endpoints directory to maximize its effectiveness?

III. Collection of Information Requirements

Please note, this is a request for information (RFI) only. In accordance with the implementing regulations of the Paperwork Reduction Act of 1995 (PRA), specifically 5 CFR 1320.3(h)(4), this general solicitation is exempt from the PRA. Facts or opinions submitted in response to general solicitations of comments from the public, published in the **Federal Register** or other publications, regardless of the form or format thereof, provided that no person is required to supply specific information pertaining to the commenter, other than that necessary for self-identification, as a condition of the agency's full consideration, are not generally considered information collections and therefore not subject to the PRA.

This RFI is issued solely for information and planning purposes; it does not constitute a Request for Proposal (RFP), applications, proposal abstracts, or quotations. This RFI does not commit the U.S. Government to contract for any supplies or services or make a grant award. Further, CMS and ASTP/ONC are not seeking proposals through this RFI and will not accept unsolicited proposals. Responders are advised that the U.S. Government will not pay for any information or administrative costs incurred in response to this RFI; all costs associated with responding to this RFI will be solely at the interested party's expense. CMS and ASTP/ONC note that not responding to this RFI does not preclude participation in any future procurement, if conducted. It is the responsibility of the potential responders to monitor this RFI announcement for additional information pertaining to this request. In addition, CMS and ASTP/ONC note that we will not respond to questions about potential policy issues raised in this RFI.

CMS and ASTP/ONC will actively consider input as we develop future regulatory proposals or future subregulatory policy guidance. We may or may not choose to contact individual responders. Such communications would be for the sole purpose of clarifying statements in the responders' written responses. Contractor support personnel may be used to review responses to this RFI. Responses to this notice are not offers and cannot be accepted by the Government to form a binding contract or issue a grant. Information obtained as a result of this RFI may be used by the Government for program planning on a non-attribution basis. Respondents should not include any information that might be considered proprietary or confidential. This RFI should not be construed as a commitment or authorization to incur cost for which reimbursement would be required or sought. All submissions become U.S. Government property and will not be returned. In addition, we may publicly post the public comments received or a summary of those public comments.

Stephanie Carlton, Deputy Administrator of the Centers for Medicare & Medicaid Services, approved this document on May 9, 2025.

Steven Posnack, Acting Assistant Secretary for Technology Policy, Acting National Coordinator for Health Information Technology, approved this document on May 6, 2025.

Robert F. Kennedy, Jr.,

Secretary, Department of Health and Human Services.

[FR Doc. 2025–08701 Filed 5–13–25; 11:15 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–4211–PN]

Medicare Program; Request for Renewal of Deeming Authority of the Utilization Review Accreditation Commission (URAC) for Medicare Advantage Health Maintenance Organizations and Preferred Provider Organizations

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

ACTION: Notice with request for comment.

SUMMARY: This proposed notice announces that the Centers for Medicare & Medicaid Services is considering granting approval of the Utilization Review Accreditation Commission's renewal application for Medicare Advantage ''deeming authority'' of Health Maintenance Organizations and Preferred Provider Organizations to continue participation in the Medicare or Medicaid program.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. June 16, 2025.

ADDRESSES: In commenting, refer to file code CMS–4211–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 *https://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–4211–PN, P.O. Box 8016, Baltimore, MD 21244–8016.

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–4211–PN, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

FOR FURTHER INFORMATION CONTACT: Dawn Johnson Scott, (410) 786–3159 or Katie Schenck, (410) 786–0628.

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: *https://www.regulations.gov.* Follow the search instructions on that website to view public comments.

I. Background

Under the Medicare program, eligible beneficiaries may receive covered services through a Medicare Advantage (MA) organization that contracts with the Center for Medicare & Medicaid Services (CMS). The regulations specifying the Medicare requirements that must be met for a Medicare Advantage organization (MAO) to enter into a contract with CMS are located at 42 CFR 422.503(b). These regulations implement Part C of Title XVIII of the Social Security Act (the Act), which specifies the services that an MAO must provide and the requirements that the organization must meet to be an MA contractor. Other relevant provisions of the Act include Parts A and B of Title XVIII and Parts A and E of Title XI of the Act pertaining to the provision of

services by Medicare-certified providers and suppliers. Generally, for an entity to be an MAO, the organization must be licensed by the state as a risk bearing organization, as set forth in 42 CFR 422.400.

As a method of assuring compliance with certain Medicare requirements, an MAO may choose to become accredited by a CMS-approved accreditation organization (AO). By virtue of its accreditation by a CMS-approved AO, the MAO may be ''deemed'' compliant in one or more requirements set forth in section 1852(e)(4)(B) of the Act. For CMS to recognize an AO's accreditation program as establishing an MA plan's compliance with our requirements, the AO must, as set forth in § 422.157(a)(1), prove to CMS that their standards are at least as stringent as Medicare requirements for MAOs. MAOs that are licensed as health maintenance organizations (HMOs) or preferred provider organizations (PPOs) and are accredited by an approved AO may receive, at their request, ''deemed'' status for CMS requirements for the deemable areas. These areas include Quality Improvement, Anti-Discrimination, Confidentiality and Accuracy of Enrollee Records, Information on Advance Directives, and Provider Participation Rules.

At this time, CMS does not recognize accreditation of the following areas: Access to Services set out in § 422.156(b)(3) or the Part D areas of review set out at § 423.165(b) as part of the MA deeming program. AOs that apply for MA deeming authority are generally recognized by the health care industry as entities that accredit HMOs and PPOs. As we specify at § 422.157(b)(2)(ii), the term for which an AO may be approved by CMS may not exceed 6 years. For continuing approval, the AO must apply to CMS to renew their deeming authority for a subsequent approval period.

The Utilization Review Accreditation Commission (URAC) was previously approved by CMS as an accreditation organization for MA deeming of HMOs and PPOs for a term from May 31, 2019 to June 2, 2025. On March 14, 2025, URAC submitted its initial application to renew its deeming authority, including materials requested by CMS that included information intended to address the requirements set out in regulations at § 422.158(a) and (b) that are prerequisites for receiving approval of its accreditation program from CMS. CMS subsequently requested that additional materials be submitted by URAC to satisfy these requirements.

II. Provisions of the Proposed Notice

This proposed notice notifies the public of URAC's request to renew its MA deeming authority for HMOs and PPOs. URAC submitted all the necessary materials (including its standards and monitoring protocol) to enable us to make a determination concerning its request for approval as an accreditation organization for CMS. This renewal application was submitted on March 14, 2025, and CMS has determined the application is complete. Under section 1852(e)(4) of the Act and § 422.158 (Federal review of accreditation organizations), our review and evaluation of URAC will be conducted as discussed below.

A. Components of the Review Process

The review of URAC's renewal application for approval of MA deeming authority includes, but is not limited to, the following components:

- The types of MA plans that it would review as part of its accreditation process.
- A detailed comparison of URAC's accreditation requirements and standards with the Medicare requirements (for example, a crosswalk) in the following 5 deemable areas: Quality Improvement, Anti-Discrimination, Confidentiality and Accuracy of Enrollee Records, Information on Advance Directives, and Provider Participation Rules.
- Detailed information about the organization's survey process, including—
  - ++ Frequency of surveys and whether surveys are announced or unannounced.
  - ++ Copies of survey forms, and guidelines and instructions to surveyors.
  - ++ Descriptions of—
    - —The survey review process and the accreditation status decision making process.
    - —The procedures used to notify accredited MAOs of deficiencies and to monitor the correction of those deficiencies; and
    - —The procedures used to enforce compliance with accreditation requirements.
- Detailed information about the individuals who perform surveys for the AO, including—
  - ++ The size and composition of accreditation survey teams for each type of plan reviewed as part of the accreditation process;
  - ++ The education and experience requirements surveyors must meet;
  - ++ The content and frequency of the in-service training provided to survey personnel;
  - ++ The evaluation systems used to monitor the performance of individual surveyors and survey teams; and
  - ++ The organization's policies and practice for participation, in surveys or in the accreditation decision process, by an individual who is professionally or financially affiliated with the entity being surveyed.
- A description of the organization's data management and analysis system for its surveys and accreditation decisions, including the kinds of reports, tables, and other displays generated by that system.
- A description of the organization's procedures for responding to and investigating complaints against accredited organizations, including policies and procedures regarding coordination of these activities with appropriate licensing bodies and ombudsmen programs.
- A description of the organization's policies and procedures for the withholding or removal of accreditation for failure to meet the AO's standards or requirements, and other actions the organization takes in response to noncompliance with its standards and requirements.
- A description of all types (for example, full, partial) and categories (for example, provisional, conditional, temporary) of accreditation offered by the organization, the duration of each type and category of accreditation and a statement identifying the types and categories that would serve as a basis for accreditation if CMS approves the AO.
- A list of all currently accredited MAOs and the type, category, and expiration date of the accreditation held by each of them.
- A list of all full and partial accreditation surveys scheduled to be performed by the AO.
- The name and address of each person with an ownership or control interest in the AO.
- CMS will also consider URAC's past performance in the deeming program and results of recent deeming validation reviews or equivalency reviews conducted as part of continuing Federal oversight of the deeming program under § 422.157(d).

B. Notice Upon Completion of Evaluation

Upon completion of our evaluation, including a review of comments received as a result of this proposed notice, we will publish a notice in the **Federal Register** announcing the result of our evaluation. Section 1852(e)(4)(C) of the Act provides a statutory timetable to ensure that our review of deeming applications is conducted in a timely

manner. The Act provides us with 210 calendar days after the date of receipt of a completed application to complete our survey activities and application review process. Within the 210-day period, we will publish an approval or denial of the application in the **Federal Register**.

III. Collection of Information Requirements

This document does not impose any new or revised ''collection of information'' requirements or burden. Consequently, there is no need for review by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501 *et seq.*). With respect to the PRA and this section of the preamble, collection of information is defined under 5 CFR 1320.3(c) of the PRA's implementing regulations.

IV. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

The Administrator of the Centers for Medicare & Medicaid Services (CMS), Mehmet Oz, having reviewed and approved this document, authorizes Trenesha Fultz-Mimms, who is the Federal Register Liaison, to electronically sign this document for purposes of publication in the **Federal Register**.

Trenesha Fultz-Mimms,

Federal Register Liaison, Centers for Medicare & Medicaid Services.

[FR Doc. 2025–08722 Filed 5–14–25; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–9154–N]

Medicare and Medicaid Programs; Quarterly Listing of Program Issuances—January Through March 2025

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

ACTION: Notice.

SUMMARY: This quarterly notice lists Centers for Medicare & Medicaid Services (CMS) manual instructions, substantive and interpretive regulations, and other **Federal Register** notices that were published in the 3-month period, relating to the Medicare and Medicaid programs and other programs administered by CMS.

FOR FURTHER INFORMATION CONTACT: It is possible that an interested party may need specific information and not be able to determine from the listed information whether the issuance or regulation would fulfill that need. Consequently, we are providing contact persons to answer general questions concerning each of the addenda published in this notice.

Addenda	Contact	Phone No.
I. CMS Manual Instructions	Ronda Allen-Bonner	(410) 786–4657
II. Regulation Documents Published in the **Federal Register**	Terri Plumb	(410) 786–4481
III. CMS Rulings	Tiffany Lafferty	(410) 786–7548
IV. Medicare National Coverage Determinations	Wanda Belle, MPA	(410) 786–7491
V. FDA-Approved Category B IDEs	John Manlove	(410) 786–6877
VI. Collections of Information	William Parham	(410) 786–4669
VII. Medicare—Approved Carotid Stent Facilities	Sarah Fulton, MHS	(410) 786–2749
VIII. American College of Cardiology-National Cardiovascular Data Registry Sites	Sarah Fulton, MHS	(410) 786–2749
IX. Medicare's Active Coverage-Related Guidance Documents	Lori Ashby, MA	(410) 786–6322
X. One-time Notices Regarding National Coverage Provisions	JoAnna Baldwin, MS	(410) 786–7205
XI. National Oncologic Positron Emission Tomography Registry Sites	David Dolan, MBA	(410) 786–3365
XII. Medicare-Approved Ventricular Assist Device (Destination Therapy) Facilities	David Dolan, MBA	(410) 786–3365
XIII. Medicare-Approved Lung Volume Reduction Surgery Facilities	Sarah Fulton, MHS	(410) 786–2749
XIV. Medicare-Approved Bariatric Surgery Facilities	Sarah Fulton, MHS	(410) 786–2749
XV. Fluorodeoxyglucose Positron Emission Tomography for Dementia Trials	David Dolan, MBA	(410) 786–3365
All Other Information	Renee Swann	(410) 786–4492

SUPPLEMENTARY INFORMATION:

I. Background

The Centers for Medicare & Medicaid Services (CMS) is responsible for administering the Medicare and Medicaid programs and coordination and oversight of private health insurance. Administration and oversight of these programs involves the following: (1) furnishing information to Medicare and Medicaid beneficiaries, health care providers, and the public; and (2) maintaining effective communications with CMS regional offices, state governments, state Medicaid agencies, state survey agencies, various providers of health care, all Medicare contractors that process claims and pay bills, National Association of Insurance Commissioners (NAIC), health insurers, and other stakeholders. To implement the various statutes on which the programs are based, we issue regulations under the authority granted to the Secretary of the Department of Health and Human Services under sections 1102, 1871, 1902, and related provisions of the Social Security Act (the Act) and Public Health Service Act. We also issue various manuals, memoranda, and statements necessary to administer and oversee the programs efficiently.

Section 1871(c) of the Act requires that we publish a list of all Medicare manual instructions, interpretive rules, statements of policy, and guidelines of general applicability not issued as regulations at least every 3 months in the **Federal Register**.

II. Format for the Quarterly Issuance Notices

This quarterly notice provides only the specific updates that have occurred in the 3-month period along with a hyperlink to the full listing that is