Comments erroneously 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: Patricia Taft, (410) 786–4561.

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

Organ Procurement Organizations (OPOs) are not-for-profit organizations that are responsible for the procurement, preservation, and transport of organs to transplant centers throughout the country. Qualified OPOs are designated by the Centers for Medicare & Medicaid Services (CMS) to recover or procure organs in CMS-defined exclusive geographic service areas, pursuant to section 371(b)(1) of the Public Health Service Act (42 U.S.C. 273(b)(1)) and our regulations at 42 CFR 486.306. Once an OPO has been designated for an area, hospitals in that area that participate in Medicare and Medicaid are required to work with that OPO in providing organs for transplant, pursuant to section 1138(a)(1)(C) of the Social Security Act (the Act) and our regulations at 42 CFR 482.45.

Section 1138(a)(1)(A)(iii) of the Act provides that a hospital must notify the designated OPO (for the service area in which it is located) of potential organ donors. Under section 1138(a)(1)(C) of the Act, every participating hospital must have an agreement only with its designated OPO to identify potential donors.

However, section 1138(a)(2)(A) of the Act provides that a hospital may obtain a waiver of the above requirements from the Secretary of the Department of Health and Human Services (the Secretary) under certain specified conditions. A waiver allows the hospital to have an agreement with an OPO other than the one initially designated by CMS, if the hospital meets certain conditions specified in section 1138(a)(2)(A) of the Act. In addition, the Secretary may review additional criteria described in section 1138(a)(2)(B) of the Act to evaluate the hospital's request for a waiver.

Section 1138(a)(2)(A) of the Act states that in granting a waiver, the Secretary must determine that the waiver—(1) is expected to increase organ donations; and (2) will ensure equitable treatment of patients referred for transplants within the service area served by the designated OPO and within the service area served by the OPO with which the hospital seeks to enter into an agreement under the waiver. In making a waiver determination, section 1138(a)(2)(B) of the Act provides that the Secretary may consider, among other factors: (1) Cost-effectiveness; (2) improvements in quality; (3) whether there has been any change in a hospital's designated OPO due to the changes made in definitions for metropolitan statistical areas; and (4) the length and continuity of a hospital's relationship with an OPO other than the hospital's designated OPO. Under section 1138(a)(2)(D) of the Act, the Secretary is required to publish a notice of any waiver application received from a hospital within 30 days of receiving the application, and to offer interested parties an opportunity to submit comments during the 60-day comment period beginning on the publication date in the **Federal Register**.

The criteria that the Secretary uses to evaluate the waiver in these cases are the same as those described above under sections 1138(a)(2)(A) and (B) of the Act and have been incorporated into the regulations at § 486.308(e) and (f).

II. Waiver Request Procedures

In October 1995, we issued a Program Memorandum (Transmittal No. A–95–11) detailing the waiver process and discussing the information hospitals must provide in requesting a waiver. We indicated that upon receipt of a waiver request, we would publish a **Federal Register** notice to solicit public comments, as required by section 1138(a)(2)(D) of the Act.

According to these requirements, we will review the comments received. During the review process, we may consult on an as-needed basis with the Health Resources and Services Administration's Division of Transplantation, the United Network for Organ Sharing, and our regional offices. If necessary, we may request additional clarifying information from the applying hospital or others. We will then make a final determination on the waiver request and notify the hospital and the designated and requested OPOs.

III. Hospital Waiver Request

As permitted by § 486.308(e), the following hospital has requested a waiver to enter into an agreement with a designated OPO other than the OPO designated for the service area in which the hospital is located:

Banner Churchill Community Hospital, Fallon, Nevada, is requesting a waiver to work with: California Transplant Donor Network, 1000 Broadway, Suite 600, Oakland, California 94607–4099.

The Hospital's Designated OPO is: Nevada Donor Network, 2061 E Sahara Ave., Las Vegas, Nevada 89104.

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

We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble.

Dated: May 2, 2014.

Marilyn Tavenner,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2014–10638 Filed 5–9–14; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1615–NC]

Medicare Program; Request for an Exception to the Prohibition on Expansion of Facility Capacity Under the Hospital Ownership and Rural Provider Exceptions to the Physician Self-Referral Prohibition

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

ACTION: Notice with comment period.

SUMMARY: Under section 1877(i) of the Social Security Act (the Act), a physician-owned hospital is effectively prohibited from expanding facility capacity, unless the Secretary grants the hospital's request for an exception to that prohibition after considering input on the hospital's request from individuals and entities in the community where the hospital is located. The Centers for Medicare & Medicaid Services (CMS) has received a request from a physician-owned hospital for an exception to the prohibition against expansion of facility capacity. This notice solicits comments on the request from individuals and entities in the community in which the physician-owned hospital is located. Community input may inform our determination regarding whether the requesting hospital qualifies for an exception to the prohibition against expansion of facility capacity.

DATES: *Comment Date:* To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on June 11, 2014.

ADDRESSES: In commenting, please refer to file code CMS–1615–NC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of three ways (please choose only one of the ways listed):

1. Electronically. You may submit electronic comments on this exception request to *http://www.regulations.gov.* Follow the instructions under the ''More Search Options'' tab.

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–1615–NC, P.O. Box 8010, Baltimore, MD 21244–1850.

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: Department of Health and Human Services, Attention: CMS–1615–NC, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

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

FOR FURTHER INFORMATION CONTACT: Patricia Taft, (410) 786–4561 or Teresa Walden, (410) 786–3755.

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.

We will allow stakeholders 30 days from the date of this notice to submit written comments. Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of this notice, 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, please phone 1–800–743–3951.

I. Background

Section 1877 of the Social Security Act (the Act), also known as the physician self-referral law—(1) prohibits a physician from making referrals for certain ''designated health services'' (DHS) payable by Medicare to an entity with which he or she (or an immediate family member) has a financial relationship (ownership or compensation), unless an exception applies; and (2) prohibits the entity from filing claims with Medicare (or billing another individual, entity, or third party payer) for those DHS furnished as a result of a prohibited referral.

Section 1877(d)(3) of the Act provides an exception, known as the ''whole hospital exception,'' for physician ownership or investment interests held in a hospital located outside of Puerto Rico, provided that the referring physician is authorized to perform services at the hospital and the ownership or investment interest is in the hospital itself (and not merely in a subdivision of the hospital).

Section 1877(d)(2) of the Act provides an exception for physician ownership or investment interests in rural providers (the ''rural provider exception''). In order for an entity to qualify for the rural provider exception, the DHS must be furnished in a rural area (as defined in section 1886(d)(2) of the Act) and substantially all the DHS furnished by the entity must be furnished to individuals residing in a rural area.

Section 6001(a)(3) of the Patient Protection and Affordable Care Act (Pub. L. 111–148) as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152) (hereafter referred to together as ''the Affordable Care Act'') amended the whole hospital and rural provider exceptions to the physician self-referral prohibition to impose additional restrictions on physician ownership and investment in hospitals and rural providers. Since March 23, 2010, a physician-owned hospital that seeks to avail itself of either exception is prohibited from expanding facility capacity unless it qualifies as an ''applicable hospital'' or ''high Medicaid facility'' (as defined in sections 1877(i)(3)(E), (F) of the Act and 42 CFR 411.362(c)(2), (3) of our regulations) and has been granted an exception to the prohibition by the Secretary. Section 1877(i)(3)(A)(ii) of the Act provides that individuals and entities in the community in which the provider requesting the exception is located must have an opportunity to provide input with respect to the provider's application for the exception. For further information, visit our Web site at: *http://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Physician_Owned_Hospitals.html.*

II. Exception Request Process

On November 30, 2011, we published a final rule in the **Federal Register** (76 FR 74122, 74517 through 74525) that, among other things, finalized § 411.362(c), which specified the process for submitting, commenting on, and reviewing a request for an exception to the prohibition on expansion of facility capacity. We specified that prior to our review of the request, we will solicit community input on the request for an exception by publishing a notice of the request in the **Federal Register** (see § 411.362(c)(5)). We also stated that individuals and entities in the hospital's community have 30 days to submit comments on the request. Community input must take the form of written comments and may include documentation demonstrating that the physician-owned hospital requesting the exception does or does not qualify as an ''applicable hospital'' or ''high Medicaid facility,'' as such terms are defined in § 411.362(c)(2) and (3). Although we gave examples of community input, such as documentation demonstrating that the hospital does not satisfy one or more of the data criteria or that the hospital discriminates against beneficiaries of Federal health programs, we noted that

these were examples only and that we will not restrict the type of community input that may be submitted (76 FR 74522). If we receive timely comments from the community, we will notify the hospital, and the hospital has 30 days after such notice to submit a rebuttal statement (§ 411.362(c)(5)(ii)).

A request for an exception to the facility expansion prohibition is considered complete and ready for CMS review if no comments from the community are received by the close of the 30-day comment period. If we receive timely comments from the community, we consider the request to be complete 30 days after the hospital is notified of the comments. If we grant the request for an exception to the prohibition on expansion of facility capacity, the expansion may occur only in facilities on the hospital's main campus and may not result in the number of operating rooms, procedure rooms, and beds for which the hospital is licensed exceeding 200 percent of the hospital's baseline number of operating rooms, procedure rooms, and beds (§ 411.362(c)(6)). Our decision to grant or deny a hospital's request for an exception to the prohibition on expansion of facility capacity will be published in the **Federal Register** in accordance with our regulations at § 411.362(c)(7).

III. Hospital Exception Request

As permitted by section 1877(i)(3) of the Act and our regulations at § 411.362(c), the following physician-owned hospital has requested an exception to the prohibition on expansion of facility capacity:

Name of Facility: Lake Pointe Medical Center

Location: 6800 Scenic Drive, Rowlett, Texas 75088–4552 (Rockwall County)

Basis for Exception Request: High Medicaid Facility

We seek comments on this request from individuals and entities in the community in which the hospital is located. We encourage interested parties to review the hospital's request, which is posted on the CMS Web site at: *http://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Physician_Owned_Hospitals.html*. We especially welcome comments regarding whether the hospital qualifies as a ''high Medicaid facility.'' Under § 411.362(c)(3), a ''high Medicaid facility'' is a hospital that satisfies all of the following criteria:

- The hospital is not the sole hospital in the county in which it is located;
- The hospital does not discriminate against beneficiaries of Federal health care programs and does not permit physicians practicing at the hospital to discriminate against such beneficiaries; and
- With respect to each of the 3 most recent fiscal years for which data are available as of the date the hospital submits its request, the hospital has an annual percent of total inpatient admissions under Medicaid that is estimated to be greater than such percent with respect to such admissions for any other hospital located in the county in which the hospital is located.

We note that our regulations require the requesting hospital to use filed hospital cost report discharge data to estimate its annual percentage of total inpatient admissions under Medicaid and the annual percentages of total inpatient admissions under Medicaid for every other hospital located in the county in which the hospital is located.

Individuals and entities wishing to submit comments on the hospital's request should review the **DATES** and **ADDRESSES** sections above and state whether or not they are in the community in which the hospital is located.

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

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.

Dated: May 6, 2014.

Marilyn Tavenner,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2014–10872 Filed 5–9–14; 8:45 am]

BILLING CODE P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Proposed Information Collection Activity; Comment Request Proposed Projects:

Title: Multistate Financial Institution Data Match with Federally Assisted State Transmitted Levy (FIDM/FAST Levy)

OMB No.: 0970–0196.

Description: State child support enforcement agencies are required to attach and seize an obligor's assets in financial institutions to satisfy any current support obligation and arrearage when the obligor owes past-due support. To locate an obligor's account, state child support enforcement agencies are required to enter into data matching agreements with financial institutions doing business in their state. State child support enforcement agencies use the results of data matches to secure information leading to the enforcement of the support obligation. The federal Office of Child Support Enforcement (OCSE) assists states to fulfill the data matching requirements with multistate financial institutions by facilitating matching through the Federal Parent Locator Service's Multistate Financial Institution Data Match (MSFIDM) program.

To further assist states to meet this statutory requirement, the OCSE enhanced the Federal Parent Locator Service by developing the Federally Assisted State Transmitted (FAST) Levy application that provides a secure and automated method of collecting and disseminating electronic levy notices between state child support enforcement agencies and multistate financial institutions. This increases states' efficiency to secure financial assets.

The FIDM/FAST Levy information collection activities are authorized by: 42 U.S.C. 652(l) which authorizes OCSE, through the Federal Parent Locator Service, to aid state child support agencies and financial institutions doing business in two or more states in reaching agreements regarding the receipt from financial institutions, and the transfer to the state child support agencies, of information pertaining to the location of accounts held by obligors who owe past-due support; 42 U.S.C. 666 (a)(2) and (c)(1)(G)(ii) which require state child support agencies in cases in which there is an arrearage to establish procedures to secure assets to satisfy any current support obligation and the