C. Regulatory Flexibility Act (RFA)

I certify that this action will not have a significant economic impact on a substantial number of small entities under the RFA, 5 U.S.C. 601 *et seq.* Because this use has not been registered in the United States for some time, there has been no need for this tolerance exemption and thus the revocation will impose no net burden on small entities subject to the rule. Furthermore, the Agency did not receive any comments on these conclusions as presented in the proposed rule.

D. Unfunded Mandates Reform Act (UMRA)

This action does not contain any unfunded mandate as described in UMRA, 2 U.S.C. 1531–1538, and does not significantly or uniquely affect small governments. The action imposes no enforceable duty on any state, local or tribal governments or the private sector.

E. Executive Order 13132: Federalism

This action does not have federalism implications as specified in Executive Order 13132, August 10, 1999 (64 FR 43255). It will not have substantial direct effects 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.

F. Executive Order 13175: Consultation and Coordination With Indian Tribal Governments

This action does not have tribal implications as specified in Executive Order 13175, November 9, 2000 (65 FR 67249), because it will not have substantial direct effects on tribal governments, on the relationship between the Federal government and the Indian tribes, or on the distribution of power and responsibilities between the Federal government and Indian tribes.

G. Executive Order 13045: Protection of Children From Environmental Health Risks and Safety Risks

Executive Order 13045 (62 FR 19885, April 23, 1997) directs federal agencies to include an evaluation of health and safety effects of the planned regulation on children in federal health and safety standards and explain why the regulation is preferable to potential effective and reasonably feasible alternatives. This action is also not subject to Executive Order 13045 because it is not a significant regulatory action under section 3(f)(1) of Executive Order 12866 (*See* Unit V.A.). However, EPA's *Policy on Children's Health* applies to this action. Since phenol has not been used in any registered pesticides for several years, it is unlikely that there has been much, if any, exposure to children from pesticide use. The revocation of the tolerance exemption also ensures that residues of the pesticide will not be in food.

H. Executive Order 13211: Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution or Use

This action is not a subject to Executive Order 13211 (66 FR 28355, May 22, 2001) because it is not a significant regulatory action under Executive Order 12866.

I. National Technology Transfer Advancement Act (NTTAA)

This action does not involve technical standards under NTTAA section 12(d), 15 U.S.C. 272.

J. Executive Order 12898: Federal Actions To Address Environmental Justice in Minority Populations and Low-Income Populations

Executive Order 12898 (59 FR 7629, February 16, 1994) directs federal agencies, to the greatest extent practicable and permitted by law, to make environmental justice part of their mission by identifying and addressing, as appropriate, disproportionately high and adverse human health or environmental effects of their programs, policies, and activities on minority populations (people of color and/or indigenous peoples) and low-income populations. As discussed in more detail in the pesticide specific risk assessments conducted as part of the registration review for phenol, EPA has considered the safety risks for phenol. EPA believes that the human health and environmental conditions that exist prior to this action do not result in disproportionate and adverse effects on people of color, low-income populations, and/or indigenous peoples. Furthermore, EPA believes that this action is not likely to result in new disproportionate and adverse effects on people of color, low-income populations and/or indigenous peoples.

K. Congressional Review Act (CRA)

This action is subject to the CRA, 5 U.S.C. 801 *et seq.,* and EPA will submit a rule report to each House of the Congress and to the Comptroller General of the United States. This action is not a ''major rule'' as defined by 5 U.S.C. 804(2).

List of Subjects in 40 CFR Part 180

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

Dated: August 26, 2024.

Anita Pease,

Director, Antimicrobials Division, Office of Pesticide Programs.

Therefore, 40 CFR chapter I is amended to read 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.

§ 180.920 [Amended]

■ 2. In § 180.920, amend table 1 by removing the inert ingredient ''Phenol''.

[FR Doc. 2024–19531 Filed 8–29–24; 8:45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Indian Health Service

42 CFR Part 136

[RIN 0917–AA10]

Catastrophic Health Emergency Fund

AGENCY: Indian Health Service, Department of Health and Human Services (HHS).

ACTION: Final rule.

SUMMARY: The Indian Health Service (IHS or Service) administers the Catastrophic Health Emergency Fund (CHEF) pursuant to section 202 of the Indian Health Care Improvement Act (IHCIA). The purpose of the CHEF is to meet the extraordinary medical costs associated with the treatment of victims of disasters or catastrophic illnesses who are within the responsibility of the Service. This document finalizes the regulations governing the administration of the CHEF, with clarifying edits, and responds to comments received on the proposed rule.

DATES: This final rule is effective on October 29, 2024.

FOR FURTHER INFORMATION CONTACT: For technical questions concerning this rule contact: Carl Mitchell, Director, Division of Regulatory and Policy Coordination (DRPC), Office of Management Services (OMS), Indian Health Service, 301–443–

6384, *carl.mitchell@ihs.gov;* or CAPT John Rael, Director, Office of Resource Access and Partnerships (ORAP), Indian Health Service, 301–443–0969, *john.rael@ihs.gov.*

SUPPLEMENTARY INFORMATION: The CHEF was established by section 202 of the IHCIA, Public Law 94–437 (25 U.S.C. 1621a). The Patient Protection and Affordable Care Act, Public Law 111–148, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111–152 (collectively, the Affordable Care Act or ''the ACA''), reauthorized the IHCIA and amended the CHEF, directing the Secretary to promulgate regulations governing the administration of the CHEF.

In the **Federal Register** of July 18, 2023 (88 FR 45867), the IHS published a proposed rule entitled ''Catastrophic Health Emergency Fund'' with a 60-day comment period.

I. Background

The purpose of the CHEF is to meet the extraordinary medical costs associated with the treatment of victims of disasters or catastrophic illnesses who are within the responsibility of the Service. The IHS administers the CHEF to reimburse certain IHS and Tribal purchased/referred care (PRC) costs that exceed the cost threshold. Although the CHEF was first established in 1988, a similar fund was authorized by Public Law 99–591, a Joint Resolution continuing appropriations for fiscal year (FY) 1987. The IHS developed operating guidelines for the management of the CHEF in August of 1987, which were approved by the Office of Management and Budget (OMB). Those guidelines were developed with input from Tribal Organizations and IHS personnel who work with the daily processing and management of Contract Health Services (CHS), now known as the Purchased/Referred Care (PRC) Program. Congress passed the Indian Health Care Improvement Reauthorization and Extension Act of 2009, S. 1790, 111th Cong. (2010) (IHCIREA), as section 10221(a) of the Patient Protection and Affordable Care Act, Public Law 111–148. Through IHCIREA, Congress permanently reauthorized and amended the IHCIA, Public Law 94–437. Section 202 of the IHCIA (25 U.S.C. 1621a) establishes the CHEF and directs the IHS to promulgate regulations for its administration.

The operating guidelines and twenty-eight (28) years of experience (FYs 1987–2015) contributed to the design of the proposed rule published on January 26, 2016 (81 FR 4239). Following additional Tribal Consultation and additional years of experience, the IHS issued a new notice of proposed rulemaking (NPRM). The new NPRM, published on July 18, 2023 (88 FR 45867), superseded and replaced the proposed rule published on January 26, 2016 (81 FR 4239); as such, the 2016 NPRM was rescinded.

II. Provisions of This Final Regulation

This final regulation (1) establishes definitions governing the CHEF, including definitions of disasters and catastrophic illnesses; (2) establishes that a Service Unit shall not be eligible for reimbursement for the cost of treatment from the CHEF until its cost of treating any victim of such catastrophic illness or disaster has reached a certain threshold cost; (3) establishes a procedure for reimbursement of the portion of the costs for authorized services that exceed such threshold costs; (4) establishes a procedure for payment from the CHEF for cases in which the exigencies of the medical circumstances warrant treatment prior to the authorization of such treatment; and, (5) establishes a procedure that will ensure no payment will be made from the CHEF to a Service Unit to the extent the provider of services is eligible to receive payment for the treatment from any other Federal, State, local, or private source of reimbursement for which the patient is eligible.

No part of the CHEF, or its administration, shall be subject to contract or grant under any law, including the Indian Self-Determination and Education Assistance Act (ISDEAA), Public Law 93–638 (25 U.S.C. 5301 *et seq.*) and may not be allocated, apportioned, or delegated to a Service Unit, Area Office, or any other IHS organizational unit. Accordingly, the IHS Division of Contract Care within ORAP, the IHS, shall remain responsible for administration of the CHEF.

This final regulation incorporates provisions on severability. Congress has specifically directed the promulgation of these rules for the administration of the CHEF, which is administered by the Secretary, United States (U.S.) Department of Health and Human Services (HHS) (''the Secretary'') acting through IHS Headquarters. The sole purpose of the CHEF is meeting extraordinary medical costs associated with treatment of victims of disasters or catastrophic illnesses who are within the responsibility of the Service. In the event that any portion of the final regulation is declared invalid, the Secretary, acting through the IHS, will continue to be responsible for the administration of the CHEF. The IHS anticipates that the remainder of the regulation could function sensibly and continue to govern the administration of the CHEF. For these reasons, if any portion of the final regulation is declared invalid, the IHS intends that the remaining provisions be severable.

The final regulation also incorporates clarifying edits to §§ 136.501, 136.503, and 136.506. Under § 136.501, the IHS added a missing comma in the definition of alternate resources. The IHS had unintentionally omitted the comma from the proposed rule and correction was important to ensure consistency with § 136.61(c). The IHS removed an unnecessary comma in the definition of catastrophic illness in § 136.501 for clarity. The IHS also corrected a typographical error in the preamble regarding the definition of PRC, which did not change the definition of PRC under § 136.501. In § 136.503(a), the IHS clarified that the initial threshold is being established for fiscal year 2024. Under § 136.506, the IHS added two clarifications regarding alternate resources, based upon public comments received in response to the proposed rule. The first clarification regarding alternate resources, located at § 136.506(b), explains that patients are not required to expend personal resources for health services to meet alternate resource eligibility, nor are they required to sell valuables or property to become eligible for alternate resources. The second clarification, located at § 136.506(c), explains that when a PRC program pays primary to (*i.e.,* before) a Tribal self-insurance plan, this will not impact whether a PRC program's expenditures are eligible for reimbursement from the CHEF, as long as the Service Unit clearly demonstrates that the PRC program was responsible and did in fact assume that responsibility by making the payments at issue in the CHEF request. Further details are included in response to the comments under section IV, below.

A. Definitions

The IHS establishes the following definitions for governing the CHEF, including definitions of disasters and catastrophic illnesses:

1. Alternate Resources—health care resources other than those of the IHS. Such resources include health care providers and institutions, and health care programs for the payment of health services including, but not limited to programs under title XVIII or XIX of the Social Security Act (*i.e.,* Medicare, Medicaid), State or local health care programs, and private insurance.

2. Catastrophic Health Emergency Fund (CHEF)—the fund established by Congress to reimburse extraordinary medical expenses incurred for catastrophic illnesses and disasters paid by a PRC program of the IHS, whether such program is carried out by the IHS or an Indian Tribe or Tribal Organization under the ISDEAA.

3. Catastrophic Illness—a medical condition that is costly by virtue of the intensity and/or duration of its treatment. Examples of conditions that frequently require multiple hospital stays and extensive treatment are cancer, burns, premature births, cardiac disease, end-stage renal disease, strokes, trauma-related cases such as automobile accidents and gunshot wounds, and certain mental disorders. The CHEF is intended to insulate the IHS and Tribal PRC operations from financial disruption caused by the intensity of expenses incurred as a result of high cost illnesses and/or disasters.

4. Disasters—situations that pose a significant level of threat to life or health or cause loss of life or health stemming from events such as tornadoes, earthquakes, floods, catastrophic accidents, epidemics, fires, and explosions. The CHEF is intended to insulate the IHS and Tribal PRC operations from financial disruption caused by the intensity of expenses incurred as a result of high cost illnesses and/or disasters.

5. Episode of Care—the period of consecutive days for a discrete health condition during which reasonable and necessary medical services related to the condition occur.

6. Purchased/Referred Care (PRC)—any health service that is—

(a) delivered based on a referral by, or at the expense of, an Indian health program; and

(b) provided by a public or private medical provider or hospital that is not a provider or hospital of the Indian health program.

7. Service Unit—an administrative entity of the Service or a Tribal health program through which services are provided, directly or by contract, to eligible Indians within a defined geographic area.

8. Threshold Cost—the annual designated amount above which incurred medical costs will be considered for the CHEF reimbursement after a review of the authorized expenses and diagnosis.

B. Threshold Cost

The IHCIA section 202 provides that a Service Unit shall not be eligible for reimbursement from the CHEF until its cost of treating any victim of a catastrophic illness or event has reached a certain threshold cost. The Secretary is directed to establish the initial CHEF threshold at—

(1) the FY 2000 level of $19,000; and

(2) for any subsequent year, the threshold will not be less than the threshold cost of the previous year increased by the percentage increase in the medical care expenditure category of the Consumer Price Index (CPI) for all urban consumers (United States city average) for the 12-month period ending with December of the previous year.

In the proposed rule, the IHS stated its intention to establish the initial threshold of $19,000 for the current FY, which was FY 2023 at that time. Since the IHS is publishing this final rule after FY 2023, the IHS is setting the initial threshold governed by this rule at $19,000 for the current FY, which is FY 2024. In reaching this determination, the IHS adopted the recommendation of the IHS Director's Workgroup on Improving PRC (Workgroup). The Workgroup, composed of Tribal leaders and Tribal and Federal representatives, voted 18–2 to recommend $19,000 as the initial threshold. For this recommendation, the Workgroup considered several factors, including the following: (1) Tribal concerns regarding the lower threshold and the potential to exhaust the CHEF earlier in the fiscal year leaving PRC programs without the ability to recover costs for treating victims of catastrophic illnesses or disasters; and (2) Tribal concerns about setting the threshold at the FY 2000 level and then applying the Consumer Price Index for All Urban (CPI–U) Medical for each year since FY 2000, which would have resulted in a $30,000 plus threshold requirement by FY 2013. At this higher level, PRC programs with limited budgets would be unable to access the CHEF to seek recovery for extraordinary medical costs. Accordingly, the IHS is setting the initial threshold at $19,000 for FY 2024, with increases in subsequent years based on the annual CPI–U Medical factor. The IHS will publish annual updates to the threshold amount yearly in the **Federal Register**.

C. Compliance With PRC Regulations

In order to qualify for reimbursement from the CHEF, a Service Unit must follow PRC regulations at 42 Code of Federal Regulations (CFR) part 136. For example, payment or reimbursement from the CHEF may be made for the costs of treating persons eligible for PRC in accordance with 42 CFR 136.23 and authorized for PRC in accordance with 42 CFR 136.24. In cases where the exigencies of the medical circumstances warrant treatment prior to the authorization of such treatment by the Service Unit, authorization must be obtained in accordance with 42 CFR 136.24(c). For example, claims for reimbursement of services provided that do not meet the 72-hour emergency notification requirements found at 42 CFR 136.24(c) will be denied. The applicable Area PRC program shall review the CHEF requests for CHEF reimbursement to ensure consistency with PRC regulations.

D. Alternate Resources

In accordance with section 202(d)(5) of the IHCIA [25 U.S.C. 1621a(d)(5)], alternate resources must be exhausted before reimbursement is made from the CHEF. No reimbursement shall be made from the CHEF to any Service Unit to the extent that the provider of treatment is eligible to receive payment for the treatment from any other Federal, State, local, or private source of reimbursement for which the patient is eligible. Medical expenses incurred for catastrophic illnesses and events will not be considered eligible for reimbursement if they are payable by alternate resources, as determined by the IHS. The IHS is the payer of last resort and, if the provider of services is eligible to receive payment from other resources, the medical expenses are payable by PRC and reimbursable by the CHEF only to the extent that the IHS would not consider the other resources to be ''alternate resources'' under the applicable authorities. Expenses paid by alternate resources are not eligible for payment by PRC or reimbursement by the CHEF. However, if the patient is found to have been eligible for alternate resources at the time of service, the Service Unit shall promptly return all funds reimbursed from the CHEF to the IHS Headquarters CHEF account.

E. Reimbursement Procedure

A patient must be eligible for PRC services and the Service Unit must adhere to regulations (42 CFR 136.23(a)

through (f)) governing the PRC program to be reimbursed for catastrophic cases from the CHEF. Once the catastrophic case meets the threshold cost for the year at issue and the Service Unit has authorized PRC resources exceeding that threshold requirement, the Service Unit may qualify for reimbursement from the CHEF. Reimbursable costs are those costs that exceed the threshold cost after payment has been made by all alternate resources such as Federal, State, local, private insurance, and other resources. Reimbursement of PRC expenditures incurred by the Service Unit and approved by the PRC program at IHS Headquarters will be processed through the respective IHS Area Office. Reimbursement from the CHEF shall be subject to availability of funds, and usually done on a first in first out for complete applications.

F. Recovery of the CHEF Reimbursement Funds

In the event a PRC program has been reimbursed from the CHEF for an episode of care and that same episode of care becomes eligible for and is paid by any Federal, State, local, or private source (including third-party insurance), the PRC program shall return all the CHEF funds received for that episode of care to the CHEF at the IHS Headquarters. These recovered CHEF funds will be used to reimburse other approved CHEF requests.

III. Collection of Information Requirements

Prior to implementing the rule, the IHS may be required to develop new information collection forms that would require approval from the OMB in accordance with the Paperwork Reduction Act of 1995, 44 United States Code (U.S.C.) 3507(d).

IV. Summary of Comments

The IHS received comments [1] from eight Tribal entities. Their comments are grouped by topic and summarized below, together with responses. No other comments were received.

Threshold

Comment: The IHS received seven comments in full support of the threshold establishment, including two commenters who specifically supported the adjustment language. An additional commenter [2] supported the establishment of the threshold, but opposed the annual adjustment based upon the CPI and would like to see the threshold maintained at $19,000 permanently.

Response: The IHS appreciates the comments and in response to the comment opposing adjustment, the IHS clarifies here that the annual adjustment in the final rule is mandated by the specific language of 25 U.S.C. 1621a(d)(2)(B).

Process (General)

Comment: The IHS received four comments in support of the process, either generally or in regards to certain parts of the process.

Response: The IHS appreciates the supportive comments.

Comment: An additional commenter [3] expressed concerns about unspecified timelines in the processing of the CHEF reimbursement requests and recommended specific deadlines, including deadlines for review and submission by the Area Office, review and submission by IHS Headquarters, and payment by the Fiscal Intermediary (FI).

Response: The IHS takes this opportunity to clarify that the FI is not involved in payment of the CHEF reimbursements. The IHS considered whether to add the recommended deadlines, but it has decided not to do so at this time. For the time being, the IHS believes that the concern is sufficiently addressed by the provision permitting a Service Unit to appeal as a ''deemed denial'' after 180 calendar days. See § 136.509(b). Also, the IHS has established a process that it believes will expedite review and approval of CHEF claims once they are received which typically occurs within 60 calendar days.

Process (Appeals)

Comment: The IHS received four comments in support of the appeals process set out in the proposed rule.

Response: The IHS appreciates the supportive comments.

Comment: An additional commenter [4] expressed concerns about the timeline to provide written notice of the denial, believing 130 business days from receipt to be excessive, and recommended that this timeline be changed to 40 days, consistent with the deadline to submit an appeal.

Response: The IHS considered whether to shorten this timeline and it has decided not to do so at this time. The vast majority of CHEF claims do not take 130 business days to process. The IHS has established a process that expedites review and approval of CHEF claims once they are received. On average, it takes less than 1 month for IHS Headquarters to review, process and initiate payment. There may be situations based upon volume and complexity of cases that require much longer. The IHS has also considered the time that the Area Offices need to fulfill their roles in the process and how the timeline affords the Service Units an opportunity to supplement missing and/or indecipherable information.

PRC Authorities

Comment: The IHS received two comments in support of following the PRC authorities, meaning that only appropriately-paid PRC expenditures are eligible for CHEF reimbursement.

Response: The IHS appreciates the supportive comments.

Comment: The IHS also received two comments [5] in opposition, based upon their belief that the CHEF statute is not restricted to PRC and that direct care costs should qualify for reimbursement from the CHEF.

Response: Reimbursements from the CHEF are limited to expenditures by PRC programs, consistent with the CHEF statute and congressional intent. The CHEF statute, at 25 U.S.C. 1621a(d)(1), specifically authorizes the Secretary to promulgate regulations establishing the types of disasters and illnesses for which ''the cost of the treatment provided under contract'' will be reimbursed. This explicit reference to services provided under contract demonstrates that the CHEF is intended to provide reimbursement for PRC (formerly known as contract health services) program expenditures.

This interpretation is further supported by the legislative history of the CHEF statute. When the CHEF statute was first introduced in 1983, reimbursement from the CHEF was to be for ''. . . the cost of treatment, whether provided under contract or in a Service or Service-supported facility . . .''. HR 4567, 98th Congress, 1st Session (Nov. 18, 1983). However, following legislative hearings and several rounds of amendment over the next 2 years, the language providing reimbursement from

[1] See generally, public comments posted in response to Docket ID #IHS–2016–0002–0022, 09/15–22/2023, *https://www.regulations.gov/docket/IHS-2016-0002/comments*.

[2] Docket ID #IHS–2016–0002–0023, 09/15/2023, *https://www.regulations.gov/comment/IHS-2016-0002-0023*.

[3] Docket ID #IHS–2016–0002–0029, 09/18/2023, *https://www.regulations.gov/comment/IHS-2016-0002-0029*.

[4] Docket ID #IHS–2016–0002–0029, 09/18/2023, *https://www.regulations.gov/comment/IHS-2016-0002-0029*.

[5] Docket ID #IHS–2016–0002–0026, 09/18/2023, *https://www.regulations.gov/comment/IHS-2016-0002-0026*.

Docket ID #IHS–2016–0002–0027, 09/18/2023, *https://www.regulations.gov/comment/IHS-2016-0002-0027*.

the CHEF for treatment costs incurred ''in a Service or Service-supported facility'' was removed from the proposed legislation, leaving only reimbursement for treatment provided under contract. *See* HR 1426, 99th Congress, 1st Session (May 23, 1985), *and* S 277, 99th Congress, 1st Session (May 16, 1985). In a report accompanying the Senate version of the bill, a summary of the bill noted that it established ''[a]n Indian Catastrophic Health Emergency Fund . . . to relieve the financial burden on the contract health care budget of the Indian Health Service . . .''. S. Comm. Rep. 99–62 (May 16, 1985). Finally, funds for the CHEF are appropriated through the PRC line item, further indicating that Congress intends for the CHEF funds to be used to reimburse PRC costs, not direct care costs.

Comment: An additional commenter [6] expressed concerns about the definition of PRC and recommended that a different definition be created for purposes of reimbursements from the CHEF.

Response: Based upon the tie between the CHEF and expenditures by PRC programs, as discussed in the response above, the IHS has utilized the statutory definition of PRC. The IHS did correct a typographical error in the preamble regarding the definition of PRC, which did not change the definition of PRC under § 136.501. Otherwise, the IHS has decided to finalize the rule without changes to this definition.

Alternate Resources, § 136.501

Comment: The IHS received a comment in support of the language regarding alternate resources in § 136.501.

Response: The IHS appreciates the supportive comment.

Comment: The IHS also received two comments [7] that supported the absence of the term ''Tribal'' from the list of alternate resources and/or explaining that they read the rule to exclude Tribal self-insurance as an alternate resource. The IHS also received five comments [8] that recommended an explicit exclusion for Tribal self-insurance and four of those commenters sought a broader exclusion for Tribal programs or Tribal resources.

Response: The IHS appreciates this opportunity to clarify the change between the 2016 NPRM and the 2023 NPRM. Consistent with the IHS' current PRC policy, the IHS assumes that Tribal self-insurance is not an alternate resource for purposes of the CHEF. However, the IHS has also long recognized that Tribal self-insurance plans can choose to pay primary to PRC, meaning they can choose to be an alternate resource to PRC. This is a coordination between the payers of last resort, with one needing to pay primary to the other, but until the IHS is informed otherwise, the IHS assumes that the Tribal self-insurance does *not* wish to be an alternate resource. For tribally operated PRC programs, the Tribal Health Program would decide how to coordinate with Tribal self-insurance. For example, a Tribal Health Program may decide to coordinate in a complicated manner in order to maximize discounts. This coordination process will *not* impair eligibility for reimbursement from the CHEF, as long as the Tribal Health Program clearly demonstrates that their PRC program was responsible and did in fact assume that responsibility by making the payments at issue in the CHEF request. This is not an issue of who *must* pay primary; it is a factual question of whether the PRC program paid. Again, regardless of whether the PRC program is operated by the IHS or a Tribal Health Program, when a PRC program pays primary to (*i.e.,* before) the Tribal self-insurance plan, this will not impair the PRC program's eligibility for reimbursement from the CHEF. The IHS added clarification in this regard to § 136.506.

For programs or resources other than Tribal self-insurance, it will depend upon the circumstances. For example, if a Tribal Health Program is reasonably accessible or available to meet the patient's needs through direct care, PRC cannot be authorized for that care, meaning it cannot be reimbursed from the CHEF. Similarly, when sponsorship occurs through private insurance (*i.e.,* not Tribal self-insurance), the private insurance would be an alternate resource.

Unrelated to this issue, the IHS is adding a missing comma to the definition of alternate resources in § 136.501, to ensure it is consistent with § 136.61(c).

Alternate Resources, § 136.506

Comment: A commenter [9] recommended revisions to clarify that if a patient is required to pay premiums or cost-sharing out of pocket, it would not be an alternate resource.

Response: The IHS appreciates this comment and the opportunity to clarify this issue. Through policy, the IHS has already explicitly recognized that IHS beneficiaries are not required to either expend personal resources for health services to meet alternate resource eligibility, or to sell valuables or property to become eligible for alternate resources. The IHS added clarifying language to § 136.506, to make sure this is clear for purposes of CHEF reimbursement.

Comment: The IHS also received a comment [10] recommending revisions to this section that explicitly exclude Tribal resources and Tribal self-insurance.

Response: Please see the response to the same comment regarding § 136.501, including the explanation of the clarification added to § 136.506. For the same reasons, the IHS is not presupposing how Tribal Health Programs and Tribal self-insurance may wish to coordinate amongst each other. That coordination is not an IHS decision to make. The IHS is looking factually at whether the PRC program was ultimately responsible and did in fact make the payment at issue in the CHEF reimbursement request. The IHS takes this opportunity to clarify again the following two points: (1) IHS-operated PRC programs do not treat Tribal self-insurance as alternate resources unless and until the Tribe's governing body clearly asks them to do so through a Tribal Resolution; and (2) regardless of whether the PRC program is operated by the IHS or a Tribal Health Program, if a PRC program pays primary to Tribal self-insurance, that PRC program's eligibility for reimbursement from the CHEF is not impaired in any way. The Service Unit simply needs to show that their PRC program paid the amount at issue in the CHEF request, because the CHEF is not intended to reimburse

[6] Docket ID #IHS–2016–0002–0029, 09/18/2023, *https://www.regulations.gov/comment/IHS-2016-0002-0029*.

[7] Docket ID# IHS–2016–0002–0023, 09/15/2023, *https://www.regulations.gov/comment/IHS-2016-0002-0023*.

Docket ID #IHS–2016–0002–0029, 09/18/2023, *https://www.regulations.gov/comment/IHS-2016-0002-0029*.

[8] Docket ID #IHS–2016–0002–0027, 09/18/2023, *https://www.regulations.gov/comment/IHS-2016-0002-0027*.

Docket ID #IHS–2016–0002–0024, 09/15/2023, *https://www.regulations.gov/comment/IHS-2016-0002-0024*.

Docket ID #IHS–2016–0002–0025, 09/05/2023, *https://www.regulations.gov/comment/IHS-2016-0002-0025*.

Docket ID #IHS–2016–0002–0026, 09/18/2023, *https://www.regulations.gov/comment/IHS-2016-0002-0026*.

Docket ID #IHS–2016–0002–0028,09/18/2023, *https://www.regulations.gov/comment/IHS-2016-0002-0028*.

[9] Docket ID #IHS–2016–0002–0029, 09/18/2023, *https://www.regulations.gov/comment/IHS-2016-0002-0029*.

[10] Docket ID #IHS–2016–0002–0026, 09/18/2023, *https://www.regulations.gov/comment/IHS-2016-0002-0026*.

programs other than PRC. As noted above, the IHS has added clarification in response to this comment under § 136.506.

Consultation

Comment: Two comments [11] requested additional Tribal Consultation before the proposed rule is finalized, based upon fundamental changes they thought needed to be considered through Tribal Consultation.

Response: The IHS has already held a number of Tribal Consultations on the proposed rule, including multiple in-person and telephonic Tribal Consultations. The IHS has also repeatedly sought recommendations from Tribal representatives on the Director's Workgroup. The IHS does not intend to do any further Tribal Consultation before finalizing this rule. As more fully discussed below, the fundamental changes suggested by these two commenters are outside the scope of rulemaking. However, the IHS will assess the final CHEF regulations following implementation, and we will look to hold future Tribal Consultations to receive input from Tribal Health Programs regarding potential improvements.

Supplementary Tribal Funds

Comment: Two commenters [12] recommended changing the rule to give ''credit'' to Tribal expenditures that supplement direct care budgets or PRC.

Response: Direct supplements to the PRC program (*i.e.,* adding funds directly to the PRC program, for PRC expenditure in accordance with PRC authorities) are eligible for reimbursement from the CHEF on the same basis as PRC-appropriated funds. We understand that a number of Tribes operate Tribal self-insurance plans outside of an ISDEAA agreement and may consider those plans to be a ''supplement'' to the PRC program. However, this is not a direct supplement of funds to the PRC program for expenditure by the PRC program in accordance with PRC authorities, meaning the expenditures by those Tribal self-insurance plans are not reimbursable by the CHEF. Similarly, expenditures by the direct care programs are not eligible for CHEF reimbursement. The IHS appreciates the opportunity to clarify these points, but for these reasons and those stated above, the IHS is not making any changes in response to the comment.

Other

Comment: Two commenters [13] recommended adding language regarding the Indian canon of statutory construction and trust responsibilities.

Response: Because these suggestions are outside the scope of the proposed rule, the IHS did not make any changes. However, the IHS notes that it did consider the Indian canon of statutory construction for purposes of establishing the initial CHEF threshold.

Comment: A second commenter [14] recommended splitting the regulation into two phases to first address the threshold alone, then address all remaining aspects of the proposed rule.

Response: Congress directed the promulgation of CHEF regulations on a number of items, including topics beyond the threshold cost. *See* 25 U.S.C. 1621a(d). Following extensive consultation, the IHS needs to move forward with finalizing the regulations, as directed by Congress. For these reasons, the IHS is not making changes in response to this comment.

Comment: One commenter [15] indicated support, generally, for CHEF reimbursement of payments to non-PRC providers.

Response: In the proposed rule, the IHS sought comment on whether payments by PRC programs to patients, or other individuals or entities that are not PRC providers, should be included as eligible for CHEF reimbursement under these regulations and if so, under what circumstances. The IHS received no comments regarding payments to patients, such as reimbursements to patients who needed to pay out-of-pocket for their healthcare expenses prior to authorization by the PRC program. The IHS also did not receive any comments regarding payments made on behalf of patients in these circumstances. This is not an issue faced by IHS-operated PRC programs. We were seeking comments in case the Tribal Health Programs dealt with different scenarios or experiences. The IHS did not receive sufficient information to consider changes in this regard.

V. Regulatory Impact Analysis

We have examined the impacts of this rule as required by Executive Order (E.O.) 12866 on Regulatory Planning and Review (September 30, 1993); section 604 of the Regulatory Flexibility Act (RFA), Public Law 96–354 [5 U.S.C. 601–612], as amended by subtitle D of the Small Business Regulatory Fairness Act of 1996, Public Law 104–121; the Unfunded Mandates Reform Act (UMRA) of 1995, Public Law 104–4; E.O. 13132 on Federalism (August 4, 1999); E.O. 13175 on Consultation and Coordination with Indian Tribal Governments; and the Congressional Review Act.

A. Executive Order 12866

Executive Order 12866, as amended by Executive Order 14094, directs 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, as amended, defines a ''significant regulatory action'' as one that is likely to result in a rule that may: (1) have an annual effect on the economy of $200 million or more in any one year (adjusted every three years by the Administrator of the Office of Information and Regulatory Affairs (OIRA) for changes in gross domestic product), or adversely affect in a material way a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, territorial, or Tribal governments or communities (2) create a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raise legal or policy issues for which centralized review would meaningfully further the President's priorities or the principles set forth in Executive Order 12866. OIRA has determined that this is a significant regulatory action as defined by Executive Order 12866, section 3(f).

B. Regulatory Flexibility Act (RFA)

RFA requires analysis of regulatory options that minimize any significant economic impact of a rule on small entities, unless it is certified that the

[11] Docket ID #IHS–2016–0002–0026, 09/18/2023, *https://www.regulations.gov/comment/IHS-2016-0002-0026*.

Docket ID #IHS–2016–0002–0027, 09/18/2023, *https://www.regulations.gov/comment/IHS-2016-0002-0027*.

[12] Docket ID #IHS–2016–0002–0026, 09/18/2023, *https://www.regulations.gov/comment/IHS-2016-0002-0026,*

Docket ID #IHS–2016–0002–0027, 09/18/2023, *https://www.regulations.gov/comment/IHS-2016-0002-0027*.

[13] Docket ID #IHS–2016–0002–0026, 09/18/2023, *https://www.regulations.gov/comment/IHS-2016-0002-0026*.

Docket ID #IHS–2016–0002–0027, 09/18/2023, *https://www.regulations.gov/comment/IHS-2016-0002-0027*.

[14] Docket ID # IHS–2016–0002–0026, 09/18/2023, *https://www.regulations.gov/comment/IHS-2016-0002-0026*.

[15] Docket ID # IHS–2016–0002–0030, 09/22/2023, *https://www.regulations.gov/comment/IHS-2016-0002-0030*.

final rule is not expected to have a significant economic impact on small entities. HHS certifies that this final rule is not expected to have a significant economic impact on small entities, because the rule only governs reimbursements of certain expenditures made by Service Units under PRC authorities. Many PRC programs are operated by the Federal Government, through the IHS. The remaining PRC programs are operated by Tribes and Tribal Organizations under ISDEAA agreements with the IHS. Presently, there are 62 federally operated PRC programs and 188 tribally operated PRC programs. Some of the entities operating PRC programs may be small entities, but the rule does not directly impact a substantial number of small entities and the rule is not expected to reduce their revenues or raise their costs.

C. Unfunded Mandates Reform Act (UMRA)

Section 202 of UMRA (Pub. L. 104–4) requires an assessment of anticipated costs and benefits before proposing any rule that may result in expenditure by State, local, and Tribal governments, in aggregate, or by the private sector of $100 million or more (adjusted annually for inflation) in any one year. The current threshold after adjustment for inflation is $183 million (in 2023 dollars), using the most recent full year of data for the Implicit Price Deflator for the Gross Domestic Product. We find that this rule will not have an effect on the economy that exceeds the UMRA threshold in any one year. The IHS FY 2023 annual appropriation for the CHEF was $54 million. Thus, this final rule is not anticipated to have an effect on State, local, or Tribal governments in the aggregate, or by the private sector that exceed the UMRA monetary threshold.

D. Federalism

E.O. 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has federalism implications. We reviewed this rule under the threshold criteria of E.O. 13132 and determined that it would not have substantial direct effect on States, on the relationship between the Federal Government and States, or on the distribution of power and governmental responsibilities among the various levels of the government(s). As this rule has no Federal implications, a federalism summary impact statement is not required.

E. E.O. 13175

This rule has Tribal implications under E.O. 13175, Consultation and Coordination with Indian Tribal Governments, because it would have a substantial direct effect on one or more Indian Tribes.

The first proposed CHEF rule, published on January 26, 2016 (81 FR 4239), was developed with input from Tribes and IHS personnel who work with the daily processing and management of PRC resources. Specifically, the IHS Director's Workgroup met and discussed the CHEF guidelines on October 12–13, 2010, and June 1–2, 2011, in Denver, Colorado, and on January 11–12, 2012, in Albuquerque, New Mexico. This Workgroup is a Federal-Tribal workgroup established in 2010 to provide advice and recommendations on strategies to improve the PRC Program to the IHS Director. In addition, the IHS issued Tribal Leader letters related to the development of these regulations on February 9, 2011,[16] and May 6, 2013.[17]

The IHS sought additional Tribal input throughout the development of the new proposed rule. Specifically, Tribal Consultations were held in the fall of 2016, including multiple in-person and telephonic Tribal Consultation sessions.[18] The proposed regulations were also a topic of discussion during multiple meetings of the IHS Director's Workgroup. At meetings of the Workgroup in 2015 and 2018, the Workgroup recommended establishing a $19,000 CHEF threshold. Moreover, in November 2020, the Workgroup recommended that the IHS promulgate new regulations based on Workgroup input. Based on the recommendation of the Workgroup, the threshold amount of $19,000 was proposed to be established for the current fiscal year, which at the time was FY 2020.

F. Congressional Review Act (CRA)

Before a rule can take effect, the CRA requires agencies to submit to the U.S. House of Representatives, U.S. Senate, and the Comptroller General a report containing a copy of the rule and a statement identifying whether it is a ''major rule.'' 5 U.S.C. 801. The OMB determines if a final rule constitutes a major rule. The CRA defines a major rule as any rule that the Administrator of OMB's Office of Information and Regulatory Affairs finds has resulted in or is likely to result in—(A) an annual effect on the economy of $100,000,000 or more; (B) a major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions, or (C) 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. 5 U.S.C. 804(2).

This final rule *is not* a major rule for purposes of the Congressional Review Act. HHS/IHS will submit a report, including the final rule, to both houses of Congress and the Government Accountability Office for review.

List of Subjects in 42 CFR Part 136

Alaska Natives, Health, Health facilities, Indians, Purchased/referred care (formerly contract health services).

For the reasons set out in the preamble, the IHS amends 42 CFR part 136 as set forth below:

PART 136—INDIAN HEALTH

■ 1. The authority citation for part 136 is revised to read as follows:

Authority: 42 U.S.C. 2001 and 2003; 25 U.S.C. 13; and 25 U.S.C. 1621a.

■ 2. Add subpart L, consisting of §§ 136.501 through 136.510, to read as follows:

Subpart L—Indian Catastrophic Health Emergency Fund

Sec.

§ 136.501 Definitions.

Alternate resources means health care resources other than those of the Indian Health Service (IHS or Service). Such resources include health care providers and institutions, and health care programs for the payment of health services including but not limited to programs under title XVIII or XIX of the Social Security Act (*i.e.,* Medicare, Medicaid), State or local health care programs, and private insurance.

[16] *https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/2011_Letters/02-09-2011%20DTL%20Letter%20and%20Attachment.pdf.*

[17] *https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/2013_Letters/05-06-2013_DTLL_CHS_WG_Recommendations.pdf.*

[18] *https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/2016_Letters/55914-1_CHEF_DTLL_07292016.pdf.*

Catastrophic Health Emergency Fund (CHEF) means the fund established by Congress to reimburse extraordinary medical expenses incurred for catastrophic illnesses and disasters paid by a purchased/referred care (PRC) program of the IHS, whether such program is carried out by the IHS or an Indian Tribe or Tribal Organization under the Indian Self-Determination and Education Assistance Act (ISDEAA).

Catastrophic illness refers to a medical condition that is costly by virtue of the intensity and/or duration of its treatment. Examples of conditions that frequently require multiple hospital stays and extensive treatment are cancer, burns, premature births, cardiac disease, end-stage renal disease, strokes, trauma-related cases such as automobile accidents and gunshot wounds, and some mental disorders. The CHEF is intended to insulate the IHS and Tribal PRC operations from financial disruption caused by the intensity of expenses incurred as a result of high cost illnesses and/or disasters.

Disaster means a situation that poses a significant level of threat to life or health or causes loss of life or health stemming from events such as tornadoes, earthquakes, floods, catastrophic accidents, epidemics, fires, and explosions. The CHEF is intended to insulate the IHS and Tribal PRC operations from financial disruption caused by the intensity of expenses incurred as a result of high cost illnesses and/or disasters.

Episode of care means the period of consecutive days for a discrete health condition during which reasonable and necessary medical services related to the condition occur.

Purchased/referred care means any health service that is—

(1) Delivered based on a referral by, or at the expense of, an Indian health program; and

(2) Provided by a public or private medical provider or hospital which is not a provider or hospital of the Indian health program.

Service Unit means an administrative entity of the Service or a Tribal Health Program through which services are provided, directly or by contract, to eligible Indians within a defined geographic area.

Threshold cost means the annual designated amount above which incurred medical costs will be considered for the CHEF reimbursement after a review of the authorized expenses and diagnosis.

§ 136.502 Purpose of this subpart.

The CHEF is authorized by section 202 of the Indian Health Care Improvement Act (IHCIA) [25 U.S.C. 1621a]. The CHEF is administered by the Secretary, Department of Health and Human Services (HHS) (''the Secretary'') acting through the Headquarters of IHS, solely for the purpose of meeting extraordinary medical costs associated with treatment of victims of disasters or catastrophic illnesses who are within the responsibility of the Service. This subpart:

(a) Establishes definitions of terms governing the CHEF, including definitions of disasters and catastrophic illnesses for which the cost of treatment provided under contract would qualify for payment from the CHEF;

(b) Establishes a threshold level for reimbursement for the cost of treatment;

(c) Establishes procedures for reimbursement of the portion of the costs incurred by Service Units that exceeds such threshold costs, including procedures for when the exigencies of the medical circumstances warrant treatment prior to the authorization of such treatment by the Service; and

(d) Establishes procedures for reimbursements pending the outcome or payment by alternate resources.

§ 136.503 Threshold cost.

A Service Unit shall not be eligible for reimbursement from the CHEF until its cost of treating any victim of a catastrophic illness or disaster for an episode of care has reached a certain threshold cost.

(a) The threshold cost shall be established at the level of $19,000 for fiscal year 2024.

(b) The threshold cost in subsequent years shall be calculated from the threshold cost of the previous year, increased by the percentage increase in the medical care expenditure category of the Consumer Price Index for all urban consumers (United States city average) for the 12-month period ending with December of the previous year. The revised threshold costs shall be published yearly in the **Federal Register**.

§ 136.504 Reimbursement procedure.

Service Units whose scope of work and funding include the purchase of medical services from private or public vendors under PRC are eligible to participate. The CHEF payments shall be based only on valid PRC expenditures, including expenditures for exigent medical circumstances without prior PRC authorization. Reimbursement from the CHEF will not be made if applicable PRC requirements are not followed.

(a) *Claim submission.* Requests for reimbursement from the CHEF must be submitted to the appropriate IHS Area Office. Area PRC programs will review requests for reimbursement to ensure compliance with PRC requirements, including but not limited to: patient eligibility, medical necessity, notification requirements for emergent and non-emergent care, medical priorities, allowable expenditures, and eligibility for alternate resources. Following this review, Area PRC programs may provide Service Units an opportunity to submit missing information or to resubmit documents that are indecipherable. Area PRC programs will then forward all requests to the Division of Contract Care, along with any recommendations or observations from the Area PRC program regarding compliance with PRC or other CHEF requirements. The Division of Contract Care will adjudicate the claim based upon an independent review of the claim documentation, but it may consider any recommendations or observations from the Area PRC program.

(b) *Content of claims.* All claims submitted for reimbursement may be submitted electronically utilizing the secure IHS system(s) established for this purpose or may be submitted in paper form but must include:

(1) A fully completed Catastrophic Health Emergency Fund Reimbursement Request Form.

(2) A statement of the provider's charges on a form that complies with the format required for the submission of claims under title XVIII of the Social Security Act. For example, charges may be printed on forms such as the Centers for Medicare & Medicaid Services (CMS) 1500, UB–04 (formerly CMS–1450), American Dental Association (ADA) dental claim form, or National Council for Prescription Drug Program (NCPDP) universal claim forms. The forms submitted for review must include specific appropriate diagnostic and procedure codes.

(3) An explanation of benefits or statement of payment identifying how much was paid to the provider by the Service Unit for the catastrophic illness or disaster. Payments to the patient or any other entity are ineligible for the CHEF reimbursement.

(4) The Division of Contract Care may request additional medical documentation describing the medical treatment or service provided, including but not limited to discharge summaries and/or medical progress notes. Cases may be submitted for 50%

reimbursement of eligible expenses pending discharge summaries. Medical documentation must be received to close the CHEF case.

(c) *Limitation of funds and reimbursement procedure.* Because of the limitations of funds, full reimbursement cannot be guaranteed on all requests and will be based on the availability of funds at the time the IHS processes the claim. To the extent funds are available, the CHEF funds may not be used to cover the cost of services or treatment for which the funds were not approved. Unused funds, including but not limited to, funds unused due to overestimates, alternate resources, and cancellations must be returned to the CHEF.

§ 136.505 Reimbursable services.

The costs of catastrophic illnesses and disasters for distinct episodes of care are eligible for reimbursement from the CHEF in accordance with the medical priorities of the Service. Only services that are related to a distinct episode of care will be eligible for reimbursement. Some of the services that may qualify for reimbursement from the fund are:

(a) Emergency treatment.

(b) Emergent and acute inpatient hospitalization.

(c) Ambulance services; air and ground (including patient escort travel costs).

(d) Attending and consultant physician.

(e) Functionally required reconstructive surgery.

(f) Prostheses and other related items.

(g) Reasonable rehabilitative therapy exclusive of custodial care not to exceed 30 days after discharge.

(h) Skilled nursing care when the patient is discharged from the acute process to a skilled nursing facility.

§ 136.506 Alternate resources.

(a) Expenses paid by alternate resources are not eligible for payment by PRC or reimbursement by the CHEF. No payment shall be made from the CHEF to any Service Unit to the extent that the provider of services is eligible to receive payment for the treatment from any other Federal, State, local, or private source of reimbursement for which the patient is eligible. A patient shall be considered eligible for such resources and no payment shall be made from the CHEF if:

(1) The patient is eligible for alternate resources; or

(2) The patient would be eligible for alternate resources if he or she were to apply for them; or

(3) The patient would be eligible for alternate resources under Federal, State, or local law or regulation but for the patient's eligibility for PRC, or other health services, from the Indian Health Service or Indian Health Service funded programs.

(b) Patients are not required to expend personal resources for health services to meet alternate resource eligibility, nor are they required to sell valuables or property to become eligible for alternate resources.

(c) When a PRC program pays primary to (*i.e.,* before) a Tribal self-insurance plan, this will not impact whether the PRC program's expenditures are eligible for reimbursement from the CHEF, as long as the Service Unit clearly demonstrates that the PRC program was responsible and did in fact assume that responsibility by making the payments at issue in the CHEF request.

(d) The determination of whether a resource constitutes an alternate resource for the purpose of the CHEF reimbursement shall be made by the Headquarters of the Indian Health Service, irrespective of whether the resource was determined to be an alternate resource at the time of PRC payment.

§ 136.507 Program integrity.

All the CHEF records and documents will be subject to review by the respective IHS Area Office and by IHS Headquarters. Internal audits and administrative reviews may be conducted as necessary to ensure compliance with the regulations in this part and the CHEF policies.

§ 136.508 Recovery of reimbursement funds.

In the event a Service Unit has been reimbursed from the CHEF for an episode of care and that same episode of care becomes eligible for and is paid by any Federal, State, local, or private source (including third party insurance) the Service Unit shall return all the CHEF funds received for that episode of care to the CHEF at the IHS Headquarters. These recovered CHEF funds will be used to reimburse other valid CHEF requests.

§ 136.509 Reconsideration and appeals.

(a) Any Service Unit to whom payment from the CHEF is denied will be notified of the denial in writing together with a statement of the reason for the denial within 130 business days from receipt.

(b) If a decision on the CHEF case is not made by the CHEF Program Manager within 180 calendar days from receipt, the Service Unit that submitted the claim may choose to appeal it as a deemed denial.

(c) In order to seek review of a denial decision or deemed denial, the Service Unit must follow the procedures set forth in paragraphs (c)(1) and (2) of this section.

(1) Within 40 business days from the receipt of the denial provided in paragraph (a) of this section, the Service Unit may submit a request in writing for reconsideration of the original denial to the Division of Contract Care. The request for reconsideration must include, as applicable, corrections to the original claim submission necessary to overcome the denial; or a statement and supporting documentation establishing that the original denial was in error. If no additional information is submitted the original denial will stand. The Service Unit may also request a telephone conference with the Division of Contract Care, to further explain the materials submitted, which shall be scheduled within 40 business days from receipt of the request for review. A decision by the Division of Contract Care shall be made within 130 business days of the request for review. The Division of Contract Care Director, or designee, shall review the application *de novo* with no deference to the original decision maker or to the applicant.

(2) If the original decision is affirmed on reconsideration, the Service Unit will be notified in writing and advised that an appeal may be taken to the Director, Indian Health Service, within 40 business days of receipt of the denial. The appeal shall be in writing and shall set forth the grounds supporting the appeal. The Service Unit may also request a telephone conference through the Division of Contract Care, which shall be scheduled with the Director or a representative designated by the Director, to further explain the grounds supporting the appeal. A decision by the Director shall be made within 180 calendar days of the request for reconsideration. The decision of the Director, Indian Health Service or designee, shall constitute the final administrative action.

§ 136.510 Severability.

If any provision of this subpart is held to be invalid or unenforceable by its terms, as applied to any person or circumstance, or stayed pending further agency action, the provision shall be construed to continue to give the maximum effect to the provision permitted by law, including as applied to those not similarly situated or to dissimilar circumstances. However, if such holding is that the provision of this subpart is invalid and unenforceable in all circumstances, the provision shall be

severable from the remainder of this subpart and shall not affect the remainder thereof.

Dated: August 26, 2024.

Xavier Becerra,

Secretary, Department of Health and Human Services.

[FR Doc. 2024–19421 Filed 8–29–24; 8:45 am]

BILLING CODE 4166–14–P

CORPORATION FOR NATIONAL AND COMMUNITY SERVICE

45 CFR Parts 2551, 2552, and 2553

RIN 3045–AA81

AmeriCorps Seniors Regulation Updates

AGENCY: Corporation for National and Community Service.

ACTION: Final rule.

SUMMARY: The Corporation for National and Community Service (operating as AmeriCorps) is revising its regulations governing AmeriCorps Seniors programs. This rule removes barriers to service for individuals and increases flexibility for grantees to accomplish project goals and recruit volunteers. Specifically, this rule removes barriers for individuals to serve as AmeriCorps Seniors volunteers in three ways: first, by modernizing what is considered income in the calculation that determines eligibility to receive a stipend; second, by allowing volunteers to continue to receive a stipend when their sponsor places them on administrative leave due to extenuating circumstances that prevent service; and third, by allowing grantees to supplement stipends. This rule reduces burden for AmeriCorps Seniors grantees in two ways: first, it establishes a single 10 percent match value regardless of grant year. Second, this rule allows grantees to choose to pay more than (but not less than) the AmeriCorps-established stipend rates, using non-AmeriCorps funds for the amount that exceeds the AmeriCorps-established rate. These changes will improve grantees' ability to recruit volunteers and allow grantees to devote to program operations resources that would otherwise be devoted to meet increasingly high match requirements. The rule also updates nomenclature to reflect that the Corporation for National and Community Service operates as AmeriCorps and that ''Senior Corps'' is now known as ''AmeriCorps Seniors.''

DATES: This rule is effective October 1, 2024.

FOR FURTHER INFORMATION CONTACT: Robin Corindo, Deputy Director, AmeriCorps Seniors, at *rcorindo@americorps.gov,* (202) 489–5578.

SUPPLEMENTARY INFORMATION:

I. Executive Summary of Final Rule

This rule updates AmeriCorps Seniors regulations implementing the Senior Companion Program (SCP), Foster Grandparent Program (FGP), and RSVP. The updates to the SCP and FGP regulations, at Code of Federal Regulations (CFR) parts 2551 and 2552, respectively, parallel each other and include changes to simplify provisions on calculation of an AmeriCorps Seniors volunteer's income to determine whether they are eligible for a stipend and removal of certain items from being considered as income. The updates to the SCP and FGP regulations also specify that volunteers who receive a stipend may be paid the stipend when the sponsor places them on administrative leave due to extenuating circumstances that prevent service. The updates also allow grantees to pay stipends at a higher rate than that established by AmeriCorps Seniors, if they choose to do so, as long as they do not use AmeriCorps grant funds to pay for the amount that is above the established stipend rate.

The updates to the RSVP regulations at part 2553 change the level of non-AmeriCorps support (''match'') that an RSVP sponsor must provide. Currently, the regulations allow AmeriCorps to grant up to 90 percent of the total RSVP budgeted project cost in the first year of a grant, but only 80 percent in the second year and 70 percent in the third and successive years. As a result, grantees currently must provide matching funds that are 10 percent of the total project cost in the first year of a grant, 20 percent in the second year, and 30 percent in successive years. The rule being finalized today instead establishes a single required match rate at 10 percent, regardless of the grant year.

Lastly, this rule makes nomenclature changes to add a definition for ''AmeriCorps'' and change references to the ''Corporation'' and ''CNCS'' to ''AmeriCorps'' throughout these regulations, to reflect that the Corporation for National and Community Service now operates as AmeriCorps. This rule also changes ''National Senior Service Corps (NSSC)'' to ''AmeriCorps Seniors'' to reflect current terminology and branding.

One change was proposed but is not being finalized today, in response to the comments opposing the change, as discussed below: the update that would have removed the requirement for grantees to employ a full-time project director.

II. Background on the AmeriCorps Seniors Programs Affected by This Rule

AmeriCorps Seniors operates four programs: the Senior Companion Program (SCP), Foster Grandparent Program (FGP), RSVP (formerly the Retired and Senior Volunteer Program), and a Senior Demonstration Program. This rule affects regulations implementing the first three programs. These programs are authorized by the Domestic Volunteer Service Act of 1973, as amended, 42 U.S.C. 4950 *et seq.,* and this rulemaking is authorized by the National and Community Service Act of 1990, as amended, 42 U.S.C. 12501 *et seq*.

AmeriCorps Seniors SCP and FGP each provide grants to qualified agencies and organizations (known as grantees) for the dual purpose of engaging persons 55 and older, particularly those with limited incomes, in volunteer service to meet critical community needs and to provide a high-quality experience that will enrich the lives of older adult volunteers. In SCP, program funds are used to support Senior Companions in providing supportive, individualized services to help older adults and those with special needs maintain their dignity and independence. They also serve caregivers with respite support. In FGP, program funds are used to support Foster Grandparents in providing