ability to investigate and respond appropriately to complaints against accredited facilities.

++ TJC's processes and procedures for monitoring a hospital found out of compliance with TJC's program requirements. These monitoring procedures are used only when TJC identifies noncompliance. If noncompliance is identified through validation reviews or complaint surveys, the SA monitors corrections as specified at § 488.9.

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

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

++ The adequacy of TJC's staff and other resources, and its financial viability.

++ TJC's capacity to adequately fund required surveys.

++ TJC's policies with respect to whether surveys are announced or unannounced, to assure that surveys are unannounced.

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

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

IV. Collection of Information Requirements

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

V. Response to Public Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

The Acting Administrator of the Centers for Medicare & Medicaid Services (CMS), Stephanie Carlton, having reviewed and approved this document, authorizes Vanessa Garcia, who is the Federal Register Liaison, to electronically sign this document for purposes of publication in the **Federal Register**.

Vanessa Garcia,

Federal Register Liaison, Centers for Medicare & Medicaid Services.

[FR Doc. 2025–02436 Filed 2–10–25; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1838–PN]

Medicare Program; Announcement of Request for an Exception From the Prohibition on Expansion of Facility Capacity Under the Hospital Ownership and Rural Provider Exceptions to the Physician Self-Referral Prohibition

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

ACTION: Notice with request for comment.

SUMMARY: The Social Security Act prohibits a hospital with physician ownership that relies on the exception to the physician self-referral law for hospitals outside of Puerto Rico or for rural providers from expanding its facility capacity unless the Secretary of the Department of Health and Human Services grants the hospital's request for an exception from that prohibition after considering input on the request from individuals and entities in the community where the hospital is located. The Centers for Medicare & Medicaid Services has received a request from a hospital with physician ownership for an exception from the prohibition on expansion of facility capacity. This notice solicits comments on the request from individuals and entities in the community in which the hospital is located. Community input may inform our decision to approve or deny the hospital's request for an exception from the prohibition on expansion of facility capacity.

DATES: To be assured consideration, comments must be received at one of the addresses provided below by April 14, 2025.

ADDRESSES: In commenting, refer to file code CMS–1838–PN.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this notice to *https://www.regulations.gov.* Follow the ''Submit a comment'' instructions.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1838–PN, P.O. Box 8010, Baltimore, MD 21244–1850.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1838–PN, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: *POH-ExceptionRequests@cms.hhs.gov.* Joi Hosley, (410) 786–2194.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following website as soon as possible after they have been received: *https://www.regulations.gov.* Follow the search instructions on that website to view public comments. CMS will not post on *https://www.regulations.gov* public comments that make threats to individuals or institutions or suggest that the commenter will take actions to harm an individual. CMS encourages commenters not to submit duplicative comments. We will post acceptable comments from multiple unique commenters even if the content is identical or nearly identical to other comments.

I. Background

Section 1877 of the Social Security Act (the Act), also known as the physician self-referral law: (1) prohibits a physician from making referrals for certain designated health services payable by Medicare to an entity with which he or she (or an immediate family member) has a financial relationship

unless the requirements of an applicable exception are satisfied; and (2) prohibits the entity from filing claims with Medicare (or billing another individual, entity, or third party payer) for any improperly referred designated health services. A financial relationship may be an ownership or investment interest in the entity or a compensation arrangement with the entity. The statute establishes a number of specific exceptions and grants the Secretary of the Department of Health and Human Services (the Secretary) the authority to create regulatory exceptions for financial relationships that do not pose a risk of program or patient abuse.

Section 1877(d) of the Act sets forth exceptions related to ownership or investment interests held by a physician (or an immediate family member of a physician) in an entity that furnishes designated health services. Section 1877(d)(2) of the Act provides an exception for ownership or investment interests in rural providers (the ''rural provider exception''). To satisfy the requirements of the rural provider exception, the designated health services must be furnished in a rural area (as defined in section 1886(d)(2) of the Act) and substantially all of the designated health services furnished by the entity must be furnished to individuals residing in a rural area, and, in the case where the entity is a hospital, the hospital must meet the requirements of section 1877(i)(1) of the Act no later than September 23, 2011. Section 1877(d)(3) of the Act provides an exception for ownership or investment interests in a hospital located outside of Puerto Rico (the ''whole hospital exception''). To satisfy the requirements of the whole hospital exception, the referring physician must be authorized to perform services at the hospital, the ownership or investment interest must be in the hospital itself (and not merely in a subdivision of the hospital), and the hospital must meet the requirements of section 1877(i)(1) of the Act no later than September 23, 2011.

II. Prohibition on Expansion of Facility Capacity

Section 6001(a)(3) of the Patient Protection and Affordable Care Act (Affordable Care Act) (Pub. L. 111–148) amended section 1877 of the Act, by adding the requirements in section 1877(i) of the Act for a hospital to qualify for the rural provider and whole hospital exceptions, including that the hospital may not increase the number of operating rooms, procedure rooms, and beds beyond that for which the hospital was licensed on March 23, 2010 (or, in the case of a hospital that did not have a provider agreement in effect as of this date, but did have a provider agreement in effect on December 31, 2010, the effective date of such provider agreement) unless the Secretary grants an exception from the prohibition on facility expansion. We refer to this prohibition herein as the ''prohibition on facility expansion.'' Section 1877(i)(3)(A)(i) of the Act requires the Secretary to establish and implement a process under which a hospital that is an ''applicable hospital'' (as defined at section 1877(i)(3)(E) of the Act) or a ''high Medicaid facility'' (as defined at section 1877(i)(3)(F) of the Act) may apply for an exception from the prohibition on facility expansion. The process for requesting an exception from the prohibition on facility expansion is discussed in section III. below.

The criteria that a hospital must meet to be an applicable hospital are set forth at § 411.363(c). An applicable hospital: (1) is located in a county that has a percentage increase in the population that is at least 150 percent of the percentage increase in population of the State in which the hospital is located during the most recent 5-year period for which data are available as of the date that the hospital submits its request, as estimated by the Bureau of the Census; (2) has an annual percent of total inpatient admissions under Medicaid that is equal to or greater than the average percent with respect to such admissions for all hospitals (including the requesting hospital) that have Medicare participation agreements with CMS and are located in the county in which the hospital is located during the most recent 12-month period for which data are available as of the date that the hospital submits its request; (3) does not discriminate against beneficiaries of Federal health care programs and does not permit physicians practicing at the hospital to discriminate against such beneficiaries; (4) is located in a State in which the average bed capacity in the State is less than the national average bed capacity during the most recent fiscal year for which the Healthcare Cost Report Information System (HCRIS), as of the date that the hospital submits its request, contains data from a sufficient number of hospitals to determine a State's average bed capacity and the national average bed capacity; and (5) has an average bed occupancy rate that is greater than the average bed occupancy rate in the State in which the hospital is located during the most recent fiscal year for which HCRIS, as of the date that the hospital submits its request, contains data from a sufficient number of hospitals to determine the requesting hospital's average bed occupancy rate and the relevant State's average bed occupancy rate. The regulation at § 411.363(c)(2) and (c)(5)(i) specify acceptable data sources for determining whether a hospital meets the criteria for an applicable hospital.

The criteria that a hospital must meet to be a high Medicaid facility are set forth at § 411.363(d). A high Medicaid facility: (1) is not the sole hospital in the county in which the hospital is located; (2) with respect to each of the three most recent 12-month periods for which data are available as of the date the hospital submits its request, has an annual percent of total inpatient admissions under Medicaid that is estimated to be greater than such percent with respect to such admissions for each other hospital that has a Medicare participation agreement with CMS and is located in the county in which the hospital is located; and (3) does not discriminate against beneficiaries of Federal health care programs and does not permit physicians practicing at the hospital to discriminate against such beneficiaries. The regulation at § 411.363(d)(2) specifies the acceptable data source for determining whether a hospital meets the criteria for a high Medicaid facility.

III. Expansion Exception Process

The process for requesting an exception from the prohibition on facility expansion (also referred to as ''expansion exception request'' or ''request'' for purposes of this notice) is set forth at § 411.363 and addresses the procedure for submitting a request, community input, the timing of a complete request, the determination that a hospital is an applicable hospital or a high Medicaid facility, and CMS' decision to approve or deny a request. CMS takes a two-step approach to considering expansion exception requests. First, CMS will determine whether the requesting hospital meets the criteria for an applicable hospital or a high Medicaid facility using the information provided by the hospital in its expansion exception request and rebuttal statement, if any, and the community input, if any. Second, using data and information provided from these sources, as well as any other data and information that is relevant to its decision, CMS will decide whether to approve or deny the expansion exception request.

Individuals and entities in the hospital's community may provide input with respect to the hospital's request for an exception from the prohibition on facility expansion,

including, but not limited to, input regarding whether the hospital meets the criteria for an applicable hospital or a high Medicaid facility and the factors that CMS will consider in deciding whether to approve or deny the hospital's expansion exception request. Community input must be in the form of written comments, submitted according to the instructions in this **Federal Register** notice, and be received no later than 60 days after the publication date of this notice in the **Federal Register**. If CMS receives written comments from the community, the hospital will have 60 days after CMS notifies the hospital of the written comments to submit a rebuttal statement.

The hospital's community includes the geographic area served by the hospital (as defined at § 411.357(e)(2)) and all of the following:

- The county in which the hospital's main campus is located.
- The counties in which the hospital provides inpatient or outpatient hospital services as of the date the hospital submits the request.

The factors that CMS will consider in deciding whether to approve or deny a hospital's request for an exception from the prohibition on facility expansion are set forth at § 411.363(i)(2) and include, but are not limited to, the following:

- The specialty (for example, maternity, psychiatric, or substance use disorder care) of the hospital or the services furnished by or to be furnished by the hospital if CMS approves the request.
- Program integrity or quality of care concerns related to the hospital.
- Whether the hospital has a need for additional operating rooms, procedure rooms, or beds.
- Whether there is a need for additional operating rooms, procedure rooms, or beds in the county in which the main campus of the hospital is located or in any county in which the hospital provides inpatient or outpatient hospital services as of the date the hospital submits the request.

If CMS determines that the requesting hospital does not meet the criteria for an applicable hospital or a high Medicaid facility, CMS will publish in the **Federal Register** notice of such determination. If CMS determines that the hospital meets the criteria for an applicable hospital or a high Medicaid facility, CMS will publish in the **Federal Register** notice of such determination and its decision regarding the hospital's request for an exception from the prohibition on facility expansion.

IV. Hospital's Expansion Exception Request

As permitted by section 1877(i)(3) of the Act and our regulations at § 411.363, the following hospital with physician ownership has requested an exception from the prohibition on facility expansion:

Name of Facility: Mountain View Hospital.

Location: 2325 Coronado Street, Idaho Falls, Idaho 83404.

Basis for this Expansion Exception Request: High Medicaid Facility.

We seek comments on this request from individuals and entities in the community in which the hospital is located. We encourage parties that wish to have their input considered to address how they are part of the requesting hospital's community in their submissions. We also encourage interested parties review the hospital's request, which is posted on the CMS website at *https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Physician_Owned_Hospitals.html.* We especially welcome comments regarding whether the hospital meets the criteria for a high Medicaid facility and the factors that CMS will consider in deciding whether to approve or deny the hospital's request for an exception from the prohibition on facility expansion.

We suggest that parties review the **DATES** and **ADDRESSES** sections of this notice to ensure timely submission of their comments.

V. Collection of Information Requirements

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

VI. Response to Comments

We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble.

The Acting Administrator of the Centers for Medicare & Medicaid Services (CMS), Stephanie Carlton, having reviewed and approved this document, authorizes Vanessa Garcia, who is the Federal Register Liaison, to electronically sign this document for purposes of publication in the **Federal Register**.

Vanessa Garcia,

Federal Register Liaison, Centers for Medicare & Medicaid Services.

[FR Doc. 2025–02441 Filed 2–10–25; 8:45 am]

BILLING CODE 4120–01–P

INTERNATIONAL TRADE COMMISSION

[Investigation Nos. 701–TA–731 and 731–TA–1700 (Final)]

Low Speed Personal Transportation Vehicles (LSPTVs) From China; Scheduling of the Final Phase of Countervailing Duty and Antidumping Duty Investigations

AGENCY: United States International Trade Commission.

ACTION: Notice.

SUMMARY: The Commission hereby gives notice of the scheduling of the final phase of antidumping and countervailing duty investigation Nos. 701–TA–731 and 731–TA–1700 (Final) pursuant to the Tariff Act of 1930 (''the Act'') to determine whether an industry in the United States is materially injured or threatened with material injury, or the establishment of an industry in the United States is materially retarded, by reason of imports of low speed personal transportation vehicles (LSPTVs) from China, provided for in subheadings 8703.10.50, 8703.90.01, 8706.00.15, and 8707.10.00 of the Harmonized Tariff Schedule of the United States, preliminarily determined by the Department of Commerce (''Commerce'') to be subsidized and sold at less-than-fair-value.

DATES: January 30, 2025.

FOR FURTHER INFORMATION CONTACT: Nitin Joshi ((202) 708–1669), Office of Investigations, U.S. International Trade Commission, 500 E Street SW, Washington, DC 20436. Hearing-impaired persons can obtain information on this matter by contacting the Commission's TDD terminal on 202–205–1810. Persons with mobility impairments who will need special assistance in gaining access to the Commission should contact the Office of the Secretary at 202–205–2000. General information concerning the Commission may also be obtained by accessing its internet server (*https://www.usitc.gov*). The public record for these investigations may be viewed on the Commission's electronic docket (EDIS) at *https://edis.usitc.gov.*

SUPPLEMENTARY INFORMATION: