We, along with the healthcare industry, believe that the availability to the facility of the type of records and general content of records is standard medical practice and is necessary in order to ensure the well-being and safety of patients and professional treatment accountability. *Form Number:* CMS–10266 (OCN: 0938–1069); *Frequency:* Yearly; *Affected Public:* Business or other for-profits and Not-for-profit institutions; *Number of Respondents:* 226; *Total Annual Responses:* 528; *Total Annual Hours:* 2,523. (For policy questions regarding this collection contact Diane Corning at 410–786–8486.)

Dated: September 10, 2013.

Martique Jones,

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

[FR Doc. 2013–22329 Filed 9–12–13; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–9953–PN]

Health Insurance Exchanges; Application by the Accreditation Association for Ambulatory Health Care To Be a Recognized Accrediting Entity for the Accreditation of Qualified Health Plans

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

ACTION: Notice.

SUMMARY: This notice announces the receipt of an application from the Accreditation Association for Ambulatory Health Care (AAAHC) to be a recognized accrediting entity for the purposes of fulfilling the accreditation requirement as part of qualified health plan (QHP) certification. Regulations require HHS to publish a notice identifying the accrediting entity, summarizing its analysis of whether the accrediting entity meets certain criteria, and providing no less than 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 October 15, 2013.

ADDRESSES: In commenting, please refer to file code CMS–9953–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 to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–9953–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 to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–9953–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) 786–9994 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 FURTHER INFORMATION CONTACT: Rebecca Zimmermann, at (301) 492–4396.

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

Regulations at 45 CFR 156.275 require qualified health plan (QHP) issuers to be accredited on the basis of local performance of its QHPs by an accrediting entity recognized by the Department of Health and Human Services (HHS). In a final rule published on July 20, 2012,[1] we established the first phase of an intended two-phase approach to recognize accrediting entities and proposed both the National Committee for Quality Assurance (NCQA) and URAC as recognized accrediting entities. On November 23, 2012, we notified the public that NCQA and URAC had both met the requirements in the final rule to be recognized as an accrediting entity (77 FR 42662 through 42668) and were recognized by the Secretary[2] as accrediting entities for the purposes of QHP certification.

On February 25, 2013, we published a subsequent final rule title, ''Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation (78 FR 1283),''[3] which amended § 156.275(c) to establish an application and review process to allow additional

[1] Patient Protection and Affordable Care Act; Data Collection To Support Standards Related to Essential Health Benefits; Recognition of Entities for the Accreditation of Qualified Health Plans Final Rule 77 FR 42658, 42662–42668 (July 20, 2012) (45 CFR 156.275(c)).

[2] Certain authority under the Affordable Care Act has been delegated from the Secretary to the Administrator of CMS., 76 FR 53903 through 53906, (Aug. 30, 2011).

[3] Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation; Final Rule, 78 FR 12834, 12854–12855 (February 25, 2013)(45 CFR 156.275(c)).

accrediting entities to seek recognition. The application submitted by an accrediting entity must include documentation described in § 156.275(c)(4) and demonstrate, in a concise and organized fashion how the accrediting entity meets the requirements of § 156.275 (c)(2) and (3). Specifically, to be recognized, an accrediting entity must provide current accreditation standards and requirements, processes and measure specifications for performance measures to demonstrate via a crosswalk that it meets the conditions described in § 156.275 (c)(2) and (c)(3). Further, once recognized, § 156.275(c)(4)(ii) requires accrediting entities to provide the Secretary with any proposed changes or updates to the accreditation standards and requirements, processes, and measure specifications for performance measures with 60 days' notice prior to public notification. Lastly, § 156.275(c)(5) requires recognized accrediting entities, when authorized by an accredited QHP issuer, to provide specific QHP issuer accreditation survey data elements to the Exchange.

II. Provisions of the Notice

The purpose of this notice is to notify the public of the Accreditation Association for Ambulatory Health Care's (AAAHC) request for recognition by the Secretary as an accrediting entity for the purposes of QHP certification. As part of the application, AAAHC submitted all the required documentation materials described in § 156.275(c)(4). Below we present, our analysis of whether AAAHC meets the criteria described in paragraphs § 156.275 (c)(2) and (3).

1. Summary of CMS's Analysis

We are providing the public with an analysis of AAAHC's completed application, including a review of the current accreditation standards and requirements, processes and measure specifications for performance measures, submitted by AAAHC. Currently, AAAHC is an accrediting body that has a CMS-approved accreditation program to conduct surveys for ambulatory surgery centers that wish to participate in the Medicare program with deemed status. The AAAHC has also obtained approval from CMS as a deeming entity allowing it to survey Medicare Advantage plans.[4] The current scope of accreditation as described in AAAHC's 2013 Accreditation Handbook for Health Plans demonstrates that AAAHC will be providing accreditation of QHPs within the statutorily required categories,[5] established in § 156.275(c), including reporting on a set of clinical quality measures and patient experience ratings on a standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey; consumer access; utilization management; quality assurance; provider credentialing; complaints and appeals; network adequacy and access; and patient information programs.

In addition, CMS evaluated AAAHC's standards relating to network adequacy and consider them to be consistent with the general requirements for network adequacy for QHP issuers (45 CFR 156.230(a)(2) and (3)). To determine health plans' compliance with network adequacy standards, the AAAHC accreditation survey includes review of areas such as member choice of providers, member satisfaction with relation to provider access, availability of services, provider network credentialing and customer complaints, appeals, and satisfaction information.

Upon review of the clinical quality measures included in AAAHC's accreditation standards, we have assessed that the measures cover a range of conditions and domains, include adult and child-specific measures, align with the priorities in the National Strategy for Quality Improvement in Health Care, are developed or adopted by the National Quality Forum (NQF) or are in common use for health plan quality measurement, and meet health plan industry standards and are evidence-based, as required in § 156.275(c)(2)(ii). The following list displays the clinical quality measures that will be used for QHP accreditation by AAAHC, spanning preventive care, behavioral health and substance abuse disorders, chronic care, and acute care:

Measure	NQF reference No.	Measure develop/steward
Mandatory Measures		
Proportion of Days Covered (Drug Therapy Adherence)	0541	Pharmacy Quality Alliance (PQA).
Provider Network Adequacy—Number of Specialists Accepting New Patients At End of Reporting Period by Specialist Type.	n/a	Centers for Medicare and Medicaid Services (CMS).
Dyslipidemia New Medication 12-Week Testing	n/a	Resolution Health, Inc.
Drug-Drug Interactions	n/a	PQA.
Diabetes Short Term Complications Event Rate	0272	Adapted by URAC from Agency for Healthcare Quality and Research (AHRQ) measure.
Diabetes Long Term Complications Admission Rate	0274	Adapted by URAC from AHRQ measure.
Adult Asthma Event Rate	0283	Adapted by URAC from AHRQ measure.
Pediatric Asthma Event Rate	n/a	Adapted by URAC from AHRQ measure.
Mandatory/Equivalent Measures		
Atherosclerotic Disease—Lipid Panel Monitoring	0616	Active Health Management.
Diabetes All-Or-None Process Measure (HbA1c, LDL–C, Nephropathy).	n/a	Wisconsin Collaborative for Healthcare Quality.
Provider Network Adequacy—Primary Care	n/a	CMS.
Medication Therapy For Patients With Asthma: Suboptimal Asthma Control (SAC), and Absence of Controller Therapy (ACT).	0548	PQA.
Call Center Performance	n/a	URAC.
Percentage of Live Births Weighing Less than 2,500 Grams	0278	AHRQ.

[4] 42 CFR 422.157.

[5] Interested persons may contact AAAHC to request a copy of the handbook.

Measure	NQF reference No.	Measure develop/steward
Annual Percentage of Asthma Patients 2 through 20 Years Old with One or More Asthma-related Emergency Room Visits.	1381	Alabama Medicaid.
Percentage of Female Patients Who Had a Mammogram Performed During the Two-Year Measurement Period.	n/a	American Medical Association/Physician Consortium Performance Improvement (AMA/PCPI).
High Risk for Pneumococcal Disease—Pneumococcal Vaccination.	0617	ActiveHealth Management.
Preventive Services: Percentage of Enrolled Members Ages Less than or Equal to 18 years Who have had Preventive Services, Recommended Risk Factor Reductions and Behavioral Health Change Interventions, Appropriate Screenings and Immunizations.	n/a	American Academy of Pediatrics/URAC.
Colorectal Cancer Screening	n/a	Veterans Health Administration (VHA).
Tobacco Use: Screening and Cessation	0028	AMA/PCPI/URAC.
Prevention and Management of Obesity in Mature Adolescents and Adults.	n/a	Institute for Clinical Systems Improvement(ICSI)/URAC.
30 Day Post-Hospital AMI Discharge Care Transition Composite Measure.	0698	Centers for Medicare and Medicaid Services (CMS)/URAC.
Congestive Heart Failure (CHF) Rate	0358	AHRQ/URAC.
Atrial Fibrillation—Warfarin Therapy	0264	ActiveHealth Management.
MRI Lumbar Spine for Low Back Pain	0514	CMS.
All Cause Readmission Index	0505	United Health Group/URAC.
Central Venous Catheter-related Bloodstream Infections (area-level): Rate per 100,000 Population.	n/a	AHRQ.
Depression Readmission	n/a	Minnesota Community Measurement/URAC.
Follow-up After Hospitalization for a Mental Illness	n/a	Florida Agency for Health Care Administration.
CAHPS®		
CAHPS® Adult Health Plan Survey 5.0	0006	AHRQ.
CAHPS® Child Survey v4.0 Medicaid and Commercial Core Survey.	n/a	AHRQ.
CAHPS® Survey for Children With Chronic Conditions	0009	AHRQ.
Exploratory Measures		
Case Management: Consumer Contact	n/a	URAC.
Complaint Response Timeliness	n/a	URAC.
Outpatient Newborn Visit Within One Month of Birth	n/a	Centene.
Diabetes: All or None Process Measure: Optimal Results for HbA1c, LDL–C, and Blood Pressure.	n/a	Wisconsin Collaborative for Healthcare Quality.
Percentage of Eligible Members that Receive Preventive Dental Services.	n/a	CMS/URAC.
Health Risk Assessment Completion Rate	n/a	URAC.
Use of High Risk Medications in the Elderly	n/a	PQA.

The AAAHC documented in its application how its measures and standards comply with the requirements contained in § 156.275. The application also clarifies how AAAHC accreditation complies with § 156.275(c)(2) and (c)(3). Specifically, AAAHC will provide accreditation at the required Exchange product type level, assuming that adequate member numbers and data are available, as required by 45 CFR 156.275(c)(2)(iii).

CMS evaluated AAAHC's application information regarding accreditation survey methodology and processes for scoring and consider the standards to be methodologically rigorous and transparent as required in § 156.275(c)(3). The AAAHC described its health plan scoring methodology for 2013 and documented that the collection and reporting of a required set of clinical quality measures and CAHPS® data will be factored into the overall accreditation score. The majority of AAAHC accreditation standards are rated on a five-point scale of Fully Compliant to Non-Compliant and a critical set of standards must be fully met for successful health plan accreditation, including the reporting of clinical quality measures.

2. Public Comment

This notice solicits public comments on the analysis above and the conclusion that it is appropriate to recognize AAAHC as an accrediting entity for the purpose of QHP certification. We seek specific comments on AAAHC's accreditation standards for QHP issuers including: whether the public believes AAAHC's standards meet the requirements in § 156.275; whether there are any deficiencies in its standards that should be reviewed; the content of the proposed clinical quality measures and their appropriateness for use in QHP accreditation; the rigor of the scoring methodology; and if the network adequacy standards will ensure sufficient network of providers for QHP enrollees.

III. 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.

IV. 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 before making a determination of recognition of an accrediting entity. Upon completion of our analysis, 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 determination. (Health Insurance Exchanges; Application by the Accreditation Association for Ambulatory Health Care to be a Recognized Accrediting Entity for the Accreditation of Qualified Health Plans)

Dated: August 29, 2013.

Marilyn Tavenner,

CMS Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2013–22369 Filed 9–12–13; 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

Title: Permanency Innovations Initiative Evaluation: Phase 3.

OMB No.: 0970–0408.

Description: The Administration for Children and Families (ACF), U.S. Department of Health and Human Services (HHS) intends to collect data for an evaluation of the Permanency Innovations Initiative (PII). This 5-year initiative, funded by the Children's Bureau (CB) within ACF, is intended to build the evidence base for innovative interventions that enhance well-being and improve permanency outcomes for particular groups of children and youth who are at risk for long-term foster care and who experience the most serious barriers to timely permanency.

Data collection for the PII evaluation includes a number of components being launched at different points in time. Phase 1 (approved August 2012, OMB# 0970–0408) included data collection for a cross-site implementation evaluation and site-specific evaluations of two PII grantees (Washoe County, Nevada, and the State of Kansas). Phase 2 (approved August 2013) included data collection for two more PII grantees (Illinois DCFS and one of two interventions offered by the Los Angeles Gay and Lesbian Center's Recognize Intervene Support Empower [RISE] project).

Phase 3 will include data collection for evaluations of two PII grantee interventions and two additional cross-site PII studies. The two grantee interventions are the California Department of Social Services' California Partnership for Permanency (CAPP) project and a second RISE intervention, the Care Coordination Team (CCT). The two PII cross-site studies are a cost study and an administrative data study. The administrative data study does not impose any new data collection requirements and will use data currently reported by states through the Adoption and Foster Care Analysis and Reporting System (AFCARS) (OMB Control # 0980–0267) and the National Child Abuse and Neglect Data System (NCANDS) (OMB Control # 0980–0229), as well as data maintained in State Automated Child Welfare Information Systems (SACWIS).

Respondents: Youth, foster parents, permanency resources, biological parents, legal guardians, team facilitators, caseworkers, supervisors, and state agency workers.

ANNUAL BURDEN ESTIMATES

Instrument	Total number of respondents	Annual number of respondents	Number of responses per respondent	Average burden hours per response	Total annual burden hours
CAPP:					
Parent/Guardian Interview	1791	597	1	0.5	299
Caseworker Data Extraction	894	298	1	0.5	149
CAPP annual burden hours					448
RISE CCT:					
Youth Interview	120	40	2	1.3	104
Qualitative Youth Interview	60	20	1	1.2	24
Interview with Permanency Resource	120	40	2	1.0	80
Interview with Current Caregiver	120	40	2	0.6	48
Current Caregiver Qualitative Interview	60	20	1	1.0	20
CCT Facilitators Emotional Permanency Pretest	12	4	5	0.2	4
CCT Facilitators Emotional Permanency Posttest	12	4	5	0.2	4
CAFAS pretest	12	4	5	1.0	20
Caseworker discussion for CAFAS pretest completion	60	20	1	0.5	10
CAFAS posttest	12	4	5	1.0	20
Caseworker discussion for CAFAS posttest completion	60	20	1	0.5	10
CCT Facilitators Permanent Connections Inventory Pretest	12	4	1	0.2	1
CCT Facilitators Permanent Connections Inventory Posttest	12	4	1	0.2	1
RISE CCT annual burden hours					346
Cost Study:					
Cost Focus Group	27	9	1	7	63
Weekly Casework Activity Log	369	123	52	0.4	2,558
Weekly Supervision Activity Log	117	39	52	0.4	811
Monthly Management/Administration Log	90	30	12	0.5	180
Cost Study annual burden hours					3,612
Administrative Data Study:					