Intimate partner and domestic violence includes physical violence, sexual violence, stalking and psychological aggression (including coercion), reproductive coercion, neglect, and the threat of violence, abuse, or both. Intervention services include, but are not limited to, counseling, education, harm reduction strategies, and appropriate supportive services.''

(2) Breast Cancer Screening for Women at Average Risk

The final Guideline for Breast Cancer Screening for Women at Average Risk reads: ''The Women's Preventive Services Initiative recommends that women at average risk of breast cancer initiate mammography screening no earlier than age 40 years and no later than age 50 years. Screening mammography should occur at least biennially and as frequently as annually. Women may require additional imaging to complete the screening process or to address findings on the initial screening mammography. If additional imaging (*e.g.,* magnetic resonance imaging (MRI), ultrasound, mammography) and pathology evaluation are indicated, these services also are recommended to complete the screening process for malignancies. Screening should continue through at least age 74 years, and age alone should not be the basis for discontinuing screening.

Women at increased risk also should undergo periodic mammography screening, however, recommendations for additional services are beyond the scope of this recommendation.''

(3) Patient Navigation Services for Breast and Cervical Cancer Screening

The final Guideline for Patient Navigation Services for Breast and Cervical Cancer Screening reads: ''The Women's Preventive Services Initiative recommends patient navigation services for breast and cervical cancer screening and follow-up, as relevant, to increase utilization of screening recommendations based on an assessment of the patient's needs for navigation services. Patient navigation services involve person-to-person (*e.g.,* in-person, virtual, hybrid models) contact with the patient. Components of patient navigation services should be individualized. Services include, but are not limited to, person-centered assessment and planning, health care access and health system navigation, referrals to appropriate support services (*e.g.,* language translation, transportation, and social services), and patient education.''

Non-grandfathered group health plans and health insurance issuers offering group or individual health insurance coverage must cover without cost-sharing the services and screenings listed on the updated Women's Preventive Services Guidelines for plan years (in the individual market, policy years) that begin 1 year after this date. Thus, for most plans, this update will take effect for purposes of the Section 2713 coverage requirement in 2026. Additional information regarding the Women's Preventive Services Guidelines can be accessed at the following link: *https://www.hrsa.gov/womens-guidelines.*

Authority: Section 2713(a)(4) of the Public Health Service Act, 42 U.S.C. 300gg–13(a)(4).

Carole Johnson,

Administrator.

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BILLING CODE 4165–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Children's Hospitals Graduate Medical Education Payment Program: Updated Methodology To Determine Full-Time Equivalent Resident Count

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

ACTION: Request for public comment.

SUMMARY: This notice seeks public comment on updating the Children's Hospitals Graduate Medical Education (CHGME) Payment Program's method of determining an eligible children's hospital (as defined within the Public Health Service Act) weighted allopathic and osteopathic full-time equivalent (FTE) resident count when a children's hospital's weighted allopathic and osteopathic FTE resident count exceeds its direct graduate medical education (GME) FTE resident cap in order to be consistent with the methodology used by the Centers for Medicare & Medicaid Services (CMS) beginning in the fiscal year (FY) 2026 application cycle.

DATES: Comments on this notice should be received no later than January 29, 2025.

ADDRESSES: Written comments should be submitted to Robyn Duarte, Public Health Analyst, by email *RDuarte1@hrsa.gov*.

FOR FURTHER INFORMATION CONTACT: Robyn Duarte, Public Health Analyst, Bureau of Health Workforce, Division of Medicine and Dentistry, HRSA, 5600 Fishers Lane, Rockville, MD 20857, 301–443–3254.

SUPPLEMENTARY INFORMATION: The CHGME Payment Program is authorized by section 340E of the Public Health Service Act. For direct GME payments, section 340E(c)(1)(B) requires that the average number of FTE residents in the hospital's approved residency programs be determined according to section 1886(h)(4) of the Social Security Act. As noticed in the March 1, 2001, **Federal Register** (66 FR 12940), section 1886(h)(4) has been implemented by regulations at 42 CFR 413.78 through 413.83 (formerly 42 CFR 413.86(f)–(i)), which HRSA has used to determine the total and weighted numbers of FTE residents. In the CMS FY 2023 inpatient prospective payment systems (IPPS) and long-term care hospital prospective payment system (LTCH PPS) final rule published in the **Federal Register** on August 10, 2022 (87 FR 48780, 49065–49072) (referred to as the ''FY 2023 IPPS/LTCH PPS final rule''), CMS modified the Medicare direct GME payment methodology and amended section 413.79 by revising paragraphs (c)(2)(iii) and (d)(3). Through this notice, HRSA is seeking comment on its intent to adopt the same direct GME payment methodology as CMS when HRSA calculates FTE residents for the CHGME Payment Program beginning in the FY 2026 application cycle.

Background

To the extent feasible, HRSA has historically sought consistency with CMS regulations to minimize burden for children's teaching hospitals participating in the CHGME Payment Program that must also comply with CMS regulations. Consistency reduces the potential challenges in reporting FTE resident counts to Medicare and CHGME.

Currently, the CHGME Payment Program methodology for determining the weighted allopathic and osteopathic FTE resident count applies the direct GME FTE resident cap when a hospital's weighted allopathic and osteopathic FTE resident count is greater than its direct GME FTE resident cap. The current CHGME direct GME methodology reduces a hospital's weighted direct GME resident count by a proportion equal to the ratio of its GME FTE resident cap to its unweighted direct GME resident count. The direct GME FTE resident cap is applied to reduce the weighting factor of residents who are beyond their initial residency

period to an amount less than 0.5. See 66 FR 12940.

CMS GME Final Regulation Change

In August 2022, CMS finalized a new methodology for applying the direct GME FTE resident cap when a hospital's weighted allopathic and osteopathic FTE resident count is greater than its direct GME FTE resident cap, in a way that does not reduce the weighting factor of residents that are beyond their initial residency period to an amount less than 0.5. Under the new method, if a hospital's unweighted allopathic and osteopathic FTE resident count exceeds its direct GME FTE resident cap, then the weighted allopathic and osteopathic FTE resident count is equal to the hospital's direct GME FTE resident cap or its actual weighted allopathic and osteopathic FTE resident count, whichever is lesser. The direct GME FTE resident cap reflects the maximum number of allopathic and osteopathic residents that a hospital may count for purposes of direct GME payment in a cost reporting period.

Alignment of CHGME and Medicare GME Policy

For more than two decades, HRSA has followed CMS's approach to calculating the FTE resident count. [See March 1, 2001, **Federal Register** *Notice* (66 FRN 12940), ''*The Department follows Medicare rules regarding the use of the initial residency period. The Medicare rules reduce counts for all hospitals that train residents beyond their initial residency period (i.e., fellows) with regard to the [direct medical education] DME and [indirect Medical Education] IME portions of the GME reimbursement.*''] Therefore, HRSA proposes to adopt CMS's modified direct GME payment methodology with respect to determining the weighted number of allopathic and osteopathic FTE residents (*i.e.,* fellows) for all eligible children's hospitals participating in the CHGME Payment Program beginning in FY 2026.

In this notice, we refer to the FTE adjusted cap (or 2013 CHGME Reauthorization cap pursuant to Pub. L. 113–98) reported on Line 4.06, 5.06, and 6.06 of the HRSA 99–1 Form as the ''direct GME FTE resident cap'' to correspond with CMS terminology.

HRSA proposes to modify its methodology to adopt the CMS methodology described in the amended 42 CFR 413.79 in whole. HRSA anticipates implementing the updated methodology for determining the weighted allopathic and osteopathic FTE resident count starting in the FY 2026 application cycle (project period October 1, 2025, through September 30, 2026).

Direct GME Methodology in FY 2026—Proposal for Public Comment

Starting in FY 2026, where a CHGME participating hospital's unweighted allopathic and osteopathic FTE resident count exceeds the hospital's FTE resident cap, and the weighted allopathic and osteopathic FTE resident count also exceeds that FTE resident cap, the respective weighted allopathic and osteopathic FTE resident count is adjusted to make the total weighted allopathic and osteopathic FTE resident count equal the FTE resident cap. If the weighted allopathic and osteopathic FTE resident count does not exceed that FTE resident cap, then the allowable weighted allopathic and osteopathic FTE resident count for direct GME payment is the actual weighted allopathic and osteopathic FTE resident count.

This proposed update to the methodology for determining the weighted allopathic and osteopathic FTE resident count for the CHGME Program is intended to reconcile weighted FTE resident counts reported in Lines 4.13 (both Hospital Data columns), 5.13, and 6.13 of the HRSA Form 99–1 with Lines 9 and 22 of the CMS Form 2552–10, Worksheet E–4, respectively. Entries in Lines 4.13 (both Hospital Data columns), 5.13, and 6.13 report the weighted resident FTE count for allopathic and osteopathic programs following application of the direct GME FTE resident cap.

This updated methodology for determining weighted allopathic and osteopathic FTE resident count may result in adjustments to the weighted FTE resident 3-year rolling average used to determine direct medical education (DME) payment amounts for the eligible children's hospitals participating in the CHGME Payment Program.

The DME payment amounts for CHGME are impacted by many factors including the number of residents the hospital trained during the year, the hospital's wage index, as well as the overall appropriation. The updated methodology for determining the weighted FTE resident count will impact awardees that add more residents and fellows above their hospital's direct GME FTE resident cap. The updated methodology may also impact the DME payments for awardees overall as a hospital may receive a different relative share of the CHGME appropriation due to these shifts in the weighted FTE resident counts experienced by some hospitals.

The CHGME Payment Program proposes to implement this updated methodology beginning in FY 2026 to reduce burden on hospitals participating in CHGME and Medicare GME and to reduce the risk of potential audit discrepancies that may impact payments.

Diana Espinosa,

Principal Deputy Administrator.

[FR Doc. 2024–31240 Filed 12–27–24; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Final Scientific Integrity Policy of the U.S. Department of Health and Human Services

AGENCY: Office of the Assistant Secretary for Planning and Evaluation, Office of the Secretary, HHS.

ACTION: Notice of final policy.

SUMMARY: The Department of Health and Human Services (HHS) is publishing its Scientific Integrity Policy to increase access to and raise awareness of the Policy.

DATES: The effective date of the Policy is October 16, 2024.

FOR FURTHER INFORMATION CONTACT: Karen Wehner, Ph.D., Scientific Integrity Officer, Office of Science and Data Policy, Office of the Assistant Secretary for Planning and Evaluation, Office of the Secretary, HHS at 240–453–8435 or *scientificintegrity@hhs.gov.*

SUPPLEMENTARY INFORMATION: Scientific integrity plays a vital role in the mission of HHS. Ensuring integrity in science throughout the Department allows HHS to foster and produce high-quality science, communicate effectively with the public, and base critical policy decisions on trustworthy and rigorous scientific findings. HHS has adopted a Department-wide scientific integrity policy to further strengthen scientific integrity and evidence-based policymaking throughout the Department.

The Scientific Integrity Policy of the U.S. Department of Health and Human Services (Policy) was approved on September 16, 2024. The finalized Policy was announced to the HHS community and posted on the HHS scientific integrity website, at *https://www.hhs.gov/programs/research/scientificintegrity/index.html,* on September 30, 2024. The effective date of the Policy is October 16, 2024.

The content of the finalized Policy, reformatted to conform to the requirements of the **Federal Register**, is