FOR FURTHER INFORMATION CONTACT: Maria Elena Jefferds, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, 4770 Buford Highway, MS S107–5, Atlanta, GA 30341, Telephone: 770.488.5862, email: *mnj5@cdc.gov.*

SUPPLEMENTARY INFORMATION: The single-source award will focus on assessments of micronutrient status and the design and implementation of systems to monitor and evaluate micronutrient interventions, such as vitamin and mineral supplementation and fortification programs, and other nutrition interventions, such as infant and young child feeding, dietary counseling, and growth monitoring, in select countries. Specifically, the award will focus on the development of recommendations that inform country-specific nutrition strategies. The award will build in-country capacity to implement standardized national nutrition programs and micronutrient interventions to reduce the worldwide burden of micronutrient deficiencies. Key strategies include collaborating with ministries of health (MOH) and other key partners in developing countries. This work will advance the knowledge base about micronutrient deficiencies, and has the potential to benefit other countries, including the U.S.

UNICEF has a unique position among the world's health agencies as the technical agency for maternal and child health within the United Nations, with access to all national health promotion and disease prevention programs and potential surveillance sites through its regional offices located in seven (7) regions (Central and Eastern Europe and the Commonwealth of Independent States, East Asia and the Pacific, Eastern and Southern Africa, Latin America and the Caribbean, Middle East and Northern Africa, South Asia, West and Central Africa) and in 190 country offices.

Summary of the Award

Recipient: United Nations Children's Fund (UNICEF).

Purpose of the Award: The purpose of this award is to develop recommendations that inform country-specific nutrition strategies and build in-country capacity to implement standardized national nutrition programs and micronutrient interventions to reduce the worldwide burden of micronutrient deficiencies.

Amount of Award: $750,000 in Federal Fiscal Year (FFY) 2022 funds, and a total of $3,750,000 for a five-year period of performance, subject to availability of funds.

Authority: Public Health Service Act, Title 42, Sections 307 and 301 U.S.C. 241*l* and 241(a).

Period of Performance: January 1, 2022 through December 31, 2026.

Dated: November 19, 2021.

Terrance Perry,

Chief Grants Management Officer, Centers for Disease Control and Prevention.

[FR Doc. 2021–25764 Filed 11–24–21; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10599, CMS–10433, CMS–10330 and CMS–10780]

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 January 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.html.*

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:* Review Choice Demonstration for Home Health Services; *Use:* Section 402(a)(1)(J) of the Social Security Amendments of 1967 (42 U.S.C. 1395b–1(a)(1)(J)) authorizes the Secretary to ''develop or demonstrate improved methods for the investigation and prosecution of fraud in the provision of care or services under the health programs established by the Social Security Act (the Act).'' Pursuant to this authority, the CMS seeks to develop and implement a Medicare demonstration project, which CMS believes will help assist in developing improved procedures for the identification, investigation, and prosecution of Medicare fraud occurring among Home Health Agencies (HHA) providing services to Medicare beneficiaries.

This revised demonstration helps assist in developing improved procedures for the identification, investigation, and prosecution of potential Medicare fraud. The demonstration helps make sure that payments for home health services are appropriate through either pre-claim or postpayment review, thereby working towards the prevention and identification of potential fraud, waste, and abuse; the protection of Medicare Trust Funds from improper payments; and the reduction of Medicare appeals. CMS has implemented the demonstration in Illinois, Ohio, North Carolina, Florida, and Texas with the option to expand to other states in the Palmetto/JM jurisdiction. Under this demonstration, CMS offers choices for providers to demonstrate their compliance with CMS' home health policies. Providers in the demonstration states may participate in either 100 percent pre-claim review or 100 percent postpayment review. These providers will continue to be subject to a review method until the HHA reaches the target affirmation or claim approval rate. Once a HHA reaches the target pre-claim review affirmation or post-payment review claim approval rate, it may choose to be relieved from claim reviews, except for a spot check of their claims to ensure continued compliance. Providers who do not wish to participate in either 100 percent pre-claim or postpayment reviews have the option to furnish home health services and submit the associated claim for payment without undergoing such reviews; however, they will receive a 25 percent payment reduction on all claims submitted for home health services and may be eligible for review by the Recovery Audit Contractors.

The information required under this collection is required by Medicare contractors to determine proper payment or if there is a suspicion of fraud. Under the pre-claim review option, the HHA sends the pre-claim review request along with all required documentation to the Medicare contractor for review prior to submitting the final claim for payment. If a claim is submitted without a pre-claim review decision one file, the Medicare contractor will request the information from the HHA to determine if payment is appropriate. For the postpayment review option, the Medicare contractor will also request the information from the HHA provider who submitted the claim for payment from the Medicare program to determine if payment was appropriate. *Form Number:* CMS–10599 (OMB control number: 0938–1311); *Frequency:* Frequently, until the HHA reaches the target affirmation or claim approval threshold and then occasionally; *Affected Public:* Private Sector (Business or other for-profits and Not-for-profits); *Number of Respondents:* 3,631; *Number of Responses:* 1,467,243; *Total Annual Hours:* 744,5143. (For questions regarding this collection contact Jennifer McMullen (410)786–7635.)

2. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Continuation of Data Collection to Support QHP Certification and other Financial Management and Exchange Operations; *Use:* As directed by the rule Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers (77 FR 18310) (Exchange rule), each Exchange is responsible for the certification and offering of Qualified Health Plans (QHPs). To offer insurance through an Exchange, a health insurance issuer must have its health plans certified as QHPs by the Exchange. A QHP must meet certain necessary minimum certification standards, such as network adequacy, inclusion of Essential Community Providers (ECPs), and non-discrimination. The Exchange is responsible for ensuring that QHPs meet these minimum certification standards as described in the Exchange rule under 45 CFR 155 and 156, based on the Patient Protection and Affordable Care Act (PPACA), as well as other standards determined by the Exchange. Issuers can offer individual and small group market plans outside of the Exchanges that are not QHPs. *Form Number:* CMS–10433 (OMB control number: 0938–1187); *Frequency:* Annually; *Affected Public:* Private sector, State, Local, or Tribal Governments, Business or other for-profits; *Number of Respondents:* 2,925; *Number of Responses:* 2,925; *Total Annual Hours:* 71,660. (For questions regarding this collection, contact Nicole Levesque at (617) 565–3138).

3. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Notice of Rescission of Coverage and Disclosure Requirements for Patient Protection under the Affordable Care Act; *Use:* Sections 2712 and 2719A of the Public Health Service Act (PHS Act), as added by the Affordable Care Act, contain rescission notice, and patient protection disclosure requirements that are subject to the Paperwork Reduction Act of 1995. The No Surprises Act, enacted as part of the Consolidated Appropriations Act, 2021, amended section 2719A of the PHS Act to sunset when the new emergency services protections under the No Surprises Act take effect. The provisions of section 2719A of the PHS Act will no longer apply with respect to plan years beginning on or after January 1, 2022. The No Surprises Act re-codified the patient protections related to choice of health care professional under section 2719A of the PHS Act in newly added section 9822 of the Internal Revenue Code, section 722 of the Employee Retirement Income Security Act, and section 2799A–7 of the PHS Act and extended the applicability of these provisions to grandfathered health plans for plan years beginning on or after January 1, 2022. The rescission notice will be used by health plans to provide advance notice to certain individuals that their coverage may be rescinded as a result of fraud or intentional misrepresentation of material fact. The patient protection notification will be used by health plans to inform certain individuals of their right to choose a primary care provider or pediatrician and to use obstetrical/gynecological services without prior authorization. The related provisions are finalized in the 2015 final regulations titled ''Final Rules under the Affordable Care Act for Grandfathered Plans, Preexisting Condition Exclusions,

Lifetime and Annual Limits, Rescissions, Dependent Coverage, Appeals, and Patient Protections'' (80 FR 72192, November 18, 2015) and 2021 interim final regulations titled ''Requirements Related to Surprise Billing; Part I'' (86 FR 36872, July 13, 2021). The 2015 final regulations also require that, if State law prohibits balance billing, or a plan or issuer is contractually responsible for any amounts balanced billed by an out-of-network emergency services provider, a plan or issuer must provide a participant, beneficiary or enrollee adequate and prominent notice of their lack of financial responsibility with respect to amounts balanced billed in order to prevent inadvertent payment by the individual. Plans and issuers will not be required to provide this notice for plan years beginning on or after January 1, 2022. *Form Number:* CMS–10330 (OMB control number: 0938–1094); *Frequency:* On Occasion; *Affected Public:* State, Local, or Tribal Governments, Private Sector; *Number of Respondents:* 2,277; *Total Annual Responses:* 15,752; *Total Annual Hours:* 814. (For policy questions regarding this collection, contact Usree Bandyopadhyay at (410) 786–6650.)

4. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Requirements Related to Surprise Billing: Qualifying Payment Amount, Notice and Consent, Disclosure on Patient Protections Against Balance Billing, and State Law Opt-in; *Use:* On December 27, 2020, the Consolidated Appropriations Act, 2021 (Pub. L. 116–260), which included the No Surprises Act, was signed into law. The No Surprises Act provides federal protections against surprise billing and limits out-of-network cost sharing under many of the circumstances in which surprise medical bills arise most frequently. The 2021 interim final regulations ''Requirements Related to Surprise Billing; Part I'' (86 FR 36872, 2021 interim final regulations) issued by the Departments of Health and Human Services, the Department of Labor, the Department of Treasury, and the Office of Personnel Management, implement provisions of the No Surprises Act that apply to group health plans, health insurance issuers offering group or individual health insurance coverage, and carriers in the Federal Employees Health Benefits (FEHB) Program that provide protections against balance billing and out-of-network cost sharing with respect to emergency services, non-emergency services furnished by nonparticipating providers at certain participating health care facilities, and air ambulance services furnished by nonparticipating providers of air ambulance services. The 2021 interim final regulations prohibit nonparticipating providers, emergency facilities, and providers of air ambulance services from balance billing participants, beneficiaries, and enrollees in certain situations unless they satisfy certain notice and consent requirements. The No Surprises Act and the 2021 interim final regulations require group health plans and issuers of health insurance coverage to provide information about qualifying payment amounts to nonparticipating providers and facilities and to provide disclosures on patient protections against balance billing to participants, beneficiaries and enrollees. Self-insured plans opting in to a specified state law are required to provide a disclosure to participants. Certain nonparticipating providers and nonparticipating emergency facilities may provide participants, beneficiaries, and enrollees with notice and obtain their consent to waive balance billing protections, provided certain requirements are met. In addition, certain providers and facilities are required to provide disclosures on patient protections against balance billing to participants, beneficiaries and enrollees. *Form Number:* CMS–10780 (OMB control number: 0938–1401); *Frequency:* On Occasion; *Affected Public:* Individuals, State, Local, or Tribal Governments, Private Sector; *Number of Respondents:* 2,494,683; *Total Annual Responses:* 58,696,352; *Total Annual Hours:* 4,933,110. (For policy questions regarding this collection, contact Usree Bandyopadhyay at 410–786–6650.)

Dated: November 22, 2021.

William N. Parham, III,

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

[FR Doc. 2021–25816 Filed 11–24–21; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Privacy Act of 1974; System of Records

AGENCY: Health Resources and Services Administration (HRSA), Department of Health and Human Services (HHS).

ACTION: Notice of a new system of records.

SUMMARY: In accordance with the requirements of the Privacy Act of 1974, as amended, the HHS is establishing a new system of records to be maintained by HHS's HRSA, 09–15–0093, ''Provider Support Records.'' The new system of records will include payment-related records containing information about any sole proprietor health care providers (including health care-practitioners and suppliers) who applied for payments or reimbursements, received a payment, attested to a payment, reported on the use of a payment, or otherwise participated in one of HRSA's provider support programs, and about patients identified in certain claims records submitted to HRSA for payment by entity providers and sole proprietor providers. The records are used to support the health care population and administer the programs.

DATES: The new system of records is applicable November 26, 2021, subject to a 30-day period in which to comment on the routine uses. Submit any comments by December 27, 2021.

ADDRESSES: The public should address written comments by email to *OPSInformation.hrsa@hrsa.gov* or by mail to Executive Officer, Provider Support, HRSA, 5600 Fishers Lane, Room 9N21, Rockville, MD, 20857.

FOR FURTHER INFORMATION CONTACT: General questions about the new system of records may be submitted to Executive Officer, Provider Support, HRSA, 5600 Fishers Lane, Room 9N21, Rockville, MD, 20857, or to *OPSInformation.hrsa@hrsa.gov.*

SUPPLEMENTARY INFORMATION: New system of records 09–15–0093 will cover records HRSA uses to reimburse claims and make payments to healthcare providers and to receive reports on the use of funds for activities under the following programs:

- COVID–19 Claims Reimbursement to Health Care Providers and Facilities for Testing, Treatment and Vaccine Administration for the Uninsured (Uninsured Program).
- COVID–19 Coverage Assistance Fund (CAF).
- Provider Relief Fund (PRF), including American Rescue Plan Act (ARPA) Rural Payments.

The records used by HRSA in these programs include patient and provider information needed to administer the programs. HHS provided advance notice of the new system of records to the Office of Management and Budget and