By the direction of the Commission.

Cynthia G. Pierre,

Chief Operating Officer.

[FR Doc. 2023–19349 Filed 9–6–23; 8:45 am]

BILLING CODE 6570–01–P

FEDERAL DEPOSIT INSURANCE CORPORATION

Notice of Termination of Receiverships

The Federal Deposit Insurance Corporation (FDIC or Receiver), as Receiver for each of the following insured depository institutions, was charged with the duty of winding up the affairs of the former institutions and liquidating all related assets. The Receiver has fulfilled its obligations and made all dividend distributions required by law.

NOTICE OF TERMINATION OF RECEIVERSHIPS

Fund	Receivership name	City	State	Termination date
10053	American Southern Bank	Kennesaw	GA	09/01/2023
10120	Irwin Union Bank and Trust Company	Columbus	IN	09/01/2023
10195	The Park Avenue Bank	New York	NY	09/01/2023
10205	Desert Hills Bank	Phoenix	AZ	09/01/2023
10317	Earthstar Bank	Southampton	PA	09/01/2023
10380	Bank of Choice	Greeley	CO	09/01/2023
10402	Country Bank	Aledo	IL	09/01/2023
10412	Community Bank of Rockmart	Rockmart	GA	09/01/2023
10488	First National Bank	Edinburg	TX	09/01/2023

The Receiver has further irrevocably authorized and appointed FDIC-Corporate as its attorney-in-fact to execute and file any and all documents that may be required to be executed by the Receiver which FDIC-Corporate, in its sole discretion, deems necessary, including but not limited to releases, discharges, satisfactions, endorsements, assignments, and deeds. Effective on the termination dates listed above, the Receiverships have been terminated, the Receiver has been discharged, and the Receiverships have ceased to exist as legal entities.

(Authority: 12 U.S.C. 1819)

Federal Deposit Insurance Corporation.

Dated at Washington, DC, on September 1, 2023.

James P. Sheesley,

Assistant Executive Secretary.

[FR Doc. 2023–19298 Filed 9–6–23; 8:45 am]

BILLING CODE 6714–01–P

FEDERAL ELECTION COMMISSION

Sunshine Act Meetings

TIME AND DATE: Tuesday, September 12, 2023, at 10:30 a.m. and its continuation at the conclusion of the open meeting on September 14, 2023.

PLACE: 1050 First Street NE, Washington, DC and virtual (this meeting will be a hybrid meeting.)

STATUS: This meeting will be closed to the public.

MATTERS TO BE CONSIDERED: Compliance matters pursuant to 52 U.S.C. 30109.

Information the premature disclosure of which would be likely to have a considerable adverse effect on the implementation of a proposed Commission action.

Matters concerning participation in civil actions or proceedings or arbitration.

CONTACT PERSON FOR MORE INFORMATION: Judith Ingram, Press Officer. Telephone: (202) 694–1220.

(Authority: Government in the Sunshine Act, 5 U.S.C. 552b)

Vicktoria J. Allen,

Deputy Secretary of the Commission.

[FR Doc. 2023–19438 Filed 9–5–23; 4:15 pm]

BILLING CODE 6715–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifiers: CMS–10390 and CMS–10865]

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 November 6, 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**).

CMS–10390 Hospice Quality Reporting Program

CMS–10865 Monoclonal Antibodies Directed Against Amyloid for the Treatment of Alzheimer's Disease

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:* Extension of a currently approved collection; *Title of Information Collection:* Hospice Quality Reporting Program; *Use:* On July 1, 2014, hospices began using a newly created data collection instrument, titled the ''Hospice Item Set'' (HIS) V1.00.0. The HIS is used for the collection of quality measure data related to the Hospice Quality Reporting Program (HQRP), and the HIS V1.00.0 specified the collection of data items that supported seven Consensus Based Entity (CBE) endorsed Quality Measures (QMs) for hospice. On April 1, 2017, hospices began using an updated HIS V2.00.0, which includes the same items from the HIS V1.00.0 along with the addition of several new items for use in new measures, measure refinement, patient record matching, and future public reporting. Data collected from the HIS are used to calculate the seven CBE-endorsed QMs and the CBE-endorsed Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission QM.

During the FY 2021 rule, the Hospice Visits when Death is Imminent measure pair was removed and replaced with the claims-based Hospice Visits in Last Days of Life (HVLDL) measure. The reduction in provider burden and costs occurred when CMS replaced the HIS-based HVWDII quality measure via the HIS information collection request that OMB approved on February 16, 2021. CMS is requesting to extend the expiration date. The HIS V3.00.0 consists of data elements that are designed to collect standardized, patient-level data for the following domains of care: pain, respiratory status, medications, patient preferences and beliefs and values. The HIS V3.00.0 was developed specifically for use by hospices and contains data elements that we can use to collect patient-level data to calculate eight CBE endorsed quality measures. *Form Number:* CMS–10390 (OMB control number: 0938–1153); *Frequency:* On Occasion; *Affected Public:* State, local, or Tribal governments, private sector (not-for-profit institutions); individuals or households; *Number of Respondents:* 5,640; *Total Annual Responses:* 2,763,850; *Total Annual Hours:* 1,323,883. (For policy questions regarding this collection contact Jermama Keys at (410) 786–7778.)

2. *Type of Information Collection Request:* New collection (Request for a new OMB control number); *Title of Information Collection:* Monoclonal Antibodies Directed Against Amyloid for the Treatment of Alzheimer's Disease; *Use:* On April 7, 2022, CMS finalized the national coverage determination (NCD) to cover FDA approved monoclonal antibodies (mAbs) directed against amyloid for the treatment of Alzheimer's disease (AD) under coverage with evidence development (CED) in patients who have a clinical diagnosis of mild cognitive impairment (MCI) due to AD or mild AD dementia, both with confirmed presence of amyloid beta pathology consistent with AD. For anti-amyloid mAbs that have accelerated approval, the mAb may be covered in a randomized controlled trial conducted under an investigational new drug (IND) application or any NIH sponsored trial. For antiamyloid mAbs that have traditional FDA approval (as opposed to accelerated approval), the NCD specifies coverage under CED in CMS approved prospective comparative studies, where data may be collected in a registry. In addition to satisfying the study criteria specified in the NCD, CMS approved studies for anti-amyloid mAbs that have received traditional FDA approval must address all of the questions below:

- Does the antiamyloid mAb meaningfully improve health outcomes (*i.e.,* slow the decline of cognition and function) for patients in broad community practice?
- Do benefits, and harms such as brain hemorrhage and edema, associated with use of the antiamyloid mAb, depend on characteristics of patients, treating clinicians, and settings?
- How do the benefits and harms change over time?

In order to remove the data collection requirement under this coverage with evidence development (CED) NCD or make any other changes to the existing policy, we must formally reopen and reconsider the policy. CMS supported development of a registry, the ''Monoclonal Antibodies Directed Against Amyloid for the Treatment of Alzheimer's Disease CED Study Registry'' (mAb Registry), to facilitate coverage under the NCD. Additionally, CMS is working with multiple organizations preparing to open their own registries. Once more registries are available, they will also be listed at *https://www.cms.gov/medicare/coverage-evidence-development/monoclonalantibodies-directed-against-amyloid-treatment-alzheimers-disease-ad,* and clinicians will be able to choose which registry to participate in.

The data collected and analyzed in the CMS-supported mAb Registry and potential CMS-approved registries will be used by to determine if monoclonal antibodies directed against amyloid for the treatment of Alzheimer's Disease (AD) is reasonable and necessary (*e.g.,* improves health outcomes) for Medicare beneficiaries under Section 1862(a)(1)(A) of the Act. CMS is collecting information to learn more about which individuals benefit the most from this drug. CMS refers to this as coverage with evidence development or CED. The information being collected via registry will be analyzed to assist clinicians and patients make informed treatment decisions. Furthermore, data from the mAb Registry will assist the pharmaceutical industry and the Food and Drug Administration (FDA) in surveillance of the quality, safety and efficacy of these types of drugs. *Form Number:* CMS–10865 (OMB control number: 0938–NEW); *Frequency:* Annually; *Affected Public:* Business or other for-profits and Not-for-profit institutions; *Number of Respondents:* 40,000; *Number of Responses:* 40,000;

Total Annual Hours: 3,320. (For policy questions regarding this collection, contact Lori Ashby at 410–786–6322.)

Dated: August 31, 2023.

William N. Parham, III,

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

[FR Doc. 2023–19211 Filed 9–6–23; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–3437–FN]

Medicare and Medicaid Programs: Application From the Accreditation Commission for Health Care, Inc. for Continued Approval of its Ambulatory Surgical Center (ASC) Accreditation Program

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

ACTION: Notice.

SUMMARY: This notice announces our decision to approve the Accreditation Commission for Health Care, Inc for continued recognition as a national accrediting organization for Ambulatory Surgical Centers that wish to participate in the Medicare or Medicaid programs.

DATES: The decision announced in this notice is applicable on September 22, 2023 through September 22, 2027.

FOR FURTHER INFORMATION CONTACT: Joy Webb, (410) 786–1667; Erin Imhoff, (410) 786–2337.

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 that certain requirements are met. Section 1832(a)(2)(F)(i) of the Social Security Act (the Act) establishes distinct criteria for facilities 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 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 a 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 entities 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 regulations at § 488.5(e)(2)(i) require AOs to reapply for continued approval of its accreditation program every 6 years or sooner as determined by CMS.

Accreditation Commission for Health Care's (ACHC's) current term of approval for its ASC accreditation program expires September 22, 2023.

II. Application Approval Process

Section 1865(a)(3)(A) of the Act provides a statutory timetable to ensure that our review of applications for CMS-approval of an accreditation program is conducted in a timely manner. The Act provides us 210 days after the date of receipt of a complete application, with any documentation necessary to make the determination, to complete our survey activities and application process. Within 60 days after receiving a complete application, we must publish a notice in the **Federal Register** that identifies the national accrediting body making the request, describes the request, and provides no less than a 30-day public comment period. At the end of the 210-day period, we must publish a notice in the **Federal Register** approving or denying the application.

III. Provisions of the Proposed Notice

On April 3, 2023, we published a proposed notice in the **Federal Register** (88 FR 19645), announcing ACHC's request for continued approval of its Medicare ASC accreditation program. In the April 3, 2023, proposed notice, we detailed our evaluation criteria. Under section 1865(a)(2) of the Act and in our regulations at § 488.5, we conducted a review of ACHC's Medicare ASC accreditation application in accordance with the criteria specified by our regulations, which include, but are not limited to the following:

- An administrative review of ACHC's: (1) corporate policies; (2) financial and human resources available to accomplish the proposed surveys; (3) procedures for training, monitoring, and evaluation of its ASC surveyors; (4) ability to investigate and respond appropriately to complaints against accredited ASCs; and (5) survey review and decision-making process for accreditation.
- The comparison of ACHC's Medicare ASC accreditation program standards to our current Medicare ASC conditions for coverage (CfCs).
- A documentation review of ACHC's survey process to do the following:

++ Determine the composition of the survey team, surveyor qualifications, and ACHC's ability to provide continuing surveyor training.

++ Compare ACHC's processes to those we require of state survey agencies, including periodic resurvey and the ability to investigate and respond appropriately to complaints against ACHC accredited ASCs.

++ Evaluate ACHC's procedures for monitoring accredited ASCs it has found to be out of compliance with ACHC's program requirements. (This pertains only to monitoring procedures when ACHC identifies non-compliance. If noncompliance is identified by a SA through a validation survey, the SA monitors corrections as specified at § 488.9(c)).

++ Assess ACHC's ability to report deficiencies to the surveyed ASCs and respond to the ASC's plans of correction in a timely manner.

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

++ Determine the adequacy of ACHC's staff and other resources.

++ Confirm ACHC's ability to provide adequate funding for performing required surveys.

++ Confirm ACHC's policies with respect to surveys being unannounced.