



SOCIAL SECURITY ADMINISTRATION

20 CFR Parts 404 and 416

[Docket No. SSA-2021-0010]

RIN 0960-AI64

Flexibility in Evaluating "Close Proximity of Time" due to COVID 19-Related Barriers to Healthcare

AGENCY: Social Security Administration.

ACTION: Temporary final rule with request for comments.

SUMMARY: Since the outset of the COVID-19 national public health emergency, many individuals have experienced barriers that prevent them from timely accessing healthcare. In response to those barriers, we are issuing this rule to temporarily revise our requirement in the Listing of Impairments (listings) that, for purposes of applying several of our musculoskeletal disorder listings, all relevant medical criteria be present simultaneously or “within a close proximity of time,” which we define as being “within a consecutive 4-month period.” While this rule is in effect, we will find that the evidence of a musculoskeletal disorder is present “within a close proximity of time” if the available evidence establishes such a condition within a consecutive 12-month period. We expect that this temporary change to our rules will allow us to make findings of disability in appropriate cases in which individuals have experienced barriers to access to healthcare because of the COVID-19 national public health emergency.

DATES: *Effective date:* This temporary final rule is effective on [INSERT DATE OF PUBLICATION IN THE *FEDERAL REGISTER*]. For more information, *see* SUPPLEMENTARY INFORMATION.

Comment date: We invite written comments. Comments must be submitted on or before [INSERT DATE 60 DAYS AFTER DATE OF PUBLICATION IN THE *FEDERAL REGISTER*].

Expiration date: Unless we extend the expiration date by a final rule published in the *Federal Register*, this temporary final rule will cease to be effective 6 months after the effective date of a determination by the Secretary of Health and Human Services under section 319 of the Public Health Service Act, 42 U.S.C. 247d, that the COVID-19 national public health emergency no longer exists. We will publish a document in the *Federal Register* announcing the expiration date. For more information, see SUPPLEMENTARY INFORMATION.

ADDRESSES: You may submit comments by any one of three methods—Internet, fax, or mail. Do not submit the same comments multiple times or by more than one method. Regardless of which method you choose, please state that your comments refer to Docket No. SSA-2021-0010 so that we may associate your comments with the correct rule.

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

1. *Internet:* We strongly recommend that you submit your comments via the Internet. Please visit the Federal eRulemaking portal at <http://www.regulations.gov>. Use the search function to find docket number SSA-2021-0010. The system will issue a tracking number to confirm your submission. You will not be able to view your comment immediately because we must post each comment manually. It may take up to a week for your comments to be viewable.

2. *Fax:* Fax comments to (410) 966–2830.

3. *Mail:* Mail your comments to the Office of Regulations and Reports Clearance,

Social Security Administration, 3100 West High Rise Building, 6401 Security Boulevard, Baltimore, Maryland 21235–6401.

Comments are available for public viewing on the Federal eRulemaking portal at <http://www.regulations.gov> or in person, during regular business hours, by arranging with the contact person identified in FOR FURTHER INFORMATION CONTACT.

FOR FURTHER INFORMATION CONTACT: Edward Sosar, Office of Regulations and Reports Clearance, Social Security Administration, 6401 Security Boulevard, Baltimore, MD 21235-6401, (410) 966-2341. 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.socialsecurity.gov>.

SUPPLEMENTARY INFORMATION: The Secretary of Health and Human Services issued a determination under section 319 of the Public Health Service Act on January 31, 2020 that a national public health emergency exists as of January 27, 2020 because of the COVID-19 pandemic.¹ The Secretary has renewed his determination several times since then, most recently on July 19, 2021 (effective July 20, 2021).² We are issuing this temporary final rule to address the ongoing effects of the COVID-19 national public health emergency. The effective date of this temporary final rule will help us ensure that we provide affected claimants with the benefit of the flexibilities offered by this rule. On April 1, 2021, we instructed our adjudicators to temporarily hold claims in which all elements of musculoskeletal disorders 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, or 101.23 were present within a consecutive 12-month period, but not within a consecutive 4-month period, and it was not possible to process a fully favorable determination or decision in some other way. By holding claims that would benefit from the flexibilities in this rule, we will

¹ (<https://www.phe.gov/emergency/news/healthactions/phe/Pages/2019-nCoV.aspx>).

² <https://www.phe.gov/emergency/news/healthactions/phe/Pages/COVID-19July2021.aspx>

process claims affected by this rule on or after the effective date of this rule. As we explain in more detail below, we will continue to apply this rule until 6 months after effective date of a determination by the Secretary of Health and Human Services under section 319 of the Public Health Service Act that the national public health emergency related to the COVID-19 pandemic no longer exists.

Background

On December 3, 2020, we published the final rule, Revised Medical Criteria for Evaluating Musculoskeletal Disorders, which became effective on April 2, 2021, revising 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).³ The final rule, among other things, revised the listings in response to the decision in *Radford v. Colvin*, 734 F.3d 288 (4th Cir. 2013). The final rule required that, for the purposes of applying certain listings,⁴ all of the required medical criteria must be present simultaneously, or within a close proximity of time, to satisfy the level of severity needed to meet the listing.⁵ We 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).⁶ We also provided 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.”⁷

We established the consecutive 4-month period as a criterion to meet the level of severity in the listings based on our extensive research of relevant medical literature and clinical guidelines. In our notice of proposed rulemaking, we also specifically asked

³ 85 FR 78164 (2020).

⁴ 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, 101.20D, 101.22, and 101.23.

⁵ See 20 CFR appendix 1 to subpart P of part 404 1.00C7b and 101.00C7b.

⁶ *Id.*

⁷ *Id.*

interested members of the public to comment on this issue and provide us with any studies and data that supported their comments;⁸ however, no studies or data were submitted. In the final rule, we concluded that the consecutive 4-month period is consistent with instructions providers receive for scheduling patients,⁹ the general standard of care,¹⁰ and the frequency of healthcare visits by individuals with musculoskeletal conditions.¹¹ At the same time, the consecutive 4-month period in the rules provides some leeway for the claimant, because the standard for patient revisits is once every 3 months.¹² 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 provides a sufficient period to ensure the criteria are present within a close proximity of time and that the claimant's musculoskeletal disorder meets the requisite severity for the listing.

Our use of the consecutive 4-month proximity of time requirement is also consistent with the standard recognized by the Veterans Health Administration (VHA) and Department of Defense (DoD), as set out in their clinical practice guidelines.¹³ For example, the VHA and DoD's Clinical Practice Guideline for the Management of Medically Unexplained Symptoms: Chronic Pain and Fatigue directs initial revisits at 2

⁸ 83 FR 20646, 20647 (May 7, 2018).

⁹ 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.)

¹⁰ 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>.)

¹¹ 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/viic2/utilization-condition-group>.)

¹² 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](https://doi.org/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.)

¹³ 85 FR at 78169 n.38 (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.)

to 3 week intervals, with visits every 3 to 4 months once the patient is doing well.¹⁴

Similarly, the VHA's and DoD's Clinical Practice Guideline for Diagnosis and Treatment of Low Back Pain describes the duration of time for intervention, based on a systematic review, as requiring a minimum follow-up for effectiveness of 12 weeks and recommends monthly reassessment after initiation of therapy if low back pain continues and no serious specific underlying cause of low back pain is found.¹⁵

Rationale for this rule

As noted above, on January 31, 2020, the Secretary of Health and Human Services declared COVID-19 a national public health emergency. The COVID-19 national public health emergency has dramatically changed the provision of, and access to, healthcare services throughout the country. Individuals with musculoskeletal impairments who, before the national public health emergency, would seek and receive healthcare at a frequency consistent with the standards cited above, now might be unable or choose not to seek care in the same manner and frequency. This is due in part to healthcare organizations and government agencies such as the Centers for Medicare & Medicaid Services (CMS)¹⁶ prioritizing the most urgent services and encouraging patients to delay other procedures during the pandemic. For example, the North American Spine Society (NASS) provided guidance for delaying non-emergent procedures for people with chronic spinal conditions.¹⁷

¹⁴ Id.

¹⁵ 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>.)

¹⁶Centers 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) (<https://www.cms.gov/files/document/cms-non-emergent-elective-medical-recommendations.pdf>.)

¹⁷<https://www.spine.org/Portals/0/assets/downloads/Publications/NASSInsider/NASSGuidanceDocument040320.pdf>.

Likewise, many individuals have delayed or deferred important treatment due to closures of medical offices, fears of contracting COVID-19 infection (including having a high risk individual in the household), and other challenges created or exacerbated by the pandemic, such as difficulty accessing transportation. According to one source, among the general U.S. population reporting delayed care for serious problems during the pandemic, 69% cited nonfinancial access barriers, such as being unable to get an appointment, find a physician who would see them, or access the care location.¹⁸ Additionally, the National Center for Health Statistics estimated that 41% of U.S. adults had delayed or avoided medical care, including urgent or emergency care (12%) and routine care (32%) because of concerns about COVID-19.¹⁹

We are also temporarily changing the consecutive 4-month close proximity of time rule to a consecutive 12-month rule because the manner of care provided changed throughout the COVID-19 national public health emergency. To be responsive to this change in the manner of care, we instructed our adjudicators to temporarily hold claims that would benefit from the flexibilities in this rule, so we will process claims affected by this rule on or after the effective date of this rule. Due to safety concerns, many healthcare providers shifted to emphasizing or exclusively scheduling telehealth or virtual visits. The optimization of telehealth is consistent with the guidance issued by many specialist organizations, such as NASS,²⁰ the American College of Surgeons (ACS),²¹ the

¹⁸ Delayed Care with Harmful Health Consequences—Reported Experiences from National Surveys During Coronavirus Disease 2019 | Infectious Diseases | JAMA Health Forum | JAMA Network. *See also* The Impact of Coronavirus on Households Across America (https://cdn1.sph.harvard.edu/wp-content/uploads/sites/21/2020/09/NPR-RWJF-Harvard-National-Report_092220_Final1-4.pdf) and COVID-19: Experiences Among the Medicare Population (<https://www.cms.gov/files/document/medicare-current-beneficiary-survey-covid-19-data-snapshot.pdf>.)

¹⁹ Reduced Access to Care: Household Pulse Survey (National Center for Health Statistics) (<https://www.cdc.gov/nchs/covid19/pulse/reduced-access-to-care.htm>.)

²⁰ <https://www.spine.org/Portals/0/assets/downloads/Publications/NASSInsider/NASSGuidanceDocument040320.pdf>.

²¹ COVID-19 Guidelines for Triage of Orthopaedic Patients (<https://www.facs.org/covid-19/clinical-guidance/elective-case/orthopaedics>).

American Academy of Orthopedic Surgeons (AAOS),²² and the American College of Rheumatology (ACR).²³

Although many individuals access telehealth visits successfully, the clinical signs and findings required by some of the listings may not be present in the telehealth record due to the limitations of telemedicine. While testing by the patient is possible through telehealth, there are limits in provocative testing (that is, testing that manipulates the areas where you have 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), and strength or stability testing.²⁴ During the beginning of the COVID-19 pandemic, orthopedists created guidelines for virtual examinations of patients through telemedicine, and found that while the patient could perform many tests, there are inherent limitations to testing in this manner. For example, the authors recommend using another person to hold the camera during gait examination to get a better view of the patient's gait mechanics, which is not always possible.²⁵ Further, the VHA has found that although patients appreciate telehealth, many are unable to complete exams that require precise measurements, such as range of motion or reflexes.²⁶

Consequently, disability claimants with musculoskeletal disorders of the severity required by the listings who would have been able to provide evidence that their musculoskeletal disorder met the consecutive 4-month close proximity of time

²² Navigating the COVID-19 Pandemic (<https://www.aaos.org/globalassets/about/covid-19/aaos-clinical-considerations-during-covid-19.pdf>).

²³ COVID-19 Clinical Guidance for Adult Patients with Rheumatic Diseases (<https://www.rheumatology.org/Portals/0/Files/ACR-COVID-19-Clinical-Guidance-Summary-Patients-with-Rheumatic-Diseases.pdf>).

²⁴ Tanaka et al. (2020). Telemedicine in the Era of COVID-19: The Virtual Orthopaedic Examination. *The Journal of Bone and Joint Surgery, Incorporated*, 00:e1 (1-7) <http://dx.doi.org/10.2106/JBJS.20.00609>.

²⁵ Laskowski, et al. (2020). The Telemedicine Musculoskeletal Examination. *Mayo Clinic Proc.* 95(8) <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7395661/>

²⁶ Baus, Shanna, PA-C. Telehealth & Disability Items: Veterans Health Administration. Presentation to the Standing Committee of the National Academies of Science and Medicine Health and Medicine Division, on December 1, 2020.

requirement before the COVID-19 national public health emergency may now have more difficulty producing evidence to meet the standard. It is possible that, in light of the pandemic and the temporary changes in healthcare described above, claimants have scheduled fewer clinical visits or have been afforded fewer appointments that would allow them to provide the necessary evidence. Because such a claimant would lack the necessary documentation to meet the listing in the absence of this temporary change, we would not find the claimant disabled under the listings, although we could make a finding of disability at later steps of our sequential evaluation process in appropriate cases.

In recognition of the economic and social services crisis caused by the COVID-19 national public health emergency, the President published Executive Order 14002 *Economic Relief Related to the COVID-19 Pandemic*,²⁷ which directed Federal agencies to consider actions to improve access to and reduce unnecessary barriers to Federally-funded programs. We are issuing this rule in furtherance of the goals in the Executive Order.

This rule will remain in effect until 6 months after the effective date of a determination by the Secretary of Health and Human Services under section 319 of the Public Health Service Act, 42 U.S.C. 247d, that the national public health emergency resulting from the COVID-19 pandemic no longer exists, which will afford claimants the opportunity to attend scheduled appointments that may have been delayed during the national public health emergency, allow us time to adjudicate claims affected by the rule, and allow sufficient time to notify the adjudicative community of the change. We will continue to apply the consecutive 12-month period until 6 months after the Secretary of HHS determines that the COVID-19 national public health emergency no longer exists to allow time for health care access to normalize back to pre-pandemic period levels and to

²⁷ 86 FR 7229 (2021).

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. Additionally, the expiration date included in this temporary final rule will provide us with the time necessary to publish a document in the Federal Register to advise the public of the date on which this rule will no longer be effective, communicate the change to adjudicators and the public, update our materials that reference the consecutive 12-month period, and process claims where the medical care was received prior to the end of the COVID-19 national public health emergency.

Summary of the changes

This rule adds a new section 1.00C7a and 101.00C7a to the musculoskeletal disorders listings. The rule also redesignates current sections 1.00C7a and 1.00C7b as 1.00C7b and 1.00C7c, respectively, and 101.00C7a and 101.00C7b as 101.00C7b and 101.00C7c, respectively. New sections 1.00C7a and 101.00C7a define the term “pandemic period” to mean “the period beginning on April 2, 2021 and ending on the date that is 6 months after the effective date of a determination by the Secretary of Health and Human Services under section 319 of the Public Health Service Act, 42 U.S.C. 247d, that the national public health emergency resulting from the COVID-19 pandemic no longer exists.” Redesignated and revised sections 1.00C7c and 101.00C7c provide that, for purposes of 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, the phrase “within a close proximity of time” means that all of the relevant criteria must appear in the medical record within a consecutive 4-month period, except for claims determined or decided during the pandemic period. For claims that we determine or decide during the pandemic period, we provide that all of the relevant criteria must appear in the medical record within a consecutive 12-month period.

Regulatory Procedures

Justification for issuing a rule without notice and comment

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. 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 under 5 U.S.C. 553(b)(B) to issue this rule without prior public comment because prior public comment is impracticable and contrary to public interest.

We find that public comment is impracticable because the delay associated with the public comment process would impede our ability to provide this flexibility to claimants affected by the changed nature of healthcare. The delay associated with the public comment process would also affect our ability to operate efficiently and provide appropriate public service because it would require us to hold or readjudicate cases affected by this change, possibly delaying benefits to disabled individuals. People eligible for disability benefits are, by definition, not able to engage in substantial gainful activity.²⁸ Therefore, many applicants may experience immediate and severe financial hardship,²⁹ placing them at risk of losing their homes, means of transportation, access to

²⁸ 42 U.S.C. 223(d)(1) and 1614(a)(3)(A), 20 CFR 404.1505, 404.1572, 416.905, 416.972

²⁹ See Bailey, Michelle Stegman and Jeffrey Hemmeter. *Characteristics of Noninstitutionalized DI and SSI Program Participants, 2013 Update*, Research and Statistics Note No. 2015-02. Washington, DC: Office of Research, Evaluation, and Statistics, Office of Retirement and Disability Policy, Social Security Administration, September 2015, <https://www.ssa.gov/policy/docs/rsnotes/rsn2015-02.html>, which shows that 51 percent of DI beneficiaries and 63 percent of SSI beneficiaries have household incomes below the poverty level, excluding their DI and SSI payments. The study also found that DI payments represented an 85 percent reduction in the poverty gap and SSI payments represented a 68 percent reduction in the poverty gap for beneficiaries. See also [SSA] Social Security Administration, *National Beneficiary Survey: Disability Statistics, 2015*, SSA Publication No. 13-11826. Washington, DC: SSA. <https://www.ssa.gov/policy/docs/statcomps/nbs/2015/nbs-statistics-2015.pdf>, which shows that over 45 percent of disability beneficiaries have a household income lower than the poverty level. Additionally, *see*

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) benefits, which has, by definition, severely limited income and financial resources.³⁰ An unnecessary delay during this vulnerable period, particularly in the context of the economic and other hardships caused by the pandemic, would cause significant harm and detract substantially from the effectiveness of the disability program in providing meaningful economic relief for disabled individuals.³¹ Even if they receive 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.

We also find that delaying immediate implementation of this temporary final rule to obtain public comment would be contrary to the public interest because it would prolong the time it would take to adjudicate claims and provide benefits to claimants. This rule is intended to provide us with flexibility to determine that an individual's musculoskeletal disorder meets the requirements of the listings, considering the emerging evidence regarding changes in healthcare delivery that have resulted from the COVID-19 national public health emergency. It also provides for claimants to receive needed

Mathews v. Eldridge, 424 U.S. 319, 342 (1976) ("in view of... the typically modest resources of the family unit of the physically disabled worker, the hardship imposed upon the erroneously terminated disability recipient may be significant."); *White v. Mathews*, 559 F.2d 852 (2d Cir. 1977) ("The disability insurance program is designed to alleviate the immediate and often severe hardships that result from a wage-earner's disability. In that context, delays... detract seriously from the effectiveness of the program.").

³⁰ 42 U.S.C. 1611(a), 20 CFR 416.202

³¹ See Deshpande, Manasi, Tal Gross, and Yalun Su. 2021. "Disability and Distress: The Effect of Disability Programs on Financial Outcomes." *American Economic Journal: Applied Economics*, 13 (2): 151-78, <https://pubs.aeaweb.org/doi/pdfplus/10.1257/app.20190709>, which found that rates of bankruptcy, foreclosure, and eviction among disability applicants are higher than in the general population; rates of these adverse financial events increase leading up to the application date and peak around the application date; and rates of these adverse financial events decline for both allowed and denied applicants after the initial disability decision, but they decline more for the allowed. This suggests that delaying the disability decision can cause long-term or permanent financial harm at a time when applicants are most vulnerable. In fact, the researchers concluded that awarding disability benefits sooner could avert a substantial amount of financial distress among applicants. See also Gross, T., & Trenkamp, B. (2015). Risk of Bankruptcy among Applicants to Disability Insurance. *Journal of health care for the poor and underserved*, 26(4), 1149–1156. <https://doi.org/10.1353/hpu.2015.0118>, which found that SSDI benefits decrease the risk of bankruptcy to a statistically significant degree among all age groups.

benefits at a time when they are financially and medically vulnerable due to onset of disability and the COVID-19 pandemic, based on the evidence that is likely to be in their file during the pandemic. Providing the opportunity for public comment before we implement this rule would prevent us from acting within a meaningful timeframe to account for current access-to-care limitations that prevent claimants who may meet the listing from establishing requisite evidence to show it, because the pandemic-related barriers to access of care that this rule attempts to alleviate would continue to occur. Providing opportunity for prior public comment could also result in the rule taking effect only after the proposed expiration date, when access to care has returned to pre-pandemic norms, which would negate the need for the rule. Consequently, if we offered the opportunity for public comment prior to immediate temporary implementation, we would be unable to offer relief to affected claimants in a timely manner, and we would be required to delay our adjudications of certain disability claims impacted by this temporary final rule and be unable to pay needed benefits to affected individuals in a timely manner. The delay associated with a public comment period would also be contrary to the public interest because it would reduce the effectiveness of the rule and the more flexible timeframe we are establishing. Prior public comment would therefore defeat the purpose of this rule, which is to provide effective and timely relief and ensure economic security to individuals affected by the changed nature of healthcare delivery.

In addition, for the reasons cited above, we find good cause for dispensing with the 30-day delay in the date of this rule provided for in 5 U.S.C. 553(d)(3). So, we are making this temporary final rule effective upon publication.

We are making this temporary final rule effective on the date of publication. However, we invite public comment on all aspects of the temporary final rule as they may apply after the effective date, including: the definition of the “pandemic period” during which we will apply expanded flexibility in the “close proximity of time”

standard; the appropriate standard for “close proximity of time” to account for barriers to access to care; information about barriers to access to care 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 temporary final rule and will issue a revised final rule if necessary after we consider the public comments. We will also study the application of this temporary final rule in our program.

Executive Order 12866, as Supplemented by Executive Order 13563

We consulted with the Office of Management and Budget (OMB) and determined that this temporary final rule meets the criteria for a significant regulatory action under Executive Order 12866 and is subject to OMB review.

Executive Order 13132 (Federalism)

We analyzed this rule under 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 rule will not have a significant economic impact on a substantial number of small entities, because it affects only individuals. Therefore, a Regulatory Flexibility Act, as amended, does not require us to prepare a regulatory flexibility analysis.

Anticipated Costs to Our Programs:

Our Office of the Chief Actuary (OCACT) was not able to provide a specific cost estimate for this temporary final rule, as it does not have any reliable information on which to base program cost estimates. Additionally, this temporary final rule is to be in

effect until 6 months after the Secretary of Health and Human Services determines the COVID-19 national public health emergency no longer exists, and it is unknown how long it will be until such declaration is made.

Anticipated Administrative Costs to SSA:

Our Office of Budget, Finance, and Management notes the unknown magnitude on allowance rates and ambiguity in the effective time period for this temporary final rule, but expects this change will have a minimal administrative effect on the agency.

Paperwork Reduction Act

This rule does not create any new or affect any existing collections and, therefore, does 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

20 CFR Part 404

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

20 CFR Part 416

Administrative practice and procedure; Aged, Blind, Disability cash payments; Public assistance programs; Reporting and recordkeeping requirements; Supplemental Security Income (SSI).

The Acting Commissioner of Social Security, Kilolo Kijakazi, 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 subpart P of 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 continues to read as follows:

Authority: Secs. 202, 205(a)-(b) and (d)-(h), 216(i), 221(a) and (h)-(j), 222(c), 223, 225, and 702(a)(5) of the Social Security Act (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 redesignating paragraphs a. and b. as b. and c., by adding a new paragraph a., and by revising newly redesignated paragraph c.; and

b. In part B, amend section 101.00C7 by redesignating paragraphs a. and b. as b. and c., by adding a new paragraph a., and by revising newly redesignated paragraph c.

The additions and revisions read as follows:

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

* * * * *

Part A

* * * * *

1.00 Musculoskeletal Disorders.

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C. * * *

7. * * *

a. The term *pandemic period* as used in 1.00C7c means the period beginning on April 2, 2021, and ending on the date that is 6 months after the effective date of a determination by the Secretary of Health and Human Services under section 319 of the Public Health Service Act, 42 U.S.C. 247d, that the national public health emergency resulting from the COVID-19 pandemic no longer exists.

* * * * *

c. For 1.15, 1.16, 1.17, 1.18, 1.20C, 1.20D, 1.22, and 1.23, all of the required criteria must be present simultaneously, or within a close proximity of time, to satisfy the level of severity needed to meet the listing. The phrase “within a close proximity of time” means that *all* of the relevant criteria must appear in the medical record within a consecutive 4-month period, except for claims determined or decided during the *pandemic period*. For claims determined or decided during the *pandemic period*, all of the relevant criteria must appear in the medical record within a consecutive 12-month period. When 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. For listings that use the word “and” to link the elements of the required criteria, the medical record must establish the simultaneous presence, or presence within a close proximity of time, of all the required medical criteria. Once this level of severity is established, the medical record must also show that this level of severity has continued, or is expected to continue, for a continuous period of at least 12 months.

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Part B

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101.00 Musculoskeletal Disorders.

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C. * * *

7. * * *

a. The term *pandemic period* as used in 101.00C7c means the period beginning on April 2, 2021, and ending on the date that is 6 months after the effective date of a determination by the Secretary of Health and Human Services under section 319 of the Public Health Service Act, 42 U.S.C. 247d, that the national public health emergency resulting from the COVID-19 pandemic no longer exists.

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c. For 101.15, 101.16, 101.17, 101.18, 101.20C, 101.20D, 101.22, and 101.23, all of the required criteria must be present simultaneously, or within a close proximity of time, to satisfy the level of severity needed to meet the listing. The phrase “within a close proximity of time” means that *all* of the relevant criteria must appear in the medical record within a consecutive 4-month period, except for claims determined or decided during the *pandemic period*. For claims determined or decided during the *pandemic period*, all of the relevant criteria must appear in the medical record within a consecutive 12-month period. When 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. For listings that use the word “and” to link the elements of the required criteria, the medical record must establish the simultaneous presence, or presence within a close proximity of time, of all the required medical criteria. Once this level of severity is

established, the medical record must also show that this level of severity has continued, or is expected to continue, for a continuous period of at least 12 months.

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