information, as appropriate, to other insurance affordability programs. The information collection requirements will assist the public to understand information about health insurance affordability programs and will assist CMS in ensuring the seamless, coordinated, and simplified system of Medicaid and CHIP application, eligibility determination, verification, enrollment, and renewal. *Form Number:* CMS–10410 (OMB control number: 0938–1147); *Frequency:* Occasionally; *Affected Public:* Individuals or Households, and State, Local, and Tribal Governments; *Number of Respondents:* 25,500,096; *Total Annual Responses:* 76,500,218; *Total Annual Hours:* 21,276,302. For policy questions regarding this collection contact Suzette Seng at 410–786–4703.

2. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Children's Health Insurance Program Managed Care and Supporting Regulations; *Use:* CHIP enrollees use the information collected and reported as a result of this regulation to make informed choices regarding health care, including how to access health care services and the grievance and appeal system. States use the information collected and reported as part of contracting processes with managed care entities, as well as its compliance oversight role. CMS uses the information collected and reported in an oversight role of State CHIP managed care programs and CHIP state agencies. *Form Number:* CMS–10554 (OMB control number: 0938–1282); *Frequency:* Yearly; *Affected Public:* State, Local, and Tribal Governments, and the Private Sector (Business or other for-profits and Not-for-profit institutions); *Number of Respondents:* 62; *Total Annual Responses:* 2,735,964; *Total Annual Hours:* 371,710. For policy questions regarding this collection contact Amy Lutzky at 410–786–0721.

3. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Disclosure and Recordkeeping Requirements for Grandfathered Health Plans under the Affordable Care Act; *Use:* Section 1251 of the Affordable Care Act provides that certain plans and health insurance coverage in existence as of March 23, 2010, known as grandfathered health plans, are not required to comply with certain statutory provisions in the Act. The 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) require that, to maintain its status as a grandfathered health plan, a plan must maintain records documenting the terms of the plan in effect on March 23, 2010, and any other documents that are necessary to verify, explain or clarify status as a grandfathered health plan. The plan must make such records available for examination upon request by participants, beneficiaries, individual policy subscribers, or a state or federal agency official. A grandfathered health plan is also required to include a statement in any summary of benefits under the plan or health insurance coverage, that the plan or coverage believes it is a grandfathered health plan within the meaning of section 1251 of the Affordable Care Act, and providing contact information for participants to direct questions and complaints. In addition, a grandfathered group health plan that is changing health insurance issuers is required to provide the succeeding health insurance issuer (and the succeeding health insurance issuer must require) documentation of plan terms (including benefits, cost sharing, employer contributions, and annual limits) under the prior health insurance coverage sufficient to make a determination whether the standards of paragraph § 147.140(g)(1) of the final regulations are exceeded. It is also required that, for an insured group health plan (or a multiemployer plan) that is a grandfathered plan, the relevant policies, certificates, or contracts of insurance, or plan documents must disclose in a prominent and effective manner that employers, employee organizations, or plan sponsors, as applicable, are required to notify the issuer (or multiemployer plan) if the contribution rate changes at any point during the plan year. *Form Number:* CMS–10325 (OMB control number: 0938–1093); *Frequency:* On Occasion; *Affected Public:* Private Sector, State, Local or Tribal governments; *Number of Respondents:* 14,669; *Total Annual Responses:* 2,651,523; *Total Annual Hours:* 40. For policy questions regarding this collection contact Usree Bandyopadhyay at 410–786–6650.

Dated: March 22, 2022.

William N. Parham, III,

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

[FR Doc. 2022–06340 Filed 3–24–22; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10507 and CMS–10105]

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 May 24, 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.*

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**).

CMS–10507 State-based Exchange Annual Report Tool (SMART)

CMS–10105 National Implementation of the In-Center Hemodialysis CAHPS Survey

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:* State-based Exchange Annual Report Tool (SMART); *Use:* The annual report is the primary vehicle to insure comprehensive compliance with all reporting requirements contained in the Affordable Care Act (ACA). It is specifically called for in Section 1313(a)(1) of the Act which requires a State Based Exchange (including an Exchange using the Federal Platform) to keep an accurate accounting of all activities, receipts, and expenditures, and to submit a report annually to the Secretary concerning such accounting. CMS will use the information collected from States to assist in determining if a State is maintaining a compliant operational Exchange. *Form Number:* CMS–10507 (OMB control number: 0938–1244); *Frequency:* Annually; *Affected Public:* State, Local, or Tribal governments; *Number of Respondents:* 21; *Total Annual Responses:* 21; *Total Annual Hours:* 4,281. (For policy questions regarding this collection contact Shilpa Gogna at 301–492–4257.)

2. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* National Implementation of the In-Center Hemodialysis CAHPS Survey; *Use:* The national implementation of the ICH CAHPS Survey is designed to allow third-party, CMS-approved survey vendors to administer the ICH CAHPS Survey using mail-only, telephone-only, or mixed (mail with telephone follow-up) modes of survey administration. Experience from previous CAHPS surveys shows that mail, telephone, and mail with telephone follow-up data collection modes work well for respondents, vendors, and health care providers. Any additional forms of information technology, such as web surveys, is under investigation as a potential survey option in this population.

Data collected in the national implementation of the ICH CAHPS Survey are used for the following purposes:

- To provide a source of information from which selected measures can be publicly reported to beneficiaries as a decision aid for dialysis facility selection.
- To aid facilities with their internal quality improvement efforts and external benchmarking with other facilities.
- To provide CMS with information for monitoring and public reporting purposes.
- To support the ESRD Quality Improvement Program.

Form Number: CMS–10105 (OMB control number: 0938–0926); *Frequency:* Semi Annually; *Affected Public:* Individuals and Households; *Number of Respondents:* 103,500; *Total Annual Responses:* 621,000; *Total Annual Hours:* 55,890. (For policy questions regarding this collection contact Israel H. Cross at 410–786–0619.)

Dated: March 22, 2022.

William N. Parham, III,

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

[FR Doc. 2022–06341 Filed 3–24–22; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

[OMHA–2201–N]

Medicare Program; Administrative Law Judge Hearing Program for Medicare Claim and Entitlement Appeals; Quarterly Listing of Program Issuances—October Through December 2021

AGENCY: Office of Medicare Hearings and Appeals (OMHA), HHS.

ACTION: Notice.

SUMMARY: This quarterly notice lists the OMHA Case Processing Manual (OCPM) instructions that were published from October through December 2021. This manual standardizes the day-to-day procedures for carrying out adjudicative functions, in accordance with applicable statutes, regulations, and OMHA directives, and gives OMHA staff direction for processing appeals at the OMHA level of adjudication.

FOR FURTHER INFORMATION CONTACT: Jon Dorman, by telephone at (571) 457–7220, or by email at *jon.dorman@hhs.gov.*

SUPPLEMENTARY INFORMATION:

I. Background

The Office of Medicare Hearings and Appeals (OMHA), a staff division within the Office of the Secretary within the U.S. Department of Health and Human Services (HHS), administers the nationwide Administrative Law Judge hearing program for Medicare claim; organization, coverage, and at-risk determination; and entitlement appeals under sections 1869, 1155, 1876(c)(5)(B), 1852(g)(5), and 1860D–4(h) of the Social Security Act (the Act). OMHA ensures that Medicare beneficiaries and the providers and suppliers that furnish items or services to Medicare beneficiaries, as well as Medicare Advantage organizations (MAOs), Medicaid State agencies, and applicable plans, have a fair and impartial forum to address disagreements with Medicare coverage and payment determinations made by Medicare contractors, MAOs, or Part D plan sponsors (PDPSs), and determinations related to Medicare eligibility and entitlement, Part B late