

care provided to Medicaid beneficiaries enrolled in Medicaid/CHIP MCOs. States use the information during their oversight of these organizations. *Form Number:* CMS–R–305 (OMB control number 0938–0786); *Frequency:* Yearly; *Affected Public:* State, Local, or Tribal Governments; *Number of Respondents:* 43; *Total Annual Responses:* 76; *Total Annual Hours:* 451,288. (For policy questions regarding this collection contact Barbara Dailey at 410–786–9012).

3. *Type of Information Collection Request:* New collection (Request for a new OMB control number); *Title of Information Collection:* Federally Qualified Health Center Cost Report Form; *Use:* Providers of services participating in the Medicare program are required under sections 1815(a) and 1861(v)(1)(A) of the Act (42 U.S.C. 1395g) to submit annual information to achieve settlement of costs for health care services rendered to Medicare beneficiaries. In addition, regulations at 42 CFR 413.20 and 413.24 require adequate cost data and cost reports from providers on an annual basis. The form CMS–224–14 cost report is needed to determine a provider's reasonable costs incurred in furnishing medical services to Medicare beneficiaries and reimbursement due to or from a provider. *Form Number:* CMS–224–14 (OMB control number 0938–New); *Frequency:* Yearly; *Affected Public:* Private sector—For-profit and Not-for-profit institutions; *Number of Respondents:* 1,296; *Total Annual Responses:* 1,296; *Total Annual Hours:* 75,168. (For policy questions regarding this collection contact Julie Stankivic at 410–786–5725).

Dated: December 16, 2014.

Martique Jones,

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

[FR Doc. 2014–29741 Filed 12–18–14; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–3307–PN]

Medicare and Medicaid Programs: Application from the Joint Commission for Continued CMS-Approval of its Hospice Accreditation Program

AGENCY: Centers for Medicare & Medicaid Services, HHS.

ACTION: Proposed Notice.

SUMMARY: This proposed notice with comment period acknowledges the receipt of an application from the Joint Commission for continued recognition as a national accrediting organization for hospices that wish to participate in the Medicare or Medicaid programs. A hospice that participates in Medicaid must also meet the Medicare conditions for participation as required under 42 CFR 488.6(b). The statute requires that within 60 days of receipt of an organization's complete application, we 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 January 19, 2015.

ADDRESSES: In commenting, please refer to file code CMS–3307–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–3307–PN, P.O. Box 8010, 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 (one original and two copies) to the following address only:

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–3307–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, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, DC 20201

(Because access to the interior of the HHS 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

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
Cindy Melanson, (410) 786–0310
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 in a hospice provided certain requirements are met by the hospice. Sections 1861(dd) of the Social Security Act (the Act) establish distinct criteria for facilities seeking designation as a hospice. 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 418, specify the conditions that a hospice must meet in order to participate in the Medicare program, the scope of covered services and the conditions for Medicare payment for hospices.

Generally, to enter into an agreement, a hospice must first be certified by a State survey agency as complying with the conditions or requirements set forth in part 418. Thereafter, the hospice 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 of the Department of Health and Human Services (the Secretary) as having standards for accreditation that meet or exceed the 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 deeming authority under part 488, subpart A must provide CMS 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 reapproval 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 deeming authority every 6 years or sooner as determined by CMS.

The Joint Commission's current term of approval for its hospice accreditation program expires June 18, 2015.

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 us 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 CMS approval of its hospice accreditation program. This notice also solicits public comment on whether the Joint Commission's requirements meet or exceed the Medicare conditions for participation for hospices.

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 hospice accreditation program. This application was determined to be complete on September 25, 2014. 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 hospices as compared with CMS' hospice conditions of participation.

- The Joint Commission's survey process to determine the following:

- ++ The Joint Commission's composition of the survey team, surveyor qualifications, and the ability of the organization to provide continuing surveyor training.

- ++ The Joint Commission's processes compared 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 a hospice 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, 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 Joint Commission's staff adequacy 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 us 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).

IV. 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.

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.

Dated: December 3, 2014.

Marilyn Tavenner,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2014–29757 Filed 12–18–14; 8:45 am]

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