improve the quality of health care. This strategy has established six priorities that support the three-part aim. The three-part aim focuses on better care, better health, and lower costs through improvement. The six priorities include: Making care safer by reducing harm caused by the delivery of care; ensuring that each person and family are engaged as partners in their care; promoting effective communication and coordination of care; promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease; working with communities to promote wide use of best practices to enable healthy living; and making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models. The CAHPS Survey for Physician Quality Reporting focuses on patient experience. Implementation of the survey supports the six national priorities for improving care, particularly engaging patients and families in care and promoting effective communication and coordination.

This survey supports the administration of the Quality Improvement Organizations Program (QIO). The Social Security Act, as set forth in Part B of Title XI—Section 1862(g), established the Utilization and Quality Control Peer Review Organization Program, now known as the QIO Program. The statutory mission of the QIO Program is to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries. This survey will provide patient experience of care data that is an essential component of assessing the quality of services delivered to Medicare beneficiaries. It also would permit beneficiaries to have this information to help them choose health care providers that provide services that meet their needs and preferences, thus encouraging providers to improve quality of care that Medicare beneficiaries receive. *Form Number:* CMS–10450 (OCN: 0938–New); *Frequency:* Annual; *Affected Public:* Individuals and Households; *Number of Respondents:* 234,600 *Total Annual Responses:* 117,300; *Total Annual Hours:* 39,530. (For policy questions regarding this collection contact Regina Chell at 410–786–6551. For all other issues call 410–786–1326.)

2. *Type of Information Collection Request:* Reinstatement of a previously approved collection; *Title:* Program for Matching Grants to States for the Operation of High Risk Pools; *Use:* The Centers for Medicare and Medicaid Services (CMS) is requiring the information in this information collection request as a condition of eligibility for grants that were authorized in the Trade Act of 2002, the Deficit Reduction Act of 2005 and the State High Risk Pool Funding Extension Act of 2006. The information is necessary to determine if a State applicant meets the necessary eligibility criteria for a grant as required by law. The respondents will be States that have a high risk pool as defined in sections 2741, 2744, or 2745 of the Public Health Service Act. The grants will provide funds to States that incur losses in the operation of high risk pools. High risk pools are set up by States to provide health insurance to individuals that cannot obtain health insurance in the private market because of a history of illness; *Form Number:* CMS–10078 (OCN: 0938–0887); *Frequency:* Occasionally; *Affected Public:* State, Local and Tribal Governments; *Number of Respondents:* 31; *Total Annual Responses:* 31; *Total Annual Hours:* 1,240. (For policy questions regarding this collection contact Paul Scholz at (410) 786–6178. For all other issues call (410) 786–1326.)

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access CMS Web Site address at *http://www.cms.hhs.gov/PaperworkReductionActof1995,* or Email your request, including your address, phone number, OMB number, and CMS document identifier, to *Paperwork@cms.hhs.gov,* or call the Reports Clearance Office on (410) 786–1326.

To be assured consideration, comments and recommendations for the proposed information collections must be received by the OMB desk officer at the address below, no later than 5 p.m. on April 22, 2013.

OMB, Office of Information and Regulatory Affairs, Attention: CMS Desk Officer, Fax Number: (202) 395–6974, Email: *OIRA_submission@omb.eop.gov.*

Dated: *March 19, 2013.*

Martique Jones,

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

[FR Doc. 2013–06632 Filed 3–21–13; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–3281–PN]

Medicare and Medicaid Programs: Application From the American Osteopathic Association/Healthcare Facilities Accreditation Program for Continued CMS-Approval of Its Hospital Accreditation Program

AGENCY: Centers for Medicare and Medicaid Services, HHS.

ACTION: Proposed notice.

SUMMARY: This proposed notice with comment period acknowledges the receipt of an application from the American Osteopathic Association/Healthcare Facilities Accreditation Program (AOA/HFAP) for continued recognition as a national accrediting organization for hospitals that wish to participate in the Medicare or Medicaid programs.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on April 22, 2013.

ADDRESSES: In commenting, please refer to file code CMS–3281–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–3281–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–3281–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 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.

SUPPLEMENTARY INFORMATION section.

FOR FURTHER INFORMATION CONTACT:

Cindy Melanson, (410) 786–0310.

Patricia Chmielewski, (410) 786–6899.

Valarie Lazerowich, (410) 786–4750.

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 in a hospital provided certain requirements are met by the hospital. Section 1861(e) of the Social Security Act (the Act), establishes distinct criteria for facilities seeking designation as a hospital. Regulations concerning provider agreements are located at 42 CFR part 489 and those pertaining to activities relating to the survey and certification of facilities are located at 42 CFR part 488. The regulations at 42 CFR part 482, specify the conditions that a hospital must meet to participate in the Medicare program, the scope of covered services, and the conditions for Medicare payment for hospitals.

Generally, to enter into an agreement, a hospital must first be certified by a State survey agency as complying with the conditions or requirements set forth in part 482 of our regulations. Thereafter, the hospital is subject to regular surveys by a State survey agency to determine whether it continues to meet these requirements.

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 an accrediting organization to reapply for continued approval of its accreditation program every 6 years or as determined by CMS. The American Osteopathic Association/Healthcare Facilities Accreditation Program (AOA/HFAP's) current term of approval for its hospital accreditation program expires September 25, 2013.

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 AOA/HFAP's request for continued CMS-approval of its hospital accreditation program. This notice also solicits public comment on whether AOA/HFAP's requirements meet or exceed the Medicare conditions of participation for hospitals.

III. Evaluation of Deeming Authority Request

AOA/HFAP submitted all the necessary materials to enable us to make a determination concerning its request for continued approval of its hospital accreditation program. This application was determined to be complete on January 25, 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 AOA/HFAP will be conducted in accordance with, but not necessarily limited to, the following factors:

- The equivalency of AOA/HFAP's standards for hospitals as compared with CMS' hospital conditions of participation.
- AOA/HFAP'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 AOA/HFAP's processes to those of state agencies, including survey frequency, and the ability to investigate and respond appropriately to complaints against accredited facilities.

++ AOA/HFAP's processes and procedures for monitoring a hospital that is out of compliance with AOA/HFAP's program requirements. These monitoring procedures are used only when AOA/HFAP identifies noncompliance. If noncompliance is identified through validation reviews or complaint surveys, the state survey agency monitors corrections as specified at § 488.7(d).

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

++ AOA/HFAP'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 AOA/HFAP's staff and other resources, and its financial viability.

++ AOA/HFAP's capacity to adequately fund required surveys.

++ AOA/HFAP's policies with respect to whether surveys are announced or unannounced.

++ AOA/HFAP'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.

(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: March 5, 2013.

Marilyn Tavenner,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2013–06640 Filed 3–21–13; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Implementation of the Updated American Veterinary Medical Association Guidelines for the Euthanasia of Animals: 2013 Edition

SUMMARY: The National Institutes of Health (NIH) is providing guidance to Public Health Service (PHS) awardee institutions on implementation of the *American Veterinary Medical Association (AVMA) Guidelines for the Euthanasia of Animals: 2013 Edition* (*Guidelines*). The NIH is seeking input from the public on any concerns they may have regarding the updated *Guidelines.*

DATES: Public concerns regarding the updated *AVMA Guidelines for the Euthanasia of Animals: 2013 Edition* must be submitted electronically at *http://grants.nih.gov/grants/olaw/2013avmaguidelines_comments/add.cfm?ID=32* by May 31, 2013, in order to be considered.

FOR FURTHER INFORMATION CONTACT: Office of Laboratory Animal Welfare, Office of Extramural Research, NIH, RKL1, Suite 360, 6705 Rockledge Drive, Bethesda, MD 20892–7982; phone 301–496–7163; email *olaw@od.nih.gov.*

SUPPLEMENTARY INFORMATION:

I. Background

The NIH Office of Laboratory Animal Welfare (OLAW) oversees PHS-funded animal activities by the authority of the Health Research Extension Act of 1985 (*http://grants.nih.gov/grants/olaw/references/hrea1985.htm*) and the PHS Policy on Humane Care and Use of Laboratory Animals (PHS Policy; *http://grants.nih.gov/grants/olaw/references/phspol.htm*). The PHS Policy IV.C.1.G. (*http://grants.nih.gov/grants/olaw/references/phspol.htm#ReviewofPHS-ConductedorSupportedResearchProjects*) requires that Institutional Animal Care and Use Committees (IACUCs) reviewing PHS-conducted or -supported research projects, determine if methods of euthanasia used in projects will be consistent with the recommendations of the AVMA Panel on Euthanasia, unless a deviation is justified for scientific reasons in writing by the investigator.

PHS-Assured institutions are encouraged to begin using the *2013 Guidelines* as soon as possible when reviewing research projects, and full implementation is expected after September 1, 2013. Previously approved projects undergoing continuing review according to PHS Policy IV.C.5. (*http://grants.nih.gov/grants/olaw/references/phspol.htm#ReviewofPHS-ConductedorSupportedResearchProjects*), which requires a complete de novo review at least once every 3 years, must be reviewed using the *2013 Guidelines* after September 1, 2013.

II. Electronic Access

The AVMA has issued and posted an update to the *2007 Guidelines on Euthanasia* with a new title, *AVMA Guidelines for the Euthanasia of Animals: 2013 Edition,* available at *https://www.avma.org/KB/Policies/Documents/euthanasia.pdf* (PDF).

Dated: March 14, 2013.

Francis S. Collins,

Director, National Institutes of Health.

[FR Doc. 2013–06661 Filed 3–21–13; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of Arthritis and Musculoskeletal and Skin Diseases; Closed Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. App.), notice is hereby given of the following meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Institute of Arthritis and Musculoskeletal and Skin Diseases Special Emphasis Panel; NIAMS Clinical Trial Outcome Development.

Date: March 29, 2013.

Time: 8:00 a.m. to 5:30 p.m.

Agenda: To review and evaluate grant applications.

Place: Hilton Washington/Rockville, 1750 Rockville Pike, Rockville, MD 20852.