organization's requirements consider, among other factors, the applying accrediting organization'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.

The purpose of this proposed notice is to inform the public of TJC's request for continued CMS-approval of its CAH accreditation program. This notice also solicits public comment on whether TJC's requirements meet or exceed the Medicare conditions of participation for CAHs.

III. Evaluation of Deeming Authority Request

TJC submitted all the necessary materials to enable us to make a determination concerning its request for continued approval of its CAH accreditation program. This application was determined to be complete on March 31, 2017. Under Section 1865(a)(2) of the Act and our regulations at 42 CFR 488.5 (Application and re-application procedures for national accrediting organizations), our review and evaluation of TJC will be conducted in accordance with, but not necessarily limited to, the following factors:

- The equivalency of TJC's standards for CAHs as compared with CMS' CAH conditions of participation.
- TJC'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 TJC's processes to those of State agencies, including survey frequency, and the ability to investigate and respond appropriately to complaints against accredited facilities.

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

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

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

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

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

++ TJC'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).

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.

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

Dated: April 25, 2017.

Seema Verma,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2017–10216 Filed 5–18–17; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifiers: CMS–10175, CMS–10220, CMS–10471 and CMS–10495]

Agency Information Collection Activities: Submission for OMB Review; 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 (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 a second opportunity for public comment on the notice. Interested persons are invited to send comments regarding the burden estimate 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 on the collection(s) of information must be received by the OMB desk officer by June 19, 2017.

ADDRESSES: When commenting on the proposed information collections, please reference the document identifier or OMB control number. To be assured consideration, comments and recommendations must be received by the OMB desk officer via one of the following transmissions: OMB, Office of Information and Regulatory Affairs, Attention: CMS Desk Officer, Fax Number: (202) 395–5806 *OR,* Email: *OIRA_submission@omb.eop.gov.*

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 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: Under the Paperwork Reduction Act of 1995 (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 (44 U.S.C. 3506(c)(2)(A)) requires federal agencies to publish a 30-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 that summarizes the following proposed collection(s) of information for public comment:

1. *Type of Information Collection Request:* Extension of a currently approved information collection; *Title of Information Collection:* Certification Statement for Electronic File Interchange Organizations; *Use:* Health care providers can currently obtain a National Provider Identifier (NPI) via a paper application or over the Internet through the National Plan and Provider Enumeration System (NPPES). These applications must be submitted individually, on a per-provider basis. The Electronic File Interchange (EFI) process allows provider-designated organizations (EFIOs) to capture multiple providers' NPI application information on a single electronic file for submission to NPPES. This process is also referred to as bulk enumeration. To ensure that the EFIO has the authority to act on behalf of each provider and complies with other federal requirements, an authorized official of the EFIO must sign a certification statement and mail it to us. No comments were received during the 60-day comment period. *Form Number:* CMS–10175 (OMB Control Number: 0938–0984). *Frequency:* Occasionally. *Affected Public:* Private Sector; *Number of Respondents:* 25; *Total Annual Responses:* 25; *Total Annual Hours:* 75. (For policy questions regarding this collection contact Kimberly McPhillips at 410–786–5374.)

2. *Type of Information Collection Request:* Revision of a currently approved information collection; *Title of Information Collection:* Security Consent and Surrogate Authorization Form; *Use:* The primary function of the Medicare enrollment application is to obtain information about the Provider or supplier and whether they meet the Federal and/or State qualifications to participate in the Medicare program. In addition, the Medicare enrollment application gathers information regarding the provider or supplier's practice location, the identity of the owners of the enrolling organization, and information necessary to establish the correct claims payment.

Enrollees have the option of submitting either a CMS–855 form, or submitting information via a web based process. In establishing a web based application process, we allow providers and suppliers the ability to enroll in the Medicare program, revalidate their enrollment and make changes to their enrollment information via Internet-based Provider Enrollment, Chain and Ownership System (PECOS). Individual providers/suppliers (hereinafter referred to as ''Individual Providers'') log into Internet-based PECOS using their User IDs and passwords established when they applied on-line to the National Plan and Provider Enumeration System (NPPES) for their National Provider Identifiers (NPIs). Authorized Officials (AOs) of the provider or supplier organizations (hereinafter referred to as ''Organizational Providers'') must register for a user account and authenticate their identity and connection to the organization they represent before being able to log into Internet-based PECOS. Once authenticated, AOs for Organizational Providers, receive complete access to their enrollment information via Internet-based PECOS. Individuals and AOs of Organizational Providers are not required to submit a Security Consent and Surrogate Authorization Form to enroll, revalidate or make changes to their Medicare enrollment information.

Individual and Organizational Providers may complete their Medicare enrollment responsibilities on their own or elect to delegate this task to a Surrogate. A Surrogate is an individual or organization identified by an Individual or Organizational Provider as someone authorized to access CMS computer systems, such as Internet-based PECOS, National Provider Plan and Enumeration System (NPPES) and the Medicare and Medicaid Electronic Health Records (EHR) Incentive Program Registration and Attestation System (HITECH), on their behalf and to modify or view any information contained therein that the Individual or Organizational Provider may have permission or right to access in accordance with Medicare statutes, regulations, policies, and usage guidelines for any CMS system. Surrogates may consist of administrative staff, independent contractors, 3rd party consulting companies or credentialing departments. In order for an Individual or Organizational Provider to delegate the Medicare credentialing process to a Surrogate to access and update their enrollment information in the above mentioned CMS systems on their behalf, it is required that a Security Consent and Surrogate Authorization Form be completed, or Individual and Organizational Providers use an equivalent online process via the PECOS Identity and Access Management (I&A) system. The Security Consent and Surrogate Authorization form replicates business service agreements between Medicare providers, suppliers or both and Surrogates providing enrollment services.

The form, once signed, mailed and approved, grants a Surrogate access to all current and future enrollment data for the Individual or Organization Provider. *Form Number:* CMS–10220 (OMB Control Number: 0938–1035); *Frequency:* Occasionally; *Affected Public:* Individuals and Private Sector; *Number of Respondents:* 226,100; *Total Annual Responses:* 226,100; *Total Annual Hours:* 226,100. (For policy questions regarding this collection contact Kimberly McPhillips at 410–786–5374.)

3. *Type of Information Collection Request:* Extension of a currently approved collection of information; *Title of Information Collection:* Medicare Prior Authorization of Power Mobility Devices (PMDs) Demonstration; *Use:* The purpose of the Medicare Prior Authorization of Power Mobility Devices Demonstration (the Demonstration) is to ensure that payments for PMDs are appropriate before the claims are paid, thereby preventing the fraud, waste, and abuse in the seven states participating in the Demonstration: California, Florida, Illinois, Michigan, New York, North Carolina and Texas. Additional benefits of the Demonstration include ensuring that a beneficiary's medical condition warrants their medical equipment under existing coverage guidelines and preserving their ability to receive

quality products from accredited suppliers. In order to gather qualitative information for analysis, the evaluation team will use semi-structured interview guides that focus on the direct impact of the Demonstration on stakeholder groups. Stakeholders will be drawn from advocacy organizations, power mobility device supply companies, state and local government, and healthcare practitioners. This information collection request explains the research methodology and data collection strategies designed to minimize the burden placed on research participants, while effectively gathering the data needed for the evaluation of the Demonstration. *Form Number:* CMS–10471 (OMB Control Number: 0938–1235); *Frequency:* Yearly; *Affected Public:* Private sector (business or other for-profit and not-for-profit institutions) and State and Local Governments; *Number of Respondents:* 254; *Total Annual Responses:* 254; *Total Annual Hours:* 288. (For policy questions regarding this collection contact Debbie Skinner at 410–786–7480.)

4. *Type of Information Collection Request:* Revision of a currently approved information collection; *Title of Information Collection:* Registration, Attestation, Dispute & Resolution, Assumptions Document and Data Retention Requirements for Open Payments; *Use:* Section 6002 of the Affordable Care Act added section 1128G to the Social Security Act (Act), which requires applicable manufacturers and applicable group purchasing organizations (GPOs) of covered drugs, devices, biologicals, or medical supplies to report annually to CMS certain payments or other transfers of value to physicians and teaching hospitals, as well as, certain information regarding the ownership or investment interests held by physicians or their immediate family members in applicable manufacturers or applicable GPOs.

Specifically, applicable manufacturers of covered drugs, devices, biologicals, and medical supplies are required to submit on an annual basis the information required in section 1128G(a)(1) of the Act about certain payments or other transfers of value made to physicians and teaching hospitals (collectively called covered recipients) during the course of the preceding calendar year. Similarly, section 1128G(a)(2) of the Act requires applicable manufacturers and applicable GPOs to disclose any ownership or investment interests in such entities held by physicians or their immediate family members, as well as information on any payments or other transfers of value provided to such physician owners or investors. Applicable manufacturers must report the required payment and other transfer of value information annually to CMS in an electronic format. The statute also provides that applicable manufacturers and applicable GPOs must report annually to CMS the required information about physician ownership and investment interests, including information on any payments or other transfers of value provided to physician owners or investors, in an electronic format by the same date. Applicable manufacturers and applicable GPOs are subject to civil monetary penalties (CMPs) for failing to comply with the reporting requirements of the statute. We are required by statute to publish the reported data on a public Web site. The data must be downloadable, easily searchable, and aggregated. In addition, we must submit annual reports to the Congress and each state summarizing the data reported. Finally, section 1128G of the Act generally preempts state laws that require disclosure of the same type of information by manufacturers. *Form Number:* CMS–10495 (OMB Control Number: 0938–1237); *Frequency:* Once; *Affected Public:* Private sector—Business or other for-profits; *Number of Respondents:* 227,157; *Total Annual Responses:* 457,454; *Total Annual Hours:* 3,099,297. (For policy questions regarding this collection contact Veronika Peleshchuk Fradlin at 410–786–3323.)

Dated: May 16, 2017.

William N. Parham, III,

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

[FR Doc. 2017–10225 Filed 5–18–17; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10371 and CMS–10507]

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 July 18, 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: Reports Clearance Office at (410) 786–1326.

SUPPLEMENTARY INFORMATION: