Disease (MIPCD) Demonstration; *Use:* Under section 4108(d)(1) of the Affordable Care Act, we are required to contract with an independent entity or organization to conduct an evaluation of the Medicaid Incentives for Prevention of Chronic Disease (MIPCD) demonstration. The contractor will conduct state site visits, two rounds of focus group discussions, interviews with key program stakeholders, and field a beneficiary satisfaction survey. Both the state site visits and interviews with key program stakeholders will entail one-on-one interviews; however each set will have a unique data collection form. Thus, each evaluation task listed above has a separate data collection form and this proposed information collection encompasses six data collection forms.

The purpose of the evaluation and assessment includes determining the following:

- The effect of such initiatives on the use of health care services by Medicaid beneficiaries participating in the program;
- The extent to which special populations (including adults with disabilities, adults with chronic illnesses, and children with special health care needs) are able to participate in the program;
- The level of satisfaction of Medicaid beneficiaries with respect to the accessibility and quality of health care services provided through the program; and
- The administrative costs incurred by state agencies that are responsible for administration of the program.

Subsequent to the initial OMB approval issued January 23, 2014, we have added two Administrative Cost forms to the information collection. The burden estimates for this information collection have been revised to account for the burden associated with the new forms.

Form Number: CMS–10477 (OMB control number: 0938–1219); *Frequency:* Annually; *Affected Public:* Individuals and households, business or other for-profits and not-for-profit institutions, State, Local or Tribal Governments; *Number of Respondents:* 4,706; *Total Annual Responses:* 4,706; *Total Annual Hours:* 2,236. (For policy questions regarding this collection contact Jean Scott at 410–786–6327.)

2. *Type of Information Collection Request:* Extension of currently approved collection; *Title of Information Collection:* Granting and Withdrawal of Deeming Authority to Private Nonprofit Accreditation Organizations and of State Exemption Under State Laboratory Programs and Supporting Regulations; *Use:* The information required is necessary to determine whether a private accreditation organization/State licensure program standards and accreditation/licensure process is at least equal to or more stringent than those of the Clinical Laboratory Improvement Amendments of 1988 (CLIA). If an accreditation organization is approved, the laboratories that it accredits are ''deemed'' to meet the CLIA requirements based on this accreditation. Similarly, if a State licensure program is determined to have requirements that are equal to or more stringent than those of CLIA, its laboratories are considered to be exempt from CLIA certification and requirements. The information collected will be used by HHS to: Determine comparability/equivalency of the accreditation organization standards and policies or State licensure program standards and policies to those of the CLIA program; to ensure the continued comparability/equivalency of the standards; and to fulfill certain statutory reporting requirements.

Form No.: CMS–R–185 (OMB control number: 0938–0686); *Frequency:* Occasionally; *Affected Public:* Private sector—business or other for-profits and not-for-profit institutions; *Number of Respondents:* 12; *Total Annual Responses:* 96; *Total Annual Hours:* 384. (For policy questions regarding this collection contact Arlene Lopez at 410–786–6782.)

3. *Type of Information Collection Request:* Reinstatement without change of a previously approved collection; *Title of Information Collection:* State Plan Preprint for Medicaid Recovery Audit Contractors (RACs); *Use:* Under section 1902(a)(42)(B)(i) of the Social Security Act, States are required to establish programs to contract with one or more Medicaid Recovery Audit Contractors (RACs) for the purpose of identifying underpayments and recouping overpayments under the State plan and any waiver of the State plan with respect to all services for which payment is made to any entity under such plan or waiver. Further, the statute requires States to establish programs to contract with Medicaid RACs in a manner consistent with State law, and generally in the same manner as the Secretary contracts with Medicare RACs. State programs contracted with Medicaid RACs were not required to be fully operational until after December 31, 2010. States may submit, to CMS, a State Plan Amendment (SPA) attesting that they will establish a Medicaid RAC program. States have broad discretion regarding the Medicaid RAC program design and the number of entities with which they elect to contract. Many States already have experience utilizing contingency-fee-based Third Party Liability recovery contractors.

Form Number: CMS–10343 (OMB control number: 0938–1126); *Frequency:* Once; *Affected Public:* State, Local, or Tribal Governments; *Number of Respondents:* 56; *Total Annual Responses:* 56; *Total Annual Hours:* 56. (For policy questions regarding this collection contact Yolanda Green at 410–786–0798.)

Dated: July 15, 2014.

Martique Jones,

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

[FR Doc. 2014–16960 Filed 7–17–14; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–3287–FN]

Medicare and Medicaid Programs; Initial Approval of The Compliance Team's (TCT's) Rural Health Clinic (RHC) Accreditation Program

AGENCY: Centers for Medicare and Medicaid Services, HHS.

ACTION: Final notice.

SUMMARY: This final notice announces our decision to approve The Compliance Team (TCT) for initial recognition as a national accrediting organization for Rural Health Clinics (RHCs) that wish to participate in the Medicare or Medicaid programs.

DATES: This final notice is effective July 18, 2014 through July 18, 2018.

FOR FURTHER INFORMATION CONTACT: Valarie Lazerowich, (410) 786–4750, Cindy Melanson, (410) 786–0310, or Patricia Chmielewski, (410) 786–6899.

SUPPLEMENTARY INFORMATION:

I. Background

Under the Medicare program, eligible beneficiaries may receive covered services in a RHC provided certain requirements are met. Section 1861(aa) and 1905(l)(1) of the Social Security Act (the Act) establishes distinct criteria for facilities seeking designation as a RHC. The minimum requirements that a RHC must meet to participate in Medicare are set forth in regulation at 42 CFR part 491, subpart A. The conditions for Medicare payment for RHCs are set forth at 42 CFR 405, subpart X. 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.

For an RHC to enter into a provider agreement with the Medicare program, the RHC must first be certified by a state survey agency as complying with the conditions or requirements set forth in section 1861(aa) of the Act and 42 CFR part 491. Thereafter, the RHC 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. Certification by a nationally recognized accreditation program can substitute for ongoing state review.

Section 1865(a)(1) of the Act provides that, if a provider entity demonstrates through accreditation by an approved national accrediting organization (AO) that all applicable Medicare conditions are met or exceeded, we will deem those provider entities as having met the requirements. Accreditation by an AO is voluntary and is not required for Medicare participation.

If an AO is recognized by the Secretary of the Department of Health and Human Services (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 have met the Medicare conditions. A national AO applying for approval of its accreditation program under part 488, subpart A, must provide us with reasonable assurance that the AO requires the accredited provider entities to meet requirements that are at least as stringent as the Medicare conditions. Our regulations concerning the approval of AOs are set forth at § 488.4 and § 488.8(d)(3).

II. Application Approval Process

Section 1865(a)(3)(A) of the Act provides a statutory timetable to ensure that our review of applications for CMS-approval of an accreditation program is conducted in a timely manner. The Act provides us 210 days after the date of receipt of a complete application, with any documentation necessary to make the determination, to complete our survey activities and application process. Within 60 days after receiving a complete application, we must publish a notice in the **Federal Register** that identifies the national accrediting body making the request, describes the request, and provides no less than a 30-day public comment period. At the end of the 210-day period, we must publish a notice in the **Federal Register** approving or denying the application.

III. Provisions of the Proposed Notice

On February 24, 2014, we published a proposed notice in the **Federal Register** (79 FR 10162) announcing TCT's request for approval of its RHC accreditation program. In the proposed notice, we detailed our evaluation criteria. Under section 1865(a)(2) of the Act and in our regulations at § 488.4 and § 488.8, we conducted a review of TCT's application in accordance with the criteria specified by our regulations, which include, but are not limited to the following:

- An onsite administrative review of TCT's: (1) Corporate policies; (2) financial and human resources available to accomplish the proposed surveys; (3) procedures for training, monitoring, and evaluation of its surveyors; (4) ability to investigate and respond appropriately to complaints against accredited facilities; and, (5) survey review and decision-making process for accreditation.
- The comparison of TCT's accreditation requirements to our current Medicare RHC conditions for certification.
- A documentation review of TCT's survey process to determine the following:

++ Determine the composition of the survey team, surveyor qualifications, and TCT's ability to provide initial and continuing surveyor training.

++ Compare TCT's processes to those of state survey agencies, including survey frequency, and the ability to investigate and respond appropriately to complaints against accredited facilities.

++ Evaluate TCT's procedures for monitoring RHCs out of compliance with TCT's program requirements. The monitoring procedures are used only when TCT identifies non-compliance. If non-compliance is identified by the state survey agency through validation surveys, the state survey agency monitors corrections as specified at § 488.7(d).

++ Assess TCT's ability to report deficiencies to the surveyed facilities and respond to the facility's plan of correction in a timely manner.

++ Establish TCT's ability to provide us with electronic data and reports necessary for effective validation and assessment of the organization's survey process.

++ Determine the adequacy of TCT's staff and other resources.

++ Confirm TCT's ability to provide adequate funding for performing required surveys.

++ Confirm TCT's policies with respect to whether surveys are announced or unannounced.

++ Obtain TCT's agreement to provide CMS with a copy of the most current accreditation survey together with any other information related to the survey as we may require, including corrective action plans.

In accordance with section 1865(a)(3)(A) of the Act, the February 24, 2014 proposed notice also solicited public comments regarding whether TCT's requirements met or exceeded the Medicare conditions for certification for RHCs. We received eight comments in response to our proposed notice. All of the comments received expressed unanimous support for TCT's RHC accreditation program.

IV. Provisions of the Final Notice

A. Differences Between TCT's Standards and Requirements for Accreditation and Medicare's Conditions and Survey Requirements

We compared TCT's RHC requirements and survey process with the Medicare conditions for certification and survey process as outlined in the State Operations Manual (SOM). Our review and evaluation of TCT's RHC application, which were conducted as described in section III of this final notice, yielded the following:

- To meet the requirements at § 491.2, TCT revised its standards to include the definition of ''Secretary'' and ''Rural Area.''
- To meet the requirements at § 491.5(a)(3), TCT revised its standards to address the requirement that RHCs can be both permanent and mobile units.
- To meet the requirements at § 491.5(d)(1)(i), TCT revised its standards to ensure the requirements related to designation of a shortage area included the ratio of primary care physicians practicing within the area to the resident population.
- To meet the requirements at § 491.7(b)(2)–(3), TCT revised its crosswalk to include standards concerning the disclosure of the names and addresses of the person principally responsible for directing the operation of the clinic or center and the person responsible for medical direction.
- To meet the requirements at § 491.8(a)(1), TCT revised its standards to address the requirement to have one or more physicians and one or more physician's assistants or nurse practitioners.
- To meet the requirements at § 491.8(b)(1)(iii), TCT revised its standards address the role of the

physician in providing medical orders and medical care services to patients of the clinic or center.

• To meet the requirements at § 491.9(b)(4), TCT revised its standards to address the requirement that patient care policies are reviewed at least annually, and as necessary by the clinic or center.

• To meet the requirements at § 491.9(c)(2), TCT revised its standards to ensure laboratory services are provided in accordance with the requirements at 42 CFR Part 493 and Section 353 of the Public Health Service Act.

• To meet the requirements at § 491.9(d)(1), TCT revised its standards to require the clinic or center have an agreement or arrangement with one or more providers or suppliers participating under Medicare or Medicaid to furnish other services to its patients.

• TCT developed an action plan to ensure compliance with its own policies regarding RHCs receiving the correct accreditation date on their notice of survey results.

• To meet the requirements at § 488.4(a)(6), TCT revised its policies to ensure timeframes for investigation of complaints are comparable with the requirements in section 5075.9 of the State Operations Manual.

• To meet the requirements at § 489.13(b), TCT revised its policies to clarify that the effective date of the agreement or approval is determined by the CMS Regional Office and may not be earlier than the latest of the dates of which CMS determines that all applicable federal requirements are met. TCT revised all Clinic Advisor On-Site Worksheets to include a descriptive title for the requirement of each worksheet for increased clarity.

B. Term of Approval

Based on our review and observations described in section III of this final notice, we have determined that TCT's RHC accreditation program requirements meet or exceed our requirements. Therefore, we approve TCT as a national accreditation organization for RHCs that request participation in the Medicare program, effective July 18, 2014 through July 18, 2018.

V. Collection of Information Requirements

This document does not impose information collection requirements, that is, reporting, recordkeeping or third-party disclosure requirements. Consequently, there is no need for review by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995.

Dated: July 8, 2014.

Marilyn Tavenner,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2014–16735 Filed 7–17–14; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Proposed Information Collection Activity; Comment Request

Proposed Projects

Title: Child Care Quarterly Case Record Report—ACF–801.

OMB No.: 0970–0167.

Description: Section 658K of the Child Care and Development Block Grant Act of 1990 (P.L. 101–508, 42 U.S.C. 9858) requires that States and Territories submit monthly case-level data on the children and families receiving direct services under the Child Care and Development Fund. The implementing regulations for the statutorily required reporting are at 45 CFR 98.70. Case-level reports, submitted quarterly or monthly (at grantee option), include monthly sample or full population case-level data. The data elements to be included in these reports are represented in the ACF–801. ACF uses disaggregate data to determine program and participant characteristics as well as costs and levels of child care services provided. This provides ACF with the information necessary to make reports to Congress, address national child care needs, offer technical assistance to grantees, meet performance measures, and conduct research. Consistent with the statute and regulations, ACF requests extension of the ACF–801 without changes.

Respondents: States, the District of Columbia, and Territories including Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Northern Marianna Islands.

ANNUAL BURDEN ESTIMATES

Instrument	Number of respondents	Number of responses per respondent	Average burden hours per response	Total burden hours
ACF–801	56	4	25	5,600

Estimated Total Annual Burden Hours: 5,600.

In compliance with the requirements of Section 506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Administration for Children and Families is soliciting public comment on the specific aspects of the information collection described above. Copies of the proposed collection of information can be obtained and comments may be forwarded by writing to the Administration for Children and Families, Office of Planning, Research and Evaluation, 370 L'Enfant Promenade SW., Washington, DC 20447, Attn: ACF Reports Clearance Officer. Email address: *infocollection@acf.hhs.gov*. All requests should be identified by the title of the information collection.

The Department specifically requests comments on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection of information; (c) the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology. Consideration will be given to