Department of Health and Human Services (HHS), the White House, Congress, and other sources. Information to be collected will also strengthen CDC's ability to monitor awardee progress, provide data-driven technical assistance, and disseminate the most current surveillance data on unintentional and intentional injuries. The information collection plan proposed here will also generate a variety of routine and customizable reports. State-specific reports will allow each awardee to summarize activities and progress towards meeting strategies and performance measure targets related to the reduction and prevention of unintentional and intentional injuries. NCIPC will also have the capacity to generate reports that describe activities and health outcomes across multiple recipients, which will enable better reporting of trends and provision of technical assistance through linking partners across state health departments and collaborating divisions within CDC.

Program recipients will use the information collected to manage and coordinate their activities and to improve their efforts to prevent and control injuries. The Partners' Portal allows recipients to fulfill their annual reporting obligations efficiently by employing user-friendly, easily accessible web-based instruments to collect necessary information for both progress reports and continuation applications including work plans. This approach enables recipients to save pertinent information from one reporting period to the next and reduces the administrative burden on the annual continuation application and the performance monitoring process.

Recipients will report progress and activity information to CDC on an annual schedule. Data will be analyzed using descriptive and summary statistics, as well as qualitative summaries. CDC requests approval for a total of 253 estimated annualized burden hours. There are no costs to respondents other than their time.

ESTIMATED ANNUALIZED BURDEN HOURS

| Type of respondents | Form name | Number of respondents | Number of responses per respondent | Average burden per response (in hours) |
|---|---|---|---|---|
| Core SIPP Program Recipients | Annual Progress Report | 23 | 1 | 11 |

**Jeffrey M. Zirger,**

*Lead, Information Collection Review Office, Office of Scientific Integrity, Office of Science, Centers for Disease Control and Prevention.*

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**BILLING CODE 4163–18–P**

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Centers for Medicare & Medicaid Services

**[Document Identifier CMS–10552]**

### Agency Information Collection Activities: Submission for OMB Review; Comment Request

**AGENCY:** Centers for Medicare & Medicaid Services, Health and Human 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 *January 20, 2022.*

**ADDRESSES:** Written comments and recommendations for the proposed information collection should be sent within 30 days of publication of this notice to *www.reginfo.gov/public/do/PRAMain.* Find this particular information collection by selecting ''Currently under 30-day Review—Open for Public Comments'' or by using the search function.

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' website address at: *https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing.html.*

**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:* Revision of a currently approved collection; *Title of Information Collection:* Implementation of Medicare and Medicaid Programs;—Promoting Interoperability Programs (Stage 3) (CMS–10552); *Use:* As discussed in the Final Rule published on October 16, 2016 (80 FR 62762), the Centers for Medicare & Medicaid Services (CMS) is requesting approval to collect information from eligible hospitals and critical access hospitals (CAHs). We are making further changes to this program as proposed in the FY 2022 Inpatient Prospective Payment System (IPPS)/Long-term Care Hospital

Prospective Payment System (LTCH PPS) Proposed Rule (86 FR 25628), and as finalized in the FY 2022 Inpatient Prospective Payment System (IPPS)/Long-term Care Hospital Prospective Payment System (LTCH PPS) Final Rule (86 FR 45460).

The American Recovery and Reinvestment Act of 2009 (Recovery Act) (*Pub. L. 111–5*) was enacted on February 17, 2009. Title IV of Division B of the Recovery Act amended Titles XVIII and XIX of the Social Security Act (the Act) by establishing incentive payments to eligible professionals (EPs), eligible hospitals and critical access hospitals (CAHs), and Medicare Advantage (MA) organizations participating in the Medicare and Medicaid programs that adopt and successfully demonstrate meaningful use of certified EHR technology (CEHRT). These Recovery Act provisions, together with Title XIII of Division A of the Recovery Act, may be cited as the ''Health Information Technology for Economic and Clinical Health Act'' or the ''HITECH Act.''

The HITECH Act created incentive programs for EPs and eligible hospitals, including CAHs, in the Medicare Fee-for-Service (FFS), MA, and Medicaid programs that successfully demonstrate meaningful use of certified EHR technology. In their first payment year, Medicaid EPs and eligible hospitals could adopt, implement, or upgrade to certified EHR technology. It also allowed for negative payment adjustments in the Medicare FFS and MA programs starting in 2015 for EPs, eligible hospitals, and CAHs participating in Medicare that are not meaningful users of CEHRT. The Medicaid Promoting Interoperability Program did not authorize negative payment adjustments, but its participants were eligible for positive incentive payments.

In CY 2017, we began collecting data from eligible hospitals and CAHs to determine the application of the Medicare payment adjustments. At this time, Medicare eligible professionals no longer reported to the EHR Incentive Program, as they began reporting under the Merit-based Incentive Payment System (MIPS). This information collected was also used to make incentive payments to eligible hospitals and critical access hospitals in Puerto Rico.

In the FY 2019 IPPS/LTCH PPS Final Rule (83 FR 41634), we focused on reducing burden on eligible hospitals and CAHs. We finalized a new scoring methodology for eligible hospitals and CAHs, removing the requirement to report on and meet the threshold for all objectives and measures. This approach required an eligible hospital or CAH to meet the requirements on six measures, with scoring based on performance. This approach reduced burden by decreasing the amount of time needed to report on measures. Additionally, we finalized two new optional opioid measures and one new care coordination measure to help address the opioid epidemic and improve interoperability.

In the FY 2020 IPPS/LTCH Final Rule (84 FR 42591), we established the EHR Reporting Period to be a minimum of any continuous 90-day period in CY 2021 for new and returning participants (eligible hospitals and CAHs) in the Medicare Promoting Interoperability Program attesting to CMS, as well as finalizing the removal of the Electronic Prescribing Objective's Verify Opioid Treatment Agreement measure beginning with the EHR reporting period in CY 2020.

In the FY 2021 IPPS/LTCH PPS Final Rule (85 FR 58966), we are finalizing as proposed changes that we believe will continue to be a low reporting burden on eligible hospitals and CAHs in the Medicare Promoting Interoperability Program while incentivizing the advanced use of CEHRT to support health information exchange, interoperability, advanced quality measurement, and maximizing clinical effectiveness and efficiencies. These finalized changes include continuing an EHR reporting period of a minimum of any continuous 90-day period in CY 2022, and maintaining the Query of PDMP measure as optional and worth 5 bonus points in CY 2021.

In the FY 2022 IPPS/LTCH PPS Proposed Rule (86 FR 25628), we proposed changes that we believe will continue to be a low reporting burden on eligible hospitals and CAHs in the Medicare Promoting Interoperability Program while incentivizing the advanced use of CEHRT to support health information exchange, interoperability, advance quality measurement, and maximize clinical effectiveness and efficiencies. The proposals include continuing an EHR reporting period of a minimum of any continuous 90-day period in CY 2023, maintaining the Query of PDMP measure as optional but worth 10 bonus points in CY 2022, the addition of a new Health Information Exchange Bi-Directional Exchange measure beginning in CY 2022 as an optional alternative to the two existing measures, a requirement of reporting 4 specific Public Health and Clinical Data Exchange Objective measures, the inclusion of a new SAFER Guides measure attestation response, and to adopt two new eCQMs to the Medicare Promoting Interoperability Program's eCQM measure set beginning with the reporting period in CY 2023 (in addition to removing three eCQMs from the measure set beginning with the reporting period in CY 2024, in alignment with the finalized changes to the Hospital IQR Program. In the FY 2022 IPPS/LTCH PPS Final Rule (86 FR 45460 through 45498), we finalized these proposals. We did not finalize a proposal to update the Provide Patients Electronic Access to their Health Information measure to include a data retention requirement; however, this proposal would not have affected our information collection burden estimate.

We note the previously approved PRA package under OMB control number 0938–1278 reflecting updates to information collection burden estimates based on policies finalized in the FY 2021 IPPS/LTCH PPS Final Rule include information collection burden estimates for 2021, which is the last year for including Medicaid eligible providers, eligible hospitals, and CAHs in the burden estimate as the Medicaid Promoting Interoperability Program concludes December 31, 2021. Therefore, this PRA request for information collection burden in 2022 does not include any burden under the Medicaid Promoting Interoperability Program. *Form Number:* CMS–10552 (OMB control number: 0938–1278); *Frequency:* Annually; *Affected Public:* State, Local or Private Government; Business and for-profit and Not-for-profit; *Number of Respondents:* 3,300; *Total Annual Responses:* 3,300; *Total Annual Hours:* 21,450. (For policy questions regarding this collection, contact Jessica Warren at 410–786–7519.)

Dated: December 16, 2021.

**William N. Parham, III,**

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

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