measures that ask beneficiaries about health outcomes related to specific mental and Physical Conditions. *Form Number:* CMS–10203 (OMB control number: 0938–0701); *Frequency:* Yearly; *Affected Public:* Individuals and Households; *Number of Respondents:* 1,275; *Total Annual Responses:* 663,150; *Total Annual Hours:* 212,208. (For policy questions regarding this collection contact Alyssa Rosen at 410–786–8559 or *Alyssa.Rosen@cms.hhs.gov.*)

William N. Parham, III

Director, Division of Information Collections and Regulatory Impacts, Office of Strategic Operations and Regulatory Affairs.

[FR Doc. 2025–00589 Filed 1–13–25; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–3472–N]

Medicare Program; Request for Nominations for Members for the Medicare Evidence Development & Coverage Advisory Committee

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Notice.

SUMMARY: This notice announces the request for nominations for membership on the Medicare Evidence Development & Coverage Advisory Committee (MEDCAC). Among other duties, the MEDCAC provides advice and guidance to the Secretary of the Department of Health and Human Services (the Secretary) and the Administrator of the Centers for Medicare & Medicaid Services (CMS) concerning the adequacy of scientific evidence available to CMS in making coverage determinations under the Medicare program.

The MEDCAC's fundamental purpose is to support the principles of an evidence-based determination process for Medicare's coverage policies. MEDCAC panels provide advice to CMS on the strength of the evidence available for specific medical treatments and technologies through a public, participatory, and accountable process.

DATES: Nominations must be received by Monday, February 17, 2025.

ADDRESSES: You may send in nominations for membership via email to *MEDCACnomination@cms.hhs.gov.*

FOR FURTHER INFORMATION CONTACT: Leah Cromwell, 410–786–2243, MEDCAC Coordinator, via email at *Leah.Cromwell1@cms.hhs.gov.*

SUPPLEMENTARY INFORMATION:

I. Background

The Secretary signed the initial charter for the Medicare Coverage Advisory Committee (MCAC) on November 24, 1998. A notice in the **Federal Register** (63 FR 68780) announcing establishment of the MCAC was published on December 14, 1998. The MCAC name was updated to more accurately reflect the purpose of the committee and on January 26, 2007, the Secretary published a notice in the **Federal Register** (72 FR 3853), announcing that the Committee's name changed to the Medicare Evidence Development & Coverage Advisory Committee (MEDCAC). The current Secretary's Charter for the MEDCAC is available on the CMS website at: *https://www.cms.gov/Regulations-and-Guidance/Guidance/FACA/Downloads/medcaccharter.pdf* or you may obtain a copy of the charter by submitting a request to the contact listed in the **FOR FURTHER INFORMATION** section of this notice.

The MEDCAC is governed by provisions of the Federal Advisory Committee Act, Pub. L. 92–463, as amended (5 U.S.C. App. 2), which sets forth standards for the formulation and use of advisory committees, and is authorized by section 222 of the Public Health Service Act as amended (42 U.S.C. 217A).

We are requesting nominations for candidates to serve on the MEDCAC. Nominees are selected based upon their individual qualifications and not solely as representatives of professional associations or societies. We wish to ensure adequate representation of those enrolled in the Medicare program including but not limited to, racial and ethnic groups, individuals with disabilities, and from across the gender spectrum. Therefore, we encourage nominations of qualified candidates who can represent these lived experiences.

The MEDCAC consists of a pool of 100 appointed members including: 90 at-large standing members (20 of whom are patient advocates), and 10 representatives of industry interests. Members generally are recognized authorities in clinical medicine including subspecialties, administrative medicine, public health, biological and physical sciences, epidemiology and biostatistics, clinical trial design, health care data management and analysis, patient advocacy, health care economics, health disparities, medical ethics, geriatrics those with an understanding of sociodemographic bias and resulting limitations of scientific evidence, or other relevant professions.

The MEDCAC works from an agenda provided by the Designated Federal Official. The MEDCAC reviews and evaluates medical literature and technology assessments, and hears public testimony on the evidence available to address the impact of medical items and services on health outcomes of Medicare beneficiaries. The MEDCAC may also advise the Centers for Medicare & Medicaid Services (CMS) as part of Medicare's "coverage with evidence development" initiative.

II. Provisions of the Notice

As of December 2025, there will be a total of 20 membership terms expiring. Of the 20 memberships expiring, 2 are industry representatives, 10 are patient advocates and the remaining 8 membership openings are for the at-large standing MEDCAC membership.

All nominations must be accompanied by curricula vitae. Nomination packages should be addressed to Leah Cromwell and sent to the email address listed in the **ADDRESSES** section of this notice. Nominees are selected based upon their individual qualifications.

Nominees for membership must have expertise and experience in one or more of the following fields:

- Clinical medicine including subspecialties
- Administrative medicine
- Public health
- Health disparities
- Biological and physical sciences
- Epidemiology and biostatistics
- Clinical trial design
- Health care data management and analysis
- Patient advocacy
- Health care economics
- Medical ethics
- Geriatrics
- Other relevant professions

We are looking particularly for experts in a number of fields. These include health disparities, cancer screening, genetic testing, clinical epidemiology, psychopharmacology, screening and diagnostic testing analysis, and vascular surgery. We also need experts in biostatistics in clinical settings, dementia treatment, observational research design, stroke epidemiology, geriatrics, and women's health.

The nomination letter must include a statement that the nominee is willing to serve as a member of the MEDCAC and appears to have no conflict of interest that would preclude membership.

We are requesting that all curricula vitae include the following:

- List of areas of expertise
- Title and current position
- Professional affiliation
- Home and business address
- Telephone numbers (Please specify if the number is for: home, office, or cell phone)
- Email address (Please specify if the email address is for work/personal)

In the nomination letter, we are requesting that nominees specify whether they are applying for a patient advocate position, an at-large standing position, or as an industry representative. Potential candidates will be asked to provide detailed information concerning such matters as financial holdings, consultancies, and research grants or contracts in order to permit evaluation of possible sources of financial conflict of interest. Department policy prohibits multiple committee memberships. A federal advisory committee member may not serve on more than one committee within an agency at the same time.

Members may be invited to serve for overlapping 2-year terms. A member may continue to serve after the expiration of the member's term until a successor is named. Any interested person may nominate one or more qualified persons. Self-nominations are also accepted. Individuals interested in the representative positions are encouraged to include a letter of support from the organization or interest group they would represent.

III. Collection of Information

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.*).

The Chief Medical Officer and Director of the Center for Clinical Standards and Quality for the Centers for Medicare & Medicaid Services (CMS), Dora Hughes, having reviewed and approved this document, authorizes Chyana Woodyard, who is the Federal Register Liaison, to electronically sign this document for purposes of publication in the **Federal Register**.

Chyana Woodyard,

Federal Register Liaison, Centers for Medicare & Medicaid Services.

[FR Doc. 2025–00391 Filed 1–13–25; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Proposed Information Collection Activity; Tribal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program Community Needs and Readiness Assessment Guidance and Implementation Plan Guidance (Office of Management and Budget#: 0970–0611)

AGENCY: Office of Early Childhood Development, Administration for Children and Families, U.S. Department of Health and Human Services.

ACTION: Request for public comments.

SUMMARY: The Administration for Children and Families (ACF), Office of Early Childhood Development (ECD) is requesting revisions to the Tribal Maternal, Infant, and Early Childhood Home Visiting Program Community Needs and Readiness Assessment Guidance and Implementation Plan Guidance (Office of Management and Budget (OMB) #: 0970–0611; expiration June 30, 2026) and a 3-year extension of approval.

DATES: *Comments due March 17, 2025.* In compliance with the requirements of the Paperwork Reduction Act of 1995, ACF is soliciting public comment on the specific aspects of the information collection described above.

ADDRESSES: You can obtain copies of the proposed collection of information and submit comments by emailing *infocollection@acf.hhs.gov.* Identify all requests by the title of the information collection.

SUPPLEMENTARY INFORMATION:

Description: Section 511(e)(8)(A) of title V of the Social Security Act requires that grantees under the Tribal MIECHV program, in the first year of their grants, submit an implementation plan on how they will meet the requirements of the program. Section 511(h)(2)(A) further states that the requirements for the MIECHV grants to Tribes, Tribal organizations, and urban Indian organizations are to be consistent, to the greatest extent practicable, with the requirements for grantees under the MIECHV program for states and jurisdictions.

ACF ECD, in collaboration with the Health Resources and Services Administration's Maternal and Child Health Bureau, awarded grants for the Tribal MIECHV Program (Tribal Home Visiting) to support cooperative agreements to conduct community needs assessments; plan for and implement high-quality, culturally relevant, evidence-based home visiting programs in at-risk Tribal communities; establish, measure, and report on progress toward meeting performance measures in six legislatively mandated benchmark areas; and conduct rigorous evaluation activities to build the knowledge base on home visiting among Native populations.

During the first grant year, Tribal Home Visiting grantees must comply with the requirement to conduct a Community Needs and Readiness Assessment (CNRA) and submit an implementation plan that should feature planned activities to be carried out under the program in years 2–5 of their cooperative agreements. To assist grantees with meeting these requirements, ACF created a CNRA and implementation guidance for grantees to use when writing their plans. The CNRA Guidance and Implementation Plan Guidance (IPG) specifies that grantees must provide a plan to address the following areas:

- CNRA
- Program Design
- Program Blueprint
- Plan for Data Collection, Management, and Performance Measurement
- Fidelity Monitoring and Quality Assurance

The previous guidance included information about the CNRA and the implementation plan for grant recipients. This extension request updates the guidance by separating the CNRA Guidance from the IPG. This separation allows the CNRA Guidance to function as an independent document, enhancing clarity and usability instead of being incorporated within the IPG.

Additionally, significant modifications have been made to the guidance compared to earlier versions, with a primary focus on reducing the burden on grant recipients. These changes include eliminating redundant sections that overlap with other reporting requirements, reducing the number of guiding questions, and allowing for shorter responses.

Respondents: Tribal Home Visiting Managers (information collection does not include direct interaction with individuals or families that receive the services).