

is used by State agencies who conduct certification surveys on CMS' behalf to maintain information on the facility's characteristics that facilitate conducting surveys, *e.g.*, determining the size and the composition of the survey team on the basis of the number of ORs/procedure rooms and the types of surgical procedures performed in the ASC. *Form Numbers:* CMS-370 and CMS-377 (OMB control number: 0938-0266); *Frequency:* Occasionally; *Affected Public:* Private Sector—Business or other for-profit and Not-for-profit institutions; *Number of Respondents:* 5,694; *Total Annual Responses:* 1,898; *Total Annual Hours:* 627. (For policy questions regarding this collection contact Erin McCoy at 410-786-2337.)

3. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Consumer Experience Survey Data Collection; *Use:* Section 1311(c)(4) of the Affordable Care Act requires the Department of Health and Human Services (HHS) to develop an enrollee satisfaction survey system that assesses consumer experience with qualified health plans (QHPs) offered through an Exchange. It also requires public display of enrollee satisfaction information by the Exchange to allow individuals to easily compare enrollee satisfaction levels between comparable plans. HHS established the QHP Enrollee Experience Survey (QHP Enrollee Survey) to assess consumer experience with the QHPs offered through the Marketplaces. The survey include topics to assess consumer experience with the health care system such as communication skills of providers and ease of access to health care services. CMS developed the survey using the Consumer Assessment of Health Providers and Systems (CAHPS®) principles (<https://www.ahrq.gov/cahps/about-cahps/principles/index.html>) and established an application and approval process for survey vendors who want to participate in collecting QHP enrollee experience data.

The QHP Enrollee Survey, which is based on the CAHPS® Health Plan Survey, will be used to (1) help consumers choose among competing health plans, (2) provide actionable information that the QHPs can use to improve performance, (3) provide information that regulatory and accreditation organizations can use to regulate and accredit plans, and (4) provide a longitudinal database for consumer research. CMS completed two rounds of developmental testing

including 2014 psychometric testing and 2015 beta testing of the QHP Enrollee Survey. The psychometric testing helped determine psychometric properties and provided an initial measure of performance for Marketplaces and QHPs to use for quality improvement. Based on psychometric test results, CMS further refined the questionnaire and sampling design to conduct the 2015 beta test of the QHP Enrollee Survey. CMS previously obtained clearance for the 2016 and 2017 administrations of the QHP Enrollee Survey.

At this time, CMS is requesting to renew approval for the information collection related to the QHP Enrollee Experience Survey in 2018–2020. These activities are necessary to ensure that CMS fulfills legislative mandates established by section 1311(c)(4) of the Affordable Care Act to develop an “enrollee satisfaction survey system” and provide such information on Marketplace Web sites. CMS is also seeking approval to remove eight survey questions beginning with the 2018 survey administration. With the removal of these eight questions, the revised total estimated annual burden hours of national implementation of the QHP Enrollee Survey is 22,523 hours with 90,015 responses. The revised total annualized burden over three years for this requested information collection is 67,569 hours and the total average annualized number of responses is 270,045 responses. *Form Number:* CMS-10488 (OMB Control Number: 0938-1221); *Frequency:* Annually; *Affected Public:* Public sector (Individuals and Households), Private sector (Business or other for-profits and Not-for-profit institutions); *Number of Respondents:* 90,015; *Total Annual Responses:* 90,015; *Total Annual Hours:* 22,523; (For policy questions regarding this collection contact Nidhi Singh-Shah at 301-492-5110.)

4. *Type of Information Collection Request:* Revision of a previously approved collection; *Title of Information Collection:* Beneficiary and Family Centered Data Collection; *Use:* The CMS Quality Improvement Organization (QIO) Program includes Beneficiary and Family Centered Care (BFCC) QIOs whose functions, as set forth in Section 1862(g) of the Social Security Act, are to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries. To accomplish these goals, the QIOs review health care services funded under Medicare to determine whether those services are reasonable, medically necessary, furnished in the appropriate setting, and

meet professionally recognized standards of quality. The QIOs also review health care services where the beneficiary or a representative has complained about the quality of those services or is appealing alleged premature discharge.

Under the current 11th QIO Statement of Work (SOW), two organizations are providing services as BFCC QIOs across all of the United States. The QIO evaluation criteria have been revised to reflect this national regionalization and it is important for CMS to understand the impact on beneficiaries from this reorganization. The information will be used to evaluate the success of each QIO in meeting its contractual requirements and to understand the experience of Medicare beneficiaries and/or their representative with QIO contract mandated work. *Form Number:* CMS-10393 (OMB Control number: 0938-1177); *Frequency:* Once; *Affected Public:* Individuals or households; *Number of Respondents:* 24,970; *Number of Responses:* 24,970; *Total Annual Hours:* 2,899. (For policy questions regarding this collection, contact David Russo at 617-565-1310.)

Dated: April 11, 2017.

William N. Parham, III,

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

[FR Doc. 2017-07568 Filed 4-13-17; 8:45 am]

BILLING CODE 4120-01-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS-5523-N]

Medicare Program; Funding in Support of the Pennsylvania Rural Health Model—Cooperative Agreement

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Notice.

SUMMARY: This notice announces the issuance of the January 12, 2017 single-source cooperative agreement funding opportunity announcement to begin the Pennsylvania Rural Health Model's implementation activities, titled “Funding in Support of the Pennsylvania Rural Health Model Cooperative Agreement” (the “Funding Opportunity”). This Funding Opportunity is available solely to the Commonwealth of Pennsylvania acting through the Pennsylvania Department of Health (the “Commonwealth”). This

Funding Opportunity provides the Commonwealth with necessary start-up funding for the Model and is open to the Pennsylvania Department of Health, and, once established, the Rural Health Redesign Center (RHRC) (or in the event that the RHRC is not established, the Pennsylvania Department of Health).

DATES: The project period of the initial award, in the amount of \$10 million, to the Pennsylvania Department of Health will be 12 months from the date of award. The project period of the second award, in the amount of \$15 million, to the RHRC, or to the Pennsylvania Department of Health if the RHRC has not been established, will be 36 months from the date of award. The performance period of the Pennsylvania Rural Health Model began on January 13, 2017, and will conclude on December 31, 2023.

FOR FURTHER INFORMATION CONTACT: Stephen Cha, (410) 786-1876.

SUPPLEMENTARY INFORMATION:

I. Background

The Pennsylvania Rural Health Model (the “Model”) is a new Centers for Medicare & Medicaid Services (CMS) alternative payment model designed to improve health and health care in rural Pennsylvania. Specifically, the Model seeks to increase rural Pennsylvanians’ access to high-quality care and improve their health, while also reducing the growth of hospital expenditures across payers, including Medicare fee-for-service, and increasing the financial viability of the State’s rural hospitals to ensure continued access to care facilities. The Model will test whether the deliberate care delivery transformation of participating rural hospitals, including critical access hospitals (CAHs), in conjunction with population-based payments to those hospitals (in the form of prospective hospital global budgets for participating payers) improves health outcomes and quality of care for the Commonwealth’s rural residents, reduces the growth of hospital expenditures across payers, and improves the financial viability of participant rural hospitals to maintain access to care for the Commonwealth’s rural residents. Participation in the model is voluntary for hospitals and payers; and CMS and the Commonwealth will collaborate to achieve participation sufficient to meet the hospital participation and payer participation scale targets in the Model. This Model is being tested by the Center for Medicare and Medicaid Innovation (the “Innovation Center”) using the authority of the Secretary of the Department of Health and Human

Services (the “Secretary”) in section 1115A of the Social Security Act (the Act).

CMS believes that states can be critical partners of the federal government and other health care payers to facilitate the design, implementation, and evaluation of community-centered health systems that can deliver significantly improved cost, quality, and population health performance results for all state residents, including Medicare, Medicaid, and Children’s Health Insurance Program (CHIP) beneficiaries. States have policy and regulatory authorities, as well as ongoing relationships with commercial health care payers, health plans, and health care providers that can accelerate delivery system reform. CMS has previously partnered with states to accelerate delivery system reform through initiatives such as the State Innovation Models (SIM) initiative. SIM provides state-based health care transformation efforts with funding to test the ability of states to utilize policy and regulatory levers to advance multi-payer health care payment and delivery system reform models.

On January 13, 2017, CMS and the Commonwealth entered into the Pennsylvania Rural Health Model Agreement (the “State Agreement”) to implement the Pennsylvania Rural Health Model. The performance period of the Model began on January 13, 2017 and will end on December 31, 2023. As part of the Model, the Commonwealth commits to achieving population health outcomes, access and quality targets, financial targets, and rural hospital participation and payer participation scale targets, as defined in the State Agreement. The Commonwealth intends to legislatively authorize and, through the Pennsylvania Department of Health, establish the RHRC to operate certain aspects of the Model.

The Funding Opportunity offers up to a total of \$25 million in funding to the Commonwealth over a 4-year period, with an initial award to the Pennsylvania Department of Health, and a second award to the RHRC (or to the Pennsylvania Department of Health, if the RHRC is not established in time). The Pennsylvania Department of Health will have the opportunity to apply for the initial award with a project period of one year (one 12-month budget period) from the date of the award. Then the RHRC, if established in time, will have the opportunity to apply for the second award with a project period of 36 months from the date of the award, comprised of three 12-month budget periods. In the event that the RHRC is

not established in time, the Pennsylvania Department of Health can apply again as the second award applicant.

II. Provisions of the Notice

The Funding Opportunity offers \$10 million in start-up funding to the Pennsylvania Department of Health to begin the Model’s implementation activities, including Model operations, global budget administration, data analytics, technical assistance, quality assurance, and to establish the RHRC (if authorized to do so by Pennsylvania’s legislature), to which the Pennsylvania Department of Health may delegate the Model’s implementation activities once the RHRC is established. The Funding Opportunity also provides the RHRC (or the Pennsylvania Department of Health, if the RHRC is not established in time) with the opportunity to apply for an additional \$15 million to continue implementation activities under the Model. In the event that the RHRC is not established in time, the Pennsylvania Department of Health can apply as the second applicant for the additional \$15 million to continue implementation activities under the Model.

As set forth in the State Agreement, the Commonwealth commits to achieving population health outcomes, access and quality targets, financial targets, and rural hospital participation and payer participation scale targets. CMS and the Commonwealth aim to transform the rural hospital care delivery system to address community health needs, achieve financial sustainability for rural hospitals, and achieve savings or budget neutrality for payers participating in the Model. Payers and rural hospitals can choose to participate in the Model, and CMS and the Commonwealth expect to work closely together to achieve participation sufficient to meet the hospital participation and payer participation scale targets. Additionally, CMS and the Commonwealth aim for this Model to deliver meaningful improvements in the health of the Commonwealth’s rural population by transforming the relationships between and among care delivery and public health systems across the Commonwealth. CMS and the Commonwealth believe the Model can help rural hospitals to succeed, in part by transitioning hospital payments from fee-for-service to, prospective hospital global budgets for participating payers. More information about the Pennsylvania Rural Health Model can be found at: <https://innovation.cms.gov/initiatives/pa-rural-health-model/>.

The Funding Opportunity is open solely to the Pennsylvania Department

of Health and to the RHRC (once established). The Pennsylvania Department of Health is uniquely positioned as the initial applicant under the Funding Opportunity based on its existing knowledge of the Model; authority and role in administering the Model; and its existing partnerships and collaborations with Pennsylvania health care providers, payers, and community-based stakeholders. The RHRC (once established) will also be uniquely positioned to meet the goals of the Model (as outlined in the State Agreement), as it will be established specifically to provide implementation support for the Model.

III. 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: April 10, 2017.

Seema Verma,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2017-07555 Filed 4-11-17; 11:15 am]

BILLING CODE 4120-01-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

[OMB NO.: 0970-0354]

Proposed Information Collection Activity; Comment Request; The Early Head Start Family and Child Experiences Survey 2018 (Baby FACES 2018)

Description: The Administration for Children and Families (ACF) at the U.S. Department of Health and Human Services (HHS) seeks approval to collect descriptive information for the Early Head Start Family and Child Experiences Survey 2018 (Baby FACES 2018). This information collection is to provide nationally representative data on Early Head Start (EHS) programs, centers, classrooms, staff, and families to guide program planning, technical assistance, and research. The proposed data collection builds upon a prior study (Baby FACES 2009; OMB 0970-0354) that longitudinally followed two cohorts of children through their experience in the program. While that study provided a great deal of information about program participation over time and about services received by children and families, it did not allow

for national level estimates of service quality, nor inferences about children who enter the program after 15 months of age. To fill these knowledge gaps and to answer additional questions about how programs function, the proposed Baby FACES 2018 design will include a cross-section of a nationally representative sample of programs, centers, home visitors, teachers, classrooms, children and families. This will allow nationally representative estimates at all levels at a point in time and will include the entire age span of enrolled children.

The goal of this work is to obtain updated information on EHS programs and understand better how program processes support relationships (*e.g.*, between home visitors and parents, between parents and children, and between teachers and children) which are hypothesized to lead to improved child and family outcomes.

Respondents: Early Head Start program directors, child care center directors, teachers and home visitors, and parents of enrolled children.

ANNUAL BURDEN ESTIMATES
[2-Year clearance]

Instrument	Total number of respondents	Annual number of respondents	Number of responses per respondent	Average burden hours per response	Annual burden hours
Classroom/home visitor sampling form from EHS staff	563	282	1	.17	48
Child roster form from EHS staff	563	282	1	.33	93
Parent consent form	2,475	1,238	1	.17	210
Parent survey	2,475	1,238	1	.5	619
Parent Child Report (PCR)	2,475	1,238	1	.25	309
Staff survey (Teacher survey and Home Visitor survey)	1,575	788	1	.5	394
Staff Child Report (SCR)	1,238	619	2	.25	310
Program director survey	150	75	1	.5	38
Center director survey	450	225	1	.33	74

Estimated Total Annual Burden Hours: 2,095.

In compliance with the requirements of Section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Administration for Children and Families is soliciting public comment on the specific aspects of the information collection described above. Copies of the proposed collection of information can be obtained and comments may be forwarded by writing to the Administration for Children and Families, Office of Planning, Research and Evaluation, 370 L'Enfant

Promenade SW., Washington, DC 20447, Attn: OPRE Reports Clearance Officer. Email address: OPREinfocollection@acf.hhs.gov. All requests should be identified by the title of the information collection.

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.

Mary Jones,

ACF/OPRE Certifying Officer.

[FR Doc. 2017-07602 Filed 4-13-17; 8:45 am]

BILLING CODE 4184-22-P