in the Medicare Fee-for-Service (FFS), and Medicaid programs that successfully demonstrated meaningful use of CEHRT. In their first payment year, Medicaid EPs, eligible hospitals including MA organizations and CAHs could adopt, implement, or upgrade to certified EHR technology. It also allowed for negative payment adjustments in the Medicare FFS and MA programs starting in 2015 for EPs, eligible hospitals including MA organizations and CAHs participating in Medicare that are not meaningful users of CEHRT. The Medicaid Promoting Interoperability Program did not authorize negative payment adjustments, but its participants were eligible for incentive payments until December 31, 2021, when the program ended.

In CY 2017, we began collecting data from eligible hospitals and CAHs to determine the application of the Medicare payment adjustments. This information collection was also used to make incentive payments to eligible hospitals in Puerto Rico from 2016 through 2021. At this time, Medicare eligible professionals no longer reported to the EHR Incentive Program, as they began reporting under the Merit-based Incentive Payment System's (MIPS) Promoting Interoperability Performance Category. In 2019, the EHR Incentives Program for eligible hospitals and CAHs was subsequently renamed the Medicare Promoting Interoperability Program. In subsequent years, we have focused on balancing reporting burden for eligible hospitals and CAHs while also implementing changes designed to incentivize the advanced use of CEHRT to support health information exchange, interoperability, advanced quality measurement, and maximizing clinical effectiveness and efficiencies.

In the FY 2024 IPPS/LTCH PPS final rule, we finalized the following policy changes for eligible hospitals and CAHs that attest to CMS under the Medicare Promoting Interoperability Program. None of the policies we finalized will affect the information collection burden: (i) to adopt three electronic clinical quality measures (eCQMs) beginning with the CY 2025 reporting period: (1) Hospital Harm—Pressure Injury eCQM; (2) Hospital Harm—Acute Kidney Injury eCQM; and (3) Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CMT) in Adults eCQM; (ii) to modify the Safety Assurance Factors for EHR Resilience (SAFER) Guides measure to require eligible hospitals and CAHs to submit a ''yes'' attestation to fulfill the measure beginning with the EHR reporting period in CY 2024; and (iii) to establish an EHR reporting period of a minimum of any continuous 180-day period in CY 2025. *Form Number:* CMS–10552 (OMB control number: 0938–1278); *Frequency:* Annually; *Affected Public:* State, Local or Private Government; Business and for-profit and Not-for-profit; *Number of Respondents:* 4,500; *Total Annual Responses:* 4,500; *Total Annual Hours:* 29,625. (For policy questions regarding this collection, contact Jessica Warren at 410–786–7519.)

William N. Parham, III,

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

[FR Doc. 2024–02306 Filed 2–5–24; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–3454–PN]

Medicare and Medicaid Programs; Application by DNV Healthcare USA Inc. (DNV) for Continued CMS Approval of Its Psychiatric Hospital Accreditation Program

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

ACTION: Proposed notice.

SUMMARY: This proposed notice acknowledges the receipt of a deeming application from DNV Healthcare USA Inc. (DNV) for continued Centers for Medicare & Medicaid Services (CMS) approval of its psychiatric hospital accreditation program. The statute requires that within 60 days of receipt of an organization's complete application, CMS must publish a notice that identifies the national accrediting body making the request, describes the nature of the request, and provides at least a 30-day public comment period.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, by March 7, 2024.

ADDRESSES: In commenting, refer to file code CMS–3454–PN.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to *http://www.regulations.gov.* Follow the ''Submit a comment'' instructions.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–3454–PN, P.O. Box 8010, Baltimore, MD 21244–8010.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–3454–PN, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT:

Joann Fitzell, (410) 786–4280.

Lillian Williams, (410) 786–8636.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following website as soon as possible after they have been received: *http://www.regulations.gov.* Follow the search instructions on that website to view public comments. CMS will not post on *Regulations.gov* public comments that make threats to individuals or institutions or suggest that the commenter will take actions to harm an individual. CMS continues to encourage individuals not to submit duplicative comments. We will post acceptable comments from multiple unique commenters even if the content is identical or nearly identical to other comments.

I. Background

Under the Medicare program, eligible beneficiaries may receive covered services from a psychiatric hospital provided certain requirements are met. Section 1861(f) of the Social Security Act (the Act), establishes distinct criteria for facilities seeking designation as a psychiatric hospital. 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 482 subpart E specify the minimum conditions that a psychiatric hospital must meet to participate in the Medicare program, the scope of covered services, and the conditions for Medicare payment for psychiatric hospitals.

Generally, to enter into an agreement, a psychiatric hospital must first be certified by a state survey agency (SA) as complying with the conditions or requirements set forth in part 482, subpart E of our regulations. Thereafter, the psychiatric hospital 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 will deem those 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 (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 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 §§ 488.4 and 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.

DNV Healthcare USA Inc.'s (DNV's) current term of approval for their psychiatric hospital accreditation program expires July 30, 2024.

II. Approval of Deeming Organization

Section 1865(a)(2) of the Act and our regulations at § 488.5 require that our findings concerning review and approval of a national AO's requirements consider, among other factors, the applying AO's requirements for accreditation; survey procedures; resources for conducting required surveys; capacity to furnish information for use in enforcement activities; monitoring procedures for provider entities found not in compliance with the conditions or requirements; and ability to provide CMS with the necessary data for validation.

Section 1865(a)(3)(A) of the Act further requires that we publish, within 60 days of receipt of an organization's complete application, a notice identifying the national accrediting body making the request, describing the nature of the request, and providing at least a 30-day public comment period. The Act provides us 210 days from the receipt of a complete application to publish notice of approval or denial of the application.

The purpose of this proposed notice is to inform the public of DNV's request for continued approval of its psychiatric hospital accreditation program. This notice also solicits public comment on whether DNV's requirements meet or exceed the Medicare conditions of participation (CoPs) for psychiatric hospitals.

III. Evaluation of Deeming Authority Request

DNV submitted all the necessary materials to enable us to make a determination concerning its request for initial approval of its psychiatric hospital accreditation program. This application was determined to be complete on January 2, 2024. Under section 1865(a)(2) of the Act and our regulations at § 488.5 (Application and re-application procedures for national accrediting organizations), our review and evaluation of the DNV will be conducted in accordance with, but not necessarily limited to, the following factors:

- The equivalency of the DNV standards for psychiatric hospitals as compared with CMS' psychiatric hospital CoPs.
- The DNV survey process to determine the following:

++ The composition of the survey team, surveyor qualifications, and the ability of the organization to provide continuing surveyor training.

++ The comparability of DNV's processes to those of state agencies, including survey frequency, and the ability to investigate and respond appropriately to complaints against accredited facilities.

++ DNV's processes and procedures for monitoring a psychiatric hospital found out of compliance with DNV's program requirements. These monitoring procedures are used only when DNV identifies noncompliance. If noncompliance is identified through validation reviews or complaint surveys, the state SA monitors corrections as specified at § 488.9(c).

++ DNV's capacity to report deficiencies to the surveyed facilities and respond to the facility's plan of correction in a timely manner.

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

++ The adequacy of DNV's staff and other resources, and its financial viability.

++ DNV's capacity to adequately fund required surveys.

++ DNV's policies with respect to whether surveys are announced or unannounced, to ensure that surveys are unannounced.

++ DNV's policies and procedures to avoid conflicts of interest, including the appearance of conflicts of interest, involving individuals who conduct surveys or participate in accreditation decisions.

++ DNV's agreement to provide CMS with a copy of the most current accreditation survey together with any other information related to the survey as CMS may require (including corrective action plans).

Upon completion of our evaluation, including evaluation of public comments received as a result of this notice, we will publish a final notice in the **Federal Register** announcing the result of our evaluation.

IV. 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.*).

V. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

The Administrator of the Centers for Medicare & Medicaid Services (CMS), Chiquita Brooks-LaSure, having reviewed and approved this document, authorizes Vanessa Garcia, who is the **Federal Register** Liaison, to electronically sign this document for purposes of publication in the **Federal Register**.

Vanessa Garcia,

Federal Register Liaison, Centers for Medicare & Medicaid Services.

[FR Doc. 2024–02342 Filed 2–5–24; 8:45 am]

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