regarding this collection contact LuAnn Piccione at (410) 786–5423.)

**William N. Parham, III,**

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

[FR Doc. 2024–21063 Filed 9–16–24; 8:45 am]

**BILLING CODE 4120–01–P**

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Centers for Medicare & Medicaid Services

**[Document Identifiers: CMS–R–297/CMS–L564 and CMS–2088–17]**

### Agency Information Collection Activities: Proposed Collection; 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 60 days for public comment on the proposed action. Interested persons are invited to send comments regarding our burden estimates 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 must be received by November 18, 2024.

**ADDRESSES:** When commenting, please reference the document identifier or OMB control number. To be assured consideration, comments and recommendations must be submitted in any one of the following ways:

1. *Electronically.* You may send your comments electronically to *http://www.regulations.gov*. Follow the instructions for ''Comment or Submission'' or ''More Search Options'' to find the information collection document(s) that are accepting comments.

2. *By regular mail.* You may mail written comments to the following address: CMS, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development, Attention: Document Identifier/OMB Control Number: ____, Room C4–26–05, 7500 Security Boulevard Baltimore, Maryland 21244–1850.

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 N. Parham at (410) 786–4669.

**SUPPLEMENTARY INFORMATION:**

**Contents**

This notice sets out a summary of the use and burden associated with the following information collections. More detailed information can be found in each collection's supporting statement and associated materials (see **ADDRESSES**).

CMS–R–297/CMS–L564 Medicare Request for Employment Information

CMS–2088–17 The Community Mental Health Center Cost Report

Under the 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 requires Federal agencies to publish a 60-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.

**Information Collections**

1. *Type of Information Collection Request:* Extension of a currently approved information collection; *Title of Information Collection:* Medicare Request for Employment Information; *Use:* Section 1837(i) of the Social Security Act (the Act) provides for a SEP for individuals who delay enrolling in Medicare Part B because they are covered by a group health plan based on their own or a spouse's current employment status. Disabled individuals with Medicare may also delay enrollment because they have large group health plan coverage based on their own or a family member's current employment status. When these individuals apply for Medicare Part B, they must provide proof that the group health plan coverage is (or was) based on current employment status. Form CMS L564 provides this proof so that SSA can determine eligibility for the SEP. Individuals eligible for the SEP can enroll in Part B without incurring a late enrollment penalty (LEP). Individuals may also use this form to prove that their group health plan coverage is based on current employment status and to have the assessed Medicare LEP reduced. *Form Number:* CMS–R–297/CMS–L564 (OMB control number: 0938–0787); *Frequency:* Annually; *Affected Public:* Individuals or households, Business or other for-profits and Not-for-profit institutions; *Number of Respondents:* 594,998; *Total Annual Responses:* 594,998; *Total Annual Hours:* 243,949. (For policy questions regarding this collection contact Candace Carter at 410–786–8466 or *Candace.Carter@cms.hhs.gov*.)

2. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Community Mental Health Center Cost Report *Use:* CMS requires the Form CMS–2088–17 to determine a provider's reasonable cost incurred in furnishing medical services to Medicare beneficiaries and reimbursement due to or from a provider. In addition, CMHCs may receive reimbursement through the cost report for Medicare reimbursable bad debts. CMS uses the Form CMS–2088–17 for rate setting; payment refinement activities, including market basket analysis; Medicare Trust Fund projections; and to support program operations. The primary function of the cost report is to determine provider reimbursement for services rendered to Medicare beneficiaries. Each CMHC submits the cost report to its contractor for reimbursement determination.

Section 1874A of the Act describes the functions of the contractor. CMHCs must follow the principles of cost reimbursement, which require they maintain sufficient financial records and statistical data for proper determination of costs. The S series of worksheets collects the provider's location, CBSA, date of certification, operations, and unduplicated census

days. The A series of worksheets collects the provider's trial balance of expenses for overhead costs, direct patient care services, and non-revenue generating cost centers. The B series of worksheets allocates the overhead costs to the direct patient care and non-revenue generating cost centers using functional statistical bases. The Worksheet C computes the apportionment of costs between Medicare beneficiaries and other patients. The D series of worksheets are Medicare specific and calculate the reimbursement settlement for services rendered to Medicare beneficiaries. The Worksheet F collects the provider's revenues and expenses data from the provider's income statement. *Form Number:* CMS–2088–17 (OMB control number: 0938–0378); *Frequency:* Annually; *Affected Public:* Private Sector, Business or other for-profits, Not-for-profits institutions; *Number of Respondents:* 191; *Total Annual Responses:* 191; *Total Annual Hours:* 17,190. (For policy questions regarding this collection contact Jill Keplinger at 410–786–4550.)

**William N. Parham, III,**

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

[FR Doc. 2024–21055 Filed 9–16–24; 8:45 am]

**BILLING CODE 4120–01–P**

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Centers for Medicare & Medicaid Services

**[CMS–3465–PN]**

### Medicare and Medicaid Programs; Application From the Accreditation Commission for Health Care, Inc. (ACHC) for Continued Approval of Its Home Health Agency Accreditation Program

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

**ACTION:** Proposed notice.

**SUMMARY:** This proposed notice acknowledges the receipt of an application from the Accreditation Commission for Health Care, Inc. (ACHC) for continued recognition as a national accrediting organization for home health agencies (HHAs) that wish to participate in the Medicare or Medicaid programs. The statute requires that within 60 days of receipt of an organization's complete application, the Centers for Medicare & Medicaid Services (CMS) must publish a notice that identifies the national accrediting body making the request, describes the nature of the request, and provides at least a 30-day public comment period.

**DATES:** To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on October 17, 2024.

**ADDRESSES:** In commenting, refer to file code CMS–3465–PN.

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

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

2. *By regular mail.* You may mail written comments to the following address ONLY:

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–3465–PN, P.O. Box 8013, Baltimore, MD 21244–8013.

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

3. *By express or overnight mail.* You may send written comments to the following address ONLY:

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–3465–PN, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

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

**FOR FURTHER INFORMATION CONTACT:**

Erin Imhoff (410) 786–2337.

Lillian Williams (410) 786–8636.

**SUPPLEMENTARY INFORMATION:**

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

## I. Background

Under the Medicare program, eligible beneficiaries may receive covered services from a home health agency (HHA), provided certain requirements are met. Sections 1861(m) and (o), 1891 and 1895 of the Social Security Act (the Act) establish distinct criteria for an entity seeking designation as an HHA. Regulations concerning provider agreements are at 42 CFR part 489 and those pertaining to activities relating to the survey and certification of facilities and other entities are at 42 CFR part 488. The regulations at 42 CFR parts 409 and 484 specify the conditions that an HHA must meet to participate in the Medicare program, the scope of covered services, and the conditions for Medicare payment for home health care.

Generally, to enter into a provider agreement with the Medicare program, an HHA must first be certified by a state survey agency as complying with the conditions or requirements set forth in 42 CFR part 484 of our regulations. Thereafter, the HHA is subject to regular surveys by a state survey agency to determine whether it continues to meet these requirements.

However, there is an alternative to surveys by state agencies. Section 1865(a)(1) of the Act provides that, if a provider entity demonstrates through accreditation by an approved national accrediting organization that all applicable Medicare conditions are met or exceeded, we will deem those provider entities as having met the requirements. Accreditation by an accrediting organization is voluntary and is not required for Medicare participation.

If an accrediting organization is recognized by the Secretary of Health and Human Services as having standards for accreditation that meet or exceed Medicare requirements, any provider entity accredited by the national accrediting body's approved program would be deemed to meet the Medicare conditions. A national accrediting organization applying for CMS approval of their accreditation program under 42 CFR part 488, subpart A, must provide CMS with reasonable assurance that the accrediting organization requires the accredited provider entities to meet requirements that are at least as stringent as the Medicare conditions. Our regulations concerning the approval of accrediting organizations are set forth at § 488.5. The regulations at § 488.5(e)(2)(i) require accrediting organizations to reapply for continued approval of their accreditation program every 6 years or sooner as determined by CMS.