EXHIBIT 2—ESTIMATED ANNUALIZED COST BURDEN—Continued

Form name	Number of respondents	Total burden hours	Average hourly wage rate	Total cost burden
Initial data pull for 10% of units that submit point prevalence survey data (*once at baseline for ICU and non-ICU cohorts, 800 units total*)	27	14	^35.17	492.38
Subsequent data pull for 10% of units that submit point prevalence data (*every six months during 18 months of implementation for ICU and non-ICU cohorts, 800 units total*)	27	20	^35.17	703.40
Initial data pull for 50% of surgical settings that do not confer rights to NHSN data—(*once at baseline for Surgical cohort, 300 settings total*)	50	50	^35.17	1,758.50
Initial data pull—(*once at baseline for LTC cohort, 300 facilities total*)	100	600	^35.17	21,102.00
Quarterly data—(*quarterly during 18 months of implementation for ICU and non-ICU cohorts, 1,100 units total*)	267	801	^35.17	28,171.17
Quarterly data collection of monthly data for 50% of hospitals that do not confer rights to their NHSN data (*quarterly during 18 months of implementation for surgical cohorts, 300 units total*)	50	150	^35.17	5,275.50
Monthly data—(*monthly per facility during 18 months of implementation for LTC cohort, 100 facilities total*)	100	1,350	^35.17	47,479.50
Total	13,516	12,052		554,699,76

*This is an average of the average hourly wage rate for physician, nurse, nurse practitioner, physician's assistant, and nurse's aide from the May 2019 National Occupational Employment and Wage Estimates, United States, U.S. Bureau of Labor Statistics (*https://www.bls.gov/oes/current/oes_nat.htm#00-0000*).

^This is an average of the average hourly wage rate for nurse and IT specialist from the May 2019 National Occupational Employment and Wage Estimates, United States, U.S. Bureau of Labor Statistics (*https://www.bls.gov/oescurrent/oes_nat.htm#00-0000*).

Request for Comments

In accordance with the Paperwork Reduction Act, 44 U.S.C. 3501–3520, comments on AHRQ's information collection are requested with regard to any of the following: (a) whether the proposed collection of information is necessary for the proper performance of AHRQ's health care research and health care information dissemination functions, including whether the information will have practical utility; (b) the accuracy of AHRQ's estimate of burden (including hours and costs) of the proposed collection(s) of information; (c) ways to enhance the quality, utility and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information upon the respondents, including the use of automated collection techniques or other forms of information technology.

Comments submitted in response to this notice will be summarized and included in the Agency's subsequent request for OMB approval of the proposed information collection. All comments will become a matter of public record.

Dated: July 18, 2022.

Marquita Cullom,

Associate Director.

[FR Doc. 2022–15627 Filed 7–20–22; 8:45 am]

BILLING CODE 4160–90–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–3429–PN]

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

AGENCY: Centers for Medicare & Medicaid Services, HHS.

ACTION: Proposed notice.

SUMMARY: This proposed notice acknowledges the receipt of an application from 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: To be assured consideration, comments must be received at one of the addresses provided below, by August 22, 2022.

ADDRESSES: In commenting, please refer to file code CMS–3429–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–3429–PN, P.O. Box 8016, 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–3429–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: Erin Imhoff (410) 786–2337; Caecilia Blondiaux (410) 786–2190.

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 individual will take actions to harm the

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 hospital provided certain requirements are met. Sections 1861(e) of the Social Security Act (the Act), establish distinct criteria for facilities seeking designation as a 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 part 482 specify the minimum conditions that a hospital must meet to participate in the Medicare program.

Generally, to enter into an agreement, a hospital must first be certified by a state survey agency (SA) as complying with the conditions or requirements set forth in part 482 of our regulations. Thereafter, the hospital is subject to regular surveys by a SA to determine whether it continues to meet these requirements. There is an alternative; however, to surveys by SAs.

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.

The Center for Improvement in Healthcare Quality's (CIHQ) current term of approval for their hospital accreditation program expires July 26, 2023.

II. Approval of Deeming Organizations

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. We have 210 days from the receipt of a complete application to publish notice of approval or denial of the application. We note that CIHQ submitted its application for renewal earlier than expected and therefore CMS will render a final decision prior to their current term of approval program expiration date.

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

III. Evaluation of Deeming Authority Request

CIHQ submitted all the necessary materials to enable us to make a determination concerning its request for continued approval of its hospital accreditation program. This application was determined to be complete on June 3, 2022. 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 CIHQ will be conducted in accordance with, but not necessarily limited to, the following factors:

- The equivalency of CIHQ's standards for hospitals as compared with CMS' hospital CoPs.
- CIHQ's 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 CIHQ's processes to those of state agencies, including survey frequency, and the ability to investigate and respond appropriately to complaints against accredited facilities.

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

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

++ CIHQ'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 CIHQ's staff and other resources, and its financial viability.

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

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

++ CIHQ'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.

++ 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).

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 Public 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. 2022–15611 Filed 7–20–22; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Proposed Information Collection Activity; Building Evidence on Employment Strategies (BEES) (OMB #0970–0537)

AGENCY: Office of Planning, Research, and Evaluation, Administration for Children and Families, Department of Health and Human Services.

ACTION: Request for public comments.

SUMMARY: The Administration for Children and Families (ACF), of the U.S. Department of Health and Human Services (HHS), is proposing to extend data collection activity for BEES. We are not proposing any changes to the currently approved materials.

DATES: *Comments are due within 60 days of publication.* In compliance with the requirements of the Paperwork Reduction Act (PRA) of 1995, ACF is soliciting public comment on the specific aspects of the information collection described above.

ADDRESSES: You can obtain copies of the proposed collection of information and submit comments by emailing *opreinfocollection@acf.hhs.gov.* Identify all requests by the title of the information collection.

SUPPLEMENTARY INFORMATION:

Description: The purpose of BEES is to evaluate the effectiveness of a range of programs designed to improve employment and earnings outcomes for individuals with low incomes. More specifically, BEES is primarily evaluating programs that serve adults whose employment prospects have been affected by Substance Use Disorder (SUD) and mental health conditions. This is being accomplished through impact and implementation studies. When possible, a randomized control trial research design is being used for the impact evaluations. This request for an extension is to complete the following data collection activities: baseline, updated contact information, and follow up surveys for the impact studies; an online staff survey; and qualitative interviews with program participants and staff. In addition to collecting these data, the BEES project will continue to maintain consent forms for the collection of administrative data. Data collected is being used to estimate the effects of the participating programs on employment, earnings, and other key outcomes for the purpose of assessing the effectiveness of the programs.

Respondents: The respondents in this extension will include individuals who will enroll in BEES and complete the baseline survey during this period. All study participants will be fielded the follow up survey. We will also conduct qualitative interviews with program staff and participants in the participating sites 1–2 times. Lastly, program staff will be asked to complete a web-based survey.

ANNUAL BURDEN ESTIMATES

Instrument	Number of respondents (total over request period)	Number of responses per respondent (total over request period)	Average burden per response (in hours)	Total burden (in hours)	Annual burden (in hours)
Burden for previously approved, ongoing data collection					
Attachment D1–D5. Baseline information form for participants	3,000	1	0.25	750	250
Attachment E. Contact Update Letter and Form	4,300	1	0.1	429	143
Attachment F. Program managers, staff, and partner interview guide—SUD Programs	80	2	1.5	360	120
Attachment G. Program managers, staff, and partner interview guide—Whole Family Approach Programs	20	2	1.5	45	15
Attachment K–1. 12-month Follow-Up Participant Interview	4,300	1	0.5	2,149.5	717
Attachment L. Program Managers, Staff, and Partners Interview Guide	200	2	1.5	300	99
Attachment M. Participant Case Study Interview Guide	84	1	1.5	126	42
Attachment N. Program Staff Case Study Interview Guide	84	1	1	84	28
Attachment O. Program Staff Survey	300	1	0.5	150	50

Estimated Total Annual Burden Hours: 1,464.

Comments: The Department specifically requests comments on (a) whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection of information; (c) the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology. Consideration will be given to comments and suggestions submitted within 60 days of this publication.