switched to IP-based networks and from copper to wireless and fiber infrastructure, have affected the quality and utility of TTY technology, prompting discussions on transitioning to an alternative advanced communications technology for text communications. Accordingly, on December 16, 2016, the Commission released Transition from TTY to Real-Time Text Technology, Report and Order, document FCC 16–169, 82 FR 7699, January 23, 2017, amending its rules that govern the obligations of wireless service providers and manufacturers to support TTY technology to permit such providers and manufacturers to provide support for real-time text (RTT) over wireless IP-based networks to facilitate an effective and seamless transition to RTT in lieu of continuing to support TTY technology.

In document FCC 16–169, the Commission adopted measures requiring the following:

(a) Each wireless provider and manufacturer that voluntarily transitions from TTY technology to RTT over wireless IP-based networks and services is encouraged to develop consumer and education efforts that include (1) the development and dissemination of educational materials that contain information pertinent to the nature, purpose, and timelines of the RTT transition; (2) internet postings, in an accessible format, of information about the TTY to RTT transition on the websites of covered entities; (3) the creation of a telephone hotline and an online interactive and accessible service that can answer consumer questions about RTT; and (4) appropriate training of staff to effectively respond to consumer questions. All consumer outreach and education should be provided in accessible formats including, but not limited to, large print, Braille, videos in American Sign Language and that are captioned and video described, emails to consumers who have opted to receive notices in this manner, and printed materials. Service providers and manufacturers are also encouraged to coordinate with consumer, public safety, and industry stakeholders to develop and distribute education and outreach materials. The information will inform consumers of alternative accessible technology available to replace TTY technology that may no longer be available to the consumer through their provider or on their device.

(b) Each wireless provider that requested or will request and receive a waiver of the requirement to support TTY technology over wireless IP-based networks and services must apprise its customers, through effective and accessible channels of communication, that (1) until TTY is sunset, TTY technology will not be supported for calls to 911 services over IP-based wireless services, and (2) there are alternative PSTN-based and IP-based accessibility solutions for people with disabilities to reach 911 services. These notices must be developed in coordination with public safety answering points (PSAPs) and national consumer organizations, and include a listing of text-based alternatives to 911, including, but not limited to, TTY capability over the PSTN, various forms of PSTN-based and IP-based TRS, and text-to-911 (where available). The notices will inform consumers on the loss of the use of TTY for completing 911 calls over the provider's network and alert them to alternatives service for which TTY may be used.

(c) Once every six months, each wireless provider that requests and receives a waiver of the requirement to support TTY technology must file a report with the Commission and inform its customers regarding its progress toward and the status of the availability of new IP-based accessibility solutions. Such reports must include (1) information on the interoperability of the provider's selected accessibility solution with the technologies deployed or to be deployed by other carriers and service providers, (2) the backward compatibility of such solution with TTYs, (3) a showing of the provider's efforts to ensure delivery of 911 calls to the appropriate PSAP, (4) a description of any obstacles incurred towards achieving interoperability and steps taken to overcome such obstacles, and (5) an estimated timetable for the deployment of accessibility solutions. The information will inform consumers of the progress towards the availability of alternative accessible means to replace TTY, and the Commission will be able to evaluate the reports to determine if any changes to the waivers are warranted or of any impediments to progress that it may be in a position to resolve.

Federal Communications Commission.

Katura Jackson,

Federal Register Liaison Officer.

[FR Doc. 2023–28819 Filed 12–29–23; 8:45 am]

BILLING CODE 6712–01–P

GOVERNMENT ACCOUNTABILITY OFFICE

Request for Medicaid and CHIP Payment and Access Commission (MACPAC) Nominations

AGENCY: Government Accountability Office.

ACTION: Request for letters of nomination and resumes.

SUMMARY: The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) established MACPAC to review Medicaid and CHIP access and payment policies and to advise Congress on issues affecting Medicaid and CHIP. CHIPRA gave the Comptroller General of the United States responsibility for appointing MACPAC's members. The U.S. Government Accountability Office (GAO) is now accepting nominations for MACPAC appointments that will be effective May 2024. Nominations should be sent to the email address listed below. Acknowledgement of receipt will be provided within a week of submission.

DATES: Letters of nomination and resumes should be submitted no later than January 25, 2024, to ensure adequate opportunity for review and consideration of nominees prior to appointment.

ADDRESSES: Submit letters of nomination and resumes to *MACPACappointments@gao.gov.*

FOR FURTHER INFORMATION CONTACT: Corissa Kiyan-Fukumoto at (206) 287–4808 or *KiyanFukumotoC@gao.gov* if you do not receive an acknowledgment or need additional information. For general information, contact GAO's Office of Public Affairs, (202) 512–4800.

Authority: 42 U.S.C. 1396.

Gene L. Dodaro,

Comptroller General of the United States.

[FR Doc. 2023–28102 Filed 12–29–23; 8:45 am]

BILLING CODE 1610–02–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–3446–FN]

Medicare and Medicaid Programs; Application from the Community Health Accreditation Program (CHAP) for Continued Approval of Its Home Health Agency Accreditation Program

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

ACTION: Notice.

SUMMARY: This notice announces our decision to approve the Community Health Accreditation Program (CHAP) for continued recognition as a national accrediting organization for home health agencies (HHAs) that wish to participate in the Medicare or Medicaid programs.

DATES: The decision announced in this notice is applicable March 31, 2024, to March 31, 2030.

FOR FURTHER INFORMATION CONTACT: Caecilia Andrews, (410) 786–2190.

SUPPLEMENTARY INFORMATION:

I. Background

Under the Medicare program, eligible beneficiaries may receive covered services from a home health agency (HHA), provided certain requirements are met. Sections 1861(m) and (o), 1891 and 1895 of the Social Security Act (the Act) establish distinct criteria for an entity seeking designation as an HHA. Regulations concerning provider agreements are at 42 Code of Federal Regulations (CFR) part 489 and those pertaining to activities relating to the survey and certification of facilities and other entities are at 42 CFR part 488. The regulations at 42 CFR parts 409 and 484 specify the conditions that an HHA must meet to participate in the Medicare program, the scope of covered services and the conditions for Medicare payment for home health care.

Generally, to enter into a provider agreement with the Medicare program, an HHA must first be certified by a state survey agency as complying with the conditions or requirements set forth in 42 CFR part 484 of our regulations. Thereafter, the HHA is subject to regular surveys by a state survey agency to determine whether it continues to meet these requirements.

However, there is an alternative to surveys by state agencies. Section 1865(a)(1) of the Act provides that, if a provider entity demonstrates through accreditation by a Centers for Medicare & Medicaid Services (CMS) approved national accrediting organization (AO) that all applicable Medicare requirements are met or exceeded, we will deem those provider entities as having met such requirements. Accreditation by an AO is voluntary and is not required for Medicare participation.

If an AO is recognized by the Secretary of the Department of Health and Human Services (HHS) (the Secretary) as having standards for accreditation that meet or exceed Medicare requirements, any provider entity accredited by the national accrediting body's approved program would be deemed to meet the Medicare requirements. A national AO applying for approval of its accreditation program under 42 CFR part 488, subpart A, must provide CMS with reasonable assurance that the AO requires the accredited provider entities to meet requirements that are at least as stringent as the Medicare requirements.

Our regulations concerning the approval of AOs are at §§ 488.4 and 488.5. The regulations at § 488.5(e)(2)(i) require an AO to reapply for continued approval of its accreditation program every 6 years or sooner, as determined by CMS. This notice is to announce our continued approval of CHAP's HHA accreditation program for a period of 6 years.

II. Application Approval Process

Section 1865(a)(3)(A) of the Act provides a statutory timetable to ensure that our review of applications for CMS-approval of an accreditation program is conducted in a timely manner. The Act provides us 210 days after the date of receipt of a complete application, with any documentation necessary to make the determination, to complete our survey activities and application process. Within 60 days after receiving a complete application, we must publish a notice in the **Federal Register** that identifies the national accrediting body making the request, describes the request, and provides no less than a 30-day public comment period. At the end of the 210-day period, we must publish a notice in the **Federal Register** approving or denying the application.

III. Provisions of the Proposed Notice

In the August 8, 2023 **Federal Register** (88 FR 53489), we published a proposed notice announcing CHAP's request for continued approval of its Medicare HHA accreditation program. In the August 2023 proposed notice (88 FR 53489), we detailed our evaluation criteria. Under section 1865(a)(2) of the Act and in our regulations at § 488.5, we conducted a review of CHAP's Medicare HHA accreditation application in accordance with the criteria specified by our regulations, which include, but are not limited to the following:

- An administrative review of CHAP's—

++ Corporate policies;

++ Financial and human resources available to accomplish the proposed surveys;

++ Procedures for training, monitoring, and evaluation of its surveyors;

++ Ability to investigate and respond appropriately to complaints against accredited facilities; and

++ Survey review and decision-making process for accreditation.

- A comparison of CHAP's accreditation to our current Medicare HHA conditions of participation (CoPs).
- A documentation review of CHAP's survey process to do the following:

++ Determine the composition of the survey team, surveyor qualifications, and CHAP's ability to provide continuing surveyor training.

++ Compare CHAP's processes to those of state survey agencies, including survey frequency, and the ability to investigate and respond appropriately to complaints against accredited facilities.

++ Evaluate CHAP's procedures for monitoring HHAs out of compliance with CHAP's program requirements. The monitoring procedures are used only when CHAP identifies noncompliance. If noncompliance is identified through validation reviews, the state survey agency monitors corrections as specified at § 488.7(d).

++ Assess CHAP's ability to report deficiencies to the surveyed facilities and respond to the facility's plan of correction in a timely manner.

++ Establish CHAP's ability to provide CMS with electronic data and reports necessary for effective validation and assessment of the organization's survey process.

++ Determine the adequacy of staff and other resources.

++ Confirm CHAP's ability to provide adequate funding for performing required surveys.

++ Confirm CHAP's policies with respect to whether surveys are unannounced.

++ Obtain CHAP's agreement to provide CMS with a copy of the most current accreditation survey together with any other information related to the survey as we may require, including corrective action plans.

++ Review CHAP's policies and procedures to avoid conflicts of interest, including the appearance of conflicts of interest, involving individuals who conduct surveys or participate in accreditation decisions.

IV. Analysis of and Responses to Public Comments on the Proposed Notice

In accordance with section 1865(a)(3)(A) of the Act, the August 8, 2023 proposed notice also solicited public comments regarding whether CHAP's requirements met or exceeded the Medicare CoPs for HHAs. We received no comments in response to our proposed notice.

V. Provisions of the Final Notice

A. Differences Between CHAP's Standards and Requirements for Accreditation and Medicare Conditions and Survey Requirements

We compared CHAP's HHA requirements and survey process with the Medicare CoPs and survey process as outlined in the State Operations Manual (SOM). Our review and evaluation of CHAP's HHA application were conducted as described in section III. of this notice and have yielded the following areas where, as of the date of this notice, CHAP has completed revising its standards and certification processes to meet the standard's requirements of all the following regulations:

- Section 484.50(c)(8), to clarify under Patient Right's that the HHA must also comply with the requirements of 42 CFR 405.1200 through 405.1204 when providing the patient with written notice, in advance of a specific service being furnished.
- Section 484.75(c)(2), to specify that when rehabilitative therapy services are provided under the supervision of an occupational therapist or physical therapist, the qualified professional meets the requirements of § 484.115(f) or (h), respectively.
- Section 484.75(c)(3), to specify that when medical social services are provided under the supervision of a social worker, the requirements of § 484.115(m) are met.
- Section 484.100(a), to appropriately cross-reference the Medicare conditions of §§ 420.201, 420.202, and 420.206 or corresponding comparable CHAP standards.
- Section 484.102(d)(2)(iii), to include the requirement for HHAs to analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.
- Section 484.105(g), to appropriately cross-reference the Medicare conditions of §§ 485.713, 485.715, 485.719, 485.723, and 485.727 or corresponding comparable CHAP standards.

In addition to the standards review, CMS also reviewed CHAP's comparable survey processes, which were conducted as described in section III. of this notice, and yielded the following areas where, as of the date of this notice, CHAP has completed revising its survey processes, in order to demonstrate that it uses survey processes that are comparable to state survey agency processes by removing references to ''blackout dates,'' by allowing facilities to select dates which suggested the facility would be unavailable for surveys, as CMS expects all Medicare-participating facilities to be survey ready at all times.

B. Term of Approval

Based on our review and observations described in sections III. and V. of this notice, we approve CHAP as a national AO for HHAs that request participation in the Medicare program. The decision announced in this final notice is effective March 31, 2024, through March 31, 2030 (6 years).

VI. Collection of Information Requirements

This document does not impose information collection requirements, that is, reporting, recordkeeping, or third-party disclosure requirements. Consequently, there is no need for review by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

The Administrator of the Centers for Medicare & Medicaid Services (CMS), Chiquita Brooks-LaSure, having reviewed and approved this document, authorizes Chyana Woodyard, who is the **Federal Register** Liaison, to electronically sign this document for purposes of publication in the **Federal Register**.

Chyana Woodyard,

Federal Register Liaison, Centers for Medicare & Medicaid Services.

[FR Doc. 2023–28831 Filed 12–29–23; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Lists of Designated Primary Medical Care, Mental Health, and Dental Health Professional Shortage Areas

AGENCY: Health Resources and Services Administration (HRSA), Department of Health and Human Services.

ACTION: Notice.

SUMMARY: This is the second of two planned notices informing the public of the availability of the complete lists of all geographic areas, population groups, and facilities designated as primary medical care, dental health, and mental health professional shortage areas (HPSA). This notice includes the lists of HPSAs in a designated status as of December 2, 2023. The lists are available on the shortage area topic page on HRSA's *data.hrsa.gov* website. The first **Federal Register** notice was published on July 3, 2023, and included HPSAs in a designated status and those proposed for withdrawal, while extending the transition time communicated in the prior notice published on July 7, 2022. State primary care offices had additional time to submit HPSA data that was re-evaluated in preparation for the publication of this notice. This second **Federal Register** notice includes the lists of HPSAs in a designated status and withdraws designations proposed for withdrawal not meeting the requirements for designation as of the data pull on December 2, 2023.

ADDRESSES: Complete lists of HPSAs designated as of December 2, 2023, are available on the website at *https://data.hrsa.gov/tools/health-workforce/shortage-areas/frn.* Frequently updated information on HPSAs is available at *https://data.hrsa.gov/topics/health-workforce/health-workforce-shortage-areas.* Information on shortage designations is available at *https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation.*

FOR FURTHER INFORMATION CONTACT: For further information on the HPSA designations listed on the website or to request additional designation, withdrawal, or reapplication for designation, please contact Anthony Estelle, Chief, Shortage Designation Branch, Division of Policy and Shortage Designation, Bureau of Health Workforce (BHW), HRSA, 5600 Fishers Lane, Room 11W16, Rockville, Maryland 20857, *sdb@hrsa.gov.*

SUPPLEMENTARY INFORMATION:

Background

Section 332 of the Public Health Service (PHS) Act, 42 U.S.C. 254e, provides that the Secretary shall designate HPSAs based on criteria established by regulation. HPSAs are defined in section 332 to include (1) urban and rural geographic areas with shortages of health professionals, (2) population groups with such shortages, and (3) facilities with such shortages. Section 332 further requires that the Secretary annually publish lists of the designated geographic areas, population groups, and facilities. The lists of HPSAs are to be reviewed at least annually and revised as necessary.

Final regulations (42 CFR part 5) were published in 1980 that include the criteria for designating HPSAs. Criteria were defined for seven health professional types: primary medical care, dental, psychiatric, vision care, podiatric, pharmacy, and veterinary care. The criteria for correctional facility