used to strengthen the evidence-base of CDC's Pre-Pandemic Guidance prior to the next pandemic.

School children are frequently the main introducers of influenza to their families. Evaluating influenza transmission within households where students are absent from school because of ILI may serve as an additional layer of influenza surveillance and could contribute to understanding of influenza transmission dynamics within the surrounding community. This aims to enhance current knowledge and understanding around the introduction of influenza infection to households that have school-age children, as well as within-household influenza transmission.

CDC requests a three-year approval for this Reinstatment. Estimated annualized burden hours requested for this collection are 449. There is no cost to respondents other than their time.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondents	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hours)	Total burden (in hours)
Parent/guardians of students or students 18 or older.	Screening Form	345	1	5/60	29
Parent/guardians of students or students 18 or older.	Acute Respiratory Infection and Influenza Surveillance Form.	300	1	15/60	75
Student	Biospecimen Collection Day 0	300	1	5/60	25
Household Members	Household Study Form Days 0, 7, 14.	720	3	5/60	120
Parent/guardians of students or students 18 or older.	Household Study Form Days 7, 14	300	2	5/60	80
Household Members	Biospecimen Collection Days 0, 7, 14.	720	3	5/60	120
Total					449

Jeffrey M. Zirger,

Lead, Information Collection Review Office, Office of Scientific Integrity, Office of Science, Centers for Disease Control and Prevention.

[FR Doc. 2021–04179 Filed 2–26–21; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Notice of Withdrawal of Development of Computed Tomography (CT) Image Quality and Safety Hospital Measures Funding Opportunity

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

ACTION: Withdrawal notice.

SUMMARY: This notice withdraws the ''Development of Computed Tomography (CT) Image Quality and Safety Hospital Measures'' notice that published in the **Federal Register** on January 5, 2021. That notice announced a funding opportunity to seek an application for a single source, cooperative agreement, to develop a radiology electronic clinical quality measure(s) (eCQM) for the following CMS hospital programs: Hospital Inpatient Quality Reporting Program (IQR); Hospital Outpatient Quality Reporting Program (OQR); and Promoting Interoperability Program for Eligible Hospitals and Critical Access Hospitals—formerly Meaningful Use (PI). CMS will no longer provide support through a cooperative agreement in its planning, technical assistance, and reporting needs related to submission of a fully developed and tested radiology measures to the 2021 Measures Under Consideration (MUC) List in May 2021.

DATES: The notice published at 86 FR 306 on January 5, 2021, is withdrawn as of February 25, 2021.

FOR FURTHER INFORMATION CONTACT:

Janis Grady, (410) 786–7217, for programmatic questions or concerns.

Monica Anderson, (410) 786–2988, for administrative and compliance concerns.

SUPPLEMENTARY INFORMATION:

I. Background

CMS has determined that current delays will not allow adequate time for the measures to be developed to meet internal deadlines, as such the determination is made to withdraw the January 5, 2021 **Federal Register** notice.

CMS will no longer provide support through a single source cooperative agreement in its planning, technical assistance, and reporting needs related to submission of a fully developed and tested radiology measures to the 2021 Measures Under Consideration (MUC) List in May 2021.

II. Provisions of the Notice

This notice withdraws the solicitation notice that we published in the **Federal Register** on January 5, 2021. For this Notice of Funding Opportunity, CMS will no longer accept an application for development of radiology electronic clinical quality measures (eCQM) that fill an existing gap or need and are high impact.

III. 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.*).

The Acting Administrator of the Centers for Medicare & Medicaid Services (CMS), Elizabeth Richter, having reviewed and approved this document, authorizes Lynette Wilson, who is the Federal Register Liaison, to electronically sign this document for purposes of publication in the **Federal Register.**

Authority: Programmatic Authority of the Social Security Act, Titles XI, XVIII, XIX, XXI.

Dated: February 24, 2021.

Lynette Wilson,

Federal Liaison, Centers for Medicare & Medicaid Services.

[FR Doc. 2021–04130 Filed 2–25–21; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–3400–FN]

Medicare and Medicaid Programs; Application From the Accreditation Commission for Health Care (ACHC) for Continued Approval of its Home Health Agency Accreditation Program

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

ACTION: Final notice.

SUMMARY: This final notice announces our decision to approve The Accreditation Commission for Health Care (ACHC) for continued recognition as a national accrediting organization for home health agencies (HHAs) that wish to participate in the Medicare or Medicaid programs. An HHA that participates in Medicaid must also meet the Medicare conditions of participation (CoPs).

DATES: This decision announced in this final notice is effective February 24, 2021 through February 24, 2025.

FOR FURTHER INFORMATION CONTACT: Tara Lemons (410) 786–3030. Lillian Williams (410) 786–8636.

SUPPLEMENTARY INFORMATION:

I. Background

Under the Medicare program, eligible beneficiaries may receive covered services from a home health agency (HHA), provided certain requirements are met. Sections 1861(m) and (o), 1891 and 1895 of the Social Security Act (the Act) establish distinct criteria for an entity seeking designation as an HHA. Regulations concerning provider agreements are at 42 CFR part 489 and those pertaining to activities relating to the survey and certification of facilities and other entities are at 42 CFR part 488. The regulations at 42 CFR parts 409 and 484 specify the conditions that an HHA must meet to participate in the Medicare program, the scope of covered services and the conditions for Medicare payment for home health care.

Generally, to enter into a provider agreement with the Medicare program, an HHA must first be certified by a state survey agency as complying with the conditions or requirements set forth in 42 CFR part 484 of our regulations. Thereafter, the HHA is subject to regular surveys by a state survey agency to determine whether it continues to meet these requirements. However, there is an alternative to certification surveys by state agencies. Accreditation by a nationally recognized Medicare accreditation program approved by CMS may substitute for both initial and ongoing state review.

Section 1865(a)(1) of the Act provides that, if a provider entity demonstrates through accreditation by an approved national accrediting organization that all applicable Medicare conditions are met or exceeded, we will deem those provider entities as having met our requirements. Accreditation by an accrediting organization is voluntary and is not required for Medicare participation.

If an accrediting organization is recognized by the Secretary of Health and Human Services (the Secretary) as having standards for accreditation that meet or exceed Medicare requirements, any provider entity accredited by the national accrediting body's approved program would be deemed to meet the Medicare conditions. A national accrediting organization applying for CMS approval of their accreditation program under 42 CFR part 488, subpart A, must provide CMS with reasonable assurance that the accrediting organization requires the accredited provider entities to meet requirements that are at least as stringent as the Medicare conditions. Our regulations concerning the approval of accrediting organizations are set forth at § 488.5. Section 488.5(e)(2)(i) requires accrediting organizations to reapply for continued approval of its Medicare accreditation program every 6 years or sooner as determined by CMS.

The Accreditation Commission for Health Care (ACHC's) term of approval for their HHA accreditation program expires February 24, 2021.

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

In the September 28, 2020 **Federal Register** (85 FR 60796), we published a proposed notice announcing ACHC's request for continued approval of its Medicare HHA accreditation program. In the September 28, 2020 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 HHA 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 HHA surveyors; (4) ability to investigate and respond appropriately to complaints against accredited HHAs; and (5) survey review and decision-making process for accreditation.
- The comparison of ACHC's Medicare HHA accreditation program standards to our current Medicare conditions of participation (CoPs) for HHAs.
- 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 accredited HHAs.

++ Evaluate ACHC's procedures for monitoring HHAs 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 state survey agency through a validation survey, the state survey agency monitors corrections as specified at § 488.9(c)).

++ Assess ACHC's ability to report deficiencies to the surveyed HHAs and respond to the HHAs plan 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.