our regulations, which include, but are not limited to the following:

- An onsite administrative review of DNV's: (1) Corporate policies; (2) financial and human resources available to accomplish the proposed surveys; (3) procedures for training, monitoring, and evaluation of its psychiatric hospital surveyors; (4) ability to investigate and respond appropriately to complaints against accredited psychiatric hospitals; and (5) survey review and decision-making process for accreditation.
- The comparison of DNV's Medicare psychiatric hospital accreditation program standards to our current Medicare hospitals Conditions of Participation (CoPs) and psychiatric hospital special CoPs.
- A documentation review of DNV's psychiatric hospital survey process to do the following:

++ Determine the composition of the survey team, surveyor qualifications, and DNV's ability to provide continuing surveyor training.

++ Compare DNV's processes to those we require of State Survey Agencies, including periodic re-survey and the ability to investigate and respond appropriately to complaints against accredited psychiatric hospitals.

++ Evaluate DNV's procedures for monitoring psychiatric hospitals it has found to be out of compliance with DNV's program requirements. (This pertains only to monitoring procedures when DNV identifies non-compliance. If noncompliance is identified by a State Survey Agency through a validation survey, the State Survey Agency monitors corrections as specified at § 488.9(c)(1)).

++ Assess DNV's ability to report deficiencies to the surveyed hospital and respond to the psychiatric hospital's plan of correction in a timely manner.

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

++ Determine the adequacy of DNV's staff and other resources.

++ Confirm DNV's ability to provide adequate funding for performing required surveys.

++ Confirm DNV's policies with respect to surveys being unannounced.

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

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

++ As authorized under 488.8(h), CMS reserves the right to conduct onsite observations of accrediting organization operations at any time as part of the ongoing review and continuing oversight of an AO's performance.

In accordance with section 1865(a)(3)(A) of the Act, the February 6, 2024, proposed notice also solicited public comments regarding whether DNV's requirements met or exceeded the Medicare CoPs for psychiatric hospitals. No comments were received in response to our proposed notice.

IV. Provisions of the Final Notice

A. Differences Between DNV's Standards and Requirements for Accreditation and Medicare Conditions and Survey Requirements

We compared DNV's psychiatric hospital accreditation program requirements and survey process with the Medicare CoPs at 42 CFR part 482 subpart E, and the survey and certification process requirements of parts 488 and 489. Our review and evaluation of DNV's psychiatric hospital application, which were conducted as described in section III. of this final notice, yielded the following areas where, as of the date of this notice, DNV has completed revising its standards and certification processes in order to meet the requirements at:

- Section 482.41(c)(2), to address the requirements regarding the Health Care Facilities Code waiver allowance.
- Section 488.5(4)(ii), to address the requirements to include the requirement for Life Safety Specialist to have training or experience in the Health Care Facilities Code.

B. Term of Approval

Based on our review and observations described in section III of this final notice, we have determined that DNV's psychiatric hospital accreditation program requirements meet or exceed our requirements, and its survey processes are also comparable. Therefore, we approve DNV as a national accreditation organization for psychiatric hospitals that request participation in the Medicare program, effective July 30, 2024 through July 30, 2028.

V. Collection of Information Requirements

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

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

Vanessa Garcia,

Federal Register Liaison, Centers for Medicare & Medicaid Services.

[FR Doc. 2024–15519 Filed 7–15–24; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifiers: CMS–P–0015A, CMS–10316, and CMS–10054]

Agency Information Collection Activities: Submission for OMB Review; Comment Request

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

ACTION: Notice.

SUMMARY: The Centers for Medicare & Medicaid Services (CMS) is announcing an opportunity for the public to comment on CMS' intention to collect information from the public. Under the Paperwork Reduction Act of 1995 (PRA), Federal agencies are required to publish notice in the **Federal Register** concerning each proposed collection of information, including each proposed extension or reinstatement of an existing collection of information, and to allow a second opportunity for public comment on the notice. Interested persons are invited to send comments regarding the burden estimate or any other aspect of this collection of information, including the necessity and utility of the proposed information collection for the proper performance of the agency's functions, the accuracy of the estimated burden, ways to enhance the quality, utility, and clarity of the information to be collected, and the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

DATES: Comments on the collection(s) of information must be received by the OMB desk officer by August 15, 2024.

ADDRESSES: Written comments and recommendations for the proposed information collection should be sent within 30 days of publication of this notice to *www.reginfo.gov/public/do/PRAMain.* Find this particular information collection by selecting ''Currently under 30-day Review—Open for Public Comments'' or by using the search function.

To obtain copies of a supporting statement and any related forms for the proposed collection(s) summarized in this notice, please access the CMS PRA website by copying and pasting the following web address into your web browser: *https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing.*

FOR FURTHER INFORMATION CONTACT: William Parham at (410) 786–4669.

SUPPLEMENTARY INFORMATION: Under the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501–3520), Federal agencies must obtain approval from the Office of Management and Budget (OMB) for each collection of information they conduct or sponsor. The term ''collection of information'' is defined in 44 U.S.C. 3502(3) and 5 CFR 1320.3(c) and includes agency requests or requirements that members of the public submit reports, keep records, or provide information to a third party. Section 3506(c)(2)(A) of the PRA (44 U.S.C. 3506(c)(2)(A)) requires Federal agencies to publish a 30-day notice in the **Federal Register** concerning each proposed collection of information, including each proposed extension or reinstatement of an existing collection of information, before submitting the collection to OMB for approval. To comply with this requirement, CMS is publishing this notice that summarizes the following proposed collection(s) of information for public comment:

1. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Medicare Current Beneficiary Survey (MCBS); *Use:* CMS is the largest single payer of health care in the United States. The agency plays a direct or indirect role in administering health insurance coverage for more than 120 million people across the Medicare, Medicaid, CHIP, and Exchange populations. A critical aim for CMS is to be an effective steward, major force, and trustworthy partner in supporting innovative approaches to improving quality, accessibility, and affordability in healthcare. CMS also aims to put patients first in the delivery of their health care needs.

The MCBS is the most comprehensive and complete survey available on the Medicare population and is essential in capturing information not otherwise collected through operational or administrative data on the Medicare program. The MCBS is a nationally-representative, longitudinal survey of Medicare beneficiaries that is sponsored by CMS and is directed by the Office of Enterprise Data and Analytics (OEDA). MCBS data collection includes both in-person and phone interviewing. The survey captures beneficiary information whether aged or disabled, living in the community or facility, or serviced by managed care or fee-for-service. Data produced as part of the MCBS are enhanced with administrative data (*e.g.,* fee-for-service claims, prescription drug event data, enrollment, etc.) to provide users with more accurate and complete estimates of total health care costs and utilization. The MCBS has been continuously fielded for more than 30 years, encompassing over 1.2 million interviews and more than 140,000 survey participants. Respondents participate in up to 11 interviews over a four-year period. The MCBS provides a holistic view of Medicare beneficiaries' social and medical risk factors and rich information on the relationship between these risk factors, healthcare utilization, and health outcomes—at a point in time and over time.

The MCBS continues to provide unique insight into the Medicare program and helps CMS and its external stakeholders better understand and evaluate the impact of existing programs and significant new policy initiatives. In the past, MCBS data have been used to assess potential changes to the Medicare program. For example, the MCBS was instrumental in supporting the development and implementation of the Medicare prescription drug benefit by providing a means to evaluate prescription drug costs and out-of-pocket burden for these drugs to Medicare beneficiaries. Beginning in 2025, this proposed revision would add new measures to the questionnaire and remove a few items that are no longer relevant for administration. The revisions would result in a net increase in respondent burden. *Form Number:* CMS–P–0015A (OMB control number: 0938–0568); *Frequency:* Occasionally; *Affected Public:* Business or other for-profits and Not-for-profits institutions; *Number of Respondents:* 35,015; *Total Annual Responses:* 35,015; *Total Annual Hours:* 35,344. (For policy questions regarding this collection contact: William Long at 410–786–7927.)

2. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Implementation of the Medicare Prescription Drug Plan (PDP) and Medicare Advantage (MA) Plan Disenrollment Reasons Survey; *Use:* Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) provides a requirement to collect and report performance data for Part D prescription drug plans. Section 1860D–4 (Information to Facilitate Enrollment) of the MMA requires CMS to conduct consumer satisfaction surveys regarding the PDP and MA contracts. Plan disenrollment is generally believed to be a broad indicator of beneficiary dissatisfaction with some aspect of plan services, such as access to care, customer service, cost of the plan, services, benefits provided, or quality of care.

This data collection complements the enrollee beneficiary experience data collected through the Medicare Consumer Assessment of Healthcare Providers and Systems (Medicare CAHPS) survey by providing information on the reasons for disenrollment from a Medicare Advantage (with or without prescription drug coverage) or Prescription Drug Plan.

The Disenrollment Survey results are an important source of information for CMS to monitor contract performance and identify potential problems (*e.g.,* plans providing incorrect information to beneficiaries or creating access problems). CMS uses the results to monitor the quality of service that Medicare beneficiaries get from contracted plans and their providers and to understand beneficiaries' expectations relative to provided benefits and services for MA and PDPs. *Form Number:* CMS–10316 (OMB control number: 0938–1113); *Frequency:* Yearly; *Affected Public:* Individuals and households; *Number of Respondents:* 36,050; *Total Annual Responses:* 36,050; *Total Annual Hours:* 6,730. (For policy questions regarding this collection contact Beth Simon at 415–744–3780.)

3. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* New Technology Services for Ambulatory Payment Classifications Under Outpatient Prospective Payment System; *Use:* In the April 7, 2000 (65 FR 18434) final rule with comment period (HCFA–1005–FC, RIN 0938–AI56) first implementing the hospital outpatient

prospective payment system (OPPS), we created a set of New Technology ambulatory payment classifications (APCs) to pay for certain new technology services under the OPPS. These APCs are intended to pay for new technology services that were not covered by the transitional pass-through payments provisions authorized by the Balanced Budget Refinement Act (BBRA) of 1999.

Since implementation of the OPPS on August 1, 2000, transitional pass-through payments have been made to hospitals for certain drugs, biologicals, and medical devices. These are temporary additional payments required by section 1833(t)(6) of the Social Security Act which was added by section 201(b) of the BBRA. The law required the Secretary to make these additional payments to hospitals for at least 2 but no more than 3 years.

In the April 7, 2000 final rule with comment period, we specified an application process and the information that must be supplied for us to consider a request for payment under the New Technology APCs (65 FR 18478). We posted the application process on our website at *www.cms.hhs.gov.* Services were only considered eligible for assignment to a New Technology APC if we listed them in one of a number of lists published in Medicare Program Memoranda, which are posted to our website (*https://www.cms.gov/medicare/regulations-guidance/transmittals/cms-program-memoranda*). We established a quarterly application process by which interested parties could submit applications to us for particular services. We assign new services to the New Technology APCs that we determine cannot be placed appropriately in clinical APCs. Under our current policy, we retain services in a New Technology APC until we gain sufficient information about actual hospital costs incurred to furnish a new technology service. *Form Number:* CMS–10054 (OMB control number: 0938–0860); *Frequency:* Once; *Affected Public:* Private sector, Business or other for-profit; *Number of Respondents:* 25; *Number of Responses:* 25; *Total Annual Hours:* 400. (For policy questions regarding this collection contact Josh Mcfeeters at 410–786–9732.)

William N. Parham III,

Director, Division of Information Collections and Regulatory Impacts, Office of Strategic Operations and Regulatory Affairs.

[FR Doc. 2024–15581 Filed 7–15–24; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Community Living

Announcing the Intent To Award a Single-Source Supplement for the National Paralysis Resource Center (PRC)

AGENCY: Administration for Community Living, HHS.

ACTION: Notice.

SUMMARY: The Administration for Community Living (ACL) announces the intent to award a single-source supplement to the current cooperative agreement held by the Christopher and Dana Reeve Foundation. The National Paralysis Resource Center (NPRC) is operated by the Christopher and Dana Reeve Foundation and offers important programmatic opportunities for persons with disabilities and older adults. The NPRC provides comprehensive information for people living with spinal cord injury, paralysis, and mobility-related disabilities and their families. Resources include information and referral by phone and email in multiple languages; a peer and family support mentoring program; a military and veterans' program; multicultural outreach services; multiple quality of life grants; and a national website. The administrative supplement for FY 2024 will be in the amount of $1,300,000, bringing the total award for FY 2024 to $10,000,000.

DATES: The supplement award will be issued to extend the project period to August 1, 2024, through June 30, 2025.

FOR FURTHER INFORMATION CONTACT: For further information or comments regarding this program supplement, contact Elizabeth Leef, U.S. Department of Health and Human Services, Administration for Community Living, Administration on Disabilities, Office of Disability Services Innovations; telephone (202) 475–2482; email *elizabeth.leef@acl.hhs.gov.*

SUPPLEMENTARY INFORMATION: The purpose of the supplemental funding is to support the expansion the National Paralysis Resource Center to improve the health and quality of life of individuals living with paralysis and their families by raising awareness of and facilitating access to a broad range of services relevant to individuals with paralysis. With the additional funding, the NPRC will work to expand the National Resource and Information Center; increase the health and quality of life of Americans with disabilities living with paralysis; increase support and resources to people with paralysis, their families and caregivers; expand collaboration with federal agencies and other national organizations that have a vested interested in the paralysis community; and strengthen performance measures.

Program Name: National Paralysis Resource Center.

Recipient: Christopher and Dana Reeve Foundation.

Period of Performance: The supplement award will be issued for the current project period, July 1, 2024, through June 30, 2025.

Award Amount: $1,300,000.

Award Type: Cooperative Agreement.

Basis for Award: The Christopher and Dana Reeve Foundation is currently funded to carry out the National Paralysis Resource Center (NPRC) for the period of July 1, 2024, through June 30, 2025. As a result of the 2024 budget, Congress appropriated additional funds for the expansion of the NPRC. It would be unnecessarily time consuming and disruptive to the NPRC project and the beneficiaries being served for the ACL to establish a new grantee at this time when critical services are presently being provided in an efficient manner.

Statutory Authority: This program is authorized under Section 317 of the Public Health Service Act (42 U.S.C. 247(b–4)); Consolidated and Further Continuing Appropriations Act, 2016, Public Law 114–113 (Dec. 18, 2015).

Dated: July 10, 2024.

Alison Barkoff,

Principal Deputy Administrator for the Administration for Community Living, performing the delegable duties of the Administrator and the Assistant Secretary for Aging.

[FR Doc. 2024–15611 Filed 7–15–24; 8:45 am]

BILLING CODE 4154–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. FDA–2024–N–2888]

Agency Information Collection Activities; Proposed Collection; Comment Request; Substantial Equivalence Reports for Tobacco Products

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA, Agency, or we) is announcing an opportunity for public comment on the proposed collection of certain information by the Agency. Under the Paperwork Reduction Act of