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.

DATES: Comments on the collection(s) of information must be received by the OMB desk officer by April 24, 2014.

ADDRESSES: When commenting on the proposed information collections, please reference the document identifier or OMB control number. To be assured consideration, comments and recommendations must be received by the OMB desk officer via one of the following transmissions: OMB, Office of Information and Regulatory Affairs, Attention: CMS Desk Officer, Fax Number: (202) 395–5806 *OR* Email: *OIRA_submission@omb.eop.gov*.

To obtain copies of a supporting statement and any related forms for the proposed collection(s) summarized in this notice, you may make your request using one of following:

1. Access CMS' Web site address at *http://www.cms.hhs.gov/PaperworkReductionActof1995*.

2. Email your request, including your address, phone number, OMB number, and CMS document identifier, to *Paperwork@cms.hhs.gov*.

3. Call the Reports Clearance Office at (410) 786–1326.

FOR FURTHER INFORMATION CONTACT: Reports Clearance Office at (410) 786–1326

SUPPLEMENTARY INFORMATION: Under the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501–3520), federal agencies must obtain approval from the Office of Management and Budget (OMB) for each collection of information they conduct or sponsor. The term ''collection of information'' is defined in 44 U.S.C. 3502(3) and 5 CFR 1320.3(c) and includes agency requests or requirements that members of the public submit reports, keep records, or provide information to a third party. Section 3506(c)(2)(A) of the PRA (44 U.S.C. 3506(c)(2)(A)) requires federal agencies to publish a 30-day notice in the **Federal Register** concerning each proposed collection of information, including each proposed extension or reinstatement of an existing collection of information, before submitting the collection to OMB for approval. To comply with this requirement, CMS is publishing this notice that summarizes the following proposed collection(s) of information for public comment:

1. *Type of Information Collection Request:* New collection (Request for a new OMB control number); *Title of Information Collection:* Community First Choice Option Evaluation; *Use:* This project is an evaluation of the implementation and progress of the Community First Choice (CFC) Option. The results of the study will be included in the final Report to Congress, to be delivered by the Secretary of Health and Human Services in 2015. The project is designed to assist us along with the Congress in our understanding of: States' CFC implementation plans, the effectiveness of the CFC Option on individuals receiving home- and community-based attendant care, and States' spending on long-term services and supports.

Researchers will request data from States approved for CFC via a data from and semi-structured interviews. Information obtained will be used to better understand CFC program design, the targeted patient population, and intended outcomes. At this time, we have only approved California's program. To provide comparative information to the Secretary, researchers will also collect data from States that have decided not to pursue the CFC option. Data will be analyzed and developed into a report to Congress which will evaluate the effectiveness of the CFC option, the program's impact on participants' physical and emotional health, and a comparative analysis of the costs of community-based services and those provided in institutional settings. *Form Number:* CMS–10462 (OCN: 0938-New); *Frequency:* Once; *Affected Public:* Individuals and households, Private sector—Business or other for-profits and Not-for-profit institutions, and State, Local, or Tribal Governments; *Number of Respondents:* 108; *Total Annual Responses:* 126; *Total Annual Hours:* 225. (For policy questions regarding this collection contact Elizabeth Garbarczyk at 410–786–0426).

Dated: March 19, 2014.

Martique Jones,

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

[FR Doc. 2014–06518 Filed 3–24–14; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–4132–PN]

Medicare Program; Renewal of Deeming Authority of the Accreditation Association for National Committee for Quality Assurance (NCQA)

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

ACTION: Proposed notice.

SUMMARY: This proposed notice announces our proposal to renew the Medicare Advantage deeming authority of the National Committee for Quality Assurance (NCQA) for a term of 6 years. This new term of approval would begin October 19, 2014 and end October 18, 2020. This notice announces a 30-day period for public comments on the renewal of the application.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on April 24, 2014.

ADDRESSES: In commenting, refer to file code CMS–4132–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–4132–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–4132–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 ONLY 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: Jennifer Bates, 410–786–6258 or Milonda Mitchell, 410–786–1644

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 through a Medicare Advantage (MA) organization that contracts with the Centers for Medicare & Medicaid Services (CMS). The regulations specifying the Medicare requirements that must be met in order for a Medicare Advantage Organization (MAO) to enter into a contract with CMS are located at 42 CFR part 422. These regulations implement Part C of Title XVIII of the Social Security Act (the Act), which specifies the services that an MAO must provide and the requirements that the organization must meet to offer an MA plan. Other relevant sections of the Act are Parts A and B of Title XVIII and Part A of Title XI pertaining to the provision of services by Medicare-certified providers and suppliers. Under § 422.400, one significant prerequisite for an entity to be an MA organization is that the organization be licensed by the state as a risk bearing organization, unless a waiver is authorized for a provider-sponsored organization pursuant to § 422.370. In addition, MAOs and MA plans must meet requirements related to access to services, antidiscrimination, confidentiality and accuracy of beneficiary records, provider participation, advance directives, and quality assurance programs.

As a method of assuring compliance with certain Medicare requirements, an MA organization may choose to become accredited by a CMS approved accrediting organization (AO). In addition to their CMS-recognized deemed status accreditation program, approved AOs offer other accreditation programs that are not recognized by CMS. For Medicare participation purposes, the MA organization may be ''deemed'' compliant in one or more of six requirements set forth in section 1852(e)(4)(B) of the Act and § 422.156(b). In order for an AO to be able to ''deem'' an MA plan as compliant with these MA requirements, the AO must demonstrate that it meet the requirements outlined in § 422.157, including demonstrating that its standards are at least as stringent as Medicare requirements with respect to the standards in the deemable area. Therefore, for example, MA organizations that are licensed as health maintenance organizations (HMOs) or preferred provider organizations (PPOs) and are accredited by an approved accrediting organization may receive, at the MA organization's request, deemed status for CMS requirements in the following six MA areas: Quality Improvement, Antidiscrimination, Access to Services, Confidentiality and Accuracy of Enrollee Records, Information on Advanced Directives, and Provider Participation Rules. *See* § 422.156(b). Organizations that apply for MA deeming authority are generally recognized by the health care industry as entities that accredit HMOs and PPOs. As specified at § 422.157(b)(2)(ii), the term for which an AO may be approved by CMS may not exceed 6 years. For continuing approval, the AO must renew its application with CMS.

The National Committee for Quality Assurance (NCQA) was approved as an accrediting organization for MA deeming of HMOs on October 19, 2010, and that term will expire on October 18, 2014. On January 30, 2014, NCQA submitted an application to renew its deeming authority. On that same date, NCQA submitted materials requested from CMS which included updates and/or changes to items listed in § 422.158(a) that are prerequisites for receiving deeming program approval by CMS, and which were furnished to CMS by NCQA as a part of its renewal applications for HMOs and PPOs.

II. Provisions of the Proposed Notice

The purpose of this notice is to notify the public of the NCQA's request to renew its Medicare Advantage deeming authority for HMOs and PPOs. NCQA submitted all the necessary materials (including its standards and monitoring protocol) to enable us to make a determination concerning its request for approval as an accreditation organization for CMS. This renewal application was determined to be complete on February 6, 2014. Under section § 1852(e)(4) of the Act and § 422.158 (federal review of accrediting organizations), our review and evaluation of NCQA will be conducted as discussed below.

A. Components of the Review Process

The review of NCQA's renewal application for approval of MA deeming authority includes the following components:

- The types of MA plans that it would review as part of its accreditation process.
- A detailed comparison of the AO's accreditation requirements and standards with the Medicare requirements (for example, a crosswalk).
- Detailed information about the organization's survey process, including—

++ Frequency of surveys and whether surveys are announced or unannounced.

++ Copies of survey forms, and guidelines and instructions to surveyors.

++ Descriptions of—

—The survey review process and the accreditation status decision making process;

—The procedures used to notify accredited MA organizations of deficiencies and to monitor the correction of those deficiencies; and
—The procedures used to enforce compliance with accreditation requirements.

• Detailed information about the individuals who perform surveys for the accreditation organization, including—

++ The size and composition of accreditation survey teams for each type of plan reviewed as part of the accreditation process;

++ The education and experience requirements surveyors must meet;

++ The content and frequency of the in-service training provided to survey personnel;

++ The evaluation systems used to monitor the performance of individual surveyors and survey teams; and

++ The organization's policies and practice with respect to the participation, in surveys or in the accreditation decision process by an individual who is professionally or financially affiliated with the entity being surveyed.

• A description of the organization's data management and analysis system with respect to its surveys and accreditation decisions, including the kinds of reports, tables, and other displays generated by that system.

• A description of the organization's procedures for responding to and investigating complaints against accredited organizations, including policies and procedures regarding coordination of these activities with appropriate licensing bodies and ombudsmen programs.

• A description of the organization's policies and procedures with respect to the withholding or removal of accreditation for failure to meet the accreditation organization's standards or requirements, and other actions the organization takes in response to noncompliance with its standards and requirements.

• A description of all types (for example, full, partial) and categories (for example, provisional, conditional, temporary) of accreditation offered by the organization, the duration of each type and category of accreditation and a statement identifying the types and categories that would serve as a basis for accreditation if CMS approves the accreditation organization.

• A list of all currently accredited MA organizations and the type, category, and expiration date of the accreditation held by each of them.

• A list of all full and partial accreditation surveys scheduled to be performed by the accreditation organization.

• The name and address of each person with an ownership or control interest in the accreditation organization.

• CMS will also consider NCQA's past performance in the deeming program and results of recent deeming validation reviews, or look-behind audits conducted as part of continuing federal oversight of the deeming program under § 422.157(d).

B. Notice Upon Completion of Evaluation

Upon completion of our evaluation, including evaluation of comments received as a result of this notice, we will publish a notice in the **Federal Register** announcing the result of our evaluation.

Section 1852(e)(4)(C) of the Act provides a statutory timetable to ensure that our review of deeming applications is conducted in a timely manner. The Act provides us with 210 calendar days after the date of receipt of an application to complete our survey activities and application review process. At the end of the 210 day period, we must publish an approval or denial of the application in the **Federal Register**.

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, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

Dated: March 14, 2014.

Marilyn Tavenner,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2014–06520 Filed 3–24–14; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1610–N]

Medicare Program; Public Meeting on July 14, 2014 Regarding New Clinical Diagnostic Laboratory Test Codes for the Clinical Laboratory Fee Schedule for Calendar Year 2015

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

ACTION: Notice.

SUMMARY: This notice announces a public meeting to receive comments and recommendations (including accompanying data on which recommendations are based) from the public on the appropriate basis for establishing payment amounts for new or substantially revised Healthcare Common Procedure Coding System (HCPCS) codes being considered for Medicare payment under the clinical laboratory fee schedule (CLFS) for calendar year (CY) 2015. This meeting also provides a forum for those who submitted certain reconsideration requests regarding final determinations made last year on new test codes and for the public to provide comment on the requests.

DATES: *Meeting Date:* The public meeting is scheduled for Monday, July 14, 2014 from 9:00 a.m. to 3:00 p.m., Eastern Daylight Savings Time.

Deadline for Registration of Presenters and Submission of Presentations: All presenters for the public meeting must register and submit their presentations electronically to Glenn McGuirk at *Glenn.McGuirk@cms.hhs.gov* by July 3, 2014.

Deadline for Submitting Requests for Special Accommodations: Requests for special accommodations must be received no later than 5:00 p.m. on July 3, 2014.

Deadline for Submission of Written Comments: We intend to publish our proposed determinations for new test codes and our preliminary determinations for reconsidered codes (as described below) for CY 2015 by early September. Interested parties may submit written comments on these determinations by early October, 2014 to the address specified in the **ADDRESSES** section of this notice or electronically to Glenn McGuirk at *Glenn.McGuirk@cms.hhs.gov* (the specific date for the publication of these determinations on the CMS Web site, as well as the deadline for submitting comments regarding these