The revisions read as follows:

§ 351.408 Calculation of normal value of merchandise from nonmarket economy countries.

* * * * *

(c) * * *

(2) *Valuation in a single country.* The Secretary normally will value all factors in a single surrogate country.

(3) *Manufacturing overhead, general expenses, and profit.* For manufacturing overhead, general expenses, and profit, the Secretary normally will use non-proprietary information gathered from producers of identical or comparable merchandise in the surrogate country.

[FR Doc. 2023–21516 Filed 9–28–23; 8:45 am]

BILLING CODE 3510–DS–P

SOCIAL SECURITY ADMINISTRATION

20 CFR Part 404

[Docket No. SSA–2023–0023]

RIN 0960–AI85

Extension of the Flexibility in Evaluating "Close Proximity of Time" To Evaluate Changes in Healthcare Following the COVID–19 Public Health Emergency

AGENCY: Social Security Administration.

ACTION: Temporary final rule with request for comments.

SUMMARY: On July 23, 2021, we issued a temporary final rule (TFR) with request for comments to lengthen the ''close proximity of time'' standard in the Listing of Impairments (the listings) for musculoskeletal disorders because the COVID–19 national public health emergency (PHE) caused many individuals to experience barriers that prevented them from timely accessing in-person healthcare. That prior TFR is effective until six months after the effective date of a determination by the Secretary of Health and Human Services (HHS) that a PHE resulting from the COVID–19 pandemic no longer exists. The Secretary of HHS made that determination, and the COVID–19 national PHE ended on May 11, 2023. However, healthcare practices in a post-PHE world are still evolving. We are therefore issuing this new TFR to extend the flexibility provided by the prior TFR until May 11, 2025, so we can evaluate changes in healthcare practices and determine the proper ''close proximity of time'' standard for the musculoskeletal disorders listings.

DATES:

Effective date: This TFR is effective on October 30, 2023.

Comment date: We invite written comments. Comments must be submitted no later than November 28, 2023.

Expiration date: Unless we extend the provisions of this TFR by a final rule published in the **Federal Register**, it will cease to be effective on May 11, 2025.

ADDRESSES: You may submit comments by any one of three methods—internet, fax, or mail. Do not submit the same comment(s) multiple times or by more than one method. Regardless of which method you choose, please state that your comment(s) refer to Docket No. SSA–2023–0023 so that we may associate your comment(s) with the correct regulation.

Caution: You should be careful to include in your comment(s) only information that you wish to make publicly available. We strongly urge you not to include any personal information in your comment(s), such as Social Security numbers or medical information.

1. *Internet:* We strongly recommend that you submit your comment(s) via the internet. Please visit the Federal eRulemaking portal at *https://www.regulations.gov.* Use the ''search'' function to find docket number SSA–2023–0023. The system will issue a tracking number to confirm your submission. You will not be able to view your comment(s) immediately because we must post each comment manually. It may take up to one week for your comment(s) to be viewable.

2. *Fax:* Fax comments to 1–833–410–1631.

3. *Mail:* Mail your comments to the Office of Legislation and Congressional Affairs Regulations and Reports Clearance Staff, Mail Stop 3253, Altmeyer, 6401 Security Blvd., Baltimore, MD 21235.

Comments are available for public viewing on the Federal eRulemaking portal at *https://www.regulations.gov* or in person, during regular business hours, by arranging with the contact person identified below.

FOR FURTHER INFORMATION CONTACT: Michael J. Goldstein, Office of Disability Policy, Social Security Administration, 6401 Security Boulevard, Baltimore, MD 21235–6401, (410) 965–1020. For information on eligibility or filing for benefits, call our national toll-free number, 1–800–772–1213 or TTY 1–800–325–0778, or visit our internet site, Social Security Online, at *http://www.ssa.gov.*

SUPPLEMENTARY INFORMATION:

Background

On December 3, 2020, we published the final rule, *Revised Medical Criteria for Evaluating Musculoskeletal Disorders* (final rule),[1] which became effective on April 2, 2021. This final rule revised the criteria in the listings that we use to evaluate disability claims involving musculoskeletal disorders in adults and children at the third step of our sequential evaluation process under titles II and XVI of the Social Security Act (Act).[2] The final rule, among other things, revised the listings in response to the decision in *Radford* v. *Colvin,*[3] which interpreted former listing 1.04A to require a disability claimant to show only ''that each of the symptoms are present, and that the claimant has suffered or can be expected to suffer from [the condition] continuously for at least 12 months.'' [4] Under the court's interpretation of the former listing, a claimant did not need to show that each necessary criterion was present simultaneously or in particularly close proximity, as required by our interpretation of that listing.[5] The final rule clarified that, for the purposes of applying certain musculoskeletal disorders listings,[6] all of the required medical criteria must be present simultaneously, or within a close proximity of time, to satisfy the level of severity needed for the impairment to meet the listing. The final rule further defined the phrase ''within a close proximity of time'' to mean ''that *all* of the relevant criteria must appear in the medical record within a consecutive 4-month period'' (emphasis in original).[7] We also provided that ''[w]hen the criterion is imaging, we mean that we

[1] 85 FR 78164 (2020).

[2] For adults, the listings describe, for each of the major body systems, impairments that we consider to be severe enough to prevent an individual from doing any gainful activity regardless of his or her age, education, or work experience. 20 CFR 404.1525(a) and 416.925(a). For children, the listings describe impairments we consider severe enough to cause marked and severe functional limitations. 20 CFR 416.925(a). We use the listings at step 3 of the sequential evaluation process to identify claims in which the individual is clearly disabled under our rules. 20 CFR 404.1520, 416.920, and 416.924). We do not deny a claim when a person's medical impairment(s) does not satisfy the criteria of a listing. Instead, we continue the sequential evaluation process. 20 CFR 404.1520(a)(4) and 416.920(a)(4).

[3] *Radford* v. *Colvin,* 734 F.3d 288 (4th Cir. 2013).

[4] Id. at 294.

[5] See Acquiescence Ruling 15–1(4). We rescinded that Acquiescence Ruling after we revised the listings in 2020. 85 FR 79063 (2020).

[6] Listings 1.15, 1.16, 1.17, 1.18, 1.20C, 1.20D, 1.22, 1.23, 101.15, 101.16, 101.17, 101.18, 101.20C, 101.20D, 101.22, and 101.23.

[7] See 85 FR 78164 (2020) (revising 20 CFR part 404, subpart P, Appendix 1, 1.00C7c and 101.00C7c).

could reasonably expect the findings on imaging to have been present at the date of impairment or date of onset.'' [8]

We established the consecutive 4-month period as a criterion to meet the level of severity in some of the musculoskeletal disorders listings based on our research of relevant medical literature and clinical guidelines.[9] When we proposed this requirement as part of a notice of proposed rulemaking (NPRM),[10] we specifically asked interested members of the public to comment on this issue and provide us with any studies and data that supported their comments for a different standard; [11] however, no studies or data were submitted in response. In the final rule, we concluded that the consecutive 4-month period was consistent with the timeframe medical providers were generally trained to use for scheduling their patients,[12] the general standard of care,[13] and the frequency of healthcare visits by individuals with musculoskeletal conditions.[14] At the same time, the consecutive 4-month period provided some leeway for claimants, because the standard for patient revisits was once every 3 months.[15] Our rules recognize that one visit alone may not ensure all necessary criteria required for a medical listing will be appropriately documented; however, the consecutive 4-month time period provided a sufficient period to ensure the criteria were present ''within a close proximity of time'' and that the musculoskeletal disorder met the requisite severity for the listing.

[8] Id.

[9] See 85 FR at 78169–78170.

[10] 83 FR 20646 (2018).

[11] Id. at 20647.

[12] 85 FR at 78169 n.37 (citing Bavafa, H., Savin, S., & Terwiesch, C. (2019). Redesigning Primary Care Delivery: Customized Office Revisit Intervals and E-Visits. *https://dx.doi.org/10.2139/ssrn.2363685*. Paper referenced by Bavafa: Schectman, G., G. Barnas, P. Laud, L. Cantwell, M. Horton, E.J. Zarling. 2005. Prolonging the return visit interval in primary care. The American Journal of Medicine, 118(4) 393–399).

[13] 85 FR at 78169 n.34 (citing Gore, M., Sadosky, A., Stacey, B.R., Tai, K.S., & Leslie, D. (2012). The burden of chronic low back pain: Clinical comorbidities, treatment patterns, and health care costs in usual care settings. Spine, 37(11), E668–E677. *https://doi.org/10.1097/BRS.0b013e318241e5de*).

[14] 85 FR at 78169 n.35 (citing BMUS: The Burden of Musculoskeletal Diseases in the United States. In: BMUS: The Burden of Musculoskeletal Diseases in the United States [internet]. [cited 15 July 2020]. *https://www.boneandjointburden.org/fourth-edition/viiic2/utilization-condition-group*).

[15] See 85 FR at 78169 n.36 (citing J Gen Intern Med. 1999 Apr; 14(4): 230–235. doi: 10.1046/j.1525–1497.1999.00322.x Lisa M Schwartz, MD, MS, Steven Woloshin, MD, MS, John H Wasson, MD, Roger A Renfrew, MD, and H Gilbert Welch, MD, MPH, Dartmouth Primary Care Cooperative Research Network).

Onset of COVID–19

In 2020, COVID–19 began to spread throughout the country, prompting the Secretary of Health and Human Services to declare a national PHE on January 31, 2020.[16] With the outbreak of COVID–19, access to and the provision of healthcare changed significantly. Throughout the PHE, individuals across the country—including those with musculoskeletal disorders—altered their frequency and manner of seeking access to healthcare. This was due in part to healthcare organizations and government agencies such as the Centers for Medicare & Medicaid Services (CMS) [17] prioritizing the most urgent services and encouraging patients to delay other procedures during the PHE. Likewise, many individuals delayed or deferred important treatments due to closures of medical offices, fears of contracting COVID–19 infection (including fear of exposing high-risk individuals living in their household to infection), and other challenges created or exacerbated by the pandemic, such as difficulty accessing transportation.

In July 2021, we published a TFR entitled *Flexibility in Evaluating ''Close Proximity of Time'' Due to COVID–19 Related Barriers to Healthcare* [18] (prior TFR), which recognized the changes in healthcare provision and consumption described above. In the prior TFR, we acknowledged that the response to the COVID–19 pandemic dramatically changed the provision of, and access to, healthcare services throughout the country, and we cited evidence showing that significant numbers of people had foregone or delayed care, or replaced in-person medical visits with telehealth visits.[19] Therefore, we concluded that individuals with musculoskeletal impairments who, before the pandemic, would have sought and received healthcare at a frequency consistent with the standards in our final rule, now might be unable or choose not to seek care for their condition in the same manner and frequency. Affected individuals whose impairments might have previously met the listings requirements may now fail to meet the ''close proximity of time'' standard because of the changes in the provision of healthcare resulting from COVID–19. We therefore extended the timeframe for an individual's record to demonstrate the necessary listing criteria throughout the pandemic period.

The prior TFR defined the ''pandemic period'' for the purposes of our regulations and provided that during the pandemic period, the phrase ''within a close proximity of time'' meant that *all* of the relevant criteria must appear in the medical record within a consecutive 12-month period.'' [20] The prior TFR defined the ''pandemic period'' as beginning on April 2, 2021 and ending 6 months after the Secretary of HHS determined that the COVID–19 national PHE no longer existed. We extended the ''pandemic period'' for 6 months after the end of the COVID–19 national PHE to allow time for healthcare access to normalize and return to pre-pandemic period levels as well as to account for potential backlogs in medical care that may continue to interfere with access to the relevant care and documentation needed to satisfy the listing criteria. We also indicated that we would study the application of the TFR on our programs.[21]

Public Comment on the Prior TFR

When we published the prior TFR in the **Federal Register**, we provided the public with a 60-day comment period, which ended on September 21, 2021. We specifically contemplated extending the prior TFR, and we invited comments on all aspects of the rule, including the definition of ''pandemic period'' and the expiration date. We received one comment from the National Organization of Social Security Claimants' Representatives (NOSSCR) [22] that encouraged us to make permanent the temporary 12-month standard. The commenter also recommended, if we chose not to make the 12-month standard permanent, that we extend the period covered by the prior TFR to one year after the end of the PHE. They argued that access to care issues exist regardless of the pandemic and that it would take longer than 6 months for healthcare delivery to normalize after the end of the PHE.

With this temporary rule, we are partially adopting this comment. Although we provided support for the consecutive 4-month period in our 2020

[16] Determination That A Public Health Emergency Exists by Alex M. Azar II, *Secretary of Health & Human Services* (Jan. 31. 2020) (*https://aspr.hhs.gov/legal/PHE/Pages/2019-nCoV.aspx*).

[17] Centers for Medicare & Medicaid Services (CMS) Recommendations: Re-opening Facilities to Provide Non-emergent Non-COVID–19 Healthcare (*https://www.cms.gov/files/document/covid-recommendations-reopening-facilities-provide-non-emergent-care.pdf*); see also Non-Emergent, Elective Medical Services, and Treatment Recommendations (*https://www.cms.gov/files/document/cms-non-emergent-elective-medical-recommendations.pdf*).

[18] 86 FR 38920 (2021).

[19] Id.

[20] 86 FR at 38925.

[21] 86 FR at 38924.

[22] See Comment from National Organization of Social Security Claimants' Representatives on Document SSA–2021–0010–0001, *https://www.regulations.gov/comment/SSA-2021-0010-0002.*

final rule, we agree with NOSSCR that some of the changes in healthcare caused by the COVID–19 pandemic may last longer than 6 months after the end of the PHE and that some changes may become permanent, including the increased use of telehealth, the nature of which limits documentation of clinical findings needed for certain listings. However, as discussed in the *Rationale for this Rule* section below, the healthcare data that was captured during the PHE has limitations both in data collection and in the ability to make ultimate conclusions about post-PHE healthcare delivery, particularly in light of policy changes affecting healthcare that will occur throughout calendar years 2023 and 2024.[23] Therefore, we are extending the flexibility provided in the prior TFR by extending the definition of ''pandemic period'' through May 11, 2025, so we can continue to review emerging evidence about post-PHE healthcare access and use. At the conclusion of that period, we expect to be able to determine whether we should extend the TFR again, make the flexibility in the TFR permanent, as the commenter recommended, propose a different standard for ''close proximity of time,'' or let the TFR expire, so that we would revert to the 4-month rule on ''close proximity of time'' in our 2020 final rule. The commenter also raised issues regarding general barriers to accessing care that disability benefit applicants may be disproportionally likely to experience. These comments are outside the scope of this very limited TFR, so we are not addressing them here. We will address these comments in a future venue. We also note that although the commenter provided significant discussion of the wait times for imaging, including citing research about these wait times, they appear to have mischaracterized the ''close proximity of time'' requirement for imaging. The listings specify at 1.00C7c and 101.00C7c that ''[w]hen the criterion is imaging, we mean that we could reasonably expect the findings on imaging to have been present at the date of impairment or date of onset.'' [24] Therefore, in listings that have an imaging criterion, we do not require the imaging to have been taken within a close proximity of time to the other required elements, as long as we can reasonably expect the findings on imaging to have been present within a close proximity of time to the other required elements.

Rationale for This Rule

We are extending the flexibility provided by the prior TFR through May 11, 2025 to allow for additional time to study changes in healthcare access and provision, and to account for the ongoing increased use of telehealth services following the COVID–19 PHE. We will evaluate these evolving practices and their effects to determine the appropriate ''close proximity of time'' standard to include in the musculoskeletal disorders listings going forward.

We published the prior TFR to provide a more flexible 12-month ''close proximity of time'' standard in the musculoskeletal disorders listings to account for changes in the provision of and access to healthcare during the COVID–19 PHE. Although the PHE has now ended,[25] the state of healthcare has not fully returned to pre-pandemic norms and the impact of ending the PHE and related flexibilities will not be fully understood for some time. For example, and as discussed in more detail below, studies and reports from multiple government agencies as well as professional medical associations document an ongoing prevalence of telehealth service methodologies at higher levels than seen pre-PHE. In addition, several PHE-related policy flexibilities aimed at increasing healthcare access through telehealth have been extended through 2023 or 2024. At the same time, Medicaid and the Children's Health Insurance Program's (CHIP) continuous coverage protections, which had required states to maintain ongoing eligibility for Medicaid and CHIP for individuals who were enrolled on or after March 18, 2020, ended on March 31, 2023, leaving states until May 31, 2024, to complete eligibility redeterminations,[26] potentially leading to an increase in uninsured individuals. These factors suggest that U.S. healthcare will be in a state of rapid change in the period immediately following the PHE, so we will need to study the changes in healthcare provision before defining the appropriate ''close proximity of time'' interval going forward.

As we discussed in the prior TFR, after the initial sharp drop in total healthcare capacity due to PHE-related closures and disruptions of care, policy flexibilities around telehealth provision and reimbursement allowed for the use of telehealth to increase substantially from pre-pandemic norms, partially offsetting the decline in in-person care, particularly for management of chronic conditions and for established patients.[27] Although telehealth visits can provide the information that clinicians need to care for patients, audio-only telehealth appointments do not provide clinical signs and findings, and video telehealth musculoskeletal examinations have inherent limitations, including in provocative testing (that is, testing that manipulates the areas where an individual has pain in order to reproduce the pain), discrete palpation (that is, a technique that uses targeted pressure to identify and quantify the abnormalities of the musculoskeletal system, such as warmth, swelling, pain, tenderness, and trigger points), strength or stability testing, and precise measurements, such as range of motion or reflexes.[28] Therefore, use of telehealth in place of in-person visits may make it more difficult for some

[23] *See, e.g.,* Neri, A. J., Whitfield, G. P., Umeakunne, E. T., Hall, J. E., DeFrances, C. J., Shah, A. B., Sandhu, P. K., Demeke, H. B., Board, A. R., Iqbal, N. J., Martinez, K., Harris, A. M., & Strona, F. V. (2022). Telehealth and Public Health Practice in the United States-Before, During, and After the COVID–19 Pandemic. *Journal of public health management and practice: JPHMP, 28*(6), 650–656. *https://doi.org/10.1097/PHH.0000000000001563.*

[24] 20 CFR part 404, subpart P, Appendix 1, 1.00C7c and 101.00C7c.

[25] Becarra, X. (2023, May 11). Statement on End of the COVID–19 Public Health Emergency. *Department of Health and Human Services. https://www.hhs.gov/about/news/2023/05/11/hhs-secretary-xavier-becerra-statement-on-end-of-the-covid-19-public-health-emergency.html.*

[26] Tsai, D. (2023, Jan 5). CMS Informational Bulletin: Key Dates Related to the Medicaid Continuous Enrollment Condition Provisions in the Consolidated Appropriations Act, 2023. *Centers for Medicare & Medicaid Services, U.S. Department of Health & Human Services. https://www.medicaid.gov/federal-policy-guidance/downloads/cib010523.pdf.*

[27] *See, e.g.,* Samson, L., Tarazi, W., Turrini, G., Sheingold, S. (2021, Dec.). Medicare Beneficiaries' Use of Telehealth Services in 2020—Trends by Beneficiary Characteristics and Location (Issue Brief No. HP–2021-27). *Office of the Assistant Secretary for Planning & Evaluation, U.S. Department of Health & Human Services. https://aspe.hhs.gov/sites/default/files/documents/a1d5d810fe3433e18b192be42dbf2351/medicare-telehealth-report.pdf* ; Centers for Medicare & Medicaid Services (2022, Dec.). Medicare Telehealth Trends Report. *Centers for Medicare & Medicaid Services, U.S. Department of Health & Human Services. https://data.cms.gov/sites/default/files/2022-12/a7c3a319-5ded-4baf-ad7c-9aa2a897263a/MedicareTelehealthTrendsSnapshot20221201.pdf;* Patel, S. Y., Mehrotra, A., Huskamp, H. A., Uscher-Pines, L., Ganguli, I., & Barnett, M. L. (2021). Trends in Outpatient Care Delivery and Telemedicine During the COVID–19 Pandemic in the US. *JAMA internal medicine, 181*(3), 388–391. *https://doi.org/10.1001/jamainternmed.2020.5928;* Cortez, C., Mansour, O., Qato, D. M., Stafford, R. S., & Alexander, G. C. (2021). Changes in Short-term, Long-term, and Preventive Care Delivery in US Office-Based and Telemedicine Visits During the COVID–19 Pandemic. *JAMA health forum, 2*(7), e211529. *https://doi.org/10.1001/jamahealthforum.2021.1529.*

[28] 86 FR 38920 (2021) (citing Tanaka et al. (2020). Telemedicine in the Era of COVID–19: The Virtual Orthopaedic Examination. *The Journal of bone and joint surgery. American volume, 102*(12), e57. *http://dx.doi.org/10.2106/JBJS.20.00609*).

claimants to provide the necessary findings in the medical record to satisfy some of the musculoskeletal disorders listing criteria within a consecutive 4-month period.

Trends suggest telehealth usage will continue into the foreseeable future. Since the prior TFR was published, the use of telehealth as a percentage of total use has remained stable, with total healthcare visits and in-person visits trending higher than in 2020, but with an increased use of telehealth compared to pre-PHE norms. For example, the Veterans' Health Administration's (VHA) update to Congress covering the period from August 2021 to March 2022 showed that total visits had surpassed pre-PHE 2019 visits during this period, but in-person visits remained below pre-PHE totals, with both video and audio telehealth visits showing steady use over the period. VHA concluded that the data marked ''positive progress for resumption of services with continued use of telehealth encounters.'' [29] Similarly, Medicare data showed telehealth use leveling off between 16 and 19 percent of eligible users in all quarters beginning in the second quarter of 2021 and through the second quarter of 2022, which is significantly higher than the 7 percent of eligible users who used telehealth services in the first quarter of 2020.[30] An HHS summary of national survey trends from the Census Bureau's April to October 2021 Household Pulse Survey found that 23.1 percent of respondents reported use of telehealth in the previous four weeks, with the data showing a leveling off around the 20 percent mark in July 2021.[31] The results of these studies suggest that the changes in healthcare delivery related to the PHE have continued, and we may not know the long-term effects of those changes before the prior TFR expires. Consequently, we are extending the expiration date of the TFR so we can continue to analyze evolving changes and new norms in healthcare delivery, including the use of telehealth, and devise the appropriate definition of ''close proximity of time'' for the musculoskeletal disorders listings. We will also continue to study other related factors such as those raised by the commenter.

Extending the TFR will further allow us to review and adapt to new clinical guidelines evolving in a post-PHE landscape. Although the research is still developing and most professional organizations have yet to update their clinical practice guidelines for a post-PHE ''new normal,'' the emerging research and data suggest that patients and providers generally appreciate the increased use of telehealth, and such increased use is expected to continue post-PHE. This increased use appears true for both audio-only and video telehealth modalities and includes specialties, such as orthopedic surgery and spine surgery, that previously used telehealth only sparingly. For example, an American Medical Association (AMA) survey of 2,232 physicians released in 2022 revealed that 85 percent of responding physicians continued to use telehealth, that nearly 70 percent of respondents reported their organization was motivated to continue using telehealth in their practice, that physicians felt telehealth increased timely access to care, and that physicians anticipated providing telehealth services for chronic disease management and ongoing medical management, care coordination, mental/behavioral health, and specialty care after the pandemic.[32]

Similarly, studies specific to the field of spine medicine generally found that practitioners and patients expected to continue using telehealth and that the majority of patients and providers only felt a need for in-person visits for the initial encounter and, if applicable, the pre-operative visit.[33] Studies of orthopedic medicine showed similar results, with a large study of orthopedic surgeons reporting that physician use of telehealth has increased significantly as a result of the COVID–19 pandemic (from 21 percent using telehealth prior to the pandemic to 85 percent using it during the pandemic), and the majority of surgeons were satisfied with its use in their practice and planned on incorporating telehealth in their practices beyond the pandemic, particularly for follow-up or postoperative patients.[34] In the realm of chronic pain, a Delphi consensus article about management of chronic pain concluded that telemedicine and remote monitoring improves management of chronic pain and that the remote management of chronic diseases can improve access to care, but that at least the first assessment should be performed in person.[35]

Some clinical practice organizations have provided recommendations or policy statements regarding the use of telehealth after the acute phase of the pandemic, suggesting an ongoing, but potentially more limited, role in healthcare provision for people with musculoskeletal disorders going forward. An international set of recommendations published in June 2022, and endorsed by the North American Spine Society, included a recommendation to expand telehealth for spine care in order to help patients with spinal diseases obtain timely advice toward alleviating pain and recognizing critical symptoms that need urgent care, and thus obtain treatment in a timely manner.[36] Additionally, the American College of Rheumatology (ACR) released a 2023 health policy statement in which it supported ongoing

[29] Veterans Health Administration (2022, Dec. 5). VHA COVID–19 Response Report, Annex C. *Veterans Health Administration, U.S. Department of Veterans Affairs. https://www.va.gov/HEALTH/docs/VHA-COVID-19-Response-2022-Annex-C.pdf.*

[30] Centers for Medicare & Medicaid Services (2022, Dec.). Medicare Telehealth Trends Report. *Centers for Medicare & Medicaid Services, U.S. Department of Health & Human Services. https://data.cms.gov/sites/default/files/2022-12/a7c3a319-5ded-4baf-ad7c-9aa2a897263a/MedicareTelehealthTrendsSnapshot20221201.pdf.*

[31] Karimi, M., Lee, E., Couture, S., Gonzales, A., Grigorescu, V., Smith, S., De Lew, N., and Sommers, B. (2022, Feb.). National Trends in Telehealth Use in 2021: Disparities in Utilization and Audio vs. Video Services. (Research Report No. HP–2022–04). *Office of the Assistant Secretary for Planning & Evaluation, U. S. Department of Health & Human Services. https://aspe.hhs.gov/sites/default/files/documents/4e1853c0b4885112b2994680a58af9ed/telehealth-hps-ib.pdf.*

[32] American Medical Association (2022). 2021 Telehealth Survey Report. *American Medical Association. https://www.ama-assn.org/system/files/telehealth-survey-report.pdf.*

[33] Mazarakis, N. K., Koutsarnakis, C., Komaitis, S., Drosos, E., & Demetriades, A. K. (2022). Reflections on the future of telemedicine and virtual spinal clinics in the post COVID–19 era. *Brain & spine, 2,* 100930. *https://doi.org/10.1016/j.bas.2022.100930;* Greven, A. C. M., McGinley, B. M., Guisse, N. F., McGee, L. J., Pirkle, S., Malcolm, J. G., Rodts, G. E., Refai, D., & Gary, M. F. (2021). Telemedicine in the Evaluation and Management of Neurosurgical Spine Patients: Questionnaire Assessment of 346 Consecutive Patients. *Spine, 46*(7), 472–477. *https://doi.org/10.1097/BRS.0000000000003821* ; Kolcun, J. P. G., Ryu, W. H. A., & Traynelis, V. C. (2020). Systematic review of telemedicine in spine surgery. *Journal of neurosurgery. Spine,* 1–10. Advance online publication. *https://doi.org/10.3171/2020.6.SPINE20863;* Satin, A. M., Shenoy, K., Sheha, E. D., Basques, B., Schroeder, G. D., Vaccaro, A. R., Lieberman, I. H., Guyer, R. D., & Derman, P. B. (2022). Spine Patient Satisfaction With Telemedicine During the COVID–19 Pandemic: A Cross-Sectional Study. *Global spine journal, 12*(5), 812–819. *https://doi.org/10.1177/2192568220965521.*

[34] Hurley, E. T., Haskel, J. D., Bloom, D. A., Gonzalez-Lomas, G., Jazrawi, L. M., Bosco, J. A., III, & Campbell, K. A. (2021). The Use and Acceptance of Telemedicine in Orthopedic Surgery During the COVID–19 Pandemic. *Telemedicine journal and e-health: the official journal of the American Telemedicine Association, 27*(6), 657–662. *https://doi.org/10.1089/tmj.2020.0255.*

[35] Cascella, M., Miceli, L., Cutugno, F., Di Lorenzo, G., Morabito, A., Oriente, A., Massazza, G., Magni, A., Marinangeli, F., Cuomo, A., & on behalf of the Delphi Panel (2021). A Delphi Consensus Approach for the Management of Chronic Pain during and after the COVID–19 Era. *International journal of environmental research and public health, 18*(24), 13372. *https://doi.org/10.3390/ijerph182413372.*

[36] Mazarakis, N. K., Koutsarnakis, C., Komaitis, S., Drosos, E., & Demetriades, A. K. (2022). Reflections on the future of telemedicine and virtual spinal clinics in the post COVID–19 era. *Brain & spine, 2,* 100930. *https://doi.org/10.1016/j.bas.2022.100930.*

expanded use of telehealth as a ''tool that can increase access and improve outcomes for patients with rheumatic diseases when used [with] face-to-face assessments.'' However, it cautioned that telehealth should not replace essential face-to-face assessments conducted at medically appropriate intervals.[37] The AMA also released a blueprint for digitally-enabled care, in which it recommended fully integrated in-person and virtual care models that based the type of care on clinical appropriateness and other factors, such as convenience and cost, and focused on health equity and centering the needs of patients and providers.[38]

The expected shift towards greater use of telehealth in medical practice after the PHE, compared to prior to the PHE, could mean that the evidence upon which we based the consecutive 4-month ''close proximity of time'' period may no longer accurately describe the standard frequency of in-person healthcare visits. In fact, some of the sources cited in the 2020 final rule and prior TFR have provided new guidance that removed specific revisit intervals. For example, in both rules, we noted that our use of the consecutive 4-month proximity of time requirement was also consistent with the standard recognized by the VHA and Department of Defense (DoD), as set out in their clinical practice guidelines.[39] We noted that the VHA and DoD's Clinical Practice Guideline for the Management of Medically Unexplained Symptoms: Chronic Pain and Fatigue directed initial revisits at 2 to 3 week intervals, with visits every 3 to 4 months once the patient is doing well.[40] However, a 2021 updated VHA and DoD Clinical Practice Guideline for Management of Chronic Multisymptom Illness (formerly known as Medically Unexplained Symptoms) does not provide suggested revisit intervals. Instead, it includes recommendations to ''[d]evelop personal health plan and timeline for follow-up and monitor progress toward personal goals'' and ''[m]aintain continuity and [a] caring relationship via in-person and/or virtual modalities,'' without specifying intervals.[41] Similarly, the previous version of the VHA's and DoD's Clinical Practice Guideline for Diagnosis and Treatment of Low Back Pain, which we also cited in our prior rulemaking, described the duration of time for intervention, based on a systematic review, as requiring a minimum follow-up for effectiveness of 12 weeks and recommended monthly reassessment after initiation of therapy if low back pain continued and no serious specific underlying cause of low back pain was found.[42] However, the updated 2022 version of this guideline allows for a more flexible, patient-centered approach and has replaced the specific interval language with recommendations to ''assess response as appropriate'' and ''reassess as appropriate.'' [43] We need the additional time provided by this TFR to assess whether and how these changes in clinical practice guidelines may affect the period we chose to use in our 2020 final rule.

In addition to the extension of telehealth flexibilities, other policy changes related to the end of the PHE may impact healthcare use and create a period of rapid changes in healthcare. Some national telehealth flexibilities have been extended until the end of calendar year 2023 (for example, payment parity for audio and video telehealth visits, which allows providers to be reimbursed for telehealth visits originated at the patient's home at the same rate and using the same ''place of service'' code as they would be if provided in-person).[44] Other flexibilities have been extended through December 31, 2024 (for example, Medicare coverage of audio-only and of video telehealth services no matter where in the United States a patient lives, rather than covering telehealth services for beneficiaries living in rural areas only, and with the ability to access telehealth services from their home, rather than going to a health care facility).[45] Conversely, certain other flexibilities, such as flexibilities related to telehealth platforms and the continuous enrollment provision for Medicaid, began winding down at the end of the PHE.[46] Extra federal payments to hospitals during the PHE, including a 20 percent increase in the Medicare payment rate for inpatient treatment of patients diagnosed with COVID–19 and the ability to charge ''facility fees'' for telehealth services to patients who are not located at the hospital, were also phased out at the end of the PHE,[47] putting additional financial strain on the medical system.

In particular, the expected substantial rise in the uninsured population after the PHE-related Medicaid and CHIP continuous enrollment provision ends will exacerbate access to care challenges during this transitional time, making it more difficult to predict revisit intervals and use of healthcare, particularly for people facing barriers to healthcare.

An HHS issue brief published in 2022 projected that 17.4 percent of Medicaid and CHIP enrollees (approximately 15 million individuals) will leave the programs after the continuous enrollment provisions end based on historical patterns of coverage loss, including 7.9 percent (6.8 million) of Medicaid enrollees losing Medicaid coverage despite still being eligible (sometimes referred to as ''administrative churning''). HHS predicted there would be a disproportionate impact on historically underserved populations, although they noted they were taking steps to reduce that outcome.[48] Information from the

[37] American College of Rheumatology (2023). 2023 ACR Health Policy Statements. *American College of Rheumatology. https://assets.contentstack.io/v3/assets/bltee37abb6b278ab2c/bltd84782969d741aba/acr-health-policy-statements.pdf.*

[38] American Medical Association (2022). AMA Future of Health Closing the Digital Health Disconnect: A Blueprint for Optimizing Digitally Enabled Care. *American Medical Association. https://www.ama-assn.org/system/files/ama-future-health-report.pdf.* (Accessed March 22, 2023).

[39] 85 FR at 78169 n.38 (2020) (citing Veterans Health Administration & Department of Defense. (2001). VHA/DoD Clinical Practice Guideline for the Management of Medically Unexplained Symptoms: Chronic Pain and Fatigue. *https://www.healthquality.va.gov/guidelines/MR/mus/mus_fulltext.pdf*). See also 86 FR at 38922 (2021).

[40] Id.

[41] Veterans Health Administration & Department of Defense (2021). VA/DoD Clinical Practice Guideline for the Management of Chronic Multisystem Illness, Version 3.0–2021. *https://www.healthquality.va.gov/guidelines/MR/cmi/VADoDCMICPG508.pdf.*

[42] 85 FR at 78169–70 (citing Veterans Health Administration & Department of Defense. (2017). VA/DoD Clinical Practice Guideline for Diagnosis and Treatment of Low Back Pain. *https://www.healthquality.va.gov/guidelines/Pain/lbp/VADoDLBPCPG092917.pdf.*)

[43] Veterans Health Administration & Department of Defense (2022, Feb.). *VA/DoD Clinical Practice Guideline for Diagnosis and Treatment of Low Back Pain (Version 3.0–2022). https://www.healthquality.va.gov/guidelines/Pain/lbp/VADoDLBPCPGFinal508.pdf.*

[44] 87 FR 69404 at 69466.

[45] U.S. Department of Health & Human Services (2023, Feb. 9). Fact Sheet: COVID–19 Public Health Emergency Transition Roadmap. *https://www.hhs.gov/about/news/2023/02/09/fact-sheet-covid-19-public-health-emergency-transition-roadmap.html.*

[46] U.S. Department of Health & Human Services (2023, May 9). Fact Sheet: End of the COVID–19 Public Health Emergency *https://www.hhs.gov/about/news/2023/05/09/fact-sheet-end-of-the-covid-19-public-health-emergency.html.*

[47] Centers for Medicare & Medicaid Services (2023, May 5). Frequently Asked Questions: CMS Waivers, Flexibilities, and the End of the COVID–19 Public Health Emergency. *Centers for Medicare & Medicaid Services, U.S. Department of Health & Human Services. https://www.cms.gov/files/document/frequently-asked-questions-cms-waivers-flexibilities-and-end-covid-19-public-health-emergency.pdf; See also* American Hospital Association (2023, Feb. 7). Special Bulletin: Public Health Emergency to End May 11. *American Hospital Association. https://www.aha.org/system/files/media/file/2023/02/Special-Bulletin-Public-Health-Emergency-to-End-May-11.pdf.*

[48] Office of the Assistant Secretary for Planning & Evaluation (2022, August 19). Unwinding the

Continued

Centers for Disease Control and Prevention (CDC) already shows an uptick in the uninsured population beginning in late 2022, with the uninsured population increasing to 12.6 percent of adults in the United States in the third quarter of 2022 from a low of 11.8 percent in the first quarter of 2022.[49] Initial data on the end of Medicaid's continuous enrollment provision from 20 states provided by the Kaiser Family Foundation demonstrated that over 1 million people had already been disenrolled from Medicaid, with many disenrolled for procedural reasons, as of June 12, 2023.[50] Data analyzed by the Kaiser Family Foundation found that the uninsured population was the only population that had delayed or foregone care due to cost more than due to the pandemic, suggesting that gaps in access to care will remain high for a growing uninsured population even as pandemic-related concerns are expected to decrease.[51] Additionally, a Gallup poll released in January 2023 noted that a record high 38 percent of Americans reported putting off medical treatment due to cost, up 12 percentage points from 2021, and that lower-income adults, younger adults, and women were more likely than their counterparts to say they or a family member have delayed care for a serious medical condition.[52]

Initial evidence also suggests that the ongoing impacts of the COVID–19 PHE and the increased use of telehealth may also affect certain populations differently. For example, the HHS' summary of national survey trends from the Census Bureau's April to October 2021 Household Pulse Survey found that the highest rates of telehealth visits were among those with Medicaid (29.3%) and Medicare (27.4%), Black individuals (26.8%), and those earning less than $25,000 (26.7%). The report found disparities in use of telehealth services, including the use of video versus audio modalities, along dimensions including race and ethnicity, age, education, income, and health insurance.[53] Similarly, an October 2022 report on telehealth use in Medicare from 2019 to 2021, issued by the Bipartisan Policy Center, found that, although the distribution of beneficiaries using telehealth by race and ethnicity was roughly proportionate to the distribution of the overall study population by race and ethnicity, there was variation in the telehealth visit rates for those who used telehealth across racial and ethnic groups. They noted that telehealth visit rates for American Indian/Alaska Native (AI/AN), Black/African American (AA), and Hispanic beneficiaries exceeded the overall telehealth rates, with AI/AN beneficiaries having the highest audio-only visit rates, and that non-Hispanic/White beneficiary telehealth visit rates were lower than the overall telehealth visit rates by 2 percent, on average, across the study period.[54] Further, a cross-sectional study of over a million veterans published in the Journal of the American Medical Association (JAMA) in January 2023 found that wait time disparities increased significantly from the pre–COVID–19 period (October 1, 2018 to March 10, 2020) to the COVID–19 period (March 11, 2020 to September 30, 2021) for Black and Hispanic veterans, and that disparities in mean wait times for orthopedic services were statistically significant both before and after the COVID–19 period.[55]

In sum, the emerging data suggests that an increased use of telehealth will likely replace some in-person visits for some people with musculoskeletal disorders even after the end of the PHE and that other policy and healthcare changes could impact access to care during the period immediately following the end of the PHE, possibly leading to extended revisit intervals between thorough examinations. However, evidence on expanded telehealth use and its expected long-term effect on healthcare quality and the use of in-person examinations is limited, partially by data challenges, although the research base is expected to grow during the period immediately following the end of the PHE. For example, a report published by CDC experts in 2022 stated that ''one of the central public health issues in the U.S. identified by CDC was the absence of telehealth identifiers in many datasets, including most of CDC's national surveillance datasets.'' The report authors stated that the CDC was working to improve access to data related to healthcare and telehealth.[56] To this end, Medicare provided for additional use of telehealth identifiers in its 2023 fee schedule, including identifiers for audio-only telehealth.[57]

There are also inherent limitations in relying on healthcare use data gathered during the PHE to determine post-PHE outcomes. For example, in an October 2022 report, the Bipartisan Policy Center concluded that studies of telehealth use during the PHE would not provide enough information to understand the impact of permanently expanded telehealth use on healthcare utilization, quality, equity, cost, and other factors due to confounding pandemic-related changes in healthcare needs, and they urged further study of telehealth during the period following the end of the PHE. The report recommended a two-year extension of telehealth flexibilities after the end of the PHE and indicated that researchers should evaluate the benefits of hybrid (in-person and virtual) care models for

Medicaid Continuous Enrollment Provision: Projected Enrollment Effects and Policy Approaches (Issue Brief HP–2022–20). *Office of the Assistant Secretary for Planning & Evaluation, U.S. Department of Health & Human Services.* Accessed on March 3, 2023 at: *https://aspe.hhs.gov/sites/default/files/documents/404a7572048090ec1259d216f3fd617e/aspe-end-mcaid-continuous-coverage_IB.pdf.*

[49] National Center for Health Statistics. Percentage of being uninsured at the time of interview for adults aged 18–64, United States, 2019 Q1, Jan-Mar—2022 Q3, Jul-Sep. National Health Interview Survey. Generated interactively: Mar 06 2023 from *https://wwwn.cdc.gov/NHISDataQueryTool/ER_Quarterly/index_quarterly.html.*

[50] Kaiser Family Foundation (2023, June 13). Medicaid Enrollment and Unwinding Tracker. *Kaiser Family Foundation. https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-and-unwinding-tracker/.*

[51] McGough, M., Krutika, A., & Cox, C., (2023, Jan. 24). How has healthcare utilization changed since the pandemic? *Peterson Center on Healthcare-Kaiser Family Foundation Health System Tracker. https://www.healthsystemtracker.org/chart-collection/how-has-healthcare-utilization-changed-since-the-pandemic/.*

[52] Brenan, Megan (2023, Jan. 17). Record High in U.S. Put Off Medical Care Due to Cost in 2022. *Gallup. https://news.gallup.com/poll/468053/record-high-put-off-medical-care-due-cost-2022.aspx.*

[53] Karimi, M., Lee, E., Couture, S., Gonzales, A., Grigorescu, V., Smith, S., De Lew, N., and Sommers, B. (2022, Feb.). National Trends in Telehealth Use in 2021: *Disparities in Utilization and Audio* vs. *Video Services.* (Research Report No. HP–2022–04). *Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. https://aspe.hhs.gov/sites/default/files/documents/4e1853c0b4885112b2994680a58af9ed/telehealth-hps-ib.pdf.*

[54] Bipartisan Policy Center, Ananya Health Solutions LLC, and L&M Policy Research (2022, Oct.). Medicare Telehealth Utilization and Spending Impacts 2019–2021. *Bipartisan Policy Center. https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2022/09/BPC-Medicare-Telehealth-Utilization-and-Spending-Impacts-2019-2021-October-2022.pdf.*

[55] Gurewich, D., Beilstein-Wedel, E., Shwartz, M., Davila, H., & Rosen, A.K. (2023). Disparities in Wait Times for Care Among US Veterans by Race and Ethnicity. *JAMA network open, 6*(1), e2252061. *https://doi.org/10.1001/jamanetworkopen.2022.52061.*

[56] Neri, A.J., Whitfield, G.P., Umeakunne, E.T., Hall, J.E., DeFrances, C.J., Shah, A.B., Sandhu, P.K., Demeke, H.B., Board, A.R., Iqbal, N.J., Martinez, K., Harris, A.M., & Strona, F.V. (2022). Telehealth and Public Health Practice in the United States—Before, During, and After the COVID–19 Pandemic. *Journal of public health management and practice: JPHMP, 28*(6), 650–656. *https://doi.org/10.1097/PHH.0000000000001563.*

[57] U.S. Government Accountability Office (2022, Sept. 26). Medicare Telehealth: Actions Needed to Strengthen Oversight and Help Providers Educate Patients on Privacy and Security Risks (GAO–22–104454). Accessed March 3, 2023 at: *https://www.gao.gov/products/gao-22-104454.*

primary and specialty care, including for which conditions and specialties it is most effective; further evaluate full telehealth flexibilities in the context of value-based payment models; and rigorously assess the quality of audio-only care.[58] Similarly, in September 2022, the Medicare Payment Advisory Commission (MedPAC), an independent congressional agency that advises Congress on Medicare payment policy, recommended using a one- to two-year period of extended flexibilities after the PHE to allow policymakers to gather more evidence about the impact of telehealth on access, quality, and cost, which could inform permanent changes to telehealth policies.[59] Along these lines, a 2021 Medicare telehealth report concluded that more research is needed on the impact of telehealth on health outcomes, stating that ''if telehealth flexibilities are temporarily extended post-pandemic . . . this would allow evaluations of whether telehealth use during non-pandemic times may increase overall healthcare utilization as suggested by some studies, or simply substitute for in-person services.'' [60] Recognizing the need for more data on telehealth use, Congress required HHS to report on Medicare telehealth use during the period immediately following the end of the PHE, with the interim report due in October 2024.[61]

Because healthcare provision has not returned to pre-pandemic norms and emerging evidence suggests that ongoing changes may lead to decreased use of in-person healthcare, we need to continue to evaluate the evidence upon which we based the consecutive 4-month ''close proximity of time'' period. We need to determine whether the evidence we relied on in adopting the 4-month standard continues to match the current status of healthcare, including the standard frequency of in-person healthcare visits. Consequently, we are extending the flexibility provided in the prior TFR until May 11, 2025.

Evidence To Review

We will use the extension period to study the actual changes in healthcare access and provision after the expiration of the PHE. We expect this additional period will allow us to consider whether a permanent change to the consecutive 12-month ''close proximity of time'' period, or to a different timeframe, would be appropriate to account for ongoing changes in healthcare access and delivery. During the extension period, we will also continue to review information about disparities in access to care or modalities of care for people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality and who have been affected by the changes in healthcare provision during the pandemic. This review is consistent with Executive Order 13985, entitled ''Advancing Racial Equity and Support for Underserved Communities Through the Federal Government,'' which directs agencies to recognize and work to redress inequities in their policies and programs that serve as barriers to equal opportunity.[62]

We will also continue to study the application of the ''close proximity of time'' rule in our programs after the expiration of the PHE. We expect that continued review of case trends over time can help inform our understanding of how the end of the PHE may affect claimants' ability to provide the required evidence within a 4-month or 12-month period for the applicable musculoskeletal disorders. We will also continue to monitor the quality of our determinations and decisions to inform our policy decision and ensure the appropriate adjudication of claims for people with musculoskeletal disorders.

Solicitation for Public Comment

Although we are publishing a temporary final rule, we invite public comment on all aspects of the rule, including:

- The appropriate standard for ''close proximity of time'' to account for barriers to access to care or changes in healthcare delivery;
- Information about barriers to access to care, changes in healthcare delivery, and disproportionate burdens faced by any subset of the population; and
- The expiration date of this rule.

Please share any supporting information that you might have. We will consider any substantive comments we receive within 60 days of the publication of this TFR.

Summary of the Changes

This rule revises sections 1.00C7a and 101.00C7a of the musculoskeletal disorders listings to redefine the term ''pandemic period'' to mean ''the period beginning on April 2, 2021, and ending on May 11, 2025.''

Justification for Foregoing Notice and Comment Rulemaking

We follow the Administrative Procedure Act's (APA) rulemaking procedures specified in 5 U.S.C. 553 when we develop regulations. Generally, the APA requires that an agency provide prior notice and opportunity for public comment before issuing a final rule. However, the APA provides exceptions to its notice and public comment procedures when an agency finds there is good cause for dispensing with such procedures because they are impracticable, unnecessary, or contrary to the public interest (5 U.S.C. 553(b)(B)).

We find that there is good cause to issue this TFR without prior notice.[63] Because we have already been following the flexible 12-month ''close proximity of time'' standard, it would be impracticable and contrary to the public interest to delay implementing this TFR. Delayed implementation of this TFR would require us to delay adjudicating affected claims, potentially resulting in delayed benefits to vulnerable individuals.[64] Otherwise (if we did not delay adjudications), we would need to apply the 4-month ''close proximity of time'' standard, which does not consider changes in healthcare access and delivery related to the PHE, as discussed in the preamble. Thus, individuals might be unable to show that they meet a listing under the 4-month ''close proximity of time'' standard merely due to changes in how the healthcare system works. To give individuals the benefit of the flexible standard that has already been in place

[58] Bipartisan Policy Center & Ananya Health Solutions LLC (2022, Oct.). The Future of Telehealth After COVID–19. *Bipartisan Policy Center. https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2022/09/BPC-The-Future-of-Telehealth-After-COVID-19-October-2022.pdf.*

[59] The Medicare Payment Advisory Commission (2022, Sept. 29). *MedPAC Mandatory report: Study on the Expansion of Telehealth. https://www.medpac.gov/wp-content/uploads/2021/10/Telehealth-MedPAC-29-Sept-2022.pdf.*

[60] Samson, L., Tarazi, W., Turrini, G., Sheingold, S. (2021, Dec.). Medicare Beneficiaries' Use of Telehealth Services in 2020—Trends by Beneficiary Characteristics and Location (Issue Brief No. HP–2021–27). *Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. https://aspe.hhs.gov/sites/default/files/documents/a1d5d810fe3433e18b192be42dbf2351/medicare-telehealth-report.pdf.*

[61] The Consolidated Appropriations Act, 2023, Public Law 117–328.

[62] 86 FR 7009 (2021).

[63] In our prior TFR, we provided notice that we would consider extending the expiration date of the rule, and we invited public comments on the expiration date. 86 FR at 38920, 38924. As discussed above, we received a public comment from NOSSCR that encouraged us to make the temporary 12-month standard permanent or, if we chose not to make the 12-month standard permanent, to extend the period covered by the prior TFR to one year after the end of the PHE.

[64] Individuals who are eligible for disability benefits are, by definition, not able to engage in substantial gainful activity, which means they may experience immediate and severe financial hardship.

for over two years, we would delay adjudicating affected claims until the effective date of this TFR.

Delay in implementing this TFR would be impracticable and contrary to the public interest because it may cause some applicants to experience immediate and severe financial hardship, placing them at risk of losing their homes, means of transportation, access to health care, and other important resources, in addition to experiencing increased stress as they await the outcome of their case and their award of benefits. This is particularly true for the population that is eligible for Supplemental Security Income (SSI), which has, by definition, severely limited income and financial resources.[65] An unnecessary delay would cause significant harm and detract substantially from the effectiveness of the disability program in providing meaningful economic relief for disabled individuals. Even if affected claimants received the same benefits at a later date, these individuals may suffer from long term or permanent consequences of the lost income during the period of delay.

For good cause shown, to avoid delaying benefits to vulnerable individuals while providing appropriate flexibility to account for COVID–19-related healthcare changes, we are dispensing with prior notice and public comment on this rule pursuant to 5 U.S.C. 553(b)(B).

Regulatory Procedures

Clarity of This Rule

Executive Order 12866, as supplemented by Executive Orders 13563 and 14094, requires each agency to write all rules in plain language. In addition to your substantive comments on this rule, we invite your comments on how to make the rule easier to understand.

For example:

- Would more, but shorter, sections be better?
- Are the requirements in the rule clearly stated?
- Have we organized the material to suit your needs?
- Could we improve clarity by adding tables, lists, or diagrams?
- What else could we do to make the rule easier to understand?
- Does the rule contain technical language or jargon that is not clear?
- Would a different format make the rule easier to understand, *e.g.,* grouping and order of sections, use of headings, paragraphing?

[65] 42 U.S.C. 1382(a); 20 CFR 416.202.

Executive Order 12866, as Supplemented by Executive Orders 13563 and 14094

We consulted with the Office of Management and Budget (OMB) and determined that this rule is a non-significant regulatory action under Executive Order 12866, as supplemented by Executive Orders 13563 and 14094.

Anticipated Transfers to Our Program

Our Office of the Chief Actuary estimates that implementation of this temporary final rule would result in negligible changes (*i.e.,* less than $500,000) in scheduled Old-Age, Survivors, and Disability Insurance benefits and Federal SSI payments.

Anticipated Administrative Cost-Savings to the Social Security Administration

The Office of Budget, Finance, and Management expects the extension provided by the TFR will have a minimal administrative effect on the agency.

Anticipated Time-Savings and Qualitative Benefits

We anticipate the following qualitative benefits generated from this policy:

- Provide a more flexible and appropriate 12-month ''close proximity of time'' standard in the musculoskeletal disorders listings to account for healthcare changes that have occurred since the beginning of the COVID–19 PHE.
- Potentially allow for faster disability determinations and decisions by preventing adjudication delays for additional medical development, which would also have quantitative financial effects.

Anticipated Costs

We do not believe there are any more than de minimis costs to the public associated with this rule. The requirements in this rule will not impose new additional costs outside of the normal course of business for applicants or change how the public interacts with our disability programs.

Executive Order 13132 (Federalism)

We analyzed this temporary final rule in accordance with the principles and criteria established by Executive Order 13132 and determined that the rule will not have sufficient Federalism implications to warrant the preparation of a Federalism assessment. We also determined that this rule will not preempt any State law or State regulation or affect the States' abilities to discharge traditional State governmental functions.

Regulatory Flexibility Act

We certify that this temporary final rule will not have a significant economic impact on a substantial number of small entities because it affects individuals only. Therefore, a regulatory flexibility analysis is not required under the Regulatory Flexibility Act, as amended.

Paperwork Reduction Act

These rules do not create any new or affect any existing collections and, therefore, do not require Office of Management and Budget approval under the Paperwork Reduction Act.

(Catalog of Federal Domestic Assistance Program Nos. 96.001, Social Security–Disability Insurance; 96.002, Social Security–Retirement Insurance; 96.004, Social Security–Survivors Insurance; and 96.006, Supplemental Security Income)

List of Subjects in 20 CFR Part 404

Administrative practice and procedure; Blind, Disability benefits; Old-age, survivors, and disability insurance; Reporting and recordkeeping requirements; Social Security.

The Acting Commissioner of Social Security, Kilolo Kijakazi, Ph.D., M.S.W., having reviewed and approved this document, is delegating the authority to electronically sign this document to Faye I. Lipsky, who is the primary Federal Register Liaison for the Social Security Administration, for purposes of publication in the **Federal Register**.

Faye I. Lipsky,

Federal Register Liaison,Office of Legislation and Congressional Affairs, Social Security Administration.

For the reasons stated in the preamble, we are amending part 404 of chapter III of title 20 of the Code of Federal Regulations as set forth below:

PART 404—FEDERAL OLD-AGE, SURVIVORS AND DISABILITY INSURANCE (1950—)

Subpart P—Determining Disability and Blindness

■ 1. The authority citation for subpart P of part 404 is revised to read as follows:

Authority: 42 U.S.C. 402, 405(a)–(b) and (d)–(h), 416(i), 421(a) and (h)–(j), 422(c), 423, 425, and 902(a)(5)); sec. 211(b), Pub. L. 104–193, 110 Stat. 2105, 2189; sec. 202, Pub. L. 108–203, 118 Stat. 509 (42 U.S.C. 902 note).

■ 2. In appendix 1 to subpart P of part 404:

■ a. In part A, amend section 1.00C7 by revising paragraph a; and

■ b. In part B, amend section 101.00C7 by revising paragraph a.

The revisions read as follows:

Appendix 1 to Subpart P of Part 404—Listing of Impairments

* * * * *

Part A

* * * * *

1.00 Musculoskeletal Disorders

* * * * *

C. * * *

7. * * *

a. The term *pandemic period* as used in 1.00C7c means the period beginning on April 2, 2021, and ending on May 11, 2025.

* * * * *

Part B

* * * * *

101.00 Musculoskeletal Disorders

* * * * *

C. * * *

7. * * *

a. The term *pandemic period* as used in 101.00C7c means the period beginning on April 2, 2021, and ending on May 11, 2025.

* * * * *

[FR Doc. 2023–21671 Filed 9–28–23; 8:45 am]

BILLING CODE 4191–02–P

DEPARTMENT OF THE TREASURY

Office of Foreign Assets Control

31 CFR Part 587

Publication of Russian Harmful Foreign Activities Sanctions Regulations Web General Licenses 55A and 72

AGENCY: Office of Foreign Assets Control, Treasury.

ACTION: Publication of web general licenses.

SUMMARY: The Department of the Treasury's Office of Foreign Assets Control (OFAC) is publishing two general licenses (GLs) issued pursuant to the Russian Harmful Foreign Activities Sanctions Regulations: GLs 55A and 72, each of which was previously made available on OFAC's website.

DATES: GLs 55A and 72 were issued on September 14, 2023. See **SUPPLEMENTARY INFORMATION** for additional relevant dates.

FOR FURTHER INFORMATION CONTACT: OFAC: Assistant Director for Licensing, 202–622–2480; Assistant Director for Regulatory Affairs, 202–622–4855; or Assistant Director for Compliance, 202–622–2490.

SUPPLEMENTARY INFORMATION:

Electronic Availability

This document and additional information concerning OFAC are available on OFAC's website: *https://ofac.treasury.gov.*

Background

On September 14, 2023, OFAC issued GLs 55A and 72 to authorize certain transactions otherwise prohibited by the Russian Harmful Foreign Activities Sanctions Regulations, 31 CFR part 587. GL 55A has an expiration date of June 28, 2024. GL 72 has an expiration date of December 13, 2023. Each GL was made available on OFAC's website (*https://ofac.treasury.gov*) at the time of publication. The text of these GLs is provided below.

OFFICE OF FOREIGN ASSETS CONTROL

Russian Harmful Foreign Activities Sanctions Regulations

31 CFR Part 587

GENERAL LICENSE NO. 55A

Authorizing Certain Services Related to Sakhalin-2

(a) Except as provided in paragraph (b) of this general license, all transactions prohibited by the determination of November 21, 2022 made pursuant to section 1(a)(ii) of Executive Order 14071 (''Prohibitions on Certain Services as They Relate to the Maritime Transport of Crude Oil of Russian Federation Origin'') related to the maritime transport of crude oil originating from the Sakhalin-2 project (''Sakhalin-2 byproduct'') are authorized through 12:01 a.m. eastern daylight time, June 28, 2024, provided that the Sakhalin-2 byproduct is solely for importation into Japan.

(b) This general license does not authorize any transactions otherwise prohibited by the Russian Harmful Foreign Activities Sanctions Regulations, 31 CFR part 587 (RuHSR), including transactions involving any person blocked pursuant to the RuHSR, unless separately authorized.

(c) Effective September 14, 2023, General License No. 55, dated November 22, 2022, is replaced and superseded in its entirety by this General License No. 55A.

Bradley T. Smith,

Director, Office of Foreign Assets Control.

Dated: September 14, 2023.

OFFICE OF FOREIGN ASSETS CONTROL

Russian Harmful Foreign Activities Sanctions Regulations

31 CFR Part 587

GENERAL LICENSE NO. 72

Authorizing the Wind Down of Transactions Involving Certain Entities Blocked on September 14, 2023

(a) Except as provided in paragraph (b) of this general license, all transactions prohibited by Executive Order (E.O.) 14024 that are ordinarily incident and necessary to the wind down of any transaction involving one or more of the following blocked persons (collectively, the ''Blocked Entities'') are authorized through 12:01 a.m. eastern standard time, December 13, 2023, provided that any payment to a Blocked Entity is made into a blocked account in accordance with the Russian Harmful Foreign Activities Sanctions Regulations, 31 CFR part 587 (RuHSR):

(1) Joint Stock Company Russian Copper Company;

(2) Joint Stock Company United Metallurgical Company;

(3) Transmashholding JSC;

(4) Joint Stock Company Avtovaz;

(5) Joint Stock Company Moscow Automotive Factory Moskvich;

(6) Limited Liability Company Machine Building Plant Tonar;

(7) Publichnoe Aktsionernoe Obschestvo Sollers;

(8) Arctic Transshipment Limited Liability Company; or

(9) Any entity in which one or more of the above persons own, directly or indirectly, individually or in the aggregate, a 50 percent or greater interest.

(b) This general license does not authorize:

(1) Any transactions prohibited by Directive 2 under E.O. 14024, *Prohibitions Related to Correspondent or Payable-Through Accounts and Processing of Transactions Involving Certain Foreign Financial Institutions;*

(2) Any transactions prohibited by Directive 4 under E.O. 14024, *Prohibitions Related to Transactions Involving the Central Bank of the Russian Federation, the National Wealth Fund of the Russian Federation, and the Ministry of Finance of the Russian Federation;* or

(3) Any transactions otherwise prohibited by the RuHSR, including transactions involving any person blocked pursuant to the RuHSR other than the Blocked Entities described in paragraph (a) of this general license, unless separately authorized.

Bradley T. Smith,

Director, Office of Foreign Assets Control.

Dated: September 14, 2023.

Bradley T. Smith,

Director, Office of Foreign Assets Control.

[FR Doc. 2023–21396 Filed 9–28–23; 8:45 am]

BILLING CODE 4810–AL–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 165

[Docket Number USCG–2023–0721]

RIN 1625–AA00

Safety Zone; Ohio River Mile Markers 79.5–80, Wellsburg, WV

AGENCY: Coast Guard, DHS.

ACTION: Temporary final rule.