

Conditions of Participation (CoP) and Supporting Regulations; *Use*: The information collection requirements contained in this request are part of the requirements classified as the conditions of participation (CoPs) which are based on criteria prescribed in law and are standards designed to ensure that each facility has properly trained staff to provide the appropriate safe physical environment for patients. These particular standards reflect comparable standards developed by industry organizations such as the Joint Commission on Accreditation of Healthcare Organizations, and the Community Health Accreditation Program. We will use this information along with state agency surveyors, the regional home health intermediaries and home health agencies (HHAs) for the purpose of ensuring compliance with Medicare CoPs as well as ensuring the quality of care provided by HHA patients. *Form Numbers*: CMS-R-39 (OCN: 0938-0365); *Frequency*: Occasionally; *Affected Public*: Private sector—Business or for-profits and Not-for-profit institutions, and State, Local or Tribal governments; *Number of Respondents*: 13,577; *Total Annual Responses*: 20,202,576; *Total Annual Hours*: 6,422,694. (For policy questions regarding this collection contact Danielle Shearer at 410-786-6617.)

4. *Type of Information Collection Request*: New collection (Request for a new OMB control number); *Title of Information Collection*: Enrollment Assistance Program; *Use*: As required by the Affordable Care Act, we will implement a grant-based Navigator Program to provide support to targeted communities. However, there will also be a need for broader based enrollment assistance in population centers we identified in states with Federally-facilitated Marketplaces (FFMs) to provide Health Insurance Marketplace enrollment assistance to populations not covered or targeted by the Navigator Program. The target populations are individual consumers and families eligible to enroll in Qualified Health Plans (QHPs) in population centers we identified. Without such access to in-person enrollment assistance, millions of individuals who will be eligible for health insurance coverage in the Marketplaces might not have access to the direct assistance required to make educated choices on available healthcare options and may therefore be unable to successfully enroll in the Marketplaces. To monitor program effectiveness, the Enrollment Assistance Program will provide weekly, monthly, quarterly and annual reports. The 60-

day **Federal Register** notice was published on July 29, 2013 (78 FR 45205). No comments were received. *Form Number*: CMS-10491 (OCN: 0938-NEW); *Frequency*: Weekly, Monthly, Quarterly, Yearly; *Affected Public*: Private Sector; *Number of Respondents*: 11; *Number of Responses*: 84; *Total Annual Hours*: 554. (For policy questions regarding this collection contact Jabaar Gray at 301-492-4255.)

5. *Type of Information Collection Request*: Reinstatement with change of a previously approved collection; *Title of Information Collection*: Conditions for Coverage of Suppliers of End Stage Renal Disease (ESRD) Services and Supporting Regulations; *Use*: The information collection requirements described herein are part of the Medicare and Medicaid Programs; Conditions for Coverage for End-Stage Renal Disease Facilities. The requirements fall into two categories: Recordkeeping requirements and reporting requirements. With regard to the recordkeeping requirements, we use these conditions for coverage to certify health care facilities that want to participate in the Medicare or Medicaid programs. For the reporting requirements, the information is needed to assess and ensure proper distribution and effective utilization of ESRD treatment resources while maintaining or improving quality of care. The recordkeeping requirements imposed by this collection are no different than other conditions for coverage in that they reflect comparable standards developed by industry organizations such as the Renal Physicians Association, American Society of Transplant Surgeons, National Kidney Foundation, and the National Association of Patients on Hemodialysis and Transplantation. *Form Number*: CMS-R-52 (OCN: 0938-0386); *Frequency*: Annually; *Affected Public*: Private sector—Business or other for-profit; *Number of Respondents*: 6,464; *Total Annual Responses*: 139,110; *Total Annual Hours*: 523,454. (For policy questions regarding this collection contact Lauren Oviatt at 410-786-4683.)

Dated: October 22, 2013.

Martique Jones,

Deputy Director, Regulations Development Group, Office of Strategic Operations and Regulatory Affairs.

[FR Doc. 2013-25171 Filed 10-24-13; 8:45 am]

BILLING CODE 4120-01-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS-3286-PN]

Medicare and Medicaid Programs: Application From the Joint Commission for Continued Approval of Its Home Health Agency (HHA) Accreditation Program

AGENCY: Centers for Medicare and Medicaid Services, HHS.

ACTION: Proposed notice.

SUMMARY: This proposed notice acknowledges the receipt of an application from the Joint Commission for continued recognition as a national accrediting organization for Home Health Agencies (HHAs) that wish to participate in the Medicare or Medicaid programs. Section 1865(b)(3)(A) of the Social Security Act (the Act) requires that within 60 days of receipt of an organization's complete application, 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 24, 2013.

ADDRESSES: In commenting, please refer to file code CMS-3286-PN. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways:

1. *Electronically*. You may submit electronic comments on specific issues in this *regulation* to <http://www.regulations.gov>. Follow the "submit a comment" instructions.

2. *By regular mail*. You may mail written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-3286-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-3286-PN, Mail Stop C4-26-05, 7500 Security Boulevard, Baltimore, MD 21244-1850.

4. *By hand or courier.* Alternatively, you may deliver (by hand or courier) your written comments to 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.)

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

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, call telephone number (410) 786–9994 in advance to schedule your arrival with one of our staff members.

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, or Monda Shaver, (410) 786–3410.

SUPPLEMENTARY INFORMATION:

Submitting Comments: We welcome comments from the public on all issues set forth in this proposed notice to assist us in fully considering issues and developing policies. Referencing the file code CMS–3286–PN and the specific “issue identifier” that precedes the section on which you choose to comment will assist us in fully considering issues and developing policies.

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 an HHA provided certain requirements are met. Sections 1861(o) and 1891 of the Social Security Act (the Act), establish distinct criteria for facilities 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 are at 42 CFR part 488. The regulations at 42 CFR part 484 specify the minimum conditions that an HHA must meet to participate in the Medicare program.

Generally, to enter into an agreement, an HHA must first be certified by a state survey agency as complying with the conditions or requirements set forth in 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. There is an alternative, however, 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 accrediting organization is voluntary and is not required for Medicare participation.

If an accrediting organization is recognized by 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 would be deemed to meet the Medicare conditions. A national accrediting organization applying for approval of its accreditation program under part 488, subpart A, must provide us with reasonable assurance that the accrediting organization requires the accredited provider entities to meet requirements that are at least as stringent as the Medicare conditions. Our regulations concerning the approval of accrediting organizations are set forth at § 488.4 and § 488.8(d)(3). The

regulations at § 488.8(d)(3) require accrediting organizations to reapply for continued approval of its accreditation program every 6 years or sooner as determined by us.

The Joint Commission’s current term of approval for their HHA accreditation program expires March 31, 2014.

II. Approval of Deeming Organizations

Section 1865(a)(2) of the Act and our regulations at § 488.8(a) require that our findings concerning review and approval of a national accrediting 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 the Joint Commission’s request for continued approval of its HHA accreditation program. This notice also solicits public comment on whether the Joint Commission’s requirements meet or exceed the Medicare conditions of participation (CoPs) for HHAs.

III. Evaluation of Deeming Authority Request

The Joint Commission submitted all the necessary materials to enable us to make a determination concerning its request for continued approval of its HHA accreditation program. This application was determined to be complete on August 30, 2013. Under section 1865(a)(2) of the Act and our regulations at § 488.8 (Federal review of accrediting organizations), our review and evaluation of the Joint Commission will be conducted in accordance with, but not necessarily limited to, the following factors:

- The equivalency of the Joint Commission’s standards for HHA’s as compared with CMS’ HHA CoPs.
- The Joint Commission’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 the Joint Commission's processes to those of state agencies, including survey frequency, and the ability to investigate and respond appropriately to complaints against accredited facilities.

++ The Joint Commission's processes and procedures for monitoring an HHA found out of compliance with the Joint Commission's program requirements. These monitoring procedures are used only when the Joint Commission identifies noncompliance. If noncompliance is identified through validation reviews or complaint surveys, the state survey agency monitors corrections as specified at § 488.7(d).

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

++ The Joint Commission'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 the Joint Commission's staff and other resources, and its financial viability.

++ The Joint Commission's capacity to adequately fund required surveys.

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

++ The Joint Commission'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 and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 35).

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.

Authority: (Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program; No. 93.773 Medicare—Hospital Insurance Program; and No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: September 27, 2013.

Marilyn Tavenner,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2013–25010 Filed 10–24–13; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–3289–N]

Medicare Program; Request for Nominations for Members for the Medicare Evidence Development & Coverage Advisory Committee

AGENCY: Centers for Medicare & Medicaid Services, HHS.

ACTION: Notice.

SUMMARY: This notice announces the request for nominations for membership on the Medicare Evidence Development & Coverage Advisory Committee (MEDCAC). Among other duties, the MEDCAC provides advice and guidance to the Secretary of the Department of Health and Human Services (the Secretary) and the Administrator of the Centers for Medicare & Medicaid Services (CMS) concerning the adequacy of scientific evidence available to CMS for “reasonable and necessary” determinations under Medicare.

We are requesting nominations for both voting and nonvoting members to serve on the MEDCAC. Nominees are selected based upon their individual qualifications and not as representatives of professional associations or societies. We wish to ensure adequate representation of the interests of both women and men, members of all ethnic groups and physically challenged individuals. Therefore, we encourage nominations of qualified candidates who can represent these interests.

The MEDCAC reviews and evaluates medical literature, technology assessments, and hears public testimony

on the evidence available to address the impact of medical items and services on health outcomes of Medicare beneficiaries.

DATES: Nominations must be received by Monday, December 9, 2013.

ADDRESSES: You may mail nominations for membership to the following address: Centers for Medicare & Medicaid Services, Center for Clinical Standards and Quality, Attention: Maria Ellis, 7500 Security Boulevard, Mail Stop: S3–02–01, Baltimore, MD 21244.

FOR FURTHER INFORMATION CONTACT: Maria Ellis, Executive Secretary for the MEDCAC, Centers for Medicare & Medicaid Services, Center for Clinical Standards and Quality, Coverage and Analysis Group, S3–02–01, 7500 Security Boulevard, Baltimore, MD 21244 or contact Ms. Ellis by phone (410–786–0309) or via email at Maria.Ellis@cms.hhs.gov.

SUPPLEMENTARY INFORMATION:

I. Background

The Secretary signed the initial charter for the Medicare Coverage Advisory Committee (MCAC) on November 24, 1998. A notice in the **Federal Register** (63 FR 68780) announcing establishment of the MCAC was published on December 14, 1998. The MCAC name was updated to more accurately reflect the purpose of the committee and on January 26, 2007, the Secretary published a notice in the **Federal Register** (72 FR 3853), announcing that the Committee's name changed to the Medicare Evidence Development & Coverage Advisory Committee (MEDCAC). The charter for the committee was renewed by the Secretary on November 24, 2012. The current charter is effective for 2 years.

The MEDCAC is governed by provisions of the Federal Advisory Committee Act, Public Law 92–463, as amended (5 U.S.C. App. 2), which sets forth standards for the formulation and use of advisory committees, and is authorized by section 222 of the Public Health Service Act as amended (42 U.S.C. 217A).

The MEDCAC consists of a pool of 100 appointed members including: 94 voting members of whom 6 are designated patient advocates, and 6 nonvoting representatives of industry interests. Members generally are recognized authorities in clinical medicine including subspecialties, administrative medicine, public health, biological and physical sciences, epidemiology and biostatistics, clinical trial design, health care data management and analysis, patient advocacy, health care economics,