

individual health insurance market or Medigap market will be required to file with the Centers for Medicare & Medicaid Services (CMS). The Notice of Research Exception under the Genetic Information Nondiscrimination Act is a model notice that can be completed by group health plans and health insurance issuers and filed with either the Department of Labor or CMS to comply with the notification requirement. *Form Number:* CMS-10286 (OCN: 0938-1077); *Frequency:* On Occasion; *Affected Public:* state, Local, or Tribal Governments, Private Sector; *Number of Respondents:* 2; *Number of Responses:* 2; *Total Annual Hours:* 0.5. (For policy questions regarding this collection, contact Usree Bandyopadhyay at 410-786-6650. For all other issues call (410) 786-1326.)

3. *Type of Information Collection Request:* Revision of a currently approved collection. *Title of Information Collection:* Parts C and D Complaints Resolution Performance Measures. *Use:* CMS seeks to conduct a survey as part of the Part C and D Complaints Resolution Performance Measure project. The purpose of the project is to develop and support implementation of internal monitoring tools for the Medicare Advantage (Part C) and Prescription Drug (Part D) program that represents, from the beneficiary's perspective, the way in which plans handle complaints. The data collection is necessary because a survey is the only way to collect information about the resolution process from the beneficiary's perspective. Currently, there is no other data source that collects such information for Part C and Part D Medicare plans. *Form Number:* CMS-10308 (OCN 0938-1107). *Frequency:* Yearly. *Affected Public:* Individuals or households. *Number of Respondents:* 18,210. *Total Annual Responses:* 18,210. *Total Annual Hours:* 3,035. (For policy questions regarding this collection contact Carolyn Scott at 410-786-1190. For all other issues call 410-786-1326.)

4. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Pre-Existing Health Insurance Plan and Supporting Regulations; *Use:* On March 23, 2010, the President signed into law H.R. 3590, the Patient Protection and Affordable Care Act (Affordable Care Act), Public Law 111-148. Section 1101 of the law establishes a "temporary high risk health insurance pool program" (which has been named the Pre-Existing Condition Insurance Plan, or PCIP) to provide health insurance coverage to currently uninsured individuals with

pre-existing conditions. The law authorizes HHS to carry out the program directly or through contracts with states or private, non-profit entities.

We are requesting an extension of this package because this information is needed to assure that PCIP programs are established timely and effectively. This request is being made based on regulations and guidance that have been issued and contracts which have been executed by HHS with states or an entity on their behalf participating in the PCIP program. PCIP is also referred to as the temporary qualified high risk insurance pool program, as it is called in the Affordable Care Act, but we have adopted the term PCIP to better describe the program and avoid confusion with the existing state high risk pool programs. *Form Number:* CMS-10339 (OMB#: 0938-1100); *Frequency:* Reporting—On occasion; *Affected Public:* state governments; *Number of Respondents:* 51; *Total Annual Responses:* 2,652; *Total Annual Hours:* 36,924. (For policy questions regarding this collection contact Laura Dash at 410-786-8623. 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.

In commenting on the proposed information collections please reference the document identifier or OMB control number. To be assured consideration, comments and recommendations must be submitted in one of the following ways by July 2, 2013:

1. *Electronically.* You may submit your comments electronically to <http://www.regulations.gov>. Follow the instructions for "Comment or Submission" or "More Search Options" to find the information collection document(s) accepting comments.

2. *By regular mail.* You may mail written comments to the following address: CMS, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development Attention: Document Identifier/OMB Control Number ____ Room C4-26-05, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

Dated: April 30, 2013.

Martique Jones,

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

[FR Doc. 2013-10522 Filed 5-2-13; 8:45 am]

BILLING CODE 4120-01-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS-3110-PN]

Medicare and Medicaid Programs: Application From the Accreditation Commission for Health Care for Continued CMS-Approval of Its Hospice 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 Accreditation Commission for Health Care (ACHC) for continued recognition as a national accrediting organization for hospices 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 June 3, 2013.

ADDRESSES: In commenting, please refer to file code CMS-3110-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-3110-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-3110-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.)

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.

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:

Valarie Lazerowich, (410) 786–4750.

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. Section 1861(dd) of the Social Security Act (the Act), establishes distinct criteria for facilities seeking designation as a hospice. 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 418, specify the conditions that a hospice must meet 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 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 Accreditation Commission for Health Care's (ACHC's) current term of approval for its hospice accreditation program expires November 27, 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 ACHC's request for continued CMS approval of its hospice accreditation program. This notice also solicits public comment on whether ACHC's requirements meet or exceed the Medicare conditions of participation for hospices.

III. Evaluation of Deeming Authority Request

ACHC submitted all of 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 April 26, 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 ACHC will be conducted in accordance with, but not necessarily limited to, the following factors:

- The equivalency of ACHC's standards for hospices as compared with CMS' hospice conditions of participation.
- ACHC's survey process to determine the following:
 - ++ ACHC's composition of the survey team, surveyor qualifications, and the ability of the organization to provide continued surveyor training.
 - ++ ACHC's processes compared to those of State agencies, including survey frequency, and the ability to investigate and respond appropriately to complaints against accredited facilities.
 - ++ ACHC's processes and procedures for monitoring a hospice found out of

compliance with ACHC's program requirements. These monitoring procedures are used only when ACHC identifies noncompliance. If noncompliance is identified through validation reviews or complaint surveys, the State survey agency monitors corrections as specified at § 488.7(d).

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

++ ACHC's capacity to provide CMS with electronic data and reports necessary for effective validation and assessment of the organization's survey process.

++ ACHC's staff adequacy and other resources, and its financial viability.

++ ACHC's capacity to adequately fund required surveys.

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

++ ACHC'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 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: April 19, 2013.

Marilyn Tavenner,

Acting Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2013-10421 Filed 5-2-13; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS-9079-N]

Medicare and Medicaid Programs; Quarterly Listing of Program Issuances—January Through March 2013

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

ACTION: Notice.

SUMMARY: This quarterly notice lists CMS manual instructions, substantive and interpretive regulations, and other **Federal Register** notices that were published from January through March 2013, relating to the Medicare and Medicaid programs and other programs administered by CMS.

FOR FURTHER INFORMATION CONTACT: It is possible that an interested party may need specific information and not be able to determine from the listed information whether the issuance or regulation would fulfill that need. Consequently, we are providing contact persons to answer general questions concerning each of the addenda published in this notice.

Addenda	Contact	Phone Number
I CMS Manual Instructions	Ismael Torres	(410) 786-1864
II Regulation Documents Published in the Federal Register	Terri Plumb	(410) 786-4481
III CMS Rulings	Tiffany Lafferty	(410) 786-7548
IV Medicare National Coverage Determinations	Wanda Belle	(410) 786-7491
V FDA-Approved Category B IDEs	John Manlove	(410) 786-6877
VI Collections of Information	Mitch Bryman	(410) 786-5258
VII Medicare—Approved Carotid Stent Facilities	Lori Ashby	(410) 786-6322
VIII American College of Cardiology-National Cardiovascular Data Registry Sites	Marie Casey, BSN, MPH	(410) 786-7861
IX Medicare's Active Coverage-Related Guidance Documents	Lori Ashby	(410) 786-6322
X One-time Notices Regarding National Coverage Provisions	Lori Ashby	(410) 786-6322
XI National Oncologic Positron Emission Tomography Registry Sites	Stuart Caplan, RN, MAS	(410) 786-8564
XII Medicare-Approved Ventricular Assist Device (Destination Therapy) Facilities	Marie Casey, BSN, MPH	(410) 786-7861
XIII Medicare-Approved Lung Volume Reduction Surgery Facilities	Marie Casey, BSN, MPH	(410) 786-7861
XIV Medicare-Approved Bariatric Surgery Facilities	Kate Tillman, RN, MAS	(410) 786-9252
XV Fluorodeoxyglucose Positron Emission Tomography for Dementia Trials	Stuart Caplan, RN, MAS	(410) 786-8564
All Other Information	Annette Brewer	(410) 786-6580

I. Background

The Centers for Medicare & Medicaid Services (CMS) is responsible for administering the Medicare and Medicaid programs and coordination and oversight of private health insurance. Administration and oversight of these programs involves the following: (1) Furnishing information to Medicare and Medicaid beneficiaries,

health care providers, and the public; and (2) maintaining effective communications with CMS regional offices, state governments, state Medicaid agencies, state survey agencies, various providers of health care, all Medicare contractors that process claims and pay bills, National Association of Insurance Commissioners (NAIC), health insurers, and other stakeholders. To implement the various

statutes on which the programs are based, we issue regulations under the authority granted to the Secretary of the Department of Health and Human Services under sections 1102, 1871, 1902, and related provisions of the Social Security Act (the Act) and Public Health Service Act. We also issue various manuals, memoranda, and statements necessary to administer and oversee the programs efficiently.