Dated: March 19, 2012.

Ron A. Otten,

Director, Office of Scientific Integrity, Office of the Associate Director for Science (OADS), Office of the Director, Centers for Disease Control and Prevention.

[FR Doc. 2012–7020 Filed 3–22–12; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–179 and CMS–R–74]

Agency Information Collection Activities: Submission for OMB Review; Comment Request

AGENCY: Centers for Medicare & Medicaid Services, HHS.

In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services, is publishing the following summary of proposed collections for public comment. Interested persons are invited to send comments regarding this burden estimate or any other aspect of this collection of information, including any of the following subjects: (1) The necessity and utility of the proposed information collection for the proper performance of the Agency's function; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

1. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* State Plan Under Title XIX of the Social Security Act (Base plan pages, Attachments, Supplements to attachments); *Use:* State Medicaid agencies complete the plan pages and CMS reviews the information to determine if the State has met all of the provisions that the State has chosen to implement. If the requirements are met, CMS will approve the amendments to the State's Medicaid plan giving the State the authority to implement the flexibilities. For a State to receive Medicaid Title XIX funding, there must be an approved Title XIX State plan. In addition to the revisions associated with the 60-day notice that published on December 16, 2011 (76 FR 78264), additional changes have been made to the Pre-Print (Attachment 4.19–B) subsequent to the publication of that notice; *Form Number:* CMS–179 (OCN 0938–0193); *Frequency:* Occasionally; *Affected Public:* State, Local, or Tribal Governments; *Number of Respondents:* 56; *Total Annual Responses:* 1,120; *Total Annual Hours:* 400. (For policy questions regarding this collection contact Falecia Smith at 202–260–5991. For all other issues call 410–786–1326.)

2. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Income and Eligibility Verification System (IEVS) Reporting and Supporting Regulations Contained in 42 CFR 431.17, 431.306, 435.910, 435.920, and 435.940–960; *Use:* The information collected is used to verify the income and eligibility of Medicaid applicants and recipients, as required by section 1137 of the Social Security Act. Under Section 1137, States must request applicants' Social Security Numbers and use that number to verify the income and eligibility information contained on each application through data matches with specified agencies and entities. The State must use information collected by unemployment compensation agencies and the Internal Revenue Service to the extent useful.

The Qualifying Individual Program Supplemental Funding Act of 2008 amended section 1903(r) of the Social Security Act to incorporate the requirement that States include data matching through the Public Assistance Reporting Information System (PARIS) in their Income and Eligibility Verification Systems (IEVS). PARIS is a system for matching data from certain public assistance programs, including State Medicaid programs, with selected Federal and State data for purposes of facilitating appropriate enrollment and retention in public programs. States are required to sign an agreement to participate in PARIS as a condition of receiving Medicaid funding for automated data systems (including the Medicaid Management Information System).

States can use the PARIS data match to ensure that individuals enrolled in Medicaid or other public assistance benefits in one State are not receiving duplicate benefits based on simultaneous enrollment in the Medicaid program or other public benefit programs in another State. In certain circumstances, PARIS may also be used as a tool to identify individuals who have not applied for Medicaid coverage, but who may be eligible based on their income.

Subsequent to the publication of the 60-day notice that published on January 4, 2012 (77 FR 291), a State Plan Amendment template has been added to the PRA package and the burden estimate and Supporting Statement have been revised; *Form Number:* CMS–R–74 (OCN 0938–0467); *Frequency:* Monthly; *Affected Public:* State, Local, or Tribal Governments; *Number of Respondents:* 54; *Total Annual Responses:* 54; *Total Annual Hours:* 134,865. (For policy questions regarding this collection contact Barbara Washington at 410–786–9964. 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.

To be assured consideration, comments and recommendations for the proposed information collections must be received by the OMB desk officer at the address below, no later than 5 p.m. on April 23, 2012.

OMB, Office of Information and Regulatory Affairs, Attention: CMS Desk Officer, Fax Number: (202) 395–6974, Email: *OIRA_submission@omb.eop.gov*.

Dated: March 19, 2012.

Martique Jones,

Director, Regulations Development Group, Division-B, Office of Strategic Operations and Regulatory Affairs.

[FR Doc. 2012–7066 Filed 3–22–12; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–2901–FN]

Medicare and Medicaid Programs; Approval of the Application by the American Association for Accreditation of Ambulatory Surgery Facilities for Deeming Authority for Rural Health Clinics

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

ACTION: Final notice.

SUMMARY: This final notice announces our decision to approve the American Association for Accreditation of Ambulatory Surgery Facilities

(AAAASF) for recognition as a national accreditation program for rural health clinics (RHCs) seeking to participate in the Medicare or Medicaid programs.

DATES: *Effective Date:* This final notice is effective March 23, 2012 through March 23, 2016.

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

SUPPLEMENTARY INFORMATION:

I. Background

Under the Medicare program, eligible beneficiaries may receive covered services in a rural health clinic (RHC) provided certain requirements are met. Sections 1861(aa) and 1905(l) of the Social Security Act (the Act) establish distinct criteria for facilities seeking designation as an 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. Applicable regulations concerning provider agreements are located in 42 CFR part 489 and those pertaining to facility survey and certification are in 42 CFR part 488, subpart A.

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 part 491 of our regulations. Subsequently, the RHC is subject to ongoing review by a State survey agency to determine whether it continues to meet the Medicare conditions for certification. There is an alternative, however, to State compliance surveys. Certification by a nationally recognized accreditation program can substitute for ongoing State review.

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

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 calendar days after the date of receipt of a complete application, with any documentation necessary to make a 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 accreditation 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 October 28, 2011, we published a proposed notice in the **Federal Register** (76 FR 66929) announcing AAAASF'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 AAAASF'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 AAAASF'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.
- A comparison of AAAASF's RHC accreditation standards to our current Medicare RHC conditions for certification.
- A documentation review of AAAASF's survey processes to:

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

+ Compare AAAASF'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 AAAASF's procedures for monitoring providers or suppliers found to be out of compliance with AAAASF's program requirements. The monitoring procedures are used only when AAAASF identifies noncompliance. If noncompliance is identified through validation reviews, the State survey agency monitors corrections as specified at § 488.7(d).

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

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

+ Determine the adequacy of staff and other resources.

+ Review AAAASF's ability to provide adequate funding for performing required surveys.

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

+ Obtain AAAASF'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.

In accordance with section 1865(a)(3)(A) of the Act, the October 28, 2011 proposed notice also solicited public comments regarding whether AAAASF's requirements met or exceeded the Medicare conditions for certification for RHCs We received no comments in response to our proposed notice.

IV. Provisions of the Final Notice

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

We compared AAAASF's RHC accreditation 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 AAAASF'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, AAAASF revised its crosswalk to ensure all RHC definitions contained correct regulatory text.
- To meet the staffing requirements at § 491.8(a)(2), AAAASF revised its standards to ensure the physician member of the RHC staff carries out the responsibilities set out at § 491.8(b).
- To meet the requirements at § 491.9(a)(3), AAAASF revised its standards to ensure the RHC provides the required laboratory services.
- To meet the requirements at § 488.4, AAAASF revised its policies to ensure its surveyors are appropriately qualified and trained.

• To meet the requirements at section 2008D of the SOM, AAAASF revised its policies related to the accreditation effective date.

• To meet the requirements at section 2200F of the SOM, AAAASF revised its policies to ensure their surveys are complete, accurate, and consistent.

• To meet the requirements at section 2700A of the SOM, AAAASF revised its policies to ensure all RHC surveys are conducted unannounced.

• To meet the requirements at section 2704 of the SOM, AAAASF revised its RHC Accreditation Facility Handbook to include pre-survey preparation requirements.

• To meet the requirements at section 2728 of the SOM, AAAASF modified its policies regarding timeframes for sending and receiving a plan of correction.

• To meet the requirements at section 3010 of the SOM, AAAASF revised its policies on immediate jeopardy.

• To meet the requirements at chapter five of the SOM, AAAASF revised its policies to ensure all complaints are appropriately triaged, investigated and resolved.

• To meet the requirements at Exhibit 7 of the SOM, AAAASF revised its policies to ensure survey deficiencies are cited at the appropriate level based on the surveyor documentation.

• To verify AAAASF's continued compliance with the provisions of this final notice, CMS will conduct a follow-up survey observation within 1 year of the date of publication of this notice.

B. Term of Approval

Based on our review and observations described in section III of this final notice, we have determined that AAAASF's requirements for RHCs meet or exceed our requirements. Therefore, we approve AAAASF as a national accreditation organization for RHCs that request participation in the Medicare program, effective March 23, 2012 through March 23, 2016.

V. 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).

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program)

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: March 8, 2012.

Marilyn Tavenner,

Acting Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2012–6331 Filed 3–22–12; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–3258–PN]

Medicare and Medicaid Programs; Application From Det Norske Veritas Healthcare (DNVHC) for Continued Approval of Its Hospital Accreditation Program

AGENCY: Centers for Medicare and Medicaid Services, HHS.

ACTION: Proposed notice.

SUMMARY: This proposed notice with comment period acknowledges the receipt of an application from Det Norske Veritas Healthcare (DNVHC) for continued recognition as a national accrediting organization for hospitals 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 April 23, 2012.

ADDRESSES: In commenting, please refer to file code CMS–3258–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 ''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–3258–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 (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–3258–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: Barbara Easterling (410) 786–0482, Patricia Chmielewski, (410) 786–6899, or Cindy Melanson, (410) 786–0310.

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,