group, department, or program that addresses many aspects of health and safety in the workplace for HCP, including the provision of clinical services for work-related injuries, exposures, and illnesses. In healthcare settings, OHS addresses workplace hazards including communicable diseases; slips, trips, and falls; patient-handling injuries; chemical exposures; HCP burnout; and workplace violence.

This *Draft Guideline: Cytomegalovirus and Parvovirus B19 Sections* update is part of a larger guideline update: *Infection Control in Healthcare Personnel.* Part I, *Infrastructure and Routine Practices for Occupational Infection Prevention and Control Services (2019)*, and the Diphtheria, Group A *Streptococcus*, Meningococcal Disease, Pertussis, and Rabies sections of Part II, *Epidemiology and Control of Selected Infections Transmitted Among Healthcare Personnel and Patients (2022)* are complete and have been published on the CDC Infection Control Guideline website: *https://www.cdc.gov/infectioncontrol/guidelines/healthcare-personnel/index.html*. The *Draft Guideline: Cytomegalovirus and Parvovirus B19 Sections*, once finalized, is intended for use by the leaders and staff of OHS to guide the management of exposed or infected HCP who may be contagious to others in the workplace. The draft recommendations in *Draft Guideline: Cytomegalovirus and Parvovirus B19 Sections* update the 1998 recommendations with current guidance on the management of HCP exposed to or potentially infected with cytomegalovirus or parvovirus B19, focusing on postexposure management, including postexposure prophylaxis, for exposed HCP and work restrictions for exposed or infected HCP. The adapted *Draft* ''*Source Control*'' *Definition* is being added to the ''Terminology'' Appendix of the *Infection Control in Healthcare Personnel Guideline* (*https://www.cdc.gov/infectioncontrol/guidelines/healthcare-personnel/terminology.html*) because the term ''Source Control'' is used in the *Draft Guideline: Parvovirus B19 Section*, and may be used in subsequent sections.

Since 2015, the Healthcare Infection Control Practices Advisory Committee (HICPAC) has worked with national partners, academicians, public health professionals, healthcare providers, and other partners to develop *Infection Control in Healthcare Personnel* (*https://www.cdc.gov/infectioncontrol/guidelines/healthcare-personnel/index.html*) as a segmental update of the *1998 Guideline*. HICPAC is a Federal advisory committee appointed to provide advice and guidance to HHS and CDC regarding the practice of infection control and strategies for surveillance, prevention, and control of healthcare-associated infections, antimicrobial resistance, and related events in United States healthcare settings. HICPAC includes, but is not limited to, representatives with expertise in public health, infectious diseases, and infection prevention and control. HICPAC also includes ex officio members who represent regulatory and other Federal agencies, and liaison representatives from professional societies. *Draft Guideline: Cytomegalovirus and Parvovirus B19 Sections*, once finalized, will be the next sections to be posted to the *Infection Control in Healthcare Personnel* website. The accompanying *Draft* ''*Source Control*'' *Definition* will be added to the *Infection Control in Healthcare Personnel* ''Terminology'' Appendix (*https://www.cdc.gov/infectioncontrol/guidelines/healthcare-personnel/terminology.html*).

The updated draft recommendations in *Draft Guideline: Cytomegalovirus and Parvovirus B19 Sections* are informed by reviews of the *1998 Guideline*; CDC resources (*e.g.*, CDC infection control website), infection control guidance, and guidelines, as noted more specifically in the draft document; and new scientific evidence, when available. CDC is seeking comments on the *Draft Guideline: Cytomegalovirus and Parvovirus B19 Sections* and the accompanying *Draft* ''*Source Control*'' *Definition.* Please provide references to new evidence and justification to support any suggested revisions or additions. This *Draft Guideline: Cytomegalovirus and Parvovirus B19 Sections* and the accompanying *Draft* ''*Source Control*'' *Definition* are not Federal rules or regulations.

Noah Aleshire,

Chief Regulatory Officer, Centers for Disease Control and Prevention.

[FR Doc. 2024–03783 Filed 2–23–24; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–3456–PN]

Medicare and Medicaid Programs; Application From the Joint Commission for Continued CMS-Approval of Its Ambulatory Surgical Center Accreditation Program

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

ACTION: Notice with comment.

SUMMARY: This notice acknowledges the receipt of an application from the Joint Commission for continued recognition as a national accrediting organization for Ambulatory Surgical Centers that wish to participate in the Medicare or Medicaid programs.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, by March 27, 2024.

ADDRESSES: In commenting, refer to file code CMS–3456–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 *http://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–3456–PN, P.O. Box 8010, Baltimore, MD 21244–8010.

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–3456–PN, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Caecilia Andrews, (410) 786–2190. Erin Imhoff, (410) 786–2337.

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. CMS will not post on *Regulations.gov* public comments that make threats to individuals or institutions or suggest that the commenter will take actions to harm an individual. CMS continues to encourage individuals not to submit duplicative comments. We will post acceptable comments from multiple unique commenters even if the content is identical or nearly identical to other comments.

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.

The Joint Commission's (TJC's) current term of approval for its ASC program expires December 20, 2024.

II. Approval of Deeming Organization

Section 1865(a)(2) of the Act and our regulations at § 488.5 require that our findings concerning review and approval of an AO's requirements consider, among other factors, the applying AO's requirements for accreditation; survey procedures; resources for conducting required surveys; capacity to furnish information for use in enforcement activities; monitoring procedures for provider entities found not in compliance with the conditions or requirements; and ability to provide CMS with the necessary data for validation.

Section 1865(a)(3)(A) of the Act further requires that we publish, within 60 days of receipt of an organization's complete application, a notice that identifies the national accrediting body making the request, describes the nature of the request, and provides at least a 30-day public comment period. We have 210 days from the receipt of a complete application to publish notice of approval or denial of the application.

The purpose of this proposed notice is to inform the public of TJC's request for continued CMS-approval of its ASC accreditation program. This notice also solicits public comment on whether TJC's requirements meet or exceed the Medicare conditions for coverage (CfCs) for ASCs.

III. Evaluation of Deeming Authority Request

TJC submitted all the necessary materials to enable us to make a determination concerning its request for continued CMS-approval of its ASC accreditation program. This application was determined to be complete on January 19, 2024. Under section 1865(a)(2) of the Act and § 488.5, our review and evaluation of TJC will be conducted in accordance with, but not necessarily limited to, the following factors:

- The equivalency of TJC's standards for ASCs as compared with Medicare's CfCs for ASCs.
- TJC's survey process to determine the following:

++ The composition of the survey team, surveyor qualifications, and the ability of the organization to provide continuing surveyor training.

++ The comparability of TJC's processes to those of State agencies, including survey frequency, and the ability to investigate and respond appropriately to complaints against accredited facilities.

++ TJC's processes and procedures for monitoring an ASC found out of compliance with TJC's program requirements. These monitoring procedures are used only when TJC identifies noncompliance. If noncompliance is identified through validation reviews or complaint surveys, the State survey agency monitors corrections as specified at § 488.9(c)(1).

++ TJC's capacity to report deficiencies to the surveyed facilities and respond to the facility's plan of correction in a timely manner.

++ TJC's capacity to provide CMS with electronic data and reports necessary for the effective validation and assessment of the organization's survey process.

++ The adequacy of TJC's staff and other resources, and its financial viability.

++ TJC's capacity to adequately fund required surveys.

++ TJC's policies with respect to whether surveys are announced or unannounced, to ensure that surveys are unannounced.

++ TJC's policies and procedures to avoid conflicts of interest, including the appearance of conflicts of interest, involving individuals who conduct surveys or participate in accreditation decisions.

++ TJC's agreement to provide CMS with a copy of the most current accreditation survey together with any other information related to the survey as CMS may require (including corrective action plans).

IV. Collection of Information Requirements

This document does not impose information collection requirements, that is, reporting, recordkeeping or third-party disclosure requirements. Consequently, there is no need for review by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

V. Response to Public 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), Chiquita Brooks-LaSure, having reviewed and approved this document, authorizes Vanessa Garcia, who is the Federal Register Liaison, to electronically sign this document for purposes of publication in the **Federal Register**.

Vanessa Garcia,

Federal Register Liaison, Centers for Medicare & Medicaid Services.

[FR Doc. 2024–03821 Filed 2–23–24; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10387 and CMS–10500]

Agency Information Collection Activities: Submission for OMB Review; 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 a second opportunity for public comment on the notice. Interested persons are invited to send comments regarding the burden estimate 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 on the collection(s) of information must be received by the OMB desk officer by March 27, 2024.

ADDRESSES: Written comments and recommendations for the proposed information collection should be sent within 30 days of publication of this notice to *www.reginfo.gov/public/do/PRAMain.* Find this particular information collection by selecting ''Currently under 30-day Review—Open for Public Comments'' or by using the search function.

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 Parham at (410) 786–4669.

SUPPLEMENTARY INFORMATION: Under the Paperwork Reduction Act of 1995 (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 (44 U.S.C. 3506(c)(2)(A)) requires Federal agencies to publish a 30-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 that summarizes the following proposed collection(s) of information for public comment:

1. *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 the MDS 3.0 v1.19.1 beginning October 1, 2024 in order to meet the requirements of policies finalized in the Federal Fiscal Year (FY) 2024 Skilled Nursing Facility (SNF) Prospective Payment System (PPS) final rule (CMS–1779–F, RIN 0938–AV02). Specifically, CMS adopted two new measures and removed three measures from the SNF QRP. As a result of these changes, the total annual hour burden across facilities has decreased, and the annual cost burden across facilities has decreased. *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:* 15,471; *Total Annual Responses:* 3,469,183; *Total Annual Hours:* 2,861,351. (For policy questions regarding this collection contact Heidi Magladry at 410–786–6034).

2. *Type of Information Collection Request:* Extension without change of the previously approved collection; *Title of Information Collection:* National Implementation of the Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) Survey; *Use:* As documented in the CY 2022 OPPS/ASC Final Rule (86 FR 63863 through 63866), OAS CAHPS Survey data will be linked to reimbursement beginning with CY 2024 for HOPDs and CY 2025 for ASCs. ASCs will continue with voluntary implementation of the OAS CAHPS Survey throughout CY 2024.

HOPDs and ASCs contract with a CMS-approved, independent third-party survey vendor to implement the survey on their behalf and to submit the OAS CAHPS data to CMS. CMS publicly reports comparative results from OAS CAHPS after each facility has conducted data collection for 4 quarters. Data from OAS CAHPS enable consumers to make more informed decisions when choosing an outpatient surgery facility, aid facilities in their quality improvement efforts, and help CMS monitor the performance of outpatient surgery facilities. Considering the increasing Medicare expenditures for outpatient surgical services from HOPDs and ASCs, the implementation of OAS CAHPS provides CMS with much-needed statistically valid data from the patient perspective to inform quality improvement and comparative consumer information about specific facilities. The information collected in the OAS CAHPS survey will be used for the following purposes: To provide a source of information from which patient experience of care measures can be publicly reported to beneficiaries to help them make informed decisions for