

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 to 10 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.

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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.

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

On February 24, 2017, we published a proposed notice in the **Federal Register** (82 FR 11579) announcing CIHQ's request for continued approval of its Medicare hospital accreditation program. In the 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 CIHQ's Medicare hospital accreditation application in accordance with the criteria specified by our regulations, which include, but are not limited to the following:

- An onsite administrative review of CIHQ's: (1) Corporate policies; (2) financial and human resources available to accomplish the proposed surveys; (3) procedures for training, monitoring, and evaluation of its hospital surveyors; (4) ability to investigate and respond appropriately to complaints against accredited hospitals; and, (5) survey review and decision-making process for accreditation.

- A comparison of CIHQ's Medicare accreditation program standards to our current Medicare hospital Conditions of Participation (CoPs).

- A documentation review of CIHQ's survey process to do the following:

- ++ Determine the composition of the survey team, surveyor qualifications, and CIHQ's ability to provide continuing surveyor training.

- ++ Compare CIHQ'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 hospitals.

- ++ Evaluate CIHQ's procedures for monitoring hospitals it has found to be out of compliance with CIHQ's program requirements. (This pertains only to

monitoring procedures when CIHQ identifies non-compliance. If non-compliance is identified by a State survey agency through a validation survey, the State survey agency monitors corrections as specified at § 488.9(c)).

- ++ Assess CIHQ's ability to report deficiencies to the surveyed hospitals and respond to the hospital's plan of correction in a timely manner.

- ++ Establish CIHQ's ability to provide CMS with electronic data and reports necessary for effective validation and assessment of the organization's survey process.

- ++ Determine the adequacy of CIHQ's staff and other resources.

- ++ Confirm CIHQ's ability to provide adequate funding for performing required surveys.

- ++ Confirm CIHQ's policies with respect to surveys being unannounced.

- ++ Obtain CIHQ's agreement to provide CMS with a copy of the most current accreditation survey together with any other information related to the survey as we may require, including corrective action plans.

In accordance with section 1865(a)(3)(A) of the Act, the February 24, 2017 proposed notice also solicited public comments regarding whether CIHQ's requirements met or exceeded the Medicare CoP for hospitals. There were no comments submitted.

IV. Provisions of the Final Notice

A. Differences Between CIHQ's Standards and Requirements for Accreditation and Medicare Conditions and Survey Requirements

We compared CIHQ's hospital accreditation requirements and survey process with the Medicare CoPs at part 482, and the survey and certification process requirements of parts 488 and 489. CIHQ's standards crosswalk, which maps CIHQ's standards with the corresponding requirements under the Medicare CoPs, was also examined to ensure that the appropriate CMS regulation was included in citations as appropriate. We reviewed and evaluated CIHQ's hospital application, conducted as described earlier. As a result, CIHQ has revised its materials, standards, and certification processes to reflect the following Medicare requirements:

- § 482.12: Updated the summary description of this provision in the crosswalk to be consistent with its accreditation standards.

- § 482.12(a)(1) through (10): Updated the summary description of this provision in the crosswalk to be consistent with its accreditation standards.

- § 482.12(a)(10): Revised its standards to address the hospital's responsibility to consult directly with the medical staff.

- § 482.12(c): Updated the summary description of this provision in the crosswalk to be consistent with its accreditation standards.

- § 482.12(c)(1)(ii): Updated the CFR citation to properly reference the regulatory requirement on its standards crosswalk.

- § 482.12(c)(2): Updated the CFR citation to properly reference the regulatory requirement on its standards crosswalk.

- § 482.12(c)(4)(i): Clarified the use of the word "develops" to indicate if the condition was present on admission or developed during the hospitalization on its standards crosswalk.

- § 482.12(f)(2): Revised its standards to ensure the medical staff have written policies and procedures for appraisals of emergencies, initial treatment and referral.

- § 482.13(a)(1) and § 482.13(a)(2): Updated the summary description of these provisions in the crosswalk to be consistent with its accreditation standards.

- § 482.13(a)(2)(i): Revised its standards to ensure the patient's right to submit "written or verbal" grievances.

- § 482.13(a)(2)(ii), § 482.13(b)(3), § 482.13(b)(4) and § 482.13(c)(2): Updated the summary description of these provisions in the crosswalk to be consistent with its accreditation standards.

- § 482.13(e)(5): Updated the CFR citation to properly reference the regulatory requirement.

- § 482.13(e)(6), § 482.13(f)(1)(ii), § 482.13(g), § 482.13(g)(2), § 482.13(h), § 482.21(b)(1), § 482.21(d)(2) and § 482.21(d)(4): Updated the summary description of these provisions in the crosswalk to be consistent with its accreditation standards.

- § 482.22(a)(2): Updated its standards to reflect that temporary practice privileges are granted by the governing body.

- § 482.22(b)(1): Updated the summary description of this provision in the crosswalk to be consistent with its accreditation standards.

- § 482.22(b)(3): Revised its standards to reflect CMS requirements for medical staff organization and accountability.

- § 482.22(b)(4): Updated the summary description of this provision in the crosswalk to be consistent with its accreditation standards.

- § 482.23(c)(4): Updated its standards to fully address requirements for blood transfusions.

- § 482.24(b): Updated its standards to fully address requirements for the form and retention of medical records.
- § 482.24(c)(2) through (c)(4)(viii): Updated the Medicare regulatory language on its standards crosswalk to ensure that its accreditation standards are consistent with Medicare standards.
- § 482.25(b)(2)(ii): Updated the crosswalk and standard to add references to the Comprehensive Drug Abuse Prevention and Control Act of 1970.
- § 482.26: Updated the summary description of this provision in the crosswalk to be consistent with its accreditation standards.
- § 482.41: Revised its standards to reflect the requirements of the “Physical Environment”.
- § 482.43: Revised its standards to ensure that the hospital discharge planning process applies to all patients.
- § 482.51(b)(6) and § 482.56(a)(2): Updated the summary description of these provisions in the crosswalk to be consistent with its accreditation standards.
- § 482.56(b)(2): Revised its standards to address the requirements at § 409.17 related to physical therapy, occupational therapy, and speech language pathology services.
- § 482.57(b)(3): Updated the CFR citation to properly reference the regulatory requirement on its crosswalk.
- § 482.57(b)(4): Updated the CFR citation to properly reference the regulatory requirement on its crosswalk and in its accreditation standards.
- § 488.4(a)(6): Revised its standards to include a process to track and trend complaints received.
- § 488.5(a)(4)(ii): Revised its standards to ensure that an appropriate number of open, inpatient medical records are fully reviewed during the survey process.
- § 488.5(a)(4)(iv): Revised its standards to assure that findings of non-compliance are documented under all appropriate CMS standards where non-compliance is found; and that adverse findings for each CoP are reviewed for manner and degree of non-compliance and subsequently cited at the appropriate level (that is, condition versus standard level).
- § 488.5(a)(7) through (9): Revised its standards to ensure that newly hired surveyors receive orientation so as to ensure AO compliance with these provisions.
- § 488.26(b): Revised its standards to improve surveyor documentation to include the appropriately detailed deficiency statements that clearly support the determination of noncompliance and level of deficiency.

- § 489.13: Revised its standards to reflect CMS policy regarding effective dates of participation in the Medicare program and develop a plan for monitoring for sustained compliance.
- CIHQ revised its complaint policy and procedure to clearly identify the individual(s) that are responsible for triaging complaints submitted to the accrediting organization.
- CIHQ revised its policy to clarify that an “Immediate Jeopardy” finding remains cited at the Conditional level, even if abated while onsite.

B. Term of Approval

Based on our review and observations described in section III of this final notice, we have determined that CIHQ’s hospital program requirements meet or exceed our requirements. Therefore, we approve CIHQ as a national accreditation organization for hospitals that request participation in the Medicare program, effective July 26, 2017 through July 26, 2023.

V. 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.*).

Dated: June 20, 2017.

Seema Verma,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2017–13207 Filed 6–23–17; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Submission for OMB Review; Comment Request

Proposed Projects

Title: Multistate Financial Institution Data Match and Federally Assisted State Transmitted Levy (MSFIDM/FAST Levy).

OMB No.: 0970–0196.

Description: Section 466(a)(17) of the Social Security Act (the Act) requires states to establish procedures for their child support agencies to enter into agreements with financial institutions doing business in their state for the purpose of securing information leading to the enforcement of child support

orders. Under 452(m) and 466(a)(17)(A)(i) of the Act, the Secretary may aid state agencies conducting data matches with financial institutions doing business in two or more states by establishing a centralized and standardized matching program through the Federal Parent Locator Service.

To further assist states collect child support, the federal Office of Child Support Enforcement (OCSE) worked with child support agencies and financial institutions to develop the Federally Assisted State Transmitted (FAST) Levy system.

FAST Levy is a central, standardized, and secure electronic process for child support agencies and financial institutions to exchange information about levying financial accounts to collect past-due support. OCSE picks up files created by child support agencies that contain FAST Levy requests and distributes them to financial institutions that use the FAST Levy system. Those financial institutions create response files that OCSE picks up and distributes to the child support agencies.

The MSFIDM/FAST-Levy information collection activities are authorized by: 42 U.S.C. 652(m), which authorizes OCSE, through the Federal Parent Locator Service, to aid state child support agencies and financial institutions doing business in two or more states reach agreements regarding the receipt from financial institutions, and the transfer to the state child support agencies, of information pertaining to the location of accounts held by obligors who owe past-due support; 42 U.S.C. 666(a)(2) and (c)(1)(G)(ii), which require state child support agencies in cases in which there is an arrearage to establish procedures to secure assets to satisfy any current support obligation and the arrearage by attaching and seizing assets of the obligor held in financial institutions; 42 U.S.C. 666(a)(17)(A), which requires state child support agencies to establish procedures under which the state child support agencies shall enter into agreements with financial institutions doing business in the State to develop and operate, in coordination with financial institutions, and the Federal Parent Locator Service (in the case of financial institutions doing business in two or more States), a data match system, using automated data exchanges to the maximum extent feasible, in which a financial institution is required to quarterly provide information pertaining to a noncustodial parent owing past-due support who maintains an account at the institution and, in response to a notice of lien or levy, encumber or surrender, assets held; 42