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 Collections

1. *Type of Information Collection Request:* Extension of a currently approved collection; Title of Information Collection: Medicaid Program Face-to-Face Requirements for Home Health Services and Supporting Regulations; *Use:* Physicians (or for medical equipment, authorized non-physician practitioners (NPPs) including nurse practitioners, clinical nurse specialists, and physician assistants) must document that there was a face-to-face encounter with the Medicaid beneficiary prior to the physician making a certification that home health services are required. The burden associated with this requirement is the time and effort to complete this documentation. The burden also includes writing, typing, or dictating the face-to-face documentation and signing/dating the documentation.

Section 3708 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act permits nurse practitioners (NPs), clinical nurse specialists (CNSs), and 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; *Number of Respondents:* 381,785; *Total Annual Responses:* 2,495,355; *Total Annual Hours:* 416,724. (For policy questions regarding this collection contact Alexandra Eitel at 410–786–0790.)

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 Identifiers: CMS–10398 Nos. 17, 37, and 96]

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. On October 23, 2011, OMB approved our initial request to use the generic clearance process under control number 0938–1148 (CMS–10398). It was last approved on April 26, 2021, via the standard PRA process which included the publication of 60- and 30-day **Federal Register** notices. The scope of the April 2021 umbrella accounts for Medicaid and CHIP State plan amendments, waivers, demonstrations, and reporting. 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 December 22, 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, 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/PRAListing.*

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 Collections

1. *Title of Information Collection:* CHIP State Plan Eligibility; *Type of Information Collection Request:* Revision of a currently approved collection; *Use:* The revised template (General Eligibility—Incarcerated CHIP Beneficiaries) and an associated implementation guide are intended to conform with Division G, Title I, Section 205 of the Consolidated Appropriations Act of 2024 which expands the prohibition of terminating an individual's CHIP eligibility because they are an inmate of a public institution to targeted low-income pregnant women. Effective January 1, 2026, states must cease terminating CHIP eligibility for targeted low-income pregnant women but may instead suspend their coverage during the enrollee's incarceration. States that elect to suspend coverage may implement either a benefits or eligibility suspension. *Form Number:* CMS–10398 #17 (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:* 2,800. (For policy questions regarding this collection contact: Mary Beth Hance at 443–934–2613.)

2. *Title of Information Collection:* Medicaid Managed Care Rate Development Guide; *Type of Information Collection Request:* Revision of a currently approved collection; *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. CMS is required to update the rate guide at least annually. To meet this requirement the 2026–2027 rate guide revises the 2025–2026 rate guide. *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.)

3. *Title of Information Collection:* Medicaid and the Children's Health Insurance Program (CHIP) Parity Tools; *Type of Information Collection Request:* New; *Use:* CMS has created a set of tools in the form of Excel workbook templates with accompanying instructions, both to assist states in complying with Mental Health Parity and Addiction Equity Act requirements and to simplify and standardize collecting information for state and CMS review. The tools will be made available for optional state use. CMS encourages states to use the tools and provide feedback to CMS. CMS will require that states use these tools as applicable to the state's program(s), and submit them to CMS, at a future date, which will be communicated through notice and comment rulemaking. *Form Number:* CMS–10398 #96 (OMB control number: 0938–1148); *Frequency:* Once and on occasion; *Affected Public:* Private Sector and State, Local, or Tribal Governments; *Number of Respondents:* 525; *Total Annual Responses:* 83; *Total Annual Hours:* 1,925. (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

[CMS–3474–FN]

Medicare and Medicaid Programs: Approval of Application by DNV Healthcare, Inc. for Initial CMS Approval of Its Ambulatory Surgical Center (ASC) Accreditation Program

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

ACTION: Notice.

SUMMARY: This notice acknowledges the approval of an application from DNV Healthcare, Inc. for initial CMS approval of its Ambulatory Surgical Centers as a national accrediting organization that wishes to participate in the Medicare or Medicaid programs.

DATES: The decision announced in this notice is applicable from December 8, 2025 to December 10, 2029.

FOR FURTHER INFORMATION CONTACT:

Joy Webb (410) 786–1667.

Kristin Shifflett (410) 786–4133.

SUPPLEMENTARY INFORMATION:

I. Background

Ambulatory Surgical Centers (ASCs) are distinct entities that operate exclusively for the purpose of furnishing outpatient surgical services to patients. Under the Medicare program, eligible beneficiaries may receive covered services from an ASC provided certain requirements are met. Section 1832(a)(2)(F)(i) of the Social Security Act (the Act) establishes distinct criteria for a facility seeking designation as an ASC. 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. The regulations at 42 CFR part 416 specify the conditions that an ASC must meet in order to participate in the Medicare program, the scope of covered services, and the conditions for Medicare payment for ASCs.

Generally, to enter into an agreement, an ASC must first be certified by a State survey agency (SA) as complying with the conditions or requirements set forth in part 416 of our Medicare regulations. Thereafter, the ASC is subject to regular surveys by an SA to determine whether it continues to meet these requirements.

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 conditions are met or exceeded, we may deem that provider entity as having met the 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 as having standards for accreditation that meet or exceed Medicare requirements, any provider entity accredited by the national accrediting body's approved program may be deemed to meet the Medicare conditions. The AO applying for approval of its accreditation program under 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 conditions. Our regulations concerning the approval of AOs are set forth at § 488.5.

This is DNV Healthcare, Inc.'s (DNV's) initial application and does not