highest-level owner of the space, including any financing entity, and disclose whether that owner is a foreign person or entity, including the country associated with the ownership entity.

This information collection covers GSA's implementation of the Act through GSAR clause 552.270–33. As this information is still required, GSA seeks to have this information collection extended for three years.

B. Annual Reporting Burden

The annual reporting burden is estimated as follows:

1. Initial Disclosure

Baseline Representation

Estimated annual responses: 542.
Estimated hours per response: 2.

Additional Representation

Estimated annual responses: 54.
Estimated hours per response: 10.
Total Initial Response Burden Hours: 1,624.

2. Annual Updates

Estimated annual responses: 542.
Estimated hours per response: 0.50.
Total Update Response Burden Hours: 271.

C. Public Comments

A 60-day notice published in the **Federal Register** at 89 FR 78305 on September 25, 2024. No public comments were received.

Jeffrey A. Koses,

Senior Procurement Executive, Office of Acquisition Policy, Office of Government-wide Policy.

[FR Doc. 2024–29130 Filed 12–11–24; 8:45 am]

BILLING CODE 6820–61–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Agency for Healthcare Research and Quality

Request for Information Regarding Diagnostic Excellence Measurement

AGENCY: Agency for Healthcare Research and Quality, Department of Health and Human Services.

ACTION: Notice of Request for Information (RFI) regarding diagnostic excellence measurement.

SUMMARY: The Agency for Healthcare Research and Quality (AHRQ) invites public comment in response to this Request for Information (RFI) on the development of measures of diagnostic excellence that may be calculated using administrative data or electronic health record (EHR) data. The purpose of diagnostic excellence measurement is to identify potential opportunities to improve the diagnostic process at a health system or geographic level. AHRQ welcomes comments on the importance and usability of existing measures and those that may be under development.

DATES: Comments on this notice must be received by February 13, 2025.

ADDRESSES: Interested parties may submit comments electronically to *qisupport@ahrq.hhs.gov* with the subject line ''Diagnostic Excellence Measurement.''

FOR FURTHER INFORMATION CONTACT: Questions may be addressed to Judy George, *judy.george@ahrq.hhs.gov,* (301) 427–1717.

SUPPLEMENTARY INFORMATION: The COVID–19 pandemic led to disruptions in healthcare service delivery and reversed some of the gains made in patient safety over the previous two decades. In 2024, AHRQ on behalf of HHS, officially launched the National Action Alliance for Patient and Workforce Safety (*https://www.ahrq.gov/action-alliance/index.html*), a collaboration between public and private partners to recommit to patient and workforce safety and to eliminate preventable harm in healthcare. Diagnostic safety events are an important contributor to patient safety, with diagnostic errors potentially impacting millions of U.S. residents each year (*https://pmc.ncbi.nlm.nih.gov/articles/PMC5502242/*). Diagnostic error is ''the failure to (a) establish an accurate and timely explanation of the patient's health problem(s) or (b) communicate that explanation to the patient'' (*https://doi.org/10.17226/21794*). However, in order to improve patient safety, a focus on diagnostic error reduction alone is not sufficient. Efforts are needed to improve the diagnostic process as a whole, with an emphasis on diagnostic excellence.

Diagnostic excellence may be defined as ''an optimal process to attain an accurate and precise explanation about a patient's condition'' (*https://jamanetwork.com/journals/jama/article-abstract/2785845*). This process should be ''timely, cost-effective, convenient, and understandable to the patient.'' Diagnostic excellence ''embraces the six dimensions of quality enumerated by the Institute of Medicine in 2001: care that is safe, effective, patient-centered, timely, efficient, and equitable'' (*https://jamanetwork.com/journals/jama/article-abstract/2785845*).

Several efforts have been underway to develop measures that provide information on the state of diagnostic excellence, including research funded by AHRQ and the Gordon and Betty Moore Foundation. The AHRQ Quality Indicators (QI) Program develops indicators of healthcare quality and patient safety in a variety of healthcare settings. The QI Program is actively engaged in collecting information on measures that can contribute to diagnostic excellence measurement. AHRQ is considering measures that rely on administrative claims data (for state and regional health departments with limited access to clinical data), as well as electronic health record data (for healthcare systems with full access to clinical data). AHRQ aims to address gaps in diagnostic excellence measurement with a population health lens and with the following goals:

1. Develop a starter set of standardized measures to support population-level diagnostic excellence surveillance.
2. Generate measures that are accessible and applicable across different types of users, especially those with limited access to clinical data sources.
3. Produce national benchmarks for population-level surveillance of diagnostic excellence.
4. Foster healthcare quality improvement in the area of diagnostic excellence.

AHRQ requests information from the public on existing measures that may be used in diagnostic excellence measurement and others that may be under development.

Criteria. Diagnostic excellence measures should be important, scientifically acceptable, feasible, and useful. These concepts are defined as follows:

Important. (1) There is evidence linking the measure to important outcomes (including either process outcomes or clinical outcomes); (2) there is evidence of inequalities across groups or opportunity for improvement on that measure; or (3) the target population of the measure (*e.g.,* patients) or users of the measure (*e.g.,* researchers, providers) value the measurement and find it meaningful.

Scientifically acceptable. A scientifically acceptable measure is both (1) valid (the measure accurately represents the concept it is trying to measure) and (2) reliable (the measure consistently produces the same result over time and in different contexts).

Feasible. A measure is feasible if it is possible to implement with existing data systems and clinical processes.

Useful. A measure is useful if it provides information useful for quality improvement programs, with the ability to capture variation in performance across reporting entities.

Additional Considerations. In addition to the criteria listed above, AHRQ aims to consider the extent to which measures:

- Identify an important gap in diagnostic performance;
- Contribute to the solution of a diagnostic safety problem;
- Are broadly applicable to a population-level diagnostic safety opportunity;
- Could be used to lessen health disparities.

AHRQ requests responses to the following questions:

1. Are you currently working on any initiatives related to diagnostic excellence, diagnostic safety, or diagnostic quality? If so, please describe. If you are working on diagnostic excellence initiatives, which ones would benefit from publicly available measurement tools or resources? Are there specific resources that you would like to see from AHRQ? If so, please describe.

2. If you are currently measuring diagnostic excellence in your organization, what measure(s) are you using? How do you use these measures (*e.g.,* for quality improvement efforts, to track population health) and what motivated the use of such measures? What data sources are you using? What data model are you using to map data to standardized concepts (*e.g.,* Observational Medical Outcomes Partnership (OMOP) Common Data Model, others)? Please specify your organization type (*e.g.,* state/local health department, professional society, healthcare system, research organization, etc.) in your answer.

3. If you or your organization are not currently measuring diagnostic excellence, what diagnostic excellence measures might be helpful to your organization? Please specify your organization type in your answer.

4. If standardized measures with national benchmarks were made available through software by AHRQ, how likely would you be to use them? What characteristics (*e.g.,* risk adjustment, frequency counts) or features (*e.g.,* statistical programming languages, data model platforms, technology [web or cloud-based applications]) of such measures would facilitate their use and usefulness within your organization?

5. AHRQ is considering the diagnostic excellence-related measures listed here: *https://bit.ly/41mg3i6.* We invite comments on:

a. The extent to which these measures meet the ''Criteria'' listed above; and

b. The extent to which these measures address the ''Additional Considerations'' listed above.

6. AHRQ invites any additional comments related to potential AHRQ measures of diagnostic excellence.

AHRQ is interested in all of the questions listed above, but respondents are welcome to address as many or as few as they choose and to address additional areas of interest not listed. It is helpful to identify the question to which a particular answer corresponds.

This RFI is for planning purposes only and should not be construed as a policy, solicitation for applications, or as an obligation on the part of the Government to provide support for any ideas in response to it. AHRQ will use the information submitted in response toto this RFI at its discretion and will not provide comments to any respondent's submission. However, responses to this RFI may be reflected in future solicitation(s) or policies. The information provided will be analyzed and may appear in reports.

Dated: December 6, 2024.

Marquita Cullom,

Associate Director.

[FR Doc. 2024–29134 Filed 12–11–24; 8:45 am]

BILLING CODE P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–3461–FN]

Medicare and Medicaid Programs; Approval of Application by the Accreditation Association for Ambulatory Healthcare for Continued CMS-Approval of Its Ambulatory Surgical Center Accreditation Program

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

ACTION: Notice.

SUMMARY: This notice acknowledges the approval of an application by the Accreditation Association for Ambulatory Healthcare 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 November 20, 2024 through November 20, 2029.

FOR FURTHER INFORMATION CONTACT:

Joy Webb, (410) 786–1667.

Joann Fitzell, (410) 786–4280.

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 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 Accreditation Association for Ambulatory Healthcare's (AAAHC's) current term of approval for its ASC program expires December 20, 2024.