Department of Health and Human Services (DHHS) Assistant Secretary for Planning and Evaluation (ASPE), the Office of Enterprise Data and Analytics (OEDA) in CMS has been designated as the lead participant for the U.S.

The PaRIS Survey will help to close critical policy gaps by focusing on: (1) Patient Reported Experience Measures (PREMS) which measure how patients experience health care, and (2) Patient Reported Outcome Measures (PROMS) which measure how patients assess the results of the care they receive. The PaRIS survey includes both PREMS and PROMS items and aims to collect vital information about primary health care, by asking about topics such as the respondent's health, health behaviors, patient activation and confidence in managing their health care, experiences with health care and health providers including access to health care, quality of life, physical functioning, and psychological well-being.

OECD and its member countries will use data collected by the PaRIS Survey to shed light on key questions about how well care in each country is organized around the needs of patients. Results from the survey will show how key outcomes and experiences vary across and within countries. This will allow countries to benchmark and learn from each other's approaches. The survey will also help policy makers in OECD member countries understand how health systems are addressing the needs of persons with chronic health conditions. Findings will foster a dialogue with service providers about how to further improve the performance and people-centeredness of primary health care services.

To facilitate U.S. participation in this important initiative, CMS will leverage the existing sample for the Medicare Current Beneficiary Survey (MCBS). The MCBS is a continuous, multi-purpose survey of a representative national sample of the Medicare population; it is conducted under OMB clearance number 0938–0568. While the MCBS sample includes the population of beneficiaries aged 65 and over and beneficiaries aged 64 and below with certain disabling conditions residing in the U.S., selection for the PaRIS Survey will be limited to beneficiaries aged 65 and over who have seen a medical provider in the last six months to provide a comparable population to survey respondents selected in other participating OECD countries. Interviewers will telephone MCBS respondents and administer the PaRIS Survey by phone as a one-time standalone survey during January through April 2023. Non-response follow-up will be conducted by telephone and in-person as needed. It is estimated that 5,144 Medicare beneficiaries will participate in this 40-minute survey. CMS plans to release a disclosure protected public use file with accompanying methodological documentation. This public use file will also be made available to OECD for analysis and released with data from other participating countries. *Form Number:* CMS–10792 (OMB: 0938-New); Frequency: One-time collection; *Affected Public:* Individuals residing in households; *Total Number of Respondents:* 10,498; *Total Number of Responses:* 10,498; *Total Hours:* 3,814 (For policy questions regarding this collection contact William Long at 410–786–7927.)

3. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Generic Clearance for the Health Care Payment Learning and Action Network; *Use:* The Center for Medicare and Medicaid Services (CMS), through the Center for Medicare and Medicaid Innovation, develops and tests innovative new payment and service delivery models in accordance with the requirements of section 1115A and in consideration of the opportunities and factors set forth in section 1115A(b)(2) of the Act. To date, CMS has built a portfolio of models (in operation or recently announced) that have attracted participation from a broad array of health care providers, states, payers, and other stakeholders.

To more effectively partner with stakeholders across the health care system and accelerate system transformation, CMS launched the Health Care Payment Learning and Action Network (LAN) to accelerate the transition to Medicare and non-Medicare alternative payment models by collaborating with a broad array of health care delivery stakeholders, identifying best practices in their implementation, and monitoring the adoption of value-based alternative payment models across the U.S. health care system—to include the percentage of Medicare, Medicaid, and non-Medicare payments tied to (and U.S. lives covered by) alternative payment models that reward the quality of care delivered. *Form Number:* CMS–10575 (OMB control number: 0938–1297); *Frequency:* Occasionally; *Affected Public:* Individuals and Households, State, Local, or Tribal Governments, Federal Government, Private Sector (Business or other for-profits and Not-for-profits); *Number of Respondents:* 30,110; *Number of Responses:* 23,110; *Total Annual Hours:* 26,467. (For questions regarding this collection contact Dustin Allison (303) 437–6123.)

Dated: February 16, 2022.

William N. Parham, III,

Director, Paperwork Reduction Staff, Office of Strategic Operations and Regulatory Affairs.

[FR Doc. 2022–03725 Filed 2–18–22; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifiers: CMS–10391, CMS–R–74, CMS–R–306, CMS–265–11 and CMS–10544]

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 (the 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 April 25, 2022.

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, you may make your request using one of following:

1. Access CMS' website address at website address at *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–10391—Methods for Assuring Access to Covered Medicaid Services Under 42 CFR 447.203 and 447.204

CMS–R–74 Income and Eligibility Verification System Reporting and Supporting Regulations

CMS–R–306 Use of Restraint and Seclusion in Psychiatric Residential Treatment Facilities (PRTFs) for Individuals Under Age 21 and Supporting Regulations

CMS–265–11 Independent Renal Dialysis Facility Cost Report

CMS–10544 Good Cause Processes

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 Collection

1. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Methods for Assuring Access to Covered Medicaid Services Under 42 CFR 447.203 and 447.204; *Use:* Current regulations at 42 CFR 447.203(b) require states to develop an access monitoring review plan (AMRP) that is updated at least every three years for: Primary care services, physician specialist services, behavioral health services, pre and post-natal obstetric services (including labor and delivery), and home health services. When states reduce rates for other Medicaid services, they must add those services to the AMRP and monitor the effects of the rate reductions for 3 years. If access issues are detected, a state must submit a corrective action plan to CMS within 90 days and work to address the issues within 12 months. Section 447.203(b)(7) requires that states have mechanisms to obtain ongoing beneficiary and provider feedback. A state is also required to maintain a record of data on public input and how the state responded to the input. Prior to submitting proposals to reduce or restructure Medicaid service payment rates, states must receive input from beneficiaries, providers, and other affected stakeholders on the extent of beneficiary access to the affected services.

The information is used by states to document that access to care is in compliance with section 1902(a)(30)(A) of the Social Security Act, to identify issues with access within a state's Medicaid program, and to inform any necessary programmatic changes to address issues with access to care. CMS uses the information to make informed approval decisions on State plan amendments that propose to make Medicaid rate reductions or restructure payment rates and to provide the necessary information for CMS to monitor ongoing compliance with section 1902(a)(30)(A). Beneficiaries, providers and other affected stakeholders may use the information to raise access issues to state Medicaid agencies and work with agencies to address those issues. *Form Number:* CMS–10391 (OMB control number: 0938–1134); *Frequency:* Annually; *Affected Public:* State, Local, or Tribal Governments); *Number of Respondents:* 51; *Total Annual Responses:* 212; *Total Annual Hours:* 12,262. (For questions regarding this collection contact Jeremy Silanskis at 410–786–1592.)

2. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Income and Eligibility Verification System Reporting and Supporting Regulations; *Use:* Section 1137 of the Social Security Act requires that States verify the income and eligibility information contained on the applicant's application and in the applicant's case file through data matches with the agencies and entities identified in this section. The State Medicaid/CHIP agency will report the existence of a system to collect all information needed to determine and redetermine eligibility for Medicaid and CHIP. The State Medicaid/CHIP agency will attest to using the PARIS system in determining beneficiary eligibility in Medicaid or CHIP benefit programs. *Form Number:* CMS–R–74 (OMB control number: 0938–0467); *Frequency:* Occasionally; *Affected Public:* State, Local, or Tribal Governments; *Number of Respondents:* 55; *Total Annual Responses:* 3,241; *Total Annual Hours:* 1,071. (For policy questions regarding this collection contact Stephanie Bell at 410–786–0617.)

3. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Use of Restraint and Seclusion in Psychiatric Residential Treatment Facilities (PRTFs) for Individuals Under Age 21 and Supporting Regulations; *Use:* Psychiatric residential treatment facilities are required to report deaths, serious injuries and attempted suicides to the State Medicaid Agency and the Protection and Advocacy Organization. They are also required to provide residents the restraint and seclusion policy in writing, and to document in the residents' records all activities involving the use of restraint and seclusion. *Form Number:* CMS–R–306 (OMB control number: 0938–0833); *Frequency:* Occasionally; *Affected Public:* Private sector (Business or other for-profits); *Number of Respondents:* 390; *Total Annual Responses:* 1,466,823; *Total Annual Hours:* 449,609. (For policy questions regarding this collection contact Kirsten Jensen at 410–786–8146.)

4. *Type of Information Collection Request:* Reinstatement with change; *Title of Information Collection:* Independent Renal Dialysis Facility Cost Report; *Use:* Under the authority of sections 1815(a) and 1833(e) of the Act, CMS requires that providers of services participating in the Medicare program submit information to determine costs

for health care services rendered to Medicare beneficiaries. CMS requires that providers follow reasonable cost principles under 1861(v)(1)(A) of the Act when completing the Medicare cost report (MCR). Regulations at 42 CFR 413.20 and 413.24 require that providers submit acceptable cost reports on an annual basis and maintain sufficient financial records and statistical data, capable of verification by qualified auditors.

ESRD facilities participating in the Medicare program submit these cost reports annually to report cost and statistical data used by CMS to determine reasonable costs incurred for furnishing dialysis services to Medicare beneficiaries and to effect the year-end cost settlement for Medicare bad debts. *Form Number:* CMS–265–11 (OMB control number: 0938–0236); *Frequency:* Annually; *Affected Public:* Private Sector, Business or other for-profits, State, Local, or Tribal Governments); *Number of Respondents:* 7,492; *Total Annual Responses:* 7,492; *Total Annual Hours:* 494,472. (For questions regarding this collection contact Keplinger, Jill C at 410–786–4550.)

5. *Type of Information Collection Request:* Reinstatement without change; *Title of Information Collection:* Good Cause Processes; *Use:* Section 1851(g)(3)(B)(i) of the Act provides that MA organizations may terminate the enrollment of individuals who fail to pay basic and supplemental premiums after a grace period established by the plan. Section 1860D–1(b)(1)(B)(v) of the Act generally directs us to establish rules related to enrollment, disenrollment, and termination for Part D plan sponsors that are similar to those established for MA organizations under section 1851 of the Act. Consistent with these sections of the Act, subpart B in each of the Parts C and D regulations sets forth requirements with respect to involuntary disenrollment procedures at 42 CFR 422.74 and 423.44, respectively. In addition, section 1876(c)(3)(B) establishes that individuals may be disenrolled from coverage as specified in regulations. Thus, current regulations at 42 CFR 417.460 specify that a cost plan, specifically a Health Maintenance Organization (HMO) or competitive medical plan (CMP), may disenroll a member who fails to pay premiums or other charges imposed by the plan for deductible and coinsurance amounts.

These good cause provisions authorize CMS to reinstate a disenrolled individual's enrollment without interruption in coverage if the non-payment is due to circumstances that the individual could not reasonably foresee or could not control, such as an unexpected hospitalization. At its inception, the process of accepting, reviewing, and processing beneficiary requests for reinstatement for good cause was carried out exclusively by CMS. *Form Number:* CMS–10544 (OMB control number: 0938–1271); *Frequency:* Annually; *Affected Public:* Business or other for-profits State, Local, or Tribal Governments); *Number of Respondents:* 312; *Total Annual Responses:* 41,289; *Total Annual Hours:* 27,499. (For questions regarding this collection contact Fabayo, Ronke at (410) 786–4460.)

Dated: February 16, 2022.

William N. Parham, III,

Director, Paperwork Reduction Staff, Office of Strategic Operations and Regulatory Affairs.

[FR Doc. 2022–03727 Filed 2–18–22; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

OMB No. 0970–0502

Proposed Information Collection Activity; Behavioral Interventions To Advance Self-Sufficiency Next Generation

AGENCY: Office of Planning, Research, and Evaluation, Administration for Children and Families, HHS.

ACTION: Request for public comment.

SUMMARY: The Office of Planning, Research, and Evaluation (OPRE) in the Administration for Children and Families (ACF), U.S. Department of Health and Human Services (HHS), requests Office of Management and Budget (OMB) approval to extend approval of the ACF Behavioral Interventions to Advance Self-Sufficiency Next Generation (BIAS–NG) Project Overarching Generic (OMB #: 0970–0502; Expiration date: 8/31/2022). Under this overarching generic, ACF collects data as part of rapid cycle testing and evaluation, in order to inform the design of interventions informed by behavioral science and to better understand the mechanisms and effects of such interventions. Interventions have been and will continue to be developed in the program area domains of Temporary Assistance for Needy Families (TANF), child welfare, and Early Head Start/Head Start (EHS/HS). These interventions are intended to improve outcomes for participants in these programs. No changes are proposed.

DATES: *Comments due within 60 days of publication.* In compliance with the requirements of the Paperwork Reduction Act of 1995, ACF is soliciting public comment on the specific aspects of the information collection described above.

ADDRESSES: You can obtain copies of the proposed collection of information and submit comments by emailing *OPREinfocollection@acf.hhs.gov.* Identify all requests by the title of the information collection.

SUPPLEMENTARY INFORMATION:

Description: OPRE is conducting the BIAS–NG project, which uses behavioral insights to design and test interventions intended to improve the efficiency, operations, and efficacy of human services programs. The BIAS–NG project is applying and testing behavioral insights to ACF programs including TANF, Child Welfare, and EHS/HS. This notice is a request for comments on ACF's proposal to extend approval of the overarching generic. Under the approved pilot generic clearance, OPRE has already completed work with five sites and has conducted five tests. The extended approval would allow OPRE to continue to work with at least three additional sites, conducting one or more tests of behavioral interventions. The design and testing of BIAS–NG interventions is rapid and, to the extent possible, iterative. Each specific intervention is designed in consultation with agency leaders and launched as quickly as possible. To maximize the likelihood that the intervention produces measurable, significant, and positive effects on outcomes of interest, rapid cycle evaluation techniques will be employed in which proximate outcomes will be measured to allow the research team to more quickly iterate and adjust the intervention design, informing subsequent tests. Due to the rapid and iterative nature of this work, OPRE sought and received generic clearance to conduct this research. Following standard OMB requirements for generic clearances, once instruments requiring burden are tailored to a specific site and the site's intervention, OPRE submits an individual generic information collection request under this umbrella clearance. Each request includes the individual instrument(s), a justification specific to the individual information collection, a description of the proposed intervention, and any supplementary documents. Each specific information collection includes up to two submissions—one submission for the formative stage research and another submission for any further data