V. 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 CAH requirements and survey process with the Medicare CoPs and survey process as outlined in the State Operations Manual (SOM). Our review and evaluation of CIHQ's CAH application were conducted as described in section III of this notice and has yielded the following areas where, as of the date of this notice, CIHQ's has completed revising its standards and certification processes in order to—

- Meet the standard's requirements of all of the following regulations:

++ Section 485.604(a)(2), to clarify the requirements for clinical nurse specialists' education, including a master's or doctoral level degree in a defined clinical area of nursing from an accredited educational institution.

++ Section 485.616(c)(4)(iv), to specify the requirement of an internal review of a distant-site physician's or practitioner's performance under privileges at the CAH whose patients are receiving the telemedicine services from the physician or practitioner.

++ Section 485.623(b)(1), to ensure that all essential mechanical, electrical and patient care equipment is maintained in safe operating condition.

++ Section 485.623(c)(1)(i), to align CIHQ's comparable standards with the Life Safety Code (LSC) (National Fire Protection Association (NFPA) 101 and Tentative Interim Amendments (TIAs): TIA 12–1, TIA 12–2, TIA 12–3, and TIA 12–4).

++ Section 485.627(a), to include additional clarification or specific language on ''determining, implementing and monitoring policies governing the CAH's total operation''.

++ Section 485.635(b)(3), to include reference to state law within its standard for radiology services.

++ Section 485.638(a)(4)(iv), to specify the qualifications of who may make entries into the medical record, which must be dated, and signed by the individual who made the entry.

++ Section 485.639(a), to further expand on the qualifications on the practitioners who are allowed to perform surgery for CAH patients, in accordance with its approved policies and procedures, and with state scope of practice laws.

In addition to the standards review, CMS also reviewed CIHQ's comparable survey processes, which were conducted as described in section III of this notice, and yielded the following areas where, as of the date of this notice, CIHQ has completed revising its survey processes in order to demonstrate that it uses survey processes that are comparable to state survey agency processes by:

- Revising CIHQ's surveyor guide to ensure a comprehensive review of environmental safety and life safety requirements are performed.

- Clarifying CIHQ's policies to align with the SOM Appendix A-Hospitals, Survey Protocol, Task 3, Survey Locations, and Appendix W–CAHs Entrance Activities, to include that all hospital departments and services at the primary hospital campus and remote locations, satellite locations, inpatient care locations, out-patient surgery locations, complex out-patient care locations, and a select sample of each type of other services provided at additional provider based locations, including contracted patient care activities or patient services will be surveyed. These facility types may have occupancy classifications other than healthcare or ambulatory occupancies, as determined by the LSC.

- Updating CIHQ's position summaries and description to include that the LSC surveyor's responsibilities is comprised of an assessment of both the LSC and Health Care Facilities Code.

B. Term of Approval

Based on our review and observations described in sections III and V of this notice, we approve CIHQ as a national AO for CAHs that request participation in the Medicare program. The decision announced in this notice is effective June 1, 2023 through June 1, 2027 (4 years).

VI. 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.*).

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

Dated: May 17, 2023.

Evell J. Barco Holland,

Federal Register Liaison, Centers for Medicare & Medicaid Services.

[FR Doc. 2023–10824 Filed 5–19–23; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–3443–PN]

Medicare and Medicaid Programs; Application by the Center for Improvement in Healthcare Quality (CIHQ) for Initial CMS Approval of Its Psychiatric Hospital Accreditation Program

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

ACTION: Notice with request for comment.

SUMMARY: This notice acknowledges the receipt of an application from the Center for Improvement in Healthcare Quality (CIHQ) for initial recognition as a national accrediting organization for psychiatric 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 June 21, 2023.

ADDRESSES: In commenting, refer to file code CMS–3443–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 *https://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–3443–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–3443–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: Donald Howard, (410) 786–6764 or Lillian Williams, (410) 786–8638.

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: *https://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 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 part 482 subparts A, B, C and 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 as complying with the conditions or requirements set forth in part 482 subparts A, B, C and E of our CMS regulations. Thereafter, the psychiatric hospital is subject to regular surveys by a State Survey Agency 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 an approved national accrediting organization that all applicable Medicare conditions are met or exceeded, we may treat the provider entity as having met those conditions, that is, we may ''deem'' the provider entity as having met the requirements. Accreditation by an accrediting organization is voluntary and is not required for Medicare participation.

If an accrediting organization 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 may be deemed to meet the Medicare conditions. A national accrediting organization (AO) applying for approval of its accreditation program under part 488, subpart A, must provide Centers for Medicare and Medicaid Services (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 AO are set forth at § 488.5.

The Center for Improvement in Healthcare Quality (CIHQ) has submitted an initial application for CMS-approval of its psychiatric hospital accreditation program.

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 us 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.

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

III. Evaluation of Deeming Authority Request

CIHQ submitted all the necessary materials to enable us to make a determination concerning its request for initial approval of its hospital accreditation program. This application was determined to be complete on March 23, 2023. Under section 1865(a)(2) of the Act and our regulations at § 488.5 (Application and re-application procedures for national AO), 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 the 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 state survey agency monitors corrections as specified at § 488.9(c).

++ 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 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 Evell Barco, who is the Federal Register Liaison, to electronically sign this document for purposes of publication in the **Federal Register**.

Dated: May 17, 2023.

Evell J. Barco Holland,

Federal Register Liaison, Centers for Medicare & Medicaid Services.

[FR Doc. 2023–10826 Filed 5–19–23; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Proposed Information Collection Activity; Case Plan Requirement, Title IV–E of the Social Security Act

AGENCY: Children's Bureau, Administration for Children and Families, United States Department of Health and Human Services.

ACTION: Request for public comments.

SUMMARY: The Administration for Children and Families (ACF) is requesting a three-year extension of the information collection Case Plan Requirement, Title IV–E of the Social Security Act, (Office of Management and Budget (OMB)) #0970–0428, expiration September 9, 2023). There are no changes to the requirements, but burden estimates have been updated to reflect current numbers of children in foster care.

DATES: *Comments due within 60 days of publication.* In compliance with the requirements of the Paperwork Reduction Act 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 *infocollection@acf.hhs.gov.* Identify all requests by the title of the information collection.

SUPPLEMENTARY INFORMATION:

Description: The case plan information collection is authorized in sections 422(b)(8)(A)(ii) and 471(a)(16) and defined in sections 475 and 475A of the Social Security Act (the Act). Statutory requirements in the Act mandate that States, Territories, and Tribes with an approved title IV–E plan develop a case review system and case plan for each child in the foster care system for whom the State, Territory, or Tribe receives title IV–E reimbursement of foster care maintenance payments. The case review system assures that each child has a case plan designed to achieve placement in a safe setting that is the least restrictive, most family-like setting available and in close proximity to the child's parental home, consistent with the best interest and special needs of the child. States, Territories, and Tribes meeting these requirements also partly comply with title IV–B, section 422(b), of the Act, which assures certain protections for children in foster care. The case plan is a written document that provides a narrative description of the child-specific program of care. Federal regulations at 45 CFR 1356.21(g) and sections 475 and 475A of the Act delineate the specific information that must be addressed in the case plan. ACF does not specify a format for the case plan nor does ACF require submission of the document to the Federal Government. Case plan information is recorded in a format developed and maintained by the State, Territorial, or Tribal title IV–E agency.

Buren estimates have been adjusted to reflect two additional agencies and an increased number of children exiting foster care.

Respondents: State, Territorial, and Tribal title IV–agencies.

ANNUAL BURDEN ESTIMATES

Instrument	Total number of respondents	Total number of responses per respondent	Average burden hours per response	Total burden hours	Annual burden hours
Case Plan	66	23,039	4.8	7,298,755	2,432,918

Estimated Total Annual Burden Hours: 2,432,918.

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.

Authority: 42 U.S.C. 622; 42 U.S.C. 671; 42 U.S.C. 675; 42 U.S.C. 675a.

Mary B. Jones,

ACF/OPRE Certifying Officer.

[FR Doc. 2023–10800 Filed 5–19–23; 8:45 am]

BILLING CODE 4184–01–P