Financial Assistance Policy *(updated October 2024)*

Purpose Statement:

Covenant Health is committed to providing measurable quality health services in a caring environment, which fulfill the needs of our patients, physicians, employers, employees, and community. It is the express philosophy of Covenant Health that no one should be denied necessary medical care because of the inability to pay. In conjunction with this philosophy, the financial assistance protocol and procedures will provide guidance to the hospital personnel in determining financial assistance.

Scope:

Entities covered under policy are:

Parkwest Medical Center	Fort Sanders Regional Medical Center
Fort Loudoun Medical Center	LeConte Medical Center
Methodist Medical Center	Morristown - Hamblen Healthcare System
Roane Medical Center	Peninsula (a Division of Parkwest)
Cumberland Medical Center	Claiborne Medical Center

Policy:

Covered Services

All emergency and other medically necessary care, including care provided in the facility by a substantially related entity, shall be eligible for financial assistance with the following exceptions:

1. The portion of services currently covered by other programs.
2. Those services which would be covered by insurance or governmental payers had the individual followed the requirements of the applicable policy.
3. Non-emergent emergency department services, services that are not medically necessary, elective inpatient services, elective outpatient services, and/or services not covered by third party insurers (e.g., solely cosmetic surgery, teeth extractions in an outpatient setting, etc.).

Eligibility for Assessment

Patients who are unable to pay and have exhausted all sources of payment assistance may be screened for potential financial assistance eligibility. In addition, patients who are deceased and verification of probate reveals that the estate contains no assets to cover their outstanding debt are eligible for financial assistance (see Covenant Health Patient Account Services Policy 3500.500 “Deceased/No Estate Verification Process). To be eligible for financial assistance consideration; the patient/guarantor must complete a financial disclosure using the Hospital Financial Assistance Application (**Attachment A**), except in cases where no survivors of a deceased patient can be located (see Procedure). The patient/guarantor first must meet income criteria as indicated within the financial assistance policy. If the patient/guarantor meets the income test for financial assistance consideration, then the patient/guarantor's financial disclosure will be screened to determine qualification for financial assistance based upon assets/holdings.

No eligible individual will be charged more for emergency or other medically necessary care than the amounts generally billed (AGB) to insured individuals. The AGB is calculated by using the “look-back” method. An annual calculation of each facility’s AGB using a 12month “look-back” method of all payers exclusive of Medicaid and Self Pay will be performed for determination of applicable adjustments to the AGB discount percentage. The AGB percentage applicable for each facility is disclosed in Covenant Health Patient Account Services Fair Charges Policy 3500.580, Table II. This policy is available free of charge by contacting the Knoxville Business Office Services, 1420 Centerpoint Blvd., Building C, Knoxville, TN, 37932, or by telephone at 865-374-3000.

Income Limitations

To qualify for financial assistance, the patient/guarantor must have anticipated future annual income, as calculated under this policy, at or below 300% of the current poverty income guidelines, as set forth by the United States Department of Health and Human Services. The poverty income guidelines are as follows:

2024 HHS (United States Department of Health & Human Services)

Persons in Family Unit	48 Contiguous States and D.C.	Alaska	Hawaii
1	$15,060.00	$18,810.00	$17,310.00
2	$20,440.00	$25,540.00	$23,500.00
3	$25,820.00	$32,270.00	$29,690.00
4	$31,200.00	$39,000.00	$35,880.00
5	$36,580.00	$45,730.00	$42,070.00
6	$41,960.00	$52,460.00	$48,260.00
7	$47,340.00	$59,190.00	$54,450.00
8	$52,720.00	$65,920.00	$60,640.00
For each add' l person, add	$5,380.00	$6,730.00	$6,190.00

Income shall include, but is not limited to, adjusted gross income plus non-taxable retirement income (i.e., Social Security), child support, unemployment compensation and "in-kind" payments (for example, use of property rent free). The value of food stamps will be excluded from "in-kind" payment consideration. In addition, 10% of the patient/guarantor's net assets, as determined by reducing the market value of assets less any outstanding debt, will be added to income for determination of total annual income (see Asset Limitations).

Asset Limitations

The guidelines for determining assets include, but are not limited to, primary dwelling (and attached land), automobiles, liquid assets, investments, farm land, business property, rental property, farm and/or business equipment including livestock and crops. All real property will be considered at fair market value. The values of both real and personal property will be reduced by any existing liabilities incurred by the applicant in obtaining the assets (net assets) with the exception of primary dwelling. The primary dwelling net asset will be the amount of equity above $100,000. Actual or potential third party liability to the patient, hospital or the guarantor by common law, contract, statute or otherwise shall be considered an asset and must be listed on the Hospital Financial Assistance application.

External Sources Used for Assessment

The following websites are used in the processing of the financial assistance application:

Kelley Blue Book – Used to find values of vehicles owned by the patient.
http://www.kbb.com/

Accurint – Used for skip tracing addresses (Return Mail) or Date of Death https://secure.accurint.com/app/bps/main

The following are examples of websites used to locate the correct value of the applicant's properties if they do not provide a copy of their tax assessment from the county they own property.

Knox County Property Search
http://tn-knox-assessor.publicaccessnow.com/PropertyLookup.aspx

State of Tennessee Property Search
http://www.assessment.cot.tn.gov/RE_Assessment/

Sevier County Property Search
http://www.seviercountytn.org/property-assessor.html

Roane County Property Search
https://roanecountytn.gov/officialsdepartments/assessor-of-property/

Catastrophic Exceptions

For catastrophic illness, exceptions to income and asset limitations may be made on a case-by-case basis. The amount considered for financial assistance will be based upon the facility's evaluation of the patient's and/or guarantor's ability to pay all or a percentage of gross charges, taking into consideration the patient's and/or guarantor's assets, liabilities, liquidity, and future earning capacity.

Procedure

Upon referral from Pre-Admission and/or Emergency Patient Registration, the patient will be assigned a Financial Counselor. The Financial Counselor shall initiate Credit Screening of the patient and/or guarantor and work with appropriate hospital and agency staff to ensure that all efforts of coverage have been exhausted before consideration of hospital financial assistance. If, as stipulated by the financial assistance policy, all payment sources have been exhausted and the patient/guarantor meets the income/asset limitations, the patient/guarantor may complete a Hospital Financial Assistance Application (see **Attachment A**) for all patient balances. **The patient/guarantor may also receive a Hospital Financial Assistance Application by:**

- Obtaining an application at any Covenant Health Facility registration area.
- Requesting to have an application mailed by calling 865-374-3000.
- Requesting an application by mail at Knoxville Business Office Services, 1420 Centerpoint Blvd. Building C, Knoxville, TN, 37932.
- Downloading an application through the Covenant Health website: www.covenanthealth.com.
- A list specifying which providers are covered by the facility's Financial Assistance policy (in addition to the facility and those delivering emergency and other medically necessary care in the facility) and which providers are not covered is available on the Financial Assistance page on each facility's website.

The patient may receive assistance with completing the application and submitting the required documentation by contacting Knoxville Business Office Services at 865-374-3000. This application must include verification of the applicant's disclosed income and assets, as listed in **Attachment B**.

Upon completion of the application process, it will be the responsibility of the Director of Patient Accounting or Collections Manager to review all applications with the Financial Counselor for the recommendation of granting financial assistance. For procedures pertaining to uninsured discounts, refer to Covenant Health Patient Account Services Fair Charges policy 3500.580. All eligible applicants authorized for financial assistance will be afforded a discount on a sliding scale based on income limitations as follows:

Annual Household Income

Family Size	Federal Poverty Guidelines	0-200% of Poverty Guidelines	201-300% of Poverty Guidelines
1	$15,060.00	$30,120.00	$45,180.00
2	$20,440.00	$40,880.00	$61,320.00
3	$25,820.00	$51,640.00	$77,460.00
4	$31,200.00	$62,400.00	$93,600.00
5	$36,580;00	$73,160.00	$109,740.00
6	$41,960.00	$83,920.00	$125,880.00
7	$47,340.00	$94,680.00	$142,020.00
8	$52,720.00	$105,440.00	$158,160.00
For each add' l person, add	$5,380.00	$10,760.00	$16,140.00

Amount of Patient Responsibility / Out-of-Pocket Expense:

Financial Assistance Percentage for Income Categories Above	
0 – 200% of Poverty Guidelines	**201 – 300% of Poverty Guidelines**
100.0%	**90.0%**

Financial assistance may take the form of the hospital writing off part or all of the payment due for covered services for eligible patients. Prior to authorizing a financial assistance discount under the hospital financial assistance policy, the Business Office Manager/Director or Collections Manager will be required to obtain approvals from the Director of Patient Accounting, Vice President Revenue Cycle, Facility CFO, Facility CAO, and Executive Vice President/CFO, as noted below:

WRITE-OFF AMOUNT	***APPROVAL REQUIREMENTS***
$0.00 - $9,999.99	Hospital Collections Mgr. & Dir. Patient Acct.
$10,000 - $49,999.99	Dir of Patient Acct., Vice President of Revenue Cycle & Facility CFO
$50,000.00 – Above	Dr. of Patient Acct., Vice President of Revenue Cycle, Facility CFO, Facility CAO & Executive Vice President/CFO

Once financial assistance has been granted to a patient and applied to the patient's account, the application and supporting documentation will be scanned into the patient's financial folder. Financial information pertinent to financial assistance granted and remaining patient balances, if applicable, will be so noted on the patient's "system" billing record. For all denied applications, a financial transaction will be applied to patient's account indicating non-eligibility.

A letter of notification will be sent to the patient informing of the final outcome of the application for financial assistance.

Billing and Collections

Should the patient fail to complete and submit the required application and documentation for financial assistance or fail to setup an agreed upon payment arrangement, further collection efforts may occur. Covenant Health will not engage in any extraordinary collection actions before it makes reasonable efforts to determine whether an individual who has an unpaid bill is eligible for financial assistance under this policy. Reasonable efforts to determine whether the individual who has an unpaid bill is eligible for financial assistance include notification to the individual of the financial assistance policy, contacting individuals who have submitted incomplete financial assistance applications regarding how to complete the FAP and allowing a reasonable time period to do so, and reviewing completed financial assistance applications for financial assistance eligibility. The actions Covenant Health may take in the event of nonpayment and the process and timeframes for taking these actions are more fully described in the Covenant Health Patient Services Bad Debt Policy 3500.040. A free copy of this policy may be obtained by calling the Business Office at 865-374-3000 or by writing to Knoxville Business Office Services, 1420 Centerpoint Blvd., Building C, Knoxville, TN, 37932.

For purposes of this policy, "extraordinary collection actions" (ECAs) include notification to credit bureaus and legal or judicial actions leading to garnishment of wages. Covenant Health notifies the patient of the financial assistance policy before initiating any ECAs and refrains from initiating any ECAs for at least 120 days from the date of the first post-discharge billing statement. At least 30 days prior to the ECA, Covenant Health provides notice informing the individual of potential ECA if the individual does not submit or complete a financial assistance application or pay the amount due by a deadline specified in the notice. Depending on dollar amounts as specified in the Covenant Health Patient Services Bad Debt Policy 3500.040, the Business Office Director, Vice President of Patient Revenue Cycle, Chief Financial Officer, or President and Chief Administrative Officer will have final authority for determining whether all reasonable efforts have been made to determine if an individual is eligible for financial assistance before any ECAs are pursued.

At least 30 days prior to initiating one or more ECAs, the hospital will provide the individual with a written notice stating that financial assistance is available for eligible individuals, identifying the ECAs that the hospital intends to initiate, and stating a deadline after which the ECA will be initiated that is at least 30 days after the date of the notice. This notification will include a plain language summary of the FAP and how the individual may obtain assistance with the FAP application process. Reasonable efforts will also be made to notify the patient by telephone or orally of the FAP and how to obtain assistance with the FAP application process. All ECAs will be halted if a financial assistance application is received and will remain on hold until a determination is made by Covenant Health and communicated in writing to the responsible party. If the financial assistance application is approved, all actions taken on the account will be reversed and any amounts paid above the amount required will be refunded.

Covenant Health does not sell any accounts receivable accounts to outside firms. All accounts remain property of and under the policies set by Covenant Health.

Copies of Referenced Policies

For copies of any policies referenced within this policy, please call 865-374-3000 and submit your request. A copy will be mailed free of charge to the address provided.

References:

Federal Register / Vol. 89, No. 11 / Wednesday, January 17, 2024 / pp. 2961-2963
Annual Update of the HHS Poverty Guidelines, available at https://aspe.hhs.gov/poverty-guidelines
26 C.F.R. § 1.501(r)

eligible entities to promote rural health care services outreach by improving and expanding the delivery of health care services to include new and enhanced services in rural areas, through community engagement and evidence-based or innovative, evidence-informed models. HRSA currently collects information about Care Coordination Program grants using an OMB-approved set of performance measures and seeks to revise that approved collection. The proposed changes to the information collection are a result of award recipient feedback and information gathered from the previously approved Care Coordination Program measures.

Need and Proposed Use of the Information: This program needs measures that will enable HRSA to provide aggregate program data required by Congress under the Government Performance and Results Act of 1993. These measures cover the principal topic areas of interest to HRSA, including: (1) access to care, (2) population demographics and social determinants of health, (3) care coordination and network infrastructure, (4) sustainability, (5) leadership and workforce, (6) electronic health record, (7) telehealth, (8) utilization, and (9) clinical measures/improved outcomes. All measures will evaluate HRSA's progress toward achieving its goals.

The proposed changes include additional components under "Access to Care" and "Population Demographic" sections that seek information about target population, counties served, direct services, and social determinants of health such as transportation barriers, housing, and food insecurity. Questions about Health Information Technology and Telehealth have been modified to reflect an updated telehealth definition and to improve understanding of how these important technologies are affecting HRSA award recipients. Sections previously titled "Care Coordination" and "Quality Improvement" were consolidated into one section titled "Care Coordination and Network Infrastructure" to improve clarity and ease of reporting for respondents. Part of the previous "Care Coordination" section was revised to include a section titled "Utilization" to improve clarity of instructions for related measures. Previously titled "Staffing" section was revised to "Leadership and Workforce Composition" to improve measure clarity and reduce overall burden for respondents by consolidating measures from previously separate "Staffing," "Quality Improvement," and "Care Coordination" sections. Revised National Quality Forum and Centers for Medicare & Medicaid Services measures were also included to allow uniform collection efforts throughout the Federal Office of Rural Health Policy.

The total number of measures has increased from 40 to 48 measures since the previous information collection request. Of the 48 measures, 11 measures are designated as "optional" or "complete as applicable." The measures within Section 6: "Electronic Health Record" are noted as optional to grantees. In Section 9: "Clinical Measures/Improved Health Outcomes," grantees are only required to respond to Clinical Measure 1: Care Coordination. Grantees can choose to provide data for Clinical Measures 2–10 if applicable to their projects. The total number of responses has remained at 10 since the previous information collection request. The new Care Coordination Program grant cycle maintained the same number of award recipients and number of respondents.

Likely Respondents: The respondents would be recipients of the Rural Health Care Coordination Program grants.

Burden Statement: Burden in this context means the time expended by persons to generate, maintain, retain, disclose, or provide the information requested. This includes the time needed to review instructions; to develop, acquire, install, and utilize technology and systems for the purpose of collecting, validating, and verifying information, processing and maintaining information, and disclosing and providing information; to train personnel and to be able to respond to a collection of information; to search data sources; to complete and review the collection of information; and to transmit or otherwise disclose the information. The total annual burden hours estimated for this ICR are summarized in the table below.

TOTAL ESTIMATED ANNUALIZED BURDEN HOURS

Form name	Number of respondents	Number of responses per respondent	Total responses	Average burden per response (in hours)	Total burden hours
Rural Health Care Coordination Program Performance Improvement Measures	10	1	10	3.5	35
Total	10	1	10	3.5	35

HRSA specifically requests comments on: (1) the necessity and utility of the proposed information collection for the proper performance of the agency's functions; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

Maria G. Button,

Director, Executive Secretariat.

[FR Doc. 2024–00818 Filed 1–16–24; 8:45 am]

BILLING CODE 4165–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

Annual Update of the HHS Poverty Guidelines

AGENCY: Department of Health and Human Services.

ACTION: Notice.

SUMMARY: This notice provides an update of the Department of Health and Human Services (HHS) poverty guidelines to account for last calendar

year's increase in prices as measured by the Consumer Price Index.

DATES: *Applicable Date:* January 11, 2024 unless an office administering a program using the guidelines specifies a different applicable date for that particular program.

ADDRESSES: Office of the Assistant Secretary for Planning and Evaluation, Room 404E, Humphrey Building, Department of Health and Human Services, Washington, DC 20201.

FOR FURTHER INFORMATION CONTACT: For information about how the guidelines are used or how income is defined in a particular program, contact the Federal, State, or local office that is responsible for that program. For information about poverty figures for immigration forms, the Hill-Burton Uncompensated Services Program, and the number of people in poverty, use the specific telephone numbers and addresses given below.

For general questions about the poverty guidelines themselves, contact Kendall Swenson, Office of the Assistant Secretary for Planning and Evaluation, Room 404E.3, Humphrey Building, Department of Health and Human Services, Washington, DC 20201—telephone: (202) 695–2107—or visit *http://aspe.hhs.gov/poverty/*.

For general questions about the poverty guidelines themselves, visit *http://aspe.hhs.gov/poverty/*.

For information about the percentage multiple of the poverty guidelines to be used on immigration forms such as USCIS Form I–864, Affidavit of Support, contact U.S. Citizenship and Immigration Services at 1–800–375–5283. You also may visit *https://www.uscis.gov/i-864*.

For information about the Hill-Burton Uncompensated Services Program (free or reduced-fee health care services at certain hospitals and other facilities for persons meeting eligibility criteria involving the poverty guidelines), visit *https://www.hrsa.gov/get-health-care/affordable/hill-burton/index.html*.

For information about the number of people in poverty, visit the Poverty section of the Census Bureau's website at *https://www.census.gov/topics/income-poverty/poverty.html* or contact the Census Bureau's Customer Service Center at 1–800–923–8282 (toll-free) or visit *https://ask.census.gov* for further information.

SUPPLEMENTARY INFORMATION:

Background

Section 673(2) of the Omnibus Budget Reconciliation Act (OBRA) of 1981 (42 U.S.C. 9902(2)) requires the Secretary of the Department of Health and Human Services to update the poverty guidelines at least annually, adjusting them on the basis of the Consumer Price Index for All Urban Consumers (CPI–U). The poverty guidelines are used as an eligibility criterion by Medicaid and a number of other Federal programs. The *poverty guidelines* issued here are a simplified version of the *poverty thresholds* that the Census Bureau uses to prepare its estimates of the number of individuals and families in poverty.

As required by law, this update is accomplished by increasing the latest published Census Bureau poverty thresholds by the relevant percentage change in the Consumer Price Index for All Urban Consumers (CPI–U). The guidelines in this 2024 notice reflect the 4.1 percent price increase between calendar years 2022 and 2023. After this inflation adjustment, the guidelines are rounded and adjusted to standardize the differences between family sizes. In rare circumstances, the rounding and standardizing adjustments in the formula result in small decreases in the poverty guidelines for some household sizes even when the inflation factor is not negative. In cases where the year-to-year change in inflation is not negative and the rounding and standardizing adjustments in the formula result in reductions to the guidelines from the previous year for some household sizes, the guidelines for the affected household sizes are fixed at the prior year's guidelines. As in prior years, these 2024 guidelines are roughly equal to the poverty thresholds for calendar year 2023 which the Census Bureau expects to publish in final form in September 2024.

The poverty guidelines continue to be derived from the Census Bureau's current official poverty thresholds; they are not derived from the Census Bureau's Supplemental Poverty Measure (SPM).

The following guideline figures represent annual income.

2024 Poverty Guidelines for the 48 Contiguous States and the District of Columbia

Persons in family/household	Poverty guideline
1	$15,060
2	20,440
3	25,820
4	31,200
5	36,580
6	41,960
7	47,340
8	52,720

For families/households with more than 8 persons, add $5,380 for each additional person.

2024 Poverty Guidelines for Alaska

Persons in family/household	Poverty guideline
1	$18,810
2	25,540
3	32,270
4	39,000
5	45,730
6	52,460
7	59,190
8	65,920

For families/households with more than 8 persons, add $6,730 for each additional person.

2024 Poverty Guidelines for Hawaii

Persons in family/household	Poverty guideline
1	$17,310
2	23,500
3	29,690
4	35,880
5	42,070
6	48,260
7	54,450
8	60,640

For families/households with more than 8 persons, add $6,190 for each additional person.

Separate poverty guideline figures for Alaska and Hawaii reflect Office of Economic Opportunity administrative practice beginning in the 1966–1970 period. (Note that the Census Bureau poverty thresholds—the version of the poverty measure used for statistical purposes—have never had separate figures for Alaska and Hawaii.) The poverty guidelines are not defined for Puerto Rico or other outlying jurisdictions. In cases in which a Federal program using the poverty guidelines serves any of those jurisdictions, the Federal office that administers the program is generally responsible for deciding whether to use the contiguous-states-and-DC guidelines for those jurisdictions or to follow some other procedure.

Due to confusing legislative language dating back to 1972, the poverty guidelines sometimes have been mistakenly referred to as the "OMB" (Office of Management and Budget) poverty guidelines or poverty line. In fact, OMB has never issued the guidelines; the guidelines are issued each year by the Department of Health and Human Services. The poverty

guidelines may be formally referenced as ''the poverty guidelines updated periodically in the **Federal Register** by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. 9902(2).''

Some federal programs use a percentage multiple of the guidelines (for example, 125 percent or 185 percent of the guidelines), as noted in relevant authorizing legislation or program regulations. Non-Federal organizations that use the poverty guidelines under their own authority in non-federally-funded activities also may choose to use a percentage multiple of the guidelines.

The poverty guidelines do not make a distinction between farm and non-farm families, or between aged and non-aged units. (Only the Census Bureau poverty thresholds have separate figures for aged and non-aged one-person and two-person units.)

This notice does not provide definitions of such terms as ''income'' or ''family'' as there is considerable variation of these terms among programs that use the poverty guidelines. The legislation or regulations governing each program define these terms and determine how the program applies the poverty guidelines. In cases where legislation or regulations do not establish these definitions, the entity that administers or funds the program is responsible to define such terms as ''income'' and ''family.'' Therefore, questions such as net or gross income, counted or excluded income, or household size should be directed to the entity that administers or funds the program.

Dated: January 11, 2024.

Xavier Becerra,

Secretary, Department of Health and Human Services.

[FR Doc. 2024-00796 Filed 1-16-24; 8:45 am]

BILLING CODE 4150-05-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Interagency Coordinating Committee on the Validation of Alternative Methods Communities of Practice Webinar on Implementing Computational Approaches for Regulatory Safety Assessments; Notice of Public Webinar; Registration Information

AGENCY: National Institutes of Health, HHS.

ACTION: Notice.

SUMMARY: The Interagency Coordinating Committee on the Validation of Alternative Methods (ICCVAM) announces the public webinar ''Implementing Computational Approaches for Regulatory Safety Assessments.'' The webinar is organized on behalf of ICCVAM by the National Toxicology Program Interagency Center for the Evaluation of Alternative Toxicological Methods (NICEATM). Interested persons may participate via the web meeting platform. Time will be allotted for questions from the audience. Information about the webinar and registration are available at *https://ntp.niehs.nih.gov/go/commprac-2024*.

DATES:

Webinar: January 29, 2024, 10 a.m. to approximately 12 noon EST.

Registration for Webinar: January 10, 2024, until 12:00 noon EST January 29, 2024. Registration to view the webinar is required.

ADDRESSES: Webinar web page: *https://ntp.niehs.nih.gov/go/commprac-2024*.

FOR FURTHER INFORMATION CONTACT: Dr. Helena Hogberg, Staff Scientist, NICEATM, email: *helena.hogberg-durdock@nih.gov*, telephone: (984) 287-3150.

SUPPLEMENTARY INFORMATION:

Background: ICCVAM promotes the development and validation of toxicity testing methods that protect human health and the environment while replacing, reducing, or refining animal use. ICCVAM also provides guidance to test method developers and facilitates collaborations that promote the development of new test methods. To address these goals, ICCVAM will hold a Communities of Practice webinar on ''Implementing Computational Approaches for Regulatory Safety Assessments.''

Computational toxicology methods can be useful for generating bioactivity predictions for chemicals for which limited toxicity data are available. They can also help users understand and interpret large, diverse bioactivity data sets, or predict how a chemical might behave in the body. However, users with limited experience with such methods may find it difficult to use them or interpret their outputs, or even understand how the methods could be applied in a specific context.

This webinar will discuss how to establish confidence in computational approaches for regulatory applications. Ongoing activities and key insights will be described in three presentations by speakers from the U.S. government and the private sector focusing on applications of tools such as structure-based models to predict chemical bioactivity and pharmacokinetic models to support understanding of chemical metabolism and disposition. The preliminary agenda and additional information about presentations will be posted at *https://ntp.niehs.nih.gov/go/commprac-2024* as they become available.

Webinar and Registration: This webinar is open to the public with time scheduled for questions by participants following each presentation. Registration for the webinar is required. Registration will open on or before January 10, 2024, and remain open through 12 noon EST on January 29, 2024. Registration is available at *https://ntp.niehs.nih.gov/go/commprac-2024*. Interested individuals are encouraged to visit this web page to stay abreast of the most current webinar information. Registrants will receive instructions on how to access and participate in the webinar in the email confirming their registration. TTY users should contact the Federal TTY Relay Service at 800-877-8339. Requests should be made at least five business days in advance of the event.

Background Information on ICCVAM and NICEATM: ICCVAM is an interagency committee composed of representatives from 17 Federal regulatory and research agencies that require, use, generate, or disseminate toxicological and safety testing information. ICCVAM conducts technical evaluations of new, revised, and alternative safety testing methods and integrated testing strategies with regulatory applicability. ICCVAM also promotes the scientific validation and regulatory acceptance of testing methods that more accurately assess the safety and hazards of chemicals and products and replace, reduce, or refine animal use.

The ICCVAM Authorization Act of 2000 (42 U.S.C. 285*l*-3) establishes ICCVAM as a permanent interagency committee of the National Institute of Environmental Health Sciences and provides the authority for ICCVAM involvement in activities relevant to the development of alternative test methods. Additional information about ICCVAM can be found at *https://ntp.niehs.nih.gov/go/iccvam*.

NICEATM administers ICCVAM, provides support for ICCVAM-related activities, and conducts and publishes analyses and evaluations of data from new, revised, and alternative testing approaches. NICEATM and ICCVAM work collaboratively to evaluate new and improved testing approaches applicable to the needs of U.S. Federal agencies. NICEATM and ICCVAM welcome the public nomination of new,