ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondents	Form name	Number of respondents	Number of responses per respondent	Avg. burden per response (in hours)
State And Local Governments (or their bona fide fiscal agents).	Awardee Lead Profile Assessment (ALPA) Questionnaire—web survey.	40	1	7/60
	ALPA Questionnaire—Word format	8	1	7/60

Leroy A. Richardson,

Chief, Information Collection Review Office, Office of Scientific Integrity, Office of the Associate Director for Science, Office of the Director, Centers for Disease Control and Prevention.

[FR Doc. 2017–22772 Filed 10–19–17; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Analyses, Research and Studies To Address the Impact of CMS Programs on American Indian/Alaska Native (AI/AN) Beneficiaries and the Health Care System Serving These Beneficiaries

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

ACTION: Notice of single source award.

SUMMARY: This notice supports expansion of research on the impact of CMS programs on the Indian health care system through a single source award. The Indian Health Service (IHS), Tribes and Tribal Organizations and Urban programs, deliver health care services to American Indian/Alaska Native (AI/AN) people through a network of hospitals, clinics and other providers. This award expands research on the impact of CMS programs and the delivery of health care to AI/AN beneficiaries.

FOR FURTHER INFORMATION CONTACT: Georgeline Sparks, Centers for Medicare & Medicaid Services, Center for Medicaid and CHIP Services/IEAG/Division of Tribal Affairs, 7500 Security Boulevard, M/S S1–05–06, Baltimore, MD 21244–1850, (410) 786–4608.

Intended Recipient: National Indian Health Board (NIHB).

Purpose of Award: The IHS and Tribal health programs have had long standing authority to bill Medicare and Medicaid for services provided at their facilities. These participating and billing authorities were expanded by the American Recovery and Reinvestment Act of 2009 (ARRA), the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), and the Affordable Care Act in 2010 (ACA). AI/AN people have traditionally been medically underserved and have health disparities significantly above those of the population as a whole. In order to ensure that AI/AN people have full knowledge of these new changes and the fullest access to CMS programs, this award will study the adoption and impact of these new authorities on the Indian health care system.

Amount of the Award: The total amount of funding available over a five year period is $4,000,000. The initial award will be awarded at $800,000. The subsequent years will be awarded on a non-competing continuation basis at approximately $800,000 per year for a total of 5 years, and will be subject to the availability of funds and satisfactory performance by the recipient.

Justification for Single Source Award: For the past five years through a Cooperative Agreement with CMS, NIHB has provided analysis and research of the potential and actual impact of CMS programs on AI/AN beneficiaries and the health care system serving these beneficiaries. This work has included analysis and research on Medicare and Medicaid data enrollment of AI/AN beneficiaries to understand utilization of the AI/AN population in the context of CMS programs. In addition, NIHB has been instrumental in tracking CMS regulations and providing analysis and research to better understand the implications of CMS regulatory guidance on the Indian health programs. Based on this experience, NIHB is the only entity capable of carrying out the scope of activities because the scope of work builds on past experience and knowledge. Any other source would not have all of the knowledge and experience gained in the last five years. The NIHB provides research on health program issues impacting AI/ANs to over 567 Federally-recognized Tribes and has historically provided these services for several decades in conjunction with the IHS. The NIHB program has a national focus relevant to its AI/AN constituency who need to know through substantive research about the changes and updates in the latest health care services and access through CMS programs.

Project Period: The anticipated period of performance for this cooperative agreement is September 29, 2017 through September 28, 2022 with funding awarded in 12-month budget increments subject to the availability of funds and satisfactory performance.

Provisions of the Notice: CMS has solicited a proposal from the NIHB to undertake analysis, research and studies to address the impact of CMS programs and AI/AN beneficiaries and the health care system serving those beneficiaries. The project consists of five principal research objectives:

- Study the ongoing impact of CMS programs on the Indian health system through analysis of, response to, and implementation of CMS regulations by Indian health providers.
- Study AI/AN demographic, enrollment, and utilization data and propose strategies to increase CMS data system capabilities to create more Indian specific reporting capacity.
- Provide ongoing study of CMS efforts to increase AI/AN knowledge of CMS programs and CMS responsiveness to Indian health system.
- Provide research support on the use and effectiveness of the CMS Tribal Consultation Policy.
- Evaluate the effectiveness of outreach and enrollment efforts to AI/AN beneficiaries in CMS programs.

CMS requested that NIHB submit an application which includes:

1. Cover Letter.
2. SF–424 Application for Federal Assistance.
3. SF–424A Budget Information—Non-Construction Programs.
4. SF–424B Assurances.
5. A budget narrative.
6. Abstract of Project.
7. A research project narrative that describes each of the five separate objectives.
8. 501(c)(3) Non-Profit certification.
9. Resumes of all key personnel.
10. Position descriptions.
11. Disclosure of Lobbying Activities, if applicable.
12. Copy of approved indirect cost rate agreement, if applicable.
13. Documentation of current OMB A–133 required financial audit, if applicable.

Evaluation criteria for review of the application will be comprised of three principal areas:

a. Program information which includes current organizational capabilities and operations.

b. Program planning and evaluation which includes identification of measurable goals, products, personnel and workplanning.

c. Program reporting which includes organizational capabilities and qualifications and categorical budget and justification.

Authority: Section 1110 of the Social Security Act, codified at 42 U.S.C. Sec. 1310

Dated: September 15, 2017.

Derrick Heard,

Chief Grants Management Officer, Office of Acquisition and Grants Management, Centers for Medicare & Medicaid Services.

[FR Doc. 2017–22811 Filed 10–19–17; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–3349–PN]

Medicare and Medicaid Programs; Application by Community Health Accreditation Partner for Continued CMS Approval of Its Home Health Agency Accreditation Program

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

ACTION: Proposed notice.

SUMMARY: This proposed notice acknowledges the receipt of an application from the Community Health Accreditation Partner (CHAP) for continued recognition as a national accrediting organization for home health agencies (HHAs) that wish to participate in the Medicare or Medicaid programs. The statute requires that within 60 days of receipt of an organization's complete application, the Centers for Medicare & Medicaid Services (CMS) publish a notice that identifies the national accrediting body making the request, describes the nature of the request, and provides at least a 30-day public comment period.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on November 20, 2017.

ADDRESSES: In commenting, please refer to file code CMS–3349–PN. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four 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–3349–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–3349–PN, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments before the close of the comment period to either of the following addresses:

a. For delivery in Washington, DC—Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, DC 20201.

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD—Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244–1850.

If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786–7195 in advance to schedule your arrival with one of our staff members.

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Lillian Williams, (410) 786–8636. Patricia Chmielewski, (410) 786–6899.

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 Web site as soon as possible after they have been received: *http://www.regulations.gov.* Follow the search instructions on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

I. Background

Under the Medicare program, eligible beneficiaries may receive covered services from a home health agency (HHA) provided certain requirements are met. Sections 1861(m) and (o), 1891 and 1895 of the Social Security Act (the Act) establish distinct criteria for entities seeking designation as an HHA. Regulations concerning provider agreements are at 42 CFR part 489 and those pertaining to activities relating to the survey and certification of facilities and other entities are at 42 CFR part 488. The regulations at 42 CFR parts 409 and 484 specify the conditions that an HHA must meet to participate in the Medicare program, the scope of covered services and the conditions for Medicare payment for home health care.

Generally, to enter into a provider agreement with the Medicare program, an HHA must first be certified by a state survey agency as complying with the conditions or requirements set forth in 42 CFR part 484 of our regulations. Thereafter, the HHA is subject to regular surveys by a state survey agency to determine whether it continues to meet these requirements.

However, there is an alternative to surveys by state agencies. 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 will deem those provider entities as having met the requirements. Accreditation by an