ACTION: Notice of special closed meeting.

SUMMARY: In accordance with section 1104(b) of title XI of the Financial Institutions Reform, Recovery, and Enforcement Act of 1989, as amended, notice is hereby given that the Appraisal Subcommittee (ASC) met for a Special Closed Meeting on these dates.

Location: Virtual meeting via Webex.

Date: August 31, 2023 and September 7, 2023.

Time: 11:00 a.m. ET.

Location: Virtual meeting via Webex.

Date: September 22, 2023.

Time: 2:01 p.m. ET.

Action and Discussion Item

Personnel Matter

The ASC convened a Special Closed Meeting to discuss a personnel matter. No action was taken by the ASC.

James R. Park,

Executive Director.

[FR Doc. 2023–22890 Filed 10–16–23; 8:45 am]

BILLING CODE 6700–01–P

FEDERAL RESERVE SYSTEM

Formations of, Acquisitions by, and Mergers of Bank Holding Companies

The companies listed in this notice have applied to the Board for approval, pursuant to the Bank Holding Company Act of 1956 (12 U.S.C. 1841 *et seq.*) (BHC Act), Regulation Y (12 CFR part 225), and all other applicable statutes and regulations to become a bank holding company and/or to acquire the assets or the ownership of, control of, or the power to vote shares of a bank or bank holding company and all of the banks and nonbanking companies owned by the bank holding company, including the companies listed below.

The public portions of the applications listed below, as well as other related filings required by the Board, if any, are available for immediate inspection at the Federal Reserve Bank(s) indicated below and at the offices of the Board of Governors. This information may also be obtained on an expedited basis, upon request, by contacting the appropriate Federal Reserve Bank and from the Board's Freedom of Information Office at *https://www.federalreserve.gov/foia/request.htm.* Interested persons may express their views in writing on the standards enumerated in the BHC Act (12 U.S.C. 1842(c)).

Comments regarding each of these applications must be received at the Reserve Bank indicated or the offices of the Board of Governors, Ann E. Misback, Secretary of the Board, 20th Street and Constitution Avenue NW, Washington, DC 20551–0001, not later than November 16, 2023.

A. Federal Reserve Bank of Boston (Prabal Chakrabarti, Senior Vice President) 600 Atlantic Avenue, Boston, Massachusetts 02210–2204. Comments can also be sent electronically to *BOS.SRC.Applications.Comments@bos.frb.org:*

1. *Eastern Bankshares, Inc., Boston, Massachusetts*; to acquire Cambridge Bancorp, and thereby indirectly acquire Cambridge Trust Company, both of Cambridge, Massachusetts.

Board of Governors of the Federal Reserve System.

Michele Taylor Fennell,

Deputy Associate Secretary of the Board.

[FR Doc. 2023–22889 Filed 10–16–23; 8:45 am]

BILLING CODE P

FEDERAL RETIREMENT THRIFT INVESTMENT BOARD

Notice of Board Meeting

DATES: October 24, 2023 at 9 a.m. PDT/12 p.m. EDT.

ADDRESSES: Telephonic. Dial-in (listen only) information: Number: 1–202–599–1426, Code: 716 481 115#; or via web: *https://teams.microsoft.com/l/meetup-join/19%3ameeting_M2VhNGNhZjYtODRjYy00NmY3LWI1NDktY2Q3YjI0YTFkYWEw%40thread.v2/0?context=%7b%22Tid%22%3a%223f6323b7-e3fd-4f35-b43d-1a7afae5910d%22%2c%22Oid%22%3a%2241d6f4d1-9772-4b51-a10d-cf72f842224a%22%7d.*

FOR FURTHER INFORMATION CONTACT: Kimberly Weaver, Director, Office of External Affairs, (202) 942–1640.

SUPPLEMENTARY INFORMATION:

Board Meeting Agenda

Open Session

1. Approval of the September 26, 2023, Board Meeting Minutes
2. Monthly Reports
   (a) Participant Report
   (b) Legislative Report
3. Quarterly Reports
   (c) Investment Review
   (d) Audit Status
   (e) Budget Review

Closed Session

4. Information covered under 5 U.S.C. 552b(c)(6) and (c)(10).

Authority: 5 U.S.C. 552b(e)(1).

Dated: October 11, 2023.

Dharmesh Vashee,

General Counsel, Federal Retirement Thrift Investment Board.

[FR Doc. 2023–22803 Filed 10–16–23; 8:45 am]

BILLING CODE P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–8083–N]

RIN 0938–AV11

Medicare Program; CY 2024 Inpatient Hospital Deductible and Hospital and Extended Care Services Coinsurance Amounts

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

ACTION: Notice.

SUMMARY: This notice announces the inpatient hospital deductible and the hospital and extended care services coinsurance amounts for services furnished in calendar year (CY) 2024 under Medicare's Hospital Insurance (Part A) program. The Medicare statute specifies the formulas used to determine these amounts. For CY 2024, the inpatient hospital deductible will be $1,632. The daily coinsurance amounts for CY 2024 will be as follows: $408 for the 61st through 90th day of hospitalization in a benefit period; $816 for lifetime reserve days; and $204 for the 21st through 100th day of extended care services in a skilled nursing facility in a benefit period.

DATES: The deductible and coinsurance amounts announced in this notice are effective on January 1, 2024.

FOR FURTHER INFORMATION CONTACT: Suzanne Codespote, (410) 786–7737.

SUPPLEMENTARY INFORMATION:

I. Background

Section 1813 of the Social Security Act (the Act) provides for an inpatient hospital deductible to be subtracted from the amount payable by Medicare for inpatient hospital services furnished to a beneficiary. It also provides for certain coinsurance amounts to be subtracted from the amounts payable by Medicare for inpatient hospital and extended care services. Section 1813(b)(2) of the Act requires the Secretary of the Department of Health and Human Services (the Secretary) to determine and publish each year the amount of the inpatient hospital deductible and the hospital and

extended care services coinsurance amounts applicable for services furnished in the following calendar year (CY).

II. Computing the Inpatient Hospital Deductible for CY 2024

Section 1813(b) of the Act prescribes the method for computing the amount of the inpatient hospital deductible. The inpatient hospital deductible is an amount equal to the inpatient hospital deductible for the preceding CY, adjusted by our best estimate of the payment-weighted average of the applicable percentage increases (as defined in section 1886(b)(3)(B) of the Act) used for updating the payment rates to hospitals for discharges in the fiscal year (FY) that begins on October 1 of the same preceding CY, and adjusted to reflect changes in real case-mix. The adjustment to reflect real case-mix is determined on the basis of the most recent case-mix data available. The amount determined under this formula is rounded to the nearest multiple of $4 (or, if midway between two multiples of $4, to the next higher multiple of $4).

Under section 1886(b)(3)(B)(i)(XX) of the Act, the percentage increase used to update the payment rates for FY 2024 for hospitals paid under the inpatient prospective payment system (IPPS) is the inpatient hospital operating market basket percentage increase, otherwise known as the IPPS market basket update, reduced by an adjustment based on changes in economy-wide productivity (the productivity adjustment) (see section 1886(b)(3)(B)(xi)(II) of the Act). Under section 1886(b)(3)(B)(viii) of the Act, for FY 2024, the applicable percentage increase for hospitals that do not submit quality data as specified by the Secretary is reduced by one quarter of the market basket update. We are estimating that after accounting for those hospitals receiving the lower market basket update in the payment-weighted average update, the calculated deductible will not be affected, since most hospitals submit quality data and receive the full market basket update. Section 1886(b)(3)(B)(ix) of the Act requires that any hospital that is not a meaningful electronic health record (EHR) user (as defined in section 1886(n)(3) of the Act) will have three-quarters of the market basket update reduced by 100 percent for FY 2017 and each subsequent FY. We are estimating that after accounting for these hospitals receiving the lower market basket update, the calculated deductible will not be affected, since most hospitals are meaningful EHR users and are expected to receive the full market basket update.

Under section 1886 of the Act, the percentage increase used to update the payment rates (or target amounts, as applicable) for FY 2024 for hospitals excluded from the inpatient prospective payment system is as follows:

- The percentage increase for long-term care hospitals is the LTCH market basket percentage increase reduced by the productivity adjustment (see section 1886(m)(3)(A) of the Act). In addition, these hospitals may also be impacted by the quality reporting adjustments and the site-neutral payment rates (see sections 1886(m)(5) and 1886(m)(6) of the Act).
- The percentage increase for inpatient rehabilitation facilities is the IRF market basket percentage increase reduced by the productivity adjustment in accordance with section 1886(j)(3)(C)(ii)(I) of the Act. In addition, these hospitals may also be impacted by the quality reporting adjustments (see section 1886(j)(7) of the Act).
- The percentage increase for inpatient psychiatric facilities is the IPF market basket percentage increase reduced by the productivity adjustment (see section 1886(s)(2)(A)(i) of the Act). In addition, these hospitals may also be impacted by the quality reporting adjustments (see section 1886(s)(4) of the Act).
- The percentage increase used to update the target amounts for other types of hospitals that are excluded from the inpatient prospective payment system and that are paid on a reasonable cost basis, subject to a rate-of-increase ceiling, is the IPPS operating market basket percentage increase, which is described at section 1886(b)(3)(B)(ii)(VIII) of the Act and 42 CFR 413.40(c)(3). These other types of hospitals include cancer hospitals, children's hospitals, extended neoplastic disease care hospitals, religious nonmedical health care institutions, and hospitals located outside the 50 states, the District of Columbia, and Puerto Rico.

The IPPS operating market basket percentage increase for FY 2024 is 3.3 percent and the productivity adjustment is 0.2 percentage point, as announced in the final rule that appeared in the **Federal Register** on August 28, 2023, entitled ''Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2024 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Rural Emergency Hospital and Physician-Owned Hospital Requirements; and Provider and Supplier Disclosure of Ownership; and Medicare Disproportionate Share Hospital (DSH) Payments: Counting Certain Days Associated With Section 1115 Demonstrations in the Medicaid Fraction'' (88 FR 59035). Therefore, the percentage increase for hospitals paid under the inpatient prospective payment system that submit quality data and are meaningful EHR users is 3.1 percent (that is, the FY 2024 market basket update of 3.3 percent less the productivity adjustment of 0.2 percentage point). The average payment percentage increase for hospitals excluded from the inpatient prospective payment system is 3.35 percent. This average includes long-term care hospitals, inpatient rehabilitation facilities, inpatient psychiatric facilities, and other hospitals excluded from the inpatient prospective payment system. Weighting these percentages in accordance with payment volume, our best estimate of the payment-weighted average of the increases in the payment rates for FY 2024 is 3.13 percent.

To develop the adjustment to reflect changes in real case-mix, we first calculated an average case-mix for each hospital that reflects the relative costliness of that hospital's mix of cases compared with those of other hospitals. We then computed the change in average case-mix for hospitals paid under the Medicare inpatient prospective payment system in FY 2023 compared with FY 2022. (We excluded from this calculation hospitals whose payments are not based on the inpatient prospective payment system because their payments are based on alternate prospective payment systems or reasonable costs.) We used Medicare bills from prospective payment hospitals that we received as of July 2023. These bills represent a total of about 6.0 million Medicare discharges for FY 2023 and provide the most recent case-mix data available at this time. Based on these bills, the change in average case-mix in FY 2023 is −1.0 percent. Based on these bills and past experience, we expect the overall FY 2023 case mix change to be −1.0 percent as the year progresses and more FY 2023 data become available.

Section 1813 of the Act requires that the inpatient hospital deductible be adjusted only by that portion of the case mix change that is determined to be real. Real case-mix is that portion of case-mix that is due to changes in the mix of cases in the hospital and not due to coding optimization. COVID–19 has complicated the determination of real case-mix changes. COVID–19 cases

typically have higher-weighted MS DRGs, which would cause a real increase in case-mix, while hospitals have experienced a reduction in the number of lower-weighted cases, which would also cause a real increase in case-mix. The lower number of COVID–19 cases in 2023 compared with the last several years would therefore mean a decrease in real case mix. Because of the uncertainty, we are assuming that all of the recently observed care is not due to coding optimization and that all of the −1.0 percent is real.

Thus, the estimate of the payment-weighted average of the applicable percentage increases used for updating the payment rates is 3.13 percent, and the real case-mix adjustment factor for the deductible is −1.0 percent. Accordingly, using the statutory formula as stated in section 1813(b) of the Act, we calculate the inpatient hospital deductible for services furnished in CY 2024 to be $1,632. This deductible amount is determined by multiplying $1,600 (the inpatient hospital deductible for CY 2023 (86 FR 64217)) by the payment-weighted average increase in the payment rates of 1.0313 multiplied by the decrease in real case-mix of 0.99, which equals $1,633.58 and is rounded to $1,632. (based on rounding to the nearest multiple of 4).

III. Computing the Inpatient Hospital and Extended Care Services Coinsurance Amounts for CY 2024

The coinsurance amounts provided for in section 1813 of the Act are defined as fixed percentages of the inpatient hospital deductible for services furnished in the same CY. The increase in the deductible generates increases in the coinsurance amounts. For inpatient hospital and extended care services furnished in CY 2024, in accordance with the fixed percentages defined in the law, the daily coinsurance for the 61st through 90th day of hospitalization in a benefit period will be $408 (one-fourth of the inpatient hospital deductible as stated in section 1813(a)(1)(A) of the Act); the daily coinsurance for lifetime reserve days will be $816 (one-half of the inpatient hospital deductible as stated in section 1813(a)(1)(B) of the Act); and the daily coinsurance for the 21st through 100th day of extended care services in a skilled nursing facility (SNF) in a benefit period will be $204 (one-eighth of the inpatient hospital deductible as stated in section 1813(a)(3) of the Act).

IV. Cost to Medicare Beneficiaries

Table 1 summarizes the deductible and coinsurance amounts for CYs 2023 and 2024, as well as the number of each that is estimated to be paid.

TABLE 1—MEDICARE PART A DEDUCTIBLE AND COINSURANCE AMOUNTS FOR CYS 2023 AND 2024

Type of cost sharing	Value		Number paid (in millions)	
	2023	2024	2023	2024
Inpatient hospital deductible	$1,600	$1,632	5.15	5.05
Daily coinsurance for 61st–90th day	400	408	1.29	1.26
Daily coinsurance for lifetime reserve days	800	816	0.64	0.63
SNF coinsurance	200	204	26.99	25.28

The estimated total decrease in costs to beneficiaries is about $240 million (rounded to the nearest $10 million) because of (1) the increase in the deductible and coinsurance amounts and (2) the decrease in the number of deductibles and daily coinsurance amounts paid. We determine the decrease in cost to beneficiaries by calculating the difference between the CY 2023 and CY 2024 deductible and coinsurance amounts multiplied by the estimated decrease in the number of deductible and coinsurance amounts paid.

V. Waiver of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment prior to a rule taking effect in accordance with section 1871 of the Act and section 553(b) of the Administrative Procedure Act (APA). Section 1871(a)(2) of the Act provides that no rule, requirement, or other statement of policy (other than a national coverage determination) that establishes or changes a substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits under Medicare shall take effect unless it is promulgated through notice and comment rulemaking. Unless there is a statutory exception, section 1871(b)(1) of the Act generally requires the Secretary to provide for notice of a proposed rule in the **Federal Register** and provide a period of not less than 60 days for public comment before establishing or changing a substantive legal standard regarding the matters enumerated by the statute. Similarly, under 5 U.S.C. 553(b) of the APA, the agency is required to publish a notice of proposed rulemaking in the **Federal Register** before a substantive rule takes effect. Section 553(d) of the APA and section 1871(e)(1)(B)(i) of the Act usually require a 30-day delay in effective date after issuance or publication of a rule, subject to exceptions. Sections 553(b)(B) and 553(d)(3) of the APA provide for exceptions from the advance notice and comment requirement and the delay in effective date requirements. Sections 1871(b)(2)(C) and 1871(e)(1)(B)(ii) of the Act also provide exceptions from the notice and 60-day comment period and the 30-day delay in effective date. Section 553(b)(B) of the APA and section 1871(b)(2)(C) of the Act expressly authorize an agency to dispense with notice and comment rulemaking for good cause if the agency makes a finding that notice and comment procedures are impracticable, unnecessary, or contrary to the public interest.

The annual inpatient hospital deductible and the hospital and extended care services coinsurance amounts announcement set forth in this notice does not establish or change a substantive legal standard regarding the matters enumerated by the statute or constitute a substantive rule, which would be subject to the notice requirements in section 553(b) of the APA. However, to the extent that an opportunity for public notice and comment could be construed as required for this notice, we find good cause to waive this requirement.

Section 1813(b)(2) of the Act requires publication of the inpatient hospital deductible and the hospital and extended care services coinsurance amounts between September 1 and September 15 of the year preceding the year to which they will apply. Further, the statute requires that the agency

determine and publish the inpatient hospital deductible and hospital and extended care services coinsurance amounts for each CY in accordance with the statutory formulas, and we are simply notifying the public of the changes to the deductible and coinsurance amounts for CY 2024. We have calculated the inpatient hospital deductible and hospital and extended care services coinsurance amounts as directed by the statute; the statute establishes both when the deductible and coinsurance amounts must be published and what information must be considered by the Secretary in establishing the deductible and coinsurance amounts, and therefore we do not have any discretion in that regard. We find notice and comment procedures to be unnecessary for this notice and we find good cause to waive such procedures under section 553(b)(B) of the APA and section 1871(b)(2)(C) of the Act, if such procedures may be construed to be required at all. Through this notice, we are simply notifying the public of the updates to the inpatient hospital deductible and the hospital and extended care services coinsurance amounts, in accordance with the statute, for CY 2024. As such, we note that even if notice and comment procedures were required for this notice, for the reasons stated above, we would find good cause to waive the delay in effective date of the notice, as additional delay would be contrary to the public interest under section 1871(e)(1)(B)(ii) of the Act. Publication of this notice is consistent with section 1813(b)(2) of the Act, and we believe that any potential delay in the effective date of the notice, if such delay were required at all, could cause unnecessary confusion both for the agency and Medicare beneficiaries.

VI. Collection of Information Requirements

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

VII. Regulatory Impact Analysis

Although this notice does not constitute a substantive rule, we nevertheless prepared this Regulatory Impact Analysis section in the interest of ensuring that the impacts of this notice are fully understood.

A. Statement of Need

This notice announces the Medicare Part A inpatient hospital deductible and associated coinsurance amounts for hospital and extended care services applicable for care provided in CY 2024, as required by section 1813 of the Act. It also responds to section 1813(b)(2) of the Act, which requires the Secretary to provide for publication of these amounts in the **Federal Register** between September 1 and September 15 of the year preceding the year to which they will apply. As this statutory provision prescribes a detailed methodology for calculating these amounts, we do not have the discretion to adopt an alternative approach on these issues.

B. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), Executive Order 14094 entitled ''Modernizing Regulatory Review'' (April 6, 2023), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999), and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). The Executive Order 14094 entitled ''Modernizing Regulatory Review'' (hereinafter, the Modernizing E.O.) amends section 3(f)(1) of Executive Order 12866 (Regulatory Planning and Review). The amended section 3(f) of Executive Order 12866 defines a ''significant regulatory action'' as an action that is likely to result in a rule (1) having an annual effect on the economy of $200 million or more in any 1 year (adjusted every 3 years by the Administrator of the Office of Information and Regulatory Affairs (OIRA) for changes in gross domestic product) or adversely affecting in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, territorial, or tribal governments or communities; (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising legal or policy issues, for which a centralized review would meaningfully further the President's priorities, or the principles set forth in this Executive order, as specifically authorized in a timely manner by the Administrator of OIRA in each case.

A regulatory impact analysis (RIA) must be prepared for major rules with significant regulatory action/s and/or significant effects as per section 3(f)(1) of Executive Order 12866 ($200 million or more in any 1 year). Based on our estimates OMB's Office of Information and Regulatory Affairs has determined that this rulemaking is significant per section 3(f)(1) as measured by the $200 million or more in any 1 year, and hence also a major rule under Subtitle E of the Small Business Regulatory Enforcement Fairness Act of 1996 (also known as the Congressional Review Act).

As stated in section IV of this notice, we estimate that the total decrease in costs to beneficiaries associated with this notice is about $240 million because of (1) the increase in the deductible and coinsurance amounts and (2) the decrease in the number of deductibles and daily coinsurance amounts paid.

C. Accounting Statement and Table

As required by OMB Circular A–4 (available at *https://www.whitehouse.gov/wp-content/uploads/legacy_drupal_files/omb/circulars/A4/a-4.pdf*), in Table 2, we have prepared an accounting statement showing the estimated total decrease in costs to beneficiaries of about $240 million, which is due to the increase in the deductible and coinsurance amounts and the decrease in the number of deductibles and daily coinsurance amounts paid. As stated in section IV of this notice, we determined the decrease in cost to beneficiaries by calculating the difference between the CY 2023 and CY 2024 deductible and coinsurance amounts multiplied by the estimated decrease in the number of deductible and coinsurance amounts paid.

TABLE 2—ESTIMATED TRANSFERS FOR CY 2024 DEDUCTIBLE AND COINSURANCE AMOUNTS

Category	Transfers
Annualized monetized transfers	−$240 million.
From Whom to Whom	Beneficiaries to Providers.

D. Regulatory Flexibility Act

The RFA requires agencies to analyze options for regulatory relief of small entities, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by being nonprofit organizations or by meeting the Small Business Administration's definition of a small business (having revenues of less than $9.0 million to $47 million in any 1 year). Individuals and states are not included in the definition of a small entity. This annual notice announces the Medicare Part A deductible and coinsurance amounts for CY 2024 and will have an impact on certain Medicare beneficiaries. As a result, we are not preparing an analysis for the RFA because the Secretary has certified that this notice will not have a significant economic impact on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare an RIA if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a metropolitan statistical area and has fewer than 100 beds. This annual notice announces the Medicare Part A deductible and coinsurance amounts for CY 2024 and will have an impact on certain Medicare beneficiaries. As a result, we are not preparing an analysis for section 1102(b) of the Act because the Secretary has certified that this notice will not have a significant impact on the operations of a substantial number of small rural hospitals.

E. Unfunded Mandates Reform Act

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2023, that threshold is approximately $177 million. This notice will not impose a mandate that will result in the expenditure by state, local, and Tribal Governments, in the aggregate, or by the private sector, of more than $177 million in any 1 year.

F. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on state and local governments, preempts state law, or otherwise has Federalism implications. This notice will not have a substantial direct effect on state or local governments, preempt state law, or otherwise have Federalism implications.

G. Congressional Review

This notice is subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 *et seq.*) and has been transmitted to the Congress and the Comptroller General for review.

Chiquita Brooks-LaSure, Administrator of the Centers for Medicare & Medicaid Services, approved this document on October 11, 2023.

Xavier Becerra,

Secretary, Department of Health and Human Services.

[FR Doc. 2023–22850 Filed 10–12–23; 4:15 pm]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–8085–N]

RIN 0938–AV13

Medicare Program; Medicare Part B Monthly Actuarial Rates, Premium Rates, and Annual Deductible Beginning January 1, 2024

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

ACTION: Notice.

SUMMARY: This notice announces the monthly actuarial rates for aged (age 65 and over) and disabled (under age 65) beneficiaries enrolled in Part B of the Medicare Supplementary Medical Insurance (SMI) program beginning January 1, 2024. In addition, this notice announces the monthly premium for aged and disabled beneficiaries, the deductible for 2024, and the income-related monthly adjustment amounts to be paid by beneficiaries with modified adjusted gross income above certain threshold amounts. The monthly actuarial rates for 2024 are $343.40 for aged enrollees and $427.20 for disabled enrollees. The standard monthly Part B premium rate for all enrollees for 2024 is $174.70, which is equal to 50 percent of the monthly actuarial rate for aged enrollees (or approximately 25 percent of the expected average total cost of Part B coverage for aged enrollees) plus the $3.00 repayment amount required under current law. (The 2024 premium is 5.9 percent or $9.80 higher than the 2023 standard premium rate of $164.90, which included the $3.00 repayment amount.) The Part B deductible for 2024 is $240.00 for all Part B beneficiaries. If a beneficiary has to pay an income-related monthly adjustment amount, that individual will have to pay a total monthly premium of about 35, 50, 65, 80, or 85 percent of the total cost of Part B coverage plus a repayment amount of $4.20, $6.00, $7.80, $9.60, or $10.20, respectively. Beginning in 2023, certain Medicare enrollees who are 36 months post kidney transplant, and therefore are no longer eligible for full Medicare coverage, can elect to continue Part B coverage of immunosuppressive drugs by paying a premium. For 2024, the immunosuppressive drug premium is $103.00.

DATES: The monthly actuarial rates are effective on January 1, 2024.

FOR FURTHER INFORMATION CONTACT: M. Kent Clemens, (410) 786–6391.

SUPPLEMENTARY INFORMATION:

I. Background

Part B is the voluntary portion of the Medicare program that pays all or part of the costs for physicians' services; outpatient hospital services; certain home health services; services furnished by rural health clinics, ambulatory surgical centers, and comprehensive outpatient rehabilitation facilities; and certain other medical and health services not covered by Medicare Part