physician assistants (PAs) to certify the need for home health services and to order services in the Medicare and Medicaid programs. As such, under CMS–5531–IFC, CMS amended 42 CFR 440.70 to remove the requirement that the NPPs have to communicate the clinical finding of the face-to-face encounter to the ordering physician. With expanding authority to order home health services, the CARES Act also provided that such practitioners are now capable of independently performing the face-to-face encounter for the patient for whom they are the ordering practitioner, in accordance with state law. *Form Number:* CMS–10609 (OMB control number: 0938–1319); *Frequency:* Occasionally; *Affected Public:* Private sector (business or other for-profits); *Number of Respondents:* 381,148; *Total Annual Responses:* 1,143,443; *Total Annual Hours:* 190,955. (For policy questions regarding this collection contact Alexandra Eitel at 410–786–0790.)

5. *Type of Information Collection Request:* New collection (Request for a new OMB control number); *Title of Information Collection:* Generic Clearance for CMS and Medicare Administrative Contractor (MAC) Generic Customer Experience; *Use:* The Centers for Medicare & Medicaid Services (CMS) is requesting approval to collect generic feedback from respondents including, but not limited to Medicare providers, Medicare suppliers, provider or supplier staff, billers, credentialing agencies, researchers, clearinghouses, consultants, and attorneys. These surveys will give us insights into customers' perceptions and opinions and will be used to improve customer experiences and communications materials; however, the results will not be generalized to the population of study.

Improving agency programs requires ongoing systemic review of service delivery and program operations compared to defined standards. We'll use multiple methods to collect, analyze, and interpret information from this generic clearance to find the strengths and weaknesses of our current services. We'll use this feedback to inform process improvements or maintain service quality offered to providers and stakeholders. *Form Number:* CMS–10731 (OMB control number: 0938–New); *Frequency:* Occasionally; *Affected Public:* Private sector (business or other for-profits); *Number of Respondents:* 997,100; *Total Annual Responses:* 997,100; *Total Annual Hours:* 50,000. (For policy questions regarding this collection contact Alyssa Schaub-Rimel at 410–786–4660.)

Dated: February 2, 2023.

William N. Parham, III,

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

[FR Doc. 2023–02579 Filed 2–6–23; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifiers CMS–10704, CMS–10387, CMS–10846, CMS–R–246 and CMS–10316]

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 April 10, 2023.

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**).

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:* Revision of a currently approved collection; *Title of Information Collection:* Health Reimbursement Arrangements and Other Account-Based Group Health Plans; *Use:* On June 20, 2019, the Department of the Treasury, the Department of Labor, and the Department of Health and Human Services (collectively, the Departments) issued final regulations titled ''Health Reimbursement Arrangements and Other Account-Based Group Health Plans'' (84 FR 28888) under section 2711 of the PHS Act and the health nondiscrimination provisions of HIPAA, Public Law 104–191 (HIPAA nondiscrimination provisions). The regulations expanded the use of health reimbursement arrangements and other account-based group health plans (collectively referred to as HRAs) and recognized certain HRAs as limited excepted benefits (the excepted benefit HRA), for plan years beginning on or after January 1, 2020. In general, the regulations expanded the use of HRAs by eliminating the prohibition on integrating HRAs with individual health insurance coverage, thereby permitting employers to offer individual coverage HRAs to employees that can be integrated with individual health insurance coverage or Medicare Parts A and B, or Part C. Under the regulations, employees are permitted to use amounts in an individual coverage HRA to pay expenses for medical care (including premiums for individual health insurance coverage and Medicare), subject to certain requirements. This information collection includes provisions related to substantiation of individual health insurance coverage (45 CFR 146.123(c)(5)), the notice requirement for individual coverage HRAs (45 CFR 146.123(c)(6)), and notification of termination of coverage (45 CFR 146.123(c)(1)(iii)). In the final rule ''Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2021; Notice Requirement for Non-federal Governmental Plans'' (85 FR 29164), under 45 CFR 146.145(b)(3)(viii)(E), excepted benefit HRAs offered by non-Federal governmental plan sponsors are required to provide a notice that describes conditions pertaining to eligibility to receive benefits, annual or lifetime caps or other limits on benefits under the excepted benefit HRA, and a description or summary of the benefits. This notice must be provided no later than 90 days after the employee becomes a participant in the excepted benefit HRA and annually thereafter. *Form Number:* CMS–10704 (OMB control number: 0938–1361); *Frequency:* Annually; *Affected Public:* Private Sector, State Governments; *Number of Respondents:* 11,574; *Total Annual Responses:* 1,037,674; *Total Annual Hours:* 5,889. (For policy questions regarding this collection contact Adam Pellillo at (667) 290–9621.)

2. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Minimum Data Set 3.0 Nursing Home and Swing Bed Prospective Payment System (PPS) For the collection of data related to the Patient Driven Payment Model and the Skilled Nursing Facility Quality Reporting Program (QRP); *Use:* We are requesting to implement to the MDS 3.0 v1.18.11 beginning October 1, 2023 to October 1, 2026 in order to meet the requirements of policies finalized in the Federal Fiscal Year (FY) 2020 Skilled Nursing Facility (SNF) Prospective Payment System (PPS) final rule (84 FR 38728). The compliance date for the finalized policies (10/01/2020) was delayed due to the COVID–19 public health emergency (PHE). While there has been no change in assessment-level burden since the approval of the MDS 3.0 v1.17.2, there has been a change in total burden since 2019 when the package was originally approved due to a decrease in the number of MDS assessments completed and a change in the hourly rate for clinicians completing the assessment.

We use the MDS 3.0 PPS Item Set to collect the data used to reimburse skilled nursing facilities for SNF-level care furnished to Medicare beneficiaries and to collect information for quality measures and standardized patient assessment data under the SNF QRP. There have been some revisions to the assessment tool since the approval of MDS 3.0 v1.17.2. *Form Number:* CMS–10387 (OMB control number: 0938–1140); *Frequency:* Yearly; *Affected Public:* Private Sector: Business or other for-profit and not-for-profit institutions; *Number of Respondents:* 15,472; *Total Annual Responses:* 3,371,993; *Total Annual Hours:* 2,866,194. (For policy questions regarding this collection contact Heidi Magladry at 410–786–6034).

3. *Type of Information Collection Request:* New Collection (Request for a new OMB control number); *Title of Information Collection:* Medicare Part D Manufacturer Discount Program Agreement; *Use:* Congress enacted the Inflation Reduction Act of 2022, Public Law 117–169 (IRA). Section 11201 of the IRA eliminates the coverage gap phase of the Part D benefit. It also sunsets the coverage gap discount program (CGDP) after December 31, 2024, and amends the Social Security Act (the Act) to add section 1860D–14C, requiring the Secretary to establish a new Medicare Part D manufacturer discount program (MDP) beginning January 1, 2025. Under the MDP, participating manufacturers are required to provide discounts on their ''applicable drugs'' (brand drugs, biologics, and biosimilars) both in the initial coverage phase and in the catastrophic coverage phase of the Part D benefit.

Information in this collection is needed to set up agreements between manufacturers and CMS. Under section 1860D–14C(a) of the Act, such agreements are required for manufacturers in order to participate in the MDP and, under section 1860D43(a) of the Act, for their applicable drugs to be covered under Part D beginning in 2025. The information collected from manufacturers in the Health Plan Management System (HPMS) (Appendix A) is needed to create and execute MDP agreements and to determine which manufacturers qualify as a specified manufacturer or specified small manufacturer for phased-in discounts under section 1860D–14C(g)(4) of the Act. Banking information collected by the TPA from manufacturers and plan sponsors (Appendix B) is needed to prepare invoices and process financial transactions (deposits and payments) through the ACH. *Form Number:* CMS–10846 (OMB control number: 0938-New); *Frequency:* Once; *Affected Public:* Private Sector: Business or other for-profit and not-for-profit institutions; *Number of Respondents:* 659; *Total Annual Responses:* 659; *Total Annual Hours:* 4,613. (For policy questions regarding this collection contact Beckie Peyton at 410–786–1572).

4. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Medicare Advantage, Medicare Part D, and Medicare Fee-For-Service Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey; *Use:* CMS is required to collect and report

information on the quality of health care services and prescription drug coverage available to persons enrolled in a Medicare health or prescription drug plan under provisions in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Specifically, the MMA under Sec. 1860D–4 (Information to Facilitate Enrollment) requires CMS to conduct consumer satisfaction surveys regarding Medicare prescription drug plans and Medicare Advantage plans and report this information to Medicare beneficiaries prior to the Medicare annual enrollment period. The Medicare CAHPS survey meets the requirement of collecting and publicly reporting consumer satisfaction information. The Balanced Budget Act of 1997 also requires the collection of information about fee-for-service plans.

The primary purpose of the Medicare CAHPS surveys is to provide information to Medicare beneficiaries to help them make more informed choices among health and prescription drug plans available to them. Survey results are reported by CMS in the Medicare & You Handbook published each fall and on the Medicare Plan Finder website. Beneficiaries can compare CAHPS scores for each health and drug plan as well as compare MA and FFS scores when making enrollment decisions. The Medicare CAHPS also provides data to help CMS and others monitor the quality and performance of Medicare health and prescription drug plans and identify areas to improve the quality of care and services provided to enrollees of these plans. CAHPS data are included in the Medicare Part C & D Star Ratings and used to calculate MA Quality Bonus Payments. *Form Number:* CMS–R–246 (OMB control number: 0938- 0732); *Frequency:* Yearly; *Affected Public:* Individuals and Households; *Number of Respondents:* 794,500; *Total Annual Responses:* 794,500; *Total Annual Hours:* 192,265. (For policy questions regarding this collection contact Lauren Fuentes at 410–786–2290).

5. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Implementation of the Medicare Prescription Drug Plan (PDP) and Medicare Advantage (MA) Plan Disenrollment Reasons Survey; *Use:* The Balanced Budget Act of 1997 required that the CMS publicly report two years of disenrollment rates on all Medicare + Choice (M+C) organizations. Disenrollment rates are a useful measure of beneficiary dissatisfaction with a plan; this information is even more useful when reasons for disenrollment are provided to consumers, insurers, and other stakeholders. Advocacy organizations agree that CMS needs to report disenrollment reasons so that disenrollment rates can be interpreted correctly.

Specifically, the MMA under Sec. 1860D–4 (Information to Facilitate Enrollment) requires CMS to conduct consumer satisfaction surveys regarding the PDP and MA contracts pursuant to section 1860D–4(d). Plan disenrollment is generally believed to be a broad indicator of beneficiary dissatisfaction with some aspect of plan services, such as access to care, customer service, cost of the plan, services, benefits provided, or quality of care.

The information generated from the disenrollment survey supports CMS' ongoing efforts to assess plan performance and provide oversight to the functioning of Medicare Advantage (Part C) and PDP (Part D) plans, which provide health care services to millions of Medicare beneficiaries (*i.e.,* 28 million for Part C coverage and 49 million for Part D coverage).

Beneficiary experiences of care (as measured in the MCAHPS survey) and dissatisfaction (as measured in the disenrollment survey) with plan performance are both important sources of information for plan monitoring and oversight. The disenrollment survey assesses different aspects of dissatisfaction (*i.e.,* reasons why beneficiaries voluntarily left a plan), which can identify problems with plan operations; performance areas evaluated include access to care, customer service, cost, coverage, benefits provided, and quality of care. Understanding how well plans perform on these dimensions of care and service helps CMS understand whether beneficiaries are satisfied with the care they are receiving from contracted plans. When and if plans are found to be performing poorly against an array of performance measures, including beneficiary disenrollment, CMS may take corrective action. *Form Number:* CMS–10316 (OMB control number: 0938–1113); *Frequency:* Yearly; *Affected Public:* Individuals and Households; *Number of Respondents:* 32,750; *Total Annual Responses:* 32,750; *Total Annual Hours:* 7,055. (For policy questions regarding this collection contact Beth Simons at 415–744–3780).

Dated: February 2, 2023.

William N. Parham, III,

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

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Proposed Information Collection Activity; Tribal Maternal, Infant, and Early Childhood Home Visiting Program Implementation Plan Guidance for Development and Implementation and Implementation and Expansion Grantees

AGENCY: Office of Early Childhood Development, Administration for Children and Families, U.S. Department of Health and Human Services.

ACTION: Request for public comments.

SUMMARY: The Administration for Children and Families (ACF), Office of Early Childhood Development (ECD) is requesting Office of Management and Budget (OMB) approval of Tribal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program Implementation Plan Guidance for Tribal Home Visiting Development and Implementation Grants (DIG) and Tribal Home Visiting Implementation and Expansion Grants (IEG).

DATES: *Comments due within 60 days of publication.* In compliance with the requirements of the Paperwork Reduction Act (PRA) 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 *infocollection@acf.hhs.gov.* Identify all requests by the title of the information collection.

SUPPLEMENTARY INFORMATION:

Description: Section 511(e)(8)(A) of title V of the Social Security Act requires that grantees under the Tribal MIECHV program, in the first year of their grants, submit an implementation plan on how they will meet the requirements of the program. Section 511(h)(2)(A) further states that the requirements for the MIECHV grants to tribes, tribal organizations, and urban Indian organizations are to be consistent, to the greatest extent practicable, with the requirements for grantees under the MIECHV program for states and jurisdictions.

The ACF Office of Early Childhood Development, in collaboration with the Health Resources and Services Administration, Maternal and Child Health Bureau awarded grants for the Tribal MIECHV Program to support cooperative agreements to conduct community needs assessments; plan for