the Medicare Program Form (CMS–377) is used by State agencies who conduct certification surveys on CMS' behalf to maintain information on the facility's characteristics that facilitate conducting surveys, *e.g.,* determining the size and the composition of the survey team on the basis of the number of ORs/procedure rooms and the types of surgical procedures performed in the ASC. *Form Numbers:* CMS–370 and CMS–377 (OMB control number: 0938–0266); *Frequency:* Occasionally; *Affected Public:* Private Sector—Business or other for-profit and Not-for-profit institutions; *Number of Respondents:* 5,694; *Total Annual Responses:* 1,898; *Total Annual Hours:* 627. (For policy questions regarding this collection contact Erin McCoy at 410–786–2337.)

Dated: June 21, 2017.

William N. Parham, III,

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

[FR Doc. 2017–13321 Filed 6–23–17; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10292, CMS–10332 and CMS–10239]

Agency Information Collection Activities: Proposed Collection; Comment Request

AGENCY: Centers for Medicare & Medicaid 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 August 25, 2017.

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, you may make your request using one of following:

1. Access CMS' Web site address at *https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing.html*.

2. Email your request, including your address, phone number, OMB number, and CMS document identifier, to *Paperwork@cms.hhs.gov*.

3. Call the Reports Clearance Office at (410) 786–1326.

FOR FURTHER INFORMATION CONTACT: William 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–10292 State Medicaid HIT Plan, Planning Advance Planning Document, and Implementation Advance Planning Document for Section 4201 of the Recovery Act

CMS–10332 Disclosure Requirement for the In-Office Ancillary Services Exception

CMS–10239 Conditions of Participation for Critical Access Hospitals (CAH) and Supporting Regulations

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:* State Medicaid HIT Plan, Planning Advance Planning Document, and Implementation Advance Planning Document for Section 4201 of the Recovery Act; *Use:* To assess the appropriateness of state requests for the administrative Federal financial participation for expenditures under their Medicaid Electronic Health Record Incentive Program related to health information exchange, our staff will review the submitted information and documentation to make an approval determination of the state advance planning document. *Form Number:* CMS–10292 (OMB control number: 0938–1088); *Frequency:* Once and occasionally; *Affected Public:* State, Local, and Tribal Governments; *Number of Respondents:* 56; *Total Annual Responses:* 56; *Total Annual Hours:* 896. (For policy questions regarding this collection contact Marty Rice at 410–786–2417.)

2. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Disclosure Requirement for the In-Office Ancillary Services Exception; *Use:* Section 6003 of the ACA established a disclosure requirement for the in-office ancillary services exception to the prohibition of physician self-referral for certain imaging services. This section of the ACA amended section 1877(b)(2) of the Social Security Act by adding a requirement that the referring physician informs the patient, at the time of the referral and in writing, that the patient may receive the imaging service from another supplier. The implementing regulations are at 42 CFR 411.355(b)(7).

Physicians who provide certain imaging services (MRI, CT, and PET) under the in-office ancillary services exception to the physician self-referral prohibition are required to provide the disclosure notice as well as the list of other imaging suppliers to the patient. The patient will then be able to use the disclosure notice and list of suppliers in making an informed decision about his or her course of care for the imaging service. CMS would use the collected information for enforcement purposes. Specifically, if we were investigating the referrals of a physician providing advanced imaging services under the in-office ancillary services exception, we would review the written disclosure in order to determine if it satisfied the requirement. *Form Number:* CMS–10332 (OMB control number: 0938–1133); *Frequency:* Occasionally; *Affected Public:* State, Local, and Tribal Governments; *Number of Respondents:* 7,100; *Total Annual Responses:* 759,700; *Total Annual Hours:* 19,638. (For policy questions regarding this collection contact Laura Dash at 410–786–8623.)

3. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Conditions of Participation for Critical Access Hospitals (CAH) and Supporting Regulations; *Use:* At the outset of the critical access hospital (CAH) program, the information collection requirements for all CAHs were addressed together under the following information collection request: CMS–R–48 (OCN: 0938–0328). As the CAH program has grown in both scope of services and the number of providers, the burden associated with CAHs with distinct part units (DPUs) was separated from the CAHs without DPUs. Section 1820(c)(2)(E)(i) of the Social Security Act provides that a CAH may establish and operate a psychiatric or rehabilitation DPU. Each DPU may maintain up to10 beds and must comply with the hospital requirements specified in 42 CFR subparts A, B, C, and D of part 482. Presently, 105 CAHs have rehabilitation or psychiatric DPUs. The burden associated with CAHs that have DPUs continues to be reported under CMS–R–48, along with the burden for all 4,890 accredited and non-accredited hospitals.

The CAH conditions of participation and accompanying information collection requirements specified in the regulations are used by surveyors as a basis for determining whether a CAH meets the requirements to participate in the Medicare program. We, along with the healthcare industry, believe that the availability to the facility of the type of records and general content of records, which this regulation specifies, is standard medical practice and is necessary in order to ensure the well-being and safety of patients and professional treatment accountability. *Form Number:* CMS–10239 (OMB Control number: 0938–1043); *Frequency:* Yearly; *Affected Public:* Private sector—Business or other for-profit; *Number of Respondents:* 1,215; *Total Annual Responses:* 144,585; *Total Annual Hours:* 24,183. (For policy questions regarding this collection contact Mary Collins at 410–786–3189.)

Dated: June 20, 2017.

William N. Parham, III,

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

[FR Doc. 2017–13198 Filed 6–23–17; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–3338–FN]

Medicare and Medicaid Programs: Approval of an Application From the Center for Improvement in Healthcare Quality for Continued CMS Approval of Its Hospital Accreditation Program

AGENCY: Centers for Medicare and Medicaid Services, HHS.

ACTION: Final notice.

SUMMARY: This final notice announces our decision to approve the Center for Improvement in Healthcare Quality (CIHQ) for continued recognition as a national accrediting organization for hospitals that wish to participate in the Medicare or Medicaid programs.

DATES: This final notice is effective July 26, 2017 through July 26, 2023.

FOR FURTHER INFORMATION CONTACT: Lillian Williams (410) 786–8638, Monda Shaver, (410) 786–3410, or Patricia Chmielewski, (410) 786–6899.

SUPPLEMENTARY INFORMATION:

I. Background

A healthcare provider may enter into an agreement with Medicare to participate in the program as a hospital provided certain requirements are met. Section 1861(e) of the Social Security Act (the Act) establishes criteria for providers seeking participation in Medicare as a hospital. Regulations concerning Medicare provider agreements in general are at 42 CFR part 489 and those pertaining to the survey and certification for Medicare participation of providers and certain types of suppliers are at 42 CFR part 488. The regulations at 42 CFR part 482 specify the specific conditions that a provider must meet to participate in the Medicare program as a hospital. Hospitals that wish to be paid under the Medicaid program must be approved to participate in Medicare, in accordance with 42 CFR 440.10(a)(3)(iii).

Generally, to enter into a Medicare hospital provider agreement, a facility must first be certified as complying with the conditions set forth in part 482 and recommended to the Centers for Medicare & Medicaid Services (CMS) for participation by a State survey agency. Thereafter, the hospital is subject to periodic surveys by a State survey agency to determine whether it continues to meet these conditions. 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 the Secretary of the Department of Health and Human Services (the Secretary) finds that accreditation of a provider entity by an approved national accrediting organization meets or exceeds all applicable Medicare conditions, we may treat the provider entity as having met those conditions, that is, we may ''deem'' the provider entity to be in compliance. Accreditation by an accrediting organization is voluntary and is not required for Medicare participation.

Part 488 subpart A implements the provisions of section 1865 of the Act and requires that a national accrediting organization applying for approval of its Medicare accreditation program must provide CMS with reasonable assurance that the accrediting organization requires its 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. The regulations at § 488.5(e)(2)(i) require an accrediting organization to reapply for continued approval of its Medicare accreditation program every 6 years or sooner as determined by CMS. The Center for Improvement in Healthcare Quality's (CIHQ's) term of approval as a recognized Medicare accreditation program for hospitals expires July 26, 2017.