The Director, Office of Strategic Business Initiatives, Office of the Chief Operating Officer, Centers for Disease Control and Prevention, has been delegated the authority to sign **Federal Register** notices pertaining to announcements of meetings and other committee management activities, for both the Centers for Disease Control and Prevention and the Agency for Toxic Substances and Disease Registry.

Kalwant Smagh,

Director, Office of Strategic Business Initiatives, Office of the Chief Operating Officer, Centers for Disease Control and Prevention.

[FR Doc. 2024–29004 Filed 12–10–24; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Notice of Closed Meeting

Pursuant to 5 U.S.C. 1009(d), notice is hereby given of the following meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended, and the Determination of the Director, Office of Strategic Business Initiatives, Office of the Chief Operating Officer, Centers for Disease Control and Prevention, pursuant to Public Law 92–463. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: Disease, Disability, and Injury Prevention and Control Special Emphasis Panel (SEP)—CE25–026, Rigorously Evaluating Programs and Policies to Prevent Child Sexual Abuse and Problematic Sexual Behavior among Youth.

Dates: April 29–30, 2025.

Times: 10 a.m.–5 p.m., EDT.

Place: Web Conference.

Agenda: To review and evaluate grant applications.

For Further Information Contact: Aisha L. Wilkes, M.P.H., Scientific Review Officer, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 4770 Buford Highway NE, Mailstop S106–9, Atlanta, Georgia 30341. Telephone: (404) 639–6473; Email: *AWilkes@cdc.gov.*

The Director, Office of Strategic Business Initiatives, Office of the Chief Operating Officer, Centers for Disease Control and Prevention, has been delegated the authority to sign **Federal Register** notices pertaining to announcements of meetings and other committee management activities, for both the Centers for Disease Control and Prevention and the Agency for Toxic Substances and Disease Registry.

Kalwant Smagh,

Director, Office of Strategic Business Initiatives, Office of the Chief Operating Officer, Centers for Disease Control and Prevention.

[FR Doc. 2024–29008 Filed 12–10–24; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Disease, Disability, and Injury Prevention and Control Special Emphasis Panel (SEP)—TS25–036, Identify and Evaluate Potential Risk Factors for ALS; Amended Notice of Closed Meeting

AGENCY: Centers for Disease Control and Prevention, Department of Health and Human Services.

ACTION: Notice.

FOR FURTHER INFORMATION CONTACT: Carlisha Gentles, Pharm.D., B.C.P.S., C.D.C.E.S., Scientific Review Officer, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 4770 Buford Highway NE, Mailstop S106–9, Atlanta, Georgia 30341. Telephone: (770) 488–1504; Email: *CGentles@cdc.gov.*

SUPPLEMENTARY INFORMATION: Notice is hereby given of a change in the meeting of the Disease, Disability, and Injury Prevention and Control Special Emphasis Panel (SEP)—TS25–036, Identify and Evaluate Potential Risk Factors for ALS; February 25–26, 2025, 10 a.m.–5 p.m., EST, web conference, in the original **Federal Register** notice. The meeting notice was published in the **Federal Register** on December 2, 2024, 89 FR 95215.

This meeting notice is being amended to change the meeting dates from a two-day meeting to a one-day meeting. The notice should read as follows:

Name of Committee: Disease, Disability, and Injury Prevention and Control Special Emphasis Panel (SEP)—TS25–036, Identify and Evaluate Potential Risk Factors for ALS.

Date: February 25, 2025.

Time: 10 a.m.–5 p.m., EST.

The meeting is closed to the public.

The Director, Office of Strategic Business Initiatives, Office of the Chief Operating Officer, Centers for Disease Control and Prevention, has been delegated the authority to sign **Federal Register** notices pertaining to announcements of meetings and other committee management activities, for both the Centers for Disease Control and Prevention and the Agency for Toxic Substances and Disease Registry.

Kalwant Smagh,

Director, Office of Strategic Business Initiatives, Office of the Chief Operating Officer, Centers for Disease Control and Prevention.

[FR Doc. 2024–29009 Filed 12–10–24; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifiers: CMS–10515 and CMS–10780]

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 February 10, 2025.

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–10515 Payment Collections Operations Contingency Plan

CMS–10780 Requirements Related to Surprise Billing: Qualifying Payment Amount, Notice and Consent, Disclosure on Patient Protections Against Balance Billing, and State Law Opt-in

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:* Revision of a currently approved collection; *Title of Information Collection:* Payment Collections Operations Contingency Plan; *Use:* The Patient Protection and Affordable Care Act, Public Law 111–148, enacted on March 23, 2010, and the Health Care and Education Reconciliation Act, Public Law 111–152, enacted on March 30, 2010 [collectively, the ''Affordable Care Act'' (ACA)], provides for consumers to receive subsidies based on income to purchase affordable health care on the Exchanges. The U.S. Department of Health and Human Services (HHS) uses a manual process to obtain enrollment and payment data from issuers in States transitioning from Federally-facilitated Exchanges (FFEs) and State-based Exchanges on the Federal platform (SBE–FPs) to State-based Exchanges (SBEs) to facilitate the payment of subsidies to issuers on behalf of eligible enrollees. This document describes the data collection requirements related to this manual process, known as the Enrollment and Payment Data template. This extension reduces burden compared to the currently approved collection based on recent program experience. *Form Number:* CMS–10515 (OMB Control Number: 0938–1217); *Frequency:* Annually; *Affected Public:* Private Sector, Business or other for-profit and not-for-profit institutions; *Number of Respondents:* 25; *Number of Responses:* 150; *Total Annual Hours:* 1,500. (For policy questions regarding this collection, contact Jacquelyn Rudich at 301–492–5211.)

2. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Requirements Related to Surprise Billing: Qualifying Payment Amount, Notice and Consent, Disclosure on Patient Protections Against Balance Billing, and State Law Opt-in; *Use:* On December 27, 2020, the Consolidated Appropriations Act, 2021 (Pub. L. 116–260), which included the No Surprises Act, was signed into law. The No Surprises Act provides federal protections against surprise billing and limits out-of-network cost sharing under many of the circumstances in which surprise medical bills arise most frequently. The July 13, 2021 interim final rules ''Requirements Related to Surprise Billing; Part I'' (86 FR 36872, July 2021 interim final rules) issued by the Department of Health and Human Services, the Department of Labor, the Department of the Treasury, and the Office of Personnel Management, implement provisions of the No Surprises Act that apply to group health plans, health insurance issuers offering group or individual health insurance coverage, and carriers in the Federal Employees Health Benefits (FEHB) Program that provide protections against balance billing and out-of-network cost sharing with respect to emergency services, non-emergency services furnished by nonparticipating providers related to patient visits to certain types of participating health care facilities, and services furnished by nonparticipating providers of air ambulance services. The July 2021 interim final rules prohibit nonparticipating providers, emergency facilities, and providers of air ambulance services from balance billing participants, beneficiaries, and enrollees in certain situations unless they satisfy certain notice and consent requirements.

The No Surprises Act and the July 2021 interim final rules require group health plans and issuers of health insurance coverage to provide information about qualifying payment amounts (QPAs) to nonparticipating providers and facilities and to provide disclosures on patient protections against balance billing to participants, beneficiaries and enrollees. Self-insured plans opting in to a specified state law are required to provide a disclosure to participants. Certain nonparticipating providers and nonparticipating emergency facilities may provide participants, beneficiaries, and enrollees with notice and obtain their consent to waive balance billing protections, provided certain requirements are met. In addition, certain providers and facilities are required to provide disclosures on patient protections against balance billing to participants, beneficiaries and enrollees. The No Surprises Act requires the Secretary of HHS to audit no more than 25 group health plans and health insurance issuers offering group or individual health insurance coverage annually, and permits additional audits based on complaints, to ensure that such plans and coverage are in compliance with the requirement of applying a QPA and that the QPA applied satisfies the definition under the No Surprises Act with respect to the year involved. *Form Number:* CMS–10780 (OMB control number:

0938–1401*); Frequency:* On Occasion; *Affected Public:* Individuals, State, Local, or Tribal Governments, Private Sector; *Number of Respondents:* 2,477,197; *Total Annual Responses:* 85,148,199; *Total Annual Hours:* 6,006,654. (For policy questions regarding this collection, contact Russell Tipps at 667–290–9640.)

William N. Parham III,

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

[FR Doc. 2024–29002 Filed 12–10–24; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–3460–FN]

Medicare and Medicaid Programs: Approval of Application by the DNV Healthcare USA, Inc. for Continued CMS-Approval of Its Critical Access Hospital Accreditation Program

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

ACTION: Notice.

SUMMARY: This notice acknowledges the approval of an application by the DNV Healthcare USA, Inc., for continued recognition as a national accrediting organization for Critical Access Hospitals that wish to participate in the Medicare or Medicaid programs.

FOR FURTHER INFORMATION CONTACT: Caecilia Andrews, (410) 786–2190.

SUPPLEMENTARY INFORMATION:

I. Background

Under the Medicare program, eligible beneficiaries may receive covered services in a critical access hospital (CAH), provided that the facility meets certain requirements. Sections 1820(c)(2)(B), 1820(e), and 1861(mm)(1) of the Social Security Act (the Act) establish distinct criteria for facilities seeking designation as a CAH. Regulations concerning provider agreements are at 42 CFR part 489 and those pertaining to activities relating to the survey and certification of facilities are at 42 CFR part 488. Our regulations at 42 CFR part 485, subpart F specify the conditions of participation (CoPs) that a CAH must meet to participate in the Medicare program, the scope of covered services, and the conditions for Medicare payment for CAHs. The regulations at § 485.647 specify that a CAH's psychiatric or rehabilitation distinct part unit (DPU), if any, must meet the hospital requirements specified in subparts A, B, C, and D of part 482 in order for the CAH DPU to participate in the Medicare program.

Prior to becoming a CAH, to enter into an agreement, a CAH must first be certified by a state survey agency as a hospital complying with the conditions of participation at 42 CFR part 482. It then can convert to a CAH by complying with the conditions or requirements at part 485, subpart F. Thereafter, the CAH 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. Certification by a nationally recognized accreditation program can substitute for ongoing state review.

Section 1865(a)(1) of the Act provides that, if a provider entity demonstrates through accreditation by a Centers for Medicare & Medicaid Services (CMS) approved national accrediting organization (AO) that all applicable Medicare requirements are met or exceeded, we will deem those provider entities as having met such requirements. Accreditation by an AO is voluntary and is not required for Medicare participation.

If an AO is recognized by the Secretary of the Department of Health and Human Services (the Secretary) 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 requirements. A national AO applying for approval of its accreditation program under 42 CFR part 488, subpart A, must provide CMS with reasonable assurance that the AO requires the accredited provider entities to meet requirements that are at least as stringent as the Medicare requirements.

Our regulations concerning the approval of AOs are at §§ 488.4 and 488.5. The regulations at § 488.5(e)(2)(i) require an AO to reapply for continued approval of its accreditation program every 6 years or sooner, as determined by CMS. This notice is to announce our continued approval of the DNV Healthcare USA, Inc.'s (DNV's) CAH accreditation program for a period of 4 years.

II. Application Approval Process

Section 1865(a)(3)(A) of the Act provides a statutory timetable to ensure that our review of applications for CMS-approval of an accreditation program is conducted in a timely manner. The Act provides us 210 days after the date of receipt of a complete application, with any documentation necessary to make the determination, to complete our survey activities and application process. Within 60 days after receiving a complete application, we must publish a notice in the **Federal Register** that identifies the national accrediting body making the request, describes the request, and provides no less than a 30-day public comment period. At the end of the 210-day period, we must publish a notice in the **Federal Register** approving or denying the application.

III. Provisions of the Proposed Notice

On June 13, 2024, we published a proposed notice in the **Federal Register** (89 FR 50332), announcing DNV's request for continued approval of its Medicare critical hospital accreditation program. In the proposed notice, we detailed our evaluation criteria. Under section 1865(a)(2) of the Act and in our regulations at § 488.5, we conducted a review of DNV's Medicare CAH accreditation application in accordance with the criteria specified by our regulations, which include, but are not limited to the following:

- An 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 surveyors; (4) ability to investigate and respond appropriately to complaints against accredited facilities; and (5) survey review and decision-making process for accreditation.
- A comparison of DNV's accreditation to our current Medicare CAH conditions of participation (CoPs).
- A documentation review of DNV's survey process to:

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

++ Compare DNV's processes to those of state survey agencies, including survey frequency, and the ability to investigate and respond appropriately to complaints against accredited facilities.

++ Evaluate DNV's procedures for monitoring CAHs out of compliance with DNV's program requirements. The monitoring procedures are used only when DNV identifies noncompliance. If noncompliance is identified through validation reviews, the state survey agency monitors corrections as specified at § 488.7(d).

++ Assess DNV's ability to report deficiencies to the surveyed facilities and respond to the facility'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