within 30 days of publication. Written comments and recommendations for the proposed information collection should be sent directly to the following:

Office of Management and Budget, Paperwork Reduction Project. Fax: 202–395–7285. E-mail: *OIRA_SUBMISSION@OMB.EOP.GOV.* Attn: Desk Officer for the Administration for Children and Families.

Dated: July 21, 2010.

Robert Sargis,

Reports Clearance Officer.

[FR Doc. 2010–18171 Filed 7–23–10; 8:45 am]

BILLING CODE 4184–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–2336–PN]

Medicare and Medicaid Programs; Application by Det Norske Veritas Healthcare for Deeming Authority for Critical Access Hospitals (CAHs)

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

ACTION: Proposed notice.

SUMMARY: This proposed notice with comment period acknowledges the receipt of an application from Det Norske Veritas Healthcare (DNVHC) for recognition as a national accrediting organization for critical access hospitals (CAHs) that wish to participate in the Medicare or Medicaid programs.

Section 1865(a)(3)(A) of the Social Security Act 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 August 25, 2010.

ADDRESSES: In commenting, please refer to file code CMS–2336–PN. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

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

1. *Electronically.* You may submit electronic comments on this regulation 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–2336–PN, P.O. Box 8016, Baltimore, MD 21244–8016.

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–2336–PN, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments before the close of the comment period to either of 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, please call telephone number (410) 786–7195 in advance to schedule your arrival with one of our staff members.

Comments 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: Lillian Williams, (410) 786–8636. 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 from a Critical Access Hospital (CAH), provided certain requirements are met. Sections 1820(c)(2)(B) and 1861(mm) of the Social Security Act (the Act) establish distinct criteria for facilities seeking designation as a CAH. Regulations concerning provider agreements are in 42 CFR part 489 and those pertaining to activities relating to the survey and certification of facilities are in 42 CFR part 488. The regulations at 42 CFR part 485, subpart F specify the conditions that a CAH must meet in order to participate in the Medicare program. The scope of covered services and the conditions for Medicare payment for CAHs are set forth at § 413.70.

Generally, in order to enter into a provider agreement with the Medicare program, a CAH must first be certified by a State survey agency as complying with the conditions or requirements set forth in part 485 of our CMS regulations. Thereafter, the CAH is subject to regular surveys by a State survey agency to determine whether it continues to meet these requirements. There is an alternative, however, to surveys by State agencies.

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 deeming authority under part 488, subpart A of our rules 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 re-approval 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.

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 re-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 DNVHC's request for CAH deeming authority. This notice also solicits public comment on whether DNVHC's requirements meet or exceed the Medicare CAH conditions of participation (CoPs).

III. Evaluation of Deeming Authority Request

DNVHC submitted all the necessary materials to enable us to make a determination concerning its request for approval as an accreditation organization for CAHs. This application was determined to be complete on June 3, 2010. Under section 1865(a)(2) of the Act and our regulations at § 488.8 (Federal review of accrediting organizations), our review and evaluation of DNVHC will be conducted in accordance with, but not necessarily limited to, the following factors:

- The equivalency of DNVHC's standards for a CAH as compared with CMS' CAH CoPs.
- DNVHC'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 DNVHC's processes to those of State agencies, including survey frequency, and the ability to investigate and respond appropriately to complaints against accredited facilities.
  + DNVHC's processes and procedures for monitoring CAHs found out of compliance with DNVHC's program requirements. These monitoring procedures are used only when DNVHC identifies noncompliance. If noncompliance is identified through validation reviews, the State survey agency monitors corrections as specified at § 488.7(d).
  + DNVHC's capacity to report deficiencies to the surveyed facilities and respond to the facility's plan of correction in a timely manner.
  + DNVHC's capacity to provide us with electronic data and reports necessary for effective validation and assessment of the organization's survey process.
  + The adequacy of DNVHC's staff and other resources, and its financial viability.
  + DNVHC's capacity to adequately fund required surveys.
  + DNVHC's policies with respect to whether surveys are announced or unannounced, to assure that surveys are unannounced.
  + NVHC'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. 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.

III. Collection of Information Requirements 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).

VI. Regulatory Impact Statement

In accordance with the provisions of Executive Order 12866, the Office of Management and Budget did not review this proposed notice.

In accordance with Executive Order 13132, we have determined that this proposed notice would not have a significant effect on the rights of States, local or tribal governments.

Authority: Section 1865 of the Social Security Act (42 U.S.C. 1395bb). (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: July 14, 2010.

Marilyn Tavenner,

Principal Deputy Administrator and Chief Operating Officer, Centers for Medicare & Medicaid Services.

[FR Doc. 2010–18371 Filed 7–23–10; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Center for Scientific Review; Notice of Closed Meetings

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 meetings.

The meetings 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