Dated: February 19, 2014.

Martique Jones,

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

[FR Doc. 2014–03874 Filed 2–21–14; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–3287–PN2]

Medicare and Medicaid Programs; Application From The Compliance Team for Initial CMS-Approval of Its Rural Health Clinic 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 Compliance Team for initial recognition as a national accrediting organization for rural health clinics (RHCs) 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 March 26, 2014.

ADDRESSES: In commenting, please refer to file code CMS–3287–PN2. 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–3287–PN2, 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–3287–PN2, 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.)

Comments erroneously 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 21244–1850.

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.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: James Cowher, (410) 786–1948; Valarie Lazerowich, (410) 786–4750; Cindy Melanson, (410) 786–0310; or Patricia Chmielewski, (410) 786–6899.

SUPPLEMENTARY INFORMATION:

Submitting Comments: We welcome comments from the public on all issues set forth in this proposed notice to assist us in fully considering issues and developing policies. Referencing the file code CMS–3287–PN2 and the specific ''issue identifier'' that precedes the section on which you choose to comment will assist us in fully considering issues and developing policies.

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 Rural Health Clinic (RHC) provided certain requirements are met. Section 1861(aa), and 1905(l)(1) of the Social Security Act (the Act), establishes distinct criteria for facilities seeking designation as an RHC. 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, subpart A. The regulations at 42 CFR part 491, subpart A specify the minimum conditions that an RHC must meet to participate in the Medicare program. The conditions for Medicare payment for RHCs are set forth at 42 CFR 405, subpart X.

Generally, to enter into an agreement, a RHC must first be certified by a state survey agency as complying with the conditions or requirements set forth in part 491 of our regulations. Thereafter, the RHC is subject to regular surveys by a state survey agency to determine whether it continues to meet these requirements. However, there is an alternative 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 approval of its accreditation program 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.

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 The Compliance Team's request for initial CMS approval of its RHC accreditation program. This notice also solicits public comment on whether The Compliance Team's requirements meet or exceed the Medicare conditions for certification for RHC. We originally published a notice on September 20, 2013 (78 FR 57857). The application described in the notice was withdrawn at the request of the applicant. This document notifies the public that The Compliance Team resubmitted its RHC application for review.

III. Evaluation of Deeming Authority Request

The Compliance Team submitted all the necessary materials to enable us to make a determination concerning its request for initial approval of its RHC accreditation program. This application was determined to be complete on January 2, 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 Compliance Team will be conducted in accordance with, but not necessarily limited to, the following factors:

- The equivalency of The Compliance Team's standards for RHCs as compared with CMS' RHC conditions for certification.
- The Compliance Team'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 The Compliance Team's processes to those of state survey agencies, including survey frequency, and the ability to investigate and respond appropriately to complaints against accredited facilities.

++ The Compliance Team's processes and procedures for monitoring a RHC found out of compliance with The Compliance Team's program requirements. These monitoring procedures are used only when The Compliance Team identifies noncompliance. If noncompliance is identified through validation reviews or complaint surveys, the state survey agency monitors corrections as specified at § 488.7(d).

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

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

++ The adequacy of The Compliance Team's staff and other resources, and its financial viability.

++ The Compliance Team's capacity to adequately fund required surveys.

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

++ The Compliance Team'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 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.

(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: February 18, 2014.

Marilyn Tavenner,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2014–03905 Filed 2–21–14; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1603–N]

Medicare Program; Public Meetings in Calendar Year 2014 for All New Public Requests for Revisions to the Healthcare Common Procedure Coding System (HCPCS) Coding and Payment Determinations

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

ACTION: Notice.

SUMMARY: This notice announces the dates, time, and location of the Healthcare Common Procedure Coding System (HCPCS) public meetings to be held in calendar year 2014 to discuss our preliminary coding and payment determinations for all new public requests for revisions to the HCPCS. These meetings provide a forum for interested parties to make oral presentations or to submit written comments in response to preliminary coding and payment determinations. The discussion will be focused on responses to our specific preliminary recommendations and will include all items on the public meeting agenda.

DATES: *Meeting Dates:* The following are the 2014 HCPCS public meeting dates:

1. Tuesday, May 20, 2014, 9 a.m. to 5 p.m. eastern daylight time (e.d.t.) (Drugs/Biologicals/Radiopharmaceuticals/Radiologic Imaging Agents).

2. Wednesday, May 21, 2014, 9 a.m. to 5 p.m. e.d.t. (Drugs/Biologicals/