and has delisted the PSO accordingly. AHRQ delisted the Proximie PSO, PSO number P0244, due to its failure to correct a deficiency.

DATES: The delisting for Proximie PSO was effective at 12:00 Midnight ET (2400) on January 11, 2025. The delisting for Michigan Surgical Quality Collaborative was effective at 12:00 Midnight ET (2400) on April 21, 2025.

ADDRESSES: The directories for both listed and delisted PSOs are ongoing and reviewed weekly by AHRQ. Both directories can be accessed electronically at the following HHS website: *https://www.pso.ahrq.gov/listed.*

FOR FURTHER INFORMATION CONTACT: Cathryn Bach, Center for Quality Improvement and Patient Safety, AHRQ, 5600 Fishers Lane, MS 06N100B, Rockville, MD 20857; Telephone (toll free): (866) 403–3697; Telephone (local): (301) 427–1111; TTY (toll free): (866) 438–7231; TTY (local): (301) 427–1130; Email: *pso@ahrq.hhs.gov.*

SUPPLEMENTARY INFORMATION:

Background

The Patient Safety Act, 42 U.S.C. 299b–21 to 299b–26, and the related Patient Safety Rule, 42 CFR part 3, published in the **Federal Register** on November 21, 2008 (73 FR 70732–70814), establish a framework by which individuals and entities that meet the definition of provider in the Patient Safety Rule may voluntarily report information to PSOs listed by AHRQ, on a privileged and confidential basis, for the aggregation and analysis of patient safety work product.

The Patient Safety Act authorizes the listing of PSOs, which are entities or component organizations whose mission and primary activity are to conduct activities to improve patient safety and the quality of health care delivery.

HHS issued the Patient Safety Rule to implement the Patient Safety Act. AHRQ administers the provisions of the Patient Safety Act and Patient Safety Rule relating to the listing and operation of PSOs. The Patient Safety Rule authorizes AHRQ to list as a PSO an entity that attests that it meets the statutory and regulatory requirements for listing. A PSO can be ''delisted'' if it is found to no longer meet the requirements of the Patient Safety Act and Patient Safety Rule, when a PSO chooses to voluntarily relinquish its status as a PSO for any reason, or when a PSO's listing expires. Section 3.108(d) of the Patient Safety Rule requires AHRQ to provide public notice when it removes an organization from the list of PSOs.

AHRQ has accepted a notification of proposed voluntary relinquishment from the Michigan Surgical Quality Collaborative to voluntarily relinquish its status as a PSO. Accordingly, the Michigan Surgical Quality Collaborative, PSO number P0143, was delisted effective at 12:00 Midnight ET (2400) on April 21, 2025.

Michigan Surgical Quality Collaborative has patient safety work product (PSWP) in its possession. The PSO will meet the requirements of section 3.108(c)(2)(i) of the Patient Safety Rule regarding notification to providers that have reported to the PSO and of section 3.108(c)(2)(ii) regarding disposition of PSWP consistent with section 3.108(b)(3). According to section 3.108(b)(3) of the Patient Safety Rule, the PSO has 90 days from the effective date of delisting and revocation to complete the disposition of PSWP that is currently in the PSO's possession.

Proximie PSO failed to submit a response to the findings of deficiency in the Notice of Proposed Revocation and Delisting by the deadline. As stated in the Patient Safety Rule at 42 CFR 3.108(a)(4)(iii), this failure means that the Notice of Proposed Revocation and Delisting becomes final as a matter of law. It also serves as the basis for AHRQ to revoke acceptance of Proximie PSO certifications for listing, remove Proximie PSO from the list of PSOs, and provide public notice in the **Federal Register** and on the AHRQ PSO website that Proximie PSO has been delisted for cause. Accordingly, the Proximie PSO, P0244, was delisted effective at 12:00 Midnight ET (2400) on January 11, 2025.

More information on PSOs can be obtained through AHRQ's PSO website at *http://www.pso.ahrq.gov.*

Dated: April 28, 2025.

Jeffrey P. Toven,

Executive Officer.

[FR Doc. 2025–10798 Filed 6–12–25; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifiers: CMS–10398 #37, #87, and #93]

Medicaid and Children's Health Insurance Program (CHIP) Generic Information Collection Activities: Proposed Collection; Comment Request

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

ACTION: Notice.

SUMMARY: On May 28, 2010, the Office of Management and Budget (OMB) issued Paperwork Reduction Act (PRA) guidance related to the ''generic'' clearance process. Generally, this is an expedited process by which agencies may obtain OMB's approval of collection of information requests that are ''usually voluntary, low-burden, and uncontroversial collections,'' do not raise any substantive or policy issues, and do not require policy or methodological review. The process requires the submission of an overarching plan that defines the scope of the individual collections that would fall under its umbrella. This **Federal Register** notice seeks public comment on one or more of our collection of information requests that we believe are generic and fall within the scope of the umbrella. Interested persons are invited to submit 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 June 27, 2025.

ADDRESSES: When commenting, please reference the applicable form number (CMS–10398 #____) and the OMB control number (0938–1148). 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: CMS–10398 #____/OMB control number: 0938–1148, Room C4–26–05, 7500 Security Boulevard, Baltimore, MD 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/medicare/regulations-guidance/legislation/paperwork-reduction-act-1995/pra-listing.*

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

SUPPLEMENTARY INFORMATION: Following is a summary of the use and burden associated with the subject information collection(s). More detailed information can be found in the collection's supporting statement and associated materials (see **ADDRESSES**).

Generic Information Collection

1. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Medicaid Managed Care Rate Development Guide; *Use:* States must submit to CMS for review and approval all rate certifications for managed care plans. The state's actuary is responsible for certifying that the managed care program's capitation rates are actuarially sound for a specific time period and documents the rate development process and the final certified capitation rates in a rate certification. The Medicaid Managed Care Rate Development Guides outline the rate development standards and CMS' expectations for documentation included in rate certifications such as descriptions of base data used, trend factors to base data, projected benefit and non-benefit costs, and any other considerations or adjustments used when setting capitation rates. *Form Number:* CMS–10398 #37 (OMB control number: 0938–1148); *Frequency:* Once and Occasionally; *Affected Public:* State, Local, or Tribal Governments; *Number of Respondents:* 47; *Total Annual Responses:* 137; *Total Annual Hours:* 754. (For policy questions regarding this collection contact: Rebecca Burch Mack at 303–844–7355.)

2. *Type of Information Collection Request:* New information collection request; *Title of Information Collection:* Managed Care Plan (MCP) Medical Loss Ratio (MLR) Reporting Template; *Use:* Medicaid managed care is the predominant delivery system for Medicaid beneficiaries to access health care services. State Medicaid agencies contract with managed care plans that accept a fixed, prospective monthly payment for each enrolled beneficiary (also referred to as risk-based managed care). Section 1903(m)(2) of the Social Security Act (SSA) and 42 CFR 438.4 require that capitation rates be actuarially sound, meaning that the capitation rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the MCP for the time period and the population covered under the terms of the contract. The MLR is a key measure of MCP financial performance and indicates the share of premium revenue (capitation payments) that a plan spends on covered health services and activities to improve health care quality compared to the share of revenue to cover administrative expenses and profit/surplus. MLRs are used as a retrospective tool to assess financial performance of MCPs. Section 438.8 provides detail on MLR calculations and MCP reporting requirements.

Section 438.8(k) requires State contracts with MCPs to include a requirement to annually report to the state specific details of the plan's MLR. The attached Medicaid managed care plan MLR reporting template provides States with a standard format for collecting the required details from their contracted MCPs. States are not required to have their MCPs use this template; it is provided in response to States' requests for a streamlined, consistent way to collect the required information. CMS' review process for managed care MLR represents an essential federal oversight function to ensure that States and MCPs are compliant with applicable federal laws and regulations.

Form Number: CMS–10398 #87 (OMB control number: 0938–1148); *Frequency:* Yearly; *Affected Public:* Private Sector and State, Local, or Tribal Governments; *Number of Respondents:* 47; *Total Annual Responses:* 47; *Total Annual Hours:* 2,350. (For policy questions regarding this collection contact: Amy Gentile at 410–786–3499.)

3. *Type of Information Collection Request:* New information collection request; *Title of Information Collection:* Medicaid 1915(l) State Plan Option to Provide Medical Assistance for Eligible Individuals Who Are Patients in Eligible Institutions for Mental Diseases; *Use:* On March 9, 2024, section 204 of the Consolidated Appropriations Act amended section 1915(l) of the SSA to remove the end date of September 30, 2023, making 1915(l) a permanent optional state plan benefit, and making additional changes to the requirements for maintenance of effort review process for eligible institutions of mental disease, patient placement and utilization management, and provider assessments.

The template is necessary for States to submit a state plan amendment on or before December 31, 2025, for an October 1, 2025, effective date. States will need adequate time to complete and vet these documents. If states do not have template, it could result in states not paying for such services, and beneficiaries not being able to receive such services. The longer the package update goes unpublished the likelihood of states missing the deadline increases.

Form Number: CMS–10398 #93 (OMB control number: 0938–1148); *Frequency:* Once and Occasionally; *Affected Public:* State, Local, or Tribal Governments; *Number of Respondents:* 56; *Total Annual Responses:* 56; *Total Annual Hours:* 1,400. (For policy questions regarding this collection contact: Marlana Thieler at 410–786–6274.)

William N. Parham, III,

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

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–276]

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