent than that in the beneficiary's case records obtained pursuant to proposed § 435.919(f)(1). The notice must request that the individual confirm their current address. The State must provide the individual with a reasonable period of time to verify the accuracy of the new contact information. Consistent with proposed § 435.919(c)(1), we propose that § 435.919(f)(2)(i) define this reasonable period of time as 30 calendar days from the date the notice is sent to the beneficiary. Sending mail to the current address on file represents a key beneficiary protection to ensure that initial piece of returned mail was not incorrectly returned.

We propose at § 435.919(f)(3) that, in attempting to contact the beneficiary using a modality other than mail, the State must make at least two attempts with at least three business days between the first and last attempt. In implementing this requirement, States have flexibility to use any combination of available electronic or telephonic modalities. Such communications, initiated either directly by the State agency or through a State contractor or partner, must be compliant with Federal communications laws such as the Telephone Consumer Protection Act (47 U.S.C. 227).

If it is not feasible to conduct outreach via an alternative modality, for example because there is no phone or other electronic contact information in the case record or obtained from third-party sources, the State must note that in the case record. For outreach conducted by electronic or telephonic modalities, States must use the contact information available on file. States also may leverage the electronic or telephonic contact information obtained by the State through data checks pursuant to § 435.919(f)(1) and reach out to the beneficiary through other modalities pursuant to § 435.919(f)(3).

We note that, under § 435.918, beneficiaries must be provided a choice to receive notices via mail or in an electronic format. If a beneficiary has elected to receive notices and communications electronically, the State must send a notice via the individual's preferred electronic format and such notice must provide at least 30 calendar days from the date the agency sends the notice to verify the accuracy of the new contact information. Regardless of the notice format a beneficiary elects, under the proposed rule States must attempt to contact individuals for whom they have received returned mail via both mail and an alternative electronic modality in an effort to confirm the beneficiary's correct current address. For a beneficiary who elected to receive electronic notices and communications in accordance with § 435.918, if a previous electronic communication attempt failed, the agency cannot use that same electronic modality as the alternative modality to satisfy the requirement at proposed § 435.919(f)(3). States have flexibility under the proposed rule as to the order in which they attempt to contact the beneficiary through the different modalities.

Step 3: State Agency Action Based on Address or No Forwarding Address if Beneficiary Does Not Respond

If a State agency has exhausted all outreach efforts described in §§ 435.919(f)(1) through (f)(3), then the proposed actions that a State must or may take depend on whether USPS

returns an in-state forwarding address, an out-of-state forwarding address or no forwarding address.

Returned mail with an in-state forwarding address reflects a potential change in circumstances that does not affect eligibility. Accordingly, if the beneficiary does not respond to the State's request to confirm their current address in a reasonable period after the State has taken the steps required under proposed §§ 435.919(f)(1) through (f)(3), we propose at § 435.919(f)(4)(i) that, consistent with current Federal policy, the State may not terminate the beneficiary's coverage if the State does not receive a response to its requests that the individual confirm their correct current address. However, while USPS may occasionally return mail sent to a beneficiary with an erroneous forwarding address, we believe that the USPS information generally is accurate, and certainly is accurate far more often than it is inaccurate. This accuracy is buoyed by controls implemented by USPS, which include charging a fee by credit card to validate online change of address (COA) requests, requiring individuals submitting a hardcopy COA request to verify that they understand an unauthorized COA order is a Federal offense, and sending two confirmation letters (to the new and old address) to authenticate the order. Therefore, we propose at § 435.919(f)(4)(ii) that, if the State does not receive a response from the beneficiary that an in-state forwarding address provided by USPS is incorrect, the State must accept the new in-state address and update the beneficiary's account accordingly.

Similarly, the USPS NCOA database includes the permanent change-of-address records maintained by the USPS. Every time an individual or family moves and submits a change-of-address form to their local post office, their new address is recorded in the NCOA database. States can establish agreements with USPS to gain access to the NCOA database in order to utilize these address changes. Therefore, we propose at § 435.919(f)(4)(iv) that, if the State does not receive a response from the beneficiary that an in-state address provided by NCOA is incorrect, the State must accept the new in-state address and update the beneficiary's account accordingly. Additionally, we believe that updated in-state address information obtained from managed care plans may be treated as reliable data, provided that the updated contact information was received by the plan directly from, or was verified with, the beneficiary. Therefore, we propose at § 435.919(f)(4)(iii) that, if the State does not receive a response from the beneficiary that an in-state address obtained from a managed care plan is incorrect, the State must accept the new in-state address and update the beneficiary's account accordingly. We seek comment on whether States should be required to update a beneficiary's in-state address using more recent contact information reflected in a forwarding address from USPS or an address provided by NCOA or a managed care plan in this situation, when the beneficiary has not responded to the State's request to verify their current address.

We note that CMS provided some States with authority under section 1902(e)(14)(A) of the Act to rely on updated contact information from a reliable third-party source, such as an MCO, without first attempting to contact the individual and providing them with a reasonable period of time to verify the accuracy of the new contact information, in accordance with the State Health Official Letter, ''Promoting Continuity of Coverage and Distributing Eligibility and Enrollment Workload in Medicaid, the Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Upon Conclusion of the COVID–19 Public Health Emergency,'' published on March 2, 2022 (SHO letter #22–001). We seek comment on whether States should be permitted or should be required to update beneficiary contact information based on information obtained from an MCO, from the USPS NCOA, or other reliable data sources without first attempting to contact the beneficiary to provide them with an opportunity to verify or dispute the new information, because such third-party data is reliable, and, if so, which data sources should States be permitted to rely upon without attempting to contact beneficiaries. We are especially interested in comments from States that received authority under section 1902(e)(14)(A) of the Act to update beneficiary contact information based on information received from a reliable third party without first attempting to contact the individual, as described in SHO letter #22–001. We also seek comment on the efficacy of the requirement to send a notice to a beneficiary's address on file to ensure that initial piece of returned mail was not incorrectly returned.

Returned mail with an out-of-state forwarding address indicates a potential change in circumstances (State residency) that may impact eligibility. Consistent with current requirements under § 435.916(d), we propose at § 435.919(f)(5) that, if a beneficiary does not respond to the State's requests per proposed § 435.919(f)(1) through (f)(3) for information to verify their current address, or if information provided does not establish that the beneficiary continues to satisfy the State residency requirement, the State must provide advance notice of termination and fair hearing rights consistent with 42 CFR part 431 subpart E.

Returned mail with no forwarding address. Current regulations at § 435.916(d) require termination of the eligibility of a beneficiary for whom an out-of-state forwarding address has been received if the beneficiary does not respond with information establishing continued State residency, current regulations at § 431.213(d) provide for an exception to advance notice in the case of a beneficiary whose ''whereabouts are unknown and the post office returns agency mail directed to him indicating no forwarding address'' and current regulations at § 431.231(d) provide for reinstatement of beneficiaries whose benefits were discontinued due to whereabouts unknown (''as evidenced by the return of unforwardable agency mail'') if their whereabouts subsequently become known. However, the current regulations are unclear with respect to what actions States must take in the case of beneficiaries who did not respond to the State's attempts to contact them to confirm their address and for whom the State has received no forwarding address and was unable to obtain an updated address from a reliable third-party source.

While it is important that beneficiaries who remain in-state are not inappropriately terminated, continued enrollment of individuals whose State residency is unknown, particularly those enrolled in a managed care plan for whom the State pays a monthly capitation payment, may result in unnecessary expense to State Medicaid program and Federal government. To balance these two interests and provide clear requirements for such situations, we propose revising and redesignating current regulation at § 431.231(d) at proposed § 435.919(f)(6) to require that, when a State receives returned beneficiary mail with no forwarding address, the State must first take reasonable steps to locate the beneficiary consistent with proposed §§ 435.919(f)(1) through (f)(3). If, after taking such steps, the State is unable to locate the beneficiary, we propose at § 435.919(f)(6)(i) that States must take appropriate steps to terminate coverage, suspend coverage, or move the beneficiary into a fee-for-service delivery system.

Under § 431.231(d) of the current regulations, redesignated at proposed

§ 435.919(f)(6), States are not required to provide advance notice of termination in the case of a beneficiary whose whereabouts remain unknown after the efforts required to locate the individual have been taken, but are required to provide notice of fair hearing rights. However, consistent with current regulations at § 431.231(d), redesignated at proposed at § 435.919(f)(6)(ii)(A), if the beneficiary's whereabouts become known prior to the beneficiary's originally-scheduled renewal date, the State must reinstate their coverage. We propose adding a requirement at § 435.919(f)(6)(ii)(A) that States must reinstate coverage back to the date of termination if the individual's whereabouts become known before their next regularly-scheduled renewal, without the need to verify eligibility. For example, suppose a beneficiary's eligibility is terminated in April 2023 on the basis of their whereabouts being unknown. In July 2023, the individual seeks care, but is told by the provider that their Medicaid coverage was terminated. If the individual contacts the agency before their next regularly-scheduled renewal, the agency must immediately reinstate their coverage retroactive to April 2023. Consistent with current § 435.916(d)(1)(ii), redesignated at proposed § 435.919(e)(2), we are adding the option at proposed at § 435.919(f)(6)(ii)(B) for States to begin a new eligibility period (defined in current regulations at § 435.916(a), redesignated and revised at § 435.916(b) in this proposed rule) for a beneficiary whose whereabouts become known if the agency has enough information available to it to renew eligibility with respect to all eligibility criteria without requiring additional information from the beneficiary.

Proposed § 435.919(g), describes the steps a State may take if it obtains updated mailing information from third-party sources other than returned mail from the USPS. Specifically, we propose at § 435.919(g)(1) that States that obtain updated in-state mailing information from NCOA or managed care plans may treat such information as reliable, provided that the State conducts the following outreach. When updated address information is obtained by the State from NCOA or from a managed care plan that has a contract with the State, the State must send a notice to the current address on file with the State and provide the individual with a reasonable period of time to verify the accuracy of the new contact information. Consistent with proposed § 435.919(c)(1), we propose that § 435.919(g)(1)(v) define this reasonable period of time as 30 calendar days from the date the notice is sent to the beneficiary.

States must also contact the beneficiary through other modalities, such as via telephone, electronic notice, email, or text message, where feasible, and must send information to the new address. We propose at § 435.919(g)(1)(iii) that, in attempting to contact the beneficiary using a modality other than mail, the State must make at least two attempts with at least 3 business days between the first and last attempt. In implementing this requirement, States have flexibility to use any combination of available electronic or telephonic modalities. Such communications, initiated either directly by the State agency or through a State contractor or partner, must be compliant with Federal communications laws such as the Telephone Consumer Protection Act (47 U.S.C. 227). If it is not feasible to conduct outreach via an alternative modality, for example because there is no phone or other electronic contact information in the case record or obtained from third-party sources, the State must note that in the case record. For outreach conducted by electronic or telephonic modalities, States must use the contact information available on file. If the beneficiary does not respond, the State may update the beneficiary record with the new contact information. If the beneficiary responds and confirms the new address, the State must update the beneficiary record with the new contact information. Critically, States should ensure that managed care plans only provide updated contact information received directly from or verified by the beneficiary, and not from a third party or other source. We remind States that the rules at §§ 435.919(b) and 435.952(d) apply for out-of-state address information obtained under § 435.919(g).

At § 435.919(g)(2), we propose that States may treat updated in-state address information from other trusted data sources in accordance with proposed paragraph (g)(1) if the State obtains approval from the Secretary. At § 435.919(g)(3), we propose the process that States must follow when obtaining any address information from any sources not listed in paragraph (g)(1) or (2) of this section. Under § 435.919(g)(3), the agency must follow the steps outlined in § 435.919(f)(2) through (6), related to returned mail in order to confirm the address change with the beneficiary. We seek comment on whether States either should be permitted or should be required to update beneficiary contact information based on information obtained from an MCO, from the USPS NCOA, or other reliable data sources, such as Indian Health Care Providers, Federally Qualified Health Centers, Rural Health Clinics, Program of All-inclusive Care for the Elderly providers, Primary Care Case Managers, Accountable Care Organizations, Patient Centered Medical Homes, Enrollment Brokers, or other State Human Services Agencies (for example, SNAP), without first attempting to contact the individual to provide them with an opportunity to verify or dispute the new information, because such third-party data is reliable, and, if so, which data sources should States be permitted to rely upon without attempting to contact beneficiaries. We are especially interested in comments from States that received authority under section 1902(e)(14)(A) of the Act to update beneficiary contact information based on information received from a reliable third party without first attempting to contact the beneficiary, as described in SHO letter #22–001. We also seek comment on the efficacy of the requirement to send a notice to a beneficiary's address on file to ensure that initial piece of returned mail was not incorrectly returned, and on the efficacy of the requirement to conduct at least two outreach attempts to the beneficiary using a modality other than mail. We also seek comment on the requirements in proposed § 435.919(g)(3) paragraphs (f)(2) through (6), related to processing out-of-state address information or address information from a source not identified in § 435.919(g)(1), including whether CMS should consider including a requirement that a State check the available data sources outlined in § 435.919(f)(1)(i) and § 435.919(f)(1)(ii).

Finally, we make a conforming amendment to § 431.213(d), which currently cross references § 431.231(d), to instead reference § 435.919(f). Proposed changes to § 457.344 regarding the responsibilities of States administering a separate CHIP in the event of returned mail and when they receive information from a third party about a change in address for individuals enrolled in a separate CHIP are discussed in further detail in section II.E.3 of this preamble.

5. Transitions Between Medicaid, CHIP and BHP Agencies (§§ 431.10, 435.1200, 600.330)

Section 1943 of the Act requires Medicaid agencies to collaborate with separate CHIP and BHP agencies, if such agencies exist in the State, and with the Exchanges to establish a coordinated

eligibility and enrollment process. Through this process, most applicants, as well as beneficiaries whose eligibility is being redetermined, are evaluated for eligibility for each of these insurance affordability programs and may enroll in the program for which they are eligible without having to complete separate applications. The requirements to coordinate eligibility and enrollment among insurance affordability programs were established in the 2012 eligibility final rule at § 435.1200. State experience in implementing § 435.1200 has revealed some weaknesses in the requirements, which permit eligible individuals to experience unnecessary gaps in coverage and periods of uninsurance. Through this proposed rule, we seek to correct those weaknesses and reduce coverage gaps wherever possible.

One weakness in the current requirements occurs when an agency has information indicating that a beneficiary is no longer Medicaid eligible and likely eligible for another insurance affordability program, but the individual does not respond to confirm this information. As discussed in sections II.B.1. and II.B.2. of this preamble, when the agency receives information reported by a beneficiary or from a reliable third-party source which may affect eligibility, the agency must promptly redetermine the individual's eligibility. If the third-party information would result in an adverse action, the agency must contact the beneficiary and request additional information to verify or dispute the information. Similarly, when a State accesses available information in attempting to renew an individual's eligibility during a regularly-scheduled renewal and obtains information indicating the individual may no longer be eligible, it must send the beneficiary a renewal form (which must be prepopulated for MAGI-based beneficiaries under the current regulations) and provide sufficient time for the individual to return the form and any other information or documentation needed to establish continued eligibility (at least 30 calendar days for MAGI-based beneficiaries under the current regulations). When a beneficiary or a beneficiary's representative does not respond to such requests, the agency must provide the individual with advance notice of termination and fair hearing rights, consistent with part 431 subpart E of the regulations.

For most individuals determined ineligible for Medicaid, current § 435.1200(e) requires the agency to determine potential eligibility for other insurance affordability programs and, as appropriate, transfer the individual's electronic account to the appropriate program. However, because this requirement applies only to a beneficiary who ''submits an application or renewal to the agency which includes sufficient information to determine Medicaid eligibility,'' the agency is not required to transfer an individual's account in all cases. When a beneficiary does not submit a required renewal form or other information needed to redetermine or renew eligibility, the Medicaid agency must send such advance notice of termination but is not required to transfer the individual's account to another insurance affordability program.

These terminations, without a resulting transfer to another insurance affordability program, can create major disruptions in health insurance coverage for otherwise eligible individuals. For example, a family may receive notification of potential income ineligibility for Medicaid, but may not respond because the information described in the notification is correct, and the family does not understand that they need to confirm their increased income so their account will be transitioned to CHIP, BHP, or the Exchange in their State in accordance with current § 435.1200(e).

Disenrollment from health insurance coverage without a corresponding transition to enrollment in another insurance affordability program is a troubling outcome, particularly since regulatory requirements at § 435.1200 for Medicaid, §§ 457.348 and 457.350 for CHIP, § 600.330 for BHP, and 45 CFR 155.302 for Exchanges were designed to ensure coordination of coverage and smooth transitions between insurance affordability programs. Losses of coverage are even more troubling when different programs share an eligibility system and a determination of eligibility for one program could be completed seamlessly as the individual is determined ineligible for another program.

When developing the coordination requirements currently published at §§ 435.1200, 457.348 and 457.350, and 600.330, and 45 CFR 155.302, we recommended, but did not require States to utilize a shared eligibility system or service for all insurance affordability programs. Today, we believe every State with separate programs for Medicaid and CHIP [60] utilizes a single eligibility system or shared eligibility service for eligibility determinations based on MAGI. As such, when a Medicaid beneficiary is determined ineligible due to an increase in household income, and the individual is screened for potential CHIP eligibility, the system effectively makes a determination of financial eligibility for CHIP. We believe the Medicaid agency could complete the determination of CHIP eligibility based on available information, so the individual does not need to be screened and then transferred to the separate CHIP agency before a determination of CHIP eligibility can be completed.

Additionally, while Medicaid and CHIP are separate programs, both use MAGI-based methodologies described at section 1902(e)(14) of the Act, further detailed at §§ 435.603 for Medicaid and cross-referenced at § 457.315 for CHIP, to determine financial eligibility. Further, States can, and often do, utilize the same policies and procedures to verify MAGI-based income eligibility for Medicaid and CHIP. In fact, current § 435.1200(d)(4) requires the Medicaid agency to accept findings related to eligibility criteria made by a separate CHIP agency without further verification if that program applies the same verification policies as those used by the Medicaid agency. A similar requirement applies to CHIP at § 457.348(c)(4). Because the same financial methodologies are used for each program, if the same verification requirements apply, a determination of financial eligibility used to determine CHIP eligibility must be accepted by the Medicaid agency in determining financial eligibility for Medicaid and vice versa.

Through this rule, we propose changes to § 435.1200 to improve transitions between Medicaid and a separate CHIP; corresponding changes to CHIP are described in section II.E.5 of this preamble. We note that these changes would apply only to transitions between Medicaid and a separate CHIP. They would not apply to transitions between title XIX funding and title XXI funding within Medicaid in States that implement CHIP through a Medicaid expansion, either in whole or in part.

Current § 435.1200 implements the ACA requirements established at section 1943(b) of the Act relating to the coordination of enrollment among insurance affordability programs. The general requirements for coordination are described at § 435.1200(b). Paragraph (b)(1) requires the Medicaid agency to fulfill the general responsibilities described in later paragraphs, while paragraph (b)(2) requires the agency to certify, for the

[60] As of June 1, 2022, 40 States have a separate CHIP; this includes 2 States with only a separate CHIP and 38 States with both a Medicaid expansion and a separate CHIP.

other insurance affordability programs, the criteria for determining Medicaid eligibility. Current § 435.1200(b)(3) requires the agency to enter into an agreement with the agency or agencies administering a separate CHIP, BHP, and the Exchange operating in the State; such agreement(s) must include a clear delineation of the responsibilities of each program with respect to eligibility determinations, notices, and fair hearings. Paragraphs (c) and (d) describe the Medicaid agency's responsibilities for eligibility and enrollment when an individual has been determined Medicaid eligible (paragraph (c)) or assessed as potentially Medicaid eligible (paragraph (d)) by a separate CHIP, BHP, or Exchange. Paragraph (e) of current § 435.1200 describes the responsibilities of the Medicaid agency to evaluate an individual's eligibility for CHIP, BHP, and coverage through the Exchanges when an individual is determined not eligible for Medicaid (§ 435.1200(e)(1)) or is undergoing a Medicaid eligibility determination on a non-MAGI basis (§ 435.1200(e)(2)). Paragraphs (f) through (i) of current § 435.1200 describe the coordination requirements for an enrollment website, appeals, and notices.

Among the requirements for enrollment simplification and coordination described in section 1943(b) of the Act, paragraph (b)(1)(F) specifically requires outreach and enrollment of underserved populations eligible for Medicaid. One of the populations called out for focused outreach and enrollment is children, including subsets of particularly underserved children, as well as racial and ethnic minorities, rural populations, and individuals with mental health and/or substance use disorders. While the increase in uninsurance among children known to be eligible for Medicaid or another insurance affordability program has leveled off since 2020 when the PHE went into effect, likely due in large measure to the continuous enrollment condition under the FFCRA discussed in the background section of this preamble, in order to reduce the likelihood of future increases in uninsurance, we propose a new approach to implementing the coordination requirements in section 1943(b) of the Act.

Section 1902(a)(19) of the Act requires that the Medicaid State plan include safeguards to ensure that eligibility is determined in a manner that is consistent with the simplicity of administration and the best interests of beneficiaries. We believe the language and requirements in § 435.1200, which do not require transition of otherwise eligible individuals from one program to another when beneficiaries have failed to provide requested information to confirm or dispute third-party data indicating a change in eligibility, have contributed to an increase in uninsurance among individuals losing coverage under Medicaid and CHIP, even though they meet the eligibility requirements for another one of those programs. This result is inconsistent with both the simplicity of administration of the Medicaid program and the best interest of Medicaid beneficiaries.

Utilizing the authority provided in sections 1902(a)(19) and 1943(b)(1)(F) of the Act, we propose to revise paragraphs (b), (c), (e), and (h) of § 435.1200 to improve enrollment of underserved populations and to reduce unnecessary administrative barriers to coverage by requiring Medicaid agencies, in States with a separate CHIP, to:

- Provide for an agreement with the separate CHIP agency to seamlessly transition the eligibility of beneficiaries between Medicaid and CHIP when their eligibility status changes;
- Accept determinations of MAGI-based Medicaid eligibility made by a separate CHIP;
- Establish procedures to receive determinations of Medicaid eligibility completed by a separate CHIP;
- Complete determinations of eligibility for a separate CHIP for individuals who are determined ineligible for Medicaid based on reliable third-party data; and
- Issue a combined notice indicating ineligibility for Medicaid and eligibility for CHIP when appropriate.

In section II.E.4. of this preamble, we discuss proposed changes to the CHIP regulations that correspond with these proposed requirements for Medicaid agencies. When proposed changes to the Medicaid and CHIP regulations are read together, they would ensure that (1) when an individual is determined ineligible for Medicaid, the individual would receive a determination of CHIP eligibility (from the Medicaid agency) and, if eligible for CHIP, the individual's electronic account would be transferred from the Medicaid agency to the separate CHIP agency, with the separate CHIP agency completing any enrollment-related activities such as collection of an applicable enrollment fee or premium and/or plan selection; and (2) when CHIP determines that an enrollee has become ineligible for CHIP, the individual would receive a determination of MAGI-based Medicaid eligibility, and, if eligible for Medicaid, the individual's electronic account would be transferred from the separate CHIP agency to the Medicaid agency, with the Medicaid agency completing any enrollment related activities such as issuing a Medicaid card.

We believe these changes could address potential declines in enrollment that may result from eligible individuals not being seamlessly transitioned to Medicaid from CHIP and from Medicaid to CHIP when available information indicates eligibility for the other program. We propose the following specific revisions to the coordination requirements for States with a separate CHIP.

Preliminarily, we propose to add a new requirement to the list of requirements in current § 435.1200(b)(3) that must be addressed in agreements between the Medicaid agency and other insurance affordability programs. Proposed § 435.1200(b)(3)(vi) would require the Medicaid agency to include in its agreement with the State's separate CHIP agency, procedures for seamlessly transitioning the eligibility of individuals from Medicaid to CHIP when they are determined ineligible for Medicaid and eligible for CHIP. The agreement would also include procedures for seamlessly transitioning the eligibility of individuals from CHIP to Medicaid when they are determined ineligible for CHIP by that program and eligible for Medicaid. The agreement required under § 435.1200(b)(3) would describe the responsibilities for each State agency administering Medicaid and CHIP to effectuate the required coordination.

We propose to add a requirement at § 435.1200(b)(4) that the Medicaid agency must accept a determination of MAGI-based Medicaid eligibility made by the State agency administering a separate CHIP (See section II.E.5. of this preamble for a discussion of the proposed requirements for agencies administering a separate CHIP to determine MAGI-based Medicaid eligibility.). There are a number of different options that the Medicaid agency could use to effectuate this requirement in compliance with the single State agency's responsibility to determine Medicaid eligibility described at § 431.10(b)(3).

- If the separate CHIP is administered by the single State agency that administers the Medicaid program, then the single State agency itself can determine Medicaid eligibility at the same time as it is determining CHIP ineligibility.
- If the separate CHIP is not part of the single State agency, then as described at proposed § 435.1200(b)(4)(i), the Medicaid and

CHIP agencies could agree to utilize the same MAGI-based methodologies under §§ 435.603 and 457.315, and verification policies and procedures under §§ 435.940 through 435.956 and 457.380, such that the Medicaid agency would accept any finding relating to a criterion of eligibility made by a separate CHIP agency without further verification in accordance with current regulations at § 435.1200(d)(4).

- As described at proposed § 435.1200(b)(4)(ii), the agency may use a shared eligibility service that allows the Medicaid agency to maintain responsibility for the rules and requirements used to determine Medicaid eligibility, while permitting the separate CHIP agency to determine Medicaid eligibility by running the rules in the shared eligibility service maintained by the Medicaid agency when ineligibility for CHIP is determined. In such cases, any functions performed by the separate CHIP agency would be solely administrative in nature, and not reflective of a delegation of authority to make Medicaid eligibility determinations.
- If the separate CHIP agency does not use the same MAGI-based methodologies and verification procedures as those used by Medicaid, and the two programs do not share an eligibility service with the Medicaid agency, we propose at § 435.1200(b)(4)(iii) that the Medicaid agency may enter into an agreement in accordance with § 431.10(d) of the regulations, as amended in this proposed rule, and § 431.10(c) under which the Medicaid agency delegates authority to make final Medicaid eligibility determinations to the entity that makes eligibility determinations for a separate CHIP agency. To effectuate this option, we propose to add the State agencies that administer the separate CHIP and BHP programs to the list of entities in § 431.10(c)(1)(i)(A) to which the Medicaid agency may delegate authority to make determinations of Medicaid eligibility. A separate BHP agency is added to the list of entities to which Medicaid may delegate eligibility determinations to accommodate either an option or a requirement for a State's BHP to complete determinations of Medicaid eligibility.
- Finally, at proposed § 435.1200(b)(4)(iv), we would provide States with the option to utilize a different policy or procedure approved by the Secretary.

We request comment on whether there are different ways that States with a separate CHIP agency should be permitted to effectuate a seamless transition of eligibility into Medicaid for individuals determined ineligible for CHIP.

We also propose to expand the scope of paragraph (c) of § 435.1200, which provides for the provision of Medicaid to individuals determined eligible by another insurance affordability program. Current § 435.1200(c) applies only to States that have entered into an agreement under which the Exchange or another insurance affordability program makes final determinations of Medicaid eligibility. We propose to amend § 435.1200(c) to require Medicaid agencies, which must accept final determinations of Medicaid eligibility completed by a separate CHIP agency in accordance with proposed paragraph (b)(4), to do so in accordance with the requirements of paragraph (c), as described below.

Current § 435.1200(c)(1) through (c)(3) require the Medicaid agency to establish procedures to receive electronic accounts from another insurance affordability program; comply with the requirements of § 435.911 (relating to determinations of Medicaid eligibility) to the same extent as if the Medicaid agency had received the application in an account transferred to it; and maintain proper oversight of the Medicaid program. We propose to redesignate the responsibilities described at current § 435.1200(c)(1) through (c)(3) as paragraphs (c)(1)(i) through (iii), to delete the current introductory language in § 435.1200(c), and to add a new paragraph (c)(2) to describe the individuals who would be subject to the requirements set out in proposed paragraph (c)(1).

Specifically, proposed § 435.1200(c)(2)(i) describes the individuals currently subject to the requirements in § 435.1200(c)—that is, individuals determined Medicaid eligible by the Exchanges or other insurance affordability programs (for example, a BHP), including as a result of a decision made by the appeals entity for such program, if the agency has entered into an agreement under which the Exchange or other insurance affordability program may make final determinations of Medicaid eligibility. Proposed § 435.1200(c)(2)(ii) describes individuals who are determined Medicaid eligible by a separate CHIP agency, including as the result of a decision made by a CHIP review entity in accordance with proposed 435.1200(b)(4).

Because we propose to require all States with a separate CHIP to fulfill the responsibilities of proposed § 435.1200(c), not just those States that choose to enter into an agreement with another insurance affordability program, we also propose to revise the general requirement at § 435.1200(b)(1) (which currently provides that the Medicaid agency fulfill the requirements set forth in § 435.1200(d) through (h)) to include paragraph (c) in the list of requirements in § 435.1200 which the Medicaid agency must fulfill. Similarly, we propose to revise § 435.1200(b)(3)(ii), which provides that the agreements established between the Medicaid agency and other insurance affordability programs must ensure compliance with § 435.1200(d) through (h), to include paragraph (c) of § 435.1200.

We do not propose to make any changes to § 435.1200(d) in this proposed rule. Paragraph (d) requires the Medicaid agency to accept a determination of potential Medicaid eligibility made by another insurance affordability program. Because this rule would not require the Medicaid agency to enter into an agreement to accept eligibility determinations made by a BHP or Exchange or to make determinations of eligibility for BHP or for insurance affordability programs available through the Exchanges, we believe this paragraph will continue to be necessary in these cases. In addition, we recognize that there may be cases in which a separate CHIP agency does not have access to all information needed to determine eligibility for Medicaid (for example, on a non-MAGI basis), but may be able to complete a determination of potential eligibility and transfer the individual's electronic account to the Medicaid agency to request the additional information and complete the determination.

The proposed revisions to § 435.1200(c) aim to improve the seamless transition of individuals from a separate CHIP *to Medicaid.* We also propose changes to § 435.1200(e) to improve the seamless transitioning of individuals *from Medicaid* to a separate CHIP. Current § 435.1200(e)(1) describes the requirements that, for individuals determined ineligible for Medicaid, the Medicaid agency determine potential eligibility for and, as appropriate, transfer via a secure electronic interface the individual's electronic account to another insurance affordability program (that is, CHIP, BHP or Exchange).

As mentioned previously, current § 435.1200(e)(1) does not require the agency to transfer an individual's account to another insurance affordability if the individual fails to submit a ''renewal to the agency which includes sufficient information to determine Medicaid eligibility[.]'' We propose to remove reference to submission of a renewal form, such that

the Medicaid agency would be required to transfer the account of an individual who, during a regularly-scheduled renewal or redetermination based on a change in circumstances, has been determined ineligible for Medicaid and determined eligible, or potentially eligible, for another insurance affordability program based on available information. We note that this does not change the agency's obligation to provide individuals with an opportunity to dispute the information obtained by the agency indicating Medicaid ineligibility before the agency terminates their Medicaid eligibility, as required at current § 435.952(d), or to provide advance notice of termination and fair hearing rights in accordance with part 431 subpart E of the regulations.

We also propose to revise § 435.1200(e)(1) by breaking it into two paragraphs—paragraphs (e)(1)(i) and (ii)—establishing separate requirements for situations in which the Medicaid agency completes a determination of eligibility for a separate CHIP agency and situations in which the Medicaid agency makes a determination of *potential* eligibility for BHP or for insurance affordability programs available through the Exchanges.

At proposed § 435.1200(e)(1)(i), we would require that in a State that operates a separate CHIP, when the Medicaid agency determines an individual to be ineligible for Medicaid, it must also determine whether the individual is eligible for CHIP using information available to the agency. Information on the individual's financial eligibility will already be available in the eligibility system, along with certain non-financial eligibility factors such as State residency and citizenship or eligible immigration status. Other eligibility criteria which may be applicable to determining eligibility for CHIP, which are not relevant in a Medicaid determination, include enrollment in other insurance coverage and access to State employee health insurance. We believe State Medicaid agencies have access to other reliable data sources from which they can obtain any additional information that may be needed about these criteria. State Medicaid agencies have information on other insurance coverage that a beneficiary may have, which States are required to obtain from insurers for purposes of third-party liability and coordination of benefits per section 1902(a)(25)(I) of the Act. State Medicaid agencies also can access information on the availability of State employee health coverage from the State agency which administers such coverage. We believe it is consistent with simplicity of administration and the best interests of beneficiaries for the agency to be expected to access these data sources to make a determination of eligibility for CHIP.

We recognize that it may be easier for some States to identify access to State employee health coverage than others. For example, in some States, a single State agency may administer the employee health plan for all State employees, and the plan may be available only to State employees and their dependents. While in other States, particularly those in which the government is more decentralized or in which local government agencies also participate in State employee health coverage, we believe it may be more difficult to access such information. We seek comment on State Medicaid agencies' ability to collect information on access to State employee health coverage, particularly if a child is not already enrolled in such coverage, without requiring additional information from the family.

Ideally, an individual's enrollment in CHIP would be effectuated at the same time the State terminates coverage in Medicaid so the individual would not experience a period of uninsurance. However, we recognize that the separate CHIP agency may require payment of an enrollment fee or premium or other action, like plan selection, before enrollment can be completed. A combined notice, discussed later in this section, may mitigate some risk of a coverage gap by notifying the individual about the CHIP enrollment fee or premium requirement at the same time advance notice of Medicaid termination is issued, providing some additional time for families to make the required CHIP payment before Medicaid coverage ends. We seek comment on challenges States may face in smoothly transitioning enrollment from Medicaid to CHIP and processes that could be implemented to address these challenges. We also seek comment on whether there are situations in which the Medicaid agency would be able to complete only a determination of potential eligibility for CHIP, such that the final regulation would need to allow for situations in which the Medicaid agency would transfer the individual's electronic account to the agency administering a separate CHIP to finalize the determination for its own program.

Proposed § 435.1200(e)(1)(ii) would require that when the Medicaid agency determines an individual to be ineligible for both Medicaid and CHIP, the agency must determine potential eligibility for BHP if the State operates a BHP and if ineligible for BHP, the agency must determine potential eligibility for insurance affordability programs available through the Exchanges. This is consistent with the current regulatory requirement at § 435.1200(e)(1).

As important as it is to transition an individual from one insurance affordability program to another when eligibility changes, it is equally important to ensure that such individual receives clear and consistent information about the transition, both before the change is effectuated and when the transition occurs. It can be very confusing for individuals to receive separate notices from the Medicaid program and CHIP, particularly when they arrive at different times. Accordingly, we propose to require that individuals be provided with a combined eligibility notice when either the Medicaid agency determines the individual ineligible for Medicaid and eligible for CHIP or the separate CHIP agency determines the individual eligible for Medicaid and ineligible for CHIP.

A ''combined eligibility notice'' is defined at current § 435.4 as an eligibility notice that informs an individual or multiple family members of a household of eligibility for each of the insurance affordability programs, for which a determination or denial of eligibility was made, as well as any right to request a fair hearing or appeal related to the determination made for each program. A combined notice must meet the general requirements described at § 435.917(a), along with the more specific requirements at §§ 435.917(b) (relating to required content) and 435.917(c) (relating to pursuing eligibility on a non-MAGI basis), except that information described in §§ 435.917(b)(1)(iii) (relating to medically needy coverage) and 435.917(b)(1)(iv) (relating to covered benefits and services) may be included either in a combined notice issued by another insurance affordability program or in a supplemental notice provided by the agency. A combined eligibility notice must be issued in accordance with the agreement(s) between the agency and other insurance affordability program(s) per § 435.1200(b)(3).

Current § 435.1200(h)(1) requires that, to the maximum extent feasible, individuals and households receive a single notice rather than separate notices from each applicable insurance affordability program, communicating the determination of eligibility as required under §§ 435.917 and 457.340. In the preamble to the 2016 final rule,

we noted concerns from a number of commenters about the ability of State systems to issue a combined notice and described several considerations when looking at the feasibility of issuing combined notices. These considerations included whether the State uses a shared eligibility service, whether the State relies on a Federally-facilitated Exchange to make determinations of Medicaid eligibility, and the maturity of the State's systems with greater use of combined eligibility notices expected as systems mature. In the 2016 final rule, we explained that it should be feasible to issue a combined notice when a single eligibility system or shared eligibility service is making determinations for multiple programs. As such, we believe that when the agency is enrolling an individual in Medicaid based on a determination of eligibility completed by another program, or vice versa, issuance of a combined eligibility notice should always be feasible.

Therefore, we propose to revise § 435.1200(h)(1) to require in all cases that individuals determined ineligible for Medicaid and eligible for CHIP in States with separate CHIP and Medicaid agencies in accordance with proposed § 435.1200(e)(1)(i) receive a combined eligibility notice informing them that: (1) they have been determined no longer eligible for Medicaid; and (2) they have been determined eligible for CHIP. Similarly, we propose to require the Medicaid agency to ensure that an individual determined eligible for Medicaid by a separate CHIP agency also receives a combined notice. We propose to effectuate this requirement through a new paragraph (h)(1)(i) at § 435.1200, which would require that the Medicaid agency include in its agreement with a separate CHIP agency (as described in § 435.1200(b)(3) and revised in this rulemaking), that either the Medicaid agency or the CHIP agency will provide such combined eligibility notice explaining both the termination of eligibility for Medicaid and the determination of eligibility for CHIP or vice versa. States that operate its CHIP and Medicaid programs under the same agency and eligibility system that already provide a seamless, combined Medicaid and CHIP notice, may not need to make any changes. Note that regardless of which entity sends the combined notice, per the definition of combined notice in § 435.4 of the current regulations, the Medicaid content of the notice must comply with the requirements set forth in § 435.917.

Proposed § 435.1200(h)(1)(ii) would maintain the requirement in current § 435.1200(h)(1) that, to the maximum extent feasible, a combined eligibility notice be issued in all other cases (that is, situations not described at proposed § 435.1200(h)(1)(i)), consistent with current regulations. This provision would apply to situations in which the Medicaid agency has determined an individual to be potentially eligible for a BHP or insurance affordability programs available through the Exchanges, and to situations in which an Exchange, CHIP or BHP has made an assessment of potential Medicaid eligibility, including on a non-MAGI basis, but not a final determination. In addition, as currently required, when more than one individual is included on an application or renewal, Medicaid and the other insurance affordability programs would be expected to provide a single combined notice for all household members to the extent possible, even if members are eligible for different programs.

We recognize that State eligibility systems still continue to mature and many States are still working through a backlog of system changes to correct issues arising from changes made in response to earlier rulemaking. We seek comment on the feasibility of implementing a combined notice for Medicaid and CHIP eligibility determinations, as well a combined notice with determinations of BHP and insurance affordability programs available through the Exchanges, both in States using a fully integrated eligibility system or shared system and in States utilizing separate systems. We also seek comment on the time that would be required for States to implement these changes if they are not already issuing combined eligibility notices.

Finally, we propose one overarching policy change and several technical amendments to § 435.1200. With respect to the policy change, we propose to clarify that the requirements at proposed § 435.1200(e)(1) (related to determining eligibility or potential eligibility for other insurance affordability programs) apply not only to individuals who have been determined ineligible for Medicaid on all bases, but also to individuals who have been determined ineligible for Medicaid coverage that is considered minimum essential coverage as defined at § 435.4. We would effectuate this requirement through a new paragraph (e)(4) at § 435.1200. Consider for example, an individual covered under the eligibility group for children under age 19 (described at § 435.118), which provides minimum essential coverage. If the agency determines that the individual's MAGI-based household income has increased such that it exceeds the income standard for that eligibility group and the only group for which that individual is eligible is the eligibility group in which coverage is limited to family planning and family planning-related services (described at § 435.214), which does not provide minimum essential coverage, then in accordance with proposed § 435.1200(e)(1), the agency would be required to determine that individual's eligibility for a separate CHIP. If the State either does not offer a separate CHIP, or the individual does not meet the eligibility requirements for that program, then the agency would need to determine that individual's potential eligibility for BHP and for insurance affordability programs available through the Exchanges and transfer the individual's account in accordance with proposed § 435.1200(e)(1)(iii).

Regarding the technical amendments, first we propose to remove ''and definitions'' from the title of § 435.1200(b), as definitions are currently included in § 435.1200(a), and we propose to correct the spelling of ''programs'' in § 435.1200(b)(3)(i). Second, we propose a technical change to 435.1200(e)(1) to replace the reference to § 435.916(d) with a reference to proposed § 435.919 to reflect the re-designation of current § 435.916(d) at § 435.919 in this proposed rule. And third, we propose to correct a numbering error in § 435.1200(h). The paragraph following § 435.1200(h)(3)(i)(B) was incorrectly numbered as (i), and we propose to renumber this paragraph as § 435.1200(h)(3)(ii).

In summary, the proposed changes to § 435.1200 would require the Medicaid agency to:

- Ensure that the agreement between the agency and the separate CHIP agency includes procedures for the seamless transition of eligibility between programs;
- Accept determinations of Medicaid eligibility made by a separate CHIP agency;
- Make determinations of CHIP eligibility and transfer eligible individuals to the separate CHIP agency; and
- Provide for the issuance of a combined notice to an individual who is determined ineligible for Medicaid and eligible for CHIP or eligible for Medicaid and ineligible for CHIP.

We considered applying these same changes to BHP agencies. Currently, the BHP regulation at § 600.330(a) requires the BHP agency to establish eligibility and enrollment mechanisms and procedures to maximize coordination with the Exchange, Medicaid, and CHIP.

Additionally, it requires a State BHP agency to fulfill the requirements of § 435.1200(d) and (e), and if applicable, paragraph (c) for BHP eligible individuals. In this proposed rule, we propose to revise § 600.330(a) to limit the Medicaid requirements that a BHP agency must fulfill to those in § 435.1200(d), (e)(1)(ii) and (e)(3). Paragraph (c) of § 435.1200 would still be required when applicable (that is, when the BHP agency has entered into an agreement with another insurance affordability program to make final determinations of BHP eligibility).

We seek comment on whether it is appropriate to apply the changes designed to create seamless transitions between Medicaid and a separate CHIP to BHP as well. This would include maintaining the current language in § 600.330(a) and revising paragraphs (b), (c), (e), and (h) of § 435.1200 to require the Medicaid agency to amend its agreement with the BHP agency to seamlessly transition eligibility between programs, to accept determinations of Medicaid eligibility made by the BHP agency, to make determinations of BHP eligibility, and to provide for the issuance of a combined Medicaid and BHP eligibility notice. or to maintain current coordination requirements, such that BHPs are required only to evaluate potential eligibility for Medicaid and CHIP and to accept determinations of potential BHP eligibility made by a Medicaid or separate CHIP agency. This would not prohibit a BHP from entering into an agreement with Medicaid and/or CHIP in which each agency completes determinations of eligibility for the other. These changes would require the State Medicaid agency to make a determination of eligibility for BHP based on information available through electronic or other data sources. We seek comment on whether it is possible for the Medicaid agency to gather the information necessary to complete such a determination, specifically, information on other affordable insurance coverage available to an individual.

6. Optional Group for Reasonable Classification of Individuals Under 21 Who Meet Criteria for Another Optional Group (§ 435.223)

Section 1902(a)(10)(A)(ii) of the Act authorizes States to provide Medicaid to one or more of the categorical populations described in section 1905(a) of the Act who also meet the requirements described in section 1902(a)(10)(A)(ii) of the Act (which lists the optional categorically needy eligibility groups). With specific regard to the categorical population described in section 1905(a)(i) of the Act—individuals under age 21 or, at State option, under age 20, 19 or 18—the introductory language in section 1902(a)(10)(A)(ii) of the Act permits States to extend medical assistance to ''reasonable categories'' of such individuals. Section 435.222 implemented optional coverage of individuals under the age of 21, 20, 19, or 18, or a reasonable category of such individuals (referred to as ''reasonable classifications'' in the regulations) who meet the AFDC income and resource requirements, as described in section 1902(a)(10)(A)(ii)(I) of the Act. Prior to January 1, 2014, and the implementation of MAGI-based methodologies under the ACA, States also were permitted to raise the effective income standard for eligibility for coverage under this group through adoption of income disregards under section 1902(r)(2) of the Act and § 435.601(d) of the regulations. Many States used a combination of these authorities to provide Medicaid to all individuals under age 21, as well as to various State-defined reasonable classifications of such individuals up to varying income standards under their State plan.

Revisions finalized in the 2016 eligibility and enrollment final rule reflect the adoption of MAGI-based methodologies in determining financial eligibility for most individuals under Medicaid, including individuals under age 21 eligible under § 435.222. The elimination of income disregards under MAGI-based methodologies (see § 435.603(g)) also effectively limits the flexibility States previously had to raise the effective income standard for coverage under § 435.222 to meet the needs of new reasonable classifications of individuals under age 21 who are not eligible under the mandatory group for children at § 435.118 or, in the case of 19 and 20-year-olds, under the adult group at § 435.119. Other flexibilities, however, are provided in the statute which States may wish to employ to meet the coverage needs of reasonable classifications of children who are excepted from mandatory application of MAGI-based methods under the statute and regulations or otherwise fall outside the scope of § 435.222 (for example, individuals under age 21 seeking coverage on the basis of a disability or blindness or who meet a specified level-of-care need).

As noted above, States have the flexibility to provide coverage to individuals under age 21 (or, at State option, under age 20, 19 or 18) or to reasonable classifications of such individuals who meet the requirements of *any* subparagraph of section 1902(a)(10)(A)(ii) of the Act, which includes, but is not limited to, clause (I) of such section. For example, a State that has selected the eligibility category described in section 1902(a)(10)(A)(ii)(I) of the Act for individuals who meet AFDC requirements could define a reasonable classification of individuals under age 21 to include individuals who meet a level-of-care need for HCBS. A State that has not selected the eligibility category described in section 1902(a)(10)(A)(ii)(I) of the Act but has instead selected the eligibility category described in section 1902(a)(10)(A)(ii)(X) of the Act, relating to individuals who have disabilities or are 65 years old or older, could similarly define a reasonable classification of individuals who are under 21 and meet an HCBS-related level of care.

The terms of the current § 435.222, however, do not accommodate the adoption of such reasonable classifications, either because the regulation requires application of an income test that is based on ''household income,'' which generally is defined in § 435.4 to mean MAGI-based income, or limits inclusion of ''reasonable classifications'' to the eligibility categories described in section 1902(a)(10)(A)(ii)(I) and (IV) of the Act (or both).

To reflect the flexibility that we believe States are afforded under the statute, we are proposing to add a new § 435.223 under which States may provide coverage to all individuals under age 21, 20, 19, or 18, or to a reasonable classification of such individuals, who meet the requirements of any clause of section 1902(a)(10)(A)(ii) of the Act (as implemented in subpart C of part 435 of the regulations to the extent to which a given clause is so implemented).

While coverage under proposed § 435.223 is not expressly limited to individuals excepted from MAGI under § 435.603(j), we believe that, as a practical matter, this will most typically be the case, as coverage for a reasonable classification of individuals under age 21 who are not excepted from the mandatory use of MAGI-based methodologies is already permitted by § 435.222. Considering this and the need to distinguish § 435.222 and the proposed § 435.223, we propose to change the heading for § 435.222 to read, ''Optional eligibility for reasonable classifications of individuals under 21 with income below a MAGI-equivalent standard.''

For individuals excepted from the mandatory use of MAGI-based methodologies, § 435.601 generally

requires that States apply the financial methodologies and requirements of the cash assistance program that is most closely categorically related to the individual's status. In the case of individuals who are under age 21 and who have blindness or disabilities, this generally means application of SSI-related financial methodologies. In the case individuals under age 21 who do not have blindness or disabilities, this means application of the financial methodologies in the State's former AFDC program.

Because of the elimination of the AFDC program in 1996 and the replacement of AFDC-based methodologies with MAGI-based methodologies for determining financial eligibility for individuals not excepted from MAGI-based methods under the ACA, in the 2012 eligibility final rule, we provided States with flexibility under § 435.831(b)(1)(ii) to apply either AFDC-based methodologies or MAGI-like methodologies, with limited exception, in determining eligibility for medically needy individuals under age 21, pregnant individuals, and parents and other caretaker relatives. Without this flexibility, States would be required to apply AFDC-based methodologies to these medically needy populations, even though the AFDC program ceased to exist over 25 years ago and those methodologies have no other applicability. Proposed § 435.601(f)(1)(i) and (ii) similarly provides States with flexibility to apply, at State option, either AFDC-based methods or MAGI-like methods in determining income eligibility for individuals under age 21, for whom the most closely categorically related cash assistance program is AFDC.

The limited exception to application of ''true'' MAGI-based methodologies described in § 435.603 of the regulations to medically needy individuals under § 435.831(b)(1)(ii) stems from section 1902(a)(17)(D) of the Act. This statutory provision, implemented at § 435.602 of the regulations, prohibits States from taking into account the financial responsibility of any individual in determining eligibility for any applicant or beneficiary under the State plan unless such applicant or recipient is the individual's spouse or the individual's child who is under age 21, or with blindness or disability. This limitation continues to apply to all individuals excepted from mandatory application of MAGI-based methods under section 1902(e)(14)(D) of the Act, implemented at § 435.603(j). Therefore, similar to the limitation on the flexibility afforded States under § 435.831(b)(1)(ii) to apply MAGI-based methodologies for otherwise AFDC-related medically needy individuals, proposed § 435.601(f)(1)(ii)(B) requires that, in applying MAGI-based methodologies, States must ensure that there is no deeming of income or attribution of financial responsibility that would conflict with the requirements of section 1902(a)(17)(D) of the Act; that is, in determining eligibility under proposed § 435.223 for an individual under age 21 who is described in § 435.603(j) as exempt from the MAGI methodologies set forth in § 435.603, no income other than the income of the individual or his or her parent(s) and/or spouse, would be counted, even if the income of someone else would be counted under the MAGI-based methods defined in § 435.603.

We also propose two technical changes related to the amendment of § 435.601(f). In paragraphs (b)(2) and (d)(1) of § 435.601, we replace the cross reference to § 435.831(b)(1) (which provides an exception to the general rule to use the methods of the most closely categorically related cash assistance program) with a reference to the new subparagraph (f)(1)(ii)(B), which provides for the same exception. Note that, under section 1902(r)(2) of the Act and § 435.601(d), a State also could apply less restrictive methodologies than either AFDC or the MAGI-like methodologies adopted in accordance with the option at proposed § 435.601(e), including application of income disregards. By disregarding all resources, States, at their option, also could effectively eliminate application of an asset test for individuals excepted from MAGI-based methods in accordance with § 435.603(j) who are seeking coverage under an optional coverage group adopted in accordance with proposed § 435.223.

C. Eliminating Barriers to Access in Medicaid

1. Remove Optional Limitation on the Number of Reasonable Opportunity Periods (§§ 435.956 and 457.380)

Sections 1902(a)(46)(B), 1902(ee)(1)(B)(ii), 1903(x)(4), and 1137(d)(4)(A) of the Act, implemented at § 435.956(b) for Medicaid and through a cross-reference at § 457.380(b)(1)(ii) for CHIP, set forth the requirement for States to provide a reasonable opportunity period (ROP) for individuals who have attested to citizenship or satisfactory immigration status, and for whom the State is unable to verify citizenship or satisfactory immigration status when the individual meets all other eligibility requirements, in accordance with § 435.956(a).

During the ROP, the State agency must continue efforts to complete verification of the individual's citizenship or satisfactory immigration status, or request documentation, if necessary. In accordance with § 435.956(b)(2), during the ROP, the State agency must furnish Medicaid benefits to individuals who meet all other eligibility requirements, and may elect to do so effective as of the date of application or the first day of the month of application, consistent with § 435.915(b).

In the November 30, 2016 **Federal Register**, we issued the ''Medicaid and Children's Health Insurance Programs: Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Other Provisions Related to Eligibility and Enrollment for Medicaid and CHIP'' Final Rule [61] (81 FR 86382) (referred to hereafter as the ''2016 eligibility and enrollment final rule''), which set forth regulations governing the ROP at § 435.956. At § 435.956(b)(4), we provided an option for States to limit the number of ROPs that a given individual may receive, if the State demonstrates that the lack of limits jeopardizes program integrity and receives approval of a State plan amendment (SPA) prior to implementing such limits. This option to limit an individual's number of ROPs applies to individuals who re-apply for coverage after they have been determined to be ineligible for Medicaid due to failure to verify citizenship, U.S. national status, or satisfactory immigration status during the ROP provided in connection with a prior application.

We finalized this State option in the 2016 eligibility and enrollment final rule in response to public comments that we received on the ''Medicaid, Children's Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing'' proposed rule that published in the January 22, 2013, **Federal Register** (78 FR 4593).[62] In particular, one commenter stated that

[61] Accessed from: *https://www.federalregister.gov/documents/2016/11/30/2016-27848/medicaid-and-childrens-health-insurance-programs-eligibility-notices-fair-hearing-and-appeal.*

[62] *https://www.federalregister.gov/documents/2013/01/22/2013-00659/medicaid-childrens-health-insurance-programs-and-exchanges-essential-health-benefits-in-alternative.*

the proposed rule could be interpreted to allow multiple (and unlimited) ROPs through the submission of subsequent applications despite the failure of verification of the individual's citizenship or immigration status. Another commenter questioned whether CMS considered limiting the number of ROPs that can be provided. In response to these comments, § 435.956(b)(4) of the final rule established the State option to limit the number of ROPs, provided that before the State implements such a limitation, the State: (1) demonstrates that the lack of limits jeopardizes program integrity; and (2) receives approval of a SPA electing the option.

Since the option was finalized, only one State has submitted a SPA requesting to implement this option, which we approved as a one-year pilot program to provide the State with an opportunity to demonstrate that not limiting the number of ROPs jeopardized program integrity in the State. The State's pilot program limited individuals to two ROPs during the 12-month pilot period. During the pilot, the State monitored requests for multiple ROPs, and collected data on the frequency and characteristics of individuals who re-applied after failing to complete verification of their status during their first ROP. From its data analysis of the pilot period, the State observed that the number of repeat ROPs provided by the State was minimal and concluded that the availability of multiple ROPs posed negligible risk to program integrity. Following the pilot, the State suspended the policy of limiting the ROP period and removed the policy from its State Plan. Other than the one State, CMS has not received any inquiries about establishing such a limitation or raising program integrity concerns related to ROPs.

Sections 1902(a)(46)(B), 1902(ee)(1)(B)(ii), 1903(x)(4), and 1137(d)(4)(A) of the Act do not expressly limit the number of ROPs an individual may receive, nor do these provisions expressly provide discretion for States to establish such a limit. In light of the absence of any indication that the availability of multiple ROPs poses significant risks to program integrity, we believe that removing the option for States to impose limits on the number of ROPs that an individual may receive is warranted. Therefore, we are interpreting the ambiguity in 1902(a)(46)(B), 1902(ee)(1)(B)(ii), 1903(x)(4), and 1137(d)(4)(A) of the Act with respect to this question of limiting the number of ROPs to remove the State option to limit the number of ROPs an applicant may receive after re-applying for benefits. We also find this proposal to be consistent with both section 1902(a)(19) of the Act, which requires that States provide safeguards as necessary to ensure that eligibility for care and services under the State plan are provided in a manner consistent with simplicity of administration and the best interests of the recipients, and section 1902(a)(8) of the Act, which requires that all individuals who wish to apply for Medicaid have the opportunity to do so. The ROP is integral to the Medicaid application process and ensuring prompt access to services for eligible individuals who have attested to U.S. citizenship, national, or satisfactory immigration status, but whose status cannot be promptly verified electronically. We note that an individual's status may change between the filing of applications or new information or evidence regarding U.S. citizenship/national status or satisfactory immigration status may become available. This policy revision supports the health and well-being of immigrants and their families in accordance with Executive Order 13993 ''Revision of Civil Immigration Enforcement Policies and Priorities'' and provides access to health coverage in Medicaid and CHIP for U.S. citizens and immigrants who are eligible to receive such coverage during a Reasonable Opportunity Period in accordance with Executive Order 14070 ''Continuing To Strengthen Americans' Access to Affordable, Quality Health Coverage.''

Therefore, we propose to revise § 435.956(b)(4) to remove the option for States to establish limits on the number of ROPs. Under proposed § 435.956(b)(4) for Medicaid and the existing cross-reference at § 457.380(b)(1)(ii) for CHIP, States would be prohibited from imposing limitations on the number of ROPs that an individual may receive.

2. Remove or Limit Requirement To Apply for Other Benefits (§ 435.608)

Under § 435.608(a) (relating to ''Applications for other benefits''), State Medicaid agencies must require that all Medicaid applicants and beneficiaries, as a condition of their eligibility, take all necessary steps to obtain other benefits to which they are entitled, unless they can show good cause for not doing so. Paragraph (b) of § 435.608 describes such benefits to include, but not be limited to, annuities, pensions, retirement, and disability benefits. (Veterans' compensation and pensions, Social Security disability insurance and retirement benefits, and unemployment compensation are specifically identified as examples). This requirement applies to all Medicaid applicants and beneficiaries, without regard to the basis of their eligibility or the financial eligibility methodology used to determine their eligibility.

This provision was originally promulgated in 1978 (see 43 FR 9810) and codified at the time at 42 CFR 448.3(b)(1)(ii) and 448.21(a)(2)(i)(C). It was redesignated later in 1978 at § 435.603 (see 43 FR 45204), and redesignated again in 1993 at § 435.608 (see 58 FR 4931). When the rule was established in 1978, we noted that: ''Section 1902(a)(17) of the Act requires that available income and resources must be considered in determining eligibility, except for amounts that would be disregarded (or set aside for future needs) by the AFDC [Aid to Families with Dependent Children] or SSI programs. Those programs require applicants and recipients to accept other cash benefits which are available to them; see: section 407(b)(2) of the Act and 45 CFR 233.20(a)(3)(ix) regarding AFDC; and section 1611(e)(2) of the Act and 20 CFR 416.230 and 416.1330 regarding SSI. Thus, this amendment conforms Medicaid requirements to those of the AFDC and SSI programs.'' (43 FR 9812).

Section 1902(a)(17)(B) of the Act directs that a State plan ''must provide for taking into account only such income and resources as are, as determined *in accordance with standards prescribed by the Secretary,* available to the applicant or recipient and . . . as would not be disregarded (or set aside for future needs) in determining his eligibility for such aid, assistance or benefits'' under various Federal cash assistance programs, including the SSI program and the former AFDC program (emphasis added). This statutory language prohibits State Medicaid agencies from taking into account income and resources not counted in determining eligibility for various Federal cash assistance programs described in section 1902(a)(17)(B) of the Act. However, section 1902(a)(17)(B) of the Act does not mandate that States must take into account all types or sources of income and resources that *are* counted in the eligibility determinations for those programs. Instead, the language specifically provides discretion to the Secretary to establish the standards under which income and resources not disregarded by the various Federal cash assistance programs should be considered ''available,'' that is, taken into account, in determining an individual's Medicaid eligibility.

Thus, while section 1902(a)(17)(B) of the Act *authorizes* the Secretary to consider as ''available'' income or resources Medicaid applicants and beneficiaries might receive if they applied for certain benefits, section 1902(a)(17)(B) of the Act does not require the Secretary to do so. Nor does section 1902(a)(17)(B) of the Act compel the Secretary to apply either the requirement in section 1611(e)(2) of the Act (that individuals seeking SSI apply for other benefits) or the requirement in former section 407(b)(2) of the Act (that individuals seeking AFDC benefits apply for AFDC) to individuals seeking Medicaid.

Adoption of the rule imposed in the SSI and AFDC programs to Medicaid was reasonable in 1978, given that the primary path to Medicaid eligibility at the time was receipt of SSI or AFDC benefits; the Medicaid eligibility pathways available for individuals not receiving assistance from a Federal cash assistance program, or deemed to be receiving assistance from such programs, were very limited.

However, Medicaid has significantly changed in the intervening years. For example, Medicaid eligibility was ''de-linked'' from cash assistance for a significant portion of the Medicaid population when the AFDC program was repealed and replaced with the Temporary Assistance for Needy Families (TANF) program in section 103 of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 (Pub. L. 104–193). Unlike AFDC, eligibility for TANF does not confer automatic eligibility for Medicaid. Additionally, numerous eligibility groups have since been authorized under the statute, including groups for children, pregnant individuals, parents and caretaker relatives, and other adults with income higher than the income standard for cash assistance programs and eligibility groups that have no income test, such as the mandatory eligibility group for former foster care children described in section 1902(a)(10)(A)(i)(IX) of the Act (implemented in the regulations at § 435.150), and the optional group serving individuals in need of breast or cervical cancer treatment described in section 1902(a)(10)(A)(ii)(XVIII) of the Act (implemented in the regulations at § 435.213).

Further, whereas financial eligibility for all eligibility groups previously had been based on the financial methodologies applied by a cash assistance program (primarily AFDC or SSI), effective January 1, 2014, the ACA directed States to apply an entirely different financial methodology in determining eligibility for most individuals seeking Medicaid coverage, based on Federal income tax rules in the Internal Revenue Code. This methodology, based on MAGI as defined under section 36B(d)(2) of the Internal Revenue Code, generally considers only amounts actually received by an individual and the individual's household members, and does not consider other amounts or benefits that the individual or other household members could receive if proactive steps were taken. Thus, there is no statutory mandate for the rule in § 435.608(a) that currently requires application for other benefits by Medicaid applicants and beneficiaries.

We have received a number of inquiries from States about the requirement to apply for other benefits. Some States specifically have requested flexibility to avoid applying this requirement to individuals otherwise eligible for the eligibility group for former foster care children which, as noted above, does not have an income test. These States noted that individuals who otherwise meet all requirements to be enrolled or remain enrolled in this group were losing Medicaid coverage due to failure to provide information on application for other benefits, such as unemployment compensation. Some States received beneficiary complaints related to the burden of this requirement and the impact on individuals who are required to apply for Social Security benefits before reaching their full retirement age. These States, in turn, reached out to CMS for guidance.

Given that the Medicaid program has largely outgrown the foundation upon which § 435.608 was based—that is, a close connection between Medicaid and cash assistance programs—and the barrier to coverage the requirement poses for some individuals, we believe it is appropriate to revisit this regulation. Specifically, we propose to reinterpret the meaning of ''such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient'' in section 1902(a)(17)(B) of the Act to encompass only the actual income and resources within the applicant's or beneficiary's immediate control, but not to encompass such income and resources that might be available if such individuals applied for, and were found eligible for, other benefits. This means that eligibility for Medicaid would no longer require that applicants and beneficiaries apply for benefits for which they may be entitled. We believe this interpretation is consistent with section 1902(a)(19) of the Act, which provides that eligibility be determined in a manner consistent with simplicity of administration and the best interests of recipients.

In developing our proposal, we are considering several alternative options to address the requirement to apply for other benefits. These alternatives are not mutually exclusive and could be used in combination with one another.

- We are considering revising the requirement in § 435.608 to include benefits that would count as income under the financial methodology used to determine the applicant or beneficiary's income. Individuals whose financial eligibility is determined using MAGI-based methodologies would not be required to apply for other benefits that would not count as income. For example, such a person would not be required to apply for benefits such as TANF or veterans' benefits as a condition of Medicaid eligibility because those benefits are not counted as income under MAGI-based methodologies. Additionally, individuals who are eligible for, or applying for coverage under, a Medicaid eligibility group that does not include an income test, would not be required to apply for other benefits, as receipt of other benefits would not impact an individual's income for purposes of Medicaid eligibility because it would not impact their eligibility. This would be true of, for example, individuals who are eligible for the former foster care children eligibility group and the eligibility group serving individuals in need of breast or cervical cancer treatment. This would also be true of individuals who are eligible for Medicaid on the basis of their receipt of assistance under title IV–E of the Act (see § 435.145). Under this option, however, individuals seeking coverage under an eligibility group applying the financial methodologies of the SSI program would be required, as a condition of eligibility, to apply for benefits that count as income in determining eligibility for SSI. For some individuals, in the course of processing an application, States must apply both the MAGI and non-MAGI methodologies before the most appropriate outcome is determined (see § 435.911(c)); eliminating the requirement to apply for other benefits for MAGI-based individuals but maintaining the requirement for non-MAGI individuals could be administratively burdensome for States. Therefore, we consider a proposal to eliminate the requirement for all Medicaid applicants and beneficiaries to be the better approach.
- We also are considering exempting SSI beneficiaries from the requirement

to apply for other benefits, including SSI beneficiaries in States that have elected their option under section 1902(f) of the Act to apply eligibility criteria more restrictive than the SSI program for individuals who seek eligibility on the basis of being 65 years old or older or who have blindness or disabilities (that is, 209(b) States), but not other applicants and beneficiaries whose financial eligibility is based on SSI financial methodologies. As mentioned above, Federal law requires SSI applicants and beneficiaries to apply for other benefits for which they may be eligible. This means that an SSI beneficiary who applies for Medicaid will have already applied for other benefits for which the individual may be eligible, except where the SSA itself has determined: (a) that it does not believe that there are other benefits for which the individual may be eligible; or (b) that, even if there are potentially other such benefits, receipt of such benefits would not affect the individual's underlying SSI eligibility or payment amount (see 20 CFR 416.210 and SI 00510.001 (''Overview of the Filing for Other Program Benefits Requirement'') in the SSA POMS). With this in mind, we believe that imposing the requirement in § 435.608(a) on SSI recipients would be duplicative. We acknowledge that it may be theoretically possible that, in non-1634 States (that is, criteria States and 209(b) States, as described above), there could be an SSI beneficiary who may be eligible for a benefit for which the SSA ultimately did not require the individual to apply but which could potentially affect the individual's Medicaid eligibility. However, we believe that such circumstances would be rare and do not outweigh the interests of the vast majority of individuals in 209(b) and criteria States, or simplicity of administration, consistent with section 1902(a)(19) of the Act, or efficiency of administration, consistent with section 1902(a)(19) of the Act. Even so, if the requirement were eliminated for all SSI beneficiaries, in addition to MAGI-based individuals, but preserved for non-SSI beneficiaries whose eligibility is based on either SSI methodologies or a 209(b) State's more restrictive methodologies, this approach could similarly create administrative burden for States. Therefore, we believe that a proposal to eliminate the requirement for all Medicaid populations is superior to this option as well.

We invite comment on these possible alternatives. If CMS were to adopt an alternative to the proposal to eliminate the requirement to apply for other benefits in its entirety, we would consider making several modifications to such requirement, as follows:

For those for whom we would maintain the requirement to apply for other benefits as a condition of eligibility, we are considering making the operation of the requirement a post-enrollment activity. Such a policy would be similar to, for example, the requirement that applicants attest that they will cooperate, while beneficiaries must cooperate, with identifying liable third parties under section 1902(a)(25) of the Act, as implemented at § 435.610(a)(2). Thus, applicants would need to attest to their agreement to apply for other benefits for which they may be eligible at application unless, consistent with the current regulation at § 435.608(a), they can show good cause for not doing so. States would follow up with the individual on compliance with the requirement post-enrollment, and non-cooperation by a beneficiary without good cause would be grounds for termination (subject to requirements for advance notice and fair hearing rights in 42 CFR part 431, subpart E).

We are considering revising the ''good cause'' exception at § 435.608(a) to incorporate language included in the ''good reason'' exception in the SSI regulations at 20 CFR 416.210(e)(2). Specifically, we are considering including two examples of situations satisfying the good cause exemption that are in the SSI provision: (a) where an individual is incapacitated; or (b) where it ''would be useless'' for an individual to apply for other benefits because the individual has previously applied for the other benefits and been denied and has not experienced a relevant change in circumstances since that time. Additionally, the SSI policy also excuses compliance with the requirement to apply for other benefits where an individual will not receive a benefit that will affect eligibility. Therefore, we are considering adding these specific examples in the reference in the ''good cause'' exception in § 435.608.

We are considering requiring States to provide written notice to each individual who is subject to the requirement in § 435.608 of the benefits for which the State believes the individual may be eligible and that the individual's Medicaid eligibility may be affected by the individual's failure to apply for such benefits. This is the SSA's approach in requiring that SSI applicants and beneficiaries file for other benefits, as described in 20 CFR 416.210(c), and we would consider this to be a reasonable condition precedent to imposing the requirement.

We seek comment on this proposal related to § 435.608 and how CMS can update the regulation to reduce unnecessary barriers to enrollment and to reduce burden on individuals and States. We are interested, for example, in whether or not it is the experience of State agencies that imposition of the existing rule commonly results in applicants or beneficiaries receiving additional eligibility-altering income. We are also interested in the experiences of applicants and beneficiaries in their compliance with this rule, such as whether it commonly delays favorable eligibility determinations, and, by extension access to care. We are mindful that the requirement imposed by § 435.608(a) is not similarly imposed in eligibility determinations for CHIP, the BHP, or insurance affordability programs available through the Exchanges, and we are interested in comments on the whether the approach of the latter programs is more practical. We also welcome comments on each of the alternatives we are considering that might be adopted in a final rule based on comments received.

In consideration of the foregoing analysis, we propose in this rulemaking to remove the requirement at § 435.608 entirely for all Medicaid applicants and beneficiaries to apply for other benefits to which they are entitled.

D. Recordkeeping (§§ 431.17, 435.914, and 457.965)

Comprehensive recordkeeping is essential to the proper and efficient administration of any State Medicaid program, consistent with section 1902(a)(4) of the Act. State Medicaid agencies must maintain records needed to justify and support the decisions made regarding all applicants and beneficiaries, defend decisions challenged by an applicant or beneficiary who requests a fair hearing, enable State and Federal auditors and reviewers to conduct appropriate oversight, and support the State's own quality control processes. Applicants and beneficiaries (or their authorized representative) must also be able to review the content of their case record prior to a fair hearing challenging an agency's decision.

Regulations at §§ 431.17 and 435.914 currently require that State Medicaid agencies' records for applicants and beneficiaries include sufficient content to substantiate the eligibility determination made by the State. However, these regulations are largely outdated and unclear. In many instances, the requirements lack the specificity reflective of the range of

records and information used by today's Medicaid programs. The requirements do not reflect modern technology, specifically the use of electronic data, and do not specify how long applicant and beneficiary case records must be retained, resulting in a range of retention periods across States. Over the years, we have received questions from Medicaid agencies requesting clarification on record retention policy, storage modalities, and retention periods.

HHS OIG reports also raise concerns about the adequacy of the case records maintained across State Medicaid agencies.[63] The HHS OIG reports identified case records that lack documentation of income, citizenship, or immigration status verification and found case records in which auditors could not access documents needed to evaluate the accuracy of a State's determination of eligibility. Additionally, PERM eligibility reviews in the FYs 2019, 2020, and 2021 cycles found that insufficient documentation was a leading cause of eligibility errors.[64]

To help States meet the requirement to maintain appropriate, comprehensive, and accessible records, consistent with section 1902(a)(4) of the Act, we propose to revise § 431.17 to more clearly delineate the types of information State Medicaid agencies must maintain in case records and to prescribe a minimum retention period. Reflecting modern forms of technology, we also propose to revise the regulations to require that States store their case records in an electronic format.

We propose revisions to § 431.17(b)(1) to detail the specific records and documentary evidence that must be retained as part of each applicant's and beneficiary's case record to support the determinations made by State Medicaid agencies. These records, which are critical to demonstrating that States are providing the proper amount of medical assistance to eligible individuals, include:

- All information provided on the initial application submitted by, or on behalf of, an applicant regardless of the modality through which a person applies for Medicaid (for example, online, by phone, in person or through the Exchange), including the signature and date of application;
- The electronic account and any information or documentation received from another insurance affordability program in accordance with § 435.1200(c) and (d);
- Any changes in circumstances reported by the individual and any actions taken by the agency in response to such reports;
- All renewal forms and information returned by or on behalf of the beneficiary to the agency in accordance with § 435.916, including the signature on any returned renewal form and the date the form was received;
- The date of and basis for any determination, denial, or other adverse action, including decisions made at application, at renewal, and as a result of a change in circumstance, affecting an applicant or beneficiary, as well as all documents or other evidence to support such action, including all information provided by, or on behalf of, the applicant or beneficiary and all information obtained electronically or otherwise by the agency or third-party sources. This includes information received from data sources as described in the regulations at §§ 435.940 through 435.960.
- The provision of, and payment for, services, items and other medical assistance. This includes services or items provided and dates that the services or items were provided; diagnoses related to services or items provided; names of the providers rendering or referring/prescribing the services or items (as applicable), including their National Provider Identifier; the full amounts billed and paid or reimbursed for the services or items; and any liable third party and the amount of such liabilities;
- All notices provided to the applicant or beneficiary under §§ 431.206, 435.917 or 435.918;
- All records pertaining to any fair hearings requested by, or on behalf of, the applicant or beneficiary, including each request submitted and the date of such request, the complete record of the hearing decision, as described in § 431.244(b), and the final administrative action taken by the agency following the hearing decision and date of such action; and
- The disposition of information received by the agency when conducting verifications per regulations at §§ 435.940 through 435.960, including evidence that no information was returned from a given data source. In documenting the disposition of information received through this process, the disposition of information received by the agency includes documentation that the agency determined that information received was not useful to verifying eligibility.

Neither the statute nor current regulations specify how long Medicaid records must be maintained. We believe that the length of record retention also is a critical factor to effective administration of the State plan and propose to revise § 431.17(c) to require that States maintain all records described in this regulation for the period that the applicant or beneficiary's case is active, plus a minimum of 3 years thereafter. In establishing this minimum time period, we assessed the areas of the Medicaid program for which there are time limits that would impact record retention, such as the PERM program, which operates on a 3-year cycle, and Medicaid timely filing, described at section 1132(a)(2) of the Act, which requires that States file any claim for payment no later than 2 years from the calendar quarter of the expenditure. We consider 3 years to be a reasonable minimum based on these factors. We consider a case to be active starting at the date of application. For applicants determined ineligible (that is, the application is denied), the case would be active through the date that a determination of ineligibility is made. For applicants determined eligible (that is, the application is approved), the case would be active until their eligibility is terminated or coverage otherwise ends. A case would also remain active for any applicant or beneficiary who has a pending fair hearing or appeal. In the event that a case becomes active again prior to the expiration of the 3-year period, the records retention clock would restart. In this case, under the proposed rule, the State would need to retain all prior records until 3 years after the individual's eligibility is again terminated or their coverage otherwise ends. For example, if a beneficiary, who initially applied for coverage in 2020, is terminated in 2022 due to an increase in income and in 2024 (2 years later) reapplies and is determined eligible, the case would become active again. The records retention clock would restart, and all of the individual's records from

[63] California Made Medicaid Payments on Behalf of Non-Newly Eligible Beneficiaries Who Did Not Meet Federal and State Requirements, Office of Inspector General, 2018. Available at *https://oig.hhs.gov/oas/reports/region9/91702002.pdf*; New York Did Not Correctly Determine Medicaid Eligibility for Some newly Enrolled Beneficiaries, Office of Inspector General, 2018. Available at *https://oig.hhs.gov/oas/reports/region2/21501015.pdf*; Kentucky Did Not Always Perform Medicaid Eligibility Determinations for Non-Newly Eligible Beneficiaries in Accordance with Federal and State Requirements, Office of Inspector General, 2017. Available at *https://oig.hhs.gov/oas/reports/region4/41608047.pdf*; Colorado Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries, Office of Inspector General, 2019. Available at *https://oig.hhs.gov/oas/reports/region7/71604228.pdf*.

[64] Fiscal Year 2019 Agency Financial Report, US Department of Health and Human Services, 2019. Available at *https://www.hhs.gov/sites/default/files/fy2019-hhs-agency-financial-report.pdf*.

his or her initial application and enrollment from 2020 to 2022 must be retained during the new retention period.

We believe that tying the retention period to the period of time that the case is active plus an additional 3 years will ensure that applicant and beneficiary records will be available for all circumstances in which such records may be needed, including after an individual is no longer enrolled in the Medicaid program. For example, if a formerly enrolled applicant reapplies to Medicaid 2 years after they lost coverage, States should rely on previously verified citizenship and immigration status unless the State has reason to believe something has changed. In order to rely on information previously verified, that information must be retained in the case record. Additionally, under the estate recovery program authorized by section 1917(b)(1) of the Act, States may recover payments for all Medicaid covered services. Therefore, States may need to access claims data in order to tally the cost of covered services for extended periods, depending on the length of the applicant's enrollment. We seek comment on the proposed retention period, as well as on whether a shorter or longer retention period should be required for certain types of records, including those pertaining to the provision of, and payment for, services, items and other medical assistance, or whether a shorter or longer period should be required for all records—for example, a period of 10 years for all records, similar to our policy regarding enrollee records for Medicare,[65] as well as the record retention policy applied to managed care organizations under § 438.3(u). We also seek comment on whether the retention period should be tied to the individual or the active case.

Current § 431.17(d) contains outdated regulation text that references obsolete or rarely used technology, including microfilm systems. We propose to update this paragraph to require that State Medicaid agencies store records in an electronic format and that the State Medicaid agency make records available to the Secretary or other appropriate parties, such as State and Federal auditors, within 30 calendar days of the date records are requested, if not otherwise specified. We seek comment on whether States should retain flexibility to maintain records in paper or other formats that reflect evolving technology. While each of the records and documentary evidence described in this section are considered part of the case record, we do not propose that these records must be stored in a single system.

Finally, we propose conforming revisions to § 431.17(a), relating to basis and purpose of § 431.17. We also propose revisions to § 435.914 of the current regulations, which also relates to case documentation, to reflect the full scope of records required under the proposed rule for both applicants and beneficiaries. Section 435.914(a) currently requires that States include in each applicant's case record facts to support the agency's decision on the application. Section 435.914(b) currently requires States to dispose of each application by either: (1) making a finding of eligibility or ineligibility; (2) documenting in the case record that the applicant voluntarily withdrew the application, and documenting that the agency sent a notice confirming such withdrawal; or (3) including an entry in the case record that the applicant has died or cannot be located. We propose to revise § 435.914(a) to apply to both applicant and beneficiary case records and to provide that the records maintained in each individual's case record include all those described in § 431.17(b)(1), as revised in this proposed rule. We propose to revise § 435.914(b) to provide that States must dispose of all applications and renewals by a finding of eligibility or ineligibility unless one of the three circumstances described above applies. The applicability of these requirements to a separate CHIP, including proposed changes to § 457.965, is discussed further in section II.E.5 of this preamble.

E. CHIP Proposed Changes—Streamlining Enrollment and Promoting Retention and Beneficiary Protections in CHIP

Current CHIP regulations adopt many of the Medicaid eligibility regulations, which require that States have methods of establishing and continuing eligibility, including coordinated and streamlined eligibility and enrollment processes between CHIP and other insurance affordability programs. In order to retain the alignment with Medicaid and other insurance affordability programs, we propose to adopt the same proposed policies for CHIP as are proposed for Medicaid in this proposed rule, except where otherwise noted. We discuss each of these proposed changes as they apply to CHIP below. We seek comment on whether there are any special considerations applicable to CHIP that warrant adoption of a different policy for CHIP than the proposed alignments with Medicaid requirements, which would include the various policies on which we specifically seek comment in the preamble discussing the proposed revisions to the Medicaid regulations.

1. Timely Determination and Redetermination of Eligibility and Related Reviews (§§ 457.340 and 457.1170)

As discussed in section II.B.3 of this proposed rule, we propose changes to §§ 435.907(d) and 435.912 of the Medicaid regulations to ensure applicants are provided a meaningful opportunity to provide additional information needed by the State to make an eligibility determination and to establish specific timeliness standards for completion of regularly-scheduled renewals and redeterminations of eligibility due to changes in circumstances, including when a State receives information needed to redetermine eligibility too close to the end of an enrollee's eligibility period to complete a redetermination of eligibility prior to the end of the eligibility period.

To ensure continued coordination between Medicaid and CHIP enrollment and renewal processes, as required by section 2102(b)(2)(E) of the Act, we propose to apply these changes equally to CHIP, except where otherwise noted. As discussed in section II.B.3 of this proposed rule, we propose revisions at § 435.907(d) to require that, if a State cannot determine Medicaid eligibility based on the information provided on the application and the State needs additional information from the applicant, the State must: (1) give applicants for whom a disability determination is not needed at least 15 calendar days from the date the request is postmarked or electronic request is sent to provide the requested information and 30 calendar days from the date the request is postmarked or electronic request is sent for applicants whose eligibility is being determined on the basis of disability; (2) allow applicants to respond through any of the modes of submission that must be available for submission of the application; and (3) reconsider the eligibility of individuals whose application is denied for failure to provide needed information if the individual provides the needed information within 30 calendar days from the date the denial notice is postmarked or electronic notice is sent without requiring the individual to submit a new application. The terms of § 435.907(d) are applicable to CHIP through an existing reference in § 457.330 to § 435.907. Therefore, these

[65] *CMS Records Schedule.* Available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/CMSRecordsSchedule/index.html.*

proposed changes would apply equally to CHIP, except as noted below with regard to a determination of disability, and no additional revisions to the CHIP regulations are needed.

We note that, unlike Medicaid, there are no distinct eligibility groups in CHIP for which a determination of disability is needed. Some States, however, have established a separate CHIP for children with special health care needs (CSHCN). We seek comment on whether the longer time to return additional information requested by the State at application at proposed § 435.907(d)(1)(i)(A) for individuals applying for Medicaid based on disability (a minimum of 30 calendar days), should be applied to children applying for a separate CHIP if a determination that the child qualifies as a CSHNC is required, as these families may similarly need more time to provide additional documentation or other information needed by the State to make a final determination on their application. We also seek comment on whether a minimum of 15 calendar days from the date the State's request for additional information is postmarked or electronically sent is sufficient for applicants generally (that is, regardless of any need for a determination of CSHCN status) or whether a longer timeframe, such as 20, 25, or 30 calendar days from the date the request is postmarked or electronically sent, similar to the longer time (30 calendar days) proposed for individuals applying for Medicaid on the basis of disability, is appropriate. As discussed in section II.B.3 of this proposed rule, we are also considering a minimum requirement of 30 calendar days from the date the request is postmarked or electronically sent for all applicants to provide additional information, along with an exception to the 45-day requirement at current § 435.912(c)(3)(ii) to provide States with an additional 15 calendar days to complete application processing if the State requested additional information from the applicant, which would apply to CHIP by existing references at § 457.340(d). We also seek comment regarding whether States should be afforded additional time to make a determination of eligibility for applicants seeking coverage under a separate CHIP for CSHCN, similar to the additional time (maximum of 90 calendar days) provided at § 435.912c)(3)(i)) for States to make a final determination of eligibility for individuals applying for Medicaid coverage based on disability and, if so, whether an a maximum of 60, 75, or 90 calendar days is appropriate for determining eligibility for a separate CHIP for CSHCN. Additionally, we seek comment on whether calendar or business days would be better suited as an appropriate timeliness measure. Finally, we also seek comment on whether a longer reconsideration period of 45 calendar days, or 90 calendar days, would be appropriate, similar to the proposed 90-day reconsideration period discussed in section II.B.1 and II.B.2 of this preamble if a beneficiary provides the requested information within 90 calendar days of termination without requiring a new application.

As also discussed in section II.B.3 of this proposed rule, we propose revisions to § 435.912 to specify that States must establish timeliness and performance standards for conducting regularly-scheduled renewals, as well as redeterminations of eligibility due to changes in enrollee circumstances, including maximum timeframes within which States must complete these actions. Proposed revisions to § 435.912 also specify the minimum timeframes that States must provide to enrollees to respond to requests for information when completing renewals. Similar to Medicaid, we also seek comment on the amount of time provided for States to complete a redetermination of eligibility at a regularly-scheduled renewal or based on changes in circumstances at proposed § 435.912(c)(4), (c)(5), and (c)(6), whether the regulations should allow for a longer or shorter period of time, and whether the use of business days rather than calendar days would be more appropriate. Section 435.912 of the Medicaid regulations is applicable to CHIP through an existing reference at § 457.340(d). Therefore, these proposed changes would apply equally to CHIP, except that we propose to revise § 457.340(d)(1) to exclude application of certain Medicaid requirements that are not applicable to CHIP. The Medicaid requirements not applicable to CHIP include § 435.912(c)(4)(iii) and (c)(6)(iii) (relating to timelines for completing renewals and redeterminations when States must consider other bases of eligibility per § 435.916(f)(1), which is redesignated as § 435.916(d)(1) in this proposed rule). We also propose to revise the title of § 457.340(d) to clarify that the timeliness standards apply both at application and renewal.

Finally, in order to support effective and efficient eligibility procedures, consistent with sections 2101(a) and 2102(b)(2) of the Act, we propose to modify section § 457.1170 to require that States ensure the opportunity for continued enrollment in CHIP during a review of a State's failure to make a timely determination of eligibility. Currently, States using a program specific review process for separate CHIP must only provide the opportunity for continued enrollment in CHIP pending the completion of a review for a suspension or termination of CHIP eligibility. We believe this proposed change to § 457.1170 will support a CHIP enrollee's rights during a review if a State fails to meet the proposed timeliness standards at both application and renewal consistent with proposed changes in § 435.912, as referenced in § 457.340(d).

Additionally, we propose to modify § 457.1170 to clarify that continuation of enrollment includes the continued provision of health benefits during the review period. Currently, § 457.1170 provides that States must ensure the opportunity for continuation of enrollment pending the completion of review of a suspension or termination of enrollment. While we acknowledge that, consistent with our definition of ''enrollee'' at § 457.10, coverage of health benefits is intrinsic to enrollment, we propose to add explicit reference to benefits at § 457.1170 to emphasize that continued enrollment without provision of benefits pending completion of a review of a termination or suspension of coverage does not satisfy the requirement at § 457.1170. Finally, we propose to make explicit references to continuation of benefits in §§ 457.1140 and 457.1180 when describing the process for continuation of enrollment or referencing in notices.

As discussed above in section II.B.3 of the preamble, we seek comment for both Medicaid and CHIP on whether proposed § 435.912(c)(4)(ii) (incorporated in CHIP through § 457.340(d)) balances maximizing the completion of timely renewals prior to the end of an enrollee's eligibility period and providing States with sufficient time to complete redeterminations and provide notice for enrollees who return needed documentation or other information prior to the end of their eligibility period, but not by the date requested by the agency to ensure completion of a timely renewal. The notice requirements for CHIP are located at § 457.340(e)(1).

2. Changes in Circumstances (§§ 457.344 and 457.960)

As discussed in sections II.B.2 of this proposed rule, we propose to revise and redesignate paragraphs (c) and (d) of current § 435.916, related to changes in circumstances, to a new § 435.919 that is devoted specifically to State and enrollees' responsibilities for acting on changes in circumstances. Proposed § 435.919 includes procedures for

enrollees to report changes to the Medicaid agency and specific steps States must take in promptly processing such changes.

We propose at § 435.919(c)(1) that States must provide a minimum of 30 calendar days for beneficiaries to respond to a request for additional information needed to determine eligibility based on a change in circumstances. We also propose at § 435.919(d) that State Medicaid agencies provide beneficiaries whose coverage is terminated due to failure to provide information needed to redetermine eligibility following a change in circumstances with a 90-day reconsideration period. During this 90-day period, if a beneficiary returns the requested information, the agency would be required to redetermine the individual's eligibility without requiring a new application.

Consistent with section 2102(b) of the Act related to a State's eligibility standards and methodologies, we propose to apply the changes at proposed § 435.919 to CHIP. Regulations governing changes in circumstances for CHIP beneficiaries are currently found in § 457.960. For greater transparency, we propose to remove § 457.960 in its entirety and incorporate the terms of proposed § 435.919 into a new § 457.344. Some of the provisions in current § 435.916 (redesignated at proposed § 435.919) are not applicable to CHIP and we are not proposing to adopt them through proposed changes to § 457.344. Specifically, we propose to not incorporate into § 457.344 the requirement proposed at § 435.919(b)(4)(i) (currently at § 435.916(f)(1)) related to determining eligibility upon all other bases. We do not believe this requirement is relevant for CHIP because the eligibility of all CHIP beneficiaries is based on MAGI, but we seek comment on whether it should be applied to CHIP in cases where a State has more than one separate CHIP population and an enrollee could transition between populations. For example, some States have a separate CHIP program specific to CSHCN or elect to provide coverage to other eligibility groups in CHIP, such as targeted low-income pregnant women.

Currently § 457.343 references § 435.916, in its entirety as applicable. For example, the current regulations specify where noted that other CHIP regulations regarding verification and noticing requirements apply in place of Medicaid regulations referenced in § 435.916. Outside the redesignation of § 435.916 (c) and (d) to § 435.919, as discussed above, the remaining changes to the regularly-scheduled renewal requirements at proposed § 435.916 will also apply to CHIP through this cross-reference. However, there are several proposed revisions to § 435.916 that would not be applicable to CHIP populations, such as proposed §§ 435.916(a)(2) related to Medicare beneficiaries, 435.916(b)(3) related to non-MAGI determinations, and 435.916(d)(1) (a redesignation of current § 435.916(f)(1)) related to considering eligibility on all bases prior to terminating a beneficiary.

3. Returned Mail (§ 457.344)

As discussed in section II.B.4 of the preamble, we propose requirements at § 435.919(f) describing the actions that States must take to verify an individual's address when the State receives returned mail, including the minimum amount of time States must provide to individuals to respond to such requests. Under this proposed rule, in addition to sending notices to the current address on file and the new address provided by USPS, the State must also attempt to contact the individual using other means, such as by telephone, email, text, or other electronic notice. Proposed §§ 435.919(f)(1), (2), and (3) specify the actions States must take to verify an individual's address, and proposed §§ 435.919(f)(4), (5) and (6) describe the actions States must take if an individual fails to confirm their address based on whether the forwarding address is in-state or out-of-state or there is no forwarding address. This rule also re-designates existing Medicaid requirements at § 431.231(d) as proposed § 435.919(f)(6). Under these requirements, States must reinstate coverage if an individual's whereabouts become known before their next renewal date. Finally, this rule proposes § 435.919(g), which describes the actions States may and must take when they receive updated in-state address information from the USPS NCOA database or the State's contracted managed care entities as well as requirements when they receive updated address information from other third-party sources, regardless of whether those data sources have or have not been approved by the Secretary.

Consistent with the section II.E.2 of the preamble, we are proposing that CHIP adopt the substance of proposed § 435.919 as § 457.344 with some exceptions. We also propose to apply the Medicaid provisions related to receipt of updated address information from returned mail, the USPS NCOA, a State's contracted managed care plans, and other third-party sources under § 435.919(f) and (g) equally to CHIP. Additionally, we clarify at § 457.344(f)(5) and (g)(1)(vii) that if any separate CHIP population is not available Statewide and the updated address lies outside of the specific geographic areas in which the State's separate CHIP provides coverage, the State is required to treat the newly identified address as out-of-state and take the appropriate actions when trying to verify an enrollee's address, regardless of whether the address is obtained due to returned mail or obtained from another third-party data source.

We seek also comment on several requirements in proposed § 457.344(f) and (g). Similar to the request for comments on proposed § 435.919(f), we seek comment with respect to proposed § 457.344(f) on whether States should be required to update an enrollee's in-state address using more recent contact information reflected in a forwarding address from USPS or an address provided by NCOA or a managed care plan in this situation, when the enrollee has not responded to the State's request to verify their current address. Additionally, we seek comment on whether States should be permitted or should be required to update enrollee contact information based on information obtained from an MCO, from the USPS NCOA, or USPS forwarding without first attempting to contact the enrollee to provide them with an opportunity to verify or dispute the new information, because such third-party data is reliable, and, if so, which data sources should States be permitted to rely upon without attempting to contact enrollees. We are especially interested in comments from States that received authority under section 1902(e)(14)(A) of the Act (which applies to CHIP through section 2107(e)(1)(I) of the Act) to update enrollee contact information based on information received from a reliable third party (for example, an MCO, USPS NCOA or USPS forwarding address) without first attempting to contact the individual, as described in SHO letter #22–001. States that received such authority were temporarily permitted to accept updated enrollee contact information from designated reliable sources without first contacting the individual in an effort to verify the accuracy of the new contact information. We also seek comment on the efficacy of the requirement to send a notice to an enrollee's address on file to ensure that initial piece of returned mail was not incorrectly returned.

We also seek comment on whether all States have a Medicaid Enterprise

System that encompasses both Medicaid and CHIP, as we have assumed under proposed § 457.344(f)(1)(i). Finally, inasmuch as proposed § 435.919(f)(6) (relating to individuals whose whereabouts become known) includes regulation text from an existing Medicaid regulation at § 431.231(d), we seek comment on whether any provisions of § 435.919(f)(6) should not be applied to CHIP at proposed § 457.344(f)(6). We believe there may be operational challenges States may face when implementing these provisions and we seek further comment on the potential impact of these provisions.

Finally, similar to Medicaid, we seek comment on whether under proposed § 457.344(g) States either should be permitted or should be required to update enrollee contact information based on information obtained from an MCO, from the USPS NCOA, or other reliable data sources, such as Indian Health Care Providers, Federally Qualified Health Centers, Rural Health Clinics, Program of All-inclusive Care for the Elderly providers, Primary Care Case Managers, Accountable Care Organizations, Patient Centered Medical Homes, Enrollment Brokers, or other State Human Services Agencies (for example, SNAP), without first attempting to contact the individual to provide them with an opportunity to verify or dispute the new information, because such third-party data is reliable, and, if so, which data sources should States be permitted to rely upon without attempting to contact enrollees.

We are especially interested in comments from States that received authority under section 1902(e)(14)(A) of the Act (which applies to CHIP through section 2107(e)(1)(I) of the Act) to update enrollee contact information based on information received from a reliable third party without first attempting to contact the enrollee, as described in SHO letter #22–001. We also seek comment on the efficacy of the requirement to send a notice to an enrollee's address on file to ensure that initial piece of returned mail was not incorrectly returned, and on the efficacy of the requirement to conduct at least two outreach attempts to the enrollee using a modality other than mail. We also seek comment on the requirements in proposed § 457.344(g)(3) cross referencing § 457.344(f)(2) through (6), related to processing out-of-state address information or address information from a source not identified in § 457.344(g)(1) or (2).

4. Transitions Between CHIP and Medicaid (§§ 457.340, 457.348, and 457.350)

As discussed in section II.B.5. of this preamble, every State with separate programs for Medicaid, CHIP, and BHP, and many States with a State-based Marketplace utilize a single eligibility system or shared eligibility service. As such, when an enrollee is determined ineligible for one program, and the individual is screened for potential eligibility in another program, the system is effectively making a determination of eligibility for the other program. An individual who applies at the Medicaid agency does not need to be screened and then transferred to the CHIP agency before a determination of CHIP eligibility can be completed, even if the CHIP agency operates separately from the Medicaid agency in the State. To improve transitions between programs and reduce the likelihood of individuals experiencing gaps in coverage, we proposed changes to the Medicaid transition requirements at § 435.1200. As discussed in detail in section II.B.5., these changes would require the Medicaid agency to determine eligibility for CHIP when an individual is determined ineligible for Medicaid, and seamlessly transition the individual's electronic account to the separate CHIP agency when determined eligible for CHIP; these changes would also require the Medicaid agency to accept determinations of MAGI-based Medicaid eligibility made by separate CHIP agencies and enroll those eligible individuals into Medicaid, through one of the mechanisms described in § 435.1200(b)(4). We also propose changes to the Medicaid regulations at § 435.1200(h)(1) to require States to provide a combined eligibility notice to individuals determined ineligible for Medicaid and eligible for separate CHIP. We similarly propose changes to § 457.340 to require the use of a combined notice for transitions between separate CHIP and Medicaid. Additionally, we propose changes to §§ 457.340, 457.348, and 457.350 to improve transitions between separate CHIP and Medicaid, as described below.

To help prevent children who are eligible for CHIP from becoming uninsured when their Medicaid eligibility is terminated, we propose to make several changes to current § 457.348, which establishes requirements for the State to coordinate transitions of eligibility between and with other insurance affordability programs. First, we propose to add a new paragraph to § 457.348 regarding agency responsibilities for transitioning eligibility. Paragraph (a) of current § 457.348 requires the State to enter into agreements with the agencies administering other insurance affordability programs to fulfill a number of requirements in this section, such as minimizing burden on individuals during the eligibility process, and ensuring prompt determination of eligibility and enrollment in the appropriate program without undue delay. We propose to revise § 457.348(a) to require that these agreements provide for not only coordination of notices, but also for a combined eligibility notice with other insurance affordability programs. We also propose to add a new paragraph (a)(6) to § 457.348, which would require the State to have an agreement with the Medicaid agency which clearly describes the responsibilities of each agency for ensuring a seamless transition between separate CHIP and Medicaid when an individual is determined ineligible for one program and eligible for another program. This is consistent with the proposed Medicaid revision at § 435.1200(b)(3)(vi).

Second, we propose to modify § 457.348(b) to require the CHIP agency to accept determinations of separate CHIP eligibility made by Medicaid. Current § 455.348(b) describes the responsibilities of the CHIP agency for individuals found CHIP eligible by another insurance affordability program, if the agency has elected to accept eligibility determinations made by other programs. We propose to require that the agency accept eligibility determinations made by Medicaid but retain the option to enter into an agreement with a BHP or Marketplace operating in the State to accept eligibility determinations made by those entities. To effectuate this change in regulation, and to improve clarity of existing regulations, we propose to delete the introductory language in current paragraph (b) and redesignate the requirements in current § 457.348(b)(1) through (3) at proposed § 457.348(b)(1)(i) through (iii). We propose to add a new paragraph (b)(2) to describe the individuals who are subject to the requirements in proposed paragraph (b)(1). Specifically, proposed § 457.348(b)(2)(i) describes the individuals who are subject to the requirements in paragraph (b) in the current regulations—that is, individuals determined eligible for CHIP by the Marketplace or another insurance affordability program (including as a result of a decision made by a Marketplace appeals entity), if the agency has entered into an agreement

under which the Exchange makes final determinations of CHIP eligibility. Proposed § 457.348(b)(2)(ii) describes individuals who are determined CHIP eligible by a separate Medicaid (including as the result of a decision made by a Medicaid appeals entity). We also propose to add new introductory language at proposed § 457.348(b)(1) to explain that the requirements in proposed paragraph (b)(1) apply to individuals described in proposed paragraph (b)(2).

Paragraph (c) of current § 457.348(c) describes the CHIP agency's responsibilities when individuals are transferred from other insurance affordability programs based on their potential eligibility for CHIP. We are not proposing any revisions to these requirements, since they will continue to apply in States that do not elect to accept determinations of eligibility made by BHP or the Marketplace. Similarly, we do not propose any changes to current § 457.384(d), which specifies that a State must certify for the Exchange and other insurance affordability programs the criteria applied in determining CHIP eligibility.

Third, we propose to add a new paragraph (e) to § 457.348 to clarify that the State must accept a determination of CHIP eligibility made by a separate Medicaid program. Similar to the proposed changes to the Medicaid regulations discussed in section II.B.5. of this rule, in order to comply with this requirement, we propose that the agency may: (1) apply the same MAGI-based methodologies without further verification as Medicaid; (2) enter into an agreement under which the State delegates authority to the Medicaid agency to make final determinations of CHIP eligibility; or (3) adopt other procedures approved by the Secretary. These options are described at proposed § 457.348(e)(1), (2), and (3) respectively. We seek comment on whether these options encompass the full range of processes that a State may establish to accept determinations of eligibility made by Medicaid.

When accepting a determination of CHIP eligibility made by Medicaid, we expect States to enroll the individual in separate CHIP as quickly and seamlessly as possible. Any action the State requires the individual to take prior to enrollment, such as payment of an enrollment fee or selection of a plan, should be described in the combined notice provided to the individual and the individual should be given adequate time to respond to prevent or minimize a gap in coverage. We request comment on the challenges a State may face in seamlessly transitioning eligibility from another program, as well as strategies to mitigate those challenges.

Next, we propose changes to § 457.350, which currently focuses on screening individuals for potential eligibility for other insurance affordability programs. We propose to require separate CHIP agencies to complete MAGI-based eligibility determinations for Medicaid and to screen for potential non-MAGI Medicaid, as well as eligibility for BHP and insurance affordability programs available through the Exchanges. As proposed, when a CHIP enrollee is determined ineligible due to a decrease in household income, the separate CHIP agency would also complete a determination of eligibility for Medicaid. The individual would no longer be screened for potential MAGI Medicaid eligibility, transferred to the Medicaid agency, and then receive a determination of Medicaid eligibility, as required by current § 457.350(b). The separate CHIP agency must utilize the option the Medicaid agency has elected to accept determinations of MAGI-based Medicaid eligibility made by a separate CHIP. The options for the Medicaid agency to accept a CHIP eligibility determination and continue to comply with Medicaid single State agency responsibilities are discussed in section II.B.5 of the Medicaid preamble. We are proposing to add a new paragraph (b)(3) at 457.350 to require the State to ensure that Medicaid eligibility determinations are conducted in accordance with the option elected by the Medicaid agency at proposed § 435.1200(b)(4) and that this be reflected in the agreement between the State and the Medicaid agency that is required at § 457.348(a). We seek comment on the feasibility of a contractor for the separate CHIP agency having the ability to conduct the Medicaid determination in accordance with the options specified at § 435.1200(b)(4).

These changes correspond with the changes proposed to the Medicaid regulations at § 435.1200(e). In addition to the changes related to Medicaid eligibility determinations, we also propose to restructure § 457.350 in order to improve the clarity of both existing and proposed requirements for separate CHIP agencies evaluating eligibility for other insurance affordability programs. These proposed changes are effectuated as follows. Specifically, we propose:

- To amend § 457.350(a)(2) to clarify that the State plan must describe how enrollment is facilitated for applicants found either potentially eligible for another insurance affordability program (that is, BHP or insurance affordability programs available through the Exchanges) or eligible for Medicaid in accordance with this section.
- To revise § 457.350(b) to require States to determine an applicant's eligibility for MAGI Medicaid and to determine potential eligibility for non-MAGI Medicaid, BHP, or insurance affordability programs available through the Exchanges for individuals who are not eligible for MAGI-based Medicaid. Current § 457.350(b) requires a State to identify potential eligibility for other insurance affordability programs (specifically MAGI-based Medicaid, non-MAGI Medicaid, and other insurance affordability programs), promptly and without undue delay and consistent with the State's timeliness standards, when an individual is determined ineligible for separate CHIP at application, at renewal, based on a change in circumstances, or following a review. At § 457.350(b)(1) we propose to retain the introductory language at current § 457.350(b) that a State act promptly and without undue delay, consistent with the timeliness standards established by the State, but we would add a new paragraph (b)(1)(i) requiring the State to determine eligibility for MAGI-based Medicaid. At proposed § 457.350(b)(1)(ii), we would require a State, if unable to make a determination of eligibility for MAGI-based Medicaid to determine potential eligibility for non-MAGI Medicaid, BHP, or insurance affordability programs available through the Exchanges. Proposed § 457.350(b)(2) would apply the requirements of proposed paragraphs (b)(1)(i) and (ii) to applicants, enrollees whose eligibility is being redetermined at renewal or based on a change in circumstances, and to individuals determined ineligible for separate CHIP as a result of a review conducted in accordance with subpart K of this part. This is consistent with the application of current paragraph (b) of § 457.350, as described in the current introductory language.
- Technical changes to paragraph (c) of this section. Current § 457.350(c) describes the income eligibility test that States must apply when determining an individual's eligibility for MAGI-based Medicaid, or potential eligibility for BHP or insurance affordability programs available through the Exchanges. We propose to revise the references to paragraph (b) to reflect the change at proposed § 457.350(b)(1)(i) requiring the State to determine eligibility for MAGI-based Medicaid and the redesignation of the requirement to determine potential eligibility for BHP and insurance affordability programs available through the Exchanges at proposed § 457.350(b)(1)(ii).

• To redesignate current paragraph (f) at proposed § 457.350(d), which is currently reserved. Current § 457.350(f) applies to individuals determined by the separate CHIP agency to be potentially eligible for Medicaid based on MAGI and requires the State to transfer the individual's account to the Medicaid agency, find the applicant provisionally ineligible for CHIP until the Medicaid determination is completed, and redetermine CHIP eligibility if the individual is found ineligible when the Medicaid agency completes the determination. Because we propose to require States to complete determinations, rather than potential determinations, of eligibility for Medicaid based on MAGI, we propose several changes to § 457.350(f) (redesignated at proposed § 457.350(d)). First, we propose to modify the title for proposed § 457.350(d) to clarify that this provision applies to actions that States must take when determining an individual eligible for Medicaid based on MAGI, rather than actions the State must take for individuals found potentially eligibility for Medicaid. Next, we propose to amend the citation in the introductory language to reflect the changes proposed at paragraph (b)(1) of this section. We propose to revise § 457.350(f)(2) (redesignated at § 457.350(d)(2)) to require that the State find the applicant ineligible for CHIP (as opposed to provisionally ineligible for CHIP until the Medicaid determination is completed). Finally, we propose to delete current paragraph (f)(3), which requires the State to determine or redetermine eligibility when the Medicaid agency returns a determination of ineligibility for an individual whom the separate CHIP agency screened as potentially Medicaid eligible, since under proposed § 457.350(b) the CHIP agency will have completed a determination of eligibility for MAGI-based Medicaid and proposed § 435.1200(c) would require the Medicaid agency to accept the determination of eligibility made by the separate CHIP agency.

• To redesignate current § 457.350(j), describing the requirements for individuals determined potentially eligible for non-MAGI Medicaid, as proposed § 457.350(e). Current § 457.350(j) requires the State to transfer the individual's account to the Medicaid agency, complete a determination of CHIP eligibility and evaluate eligibility for other insurance affordability programs if ineligible for CHIP, include coordinated content in the CHIP eligibility notice, and disenroll the individual from CHIP if they ultimately are determined eligible for Medicaid. We propose several technical changes to paragraph (j) (redesignated as proposed paragraph (e)). We propose to revise the title to clarify that this paragraph applies not only to applicants but also to individuals whose eligibility is being redetermined at renewal or based on a change in circumstances and to individuals who are determined ineligible for CHIP upon review; we note that this is not a change in policy but simply a correction to the title. Then we propose to revise existing cross-references to align with proposed changes to paragraphs (b), (e), and (g) in § 457.350.

• To redesignate, at § 457.350, current paragraph (e) as paragraph (f). Current § 457.350(e) applies only to States that use a screening procedure other than a full Medicaid eligibility determination and requires the State to provide certain information to the family when a child is found potentially ineligible for Medicaid. We propose to revise the title of § 457.350(e) (redesignated at § 457.350(f)) to clarify that, in accordance with other changes proposed to this section, this paragraph would apply to individuals who are determined ineligible for MAGI-based Medicaid and found potentially ineligible for Medicaid on a basis other than MAGI. We also propose to update the existing cross-reference in this paragraph to reflect the redesignation of current paragraph (e) as new paragraph (f).

• To delete current paragraph (g) of § 457.350 in its entirety and to redesignate current § 457.350(i) at proposed § 457.350(g). Currently, paragraph (g) describes information States must provide to help families make informed decisions about applying for Medicaid coverage. We believe that the separate CHIP agency is already required to provide similar information to families of children that may potentially be eligible for Medicaid on a non-MAGI basis in § 457.350(e) (redesignated as proposed § 457.350(f)). Therefore, we propose to eliminate the current requirements at § 457.350(g). Current § 457.350(i) (which is revised in this rulemaking to remove references to individuals subject to a period of uninsurance, as discussed in section II.F.2 of this proposed rule) sets forth procedures that the State must undertake when an individual is found potentially eligible for another insurance affordability program, including transferring the individual's electronic account to the other program. We propose to revise § 457.350(i) of the current regulations (redesignated as proposed § 457.350(g)) as discussed in section II.F.2. of this preamble.

• To redesignate requirements at current § 457.350(k) and (h) as proposed § 457.350(h) and (i) respectively. Current paragraph (k) (redesignated at proposed paragraph (h)) permits the separate CHIP agency to make determinations of eligibility for advance payments of the premium tax credit and cost sharing reductions on behalf of the Exchange; we are not proposing any changes to this paragraph. Current § 457.350(h) (redesignated at proposed § 457.350(i)) describes procedures for waiting lists, enrollment caps, and closed enrollment; we propose only a technical change to this section to update the cross-reference to reflect other changes proposed in this section.

Similar to Medicaid, we seek comment on information that the separate CHIP agency would not be able to access through electronic or other data sources when determining MAGI-based eligibility for Medicaid and for which it may need to contact the individual before completing a determination of eligibility. Additionally, we seek comment on whether there are cases in which the separate CHIP agency would be able to complete only a determination of potential MAGI-based eligibility for Medicaid, types of situations that would result in only a determination of potential eligibility, and whether the separate CHIP agency may need the option to transfer the individual's electronic account to the separate Medicaid agency to finalize the determination.

Similar to the proposed changes for coordination of notices in the Medicaid regulations at § 435.1200(h), discussed in section II.B.5 of this proposed rule, we propose changes to § 457.340(f) related to coordination of notices with other programs. These changes correspond with Medicaid changes at § 435.1200(h) to ensure that individuals receive a combined notice regardless of the agency that completes the eligibility determination or transfers the individual's electronic account to another insurance affordability program for a final eligibility determination. Providing individuals with a combined notice will be critical to ensuring that they understand the changes in coverage that are occurring and any additional obligations that may be imposed by the program to which their coverage is being transitioned. As previously mentioned above in the section related to transitions from Medicaid to CHIP, States that operate its CHIP and Medicaid programs under the same agency and eligibility system that

already provide a seamless, combined Medicaid and CHIP notice, may not need to make any changes.

To effectuate this change to the combined notice requirements, we propose changes to § 457.340(f)(1). Current § 457.340(f)(1) requires States to provide combined notices, to the maximum extent feasible, to individuals and to multiple members of the same household who are included on the same application or renewal form; this paragraph also requires the State to include coordination of notices in its agreement with other insurance affordability programs as described at § 457.348(a). We propose to separate current § 457.340(f)(1) into three separate requirements—proposed paragraphs (f)(1)(i), (ii) and (iii)—each of which must be included in the agreement into which the State enters into, in accordance with § 457.348(a). Proposed § 457.340(f)(1)(i) would establish a new requirement for the State to ensure that individuals are provided with a combined notice when their Medicaid eligibility is determined by the separate CHIP agency, or their CHIP eligibility is determined by the agency administering Medicaid. Proposed § 457.340(f)(1)(ii) and (iii) would restate the requirements currently described in paragraph (f)(1)—that is, at proposed § 457.340(f)(1)(ii) to provide a combined notice to individuals transferred between the State and another insurance affordability program to the maximum extent feasible; and at proposed § 457.340(f)(1)(iii) to require a combined notice for multiple members of the same household to the maximum extent feasible. We do not propose to make any changes to § 457.340(f)(2). We seek comment on States' ability to issue a combined notice in accordance with proposed § 457.340(f)(1)(i).

Consistent with these changes to § 457.350, we propose a conforming change to § 457.348(a), which describes the agreements that States must establish with other insurance affordability programs. We propose to revise § 457.348(a) to require that these agreements provide for not only coordination of notices, but also for a combined eligibility notice with other insurance affordability programs.

5. Recordkeeping (§ 457.965)

As discussed in section II.D of this preamble, we propose to revise § 431.17(b) to clearly detail the specific types of information that Medicaid agencies must retain as part of each applicant and/or enrollee's case records. We also propose changes to § 431.17(c) to specify the minimum duration of time that the information that should be retained for both applicant and enrollee files. Finally proposed revisions at § 431.17(d) would provide that States must be able to provide stored information within 30 calendar days after a request has been made if not otherwise specified. Additionally, we clarified in section II.D. of this preamble that we do not propose that all of the information that could be considered part of the case record be stored in a single system.

To ensure effective and efficient administration of the CHIP program, consistent with section 2101(a) of the Act, we propose to modify existing CHIP documentation requirements at § 457.965 by adopting the same requirements as we are proposing for Medicaid at § 431.17, except that cross-references to other Medicaid regulations in proposed § 431.17 are replaced with corresponding cross-references to existing CHIP regulations. As with Medicaid, we seek comment regarding whether 3 years is an appropriate minimum duration of time for States to retain case records after the case is active; additionally, we seek comment whether any longer or shorter duration would be appropriate for certain types of information, such as those related to payment and provision of child health assistance, to remain in the case records. We are also particularly interested in comments on whether the retention period should be tied to the individual or the active case. Finally, we seek comment whether States should retain flexibility to maintain records in paper or other formats that reflect evolving technology.

F. Eliminating Access Barriers in CHIP

Following passage of the ACA, CMS focused on aligning methodologies and procedures in order to create a streamlined, coordinated eligibility and enrollment process across insurance affordability programs. In such rulemaking, we left in place certain flexibilities available to States in administering separate CHIPs which are not permitted in Medicaid, including the option to specify a period of time that CHIP beneficiaries whose families fail to pay required premiums are not permitted to reenroll in CHIP coverage or ''lock out'' such beneficiaries; the option to impose a waiting period prior to enrollment for beneficiaries previously enrolled in other coverage; and the option to impose annual and lifetime limits on benefits. Each of these policies, if adopted by a State, poses a barrier to obtaining and retaining coverage for CHIP beneficiaries who otherwise meet the eligibility requirements for the State's program. As discussed further below, we propose to eliminate each of these State options.

1. Prohibit Premium Lock-Out Periods (§§ 457.570 and 600.525(b)(2))

Premium payment policies can directly influence the difficulty, or ease, eligible children and pregnant individuals face when enrolling in and retaining CHIP coverage. Under section 2103(e)(3)(C) of the Act, States must provide enrollees with a grace period of at least 30 days from the beginning of a new coverage period to make premium payments before the child or targeted low-income pregnant woman's coverage is terminated. If the premium remains unpaid at the end of the grace period, States must also offer the family an opportunity to show their income has decreased such that the CHIP enrollee may qualify for a lower premium payment in CHIP or be eligible for Medicaid. States also currently have the option under § 457.570 to impose a premium lock-out period, which is a specified period that a child or a pregnant individual must wait until being allowed to reenroll in the CHIP program after non-payment of premiums. There is no statutory provision expressly requiring CMS to provide States with the option to institute a premium lock-out period after non-payment of premiums.

Under Medicaid, premiums are authorized under sections 1902(a)(14), 1916, and 1916A of the Act, and implementing regulations at 42 CFR 447.50 through 447.57. Medicaid permits disenrollment for failure to pay premiums is at 447.55(b)(2), but does not permit premium lock-out periods.

Premium lock-out periods, by design, require children or pregnant individuals to go without coverage for a specified period. While not focused on the CHIP beneficiary populations specifically, a review of the literature on Medicaid lock-out periods previously authorized under section 1115 demonstrations indicates that premium lock-out periods pose a barrier to coverage and hinder access to care. Research on the impact of premium lock-out periods on access to care for Medicaid

beneficiaries authorized under section 1115(a) of the Act also shows that Medicaid beneficiaries who experience lock-outs are more likely to skip or delay provider visits, not fill prescriptions, and report financial barriers to accessing care.[66] One study found that individuals who experienced interruptions in coverage had higher hospitalization rates for conditions, such as asthma and diabetes, that could have been managed in outpatient settings with consistent access to treatment.[67] Gaps in coverage also make it less likely that families establish sustained relationships with health care providers, which also can undermine the quality of care they receive.[68] The literature also shows that premium lock-out periods disproportionately affect non-White populations compared to White populations, which may further exacerbate existing disparities in health outcomes. Additionally, there is no evidence to demonstrate that lock-out periods incentivize families to comply with requirements.

In order to improve continuity of care and align with Medicaid rules in this area, we propose to eliminate premium lock-out periods in CHIP. Section 2101(a) of the Act requires States to provide access to health care in an effective and efficient manner that is coordinated with other sources of health benefits coverage. In addition, the April 5, 2022 Executive Order 14070, ''Continuing to Strengthen Americans' Access to Affordable, Quality Health Coverage'' requires agencies to identify ways to expand the availability of affordable health coverage, improve quality of coverage, and to strengthen benefits. Specifically, we propose to revise § 457.570(c)(1) to prohibit States from imposing premium lock-out periods; to remove current paragraph (c)(2), and to redesignate and revise paragraph (c)(3) at paragraph (c)(2) to prohibit States from requiring collection of past due premiums or enrollment fees as a condition of eligibility for reenrollment once a lock-out period is over if an individual was terminated for failure to pay premiums.

There are a multitude of promising practices described in the literature for helping to prevent late or missed premium payments, thereby avoiding even short-term disruptions to coverage,[69] such as:

- Conducting new member calls to ensure that families understand their payment obligations and options.
- Ensuring eligibility staff who work directly with families are trained and knowledgeable about payment policies and procedures, and can explain them to people, particularly those experiencing a language or cultural barrier.
- Generating frequent payment notices and reminders.
- Providing multiple and convenient options for paying premiums.
- Providing advance payment incentives (such as pay for a certain number of months and permitting 1 free month).

Another possible approach for States to reduce the disruptive effect of non-payment of premiums is to apply an affordable annual enrollment fee or provide families with the choice between paying monthly premiums or an annual enrollment fee. Similar to premiums, States may provide varying fees based on family income level to ensure that families at a lower income can afford the enrollment fee. We note that an annual enrollment fee would need to meet the conditions specified at section 2103(e)(3)(A)(i) of the Act relating to limitations on premiums and enrollment fees for children under 150 percent of the FPL, section 2103(e)(3)(B) of the Act for all other children, and section 2112(b)(6) of the Act for targeted low-income women. To be affordable, an annual fee would likely need to be substantially lower than the equivalent of 12 monthly premium payments.[70] For example, some States with a separate CHIP charge an annual enrollment fee of $50 for one child or $100 for a family with two or more children. Requiring a single affordable annual payment may improve retention, reduce disenrollment rates, and simplify program administration, for example, by reducing the cost of billing, collecting and processing premium payments.[71] We solicit comments on the potential parameters for ensuring that an annual fee is affordable.

States will continue to have the option to disenroll children or targeted low-income pregnant women from coverage due to non-payment of premiums, including enrollment fees, as long as the State provides families a minimum 30-day premium grace period, which is required under 2103(e)(3)(C) of the Act. States must inform an individual, seven days after the first day of the grace period, that failure to make a payment within the premium grace period will result in termination of coverage, and of the individual's right to challenge the termination. Because States would no longer be able to require collection of past due premiums or enrollment fees as a condition of eligibility, a family could re-apply for coverage immediately following disenrollment. States retain the flexibility to determine whether families will be required to complete a new application in order to reenroll in coverage after disenrollment. Other States allow a period of time after disenrollment for families to make a payment and have coverage reinstated without requiring the submission of a new application.

We note that, under 42 CFR 600.320(d), States that operate a BHP have the option to enroll eligible individuals in their BHP during enrollment and special enrollment periods that are no more restrictive than those required for an Exchange at 45 CFR 155.410 and 155.420 or follow the Medicaid and CHIP rules to permit continuous open enrollment throughout the year. Under § 600.525(b)(2), States that elect to allow continuous open enrollment throughout the year must comply with the reenrollment standards set forth in the CHIP regulations at § 457.570(c). Thus, by eliminating the State option to impose a premium lock-out period in CHIP, we effectively would be eliminating the premium lock-out period for States with a BHP that allows continuous open enrollment throughout the year.

As such, we propose to remove the requirement at § 600.525(b)(2) for a BHP State to define the length of the

[66] Ku, L., & Ross, D.C. (2002). *Staying covered: the importance of retaining health insurance for low-income families.* Commonwealth Fund, Task Force on the Future of Health Insurance. *https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_fund_report_2002_dec_staying_covered__the_importance_of_retaining_health_insurance_for_low_income_families_ku_stayingcovered_586_pdf.pdf.*

[67] Bindman, A.B., Chattopadhyay, A., & Auerback, G.M. (2008). Interruptions in Medicaid coverage and risk for hospitalization for ambulatory care–sensitive conditions. *Annals of internal medicine, 149*(12), 854–860.

[68] Ku, L., & Ross, D.C. (2002). *Staying covered: the importance of retaining health insurance for low-income families.* Commonwealth Fund, Task Force on the Future of Health Insurance. *https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_fund_report_2002_dec_staying_covered__the_importance_of_retaining_health_insurance_for_low_income_families_ku_stayingcovered_586_pdf.*

[69] Brooks, T. (2013). Handle with Care: How Premiums Are Administered in Medicaid, CHIP and the Marketplace Matters. *Georgetown University Center for Children and Families. https://ccf.georgetown.edu/wp-content/uploads/2013/12/Handle-with-Care-How-Premiums-Are-Administered.pdf.*

[70] Ku, L., & Ross, D.C. (2002). *Staying covered: the importance of retaining health insurance for low-income families.* Commonwealth Fund, Task Force on the Future of Health Insurance. *https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_fund_report_2002_dec_staying_covered__the_importance_of_retaining_health_insurance_for_low_income_families_ku_stayingcovered_586_pdf.*

[71] Ibid.

premium lock-out period in its BHP Blueprint, as premium lock-out periods will no longer be permissible. We propose this change using our authority in section 1331(c)(4) of the ACA, which requires a State that operates a BHP to coordinate the administration of, and provision of benefits under its BHP with the State Medicaid, CHIP, and other State-administered health programs to maximize the efficiency of such programs and to improve the continuity of care. We request comment regarding whether BHPs should be allowed to continue operating a premium lock-out period.

We are also considering the option of permitting a 30-day lock-out period and invite comments on this option.

2. Prohibit Waiting Periods (§§ 457.65, 457.340, 457.350, 457.805, and 457.810)

Currently, the CHIP regulations permit States to impose a ''period of uninsurance,'' or ''waiting period,'' on individuals who have recently disenrolled from a group health plan prior to allowing them to enroll in a separate CHIP. Section 457.805 provides some limitations on the use of waiting periods. Our experience in implementing the ACA provisions designed to increase access for families under Medicaid and CHIP and expand coverage through the Exchanges calls into question whether the use of waiting periods in CHIP continues to be appropriate. Waiting periods are a State option unique to CHIP programs, as waiting periods are not permitted in Medicaid, BHP, and individual market Exchange plans.[72] Historically, we have interpreted section 2102(b)(3)(C) of the Act, which requires States to ensure that coverage provided under CHIP does not substitute for (or ''crowd out'') coverage under group health plans, to permit States to adopt a waiting period. Corresponding regulations at § 457.805 specify that State plans must include a description of ''reasonable procedures'' to prevent substitution.

Currently, 11 States use a waiting period in CHIP as a mechanism for preventing substitution. Children are denied eligibility under CHIP if they recently had group health coverage, within a State-prescribed waiting period, and have not qualified for a Federal or State-specified exception. Currently, States impose waiting periods that range from one month to 90 days. CHIP regulations at § 457.805 provide that a waiting period may not exceed 90 days.

At the inception of CHIP in 1997, employer-sponsored health insurance was the main alternative source of coverage for children in families within the CHIP income range. With passage of the ACA, coverage in a QHP through the Exchanges became available, and families may now qualify for premium tax credits to purchase coverage from the Exchange for their children while they wait for CHIP coverage during a waiting period.

Waiting periods, which have historically resulted in a period of uninsurance between the end of private health coverage and the beginning of CHIP enrollment, were seen as a deterrent to families dropping private coverage in order to enroll their children in CHIP. However, the availability of coverage through the Exchanges during a waiting period warrants reconsideration of the use of waiting periods in CHIP.[73]

The availability of Exchange coverage increases the complexity of implementing CHIP waiting periods, as coordinating coverage between the Exchanges and CHIP creates challenges that can lead to loss of coverage when affected children must transition from Exchange coverage to CHIP.[74] As noted, families with children who are ineligible for CHIP during a waiting period are eligible for advance payments of the premium tax credit to enroll the child in a QHP through the Exchange, if they meet other applicable requirements. However, after a child is determined eligible for enrollment in a QHP, additional time is needed for the family to select and enroll in a health plan. By the time a child is enrolled in a health plan through the Exchange, the CHIP waiting period often will have expired, or be close to expiring, at which point the child is eligible for CHIP, and the CHIP agency and family must act to move the child from Exchange coverage to the State's CHIP program. Under current regulations at § 457.350(i), the CHIP agency is expected to notify both the Exchange and family of the child's potential eligibility for CHIP at the end of the waiting period. The complexities of tracking waiting periods, sending notices to families, and requiring families to take additional steps to transition coverage likely result in children who are eligible for CHIP being unenrolled.[75] [76] [77] Furthermore, health policy experts in a number of States that continue to implement waiting periods indicate that the burden imposed on families in some cases prevents them from seeking public coverage again, even once the children are eligible after the waiting period is over.[78] [79]

Even for families that successfully navigate the administrative hurdles of moving from Exchange to CHIP coverage, coverage transitions create care complexities. A move from the Exchange to CHIP may necessitate a change of providers and/or managed care plans, which interrupt care. These potential changes in coverage may limit a child's access to needed services following a waiting period.

The 2013 eligibility final rule amended CHIP regulations at § 457.805(b)(1) to impose some limitations on waiting periods, including a 90-day maximum as mentioned above. Subsequent to this rule, the majority (23 of 36) of States elected to eliminate their CHIP waiting period. No state that has eliminated a waiting period has reported a substitution problem to CMS through their monitoring efforts. Eleven states still implement CHIP waiting periods; nine States have a 90-day waiting

[72] U.S. Department of Health and Human Services. (2016, May). Frequently Asked Questions on Health Insurance Market Reforms and Marketplace Standards. Retrieved from: *https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/Waiting-period-FAQ-05262016-Final-.pdf.*

[73] Under current Treasury regulations, some children may not qualify for Exchange premium tax credits if they are deemed eligible for affordable health coverage through a family member's employer, based on whether the cost of self-only coverage for the family member is affordable. The Treasury Department has published a Notice of Proposed Rulemaking that would change this rule. 87 FR 20354 (Apr. 7, 2022).

[74] Brooks, Tricia. Now is the time to remove CHIP waiting periods and welcome kids into coverage. April 17, 2020. Retrieved from *https://ccf.georgetown.edu/2020/04/17/now-is-the-time-to-remove-chip-waiting-periods-and-welcome-kids-into-coverage/.*

[75] Medicaid and CHIP Payment and Access Commission. March 2017. ''Chapter 1: The Future of CHIP and Children's Coverage'' in *Report to Congress on Medicaid and CHIP.* Retrieved from *https://www.macpac.gov/wp-content/uploads/2017/03/The-Future-of-CHIP-and-Childrens-Coverage.pdf.*

[76] Foster, Leslie. January 2016. ''Research Brief 3: Stakeholder perspectives from Texas'' in *Health Care Coverage and Access for Children in Low-income Families.* Mathematica Policy Research, funded by the David & Lucile Packard Foundation.

[77] Bruce, Giles. February 13, 2020. ''Why Do Some States Still Require Long Waits Before Kids Can Get Health Insurance?'' in *Children's Health Matters.* University of Southern California, Center for Health Journalism. Retrieved from *https://centerforhealthjournalism.org/2020/01/30/why-do-some-states-still-require-long-waits-kids-can-get-health-insurance.*

[78] Medicaid and CHIP Payment and Access Commission. March 2017. ''Chapter 1: The Future of CHIP and Children's Coverage'' in *Report to Congress on Medicaid and CHIP.* Retrieved from *https://www.macpac.gov/wp-content/uploads/2017/03/The-Future-of-CHIP-and-Childrens-Coverage.pdf.*

[79] Foster, Leslie. January 2016. ''Research Brief 3: Stakeholder perspectives from Texas'' in *Health Care Coverage and Access for Children in Low-income Families.* Mathematica Policy Research, funded by the David & Lucile Packard Foundation.

period, one State has a 2-month waiting period, and one State has a one month waiting period. In the 2013 final rule, we also amended § 457.805(b)(3) to require that States adopt certain exemptions to any waiting period. Under this regulation, States may not apply a waiting period if:

- The premium paid by the family for coverage of the child under the group health plan exceeds 5 percent of household income;
- The child's parent is determined eligible for advance payments of the premium tax credit for enrollment in a QHP through the Exchange because the employer-sponsored insurance in which the family was enrolled is determined unaffordable in accordance with 26 CFR 1.36B–2(c)(3)(v);
- The cost of family coverage that includes the child exceeds 9.5 percent of the household income;
- The employer stopped offering coverage of dependents (or any coverage) under an employer-sponsored health insurance plan;
- A change in employment, including involuntary separation, resulted in the child's loss of employer-sponsored insurance (other than through full payment of the premium by the parent under COBRA);
- The child has special health care needs; or
- The child lost coverage due to the death or divorce of a parent.

In addition to the Federally required exemptions to CHIP waiting periods listed above, the majority of States apply other State-specific exemptions to the waiting period. Requirements at § 457.810 apply the same 90-day maximum and Federal exceptions to waiting periods for CHIP premium assistance programs. As a result of these exceptions, States have anecdotally reported that few children are subject to waiting periods.

Sections 2102(b)(1)(B)(iii), 2102(b)(1)(B)(iv) and 2112 (b)(5) of the Act reference circumstances in which waiting periods may not be applied to CHIP populations or coverage. These provisions, included in the statute when it was first enacted in 1997, place certain limitations on the use of waiting periods, which were implicitly recognized at the time as one of the potential strategies states could use to fulfill the requirement at section 2102(b)(3)(C) of the Act to address substitution of coverage. Since the inception of CHIP, the health coverage landscape has significantly changed, including the addition of the Exchange coverage option. Any gap in coverage created by a waiting period or the administrative process to transfer children between different coverage options, such as the Exchange, can compromise child health and development and access to preventive and primary health care during childhood and adolescence. As noted above, waiting periods have never been allowed under Medicaid and are not permitted in the Exchanges, either. Nor are waiting periods permitted in the private insurance market, for example, for individuals with pre-existing conditions. These changes call into question the appropriateness of waiting periods as a tool to address substitution of coverage.

In addition, Executive Order 14070 of April 5, 2022 titled ''Continuing to Strengthen Americans' Access to Affordable, Quality Health Coverage'' instructs agencies to identify policy changes to ensure that enrollment and retention in coverage can be more easily navigated by consumers. The navigation of waiting periods for families is challenging, and CHIP is now an outlier among insurance providers compared to Medicaid and private insurance plans providing EHB coverage in allowing waiting periods to be applied before individuals can enroll in coverage. In addition, moving children between CHIP and the Exchange is not an efficient or effective use of State and Federal resources. In order to align with other programs, and consistent with the requirement in section 2101(a) of the Act to provide access for children to health care in an effective and efficient manner that is coordinated with other sources of health benefits coverage, as well as Executive Order number 14070 of April 5, 2022, we are proposing to eliminate all waiting periods in separate CHIPs. States will be required to continue monitoring efforts to prevent substitution of coverage in accordance with section 2012(b)(3)(c) of the Act.

Specifically, we propose to revise § 457.805(b) to provide that States may not impose a waiting period before enrolling eligible individuals in CHIP. We also propose the following conforming changes to other regulatory provisions to remove language referring to waiting periods.

- Revise § 457.65 to remove references to State plan amendments that implement or extend the length of a required period of uninsurance.
- Remove § 457.340(d)(3) (relating to facilitating enrollment in CHIP after a State-required period of uninsurance).
- Revise § 457.350(i) (redesignated at proposed § 457.350(g) as discussed in section II.E.4. of this proposed rule) to remove references to individuals subject to a State-required period of uninsurance, and to remove paragraphs (2) and (3) of § 457.350(i) (redesignated at proposed § 457.350(g)) relating to State notices for individuals found eligible for other insurance affordability programs during the waiting period).
- Remove § 457.805(b)(2) and (b)(3) (relating to Federal exceptions to waiting periods).
- Amend § 457.810(a) to specify that waiting periods may not be applied to CHIP premium assistance programs and remove paragraphs (a)(1) and (2) (relating to the 90-day limit for, required exemptions from, waiting periods applied to CHIP premium assistance programs).

Under the proposed rule, States would be required to continue to monitor the prevalence of substitution of coverage, consistent with requirements at § 457.805, and to report annually to CMS on the effectiveness of strategies used to prevent substitution of coverage pursuant to § 457.750(b)(2). In the preamble of the July 15, 2013 final rule (78 FR 42159), we explained that effective January 1, 2014, monitoring of substitution is a sufficient approach for addressing substitution at all income levels. There are a number of ways States monitor substitution of coverage, such as matching applicants to a database that identifies sources of other coverage, including questions on the single streamlined application about private and group health coverage, and tracking the number of applicants that reported other coverage and are later enrolled in CHIP. We expect that if this monitoring demonstrates a high rate of substitution, a State will consider strategies such as offering premium assistance to children enrolled in group health plan coverage, and improving public outreach about the range of health coverage options that are available in that State. We are available to provide technical assistance to develop additional strategies to reduce crowd out if it is determined through monitoring activities that substitution of coverage exceeds an acceptable threshold determined by the State.

We invite comments on our proposal to eliminate waiting periods to effectively balance the goal of preventing coverage gaps for children while ensuring that CHIP coverage does not substitute for coverage available under group health plans. We are also considering the option of permitting a 30-day waiting period for States that are able to demonstrate that high rates of substitution are a problem, and invite comments on this proposal.

3. Prohibit Annual and Lifetime Limits on Benefits (§ 457.480)

Section 1001 of the ACA added section 2711 to the Public Health Service Act (PHS Act), which prohibits annual and lifetime limits on the provision of essential health benefits (EHBs), as defined in section 1302(b) of the ACA, by group health plans and health insurance issuer. As such, annual and lifetime limits are not permitted for individuals enrolled in QHPs through the Exchanges. Medicaid also does not permit annual or lifetime limits. However, the CHIP regulations do not prohibit annual or lifetime limits, and a number of States have implemented annual and lifetime limits on CHIP benefits. Specifically, 12 States place an annual dollar limit on at least one CHIP benefit, and six States place a lifetime dollar limit on at least one benefit. Most commonly, annual and lifetime benefits are placed on dental, or specifically orthodontia, coverage. Ten States limit dental coverage to $500–$2,000 annually, and four States limit lifetime orthodontia coverage to $725–$1,250. These limits may present barriers to children receiving necessary dental and orthodontia care. Research on childhood oral health care indicates that dental care is the most common unmet treatment need in children.[80] Many low-income families face barriers such as accessibility and costs that deter them from seeking oral care services, leading to increased risk of dental diseases or dental emergencies.[81] Children in low-income families, including those covered by Medicaid and CHIP, are twice as likely to have untreated tooth decay compared to children with higher incomes.[82] Thus, annual and lifetime limits further exacerbate unmet treatment needs for CHIP children by placing a financial burden on low-income families.

While many States limit specific benefits to an annual or lifetime dollar amount, currently, no State imposes an aggregate annual or lifetime limit on all CHIP benefits. However, some States did impose such limits in previous years. Section 2103(f)(2) of the Act requires that coverage offered under a separate CHIP comply with the requirements of subpart 2 of part A of Title XXVII of the PHS Act insofar as such requirements apply with respect to a health insurance issuer that offers group health insurance coverage. Because section 2711 of the PHS Act is in subpart 2 of part A of Title XXVII of the PHS Act, which applies to separate CHIPs (by cross-reference in section 2103(f)(2) of the Act), States cannot impose annual or lifetime limits in the provision of any EHBs covered under a separate CHIP.

Under section 2103(a) of the Act, States may elect to provide benchmark coverage, benchmark-equivalent coverage, existing comprehensive State-based coverage, or Secretary-approved coverage to their separate population (where applicable). Regardless of the type of coverage provided, there are several required benefit categories that States must offer, including well-baby and well-child visits; dental benefits; mental health and substance use disorder services; testing, treatment, and vaccination for COVID–19; and age-appropriate immunizations.

In accordance with section 2101(a) of the Act, which calls for the provision of CHIP in a manner that is effective and efficient and coordinated with other sources of health benefits coverage for children, and section 2103(f)(2) of the Act which generally prohibits annual and lifetime limits on EHBs, we are proposing to revise the regulations at § 457.480 to prohibit all annual and lifetime dollar limits on all benefits in CHIP. Although title XXI of the Act does not apply EHB rules under a separate CHIP, the services which must be covered under title XXI also are EHBs. Specifically, pediatric services (including dental and vision services) and maternity and newborn care are EHBs. Because we believe that all of the benefits provided to children or targeted low-income pregnant women under a CHIP State plan are inherently pediatric, maternity, or newborn care services, we believe it is appropriate—indeed, the better application of the incorporated requirements in section 2711 of the PHS Act to separate CHIPs—to prohibit annual and lifetime limits on all covered CHIP benefits.

We propose that this prohibition be applied both to aggregate annual and lifetime limits on all benefits, as well as annual and lifetime limits on specific benefits (for example, dental services). Such limits construct barriers for families to access health coverage and result in a lack of coverage for children with the greatest medical needs. Additionally, these limits create a financial hardship on low-income families and/or an increase in uncompensated care that could raise costs for all health coverage payers. We note that the proposed prohibition on annual and lifetime dollar limits would not apply to non-monetary annual or lifetime limits on specific benefits. For example, a State could still implement a limitation on the number of physical therapy visits or eyeglasses that will be covered each year, provided such limitations are in compliance with all other Federal requirements. We encourage States to maintain processes that allow beneficiaries to exceed these non-financial limitations when medically necessary.

We propose to redesignate current paragraphs (a) and (b) of § 457.480, as paragraphs (b) and (c) respectively, and to add a new paragraph (a) to prohibit annual and lifetime dollar limits in the provision of all CHIP medical and dental benefits.

III. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501 *et seq.*) 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. 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.

In order 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.

We are soliciting public comment on each of these issues for the following sections of this rule that contain information collection requirements. Comments, if received, will be responded to within the subsequent final rule.

A. Wage Estimates

To derive average costs, we used data from the U.S. Bureau of Labor Statistics'

[80] Newacheck, P. W., Hughes, D. C., Hung, Y. Y., Wong, S., & Stoddard, J. J. (2000). The unmet health needs of America's children. *Pediatrics, 105*(4 Pt 2), 989–997.

[81] U.S. Department of Health and Human Services.(2004,October). *Guide to children's dental care in Medicaid*. Centers for Medicare and Medicaid Services. Retrieved from: *https://www.medicaid.gov/sites/default/files/2019-12/child-dental-guide.pdf*.

[82] Dye, B. A., Mitnik, G. L., Iafolla, T. J., & Vargas, C. M. (2017). Trends in dental caries in children and adolescents according to poverty status in the United States from 1999 through 2004 and from 2011 through 2014. *Journal of the American Dental Association (1939), 148*(8), 550–565.e7. Retrieved from: *https://doi.org/10.1016/j.adaj.2017.04.013*.

May 2021 National Occupational Employment and Wage Estimates for all salary estimates (*http://www.bls.gov/oes/current/oes_nat.htm*). In this regard, the following table presents the BLS' mean hourly wage, our estimated cost of fringe benefits and overhead (calculated at 100 percent of salary), and our adjusted hourly wage.

TABLE 1: National Occupational Employment and Wage Estimates

Occupation Title	Occupation Code	Mean Hourly Wage ($/hr)	Fringe Benefits and Overhead ($/hr)	Adjusted Hourly Wage ($/hr)
All Occupations	00-0000	28.01	n/a	n/a
Business Operations Specialist	13-1000	38.64	38.64	77.28
Computer Programmer	15-1251	46.46	46.46	92.92
Database and Network Administrator and Architect	15-1240	49.25	49.25	98.50
Eligibility Interviewers, Government Programs	43-4061	23.35	23.35	46.70
General and Operations Mgr.	11-1021	55.41	55.41	110.82
Interpreter and Translator	27-3091	28.08	28.08	56.16
Management Analyst	13-1111	48.33	48.33	96.66
Procurement Clerks	43-3061	21.60	21.60	43.20

Wages for State Governments. As indicated, we are adjusting our employee hourly wage estimates by a factor of 100 percent. This is necessarily a rough adjustment, both because fringe benefits and overhead 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 total cost is a reasonably accurate estimation method.

Cost to State Governments. To estimate State costs, it was important to take into account the Federal government's contribution to the cost of administering the Medicaid, CHIP, and BHP programs. The Federal government provides funding based on a Federal Medical Assistance Percentage (FMAP) that is established for each State, based on the per capita income in the State as compared to the national average. FMAPs range from a minimum of 50 percent in States with higher per capita incomes to a maximum of 76.25 percent in States with lower per capita incomes. States receive an ''enhanced'' FMAP for administering their CHIP programs, ranging from 65 to 83 percent. For Medicaid, all States receive a 50 percent FMAP for administration. As noted previously, States also receive higher Federal matching rates for certain services and now for systems improvements or redesign, so the level of Federal funding provided to a State can be significantly higher. As such, in taking into account the Federal contribution to the costs of administering the Medicaid, CHIP, and BHP programs for purposes of estimating State burden with respect to collection of information, we elected to use the higher end estimate that the States would contribute 50 percent of the costs, even though the burden will likely be much smaller.

Wages for Individuals. For enrollees, we believe that the burden will be addressed under All Occupations (at $28.01/hr) since the group of individual respondents varies widely from working and nonworking individuals and by respondent age, location, years of employment, and educational attainment, etc. Unlike our State adjustment to the respondent hourly wage, we did not adjust this figure for fringe benefits and overhead since the individuals' activities will occur outside the scope of their employment.

B. Proposed Information Collection Requirements (ICRs)

1. ICRs Regarding Facilitating Enrollment Through Medicare Part D Low-Income Subsidy ''Leads'' (§§ 435.601, 435.911, and 435.952)

With the exception of the proposed changes under § 435.952(e)(4), the following changes will be submitted to OMB for review under control number 0938–1147 (CMS–10410), regarding the collection of eligibility data from State Medicaid and CHIP agencies. The proposed § 435.952(e)(4) changes will be submitted to OMB under control number 0938–0467 (CMS–R–74), regarding the collection of information for income verification.

OMB Control Number 0938–1147 (CMS–10410)

Proposed § 435.911(e) focuses on using the SSA data from processing LIS applications ''leads data'' to streamline MSP eligibility determinations. Section 435.911(e)(1) would require States to accept, via secure electronic interface, the SSA LIS leads data, while § 435.911(e)(2) would require that States treat receipt of the leads data as an application for Medicaid and promptly and without undue delay determine MSP eligibility without requiring submission of a separate application. Section 435.911(e)(4) would require States to refrain from requesting information from individuals already provided through leads data unless information available to the agency is not reasonably compatible with information provided by or on behalf of the individual, while § 435.911(e)(5) requires States to accept information provided through the leads data relating to a criterion of eligibility without further verification.

We estimate that States would be able to adjudicate over 90 percent of MSP applications for LIS enrollees without gathering additional documentation from the applicants. Therefore, if there are about 400,000 new LIS applicants

approved annually in 51 States,[83] we estimate that 90 percent of those applicants or 360,000 (400,000 × 0.9) would be able to enroll in an MSP without providing additional income and resource related documentation, and without the State receiving and adjudicating such data.

The provisions in § 435.911(e) are associated with a reduction in burden for States and beneficiaries associated with application completion and eligibility determinations or redeterminations at the State Medicaid agency, including: reduced verification work for States that do not need to adjudicate the leads data for approximately 360,000 new LIS applicants; reduced paperwork to submit for the LIS enrollees applying to MSPs in 51 States; reduced time and costs for enrollees who were previously expended to obtain, print, copy, mail and fax documents to the State to support the State's verification of income and resources; and reduced enrollee burden related to the need for public transportation and cell phone usage in relation to said document activities (obtaining, printing, copying, mailing and faxing).

We estimate that the provisions in § 435.911(e) would save an Eligibility Interviewer 25 minutes (0.42 hr = 25 min/60 min) per eligibility determination at $46.14/hr for the 360,000 new LIS applicants from reduced paperwork to review because of the proposed self-attestation requirements and reduced verification work due to considering the leads data as verified. In aggregate, we estimate an annual savings of minus 151,200 hours (360,000 applicants × 0.42 hr) and minus $6,976,368 (151,200 hr × $46.14/hr). Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State savings would be minus $3,488,184.

We estimate these provisions would reduce the time needed for LIS enrollees applying to MSPs to submit paperwork from 4 hours to 15 minutes, for a savings of 3.75 hours per enrollee per year across all 51 States. In aggregate, we estimate an annual savings of minus 1,350,000 hours (360,000 applicants × 3.75 hr) and minus $37,813,500 (1,350,000 hr × $28.01/hr). We also estimate enrollee non-labor savings from the changes to § 435.911(e) from public transportation, printing, copying, postage, and fax expenses to be about $10 [($4.50 postage for small package or $1.75/page for faxing) + $4 roundtrip bus ride (from home to printing/copying place to post office and back home) + $0.13/page for printing/copying)] per LIS enrollee per year for all 51 States. In aggregate, we estimate an annual non-labor savings of minus $3,600,000 (360,000 enrollees × $10/enrollee).

Under proposed § 435.952(e)(1) through (e)(4), States would be required to accept self-attestation of certain income and resources for MSP applicants and beneficiaries, including dividend and interest income, burial funds of spouse and individual, and the face value of life insurance policy. Because 10 States (about 20 percent of all States) do not have asset tests and do not require documentation to complete an eligibility determination or redetermination at the State Medicaid agency, we expect the savings from the self-attestation proposals would only apply to approximately 8.4 million individuals (80 percent of 11 million applications/renewals[84] minus 400,000 individuals who applied to LIS counted above) in the other 41 States. We estimate that under proposed § 435.952(e)(1) through (e)(4), these 8.4 million individuals would see a reduction from 4 hours to 2 hours, for a savings of 2 hours per individual, to complete an application/renewal in all 41 States. In aggregate, we estimate an annual savings of minus 16,800,000 hours (8,400,000 individuals × 2 hr) and minus $470,568,000 (16,800,000 hr × $28.01/hr). We estimate the non-labor savings under proposed § 435.952(e)(1) through (e)(4) derived $10 [($4.50 postage for small package or $1.75/page for faxing) + $4 roundtrip bus ride (to/from post office, printing/copying place and home) + $0.13/page for printing/copying)] per MSP applicant/renewal per year for all 51 States. In aggregate, we estimate an annual non-labor savings of minus $84,000,000 (8,400,000 beneficiaries × $10/beneficiary).

We also estimate that the proposal under § 435.952(e)(1) through (e)(4) would save an Eligibility Interviewer 15 minutes (0.25 hr) per eligibility determination or renewal for these 8,400,000 applicants/beneficiaries. In aggregate, we estimate an annual labor savings for States of minus 2,100,000 hours (8,400,000 applicants × 0.25 hr) and minus $96,894,000 (2,100,000 hr × $46.14/hr). Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State savings would be minus $48,447,000.

OMB Control Number 0938–0467 (CMS–R–74)

We are also proposing to revise § 435.952(e)(4) to require States to develop a verification process to determine the cash surrender value of life insurance policies over $1,500. We anticipate this proposal would be a change for 10 States in their process for verifying the cash surrender value of life insurance policies over $1,500. We do not anticipate an impact in the following 16 States because they are using authority in section 1902(r)(2) of the Act to disregard the cash surrender value of life insurance in whole or part: Alabama, Arizona, California, Connecticut, Delaware, Louisiana, Mississippi, Nevada, New Mexico, New York, North Carolina, Oregon, South Carolina, Vermont, Wyoming, and Washington, DC. Seventy percent of the remaining States would choose to use authority in section 1902(r)(2) of the Act to disregard the cash surrender value of life insurance rather than opting to verify the cash surrender value of life insurance. As such, we expect that this change would only impact 20 percent of all 50 States and Washington, DC (or 10 States).[85] Based on enrollment in past years, we anticipate that all States would adjudicate 1,000,000 new MSP applications a year plus 10 million renewals. However, we anticipate this policy would only affect 2 percent of applicants and beneficiaries across 10 States because of the small number of people who could both afford this type of life insurance (which is much more expensive than term life insurance) and also likely to apply for MSPs (which tends to be lower-income individuals) 44,000 individuals [(11,000,000 individuals × 0.02 × 0.2].

The burden associated with proposed changes to § 435.952(e)(4) would consist of the time and effort for eligibility workers in 10 States to collect information regarding the cash surrender value of life insurance from 44,000 applicants; eligibility workers in 10 States not having to spend time coaching 44,000 applicants how to gather and find information on the cash surrender value of life insurance; and eligibility workers in 10 States not having to review life insurance documents for individuals with life insurance less than $1,500.

We estimate that under proposed § 435.952(e)(4) it would take an

[83] Over the past 5 years (2017–2021), SSA approved an average of 394,025 LIS applications annually. *https://www.ssa.gov/open/data/Data-about-Extra-Help-with-Medicare-Prescription-Drug-Plan-Cost.html.*

[84] Based on States adjudicating 1.5 million new applications and 10 million for redetermination annually.

[85] We are not including impacts for territories in these estimates because territories do not have any enrollment in MSPs.

Eligibility Interviewer about 1 hour at $46.14/hr to verify the cash surrender value of each life insurance policy over $1,500. In aggregate, we estimate an annual burden of 44,000 hours (1 hr × 44,000 individuals) at a cost of $2,030,160 (44,000 hr × $46.14/hr). Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share would be $1,015,080.

We estimate the proposal under proposed § 435.952(e)(4) would save Eligibility Interviewers an average 45 minutes (0.75 hr) per applicant from not needing to coach applicants on how to gather and find information on the cash surrender value of life insurance. In aggregate, we estimate an annual savings of minus 33,000 hours (44,000 applicants × 0.75 hr) and $1,522,620 (33,000 hr × $46.14/hr). Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State savings would be minus $761,310.

We also estimate State *savings* under proposed § 435.952(e)(4) from eligibility workers not having to review life insurance documents for individuals with life insurance less than $1,500. We anticipate it would take an eligibility worker about 10 minutes (0.167 hr) to review a life insurance document and that this savings would affect 3 percent of applicants and beneficiaries or individuals (66,000 individuals = 11,000,000 individuals × 0.03 × 0.2) across 10 States. In aggregate, we estimate an annual savings of minus 11,022 hours (66,000 individuals × −0.167 hr) and minus $508,555 (−11,022 hr × $46.14/hr). Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State savings would be minus $254,278.

In total, taking into account the Federal contribution, we estimate a State annual burden reduction of minus $51,935,692 (−$3,488,184 + −$48,447,000 + $1,015,080 + −$761,310 + −$254,278).

For individuals, we estimate an annual burden reduction of minus 18,150,000 hours (-1,350,000 + −16,800,000 hr) and minus $595,981,500 (−$37,813,500 + −$3,600,000 + −470,568,000 + −$84,000,000).

2. ICRs Regarding Defining ''Family of the Size Involved'' for the Medicare Savings Program Groups using the Definition of ''Family Size'' in the Medicare Part D Low-Income Subsidy Program (§ 435.601)

The following proposed changes will be submitted to OMB for review under control numbers 0938–1188 (CMS–10434 #15) regarding the submission of a State plan amendment (SPA) and 0938–1147 (CMS–10410) regarding Medicaid application changes.

OMB 0938–1188 (CMS–10434 #15)

Proposed § 435.601 would align the definition of ''family size'' for purposes of MSP eligibility with that of the LIS program. Specifically, ''family of the size involved'' would be defined to include *at least* the individuals included in the definition of ''family size'' in the LIS program: the applicant, the applicant's spouse, and all other individuals living in the same household who are related to and dependent on the applicant or applicant's spouse. While some States either already define family size to match the LIS definition or use a family size that is less restrictive than this definition, we estimate that 10 States use SSI methodologies to determine family size, which means that these States only use an individual or couple and any other deemed individuals as part of the family size. As such, we estimate that 10 States would need to submit a SPA to change their definition of family size for MSP eligibility groups to comply with this regulation.

We estimate that it would take each State 3 hours to submit a SPA to update the definition of ''family size'' in their Medicaid State plans. Of those 3 hours, we estimate it would take a Business Operations Specialist 2 hours at $77.28/hr and a General Operations Manager 1 hour at $110.82/hr to update and submit each SPA to CMS for review. In aggregate, we estimate a one-time burden of 30 hours (10 States × 3 hr) at a cost of $2,654 (10 States × ([2 hr × $77.28/hr] + [1 hr × $110.82/hr]) for completing the necessary SPA updates. Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State cost would be $1,327.

OMB 0938–1147 (CMS–10410)

We estimate that it would take each State 200 hours to develop and code the changes to its Medicaid application to add questions to identify other third parties in prospective MSP group households. We note that these changes do not create additional burden on beneficiaries as the new questions would be in lieu of prior questions. As such, the changes require the programming change reflected here with a neutral impact on applicants. Of those 200 hours, we estimate it would take a Database and Network Administrator and Architect 50 hours at $98.50/hr and a Computer Programmer 150 hours at $92.92/hr. In aggregate, we estimate a one-time burden of 2,000 hours (10 States × 200 hr) at a cost of $188,630 (10 States × [(50 hr × $98.50/hr) + (150 hr × $92.92/hr)]) for completing the necessary updates to the Medicaid application. Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State cost would be $94,315.

In total, taking into account the Federal contribution, we estimate a one-time State cost of $95,642 ($1,327 + $94,315).

3. ICRs Regarding Automatically Enrolling Certain SSI Recipients Into the Qualified Medicare Beneficiaries Group (§ 435.909)

The following proposed changes will be submitted to OMB for review under control number 0938–1147 (CMS–10410).

The proposal under § 435.909 would require that States deem certain individuals who are eligible for Medicare Part A and SSI eligible for QMB without requiring an application. In particular, we propose that: (1) States with 1634 agreements must deem Supplemental Security Income (SSI) recipients who are entitled to premium-free Medicare Part A; (2) all other States must deem SSI recipients who are entitled to premium-free Medicare Part A and have been determined eligible for Medicaid under either § 435.120 or § 435.121; and (3) Part A buy-in States must deem if the individual is determined eligible for Medicaid under either § 435.120 or § 435.121, entitled to SSI, only qualifies for premium Part A, and is enrolled in Part B. To implement these new requirements, States would need to identify Medicare-eligible SSI recipients in order to enroll them in the MSPs. States would also need to trigger deeming of Medicare-eligible SSI recipients to QMB by making eligibility systems changes to trigger QMB enrollment once the SSI-individual is Medicare eligible. Current regulations do not allow State Medicaid agencies to forgo an eligibility determination for Medicaid beneficiaries who are eligible for SSI when they become newly eligible for Medicare Part A and B. Therefore, this new requirement would mean system changes for all 50 States and the District of Columbia, (altogether, 51 ''States'').

While these deeming provisions are intended to enroll more SSI recipients in QMB, this rulemaking would not reach all SSI recipients eligible for QMB. We estimate currently 16 percent or 566,556 (3,540,975 × 0.16) SSI recipients are eligible but not enrolled

in QMB, and nearly 500,000 new SSI recipients who are enrolled in Medicaid under either § 435.120 or § 435.121 would enroll in QMB as a result of the proposal under § 435.909. As discussed in section II.A.3. of this proposed rule, in the 34 States with a 1634 agreement, the Medicaid agency automatically enrolls the SSI recipients in Medicaid following a data exchange with SSA and then CMS automatically initiates Part B buy-in for the individual through the ''buy-in data exchange.'' In the remaining States, individuals must submit a separate application to the State Medicaid agency to be determined eligible for Medicaid. CMS does not automatically initiate Part B buy-in for SSI individuals who live in SSI criteria and 209(b) States; rather, States must initiate Part B buy-in once the SSI recipient has separately applied for and been determined eligible for the mandatory SSI or 209(b) group. Additionally, SSI recipients who live in group payer States and are eligible for premium Part A are still required to go through a complicated two-step application process to establish QMB eligibility once an individual is determined eligible for the mandatory SSI or 209(b) groups and has been enrolled in Part B pursuant to the State's buy-in agreement. Under the proposed rule, the application process for SSI recipients who live in criteria and 209(b) States would remain the same and so would the two-step application process to establish QMB eligibility for SSI recipients living in group payer States and having premium part A.

Based on SSA data and internal CMS analysis of the 566,556 SSI recipients eligible for QMB but not enrolled, we estimate almost 83 percent (469,820) were likely eligible for premium-free Part A while approximately 17 percent (96,736) were eligible for premium Part A. Of the 469,820 who were eligible for premium-free Part A, we estimate 405,963 reside in States with 1634 agreements, and 63,857 reside in 209(b) or SSI criteria States. Because Medicaid is automatic in States with 1634 agreements, we estimate that 405,963 individuals (all of the above-mentioned SSI recipients in 1634 States) would be automatically enrolled in QMB under this new provision.

In contrast, we estimate that only 65 percent of the above-mentioned 63,857 SSI recipients in 209(b) or SSI criteria States, or 41,507 individuals, would be enrolled under the new provision. This is because it is unlikely that all SSI recipients who live in SSI or 209(b) States would complete the Medicaid application process in their State. Of the 96,736 eligible for premium Part A, we estimate 33 percent (31,923) are in Part A buy-in States and 67 percent (64,813) of those eligible for premium Part A are in group payer States, where deeming would be optional. We estimate that 95 percent (30,327) of individuals in Part A buy-in States who are eligible for premium Part A would enroll as a result of the new provision because we estimate that all of those individuals live in States with 1634 agreements. However, for the individuals eligible for premium Part A in group payer States where deeming would be optional, we expect some more populous States to use this option, so we are estimating 33 percent (21,388 = 64,813 × 0.33) of all individuals with premium Part A living in group payer States would newly enroll.

Therefore, we estimate a total of 499,185 individuals (405,963 + 41,507 + 30,327 + 21,388) would newly enroll without the need to complete an application. We estimate that those individuals would each save 2 hours from not filling out Medicaid applications and compiling associated documentation (going from 2 to zero hours) at $28.01/hr. We estimate an annual savings of minus 998,370 hours (499,185 individuals × 2 hr) and minus $27,964,344 (998,370 hr × $28.01/hr).

All 51 States would need to make eligibility systems changes to deem an SSI individual in QMB once they are eligible for Medicare. We estimate it would take a Computer Programmer an average of 180 hours per State at $92.92/hr to make systems changes to set their systems to search for Medicare eligibility in Federal systems and then enroll that individual in QMB. In aggregate, we estimate a one-time burden of 9,180 hours (51 States × 180 hr) at a cost of $853,006 (9,180 hr × $92.92/hr). Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share would be $426,503.

We also estimate that this provision would result in an annual *reduction* of burden for the State to no longer review and adjudicate QMB applications from SSI recipients. We estimate that this proposal would *save* an Eligibility Interviewer 1 hour (going from 1 hour to zero) per QMB determination at $46.14/hr. We also estimate that States conduct QMB eligibility determinations for approximately 250,000 SSI individuals across 51 States, which would no longer be necessary. In aggregate, we estimate an annual burden savings of minus 250,000 hours (250,000 individuals × −1 hr/response) and minus $11,535,000 (−250,000 hr × $46.14/hr). Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State savings would be minus $5,767,500.

In total, for the ICRs related to § 435.601 under OMB control number 0938–1147 (CMS–10410), taking into account the Federal contribution, we estimate an annual State burden *reduction* of minus $5,340,997 ($426,503 + −$5,767,500).

4. ICRs Regarding Facilitating Enrollment by Allowing Medically Needy Individuals To Deduct Prospective Medical Expenses (§ 435.831)

The following proposed changes will be submitted to OMB for review under control 0938–TBD (CMS–10819). At this time, the control number is to be determined (TBD). OMB will assign the control number upon their clearance of the proposed rule's new information collection request. The new control number will be set out in the final rule.

The amendments proposed under § 435.831(g) would permit States to project certain additional services that the State can determine with reasonable certainty will be constant in order to prevent those in the medically needy group from cycling on and off Medicaid, and preventing the occurrence of an eligibility start date each budget period that is not predictable to either the institutionalized individual or State agency. Over time, this would reduce the burden on the State by eliminating the need to process a new application or renewal each month for each individual in the medically needy group. This would also reduce the burden on the individual who would not need to reapply each month but instead would remain continuously enrolled. However, there would be an up-front cost to the States to program their eligibility systems to project the cost of care for the medically needy group and to remove the triggers to renew eligibility each month once the spenddown amount is reached.

We estimate that all 56 States (50 States, 5 territories, and the District of Columbia; hereinafter ''56 States'') would need to make system changes to program their eligibility systems to project the cost of care for the medically needy group and to remove the triggers to renew eligibility each month once the spenddown amount is reached. We estimate it would take an average of 200 hours per State to develop and code the changes to each State's system to reschedule renewals for medically needy beneficiaries no more frequently than once every 12 months. Of those 200 hours, we estimate it would take a

Database and Network Administrator and Architect 50 hours at $98.50/hr and a Computer Programmer 150 hours at $92.92/hr. Therefore, we estimate a one-time burden of 11,200 hours (56 States × 200 hr) at a cost of $1,056,328 (56 States × [(50 hr × $98.50/hr) + (150 hr × $92.92/hr)]) for completing the necessary system changes. Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share would be $528,164.

We estimate that under proposed § 435.831(g), each of all 56 States would no longer need to process a new application or renewal each month for 25 individuals in the medically needy group annually. We estimate it currently takes an Eligibility Interviewer, Government Programs, 2 hours at $46.14/hr and an Interpreter and Translator 1 hour at $56.16/hr to help process a new application or renewal each month for 6 months per year per beneficiary. Therefore, each State would save 450 hours (3 hr × 6 months/year × 25 beneficiaries) and $22,266 (6 months/year × 25 beneficiaries × [(2 hr × $46.14/hr) + (1 hr × $56.16/hr)]) annually by not processing a new application or renewal each month for each individual in the medically needy group. In aggregate, we estimate this provision would save all States minus 25,200 hours (450 hr × 56 States) and minus $1,246,896 ($22,266 × 56 States). When taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State savings would be minus $623,448.

Likewise, we estimate that under proposed § 435.831(g), those same 25 beneficiaries would no longer need to reapply each month but instead would remain continuously enrolled, thus reducing the burden on the individuals. We estimate that it currently takes a beneficiary 2 hours at $28.01/hr to reapply each month in an average of 6 months per year. Therefore, beneficiaries in each State would save a total of 300 hours (2 hr × 6 months/year × 25 beneficiaries/State) and $8,403 (300 hr × $28.01/hr) annually. In aggregate, under this provision, beneficiaries across all 56 States would save 16,800 hours (300 hr × 56 States) and $470,568 ($8,403 × 56 States) annually.

In total, for the ICRs related to § 435.831 under OMB control number 0938–TBD (CMS–10819), taking into account the Federal contribution, we estimate a one-time State cost of minus $95,284 ($528,164 + −$623,448).

5. ICRs Regarding Application of Primacy of Electronic Verification and Reasonable Compatibility Standard for Resource Information (§§ 435.952 and 435.940)

The following proposed changes will be submitted to OMB for review under control number 0938–0467 (CMS–R–74).

States have asked whether they are permitted to request additional documentation from applicants and beneficiaries related to resources that can be verified through the State's asset verification system (AVS), or if they can apply a reasonable compatibility standard for resources when resource information returned from an electronic data source is compared to the information provided by the applicant or beneficiary. We believe the requirements at § 435.952(b) and (c), which require States to apply a reasonable compatibility test to income determinations, apply to resource determinations as well. We believe that clearly applying the requirements at § 435.952(b) and (c) to resources will help streamline enrollment for individuals applying for Medicaid on a non-MAGI basis, such as on the basis of age, blindness, or disability, and decrease burden for both States and beneficiaries.

The amendments proposed under §§ 435.952 and 435.940 would clarify that, if information provided by an individual is reasonably compatible with information returned through an AVS, the State must determine or renew eligibility based on that information. They would also clarify that States must consider asset information obtained through an AVS to be reasonably compatible with attested information if either both are above or both are at or below the applicable resource standard or other relevant resource threshold.

Under the proposed changes to §§ 435.952 and 435.940, we estimate that the States would save an Eligibility Interviewer 1 hour per beneficiary at $46.70/hr to no longer reach out to 10,000 individuals per State for additional information to verify their resources. In aggregate, we estimate a *savings* for all States of 510,000 hours (51 States × 10,000 individuals/State × 1 hr) and $23,531,400 (510,000 hr × $46.14/hr). When taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State savings would be minus $11,765,700 ($23,531,400 × 0.5).

Under the proposed changes to §§ 435.952 and 435.940, we estimate that 10,000 individuals per State would save on average 1 hour each at $28.01/hr to no longer need to submit additional information to verify their resources. In aggregate for individuals in all States, we estimate a savings of minus 510,000 hours (1 hr × 10,000 individuals/State × 51 States) and minus $14,285,100 (510,000 hr × $28.01/hr).

6. ICRs Regarding Verification of Citizenship and Identity (§ 435.407)

The following proposed changes will be submitted to OMB for review under control number 0938–0467 (CMS–R–74).

The amendments proposed under § 435.407 would simplify eligibility verification procedures by considering verification of birth with a State vital statistics agency or verification of citizenship with SAVE as stand-alone evidence of citizenship. Likewise, under this provision, separate verification of identity would not be required. This proposed revision is not intended to require a State to develop a match with its vital statistics agency if it does not already have one in place. However, if a State already has established a match with a State vital statistics agency or it would be effective to establish such capability in accordance with the standard set forth in § 435.952(c)(2)(ii), the State must utilize such match before requesting paper documentation from the applicant. We estimate this provision would apply to the roughly 100,000 applicants per year for whom States cannot verify U.S. citizenship with SSA.

We estimate that the amendments proposed under § 435.407 would take a Management Analyst 15 minutes (0.25 hr) per applicant at $96.66/hr to check the State's vital statistics agency for verification of U.S. citizenship of an applicant. In aggregate for all 56 States, this provision would add a burden of 25,000 hours (0.25 hr × 100,000 applicants) and $2,416,500 (25,000 hr × $96.66/hr). Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share would be $1,208,250.

In contrast, we estimate that the amendments proposed under § 435.407 would *save* an Eligibility Interviewer 45 minutes (0.75 hr) at $46.70/hr by no longer needing to request and process paper documentation of citizenship. In aggregate, all 56 States would save minus 75,000 hours (0.75 hr × 100,000 applicants) and minus $3,460,500 (75,000 hr × $46.14/hr). Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated

State savings would be minus $1,730,250.

In total for the ICRs related to § 435.407 under OMB control number 0938–0467 (CMS–R–74), taking into account the Federal contribution, we estimate an annual State savings of minus $522,000 ($1,208,250 + −$1,730,250). For individuals, we estimate that the amendments proposed under § 435.407 would save each applicant 1 hour at $28.01/hr plus an average of $10 in miscellaneous costs [($4.50 postage for small package or $1.75/page for faxing) + $4 roundtrip bus ride (from home to printing/copying place to post office and back home) + $0.13/page for printing/copying], to no longer need to gather and submit paper documentation of citizenship. In aggregate, all 100,000 applicants would save 100,000 hours (1 hr × 100,000 applicants) and $2,801,000 (100,000 hr × $28.01/hr) in labor and + $1,000,000 ($10.00 × 100,000 applicants) in non-labor related costs.

7. ICRs Regarding Aligning Non-MAGI Enrollment and Renewal Requirements With MAGI Policies (§ 435.916)

The following proposed changes will be submitted to OMB for review under control number 0938–1147 (CMS–10410).

The amendments proposed under § 435.916(a) would align the frequency of renewals for non-MAGI beneficiaries with the current requirement for MAGI beneficiaries, which allows for renewals no more frequently than every 12 months. Proposed § 435.916(b) also requires States to adopt the existing renewal processes required for MAGI beneficiaries for non-MAGI beneficiaries when a State is unable to renew eligibility for an individual based on information available to the agency. Proposed § 435.916(b)(2) would require States to provide all beneficiaries, including non-MAGI beneficiaries, whose eligibility cannot be renewed without contacting the individual in accordance with proposed § 435.916(b)(1), a renewal form that is pre-populated with information available to the agency, a minimum of 30 calendar days to return the signed renewal form along with any required information, and a 90-day reconsideration period for individuals terminated for failure to return their renewal form but who subsequently return their form within the reconsideration period. Proposed § 435.916(b)(2) no longer permits States to require an in-person interview for non-MAGI beneficiaries as part of the renewal process.

We estimate that in 2021, six States—Minnesota, New Hampshire, Texas, Utah, Washington, and West Virginia—have policies in place to conduct regularly-scheduled renewals for at least some non-MAGI beneficiaries more frequently than once every 12 months. One other State conducts more frequent renewals for non-MAGI populations during normal operations, but elected to conduct renewals only once every 12-months for all beneficiaries during the COVID–19 PHE. We excluded the State from these estimates as it would have needed to make changes for the temporary authority in effect as of 2021 during the PHE.

Under proposed § 435.916(a), we estimate it would take an average of 200 hours per State to develop and code the changes to each State's system to reschedule renewals for non-MAGI beneficiaries no more frequently than once every 12 months. Of those 200 hours, we estimate it would take a Database and Network Administrator and Architect 50 hours at $98.50/hr and a Computer Programmer 150 hours at $92.92/hr. In aggregate, we estimate a one-time burden of 1,200 hours (6 States × 200 hr) at a cost of $113,178 (6 States × [(50 hr × $98.50/hr) + (150 hr × $92.92/hr)]) for completing the necessary system changes. Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share would be $56,589.

We also estimate that 21 States do not pull available non-MAGI beneficiary information to prepopulate a renewal form.[86] Under proposed § 435.916(b)(2), we estimate it would take an average of 200 hours per State to develop and code the changes to each State's system to pull the existing non-MAGI beneficiary information to prepopulate a renewal form. Of those 200 hours, we estimate it would take a Business Operations Specialist 50 hours at $77.28/hr and a Management Analyst 150 hours at $96.66/hr. In aggregate, we estimate a one-time burden of 4,200 hours (21 States × 200 hr) at a cost of $385,592 (21 States × [(50 hr × $77.25/hr) + (150 hr × $96.66/hr)] for completing the necessary system changes and designing the form. Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share would be $192,796.

While we do not have evidence of how many States currently require an in-person interview, to calculate this burden, we will assume all 56 States do so, with the understanding that the actual State savings will be much less. In 2020, there were about 2,688,386 non-MAGI beneficiaries[87] for whom States would no longer need to conduct an in-person interview for non-MAGI beneficiaries as part of the renewal process. Under proposed § 435.916(b)(2), we estimate that an Eligibility Interviewer would save on average 0.5 hours per beneficiary at $46.14/hr. In aggregate, we estimate this would save States minus 1,344,193 hours (0.5 hr × 2,688,386 beneficiaries) and minus $62,021,065 (1,344,193 hr × $46.14/hr). Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State savings would be minus $31,010,533.

In total for the ICRs related to § 435.916 under OMB control number 0938–1147 (CMS–10410), taking into account the Federal contribution, we estimate a one-time State savings of minus $30,761,148 ($56,589 + $192,796 − $31,010,533) with an annual savings of minus $31,010,533. We estimate that in the six States—Minnesota, New Hampshire, Texas, Utah, Washington, and West Virginia—that currently have policies to conduct regularly-scheduled renewals for non-MAGI beneficiaries more frequently than once every 12 months during normal operations, in 2020, there were about 2,688,386 non-MAGI beneficiaries[88] who would no longer need to submit a renewal under proposed § 435.916(a). Assuming impacted beneficiaries are evenly distributed across these six States, and assuming it currently takes each beneficiary 1 hour at $28.01/hr to submit a renewal form, in aggregate, beneficiaries across these six States would save minus 2,688,386 hours (2,688,386 non-MAGI beneficiaries × 1 hr) and minus $75,301,692 (−2,688,386 hr × $28.01/hr).

While we do not have evidence of how many States currently require an in-person interview, to calculate this burden, we will assume all 56 States do so, with the understanding that the actual individual burden will be much less. In 2020, there were about 2,688,386 non-MAGI beneficiaries[89] who would

[86] Kaiser Family Foundation. *Medicaid Financial Eligibility for Seniors and People with Disabilities: Findings from a 50-State Survey*. Available at: *https://files.kff.org/attachment/Issue-Brief-Medicaid-Financial-Eligibility-for-Seniors-and-People-with-Disabilities-Findings-from-a-50-State-Survey*.

[87] Major Eligibility Group Information for Medicaid and CHIP Beneficiaries by Year, accessed from: *https://data.medicaid.gov/dataset/267831f3-56d3-4949-8457-f6888d8babdd*.

[88] Ibid.

[89] Ibid.

no longer need to travel to a Medicaid office to complete an in-person interview in order to maintain coverage under proposed § 435.916(b)(2). Assuming impacted beneficiaries are evenly distributed across these 56 States and assuming it currently takes each beneficiary 1 hour to travel to and participate in an in-person interview, plus on average $10/person in travel expenses, in aggregate, beneficiaries across these 56 States would save minus 2,688,386 hours (2,688,386 beneficiaries × 1 hr) and minus $75,301,692 (2,688,386 hr × $28.01/hr) in labor and minus $26,883,860 (2,688,386 non-MAGI beneficiaries × $10.00) in non-labor related costs.

Under proposed § 435.916(b)(2), we estimate 37 States will need to establish a reconsideration period for non-MAGI beneficiaries or extend the timeframe of their existing reconsideration period for non-MAGI beneficiaries to 90 calendar days. In 2020, there were up to 2,688,386 non-MAGI beneficiaries in 56 States [90] who would newly not need to complete a new application to regain coverage after being terminated for coverage for failure to return their renewal form under this provision. Approximately 4.2 percent of beneficiaries are disenrolled from coverage and reenroll within 90 days.[91] Therefore, we estimate 74,603 beneficiaries (2,688,386 beneficiaries/56 States × 0.042 × 37 States) would newly not need to complete a full application to reenroll in coverage because they would be in a 90-day reconsideration period under proposed § 435.916(b)(2). Assuming impacted beneficiaries are evenly distributed across the 37 States and assuming it currently takes each beneficiary 1 hour at $28.01/hr to submit a new full application, this provision would save, in aggregate, beneficiaries across these 37 States a total of minus 74,603 hours (74,603 beneficiaries × 1 hr) and minus $2,089,630 (74,603 hr × $28.01/hr).

For beneficiaries, we estimate a total burden reduction of minus $179,576,874 (−$75,301,692 −$102,185,552 −$2,089,630).

8. ICRs Regarding Acting on Changes in Circumstances (§§ 435.916, 435.919, and 457.344)

The following proposed changes will be submitted to OMB for review under control number 0938–1147 (CMS–10410).

The amendments proposed under § 435.919 would, if the State cannot redetermine the individual's eligibility after a change in circumstance using third party data and information available to the agency, allow beneficiaries at least 30 calendar days from the date the State sends a request for additional information to provide such information. In addition, the amendments would require States to provide beneficiaries terminated due to failure to provide information requested after a change in circumstance with a 90-day reconsideration period.

Because the proposed requirements under §§ 435.912, 435.919, and 457.344 would result in more time for beneficiaries to respond to the State's request for additional information, it is likely that fewer beneficiaries would lose eligibility as a result of this provision. As well, because the proposed amendments would, for the first time, provide a 90-day reconsideration period after a change in circumstance for all approximately 85,809,179 Medicaid and CHIP beneficiaries (in the 51 States that reported enrollment data for November 2021),[92] to submit additional information to maintain their eligibility, it is likely that beneficiaries would not need to complete and States would not need to process full applications for 4.2 percent of those individuals or 3,603,986 beneficiaries (85,809,179 beneficiaries × 0.042) who lose coverage and later reenroll.[93]

Assuming the 40 States with a separate CHIP agency can adapt language from the Medicaid notice for their purposes, we estimate it would not take as long for those 40 States to revise the notice requesting additional information from beneficiaries regarding their eligibility after a change in circumstance to include language allowing the beneficiary 30 calendar days to respond. Therefore, we estimate it would take an average of 6 hours per State Medicaid agency and 3 hours per separate CHIP agency to complete this task. Of the 6 Medicaid hours, we estimate it would take a Business Operations Specialist 4 hours (and 2 hr for CHIP) at $77.28/hr and a Management Analyst 2 hours (and 1 hr for CHIP) at $96.66/hr. We estimate an aggregate, one-time burden of 426 hours [(51 Medicaid States [94] × 6 hr) + (40 CHIP States × 3 hr)] at a cost of $35,673 (51 States × [(4 hr × $77.28/hr) + (2 hr × $96.66/hr)] + (40 States × [(2 hr × $77.28/hr) + (1 hr × $96.66/hr)]) for revising the notice requesting additional information. Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share would be $17,837.

We also estimate it would take each State 6 hours to revise the termination notice to beneficiaries who did not respond to the State's request for additional information regarding their eligibility after a change in circumstance to include language allowing the beneficiary a 90-day reconsideration period. Of those 6 hours, we estimate it would take a Business Operations Specialist an average of 4 hours at $77.28/hr and a Management Analyst 2 hours at $96.66/hr. In aggregate, we estimate a one-time burden of 336 hours (56 States × 6 hr) at a cost of $28,137 (56 States × [(4 hr × $77.28/hr) + (2 hr × $96.66/hr)] for revising the termination notice. Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share would be $14,068.

We also estimate that it would save each State 50 hours to process full applications annually for beneficiaries who would no longer lose coverage and later reenroll. Specifically, we estimate it would save an Eligibility Interviewer 40 hours at $46.14/hr and an Interpreter and Translator 10 hours at $56.16/hr. In aggregate, we estimate an annual savings of minus 2,800 hours (56 States × 50 hr) and minus $134,803 ([(40 hr × $46.14/hr) + (10 hr × $56.16/hr)] × 56 States) for processing fewer full applications. Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State savings would be minus $67,402.

In total, for ICRs related to § 435.919 under OMB control number 0938–1147 (CMS–10410), taking into account the Federal contribution, we estimate a total State savings of minus $35,497 ($17,837 + $14,068 − $67,402).

[90] Ibid.

[91] Kaiser Family Foundation (2021). Medicaid Enrollment Churn and Implications for Continuous Coverage Policies. *https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-churn-and-implications-for-continuous-coverage-policies/.*

[92] CMS, *November 2021 Medicaid & CHIP Enrollment.* Available at *https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html.*

[93] Kaiser Family Foundation. (2021). Medicaid Enrollment Churn and Implications for Continuous Coverage Policies. *https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-churn-and-implications-for-continuous-coverage-policies/.*

[94] While this provision applies to all States, Washington, DC, and the 5 territories, we are only estimating the burden for the 51 States for which we have current enrollment data, per the November 2021 CMS enrollment snapshot, available at *https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/downloads/october-november-2021-medicaid-chip-enrollment-trend-snapshot.pdf.*

We estimate that it would *save* each beneficiary who is disenrolled after a change in circumstance 2 hours at $28.01/hr to no longer submit a full application. As stated above, approximately 4.2 percent of beneficiaries are disenrolled from coverage and reenroll within 90 days.[95] Because this provision applies to all beneficiaries, which numbered approximately 85,809,179 individuals for Medicaid and CHIP (in the 51 States that reported enrollment data for November 2021),[96] we estimate approximately 3,603,986 beneficiaries (85,809,179 beneficiaries × 0.042) would save this time not reapplying after a change in circumstance. In aggregate, we estimate that this provision would save beneficiaries minus 7,207,972 hours (3,603,986 beneficiaries × 2 hr) and minus $201,895,296 (7,207,972 hr × $28.01/hr).

9. ICRs Regarding Timely Determination and Redetermination of Eligibility in Medicaid (§ 435.912) and CHIP (§ 457.340)

The following proposed changes will be submitted to OMB for review under control number 0938–1188 (CMS–10434 #15) for the State plan changes and 0938–1147 (CMS–10410) for the remaining burden related to updating notices and systems.

OMB Control Number 0938–1188 (CMS–10434 #15)

The amendments in this section would establish standards to ensure that applicants have enough time to gather and provide additional information and documentation requested by a State in adjudicating eligibility. In addition, the proposed amendments would apply to redeterminations either at renewal or based on changes in circumstances, the current requirements which apply at application. To address the current situation where redeterminations remain unprocessed for several months following the end of a beneficiary's eligibility period due to the beneficiary failing to return needed information to the State, these proposed amendments would require States to establish timeliness standards for both beneficiaries to return requested information to the State, as well as for the State to complete a redetermination of eligibility when the beneficiary returns information too late to process before the end of the eligibility period. In addition, these proposed amendments would require States to establish performance and timeliness standards for determining Medicaid eligibility, as well as determining eligibility for CHIP and BHP when an individual is determined ineligible for Medicaid.

Lastly, the amendments proposed under § 435.912 would for the first time establish set timeframes for when States must complete existing requirements related to acting on change in circumstances. The amendments would require States to process a redetermination within 30 calendar days from the date the State receives information indicating a potential change in a beneficiary's circumstance if no information is needed from the individual to redetermine eligibility and within 60 calendar days if the State needs to request additional information from the individual.

We estimate that it would take each State 3 hours to update their Medicaid State plans via a SPA to establish timeliness standards for the State to process redeterminations. Of those 3 hours per SPA, we estimate it would take a Business Operations Specialist 2 hours at $77.28/hr and a General Operations Manager 1 hour at $110.82/hr to update and submit each SPA to CMS for review. In aggregate, we estimate a one-time burden of 168 hours (56 States × 3 hr) at a cost of $14,861 (56 responses × ([2 hr × $77.28/hr] + [1 hr × $110.82/hr])) for completing the necessary SPA updates. Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share would be $7,431.

OMB Control Number 0938–1147 (CMS–10410)

We estimate that it would take each State 6 hours to update their notices to inform beneficiaries of the newly established timeframes within which they must return requested additional information in order for the State to process their redeterminations. Of those 6 hours, we estimate it would take a Business Operations Specialist 4 hours at $77.28/hr and a Computer Programmer 2 hours at $92.92/hr. In aggregate, we estimate a one-time burden of 336 hours (56 States × 6 hr) and $27,718 (56 States × ([4 hr × $92.92/hr] + [2 hr × $77.28/hr])) for all States to update the notices. Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share would be $13,859.

We also estimate it would take an average of 200 hours per State to develop and code the changes to each State's system to remove the edit to disenroll those beneficiaries who fail to return additional information within the newly established timeframes. Of those 200 hours, we estimate it would take a Business Operations Specialist 50 hours at $77.28/hr and a Management Analyst 150 hours at $96.66/hr. In aggregate, we estimate a one-time burden for all States of 11,200 hours (56 States × 200 hr) at a cost of $1,028,244 ([(50 hr × $77.25/hr) + (150 hr × $96.66/hr)] × 56 States) for completing the necessary system changes. Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share would be $514,122.

In total for the ICRs related to §§ 435.912 and 457.340 under OMB control number 0938–1188 (CMS–10434 #15) and 0938–1147 (CMS–10410), taking into account the Federal contribution, we estimate a total one-time State cost of $535,412 ($7,431 + $13,859 + $514,122).

10. ICRs Regarding Returned Mail (§§ 435.919 and 457.344)

The following proposed changes will be submitted to OMB for review under control number 0938–1147 (CMS–10410).

This rule proposes to specify the steps States must take when beneficiary mail is returned to the agency. States would be required to first conduct a series of data checks to identify updated beneficiary contact information, including the State's Medicaid Enterprise System (MES), managed care plans, enrollment brokers, claims data, and other State administered public benefit systems, like TANF, SNAP, the DMV, as well as the NCOA. If updated contacted information is found, States must send a notice to that new address. Second, based on this information available to the State agency, the State must attempt to contact the beneficiaries by both mail, as well as a modality other than mail, such as by phone, electronic notice, email, or text message, as permissible. This provision also requires the State to send notices to both the current address on file and the forwarding address, if one is provided on the returned mail, requesting that the beneficiary confirm the new address. Third, only after the above has occurred with no response may the State take action, including updating the beneficiary's in-state address, terminating or suspending the

[95] Kaiser Family Foundation (2021). Medicaid Enrollment Churn and Implications for Continuous Coverage Policies. *https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-churn-and-implications-for-continuous-coverage-policies/.*

[96] CMS, *November 2021 Medicaid & CHIP Enrollment.* Available at *https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html.*

beneficiary's enrollment, or moving the beneficiary from managed care to fee-for-service Medicaid.

We estimate that it would take all 42 Medicaid managed care States (and 34 States with managed care in separate CHIP) 40 hours to update their managed care contracts to enter into regular data-sharing arrangements with their MCOs to obtain up-to-date beneficiary contact information. While some of these States have both Medicaid and CHIP managed care and may even contract with the same plans for both programs, we assume there is no overlap for purposes of this estimate. Of those 40 hours, we estimate it would take a Procurement Clerk 10 hours at $43.20/hr and a Management Analyst 30 hours at $96.66/hr. In aggregate, we estimate this would create a one-time burden for States of 3,040 hours [40 hr × (42 Medicaid States + 34 CHIP States] at a cost of $253,217 [(10 hr × $43.20/hr) + (30 hr × $96.66/hr) × 76 State agencies]. Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share would be $126,609.

We estimate, using CMS' own analysis, that about half of all States (56 States/2 = 28 States) currently check DMV data for updated beneficiary information, such as contact information, as a part of their routine verification plans. Using this as a proxy for whether the State has an agreement with third-party sources, for example, NCOA, DMV, etc., we estimate that it would take 28 States each 40 hours to establish these data-sharing agreements. Of those 40 hours, we estimate it would take a Procurement Clerk 10 hours at $43.20/hr and a Management Analyst 30 hours at $96.66/hr. In aggregate, we estimate a one-time burden of 1,120 hours (40 hr × 28 States) at a cost of $93,290 ([(10 hr × $43.20/hr) + (30 hr × $96.66/hr)] × 28 States). Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share would be $46,645.

Assuming 15 percent [97] of all Medicaid beneficiaries (12,871,377 beneficiaries = 85,809,179 beneficiaries × 0.15) [98] generate returned mail each year, we estimate that it would take 51 States each 30 seconds (approximately 0.0083 hr) per notice to send one additional notice by mail not only to the current address on file, but also to the forwarding address, if one is provided. We estimate that it would take a Management Analyst in each State 0.0083 hr/notice at $96.66/hr to program the sending of these extra notices for a total of 106,832 hours (0.0083 hr × 12,871,377 beneficiaries) at a cost of $10,326,381 (106,832 hr × $96.66/hr). We also estimate this amendment would create additional burden in postage costs for all States and all beneficiaries totaling $7,722,826 ($0.60/notice [99] × 12,871,377 [100]). Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share would be $9,024,603.

We estimate that it would take an Eligibility Interviewer an average of 5 minutes (5/60 = approximately 0.083 hr) per beneficiary at $46.14/hr to make one additional outreach attempt using a modality other than mail to the estimated 12,871,377 beneficiaries per year for whom the State receives returned mail. In aggregate, we estimate this would add a burden of 1,068,324 hours (0.083 hr × 12,871,377 beneficiaries) at a cost of $49,292,469 (1,068,324 hr × $46.14/hr). Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share would be $24,646,235.

In total for the ICRs related to §§ 435.919 and 457.344 under OMB control number 0938–1147 (CMS–10410), and taking into account the 50 percent Federal contribution, we estimate a total State cost of $33,844,092 ($126,609 + $46,645 + $9,024,603 + $24,646,235).We estimate that current State policies on returned mail may have contributed to approximately 2.125 percent drop in enrollment.[101] Applying that change, we estimate that 273,517 beneficiaries (12,871,377 beneficiaries × 0.02125) would no longer be disenrolled after non-response to a State notice generated by returned mail and would no longer need to reapply to Medicaid. Therefore, we estimate that these amendments would lead to a reduction in burden for 273,517 beneficiaries who would otherwise be disenrolled after generating returned mail. We estimate that these beneficiaries at $28.01/hr would each save 2 hours of time not needed to reapply for Medicaid. In aggregate, we estimate this amendment would save beneficiaries in all States minus 547,034 hours (273,517 beneficiaries × 2 hr) and minus $15,322,422 (547,034 hr × $28.01/hr).

11. ICRs Regarding Improving Transitions Between Medicaid and CHIP (§§ 435.1200, 457.340, 457.348, 457.350, and 600.330)

The following proposed changes will be submitted to OMB for review under control number 0938–1147 (CMS–10410).

In States with separate Medicaid and CHIP programs, proposed § 435.1200 would require both the Medicaid and CHIP agencies to make system changes to more seamlessly transition the eligibility of individuals from one program to the other. We have not included a burden estimate for changes to the BHP regulations, since revisions to the Medicaid cross-references are intended to maintain current BHP policies.

We estimate that proposed § 435.1200 would take each of the 40 States with a separate CHIP 40 hours to execute a delegation agreement between the Medicaid and CHIP agencies to implement more seamless coverage transitions. Of those 40 hours, we estimate it would take a Procurement Clerk 10 hours at $43.20/hr and a Management Analyst 30 hours at $96.66/hr. In aggregate, we estimate a one-time burden of 1,600 hours (40 hr × 40 States) at a cost of $133,272 [(10 hr × $43.20/hr) + (30 hr × $96.66/hr) × 40 States]. Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share would be $66,636.

We estimate that it would take all 40 States with a separate CHIP an average of 42 hours each to review any policy differences between their Medicaid and CHIP programs and make any necessary administrative actions to permit coordination of enrollment, such as a delegation of eligibility determinations or alignment of financial eligibility requirements between the two programs approximately. Of those 42 hours, we estimate it would take a Business Operations Specialist 22 hours at $77.28/hr and a Management Analyst 20 hours at $96.66/hr. In aggregate, we

[97] KHN, November 9, 2019, ''Return to Sender: A Single Undeliverable Letter Can Mean Losing Medicaid.'' Available at *https://khn.org/news/tougher-returned-mail-policies-add-to-medicaid-enrollment-drop/*.

[98] Centers for Medicare & Medicaid Services, ''October and November 2021 Medicaid and CHIP Enrollment Trends Snapshot,'' March 28, 2022. Available at *https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/downloads/october-november-2021-medicaid-chip-enrollment-trend-snapshot.pdf*.

[99] This amount is based on the current USPS postage rate for standard letters.

[100] While this provision applies to all States, Washington, DC, and the 5 territories, we are only estimating the burden for the 51 States for which we have current enrollment data, per the November 2021 CMS enrollment snapshot available at *https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/downloads/october-november-2021-medicaid-chip-enrollment-trend-snapshot.pdf*.

[101] KHN, November 9, 2019, ''Return to Sender: A Single Undeliverable Letter Can Mean Losing Medicaid.'' Available at *https://khn.org/news/tougher-returned-mail-policies-add-to-medicaid-enrollment-drop/*.

estimate a one-time burden of 1,680 hours (40 States × 42 hr) at a cost of $145,334 ([(22 hr × $77.28/hr) + (20 hr × $96.66/hr)] × 40 States) to review and make necessary policy changes. Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share would be $72,667.

We estimate that it would take all 40 States with a separate CHIP 200 hours to make changes to their shared eligibility system or service to determine, based on available information, whether the individual is eligible for Medicaid or CHIP when determined ineligible for the other program and before a notice of ineligibility is sent. Of those 200 hours, we estimate it would take a Business Operations Specialist 50 hours at $77.28/hr and a Management Analyst 150 hours at $96.66/hr. In aggregate, we estimate a one-time burden for all 40 States of 8,000 hours (40 States × 200 hr) at a cost of $734,520 ([(50 hr × $77.28/hr) + (150 hr × $96.66/hr)] × 40 States) for completing the necessary system changes. Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share would be $367,260.

We estimate that 25 percent of States with a separate CHIP (40 States × 0.25 = 10) are already using combined notices and would see no additional burden from this provision. For the 30 of the 40 States with separate CHIPs who do not currently use a combined notice, we estimate that it would take 6 hours to develop or update a combined eligibility notice for individuals determined ineligible for Medicaid and eligible for CHIP or vice versa and 40 hours to make the system changes necessary to implement it. Of those 46 hours, we estimate that it would take a Business Operations Specialist 14 hours at $77.28/hr and a Management Analyst 32 hours at $96.66/hr. In aggregate, we estimate a one-time burden of 1,380 hours (30 States × 46 hr) at a cost of $125,251 ([(14 hr × $77.28/hr) + (32 hr × $96.66/hr)] × 30 States) to develop the notice. Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share would be $62,626.

In total for the ICRs related to §§ 435.1200, 457.340, 457.348, 457.350, and 600.330 under OMB control number 0938–1147 (CMS–10410), and taking into account the Federal contribution, we estimate a total cost of $1,138,377.60 ($66,636 + $72,667 + $367,260 + $62,626).We also estimate that this provision would *save* each beneficiary on average 3 hours to no longer submit a renewal form once they have been determined ineligible for one program and determined potentially eligible for another insurance affordability program based on available information. Assuming 1 percent of beneficiaries (85,809,179 beneficiaries × 0.01 = 858,092 beneficiaries) currently submit a Medicaid renewal for this reason, in aggregate, we estimate an annual saving for beneficiaries in all States of minus 2,574,276 hours (3 hr × 858,092 individuals) and minus $72,105,471 (2,574,276 hr × $28.01/hr).

We estimate that it would *save* each beneficiary 4 hours previously spent reapplying for coverageAssuming 0.25 percent of beneficiaries (214,523 beneficiaries = 85,809,179 beneficiaries × 0.0025) currently lose coverage for failure to return a renewal form when no longer eligible, instead of being transitioned to the program for which they are eligible, we estimate an annual saving for beneficiaries in all States of minus 858,092 hours (4 hr × 214,523 individuals) and minus $24,035,157 (858,092 hr × $28.01/hr).

For beneficiaries, we estimate a total savings of minus $96,140,628 (−$72,105,471 − $24,035,157).12. ICRs Regarding Eliminating Requirement to Apply for Other Benefits (§ 435.608)

With regard to the burden associated with developing and coding the changes to each State's application system to eliminate the trigger for the Medicaid applicant to apply for other benefit programs, the proposed requirement and burden will be submitted to OMB for review under control number 0938–TBD (CMS–10819). At this time, the control number is to be determined (TBD). OMB will assign the control number upon their clearance of the proposed rule's new information collection request. The new control number will be set out in the final rule.

This rule proposes to remove the requirement at § 435.608 that State Medicaid agencies must require all Medicaid applicants and beneficiaries, as a condition of their eligibility, to take all necessary steps to obtain any benefits to which they are entitled. The requirement applies to adults only, which equates to approximately 46,000,000 Medicaid applicants.[102] Most individuals already apply for other benefits such as Veterans' compensation and pensions, Social Security disability insurance and retirement benefits, and unemployment compensation, because they want to receive them. As such, the requirement only impacts those individuals who only applied for a benefit because they had to in order to get or keep Medicaid.

If we estimate that, in a given year, 5 percent of beneficiaries need to apply for another benefit, that would be 2,300,000 people to whom the requirement would no longer apply by removing this provision. However, the burden of this requirement on beneficiaries with respect to the collection of information relates to the application requirements of other agencies, and therefore an estimate of burden reduction is not reflected in this section.

We estimate it would take an average of 200 hours per State to develop and code the changes to each State's application system to eliminate the trigger for the Medicaid applicant to apply for other benefit programs. Of those 200 hours, we estimate it would take a Database and Network Administrator and Architect 50 hours at $98.50/hr and a Computer Programmer 150 hours at $92.92/hr. For States, we estimate a total one-time burden of 11,200 hours (56 States × 200 hr) at a cost of $1,056,328 ([(50 hr × $98.50/hr) + (150 hr × $92.92/hr)] × 56 States) to complete the necessary system changes.

Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share would be $528,164.

13. ICRs Regarding Removing Optional Limitation on the Number of Reasonable Opportunity Periods (§ 435.956)

This provision does not create any new or revised reporting, recordkeeping, or third party disclosure requirements or burden. The requirements and burden are addressed as part of the single streamlined application that is approved by OMB under control number 0938–1191 (CMS–10440).

We propose to revise § 435.956(b)(4) to remove the option for States to establish limits on the number of ROPs. Under proposed § 435.956(b)(4), all 56 States would be prohibited from imposing limitations on the number of ROPs that an individual may receive.

Since the option was finalized, only one State submitted a SPA requesting to implement this option, and implemented via a 12-month pilot. Following the pilot, the State suspended the policy of limiting the ROP period and removed the option from its State Plan. Other than the one State, CMS has not received any inquiries about establishing such a limitation. Therefore, we estimate that the

[102] CMS, *November 2021 Medicaid & CHIP Enrollment.* Available at *https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html.*

proposed amendments to § 435.956(b)(4) will not lead to any change in burden on States.

14. ICRs Regarding Recordkeeping (§§ 431.17 and 457.965)

The following proposed changes will be submitted to OMB for review under control number 0938–TBD (CMS–10819). At this time, the control number is to be determined (TBD). OMB will assign the control number upon their clearance of the proposed rule's new information collection request. The new control number will be set out in the final rule.

The amendments proposed under §§ 431.17 (Medicaid) and 457.965 (CHIP) would clearly delineate the types of information that States must maintain in Medicaid and CHIP case records while the case is active in addition to the minimum retention period of 3 years. This proposal clearly defines the records, such as the date and basis of any determination and the notices provided to the applicant/beneficiary. While current regulations do not include a timeframe for records retention, proposed §§ 431.17(c) and 457.965(c) would establish a minimum retention period of 3 years, and proposed §§ 431.17(d) and 457.965(d) would require that records be stored in an electronic format and that such records be made available to appropriate parties within 30 days of a request if not otherwise specified.

We recognize that States are in various stages of electronic recordkeeping today and that a portion of non-MAGI beneficiary case records are currently stored in a paper-based format, along with a small portion of MAGI-based beneficiary case records. Therefore, under proposed §§ 431.17(c) and 457.965(c), we estimate it would take an average of 20 hours per State for a Management Analyst at $96.66/hr to update each State's policies and procedures to retain records electronically for 3 years minimum. In aggregate, we estimate a one-time burden of 1,120 hours (56 States × 20 hr) at a cost of $108,259 (1,120 hr × $96.66/hr) for completing the necessary updates.

Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share would be $54,130 ($108,259 × 0.5).

15. ICRs Regarding Prohibiting Premium Lock-Out Periods and Disenrollment for Failure To Pay Premiums (§§ 457.570 and 600.525(b)(2))

The following proposed CHIP State plan changes will be submitted to OMB for review under control number 0938–1147 (CMS–10410). The BHP Blueprint changes will be submitted to OMB for review under control number 0938–1218 (CMS–10510).

OMB Control Number 0938–1147 (CMS–10410)

The amendments proposed to §§ 457.570 and 600.525(b)(2) would eliminate the option for States to impose premium lock-out periods in CHIP and in States with a BHP that allows continuous open enrollment throughout the year.

Under proposed § 457.570, we estimate it would take a Management Analyst 2 hours at $96.66/hr and a General and Operations Manager 1 hour at $110.82/hr in all 15 States that currently impose lock-out periods to amend their CHIP State plans to remove the lock-out period and submit in MMDL for review. We estimate an aggregate one-time burden of 45 hours (15 States × 3 hr) at a cost of $4,562 (([2 hr × $96.66/hr] + [1 hr × $110.82/hr]) × 15 States). Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share would be $2,281.

OMB Control Number 0938–1218 (CMS–10510)

Our proposed amendments would require BHP States to revise their BHP Blueprints to remove the premium lock-out period. Under proposed § 600.525(b)(2), in the one BHP State that imposes a lock-out period, we estimate it would take a Management Analyst 2 hours at $96.66/hr and a General and Operations Manager 1 hour at $110.82/hr to revise their BHP Blueprints to remove the premium lock-out period. We estimate an aggregate one-time burden of 3 hours (1 State × 3 hr) at a cost of $304 (([2 hr × $96.66/hr] + [1 hr × $110.82/hr]) × 1 State).

In total for the ICRs related to §§ 457.570 and 600.525(b)(2) under OMB control numbers 0938–1147 (CMS–10410), and OMB Control Number 0938–1218 (CMS–10510), taking into account the Federal contribution for the CHIP-related changes, we estimate a total one-time cost for the State of $2,585 ($2,281+ $304).

16. ICRs Regarding Prohibiting Waiting Periods in CHIP (§§ 457.65, 457.340, 457.350, 457.805, and 457.810)

The following proposed changes will be submitted to OMB for review under control number 0938–1147 (CMS–10410).

The amendments proposed to §§ 457.65, 457.340, 457.350, 457.805, and 457.810 would eliminate the State option to impose a waiting period for families with children eligible for CHIP who were recently enrolled in a group health plan. Currently, 11 States with a separate CHIP program impose waiting periods between 1 month and 90 days. We estimate that the proposed amendments would require these 11 States to process CHIP applications earlier than under current rules and without evaluating whether the applicant just lost coverage through a group health plan. Therefore, these States would need to update their applications to eliminate the question asking for attestation of recently lost coverage and all related follow-up questions, such as to evaluate whether the person falls into an exception for a waiting period. If the State uses a data source to check for other coverage, the State would need to update the application to remove the trigger to query the data source.

We estimate it would take an average of 200 hours in each of these 11 States to develop and code the changes to each State's application to remove all questions and queries related to recently lost coverage. Of those 200 hours, we estimate it would take a Database and Network Administrator and Architect 50 hours at $98.50/hr and a Computer Programmer 150 hours at $92.92/hr. In aggregate, we estimate a one-time burden of 2,200 hours (11 States × 200 hr) at a cost of $207,493 ([(50 hr × $98.50/hr) + (150 hr × $92.92/hr)] × 11 States) for completing the necessary system changes. Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share would be $103,747.

We estimate it would take an average of 3 hours in each of 11 unique States to update each State's CHIP SPAs in MMDL to document the other strategy(ies) the states will use to monitor substitution of coverage. We estimate it would take a General and Operations Mgr. 1 hour at $110.82/hr and a Business Operations Specialist 2 hours at $77.25/hr for a per State total of $265. In aggregate, we estimate a one-time burden for all States of 33 hours (11 States × 3 hr) and $2,915 ([(1 hr × $110.82/hr) + (2 hr × $77.25/hr)] × 11 States) for completing the necessary SPA updates. Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share would be $1,458.

In total for the ICRs related to §§ 457.65, 457.340, 457.350, 457.805,

and 457.810, and taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share would be $105,205 ($103,747 + $1,458).

17. ICRs Regarding Prohibiting Annual and Lifetime Limits on Benefits (§ 457.480)

The following proposed CHIP State plan changes will be submitted to OMB for review under control number 0938–1148 (CMS–10398 #17) as they relate to updating CHIP SPAs and under control number 0938–TBD (CMS–10819) as they relate to programming in necessary system changes. At this time, the control number for CMS–10819 is to be determined (TBD). OMB will assign the control number upon their clearance of the proposed rule's new information collection request. The new control number will be set out in the final rule.

OMB Control Number 0938–TBD (CMS–10819)

The amendments proposed to § 457.480 would prohibit annual and lifetime dollar limits in the provision of all CHIP medical and dental benefits. Currently, 13 unique States place either an annual or lifetime dollar limit on at least 1 CHIP benefit. Twelve of the 13 States place an annual dollar limit on at least one CHIP benefit (AL, AR, CO, IA, MI, MS, MT, OK, PA, TN, TX, and UT), and 6 of the 13 States place a lifetime dollar limit on at least one benefit (CO, CT, MS, PA, TN, and TX). We estimate that the proposed amendments would require 13 States to update their systems and their CHIP SPAs to eliminate annual or lifetime benefit limits.

We estimate it would take an average of 20 hours to develop and code the changes to remove just 1 limit on either an annual or lifetime benefit. Of those 20 hours, we estimate it would take a Database and Network Administrator and Architect 5 hours at $98.50/hr and a Computer Programmer 15 hours at $92.92/hr. In aggregate, we estimate a one-time burden across all 13 States of 260 hours (20 hr × 13 States) and $24,522 ([(5 hr × $98.50/hr) + (15 hr × $92.92/hr)] × 13 States) for completing the necessary system changes. Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share would be $12,261.

OMB Control Number 0938–1148 (CMS–10398 #17)

The amendments proposed to § 457.480 would require States submit updated CHIP SPAs. We estimate it would take an average of 3 hours in each of 13 unique States to update each State's CHIP SPAs in MMDL to remove 21 different limits on annual and/or lifetime benefits (calculated as 21/13, or approximately 1.62, limits per State). Of those 3 hours, we estimate it would take a General and Operations Mgr. 1 hour at $110.82/hr and a Business Operations Specialist 2 hours at $77.25/hr for a per State total of 5 hours (3 hr/limit × 1.62 limits). In aggregate, we estimate a one-time burden for all States of 65 hours (13 States × 5 hr) and $5,573 ([(1 hr × $110.82/hr) + (2 hr × $77.25/hr)] × 21 limits) for completing the necessary SPA updates. Taking into account the 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share would be $2,786.

In total for the ICRs related to § 457.480 under control numbers 0938–TBD (CMS–10819) and 0938–1148 (CMS–10398 #17), taking into account the 50 percent Federal contribution, we estimate a total one-time State cost of $15,047 ($12,261 + $2,786).

C. Summary of Proposed Burden Estimates

In Table 2, we present a summary of the proposed requirements and burden estimates.

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TABLE 2: Summary of Proposed Burden Estimates

Regulation Section(s)	OMB Control No. (CMS ID No.)	# of Respondents	Total # of Responses	Time per Response (Hours)	Total Time (Hours)	Hourly Labor Cost ($/hr)	Labor Cost ($)	Total State Share ($)	Total Beneficiary Cost ($)	Total Non-Labor Cost ($)	Frequency
§ 435.407	0938-0467 (CMS-R-74)	56	1,786	-1	n/a	28.01	n/a	n/a	-2,801,000	-1,000,000	Annual
§ 435.407	0938-0467 (CMS-R-74)	56	1,786	-0.75	(75,000)	46.14	-3,460,500	-1,730,250	n/a	n/a	Annual
§ 435.407	0938-0467 (CMS-R-74)	56	1,786	0.25	25,000	96.66	2,416,500	1,208,250	n/a	n/a	Annual
§§ 435.952 and 435.940	0938-0467 (CMS-R-74)	51	10,000	-1	(510,000)	46.14	-23,531,400	-11,765,700	n/a	n/a	Annual
§§ 435.952 and 435.940	0938-0467 (CMS-R-74)	51	10,000	-1	n/a	28.01	n/a	n/a	-14,285,100	n/a	Annual
Subtotal	***0938-0467 (CMS-R-74)***	***270***	***25,358***	Varies	***(560,000)***	Varies	***-22,487,400***	***-11,243,700***	***-17,086,100***	***-1,000,000***	***Annual***
§ 435.1200	0938-1147 (CMS-10410)	56	15,323	-3	n/a	28.01	n/a	n/a	-72,105,471	n/a	Annual
§ 435.1200	0938-1147 (CMS-10410)	56	3,831	-4	n/a	28.01	n/a	n/a	-24,035,157	n/a	Annual
§ 435.1200	0938-1147 (CMS-10410)	40	1	40	1,600	Varies	133,272	66,636	n/a	n/a	One-Time
§ 435.1200	0938-1147 (CMS-10410)	40	1	42	1,680	Varies	145,334	72,667	n/a	n/a	One-Time
§ 435.1200	0938-1147 (CMS-10410)	40	1	200	8,000	Varies	734,520	367,260	n/a	n/a	One-Time
§ 435.1200	0938-1147 (CMS-10410)	30	1	46	1,380	Varies	125,251	62,626	n/a	n/a	One-Time
§ 435.601	0938-1147 (CMS-10410)	10	1	200	2,000	Varies	188,630	94,315	n/a	n/a	One-Time
§ 435.909	0938-1147 (CMS-10410)	51	9,788	-2	n/a	28.01	n/a	n/a	-27,964,344	n/a	Annual
§ 435.909	0938-1147 (CMS-10410)	51	1	180	9,180	92.92	853,006	426,503	n/a	n/a	One-Time
§ 435.909	0938-1147 (CMS-10410)	51	4,902	-1	(250,000)	46.14	-11,535,000	-5,767,500	n/a	n/a	Annual

Regulation Section(s)	OMB Control No. (CMS ID No.)	# of Respondents	Total # of Responses	Time per Response (Hours)	Total Time (Hours)	Hourly Labor Cost ($/hr)	Labor Cost ($)	Total State Share ($)	Total Beneficiary Cost ($)	Total Non-Labor Cost ($)	Frequency
§ 435.916	0938-1147 (CMS-10410)	6	448,064	-1	n/a	28.01	n/a	n/a	-75,301,692	n/a	Annual
§ 435.916	0938-1147 (CMS-10410)	56	48,007	-1	n/a	28.01	n/a	n/a	-75,301,692	-26,883,860	Annual
§ 435.916	0938-1147 (CMS-10410)	37	2,016	-1	n/a	28.01	n/a	n/a	-2,089,630	n/a	Annual
§ 435.916	0938-1147 (CMS-10410)	6	1	200	1,200	Varies	113,178	56,589	n/a	n/a	One-Time
§ 435.916	0938-1147 (CMS-10410)	21	1	200	4,200	Varies	385,623	192,812	n/a	n/a	One-Time
§ 435.916	0938-1147 (CMS-10410)	56	48,007	-0.5	(1,344,193)	46.14	-62,021,065	-31,010,533	n/a	n/a	Annual
§§ 435.919 and 457.344	0938-1147 (CMS-10410)	51	5,363	-2	n/a	28.01	n/a	n/a	-15,322,422	n/a	Annual
§§ 435.919 and 457.344	0938-1147 (CMS-10410)	76	1	40	3,040	Varies	253,217	126,608	n/a	n/a	One-Time
§§ 435.919 and 457.344	0938-1147 (CMS-10410)	28	1	40	1,120	Varies	93,290	46,645	n/a	n/a	One-Time
§§ 435.919 and 457.344	0938-1147 (CMS-10410)	51	252,380	0.0083	106,832	96.66	10,326,422	9,024,603	n/a	7,722,826	Annual
§§ 435.919 and 457.344	0938-1147 (CMS-10410)	51	252,380	0.083	1,068,324	46.14	49,292,469	24,646,235	n/a	n/a	Annual
§§ 435.601, 435.911, and 435.952	0938-1147 (CMS-10410)	51	7,059	-3.75	n/a	46.14	n/a	n/a	-62,289,000	n/a	Annual
§§ 435.601, 435.911, and 435.952	0938-1147 (CMS-10410)	51	7,059	0	n/a	n/a	n/a	n/a	n/a	-3,600,000	Annual
§§ 435.601, 435.911, and 435.952	0938-1147 (CMS-10410)	41	204,878	-2	n/a	28.01	n/a	n/a	-470,568,000	n/a	Annual
§§ 435.601, 435.911, and 435.952	0938-1147 (CMS-10410)	41	204,878	0	n/a	n/a	n/a	n/a	n/a	-84,000,000	Annual
§§ 435.601, 435.911, and 435.952	0938-1147 (CMS-10410)	51	7,059	-0.42	(151,200)	46.14	-6,976,368	-3,488,184	n/a	n/a	Annual
§§ 435.601, 435.911, and 435.952	0938-1147 (CMS-10410)	41	204,878	-0.25	(2,100,000)	46.14	-96,894,000	-48,447,000	n/a	n/a	Annual

Regulation Section(s)	OMB Control No. (CMS ID No.)	# of Respondents	Total # of Responses	Time per Response (Hours)	Total Time (Hours)	Hourly Labor Cost ($/hr)	Labor Cost ($)	Total State Share ($)	Total Beneficiary Cost ($)	Total Non-Labor Cost ($)	Frequency
§§ 435.601, 435.911, and 435.952	0938-1147 (CMS-10410)	10	4,400	1	44,000	46.14	2,030,160	1,015,080	n/a	n/a	Annual
§§ 435.601, 435.911, and 435.952	0938-1147 (CMS-10410)	10	4,400	-0.75	(33,000)	46.14	-1,522,620	-761,310	n/a	n/a	Annual
§§ 435.601, 435.911, and 435.952	0938-1147 (CMS-10410)	10	6,600	-0.167	(11,022)	46.14	-508,555	-254,278	n/a	n/a	Annual
§§ 435.912 and 457.340	0938-1147 (CMS-10410)	56	1	6	336	Varies	27,718	13,859	n/a	n/a	One-Time
§§ 435.912 and 457.340	0938-1147 (CMS-10410)	56	1	200	11,200	Varies	1,028,244	514,122	n/a	n/a	One-Time
§§ 435.916 and 435.919	0938-1147 (CMS-10410)	56	64,357	-2	n/a	28.01	n/a	n/a	-201,895,296	n/a	Annual
§§ 435.916, 435.919, and 457.344	0938-1147 (CMS-10410)	51	1	6	306	Varies	25,624	12,812	n/a	n/a	One-Time
§§ 435.916, 435.919, and 457.344	0938-1147 (CMS-10410)	40	1	3	120	Varies	10,049	5,024	n/a	n/a	One-Time
§§ 435.601, 435.911, and 435.952	0938-1147 (CMS-10410)	56	1	6	336	Varies	28,137	14,068	n/a	n/a	One-Time
§ 435.919	0938-1147 (CMS-10410)	56	1	-50	(2,800)	Varies	-134,803	-67,402	n/a	n/a	Annual
§§ 457.65, 457.340, 457.350, 457.805, and 457.810	0938-1147 (CMS-10410)	11	1	200	2,200	Varies	207,493	103,747	n/a	n/a	One-Time
§§ 457.65, 457.340, 457.350, 457.805, and 457.810	0938-1147 (CMS-10410)	11	1	3	33	Varies	$2,915	$1,458	n/a	n/a	One-Time
Subtotal	***0938-1147 (CMS-10410)***	***1563***	***1,805,647***	Varies	***(2,625,128)***	Varies	***-113,587,859***	***-56,793,930***	***-1,026,872,704***	***-106,711,034***	Varies
§ 457.480	0938-1148 (CMS-10398 #17)	13	2	3	63	Varies	5,573	2,786	n/a	n/a	One-Time
§§ 457.570 and 600.525(b)(2)	0938-1148 (CMS-10398 #17)	15	1	3	45	Varies	4,562	2,281	n/a	n/a	One-Time
Subtotal	***0938-1148 (CMS-10398 #17)***	***28***	***3***	***3***	***108***	Varies-	***10,135***	***5,067***	***n/a***	***n/a***	**One-Time**

Regulation Section(s)	OMB Control No. (CMS ID No.)	# of Respondents	Total # of Responses	Time per Response (Hours)	Total Time (Hours)	Hourly Labor Cost ($/hr)	Labor Cost ($)	Total State Share ($)	Total Beneficiary Cost ($)	Total Non-Labor Cost ($)	Frequency
§ 435.601	0938-1188 (CMS-10434 # 15)	10	1	3	30	Varies	2,654	1,327	n/a	n/a	One-Time
§§ 435.912 and 457.340	0938-1188 (CMS-10434 # 15)	56	1	3	168	Varies	14,861	7,431	n/a	n/a	One-Time
Subtotal	***0938-1188 (CMS-10434 # 15)***	***66***	***2***	***3***	***198***	***Varies***	***17,515***	***8,758***	***n/a***	***n/a***	***One-Time-***
§ 435.956	0938–1191 (CMS–10440)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
§§ 457.570 and 600.525(b)(2)	0938-1218 (CMS-10510)	1	1	3	3	Varies	304	304	n/a	n/a	One-Time
Subtotal	***0938-1218 (CMS-10510)***	***1***	***1***	***3***	***3***	***Varies***	***304***	***304***	***0***	***0***	***One Time***
§ 435.608	0938-TBD (CMS-10819)	56	1	200	11,200	Varies	1,056,328	528,164	n/a	n/a	One-Time
§ 435.831(g)	0938-TBD (CMS-10819)	56	25	-12	n/a	28.01	n/a	n/a	-470,568	n/a	Annual
§ 435.831(g)	0938-TBD (CMS-10819)	56	1	200	11,200	Varies	1,056,328	528,164	n/a	n/a	One-Time
§ 435.831(g)	0938-TBD (CMS-10819)	56	25	-18	(25,200)	Varies	-1,246,896	-623,448	n/a	n/a	Annual
§ 457.480	0938-TBD (CMS-10819)	13	1	20	260	Varies	24,522	12,261	n/a	n/a	One-Time
§§ 431.17 and 457.965	0938-TBD (CMS-10819)	56	1	20	1,120	96.66	108,259	54,130	n/a	n/a	One-Time
Subtotal	***0938-TBD (CMS-10819)***	***293-***	***54***	***Varies***	***(1,420)***	***Varies***	***998,541***	***499,271***	***-470,568***	***n/a***	***Varies***
§ 406.21	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
§ 435.223	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
				Total - Annual	**(3,258,259)**		**(143,765,656)**	**(71,882,828)**	**(828,744,076)**	**(107,761,034)**	
				Total – One-Time	**72,020**		**6,628,892**	**3,314,598**	**n/a**	**n/a**	

D. Submission of PRA-Related Comments

We have submitted a copy of this proposed rule to OMB for its review of the rule's information collection requirements. The requirements are not effective until they have been approved by OMB.

To obtain copies of the supporting statement and any related forms for the proposed collections discussed above, please visit the CMS website at *www.cms.hhs.gov/PaperworkReductionActof1995*, or call the Reports Clearance Office at 410–786–1326.

We invite public comments on these potential information collection requirements. If you wish to comment, please submit your comments electronically as specified in the **DATES** and **ADDRESSES** section of this proposed rule and identify the rule (CMS–2421–P), the ICR's CFR citation, and OMB control number.

IV. Response to Comments

Because of the large number of public comments, we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

V. Regulatory Impact Analysis

A. Statement of Need

We have learned through our experiences in working with States and other stakeholders that there are gaps in our regulatory framework related to Medicaid, CHIP, and BHP eligibility and enrollment. While we have made great strides in expanding access to coverage over the past decade, certain policies continue to result in unnecessary burdens and create barriers to enrollment and retention of coverage. In response to the President's Executive Order on Continuing to Strengthen Americans' Access to Affordable, Quality Health Coverage, we reviewed existing regulations to look for areas where access could be improved.

In this rulemaking, we seek to eliminate obstacles that make it harder for eligible people to remain enrolled, particularly those individuals who are exempted from MAGI and did not benefit from many of the enrollment simplifications in our 2012 and 2013 eligibility final rules. We seek to streamline enrollment for individuals known to be Medicaid eligible, like current enrollees who are also eligible for but not enrolled in the MSPs. We seek to remove coverage barriers, like premium lock-out periods and waiting periods that are not permitted under other insurance affordability programs, and to reduce coverage gaps as individuals transition from one insurance affordability program to another. Together, the changes in this proposed rule would streamline Medicaid, CHIP and BHP eligibility and enrollment processes, reduce administrative burden on States and enrollees, expand coverage of eligible applicants, increase retention of eligible enrollees, and improve health equity.

B. Overall Impact

We have examined the impacts of this rule as required by E.O. 12866 on Regulatory Planning and Review (September 30, 1993), E.O. 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96354), section 1102(b) of the Act, section 202 of the Unfunded Mandates Reform Act (UMRA) of 1995 (March 22, 1995; Pub. L. 104–4), E.O. 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). 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 $100 million or more in any 1 year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local or tribal governments or communities (also referred to as ''economically significant''); (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 novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order.

A regulatory impact analysis (RIA) must be prepared for major rules with significant regulatory action(s) or with economically significant effects ($100 million or more in any 1 year). Based on our estimates, OMB's Office of Information and Regulatory Affairs has determined this rulemaking is ''economically significant'' as measured by the $100 million threshold. Accordingly, we have prepared a Regulatory Impact Analysis that to the best of our ability presents the costs and benefits of the rulemaking.

The aggregate economic impact of this proposed rule is estimated to be $61.93 billion (in real FY 2023 dollars) over 5 years. This represents additional health care spending made by the Medicaid and CHIP programs on behalf of Medicaid and CHIP beneficiaries, with $41.41 billion paid by the Federal government and $20.52 billion paid by the States.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of less than $8.0 million to $41.5 million in any one year. Individuals and States are not included in the definition of a small entity. Since this proposed rule would only impact States and individuals, therefore, we do not believe that this proposed rule will have a significant economic impact on a substantial number of small businesses. We seek comment on the relevant impact.

In addition, section 1102(b) of the Act requires CMS 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 603 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 a Metropolitan Statistical Area and has fewer than 100 beds. This proposed rule applies to State Medicaid and CHIP agencies and would not add requirements to rural hospitals or other small providers. Therefore, we are not preparing an analysis for section 1102(b) of the Act because we have determined, and the Secretary certifies, that this proposed rule would not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the UMRA also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any one year of $100 million in 1995 dollars, updated annually for inflation.

In 2022, that is approximately $165 million. We believe that this proposed rule would have such an effect on spending by State, local, or tribal governments but not by private sector entities.

Overall Assumptions

In developing these estimates, we have relied on several global assumptions. All estimates are based on the projections from the President's FY 2023 Budget. We have assumed that new enrollees would have the same average costs as current enrollees by eligibility group, unless specified in the description of the estimates (for example, some enrollees only would receive Medicare premium assistance). We have assumed that the rule would be effective on April 1, 2023. In addition, we have relied on the data sources and assumptions described in the next section to develop estimates for specific provisions of this proposed rule.

C. Anticipated Effects

1. Facilitate Enrollment Through Medicare Part D LIS Leads Data

To calculate the impact of easing enrollment for persons already receiving the LIS benefit, we analyzed data from the Medicare Integrated Data Repository (IDR) from July 2020. We determined the number of people who were enrolled in the LIS program by: (1) State; (2) the category of LIS benefit they received; and (3) whether or not they were also enrolled in Medicaid. We identified 13.1 million persons receiving the Part D LIS, of which 11.1 million were enrolled in Medicaid and 2.0 million were not.

We developed a regression using the percentage of LIS enrollees who were also enrolled as dual eligibles as the dependent variable, and used several policy factors as independent variables: State use of MIPPA applications; verification policies and procedures; grace period for providing verifications after initial denial; redetermination grace period; counting children towards income; income disregard; and asset disregard. While the latter three policies would not change under the proposed rule, we believed that they may explain some of the variation in the percentage of LIS recipients who are dual eligibles. We found that this model explained some amount of the variation in the percentage of LIS enrollees who are enrolled as dual eligibles, and that the most significant variable was the State use of MIPPA applications. Other policies appeared to have weak correlations. The model suggested that the use of these policies—and in particular the use of the Part D LIS leads data—would result in an average increase in the percentage of LIS recipients who are dual eligible enrollees from 84.6 percent to 88.0 percent (an increase of 3.4 percentage points). We estimated that about 0.44 million additional persons would have been enrolled in Medicaid as a result of these changes, had they been made in 2020.

We assumed these enrollees, as QMBs, would receive payment for the Medicare Part B premium. The premium is $170.10 per month in 2022.

To calculate future impacts to enrollment, we assumed that the increase in enrollment due to this provision would grow at the same rate as Medicaid enrollment among aged persons and persons with disabilities. We estimate that this would increase enrollment by about 0.52 million persons by FY 2027, and would increase total Medicaid spending by $4.84 billion from FY 2023 through FY 2027. Detailed estimates are shown in Table 3.

TABLE 3: Impact of Facilitating Medicaid Enrollment through Medicare Part D LIS Leads Data on Medicaid expenditures and enrollment (expenditures in millions of dollars, enrollment in millions of person-year equivalents)

	2023	2024	2025	2026	2027
Enrollment	0.24	0.48	0.49	0.51	0.52
Total Spending	510	1,040	1,060	1,100	1,130
Federal Spending	290	600	620	640	660

2. Automatically Enroll Certain SSI Recipients Into QMB Program

To calculate the impact of automatically enrolling SSI recipients into QMB Medicaid coverage, we examined data on SSI recipients and their health care coverage.[103] As of 2017, about 17 percent of all SSI recipients had Medicare coverage but were not dually enrolled in Medicaid.

First, we estimated how many persons would enroll who already receive Medicare Part A without paying a premium. We estimated that there are 2.6 million people enrolled in SSI who are enrolled in Part A and do not pay the premium. Of these, we estimated about 67 percent reside in ''1634 States'' (about 1.7 million) and therefore are automatically enrolled in Medicaid. Of the remaining 0.9 million, we have assumed that 90 percent would enroll in the QMB group and receive Medicare Part B premium and cost-sharing assistance. We estimated those benefits to be about $5,000 per enrollee per year for 2022.

Second, we estimated how many persons would enroll who receive Medicare Part A but have to pay a premium. We estimate that there are 5.2 million such people enrolled in SSI. We estimated that 27 percent of this population lives in States that do not automatically enroll these individuals in the QMB group. Of States that do not automatically enroll these individuals in the QMB group, we assumed that about 20 percent of States would use the option provided in this proposed rule, and that about 50 percent of this population would be enrolled in the QMB group as a result. In total, this would result in an increase of about 0.15 million enrollees in the QMB group. We assumed these beneficiaries would receive Medicare Part B premium and cost-sharing assistance as well as Medicare Part A premium assistance. We estimated those benefits would be about $11,000 per enrollee per year in 2022.

[103] *https://www.census.gov/content/dam/Census/library/publications/2021/demo/p70br-171.pdf.*

TABLE 4: Impact of Automatically Enrolling Certain SSI Recipients into QMB Program on Medicaid Expenditures and Enrollment (expenditures in millions of dollars, enrollment in millions of person-year equivalents)

	2023	2024	2025	2026	2027
Enrollment	0.47	0.94	0.96	0.97	0.98
Total Spending	2,810	5,660	5,700	5,740	5,790
Federal Spending	1,640	3,280	3,300	3,320	3,350

3. Other Provisions To Facilitate Medicaid Enrollment

For other provisions that would facilitate Medicaid enrollment (including the definition of family size; making the QMB effective date earlier; the electronic verification and reasonable compatibility standard; and the verification of citizenship and identity), we assumed that these provisions would increase enrollment by about 0.1 percent among aged enrollees and enrollees with disabilities, and would have a negligible impact on other categories of enrollees. We estimated that this would increase enrollment by about 20,000 person-year equivalents by 2027.

TABLE 5: Impact of Other Provisions to Facilitate Enrollment on Medicaid Expenditures and Enrollment (expenditures in millions of dollars, enrollment in millions of person-year equivalents)

	2023	2024	2025	2026	2027
Enrollment	0.01	0.02	0.02	0.02	0.02
Total Spending	220	440	460	460	480
Federal Spending	130	260	260	270	280

It is likely that those SSI enrollees newly gaining Medicaid coverage would also have higher Medicare costs following enrollment. Primarily, receiving cost-sharing assistance for Medicare would lead to these individuals seeking out more care that may have been difficult to afford previously, also known as induction.

To estimate these impacts, we reviewed research on the effects of changing out of pocket costs on total health care costs, and specifically on Medicare. In general, we have historically estimated that reductions in out of pocket costs would increase total spending by $0.60 to $1.30 for every $1.00 reduction in out of pocket costs. Among research on health care costs, we relied primarily on research that examined the impacts on changing Medicare out of pocket costs.[104]

This research is useful, particularly because of the analysis reviewing cost-sharing among those Medicare enrollees without any other coverage, those with supplemental coverage (such as ''Medigap'' plans or retiree health benefits), and those with Medicaid. First, the analysis found that Medicare enrollees without other coverage had an average of $13,693 in costs, of which $2,399 was paid out of pocket (18 percent). Among those with supplemental coverage, average costs were $14,349, with $594 paid out of pocket (4 percent) and $2,095 paid through supplemental coverage (15 percent). Enrollees with Medicaid coverage had $26,181 in average costs, with $209 paid out of pocket (1 percent) and $3,190 paid by Medicaid (12 percent). A significant amount of cost differences is likely due to health status. Most notably, those with Medicaid coverage are on average older and more likely to have a disability or chronic condition, which would result in higher costs regardless of who pays for care.

The analysis also examines the effect of changing Medicare cost-sharing structures on total, Medicare, and out of pocket spending. While the specific proposed benefit changes are not related to this proposed rule, it does provide the relative magnitude of changes between Medicare and out of pocket costs. The analysis found a larger change in costs for those without any other coverage than those with supplemental coverage. For those without other coverage, out of pocket costs decreased by $428 while total costs increased by $764 (or $1.80 for every $1.00 reduction in out of pocket costs). For those with supplemental coverage, there was a decrease of $158 in out of pocket costs and an increase of $130 in total costs (or $0.80 for every $1.00 reduction in out of pocket costs).

We also reviewed how many Medicare enrollees have supplemental coverage or Medicaid. Research from the Kaiser Family Foundation recently looked at this.[105] This analysis found that 26 percent of Medicare beneficiaries had annual income of less than $20,000 (which is reasonably close to the SSI income limit of $1,767 monthly, which would be $21,204 annually). Of these beneficiaries, 37 percent had Medicaid and 11 percent had supplemental coverage. Excluding those with Medicaid and assuming the two groups are mutually exclusive, 17 percent of low-income beneficiaries without Medicaid had supplemental coverage. We believe it is reasonable to assume that very few beneficiaries had both Medicaid and other supplemental coverage.

We estimated the impact assuming that the overall increase in total costs would be $0.80 for every $1.00 reduction in out of pocket costs. For

[104] B Garrett, A Gangopadhyaya, A Shartzer, and D Arnos, ''A Unified Cost-Sharing Design for Medicare: Effects on Beneficiary and Program Spending,'' The Urban Institute, July 2019. *https://www.urban.org/sites/default/files/publication/100528/a_unified_cost-sharing_design_for_medicare_effects_on_beneficiary_an_1.pdf.* [Accessed August 3 2022].

[105] W Koma, J Cubanski, and T Neuman, ''A Snapshot of Coverage Among Medicare Beneficiaries in 2018,'' Kaiser Family Foundation, March 23 2021. *https://www.kff.org/medicare/issue-brief/a-snapshot-of-sources-of-coverage-among-medicare-beneficiaries-in-2018/.* [Accessed August 3 2022].

those without supplemental coverage, this would be expected to result in an increase of 14 percent in total costs and 20 percent in Medicare costs, and for those without supplemental coverage, increases of 3 percent for total costs and 10 percent for Medicare costs. Using the analysis on SSI enrollees and coverage, this is a weighted average of an 18 percent increase in Medicare costs for those newly gaining Medicaid.

To calculate the annual impacts, we multiply the Medicare per enrollee costs each year by 18 percent and by the number of SSI enrollees newly receiving Medicaid, and then adjust for cost-sharing to calculate the Federal Medicare spending amounts. Using total Medicare per enrollee costs (as projected in the 2022 Trustees Report),[106] we project that this would increase Medicare spending by $11.1 billion over 2023 to 2027 under this proposed rule. Annual impacts are shown in Table 6.

TABLE 6: Projected change in Medicare expenditures from additional SSI enrollees receiving Medicaid (in millions of 2023 dollars)

	Medicare expenditures
2023	1,200
2024	2,400
2025	2,400
2026	2,500
2027	2,600
Total	11,100

There is a wide range of possible costs due to this effect of the proposed rule. Most notably, and described previously in this section, is that the impact of reducing out of pocket costs could have different impacts than estimated here. Thus, individuals could use greater or lesser levels of additional services, resulting in different levels of Medicare spending changes than estimated here. This uncertainty is addressed in the high and low range estimates provided in the accounting statement (see section V.F. of this proposed rule).

4. Promoting Enrollment and Retention of Eligible Individuals

These provisions are expected to increase coverage by assisting persons with gaining and maintaining Medicaid coverage. We have considered several effects of the provisions in this proposed rule.

First, we estimated the impacts of aligning non-MAGI enrollment and renewal requirements with MAGI policy. We anticipate that this provision would increase the number of member months of coverage among enrollees eligible based on non-MAGI criteria (older adults and persons with disabilities). In an analysis of dually eligible enrollees from 2015 to 2018, CMS found that about 29 percent of new dually eligible enrollees lost coverage for at least 1 month in the first year of coverage, and about 24 percent lost coverage for at least 3 months. While some of this loss of coverage is likely due to enrollees no longer being eligible, we expect that many enrollees may still be eligible despite losing coverage, and that this provision would assist enrollees in continuing coverage. We assumed that this provision would increase enrollment among aged enrollees and enrollees with disabilities by about 1 percent.

For all other provisions under this section, we assumed that they would increase coverage for children by about 1 percent and for all other enrollees by about 0.75 percent. In particular, we assumed that provisions for acting on changes in circumstances, timely eligibility determinations and redeterminations, and action on returned mail would all contribute to modest increases in enrollment (mostly through continuing coverage for persons already enrolled) and that the provision to improve transitions between Medicaid and CHIP would further increase Medicaid enrollment.

In total, we estimated these provisions would increase enrollment by about 880,000 person-year equivalents by 2027.

TABLE 7: Impact of Provisions to Promote Enrollment and Retention on Medicaid Expenditures and Enrollment (expenditures in millions of dollars, enrollment in millions of person-year equivalents)

	2023	2024	2025	2026	2027
Enrollment	0.43	0.86	0.86	0.87	0.88
Total Spending	5,120	10,480	10,650	10,870	11,090
Federal Spending	3,140	6,440	6,550	6,660	6,800

[106] ''2022 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.'' *https://www.cms.gov/files/document/2022-medicare-trustees-report.pdf.* [Accessed August 3 2022].

5. Eliminating Barriers To Access in Medicaid

We assumed that removing or limit requirements to apply for other benefits as a condition of Medicaid enrollment would lead to an increase in Medicaid coverage. We have not assessed the impacts across different benefits (that is, SSI, TANF, etc.). We assumed that this would increase overall enrollment by about 0.5 percent, or about 410,000 person-year equivalents by 2027.

We have assumed that removing optional limitations on the number of reasonable opportunity periods would have a negligible impact on Medicaid enrollment and expenditures.

TABLE 8: Impact of Provisions to Eliminate barriers to access in Medicaid on Medicaid Expenditures and Enrollment (expenditures in millions of dollars, enrollment in millions of person-year equivalents)

	2023	2024	2025	2026	2027
Enrollment	0.20	0.40	0.40	0.41	0.41
Total Spending	1,960	4,020	4,080	4,170	4,250
Federal Spending	1,240	2,580	2,600	2,660	2,710

6. CHIP Proposed Changes and Eliminating Access Barriers in CHIP

We estimated that proposed changes to CHIP enrollment (including timely determinations and redeterminations, acting on changes in circumstances, acting on returned mail, and improving transitions between CHIP and Medicaid) would increase CHIP enrollment by about 1 percent. These are comparable to the impacts on Medicaid children of the comparable Medicaid provisions.

For prohibitions on premium lockout periods and waiting periods, there are currently 14 States that have such lockout periods and 11 States that have waiting periods for CHIP enrollment. We assumed that in those States, removing these barriers to coverage would increase enrollment by about 1 percent. We assumed that prohibiting annual and lifetime limits on benefits in CHIP would have a negligible impact.

In total, we estimate these provisions would increase enrollment by about 120,000 by 2027.

TABLE 9: Impact of Provisions to Promote Enrollment and Retention in CHIP and Reduce Barriers to Coverage on CHIP Expenditures and Enrollment (expenditures in millions of dollars, enrollment in millions of person-year equivalents)

	2023	2024	2025	2026	2027
Enrollment	0.06	0.12	0.12	0.12	0.12
Total Spending	180	370	370	380	390
Federal Spending	120	250	260	260	280

7. Impacts on the Marketplaces

We anticipate that many of the enrollees that would either be gaining Medicaid or CHIP coverage or retaining Medicaid or CHIP coverage as a result of this proposed rule would have had other coverage under current policies. In particular, we expect that many of the children and adults would have enrolled in the Marketplace and been eligible for subsidized care (excluding those age 65 or older and those with disabilities who are enrolled in Medicare).

To estimate the impacts this proposed rule would have on Marketplace expenditures, we started by calculating the cost of care and Federal subsidy payments for different households shifting from Marketplace coverage to Medicaid and CHIP. We made the following assumptions. We estimated that health care prices are 30 percent higher in Marketplace plans than in Medicaid and CHIP, and that the average percentage of costs for non-benefit costs in managed care was 10 percent—this also considers that some beneficiaries receive all or part of their care outside of managed care. Next, we assumed that individuals would reduce health spending by 10 percent in the Marketplace due to increased cost sharing requirements. We used an actuarial value of 70 percent, consistent with silver level plans on the Marketplace, and assumed that the average percentage of non-benefit costs in Marketplace plans was 20 percent. Finally, we assumed that the average income of persons shifting from Marketplace coverage to Medicaid and CHIP would be 125 percent of the Federal poverty level (FPL) and that the premium tax credits would be calculated assuming that they would not have to pay any contribution in 2023, 2024, and 2025 under the Inflation Reduction Act of 2022, and that they would have to pay 2 percent of income for coverage for 2026 and beyond.

We calculated the amount of Federal subsidies (measured by premium tax credits) for households of one adult, two adults, one adult and one child, one adult and two children, and two adults and two children, and then calculated the total Federal cost of Marketplace coverage to be consistent with the distribution of projected enrollment change in Medicaid and CHIP under the proposed rule. We made a final assumption that 60 percent of individuals would have enrolled in Marketplace coverage, and the remaining 40 percent would have either received other coverage or become uninsured.

We estimated that Marketplace costs would have decreased by $3.8 billion in 2022 under the policies in the proposed rule. To project costs for future years that would be affected by the proposed rule, we assumed that per capita costs,

premiums, and Federal subsidies would increase consistent with the projected growth rates in the President's Budget with adjustments to account for the impacts of the Inflation Reduction Act of 2022, and that enrollment would increase consistent with the projections made for the Medicaid and CHIP provisions of this proposed rule.

TABLE 10: Projected change in Federal Marketplace subsidy expenditures (in millions of 2023 dollars)

	Federal Marketplace subsidy expenditures
2023	–1,930
2024	–3,940
2025	–3,980
2026	–3,940
2027	–4,000
Total	–17,790

There is a wide range of possible savings due to this effect of the proposed rule. For these estimates, participation in the Marketplace and health care costs and prices may vary from what we assumed here. Thus, actual savings could be greater or lesser than estimated here. This uncertainty is addressed in the high and low range estimates provided in the accounting statement (see section V.F. of this proposed rule).

8. Total

In total, we project that these provisions would increase Medicaid enrollment by 2.81 million by 2027, and would increase total Medicaid spending by $99,290 million from 2023 through 2027. Of that amount, we estimate that $60,280 million would be paid by the Federal government and $39,010 million would be paid by the States. We expect the majority of the additional enrollment and cost to be provided for older adults and persons with disabilities. We also estimate that CHIP enrollment would increase by 0.12 million by 2027, and that total CHIP expenditures would increase by $1,690 million from 2023 to 2027 ($1,170 Federal and $520 million State costs). Table 11 shows the net impacts for Medicaid and for CHIP.

TABLE 11: Impact of Proposed Provisions on Medicaid and CHIP Expenditures and Enrollment (expenditures in millions of dollars, enrollment in millions of person-year equivalents)

Medicaid	2023	2024	2025	2026	2027	2023-2027
Enrollment	1.34	2.70	2.74	2.78	2.81	
Total Spending	10,620	21,640	21,950	22,340	22,740	99,290
Federal Spending	6,440	13,160	13,330	13,550	13,800	60,280
State Spending	4,180	8,480	8,620	8,790	8,940	39,010
CHIP	2023	2024	2025	2026	2027	2023-2027
Enrollment	0.06	0.12	0.12	0.12	0.12	
Total Spending	180	370	370	380	390	1,690
Federal Spending	120	250	260	260	280	1,170
State Spending	60	120	110	120	110	520

TABLE 12: Estimated Impacts for the Medicaid and CHIP Eligibility Rule [Millions of 2023 dollars]

	2023	2024	2025	2026	2027	Total
Total costs	10,800	22,010	22,320	22,720	23,130	100,980
Federal costs	6,560	13,410	13,590	13,810	14,080	61,450
State costs	4,240	8,600	8,730	8,910	9,050	39,530

In addition to the effects on Medicaid and CHIP, we have also estimated impacts on Medicare and the Federal subsidies for Marketplace coverage. Table 13 shows the net impact on Federal spending for Medicaid, CHIP, Medicare, and Federal Marketplace subsidies.

TABLE 13: Estimated Impacts of the Medicaid and CHIP Eligibility Rule on Federal Spending [Millions of 2023 dollars]

Medicare	2023	2024	2025	2026	2027	2023-2027
Medicaid Federal Spending	6,440	13,160	13,330	13,550	13,800	60,280
CHIP Federal Spending	120	250	260	260	280	1,170
Medicare Federal Spending	1,200	2,400	2,400	2,500	2,600	11,100
Federal Marketplace Subsidies Federal Spending	–1,930	–3,940	–3,980	–3,940	–4,000	–17,790
Total Federal Spending	5,830	11,870	12,010	12,370	12,680	54,760

9. Administrative Burden

We anticipate a reduction in administrative burden for States resulting from the proposed elimination of the requirement to apply for other benefits outlined in the preamble of this proposed rule. Specifically, we estimate that this provision would save State Eligibility Interviewers on average 1 hour per enrollee at $46.70/hr from no longer needing to prepare and send notices and requests for additional information about applying for other benefits, or to process requests for good cause exemptions. In aggregate for all States, we estimate an annual savings of minus 2,300,000 hours (1 hr × 2.3M enrollees) and minus $106,122,000 (2,300,000 hrs × $46.70/hr).

We also estimate that this provision would save each enrollee who otherwise meets all requirements to be enrolled or remain enrolled in Medicaid but who, absent this provision, would lose Medicaid coverage due to failure to provide information on application for other benefits on average 2 hours at $28.01/hr. In aggregate, we estimate that enrollees in all States would save minus 4,600,000 hours (2 hrs × 2,300,000 enrollees) and $128,846,000 (4,600,000 hrs × $28.01/hr) annually.

D. Alternatives Considered

In developing this proposed rule, the following alternatives were considered:

1. Not Proposing the Rule

We considered not proposing this rule and maintaining the status quo. However, we believe this proposed rule will lead to more eligible individuals gaining access to coverage and maintaining their coverage across all States. In addition, we believe that provisions in this proposed rule, such as updates to the recordkeeping requirements, will reduce the incidence of improper payments and improve the integrity of the Medicaid program and CHIP.

2. Providing States With Discretion Regarding the Date of Application for QMBs

Section 406.26 describes enrollment in Medicare Part A through the buy-in process. We considered proposing modifications to § 406.26(b) to provide States with discretion to use the Part A conditional enrollment filing date as the date of the Medicaid application for QMB eligibility. As background, the QMB eligibility group covers Part A premiums for individuals who do not qualify for premium-free Part A. However, to apply for the QMB eligibility group, an individual must be entitled to Part A—and many cannot afford the monthly premium ($499 in 2022). Such individuals have to navigate a complex two-step process where they first apply for conditional enrollment in Part A at SSA, then go to the State Medicaid agency to apply for the QMB eligibility group. Providing States the option to use the date of application at SSA for conditional enrollment as the date of application for a QMB application could permit States to offer an earlier effective date for QMB. We chose not to propose a regulatory change at this time because we do not have enough information to accurately assess its impact. However, we seek comments on this alternative considered that might be adopted in the final rule based on comments received.

3. Maintaining Records in Paper Format

We considered allowing States, which have not yet transitioned their enrollee records into an electronic format, to continue to maintain a paper-based record keeping system. As documented by the OIG and PERM eligibility reviews, many existing enrollee case records lack adequate information to verify decisions of Medicaid eligibility. A move to electronic recordkeeping will not only help States to ensure adequate documentation of their eligibility decisions, but will also make it easier to report such information to State auditors and other relevant parties. Therefore, we proposed to require State Medicaid agencies to store records in electronic format (estimated above, in the Collection of Information section, as a one-time cost of $108,260) and sought comment on whether States should retain flexibility to maintain records in paper or other formats that reflect evolving technology.

E. Limitations of the Analysis

There are a number of caveats to these estimates. Foremost, there is significant uncertainty about the actual effects of these provisions. Each of these provisions could be more or less effective than we have assumed in developing these estimates, and for many of these provisions we have made assumptions about the impacts they would have. In many cases, determining the reasons why a person may not be enrolled despite being eligible for Medicaid or CHIP is difficult to do in an analysis such as this. Therefore, these assumptions rely heavily on our judgment about the impacts of these provisions. While we believe these are reasonable estimates, we note that this could have a substantially greater or lesser impact than we have projected.

Second, there is uncertainty even under current policy in Medicaid and CHIP. Due to the COVID–19 pandemic and legislation to address the pandemic, Medicaid enrollment (and to a lesser extent, CHIP enrollment) have experienced significant increases in enrollment since the beginning of 2020. Actual underlying economic and public health conditions may differ than what we assume here.

In addition to the sources of uncertainty described previously, there are other reasons the actual impacts of these provisions may differ from the estimates. There may be differences in the impacts of these provisions across eligibility groups or States that are not reflected in these estimates. There may also be different costs per enrollee than we have assumed here—those gaining coverage altogether or keeping coverage for longer durations of time may have different costs than those who were already assumed to be enrolled in the program. Lastly, to the extent that States have discretion in provisions that are

optional in this proposed rule or in the administration of their programs more broadly, States' efforts to implement these provisions may lead to larger or smaller impacts than estimated here.

To address these limitations, we have developed a range of impacts. We believe that the actual impacts would likely fall within a range 50 percent higher or lower than the estimates we have developed. While this is a significant range, we would note that in the context of the entire Medicaid program ($743 billion in FY 2021), this is still a relatively narrow range.

F. Accounting Statement

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*), we have prepared an accounting statement in Table 14 showing the classification of the transfer payments with the provisions of this proposed rule. These impacts are classified as transfers, with the Federal government and States incurring additional costs and beneficiaries receiving medical benefits and reductions in out-of-pocket health care costs.

This provides our best estimates of the transfer payments outlined in the ''Section C. Detailed Economic Analysis'' above. To address the significant uncertainty related to these estimates, we have assumed that the costs could be 50 percent greater than or lesser than we have estimated here. We recognize that this is a relatively wide range, but we note several reasons for uncertainty regarding these estimates. First, there are numerous provisions that affect Medicaid and CHIP in this rule. For several provisions, we have limited information, analysis, or comparisons to prior experience to use in developing our estimates. Thus, the range reflects that impacts of these provisions could be greater or lesser than we assume. In addition, given the number of provisions, there may be cases where multiple provisions would help an individual maintain coverage. This could lead to these estimates ''double counting'' some effects. We also note that there are expected impacts on Medicare and the Marketplace subsidies; we believe this range adequately accounts for the potential variation in costs or savings to those programs as well. Finally, given the significant effects of the COVID–19 pandemic and legislation intended to address this, the current outlook for Medicaid and CHIP are less certain than typically. We provide this wider range to account for this uncertainty as well. This range provides the high cost and low cost ranges shown in Table 14.

TABLE 14: Accounting Statement [Millions of 2023 dollars]

Category	Primary estimate	Low estimate	High estimate	Units		
				Year dollars	Discount rate	Period covered
Annualized Monetized Transfers from Federal Government to beneficiaries	$10,755	$5,378	$16,133	2023	7%	2023-2027
	$10,867	$5,434	$16,301	2023	3%	2023-2027
Annualized Monetized Transfers from States to beneficiaries	$7,768	$3,884	$11,652	2023	7%	2023-2027
	$7,847	$3,923	$11,770	2023	3%	2023-2027

Chiquita Brooks-LaSure, Administrator of the Centers for Medicare & Medicaid Services, approved this document on August 25, 2022.

List of Subjects

42 CFR Part 406

Diseases, Health facilities, Medicare.

42 CFR Part 431

Grant programs—health, Health facilities, Medicaid, Privacy, Reporting and recordkeeping requirements.

42 CFR Part 435

Aid to Families with Dependent Children, Grant programs—health, Medicaid, Reporting and recordkeeping requirements, Supplemental Security Income (SSI), Wages.

42 CFR Part 457

Administrative practice and procedure, Grant programs—health, Health insurance, Reporting and recordkeeping requirements.

42 CFR Part 600

Administrative practice and procedure, Health care, Health insurance, Intergovernmental relations, Penalties, 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 406—HOSPITAL INSURANCE ELIGIBILITY AND ENTITLEMENT

■ 1. The authority citation for part 406 is revised to read as follows:

Authority: 42 U.S.C. 1302, 1395i–2, 1395i–2a, 1395p, 1395q and 1395hh.

■ 2. Section 406.21 is amended by adding paragraph (c)(5) to read as follows:

§ 406.21 Individual enrollment.

* * * * *

(c) * * *

(5) If an individual resides in a State that pays premium hospital insurance for Qualified Medicare Beneficiaries under § 406.32(g) and enrolls or reenrolls during a general enrollment period after January 1, 2023, QMB coverage is effective the month entitlement begins (if the individual is determined eligible for QMB before the month following the month of enrollment), or a month later than the month entitlement begins (if the individual is determined eligible for QMB the month entitlement begins or later).

* * * * *

PART 431—STATE ORGANIZATION AND GENERAL ADMINISTRATION

■ 3. The authority citation for part 431 is revised to read as follows:

Authority: 42 U.S.C. 1302.

■ 4. Section 431.10 is amended by—

■ a. Redesignating paragraphs (c)(1)(i)(A)(*2*) and (*3*) as (c)(1)(i)(A)(*4*) and (*5*), respectively; and

■ b. Adding new paragraphs (c)(1)(i)(A)(*2*) and (*3*).

The additions read as follows:

§ 431.10 Single State agency.

* * * * *

(c) * * *

(1) * * *

(i) * * *

(A) * * *

(*2*) The separate Children's Health Insurance Program agency;

(*3*) The Basic Health Program agency;

* * * * *

■ 5. Section 431.17 is revised to read as follows:

§ 431.17 Maintenance of records.

(a) *Basis and purpose.* This section, based on section 1902(a)(4) of the Act, prescribes the kinds of records a Medicaid agency must maintain, the minimum retention period for such records, and the conditions under which those records must be provided or made available.

(b) *Content of records.* A State plan must provide that the Medicaid agency will maintain or supervise the maintenance of the records necessary for the proper and efficient operation of the plan. The records must include all of the following—

(1) Individual records on each applicant and beneficiary that contain all of the following:

(i) All information provided on the initial application submitted through any modality described in § 435.907 of this subchapter by, or on behalf of, the applicant or beneficiary, including the signature on and date of application.

(ii) The electronic account and any information or other documentation received from another insurance affordability program in accordance with § 435.1200(c) and (d) of this subchapter.

(iii) The date of, basis for, and all documents or other evidence to support any determination, denial, or other adverse action, including decisions made at application, renewal, and as a result of a change in circumstance, taken with respect to the applicant or beneficiary, including all information provided by, or on behalf of, the applicant or beneficiary, and all information obtained electronically or otherwise by the agency from third-party sources.

(iv) The provision of, and payment for, services, items and other medical assistance, including the service or item provided, relevant diagnoses, the date that the service or item was provided, the practitioner or provider rendering, providing or prescribing the service or item, including their National Provider Identifier, and the full amount paid or reimbursed for the service or item, and any third-party liabilities.

(v) Any changes in circumstances reported by the individual and any actions taken by the agency in response to such reports.

(vi) All renewal forms and documentation returned by, or on behalf of, a beneficiary, to the Medicaid agency in accordance with § 435.916 of this subchapter, regardless of the modality through which such forms are submitted, including the signature on the form and date received.

(vii) All notices provided to the applicant or beneficiary in accordance with § 431.206 and §§ 435.917 and 435.918 of this subchapter.

(viii) All records pertaining to any fair hearings requested by, or on behalf of, the applicant or beneficiary, including each request submitted and the date of such request, the complete record of the hearing decision, as described in § 431.244(b), and the final administrative action taken by the agency following the hearing decision and date of such action.

(ix) The disposition of income and eligibility verification information received under §§ 435.940 through 435.960 of this subchapter, including evidence that no information was returned from an electronic data source.

(2) Statistical, fiscal, and other records necessary for reporting and accountability as required by the Secretary.

(c) *Retention of records.* The State plan must provide that the records required under paragraph (b) of this section will be retained for the period when the applicant or beneficiary's case is active, plus a minimum of 3 years thereafter.

(d) *Accessibility and availability of records.* The agency must—

(1) Maintain the records described in paragraph (b) of this section in an electronic format; and

(2) Make the records available to the Secretary, Federal and State auditors and other parties who request, and are authorized to review, such records within 30 calendar days of the request, if not otherwise specified, and to the extent permissible by Federal law.

§ 431.213 [Amended]

■ 6. Section 431.213 is amended by removing and reserving paragraph (d).

PART 435—ELIGIBILITY IN THE STATES, DISTRICT OF COLUMBIA, THE NORTHERN MARIANA ISLANDS, AND AMERICAN SAMOA

■ 7. The authority citation for part 435 is revised to read as follows:

Authority: 42 U.S.C. 1302.

■ 8. Section 435.4 is amended by adding a definition for ''Low Income Subsidy Application data (LIS leads data)'' in alphabetical order to read as follows:

§ 435.4 Definitions and use of terms.

* * * * *

Low-Income Subsidy Application data (LIS leads data) means data from an individual's application for low-income subsidies under section 1860D–14 of the Act that the Social Security Administration electronically transmits to the appropriate State Medicaid agency as described in section 1144 (c)(1) of the Act.

* * * * *

■ 9. Section 435.222 is amended by revising the section heading to read as follows:

§ 435.222 Optional eligibility for reasonable classifications of individuals under age 21 with income below a MAGI-equivalent standard.

* * * * *

■ 10. Section 435.223 is added as follows:

§ 435.223 Other optional eligibility for reasonable classifications of individuals under age 21.

(a) *Basis.* This section implements section 1902(a)(10)(A)(ii) of the Act.

(b) *Eligibility.* The agency may provide Medicaid to individuals under age 21 (or, at State option, under age 20, 19, or 18) or to one or more reasonable classifications of individuals under age 21 who meet the requirements described in any clause of section 1902(a)(10)(A)(ii) of the Act and implementing regulations in this subpart, if any.

■ 11. Section 435.407 is amended by—

■ a. Adding paragraphs (a)(7) and (8);

■ b. Removing paragraphs (b)(2) and (11);

■ c. Redesignating paragraphs (b)(3) through (b)(10) as paragraphs (b)(2) through (b)(9), and paragraphs (b)(12) through (b)(18) as paragraphs (b)(10) through (b)(16), respectively; and

■ d. In newly redesignated paragraph (b)(16), removing the reference to paragraph ''(17)'' and adding in its place a reference to paragraph ''(15)''.

The additions read as follows:

§ 435.407 Types of acceptable documentary evidence of citizenship.

(a) * * *

(7) Verification with a State vital statistics agency documenting a record of birth.

(8) A data match with the Department of Homeland Security Systematic Alien Verification for Entitlements (SAVE) Program or any other process

established by DHS to verify that an individual is a citizen.

* * * * *

■ 12. Section 435.601 is amended—

■ a. In paragraph (b)(2) by removing the phrase ''specified in paragraphs (c) and (d) of this section or in § 435.121 or as permitted under § 435.831(b)(1), in determining'' and adding in its place the phrase ''specified in paragraphs (c) through (e) of this section or in § 435.121 of this part or as permitted under (f)(1)(ii)(B) of this paragraph, in determining'';

■ b. In paragraph (d)(1) introductory text by removing the phrase ''permitted under § 435.831(b)(1) in determining eligibility'' and adding in its place the phrase ''permitted under paragraph (e) or (f)(1)(ii)(B) of this section in determining eligibility'';

■ c. By adding paragraph (e); and

■ d. By revising paragraph (f).

The addition and revision read as follows:

§ 435.601 Application of financial eligibility methodologies.

* * * * *

(e) *Procedures for determining eligibility for the Medicare Savings Program groups.* When a State determines eligibility for a Medicare Savings Program group, for income eligibility the agency must include at least the individuals described in § 423.772 in determining family of the size involved.

(f) *State plan requirements.* (1)(i) The State plan must specify that, except to the extent precluded in § 435.602, in determining financial eligibility of individuals, the agency will apply the cash assistance financial methodologies and requirements, unless the agency chooses the option described in paragraph (f)(1)(ii)(B) of this section, or chooses to apply less restrictive income and resource methodologies in accordance with paragraph (d) of this section, or both.

(ii) In the case of individuals for whom the program most closely categorically-related to the individual's status is AFDC (individuals under age 21, pregnant individuals and parents and other caretaker relatives who are not disabled, blind or age 65 or older), the agency may apply—

(A) The financial methodologies and requirements of the AFDC program; or

(B) The MAGI-based methodologies defined in § 435.603, except that, the agency must comply with the terms of § 435.602.

(2) [Reserved]

§ 435.608 [Removed and Reserved]

■ 13. Section 435.608 is removed and reserved.

■ 14. Section 435.831 is amended by—

■ a. Redesignating paragraphs (g)(2) and (3) as paragraphs (g)(3) and (4), respectively; and

■ b. Adding new paragraph (g)(2).

The addition reads as follows:

§ 435.831 Income eligibility.

* * * * *

(g) * * *

(2) May include expenses for services that the agency has determined are reasonably constant and predictable, including, but not limited to, services identified in a person-centered service plan developed pursuant to § 441.301(b)(1)(i), § 441.468(a)(1), § 441.540(b)(5), or § 441.725 and expenses for prescription drugs, projected to the end of the budget period at the Medicaid reimbursement rate.

* * * * *

■ 15. Section 435.907 is amended by adding paragraph (c)(4) and revising paragraph (d) to read as follows:

§ 435.907 Application.

* * * * *

(c) * * *

(4) Any MAGI-exempt applications and supplemental forms must be accepted through all modalities described at 435.907(a).

(d)(1) If the agency needs to request additional information from the applicant to determine and verify eligibility in accordance with § 435.911, the agency must—

(i) Provide the applicant with no less than the following number of days, measured from the date the agency sends the request, to respond and provide any necessary information:

(A) Thirty (30) calendar days for applicants who apply for Medicaid on the basis of disability, and

(B) Fifteen (15) calendar days for all other applicants;

(ii) Allow applicants to provide requested information through any of the modes of submission specified in paragraph (a) of this section; and

(iii)(A) In the case of an individual who is denied eligibility for failure to submit requested information and who subsequently submits the requested information within the period allowed by the agency in accordance with paragraph (d)(1)(ii) of this section, reconsider eligibility without requiring a new application;

(B) For purposes of the application timeliness standards at § 435.912(c)(3) of this subpart, the date of application for individuals described in paragraph (d)(1)(iv)(A) of this section is considered the date upon which the individual submits the additional information requested by the agency; and

(C) For purposes of the effective date of eligibility under § 435.915 of this subpart, the date of application for individuals described in paragraph (d)(1)(iiii)(A) of this section is date on which the original application was submitted.

(2) The agency may not require an in-person interview as part of the application process.

* * * * *

■ 16. Section 435.909 is revised to read as follows:

§ 435.909 Automatic entitlement to Medicaid following a determination of eligibility under other programs.

(a) *Automatic enrollment of certain individuals in Medicaid.* The agency must not require a separate application for Medicaid from an individual, if the agency has an agreement with the Social Security Administration (SSA) under section 1634 of the Act for determining Medicaid eligibility; and—

(1) The individual receives SSI;

(2) The individual receives a mandatory State supplement under either a federally-administered or State-administered program; or

(3) The individual receives an optional State supplement and the agency provides Medicaid to beneficiaries of optional supplements under § 435.230.

(b) *Automatic enrollment of SSI recipients in the Qualified Medicare Beneficiary group.* (1) The agency must deem individuals eligible for the Qualified Medicare Beneficiary group as described in § 400.200 of this chapter if the individual receives SSI and is determined eligible for medical assistance under § 435.120 or § 435.121 and—

(i) The individual is entitled to Part A under part 406, subpart B of this chapter; or

(ii) The individual is entitled to Part A under § 406.20 of this chapter and the agency has a State buy-in agreement authorized under section 1843 of the Act and modified under section 1818(g) of the Act.

(2) The agency may deem individuals eligible for the Qualified Medicare Beneficiary group as described in § 400.200 of this chapter if the individual receives SSI and is determined eligible for medical assistance under § 435.120 or § 435.121; and—

(i) The individual is entitled to Part A under § 406.5(b) of this chapter; and

(ii) The agency uses the group payer arrangement under § 406.32(g) of this chapter to pay Part A premiums for Qualified Medicare Beneficiaries.

(3) The automatic enrollment of SSI recipients in the Qualified Medicare

Beneficiaries group described in paragraphs (b)(1) and (2) of this section is effective no earlier than the effective date of coverage under a buy-in agreement for individuals described in § 407.47(b) of this chapter.

■ 17. Section 435.911 is amended by revising paragraph (c) introductory text and adding paragraph (e) to read as follows:

§ 435.911 Determination of eligibility.

* * * * *

(c) For each individual who has submitted an application described in § 435.907, whose eligibility is being renewed in accordance with § 435.916, or whose eligibility is being redetermined in accordance with § 435.919 and who meets the non-financial requirements for eligibility (or for whom the agency is providing a reasonable opportunity to verify citizenship or immigration status in accordance with § 435.956(b)), the State Medicaid agency must comply with the following—

* * * * *

(e) The agency must—

(1) Accept, via secure electronic interface, Low Income Subsidy application data (LIS leads data) transmitted to the agency from the Social Security Administration;

(2) Treat received LIS leads data relating to an individual as an application for eligibility under section 1902(a)(10)(E) of the Act and, promptly and without undue delay, consistent with timeliness standards established under § 435.912, determine the eligibility of the individual under such section, without requiring submission of another application;

(3) Request additional information needed by the agency to make a determination of eligibility for the Medicare Savings Programs;

(4) Not request information or documentation from the individual already provided to SSA through the LIS application and included in the transmission to the agency by the Social Security Administration; and

(5) Accept any information verified by SSA, without further verification, if the information provided through the LIS leads data supports a determination of eligibility under section 1902(a)(10)(E) of the Act.

(6) Collect such additional information as may be needed—

(i) Consistent with § 435.907(b), to determine whether such individual is eligible for Medicaid on the basis of the applicable modified adjusted gross income standard, and furnish Medicaid on such basis;

(ii) Consistent with § 435.907(c), to determine whether such individual is eligible for Medicaid benefits on any basis other than the applicable modified adjusted gross income standard or under section 1902(a)(10)(E) of the Act, and furnish Medicaid on such basis; and

(iii) Consistent with § 435.956, to verify an individual's U.S. citizenship or satisfactory immigration status, including providing the required reasonable opportunity period under 435.956(b).

(7) If any of the LIS leads data does not support a determination of eligibility under section 1902(a)(10)(E) of the Act, the agency must—

(i) Determine whether additional information is needed to make a determination of eligibility under section 1902(a)(10)(E) of the Act;

(ii) If such information is needed, notify the individual that they may be eligible for assistance with their Medicare premium and/or cost sharing charges, but that additional information is needed for the agency to make a determination of such eligibility;

(iii) Provide the individual with a minimum of 30 days to furnish information any information needed by the agency to make such determination of eligibility; and

(iv) Verify the individual's eligibility under section 1902(a)(10)(E) of the Act in accordance with the agency's verification plan developed in accordance with § 435.945(j).

■ 18. Section 435.912 is revised to read as follows:

§ 435.912 Timely determination and redetermination of eligibility.

(a) *Definitions.* For purposes of this section—

Performance standards are overall standards for determining, renewing and redetermining eligibility in an efficient and timely manner across a pool of applicants or beneficiaries, and include standards for accuracy and consumer satisfaction, but do not include standards for an individual applicant's determination, renewal, or redetermination of eligibility.

Timeliness standards refer to the maximum periods of time, subject to the exceptions in paragraph (e) of this section and in accordance with § 435.911(c), in which every applicant is entitled to a determination of eligibility, a redetermination of eligibility at renewal, and a redetermination of eligibility based on a change in circumstances.

(b) *State plan requirements.* Consistent with guidance issued by the Secretary, the agency must establish in its State plan timeliness and performance standards for, promptly and without undue delay—

(1) Determining eligibility for Medicaid for individuals who submit applications to the single State agency or its designee in accordance with § 435.907, including determining eligibility or potential eligibility for, and transferring individuals' electronic accounts to, other insurance affordability programs pursuant to § 435.1200(e);

(2) Determining eligibility for Medicaid for individuals whose accounts are transferred from other insurance affordability programs, including at initial application, as well as at a regularly-scheduled renewal or due to a change in circumstances;

(3) Redetermining eligibility for current beneficiaries at regularly-scheduled renewals in accordance with § 435.916, including determining eligibility or potential eligibility for, and transferring individuals' electronic accounts to, other insurance affordability programs pursuant to 435.1200(e);

(4) Redetermining eligibility for current beneficiaries based on a change in circumstances reported by the beneficiary in accordance with § 435.919(b)(1) or received from a third party in accordance with § 435.919(b)(2), including determining eligibility or potential eligibility for, and transferring individuals' electronic accounts to, other insurance affordability programs pursuant to 435.1200(e); and

(5) Redetermining eligibility for current beneficiaries based on anticipated changes in circumstances in accordance with § 435.919(b)(3), including determining eligibility or potential eligibility for, and transferring individuals' electronic accounts to, other insurance affordability programs pursuant to 435.1200(e).

(c) *Timeliness and performance standard requirements*—(1) *Period covered.* The timeliness and performance standards adopted by the agency under paragraph (b) of this section must—

(i) For determinations of eligibility at initial application or upon receipt of an account transfer from another insurance affordability program, as described in paragraphs (b)(1) and (2) of this section, cover the period from the date of application or transfer from another insurance affordability program to the date the agency notifies the applicant of its decision or the date the agency transfers the individual's electronic account to another insurance affordability program in accordance with § 435.1200(e);

(ii) For regularly-scheduled renewals of eligibility under § 435.916, cover the period from the date that the agency initiates the steps required to renew eligibility on the basis of information available to the agency, as required under § 435.916(b)(1), to the date the agency sends the individual notice required under § 435.916(b)(1)(i) or (b)(2)(i)(C) of its decision to approve their renewal of eligibility or, as applicable, to the date the agency terminates eligibility and transfers the individual's electronic account to another insurance affordability program in accordance with § 435.1200(e);

(iii) For redeterminations of eligibility due to changes in circumstances under § 435.919(b), cover the period from the date the agency receives information reported by the beneficiary, as described at § 435.919(b)(1)(i), or received from the third party, as described at § 435.919(b)(2)(i), to the date the agency notifies the individual of its decision or, as applicable, to the date the agency terminates eligibility and transfers the individual's electronic account to another insurance affordability program in accordance with § 435.1200(e); and

(iv) For redeterminations of eligibility based on anticipated changes in circumstances under § 435.919(b)(3), cover the period from the date the agency begins the redetermination of eligibility, to the date the agency notifies the individual of its decision or, as applicable, to the date the agency terminates eligibility and transfers the individual's electronic account to another insurance affordability program in accordance with § 435.1200(e).

(2) *Criteria for establishing standards.* To promote accountability and a consistent, high quality consumer experience among States and between insurance affordability programs, the timeliness and performance standards included in the State plan must address—

(i) The capabilities and cost of generally available systems and technologies;

(ii) The general availability of electronic data matching, ease of connections to electronic sources of authoritative information to determine and verify eligibility, and the time needed by the agency to evaluate information obtained from electronic data sources;

(iii) The demonstrated performance and timeliness experience of State Medicaid, CHIP and other insurance affordability programs, as reflected in data reported to the Secretary or otherwise available;

(iv) The needs of applicants and beneficiaries, including preferences for mode of application and submission of information at renewal or redetermination (such as through an internet website, telephone, mail, in-person, or other commonly available electronic means), the time needed to return a renewal form or any additional information needed to complete a determination of eligibility at application or renewal, as well as the relative complexity of adjudicating the eligibility determination based on household, income or other relevant information; and

(v) The advance notice that must be provided to beneficiaries in accordance with §§ 431.211, 431.213, and 431.214 of this subchapter when the agency makes a determination resulting in termination or other action as defined in § 431.201 of this subchapter.

(3) *Standard for new applications and transferred accounts.* Except as provided in paragraph (e) of this section, the determination of eligibility for any applicant or individual whose account was transferred from another insurance affordability program may not exceed—

(i) Ninety (90) days for applicants who apply for Medicaid on the basis of disability; and

(ii) Forty-five (45) days for all other applicants.

(4) *Standard for renewals.* Except as provided in paragraph (e) of this section, the redetermination of eligibility for a beneficiary at a regularly-scheduled renewal may not exceed—

(i) The end of the beneficiary's eligibility period, in the case of a beneficiary whose eligibility can be renewed based on information available to the agency as described at § 435.916(b)(1) or in the case of a beneficiary whose renewal requires additional information and who returns a renewal form 25 or more calendar days prior to the end of the eligibility period described in § 435.916(a);

(ii) The end of the month following the end of the beneficiary's eligibility period, in the case of a beneficiary whose eligibility is being redetermined on the basis for which the beneficiary has been receiving Medicaid (the applicable modified adjusted gross income standard described in § 435.911(b)(1) and (2) or another basis) and who returns a renewal form less than 25 calendar days prior to the end of the beneficiary's eligibility period; and

(iii) The following time periods, in the case of a beneficiary who is determined ineligible on the basis for which they are currently receiving Medicaid and for whom the agency is considering eligibility on another basis—

(A) Ninety (90) calendar days from the date the agency determines the beneficiary is not eligible on the current basis, if eligibility is being determined on the basis of disability;

(B) Twenty-five (25) calendar days from the date the agency determines the beneficiary is not eligible on the current basis, for all bases of determination other than the basis of disability.

(5) *Standard for redeterminations based on changes in circumstances.* Except as provided in paragraph (e) of this section, the redetermination of eligibility for a beneficiary based on a change in circumstances reported by the beneficiary or received from a third party may not exceed the end of the month that occurs—

(i) Thirty (30) calendar days following the agency's receipt of information related to the change in circumstances, unless the agency needs to request additional information from the beneficiary; and

(ii) Sixty (60) calendar days following the agency's receipt of information related to the change in circumstances if the agency must request additional information from the beneficiary.

(6) *Standard for redeterminations based on anticipated changes.* Except as provided in paragraph (e) of this section, the redetermination of eligibility for a beneficiary based on an anticipated change in circumstances, may not exceed—

(i) The date of the anticipated change, or at State option the last day of the month in which the anticipated change occurs, in the case of a beneficiary who returns requested information or documentation 25 or more calendar days prior to the date of the change (or the last day of the month if elected by the State);

(ii) The end of the month following the month in which the anticipated change occurs, in the case of a beneficiary whose eligibility is being redetermined on the basis for which the beneficiary has been receiving Medicaid (the applicable modified adjusted gross income standard described in § 435.911(b)(1) and (2) or another basis, as described in § 435.911(c)(2)) and who returns requested information or documentation less than 25 calendar days prior to the date of the change (or the last day of the month if elected by the State); and

(iii) The following time periods, in the case of a beneficiary who is determined ineligible on the basis for which they are currently receiving Medicaid and for whom the agency is considering eligibility on another basis—

(A) Ninety (90) calendar days from the date the agency determines the beneficiary is not eligible on the current basis, if eligibility is being determined on the basis of disability;

(B) Twenty-five (25) calendar days from the date the agency determines the beneficiary is not eligible on the current basis, for all other beneficiaries.

(d) *Availability of information.* The agency must inform individuals of the timeliness standards adopted in accordance with this section.

(e) *Exceptions.* The agency must determine or redetermine eligibility within the standards except in unusual circumstances, for example—

(1) When the agency cannot reach a decision because the applicant or beneficiary, or an examining physician, delays or fails to take a required action, or

(2) When there is an administrative or other emergency beyond the agency's control.

(f) *Case documentation.* The agency must document the reason(s) for delay in the applicant's or beneficiary's case record.

(g) *Prohibitions.* The agency must not use the timeliness standards—

(1) As a waiting period before determining eligibility;

(2) As a reason for denying or terminating eligibility (because it has not determined or redetermined eligibility within the timeliness standards); or

(3) As a reason for delaying termination of a beneficiary's coverage or taking other adverse action.

§ 435.914 [Amended]

■ 19. Section 435.914 is amended—

■ a. In paragraph (a), by removing the phrase ''case record facts to support the agency's decision on his application'' and adding in its place the phrase ''and beneficiary's case record the information and documentation described in § 431.17(b)(1) of this subchapter''; and

■ b. In paragraph (b) introductory text, by removing the phrase ''by a finding of eligibility or ineligibility'' and adding in its place the phrase ''and renewal by a finding of eligibility or ineligibility''.

■ 20. Section 435.916 is revised to read as follows:

§ 435.916 Regularly-scheduled renewals of Medicaid eligibility.

(a) *Frequency of renewals.* Except as provided in § 435.919:

(1) The eligibility of all Medicaid beneficiaries not described in paragraph (a)(2) of this section must be renewed once every 12 months, and no more frequently than once every 12 months.

(2) The eligibility of qualified Medicare beneficiaries described in section 1905(p)(1) of the Act must be renewed at least once every 12 months, and no more frequently than once every 6 months.

(b) *Renewals of eligibility.* (1) Renewal on basis of information available to agency. The agency must make a redetermination of eligibility for all Medicaid beneficiaries without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency, including but not limited to information through any data bases accessed by the agency under §§ 435.948, 435.949, and 435.956. If the agency is able to renew eligibility based on such information, the agency must, consistent with the requirements of this subpart and subpart E of part 431 of this subchapter, notify the individual—

(i) Of the eligibility determination, and basis; and

(ii) That the individual must inform the agency, through any of the modes permitted for submission of applications under § 435.907(a), if any of the information contained in such notice is inaccurate, but that the individual is not required to sign and return such notice if all information provided on such notice is accurate.

(2) Renewals requiring information from the individual. If the agency cannot renew eligibility for beneficiaries in accordance with paragraph (b)(1) of this section, the agency —

(i) Must provide the individual with—

(A) A pre-populated renewal form containing information, as specified by the Secretary, available to the agency that is needed to renew eligibility.

(B) At least 30 calendar days from the date the agency sends the renewal form to respond and provide any necessary information through any of the modes of submission specified in § 435.907(a), and to sign the renewal form under penalty of perjury in a manner consistent with § 435.907(f);

(C) Notice of the agency's decision concerning the renewal of eligibility in accordance with this subpart and subpart E of part 431 of this chapter;

(ii) Must verify any information provided by the beneficiary in accordance with §§ 435.945 through 435.956;

(iii) If the individual subsequently submits the renewal form or other needed information within 90 calendar days after the date of termination, or a longer period elected by the State, must treat the renewal form as an application and reconsider the eligibility of an individual whose coverage is terminated for failure to submit the renewal form or necessary information in accordance with the application time standards at § 435.912(c)(3) without requiring a new application;

(iv) Not require an individual to complete an in-person interview as part of the renewal process.

(v) May request from beneficiaries only the information needed to renew eligibility. Requests for non-applicant information must be conducted in accordance with § 435.907(e).

(3) Special rules related to beneficiaries whose Medicaid eligibility is determined on a basis other than modified adjusted gross income.

(i) The agency may consider blindness as continuing until the reviewing physician under § 435.531 determines that a beneficiary's vision has improved beyond the definition of blindness contained in the plan; and

(ii) The agency may consider disability as continuing until the review team, under § 435.541, determines that a beneficiary's disability no longer meets the definition of disability contained in the plan.

(c) *Timeliness of renewals.* The agency must complete the renewal of eligibility in accordance with this section by the end of the beneficiary's eligibility period described in paragraph (a) of this section and in accordance with the time standards in § 435.912(c)(4).

(d) *Determination of ineligibility and transmission of data pertaining to individuals no longer eligible for Medicaid.* (1) Prior to making a determination of ineligibility, the agency must consider all bases of eligibility, consistent with § 435.911.

(2) Prior to terminating coverage for individuals determined ineligible for Medicaid, the agency must determine eligibility or potential eligibility for other insurance affordability programs and comply with the procedures set forth in § 435.1200(e).

(e) *Accessibility of renewal forms and notices.* Any renewal form or notice must be accessible to persons who are limited English proficient and persons with disabilities, consistent with § 435.905(b).

■ 21. Section 435.919 is added to read as follows:

§ 435.919 Changes in circumstances.

(a) *Procedures for reporting changes.* The agency must:

(1) Have procedures designed to ensure that beneficiaries understand the importance of making timely and accurate reports of changes in

circumstances that may affect their eligibility; and

(2) Accept reports made under paragraph (a)(1) of this section and any other beneficiary reported information through any of the modes permitted for submission of applications under § 435.907(a);

(b) *Agency action on information about changes.* Consistent with the requirements of § 435.952, the agency must promptly redetermine eligibility between regularly-scheduled renewals of eligibility required under § 435.916(a) whenever it receives information about a change in a beneficiary's circumstances.

(1) *Changes reported by the beneficiary.* When a beneficiary reports information about a change in circumstances, the agency must:

(i) Evaluate whether the reported change may impact the beneficiary's eligibility for Medicaid or the amount of medical assistance for which the beneficiary is eligible, premiums or cost sharing charges. If additional information is needed to determine whether the beneficiary is no longer eligible due to the reported change, the agency must redetermine eligibility based on available information, if able to do so, and if the additional information is not available to the agency, request such information from the beneficiary;

(ii) If the agency determines that the reported change results in an adverse action, as defined in § 431.201 of this subchapter, take appropriate action in accordance with paragraph (b)(4) of this section.

(iii) If the agency finds that the reported change may result in eligibility for additional medical assistance or lower premium or cost sharing charges, the agency must verify the reported change in accordance with §§ 435.940 through 435.960 and the agency's verification plan developed under § 435.945(j) prior to furnishing additional assistance or lowering applicable premiums or cost sharing charges. The agency may not terminate the beneficiary's coverage if the beneficiary does not respond to agency requests for additional information under this paragraph;

(iv) If the agency's evaluation pursuant to paragraph (b)(1)(i) of this section indicates that the reported change has no impact on eligibility, the agency must provide the beneficiary with notice acknowledging receipt of the information from the beneficiary and explaining that the beneficiary's eligibility is not impacted.

(2) *Information received from a third party.* If the agency receives information regarding a beneficiary's change in circumstances from a third party, the agency must:

(i) Evaluate the reliability of the information received and determine whether, if accurate, the information received would impact the beneficiary's eligibility, the amount of medical assistance for which the beneficiary is eligible, premiums or cost sharing charges;

(ii) If the agency finds that the third-party information is reliable and may adversely impact the beneficiary, the agency must request information from the beneficiary to verify or dispute the information received, consistent with § 435.952. If the agency determines that the reported change results in an adverse action, take appropriate action in accordance with paragraph (b)(4) of this section.

(iii) If the agency determines that the third-party information is reliable and results in eligibility for additional medical assistance or lower premium or cost sharing charges, the agency must notify the beneficiary of such determination. Prior to providing such notice or additional medical assistance or lowering premium or cost sharing charges, the agency may verify third-party information with the beneficiary; the agency may not terminate the beneficiary's coverage if the beneficiary does not respond to the agency's request for additional assistance under this paragraph (b). The agency may accept the third-party information if the beneficiary does not respond to agency requests for additional information under this paragraph (b);

(iv) Except as provided in paragraphs (f) and (g) of this section, if the agency determines that the third-party information is not reliable or does not impact the beneficiary's eligibility, no action is required.

(3) *Anticipated changes.* If the agency has information about anticipated changes in a beneficiary's circumstances that may affect his or her eligibility, it must initiate a redetermination of eligibility at an appropriate time based on such changes consistent with the timeliness standards at § 435.912(c)(6).

(4) *Determination of ineligibility and transmission of data pertaining to individuals no longer eligible for Medicaid.* (i) The agency must comply with the requirements at § 435.916(d)(1) (relating to consideration of eligibility on other bases) and § 435.916(d)(2) (relating to determining potential eligibility for other insurance affordability programs) prior to terminating a beneficiary in accordance with this section.

(ii) The agency must provide advance notice of adverse action and fair hearing rights, in accordance with the requirements of part 431, subpart E of this chapter, prior to taking any adverse action resulting from a change in a beneficiary's circumstances.

(c) *Response times and time standards*—(1) *Beneficiary response times.* The agency must—

(i) Provide beneficiaries with at least 30 days from the date the agency sends the notice requesting the beneficiary to provide the agency with any additional information needed for the agency to redetermine eligibility.

(ii) Allow beneficiaries to provide any requested information through any of the modes of submission specified in § 435.907(a).

(2) *Time standards for redetermining eligibility.* The agency must redetermine eligibility within the time standards described in § 435.912(c)(5) and (6), except in unusual circumstances, such as those described in § 435.912(e); States must document the reason for delay in the individual's case record.

(d) *Ninety (90)-day reconsideration period.* If an individual terminated for not returning requested information in accordance with this section subsequently submits the information within 90 days after the date of termination, or a longer period elected by the State, the agency must—

(1) Reconsider the individual's eligibility without requiring a new application in accordance with the application timeliness standards established under § 435.912(c)(3).

(2) Request additional information needed to determine eligibility consistent with § 435.907(e) and obtain a signature under penalty of perjury consistent with § 435.907(f) if such information or signature is not available to the agency or included in the information described in this paragraph (d).

(e) *Scope of redeterminations following a change in circumstance.* For redeterminations of eligibility for Medicaid beneficiaries completed in accordance with this section—

(1) The agency must limit any requests for additional information under this section to information relating to a change in circumstance that may impact the beneficiary's eligibility.

(2) If the agency has enough information available to it to renew eligibility with respect to all eligibility criteria, the agency may begin a new eligibility period, as defined in § 435.916(a).

(f) *Agency action on returned mail:* Whenever beneficiary mail is returned

to the agency by the United States Postal Service (USPS), the agency—

(1) Must check the following sources for updated mailing address and other contact information—

(i) The agency's Medicaid Enterprise System;

(ii) The agency's contracted managed care plans, if applicable; and

(iii) One or more of the following: the State agency that administers Supplemental Nutrition Assistance Program; the State agency that administers Temporary Assistance for Needy Families; the State Department of Motor Vehicles; the USPS National Change of Address (NCOA) database; or other sources specified in the State's verification plan described in § 435.945(j).

(2) Must send the beneficiary a notice by mail to the address currently on file in the beneficiary's case record, the forwarding address (if provided on the returned mail), and any address identified by the agency per paragraph (f)(1) of this section.

(i) Consistent with paragraph (c)(1) of this section, the agency must provide beneficiaries with at least 30 days from the date the agency sends the notice to verify the accuracy of the new contact information.

(ii) [Reserved]

(3) Must send the beneficiary at least two notices, by one or more modalities other than mail, such as by phone, electronic notice, email or text messaging.

(i) For a beneficiary who elected to receive electronic notices and communications in accordance with § 435.918, at least one communication attempt must use the beneficiary contact information on file via the preferred electronic format and such notice must provide at least 30 days from the date the agency sends the notice to verify the accuracy of the new contact information. If there is a failed electronic communication attempt then the agency cannot use that same electronic modality as the alternative modality to satisfy this proposed requirement and may use telephonic or electronic contact information obtained in (f)(1) of this section, as feasible.

(ii) The notices required under this paragraph must be sent to the contact information in the beneficiary's case record, if available, and may be sent to other contact information obtained by the agency per paragraph (f)(1) of this section.

(iii) The agency may elect to utilize any combination or order of other modalities.

(iv) The first and last such notice must be separated by no less than 3 business days.

(v) If the agency does not have contact information for any alternative modality, the agency must make a note of that fact in the beneficiary's case record.

(4) In the case of beneficiary mail returned with an in-state forwarding address, whose current address the agency is unable to confirm pursuant to paragraphs (f)(1) through (3) of this section—

(i) May not terminate a beneficiary's coverage for failure to respond to a request to confirm their address or State residency.

(ii) Must accept and update the beneficiary's case record with—

(A) The in-state forwarding address provided on the returned beneficiary mail;

(B) An in-state address obtained from the managed care organization pursuant to paragraph (f)(1)(i) or (ii) of this section, provided that such address was received by the plan directly from, or was verified with, the beneficiary; or

(C) The in-state address obtained from the USPS NCOA database pursuant to paragraph (f)(1)(iii) of this section.

(5) In the case of a beneficiary mail returned with an out-of-state address, whose current address the agency is unable to confirm pursuant to paragraphs (f)(1) through (3) of this section, the agency must provide advance notice of termination and fair hearing rights consistent with 42 CFR part 431, subpart E.

(6) If a beneficiary's whereabouts are unknown, as indicated by the return of beneficiary mail with no forwarding address and the beneficiary's failure to respond to the notices described in paragraphs (f)(2) and (3) of this section, and the agency has not updated the beneficiary's address based on a reliable third-party source pursuant to paragraph (f)(1) of this section, the agency must take appropriate steps to terminate or suspend the beneficiary's coverage or move the beneficiary to a fee-for-service delivery system.

(i) If the agency elects to terminate or suspend coverage in accordance with this paragraph, the agency must send notice to the beneficiary's last known address or via electronic notification, in accordance with the beneficiary's election under § 435.918 of this subpart, no later than the date of termination or suspension and provide notice of fair hearing rights in accordance with 42 CFR part 431 subpart E.

(ii) If whereabouts of a beneficiary whose coverage was terminated or suspended in accordance with this paragraph become known within the beneficiary's eligibility period, as defined in § 435.916(b), the agency—

(A) Must reinstate coverage back to the date of termination without requiring the individual to provide additional information to verify their eligibility, unless the agency has other information available to it that indicates the beneficiary may not meet all eligibility requirements.

(B) May begin a new eligibility period, consistent paragraph (e)(2) of this section, if the agency has sufficient information available to it to renew eligibility with respect to all eligibility criteria without requiring additional information from the beneficiary.

(g) *Agency action on updated address information from other sources.* (1) Whenever the agency obtains updated in-state mailing address information from the United States Postal Service National Change of Address (NCOA) or agency's contracted managed care plans, the agency—

(i) In the case of updated mailing address information from a contracted managed care plan, must ensure that an address was received by the plan directly from, or was verified with, the beneficiary;

(ii) Must send the beneficiary a notice by mail to both the address currently on file in the beneficiary's case record and the new in-state address and provide the individual with a reasonable period of time to verify the accuracy of the new contact information;

(iii) Must send the beneficiary at least two notices, by one or more modalities other than mail, such as by phone, electronic notice, email or text messaging consistent with paragraph (f)(3) of this section;

(iv) May not terminate a beneficiary's coverage for failure to respond to a request to confirm an in-state change of address;

(v) May accept the in-state address as the beneficiary's new address and update the beneficiary's case record accordingly, if the beneficiary does not respond to a request to confirm their address or State residency, provided the beneficiary is given at least 30 days from the date the agency sent the notice; and

(vi) Must accept the in-state address as the beneficiary's new address and update the beneficiary's case record accordingly, if the beneficiary confirms their address or State residency.

(2) Upon approval from the Secretary, the agency may treat updated in-state address information from other trusted data sources in accordance with paragraph (g)(1) of this section.

(3) Whenever the agency obtains updated mailing address information

from any source not listed in paragraph (g)(1) or (2) of this section, including out-of-state mailing address information, the agency must follow the steps outlined in paragraphs (f)(2) through (6) of this section.

■ 22. Section 435.940 is revised as follows:

§ 435.940 Basis and scope.

The income and eligibility verification requirements set forth in this section and §§ 435.945 through 435.960 are based on sections 1137, 1902(a)(4), 1902(a)(19), 1902(a)(46)(B), 1902(ee), 1903(r)(3), 1903(x), 1940, and 1943(b)(3) of the Act, and section 1413 of the Affordable Care Act. Nothing in the regulations in this subpart should be construed as limiting the State's program integrity measures or affecting the State's obligation to ensure that only eligible individuals receive benefits, consistent with parts 431 and 455 of this subchapter, or its obligation to provide for methods of administration that are in the best interest of applicants and beneficiaries and are necessary for the proper and efficient operation of the plan, consistent with § 431.15 of this subchapter and section 1902(a)(19) of the Act.

■ 23. Section 435.952 is amended by revising paragraphs (b) and (c) and adding paragraph (e) to read as follows:

§ 435.952 Use of information and requests for additional information from individuals.

* * * * *

(b) If information provided by or on behalf of an individual (on the application or renewal form or otherwise) is reasonably compatible with information obtained by the agency, including information obtained in accordance with § 435.948, § 435.949, or § 435.956, the agency must determine or renew eligibility based on such information.

(c) An individual must not be required to provide additional information or documentation unless information needed by the agency in accordance with § 435.948, § 435.949, or § 435.956 cannot be obtained electronically or information obtained electronically is not reasonably compatible, as provided in the verification plan described in § 435.945(j), with information provided by or on behalf of the individual.

(1) Income and resource information obtained through an electronic data match shall be considered reasonably compatible with income and resource information provided by or on behalf of an individual if both are either above or at or below the applicable standard or other relevant threshold.

(2) [Reserved]

* * * * *

(e) When determining eligibility for individuals applying for the Medicare Savings Programs specified in sections 1902(a)(10)(E)(i), (iii), and (iv) and 1905(p) of the Act, the agency must accept attestation (either self-attestation by the individual or attestation by an adult who is in the applicant's household, as defined in § 435.603(f), or family, as defined in section 36B(d)(1) of the Internal Revenue Code, an authorized representative, or, if the individual is a minor or incapacitated, someone acting responsibly for the individual) of the following income and asset information without requiring further information (including documentation) from the individual:

(1) *Income and interest income.* (i) Except as provided in paragraph (e)(1)(ii) of this section, the agency must accept an applicant's attestation of the value of any dividend and interest income earned on resources owned by the applicant or the applicant's spouse.

(ii) If the agency has information that is not reasonably compatible with an applicant's attestation, the agency must seek additional information from the individual in accordance with paragraph (c) of this section.

(iii) The agency may verify interest and dividend income after the agency has determined that an applicant is eligible for the Medicare Savings Programs, in accordance with paragraph (c) of this section. If the agency requests documentation in accordance with this paragraph, the agency must provide the individual with at least 90 days from the date of the request to provide any necessary information requested and must allow the individual to submit such documentation through any of the modalities described in § 435.907(a).

(2) *Non-liquid resources.* (i) Except as provided in paragraph (e)(2)(ii) of this section, the agency must accept an applicant's attestation of the value of any non-liquid resources owned.

(ii) If the agency has information that is not reasonably compatible with an applicant's attestation, the agency must seek additional information from the individual in accordance with paragraph (c) of this section.

(iii) The agency may verify the value of non-liquid resources after the agency has determined that an applicant is eligible for the Medicare Savings Programs, in accordance with paragraph (c) of this section. If the agency requests documentation in accordance with this paragraph, the agency must provide the individual with at least 90 days from the date of the request to provide any necessary information requested and must allow the individual to submit such documentation through any of the modalities described in § 435.907(a).

(3) *Burial funds.* (i) Except as provided in paragraph (e)(3)(ii) of this section, the agency must accept an applicant's attestation that up to $1,500 of their resources, and up to $1,500 of their spouse's resources, are set aside in a separate account and are not countable as resources when determining eligibility for the Medicare Savings Programs.

(ii) If the agency has information that is not reasonably compatible with an applicant's attestation, the agency must seek additional information from the individual in accordance with paragraph (c) of this section.

(iii) The agency may verify resources in burial funds after the agency has determined that an applicant is eligible for the Medicare Savings Programs, in accordance with paragraph (c) of this section. If the agency requests documentation in accordance with this paragraph, the agency must provide the individual with at least 90 days from the date of the request to provide any necessary information requested and must allow the individual to submit such documentation through any of the modalities described in § 435.907(a).

(4) *Life insurance policies.* (i) Except as provided in paragraph (e)(4)(ii) of this section, the agency must accept an applicant's attestation of the face value of life insurance.

(A) If an individual attests to a face value of life insurance policy that is above $1,500, the State may accept an attestation of the cash surrender value of the life insurance policy for the purpose of determining resource eligibility for the Medicare Savings Programs.

(ii) If the agency has information about either the face value or the cash surrender value that is not reasonably compatible with an applicant's attestation, the agency must seek additional information from the individual in accordance with paragraph (c) of this section, which may include a reasonable explanation of the discrepancy or documentation.

(iii) The agency may verify the face value of a life insurance policy after the agency has determined that an applicant is eligible for a Medicare Savings Program, in accordance with paragraph (c) of this section.

(iv)(A) When an individual must provide documentation of the cash surrender value of a life insurance policy, the agency must assist the individual with obtaining this information and documentation by requesting that the individual provide

the name of the insurance company and policy number and authorize the agency to obtain such documentation from the issuer of the policy on the individual's behalf. The agency may also request, but may not require, additional information from the applicant to assist the agency is obtaining the needed documentation, such as the name of an agent.

(B) If the individual does not provide the information and authorization in paragraph (e)(4)(iv)(A), the agency may require that the individual provide documentation of the cash surrender value.

(C) The agency must allow the individual to submit documentation through any of the modalities described in § 435.907(a) and provide the individual with at least 15 days to provide information or documentation described in this paragraph if such information or documentation is requested pursuant to paragraph (e)(4)(i) or (ii) of this section and at least 90 days if required pursuant to paragraph (e)(4)(iii) of this section.

■ 24. Section 435.956 is amended by revising paragraph (b)(4) to read as follows:

§ 435.956 Verification of other non-financial information.

* * * * *

(b) * * *

(4) The agency may not limit the number of reasonable opportunity periods an individual may receive.

* * * * *

■ 25. Section 435.1200 is amended—

■ a. By revising the heading for paragraph (b) introductory text;

■ b. By revising paragraph (b)(1);

■ c. In paragraph (b)(3)(i), by removing the phrase ''one or more insurance affordability program'' and adding in its place the phrase ''one or more insurance affordability programs'';

■ d. By revising paragraph (b)(3)(ii);

■ e. By adding paragraphs (b)(3)(vi) and (b)(4);

■ f. By revising paragraphs (c) and (e)(1);

■ g. By adding paragraph (e)(4);

■ h. By revising paragraphs (h)(1) and (h)(3)(i) introductory text; and

■ i. By redesignating the ''(i)'' paragraph following (h)(3)(i)(B) as paragraph (h)(3)(ii).

The revisions and additions read as follows:

§ 435.1200 Medicaid agency responsibilities for a coordinated eligibility and enrollment process with other insurance affordability programs.

* * * * *

(b) *General requirements.* * * *

(1) Fulfill the responsibilities set forth in paragraphs (c) through (h) of this section.

* * * * *

(3) * * *

(ii) Ensure compliance with paragraphs (c) through (h) of this section;

* * * * *

(vi) Seamlessly transition the eligibility of beneficiaries between Medicaid and the Children's Health Insurance Program (CHIP) when an agency administering one of these programs determines that a beneficiary is eligible for the other program.

(4) Accept a determination of eligibility for Medicaid made using MAGI-based methodologies by the State agency administering a separate CHIP in the State. In order to comply with this requirement, the agency may:

(i) Apply the same MAGI-based methodologies in accordance with§ 435.603, and verification policies and procedures in accordance with §§ 435.940 through 435.956 as those used by the separate CHIP in accordance with §§ 457.315 and 457.380 of subchapter D, such that the agency will accept any finding relating to a criterion of eligibility made by a separate CHIP without further verification, in accordance with this paragraph (d)(4);

(ii) Utilize a shared eligibility service through which determinations of Medicaid eligibility are governed exclusively by the Medicaid agency and any functions performed by the separate CHIP are solely administrative in nature;

(iii) Enter into an agreement in accordance with § 431.10(d) of this chapter under which the Medicaid agency delegates authority to the separate CHIP in accordance with § 431.10(c) of this chapter to make final determinations of Medicaid eligibility; or

(iv) Adopt other procedures approved by the Secretary.

(c) *Provision of Medicaid for individuals found eligible for Medicaid by another insurance affordability program.* (1) For each individual determined Medicaid eligible in accordance with paragraph (c)(2) of this section, the agency must—

(i) Establish procedures to receive, via secure electronic interface, the electronic account containing the determination of Medicaid eligibility;

(ii) Comply with the provisions of § 435.911 to the same extent as if an application had been submitted to the Medicaid agency; and

(iii) Comply with the provisions of § 431.10 of this chapter to ensure it maintains oversight for the Medicaid program.

(2) For purposes of paragraph (c)(1) of this section, individuals determined eligible for Medicaid in this paragraph include:

(i) Individuals determined eligible for Medicaid by another insurance affordability program, including the Exchange, pursuant to an agreement between the agency and the other insurance affordability program in accordance with § 431.10(d) of this chapter (including as a result of a decision made by the program or the program's appeals entity in accordance with paragraph (g)(6) or (g)(7)(i)(A) of this section); and

(ii) Individuals determined eligible for Medicaid by a separate CHIP (including as the result of a decision made by a CHIP review entity) in accordance with paragraph (b)(4) of this section.

* * * * *

(e) * * *

(1) *Individuals determined not eligible for Medicaid.* For each individual who submits an application to the agency which includes sufficient information to determine Medicaid eligibility or whose eligibility is being renewed in accordance with § 435.916 (regarding regularly-scheduled renewals of eligibility) or § 435.919 (regarding changes in circumstances) and whom the agency determines is ineligible for Medicaid, and for each individual determined ineligible for Medicaid in accordance with a fair hearing under subpart E of part 431 of this chapter, the agency must promptly and without undue delay, consistent with timeliness standards established under § 435.912:

(i) Determine eligibility for a separate CHIP if operated in the State, and if eligible, transfer the individual's electronic account, via secure electronic interface, to the separate CHIP agency and ensure that the individual receives a combined eligibility notice as defined at § 435.4; and

(ii) If not eligible for CHIP, determine potential eligibility for BHP (if offered by the State) and coverage available through the Exchange, and if potentially eligible, transfer the individual's electronic account, via secure electronic interface, to the program for which the individual is potentially eligible.

* * * * *

(4) *Ineligible individuals.* For purposes of paragraph (e)(1) of this section, an individual is considered ineligible for Medicaid if they are not eligible for any eligibility group covered by the agency that provides minimum essential coverage as defined at § 435.4. An individual who is eligible only for

a limited benefit group, such as the eligibility group for individuals with tuberculosis described at § 435.215, would be considered ineligible for Medicaid for purposes of paragraph (e)(1).

* * * * *

(h) * * *

(1) Include in the agreement into which the agency has entered under paragraph (b)(3) of this section that a combined eligibility notice, as defined in § 435.4, will be provided:

(i) To an individual, by either the agency or a separate CHIP, when a determination of Medicaid eligibility is completed for such individual by the State agency administering a separate CHIP in accordance with paragraph (b)(4) of this section, or a determination of CHIP eligibility is completed by the Medicaid agency in accordance with paragraph (e)(1)(i) of this section; and

(ii) To the maximum extent feasible to an individual who is not described in paragraph (i) of this section but who is transferred between the agency and another insurance affordability program by the agency, Exchange, or other insurance affordability program, as well as to multiple members of the same household included on the same application or renewal form.

* * * * *

(3) * * *

(i) Provide the individual with notice, consistent with § 435.917, of the final determination of eligibility on all bases, including coordinated content regarding, as applicable.

* * * * *

PART 457—ALLOTMENTS AND GRANTS TO STATES

■ 26. The authority citation for part 457 continues to read as follows:

Authority: 42 U.S.C. 1302.

■ 27. Section 457.65 is amended by revising paragraph (d) to read as follows:

§ 457.65 Effective date and duration of State plans and plan amendments.

* * * * *

(d) *Amendments relating to enrollment procedures.* A State plan amendment that institutes or extends the use of waiting lists, enrollments caps or closed enrollment periods is considered an amendment that restricts eligibility and must meet the requirements in paragraph (b) of this section.

* * * * *

■ 28. Section 457.340 is amended by—

■ a. Revising the paragraph (d) heading;

■ b. Revising paragraph (d)(1);

■ c. Removing paragraph (d)(3); and

■ d. Revising paragraph (f)(1),

The revisions read as follows:

§ 457.340 Application for and enrollment in CHIP.

* * * * *

(d) *Timely determination and redetermination of eligibility.* (1) The terms in § 435.912 of this chapter apply equally to CHIP, except that—

(i) The terms of § 435.912(c)(4)(iii) and (c)(6)(iii) of this chapter (relating to timelines for completing renewals and redeterminations when States must consider other bases of eligibility) do not apply; and

(ii) The standards for transferring electronic accounts to other insurance affordability programs are pursuant to § 457.350 and the standards for receiving applications from other insurance affordability programs are pursuant to § 457.348.

* * * * *

(f) * * *

(1) Include in the agreement into which the State has entered under § 457.348(a) that, a combined eligibility notice, as defined in § 457.10, will be provided:

(i) To an individual, by the State agency administering a separate CHIP or the Medicaid agency, when a determination of CHIP eligibility is completed for such individual by the State agency administering Medicaid in accordance with § 457.348(e), or a determination of Medicaid eligibility is completed by the State in accordance with § 457.350(b)(1);

(ii) To the maximum extent feasible, to an individual who is not described in paragraph (f)(1)(i) of this section but who is transferred between the State and another insurance affordability program in accordance with § 457.348 or § 457.350; and

(iii) To the maximum extent feasible, to multiple members of the same household included on the same application or renewal form.

* * * * *

■ 29. Section 457.344 is added to read as follows:

§ 457.344 Changes in circumstances.

(a) *Procedures for reporting changes.* The State must:

(1) Have procedures designed to ensure that enrollees understand the importance of making timely and accurate reports of changes in circumstances that may affect their eligibility; and

(2) Accept reports made under paragraph (a)(1) of this section and any other enrollee reported information through any of the modes permitted for submission of applications under § 435.907(a), as referenced at § 457.330.

(b) *State action on information about changes.* Consistent with the requirements of § 457.380(f), the State must promptly redetermine eligibility between regularly-scheduled renewals of eligibility required under § 457.343, whenever it receives information about a change in an enrollee's circumstances.

(1) *Changes reported by the enrollee.* When an enrollee reports information about a change in circumstances, the State must:

(i) Evaluate whether the reported change may impact the enrollee's eligibility for CHIP or the amount of child health assistance or pregnancy-related assistance for which the enrollee is eligible, premiums or cost sharing charges. If additional information is needed to determine whether the enrollee is no longer eligible due to the reported change, the State must redetermine eligibility based on available information, if able to do so, and if the additional information is not available to the State, request such information from the enrollee;

(ii) If the State determines that the reported change results in an adverse action, take appropriate action in accordance with paragraph (b)(4) of this section.

(iii) If the State finds that the reported change may result in eligibility for additional child health or pregnancy-related assistance or lower premium or cost sharing charges, the State must verify the information in accordance with § 457.380 and the State's verification plan prior to furnishing additional assistance or lowering applicable premiums or cost sharing charges. The State may not terminate the enrollee's coverage if the enrollee does not respond to agency requests for additional information under this paragraph (b).

(iv) If the State's evaluation pursuant to paragraph (b)(1)(i) of this section indicates that the reported change has no impact on eligibility, the State must provide the enrollee with notice acknowledging receipt of the information from the enrollee and explaining that the enrollee's eligibility is not impacted.

(2) *Information received from a third party.* If the State receives information regarding an enrollee's change in circumstances from a third party, the State must:

(i) Evaluate the reliability of the information received and whether, if accurate, the information received would impact the enrollee's eligibility for CHIP, the amount of child health assistance or pregnancy-related

assistance for which the enrollee is eligible, premiums or cost sharing charges.

(ii) If the State finds that the third-party information is reliable and may adversely impact the enrollee, the State must request information from the enrollee to verify or dispute the information received, consistent with § 457.380(f). If the State determines that the reported change results in an adverse action, take appropriate action in accordance with paragraph (b)(4) of this section.

(iii) If the State determines that the third-party information is reliable and results in eligibility for additional child health assistance or pregnancy-related assistance or lower premium or cost sharing charges, the State must notify the enrollee of such determination. Prior to providing such notice or additional child health assistance or pregnancy-related assistance or lowering premium or cost sharing charges, the State may verify third-party information with the enrollee; the State may not terminate the enrollee's coverage if the enrollee does not respond to the State's request for additional or pregnancy-related assistance under this paragraph.

(iv) Except as provided paragraphs (f) and (g) of this section, if the State determines that the third-party information is not reliable or does not impact the enrollee's eligibility, no action is required.

(3) *Anticipated changes.* If the State has information about anticipated changes in an enrollee's circumstances that may affect his or her eligibility, it must initiate a determination of eligibility at the appropriate time based on such changes consistent with the requirements at § 435.912(c)(6) of this chapter as referenced in § 457.340(d)(1).

(4) *Determination of ineligibility and transmission of data pertaining to individuals no longer eligible for CHIP.* (i) The State must comply with the requirements at § 435.916(d)(2) of this chapter as referenced in § 457.343 (relating to determining potential eligibility for other insurance affordability programs), prior to terminating an enrollee's eligibility in accordance with this section.

(ii) The State must provide notice of adverse action and State review rights, in accordance with the requirements of § 457.340(e), § 457.1260 (if enrolled in managed care), and subpart K of this part, prior to taking any adverse action resulting from a change in an enrollee's circumstances.

(c) *Enrollee response times*—(1) *State requirements.* The State must—

(i) Provide enrollees with at least 30 days from the date the State sends the notice requesting the enrollee to provide the State with any additional information needed for the State to redetermine eligibility.

(ii) Allow enrollees to provide any requested information through any of the modes of submission specified in § 435.907(a) of this chapter as referenced in § 457.330 of this subpart.

(2) *Time standards for redetermining eligibility.* The State must redetermine eligibility within the time standards described in § 435.912(c)(5) and (6) of this chapter, except in unusual circumstances, such as those as described in § 435.912(e) of this chapter, as referenced in § 457.340(d); States must document the reason for delay in the individual's case record.

(d) *Ninety (90)-day reconsideration period.* If an individual terminated for not returning requested information in accordance with this section subsequently submits the information within 90 days after the date of termination, or a longer period elected by the State, the State must—

(1) Reconsider the individual's eligibility without requiring a new application in accordance with the timeliness standards described at § 435.912(c)(3) of this chapter as referenced in § 457.340(d).

(2) Request additional information needed to determine eligibility and obtain a signature under penalty of perjury consistent with § 435.907(e) and (f) of this chapter respectively as referenced in § 457.330 if such information or signature is not available to the State or included in the information described in this paragraph (d).

(e) *Scope of redeterminations following a change in circumstances.* For redeterminations of eligibility for CHIP enrollees completed in accordance with this section—

(1) The State must limit any requests for additional information under this section to information relating to change in circumstances which may impact the enrollee's eligibility.

(2) If the State has enough information available to it to renew eligibility with respect to all eligibility criteria, the State may begin a new eligibility period under § 457.343.

(f) *State action on returned mail.* Whenever beneficiary mail is returned to the State by the United States Postal Service (USPS), the State—

(1) Must check the following sources for updated mailing address and other contact information—

(i) The State's Medicaid Enterprise System;

(ii) The State's contracted managed care plans, if applicable; and

(iii) One or more of the following: the State agency that administers Supplemental Nutrition Assistance Program; the State agency that administers Temporary Assistance for Needy Families; the State Department of Motor Vehicles; the USPS National Change of Address (NCOA) database; or other sources specified in the State's verification plan described in § 457.380(j).

(2) Must send the enrollee a notice by mail to the address currently on file in the enrollee's case record, the forwarding address (if provided on the returned mail), and any address identified by the State per paragraph (f)(1) of this section;

(i) Consistent with paragraph (c)(1) of this section, the State must provide beneficiaries with at least 30 days from the date the State sends the notice to verify the accuracy of the new contact information.

(ii) [Reserved]

(3) Must send the enrollee at least two notices, by one or more modalities other than mail, such as by phone, electronic notice, email or text messaging.

(i) For an enrollee who elected to receive electronic notices and communications in § 457.110, at least one communication attempt must use the enrollee contact information on file via the preferred electronic format and such notice must provide at least 30 days from the date the agency sends the notice to verify the accuracy of the new contact information. If there is a failed electronic communication attempt then the State cannot use that same electronic modality as the alternative modality to satisfy this proposed requirement and may use telephonic or electronic contact information obtained in paragraph (f)(1) of this section, as feasible.

(ii) The notices required under this paragraph must be sent to the contact information in the enrollee's case record, if available, and may be sent to other contact information obtained by the State per paragraph (f)(1) of this section.

(iii) The State may elect to utilize any combination or order of other modalities.

(iv) The first and last such notice must be separated by no less than 3 business days.

(v) If the State does not have contact information for any alternative modality, the State must make a note of that fact in the enrollee's case record.

(4) In the case of enrollee mail returned with an in-state forwarding address, whose current address the State is unable to confirm pursuant to

paragraphs (f)(1) through (3) of this section, a State—

(i) May not terminate an enrollee's coverage for failure to respond to a request to confirm their address or State residency.

(ii) Must accept and update the enrollee's case record with—

(A) The in-state forwarding address provided on the returned enrollee mail;

(B) An in-state address obtained from the managed care organization pursuant to paragraph (f)(1)(i) or (ii) of this section, provided that such address was received by the plan directly from, or was verified with, the enrollee; or

(C) The in-state address obtained from the USPS NCOA database pursuant to paragraph (f)(1)(iii) of this section.

(5) In the case of an enrollee whose mail is returned with an out-of-state address (or an address outside of the geographic area for separate CHIPs that are not Statewide) and whose current address the State is unable to confirm pursuant to paragraphs (f)(1) through (3) of this section, the State must provide sufficient notice of termination including information describing an individual's right to a CHIP review process, consistent with § 457.340(e)(1).

(6) If an enrollee's whereabouts are unknown, as indicated by the return of enrollee mail with no forwarding address and the enrollee's failure to respond to the notices described in paragraphs (f)(2) and (3) of this section, and the State has not updated the enrollee's address based on a reliable third-party source pursuant to paragraph (f)(1) of this section, the State must take appropriate steps to terminate coverage, suspend coverage, or move the individual to the fee-for-service delivery system, if available.

(i) If the State elects to terminate or suspend coverage in accordance with this paragraph, the State must send notice to the enrollee's last known address or via electronic notification, in accordance with the enrollee's election under § 457.110, no later than the date of termination or suspension and provide notice of an individual's rights to a CHIP review in accordance with § 457.340(e).

(ii) If whereabouts of a beneficiary whose coverage was terminated or suspended in accordance with this paragraph become known within the beneficiary's eligibility period, as defined in § 435.916(b) of this chapter as referenced in § 457.343, the State—

(A) Must reinstate coverage back to the date of termination without requiring the individual to provide additional information to verify their eligibility, unless the agency has other information available to it that indicates the enrollee may not meet all eligibility requirements.

(B) May begin a new eligibility period, consistent paragraph (e)(2) of this section, if the State has sufficient information available to it to renew eligibility with respect to all eligibility criteria without requiring additional information from the enrollee.

(g) State action on updated address information from other sources. (1) Whenever the State obtains updated in-state mailing address information from the United States Postal Service National Change of Address (NCOA) or the State's contracted managed care plans, if applicable, the State—

(i) In the case of updated mailing address information from a contracted managed care plan, must ensure that an address was received by the plan directly from, or was verified with, the enrollee;

(ii) Must send the enrollee a notice by mail to both the address currently on file in the enrollee's case record and the new in-state address and provide the individual with a reasonable period of time to verify the accuracy of the new contact information;

(iii) Must send the enrollee at least two notices, by one or more modalities other than mail, such as by phone, electronic notice, email or text messaging consistent with paragraph (f)(3) of this section;

(iv) May not terminate an enrollee's coverage for failure to respond to a request to confirm an in-state change of address;

(v) May accept the in-state address as the enrollee's new address and update the enrollee's case record accordingly, if the enrollee does not respond to a request to confirm their address or State residency, provided the beneficiary is given at least 30 days from the date the agency sent the notice; and

(vi) Must accept the in-state address as the enrollee's new address and update the beneficiary's case record accordingly, if the enrollee confirms their address or State residency.

(vii) For separate CHIPs that are not Statewide, if the address obtained from NCOA or the State's managed care plans are outside of the State's specific geographic area for its separate CHIP, the requirements of paragraphs (f)(1) through (3) of this section to verify out-of-state addresses are applicable.

(2) Upon approval from the Secretary, the State may treat updated in-state address information from other trusted data sources in accordance with paragraph (g)(1) of this section.

(3) Whenever the State obtains updated mailing address information from any source not listed in paragraph (g)(1) or (2) of this section, including out-of-state mailing address information, the State must follow the steps outlined in paragraphs (f)(2) through (6) of this section.

■ 30. Section 457.348 is amended—

■ a. In paragraph (a)(4), by removing the phrase ''Provide for coordination of notices with other insurance'' and adding in its place the phrase ''Provide for a combined eligibility notice and coordination of notices with other insurance'';

■ b. By adding paragraph (a)(6);

■ c. By revising paragraph (b);

■ d. In paragraph (c)(3), by removing the reference to ''§ 457.350(i)'' and adding in its place the reference ''§ 457.350(g)''; and

■ e. By adding paragraph (e).

The additions and revision read as follows:

§ 457.348 Determinations of Children's Health Insurance Program eligibility by other insurance affordability programs.

(a) * * *

(6) Seamlessly transition the enrollment of beneficiaries between CHIP and Medicaid when a beneficiary is determined eligible for one program by the agency administering the other.

(b) *Provision of CHIP for individuals found eligible for CHIP by another insurance affordability program.* (1) For each individual determined CHIP eligible in accordance with paragraph (b)(2) of this section, the State must—

(i) Establish procedures to receive, via secure electronic interface, the electronic account containing the determination of CHIP eligibility and notify such program of the receipt of the electronic account;

(ii) Comply with the provisions of § 457.340 to the same extent as if the application had been submitted to the State; and

(iii) Maintain proper oversight of the eligibility determinations made by the other program.

(2) For purposes of paragraph (b)(1) of this section, individuals determined eligible for CHIP in this paragraph include:

(i) Individuals determined eligible for CHIP by another insurance affordability program, including the Exchange, pursuant to an agreement between the State and the other insurance affordability program (including as a result of a decision made by the program or the program's appeal entity in accordance with paragraph (a) of this section)); and

(ii) Individuals determined eligible for CHIP by the State Medicaid agency (including as the result of a decision made by the Medicaid appeals entity) in

accordance with paragraph (e) of this section.

* * * * *

(e) *CHIP determinations made by other insurance affordability programs.* The State must accept a determination of eligibility for CHIP from the Medicaid agency in the State. In order to comply with this requirement, the agency may:

(1) Apply the same MAGI-based methodologies in accordance with§ 457.315, and verification policies and procedures in accordance with § 457.380 as those used by the Medicaid agency in accordance with §§ 435.940 through 435.956 of subchapter C, such that the agency will accept any finding relating to a criterion of eligibility made by a Medicaid agency without further verification;

(2) Enter into an agreement under which the State delegates authority to the Medicaid agency to make final determinations of CHIP eligibility; or

(3) Adopt other procedures approved by the Secretary.

■ 31. Section 457.350 is revised to read as follows:

§ 457.350 Eligibility screening and enrollment in other insurance affordability programs.

(a) *State plan requirement.* The State plan shall include a description of the coordinated eligibility and enrollment procedures used, at an initial and any follow-up eligibility determination, including any periodic redetermination, to ensure that:

(1) Only targeted low-income children are furnished CHIP coverage under the plan; and

(2) Enrollment is facilitated for applicants and enrollees found to be eligible or potentially eligible for other insurance affordability programs in accordance with this section.

(b) *Evaluation of eligibility for other insurance affordability programs.* (1) For individuals described in paragraph (b)(2) of this section, promptly and without undue delay, consistent with the timeliness standards established under § 457.340(d), the State must:

(i) Determine eligibility for Medicaid on the basis of having household income at or below the applicable modified adjusted gross income standard, as defined in § 435.911(b) of this chapter (''MAGI-based Medicaid''); and

(ii) If unable to make a determination of eligibility for MAGI-based Medicaid, identify potential eligibility for other insurance affordability programs, including Medicaid on a basis other than MAGI, eligibility for the Basic Health Program (BHP) in accordance with 42 CFR 600.305(a), or insurance affordability programs available through the Exchange as indicated by information provided on the application or renewal form provided by or on behalf of the beneficiary.

(2) Individuals to whom paragraph (b)(1) of this section applies include:

(i) Any applicant who submits an application to the State which includes sufficient information to determine CHIP eligibility;

(ii) Any enrollee whose eligibility is being redetermined at renewal or due to a change in circumstance per § 457.343; and

(iii) Any enrollee whom the State determines is not eligible for CHIP, or who is determined not eligible for CHIP as a result of a review conducted in accordance with subpart K of this part.

(3) In determining eligibility for Medicaid as described in paragraph (b)(1) of this section, the State must utilize the option the Medicaid agency has elected at § 435.1200(b)(4) of this chapter to accept determinations of MAGI-based Medicaid eligibility made by a separate CHIP, and which must be detailed in the agreement described at § 457.348(a).

(c) *Income eligibility test.* To determine eligibility as described in paragraph (b)(1)(i) of this section and to identify the individuals described in paragraph (b)(1)(ii) of this section who are potentially eligible for BHP or insurance affordability programs available through an Exchange, a State must apply the MAGI-based methodologies used to determine household income described in § 457.315 or such methodologies as are applied by such other programs.

(d) *Individuals found eligible for Medicaid based on MAGI.* For individuals identified in paragraph (b)(1) of this section, the State must—

(1) Promptly and without undue delay, consistent with the timeliness standards established under § 457.340(d), transfer the individual's electronic account to the Medicaid agency via a secure electronic interface; and

(2) Except as provided in § 457.355, find the applicant ineligible for CHIP.

(e) *Individuals potentially eligible for Medicaid on a basis other than MAGI.* For individuals identified as potentially eligible for Medicaid on a non-MAGI basis, as described in paragraph (b)(1)(ii) of this section, the State must—

(1) Promptly and without undue delay, consistent with the timeliness standards established under § 457.340(d), transfer the electronic account to the Medicaid agency via a secure electronic interface.

(2) Complete the determination of eligibility for CHIP in accordance with § 457.340 or evaluation for potential eligibility for other insurance affordability programs in accordance with paragraph (b) of this section.

(3) Include in the notice of CHIP eligibility or ineligibility provided under § 457.340(e), as appropriate, coordinated content relating to—

(i) The transfer of the individual's electronic account to the Medicaid agency per paragraph (e)(1) of this section;

(ii) The transfer of the individual's account to another insurance affordability program in accordance with paragraph (g) of this section, if applicable; and

(iii) The impact that an approval of Medicaid eligibility will have on the individual's eligibility for CHIP or another insurance affordability program, as appropriate.

(4) Dis-enroll the enrollee from CHIP if the State is notified in accordance with § 435.1200(d)(5) of this chapter that the applicant has been determined eligible for Medicaid.

(f) *Children found ineligible for Medicaid based on MAGI, and potentially ineligible for Medicaid on a basis other than MAGI.* If a State uses a screening procedure other than a full determination of Medicaid eligibility under all possible eligibility groups, and the screening process reveals that the child does not appear to be eligible for Medicaid, the State must provide the child's family with the following in writing:

(1) A statement that based on a limited review, the child does not appear eligible for Medicaid, but Medicaid eligibility can only be determined based on a full review of a Medicaid application under all Medicaid eligibility groups;

(2) Information about Medicaid eligibility rules, covered benefits, and restrictions on cost sharing; and

(3) Information about how and where to apply for Medicaid under all eligibility groups.

(4) The State will determine the written format and timing of the information regarding Medicaid eligibility, benefits, and the application process required under this paragraph (f).

(g) *Individuals found potentially eligible for other insurance affordability programs.* For individuals identified in paragraph (b)(1)(ii) of this section who have been identified as potentially eligible for BHP or insurance affordability programs available through the Exchange, the State must promptly and without undue delay, consistent

with the timeliness standards established under § 457.340(d), transfer the electronic account to the other insurance affordability program via a secure electronic interface.

(h) *Evaluation of eligibility for Exchange coverage.* A State may enter into an arrangement with the Exchange for the entity that determines eligibility for CHIP to make determinations of eligibility for advance payments of the premium tax credit and cost sharing reductions, consistent with 45 CFR 155.110(a)(2).

(i) *Waiting lists, enrollment caps and closed enrollment.* The State must establish procedures to ensure that—

(1) The procedures developed in accordance with this section have been followed for each child applying for a separate child health program before placing the child on a waiting list or otherwise deferring action on the child's application for the separate child health program;

(2) Children placed on a waiting list or for whom action on their application is otherwise deferred are transferred to other insurance affordability programs in accordance with paragraph (h) of this section; and

(3) Families are informed that a child may be eligible for other insurance affordability programs, while the child is on a waiting list for a separate child health program or if circumstances change, for Medicaid.

■ 32. Section 457.480 is amended by—

■ a. Revising the section heading;

■ b. Redesignating paragraphs (a) and (b) as paragraphs (b) and (c), respectively; and

■ c. Adding a new paragraph (a).

The revision and addition read as follows:

§ 457.480 Prohibited coverage limitations, preexisting condition exclusions, and relation to other laws.

(a) *Prohibited coverage limitations.* The State may not impose any annual, lifetime or other aggregate dollar limitations on any medical or dental services which are covered under the State plan.

* * * * *

■ 33. Section 457.570 is amended by—

■ a. Revising paragraph (c)(1);

■ b. Removing paragraph (c)(2);

■ c. Redesignating paragraph (c)(3) as paragraph (c)(2); and

■ d. Revising newly redesignated paragraph (c)(2).

The revisions read as follows:

§ 457.570 Disenrollment protections.

* * * * *

(c) * * *

(1) Impose a specified period of time that a CHIP eligible targeted low-income child or targeted low-income pregnant woman who has an unpaid premium or enrollment fee will not be permitted to reenroll for coverage in CHIP.

(2) Require the collection of past due premiums or enrollment fees as a condition of eligibility for reenrollment if an individual was terminated for failure to pay premiums.

* * * * *

■ 34. Section 457.805 is amended by revising paragraph (b) to read as follows:

§ 457.805 State plan requirement: Procedures to address substitution under group health plans.

* * * * *

(b) *Limitations.* A State may not, under this section, impose a waiting period before enrolling an eligible individual in CHIP that has been disenrolled from group health plan coverage. States should conduct monitoring activities to prevent substitution of coverage.

■ 35. Section 457.810 is amended by revising paragraph (a) to read as follows:

§ 457.810 Premium assistance programs: Required protections against substitution.

* * * * *

(a) *Prohibition of imposing a waiting period.* A State may not, under this section, impose a waiting period before enrolling an eligible individual who has, but is not enrolled in, group health plan coverage into CHIP premium assistance coverage.

* * * * *

§ 457.960 [Removed]

■ 36. Section 457.960 is removed.

■ 37. Section 457.965 is revised to read as follows:

§ 457.965 Documentation.

(a) *Basis and purpose.* This section, based on section 2101 of the Act, prescribes the kinds of records a State must maintain, the minimum retention period for such records, and the conditions under which those records must be provided or made available.

(b) *Content of records.* A State plan must provide that the State will maintain or supervise the maintenance of the records necessary for the proper and efficient operation of the plan. The records must include all of the following—

(1) Individual records on each applicant and enrollee that contain—

(i) All information provided on the initial application submitted through any modality described in § 435.907(a) of this chapter as referenced in § 457.330, by, or on behalf of, the applicant or enrollee, including the signature on and date of application;

(ii) The electronic account and any information or other documentation received from another insurance affordability program in accordance with § 457.348(c) and (d);

(iii) The date of, basis for, and all documents or other evidence to support any determination, denial, or other adverse action taken with respect to the applicant or enrollee, including all information provided by the applicant or enrollee, and all information obtained electronically or otherwise by the State from third-party sources;

(iv) The provision of, and payment for, services, items and other child health assistance or pregnancy-related assistance, including the service or item provided, relevant diagnoses, the date that the item or service was provided, the practitioner or provider rendering, providing or prescribing the service or item, including their National Provider Identifier, and the full amount paid or reimbursed for the service or item, and any third-party liabilities;

(v) Any changes in circumstances reported by the individual and any actions taken by the State in response to such reports;

(vi) All renewal forms returned by, or on behalf of, a beneficiary, to the State in accordance with § 457.343, regardless of the modality through which such forms are submitted, including the signature on the form and date received.

(vii) All notices provided to the applicant or enrollee in accordance with §§ 457.340(e) and 457.1180; and

(viii) All records pertaining to any State reviews requested by, or on behalf of, the applicant or enrollee, including each request submitted and the date of such request, the complete record of the review decision, as described in subpart K of this part, and the final administrative action taken by the agency following the review decision and date of such action; and

(ix) The disposition of income and eligibility verification information received under § 457.380, including evidence that no information was returned from an electronic data source.

(2) Statistical, fiscal, and other records necessary for reporting and accountability as required by the Secretary.

(c) *Retention of records.* The State plan must provide that the records required under paragraph (b) of this section will be retained for the period when the applicant or enrollee's case is active, plus a minimum of 3 years thereafter.

(d) *Accessibility and availability of records.* The agency must—

(1) Maintain the records described in paragraph (b) of this section in paper in an electronic format; and

(2) Make the records available to the Secretary, Federal and State auditors and other parties who request, and are authorized to review, such records within 30 calendar days of the request if not otherwise specified, and to the extent permissible by Federal law.

■ 38. Section 457.1140 is amended by revising paragraph (d)(4) to read as follows:

§ 457.1140 Program specific review process: Core elements of review.

* * * * *

(d) * * *

(4) Receive continued enrollment and benefits in accordance with § 457.1170.

■ 39. Section 457.1170 is revised to read as follows:

§ 457.1170 Program specific review process: Continuation of enrollment.

(a) A State must ensure the opportunity for continuation of enrollment and benefits pending the completion of review of the following:

(1) A suspension or termination of enrollment, including a decision to disenroll for failure to pay cost sharing and;

(2) A failure to make a timely determination of eligibility at application and renewal.

(b) [Reserved]

■ 40. Section 457.1180 is revised to read as follows:

§ 457.1180 Program specific review process: Notice.

A State must provide enrollees and applicants timely written notice of any determinations required to be subject to review under § 457.1130 that includes the reasons for the determination, an explanation of applicable rights to review of that determination, the standard and expedited time frames for review, the manner in which a review can be requested, and the circumstances under which enrollment and benefits may continue pending review.

PART 600—ADMINISTRATION, ELIGIBILITY, ESSENTIAL HEALTH BENEFITS, PERFORMANCE STANDARDS, SERVICE DELIVERY REQUIREMENTS, PREMIUM AND COST SHARING, ALLOTMENTS, AND RECONCILATION

■ 41. The authority citation for part 600 continues to read as follows:

Authority: Section 1331 of the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111–148, 124 Stat. 119), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152, 124 Stat 1029).

■ 42. Section 600.330 is amended by revising paragraph (a) to read as follows:

§ 600.330 Coordination with other insurance affordability programs.

(a) *Coordination.* The State must establish eligibility and enrollment mechanisms and procedures to maximize coordination with the Exchange, Medicaid, and CHIP. The terms of 45 CFR 155.345(a) regarding the agreements between insurance affordability programs apply to a BHP. The State BHP agency must fulfill the requirements of 42 CFR 435.1200(d), (e)(1)(ii), and (e)(3) and, if applicable, paragraph (c) of this section for BHP eligible individuals.

* * * * *

■ 43. Section 600.525 is amended by revising paragraph (b)(2) to read as follows:

§ 600.525 Disenrollment procedures and consequences for nonpayment of premiums.

* * * * *

(b) * * *

(2) A State electing to enroll eligible individuals throughout the year must comply with the reenrollment standards set forth in § 457.570(c) of this chapter.

Dated: August 29, 2022.

Xavier Becerra,

Secretary, Department of Health and Human Services.

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