review by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35).

Authority: 5 U.S.C. App. 2, section 10(a).

Dated: April 16, 2015.

Patrick Conway,

Acting Principal Deputy Administrator, Deputy Administrator for Innovation and Quality, CMS Chief Medical Officer, Centers for Medicare & Medicaid Services.

[FR Doc. 2015–09607 Filed 4–23–15; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1639–N]

Medicare Program: Renewal of the Advisory Panel on Hospital Outpatient Payment

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Notice.

SUMMARY: This notice announces the renewal of the Advisory Panel (the Panel) on Hospital Outpatient Payment (HOP) charter. The charter was approved on November 6, 2014 for a 2-year period effective through November 6, 2016. This notice publicly announces the renewal of the HOP Panel for another 2-year period. The purpose of the Panel is to advise the Secretary of the Department of Health and Human Services (DHHS) and the Administrator of the Centers for Medicare & Medicaid Services (CMS) concerning the clinical integrity of the Ambulatory Payment Classification groups and their relative payment weights. The Panel also addresses and makes recommendations regarding supervision of hospital outpatient services. The advice provided by the Panel will be considered as we prepare the annual updates for the hospital outpatient prospective payment system.

DATES: April 24, 2015.

ADDRESSES: *Web site:* For additional information on the Panel meeting dates, agenda topics, copy of the charter, and updates to the Panel's activities, we refer readers to our Web site at the following address: *https://www.cms.gov/Regulations-and-Guidance/Guidance/FACA/AdvisoryPanelonAmbulatoryPaymentClassificationGroups.html.*

FOR FURTHER INFORMATION CONTACT: Designated Federal Official (DFO): Carol Schwartz, DFO, 7500 Security Boulevard, Mail Stop: C4–04–25, Woodlawn, MD 21244–1850. Phone: (410) 786–3985. Email: *APCPanel@cms.hhs.gov.*

SUPPLEMENTARY INFORMATION:

I. Background

The Secretary of the Department of Health and Human Services (the Secretary) is required by section 1833(t)(9)(A) of the Social Security Act (the Act) (42 U.S.C. 1395l(t)(9)(A)) and is allowed by section 222 of the Public Health Service Act (PHS Act) (42 U.S.C. 217(a)) to consult with an expert outside advisory panel on the clinical integrity of the Ambulatory Payment Classification (APC) groups and relative payment weights, which are major elements of the Medicare Hospital Outpatient Prospective Payment System (OPPS), and the appropriate supervision level for hospital outpatient services. The Panel is governed by the provisions of the Federal Advisory Committee Act (FACA) (Pub. L. 92–463), as amended (5 U.S.C. Appendix 2), which sets forth standards for the formation and use of advisory panels.

The Panel Charter provides that the Panel shall meet up to 3 times annually. We consider the technical advice provided by the Panel as we prepare the proposed and final rules to update the OPPS for the following calendar year.

II. Renewal of the Hospital Outpatient Payment (HOP) Panel

The Panel was originally chartered on November 21, 2000 and the Panel requires a recharter every 2 years. This notice announces the renewal of the HOP Panel charter, which was approved on November 6, 2014 for a 2-year period effective through November 6, 2016. The charter will terminate on November 6, 2016, unless renewed by appropriate action. CMS intends to recharter the Panel for another 2-year period prior to the expiration of the current charter.

Pursuant to the renewed charter, the Panel will advise the Secretary and CMS concerning optimal strategies for the following:

- Addressing whether procedures within an APC group are similar both clinically and in terms of resource use.
- Reconfiguring APCs (for example, splitting of APCs, moving Healthcare Common Procedures Coding System (HCPCS) codes from one APC to another, and moving HCPCS codes from new technology APCs to clinical APCs).
- Evaluating APC group weights.
- Reviewing packaging the cost of items and services, including drugs and devices into procedures and services; including the methodology for packaging and the impact of packaging the cost of those items and services on APC group structure and payment.
- Removing procedures from the inpatient list for payment under the OPPS payment system.
- Using claims and cost report data for CMS' determination of APC group costs.
- Addressing other technical issues concerning APC group structure.
- Evaluating the required level of supervision for hospital outpatient services.

III. Copies of the Charter

To obtain a copy of the Panel's Charter, we refer readers to the CMS Web site at: *http://www.cms.gov/Regulations-andGuidance/Guidance/FACA/AdvisoryPanelonAmbulatoryPaymentClassificationGroups.html. Also, a* copy of the Panel's Charter can be received by submitting a request to the contact listed in the **FOR FURTHER INFORMATION** section of this notice.

IV. Collection of Information Requirements

This document does not impose information collection requirements, that is, reporting, recordkeeping or third-party disclosure requirements. Consequently, there is no need for review by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35).

Dated: April 13, 2015.

Andrew M. Slavitt,

Acting Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2015–09609 Filed 4–23–15; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–3315–PN]

Medicare and Medicaid Programs; Application by the American Association of Diabetes Educators for Continued Deeming Authority for Diabetes Self-Management Training

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

ACTION: Proposed notice.

SUMMARY: This proposed notice announces the receipt of an application from the American Association of Diabetes Educators for continued recognition as a national accreditation

program for accrediting entities that wish to furnish outpatient diabetes self-management training to Medicare beneficiaries.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on May 26, 2015.

ADDRESSES: In commenting, refer to file code CMS–3315–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–3315–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–3315–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: Kristin Shifflett, (410) 786–4133. Jacqueline Leach, (410) 786–4282.

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 outpatient Diabetes Self-Management Training (DSMT) when ordered by the physician (or qualified non-physician practitioner) treating the beneficiary's diabetes, provided certain requirements are met. Pursuant to our regulations at 42 CFR 410.141(e)(3), we use national accrediting organizations to assess whether provider entities meet Medicare requirements when providing services for which Medicare payment is made. If a provider entity is accredited by an approved accrediting organization, it is ''deemed'' to meet applicable Medicare requirements.

Under section 1865(a)(1)(B) of the Social Security Act (the Act), a national accrediting organization must have an agreement in effect with the Secretary of the Department of Health and Human Services (the Secretary) and meet the standards and requirements specified by the Secretary in 42 CFR part 410, subpart H, to qualify for deeming authority. Our regulations pertaining to application procedures for the national accreditation organizations for DSMT are specified at § 410.142 (CMS process for approving national accreditation organizations).

A national accreditation organization applying for deeming authority must provide CMS with reasonable assurance that the accrediting organization requires accredited entities to meet requirements that are at least as stringent as the Medicare requirements.

We may approve and recognize a nonprofit organization with demonstrated experience in representing the interests of individuals with diabetes to accredit entities to furnish training. The accreditation organization, after being approved and recognized by CMS, may accredit an entity to meet one of the sets of quality standards in § 410.144 (Quality standards for deemed entities).

II. Approval of Deeming Organizations

Section 1865(a)(2) of the Act further requires that we review the applying accreditation organization's requirements for accreditation, as follows:

- Survey procedures;
- Ability to provide adequate resources for conducting required surveys;
- Ability to supply information for use in enforcement activities;
- Monitoring procedures for providers found out of compliance with the conditions or requirements; and
- Ability to provide CMS with necessary data for validation.

We then examine the national accreditation organization's accreditation requirements to determine if they meet or exceed the Medicare conditions as we would have applied them. Section 1865(a)(3)(A) of the Act requires that we publish a notice identifying the national accreditation organization that is making the request for approval or renewal within 60 days of receipt of a completed application. The notice must describe the nature of the request and provide at least a 30-day public comment period. We have 210 days from receipt of the request to publish a finding of approval or denial of the application. If CMS recognizes an accreditation organization in this manner, any entity accredited by the national accreditation organization's program for that service will be deemed to meet the Medicare conditions for coverage.

III. Evaluation of Deeming Authority Request

The purpose of this notice is to notify the public of the American Association

of Diabetes Educators' (AADE) request for the Secretary's approval of its accreditation program for outpatient DSMT services. The AADE submitted all the necessary materials to enable us to make a determination concerning its request for re-approval as a deeming organization for DSMTs. AADE was initially accredited on August 27, 2012, for a period of 3 years. This application was determined to be complete on February 27, 2015. This notice also solicits public comments on the ability of the AADE to continue to develop standards that meet or exceed the Medicare conditions for coverage and apply them to entities furnishing outpatient.

The regulations specifying the Medicare conditions for coverage for outpatient diabetes self-management training services are located in parts 410, subpart H. These conditions implement section 1861(qq) of the Act, which provides for Medicare Part B coverage of outpatient DSMT services specified by the Secretary.

Under section 1865(a)(2) of the Act and our regulations at § 410.142 (CMS process for approving accreditation organizations) and § 410.143 (Requirements for approved accreditation organizations), we review and evaluate a national accreditation organization based on (but not necessarily limited to) the criteria set forth in § 410.142(b).

We may conduct on-site inspections of a national accreditation organization's operations and office to verify information in the organization's application and assess the organization's compliance with its own policies and procedures. The on-site inspection may include, but is not limited to, reviewing documents, auditing documentation of meetings concerning the accreditation process, evaluating accreditation results or the accreditation status decision making process, and interviewing the organization's staff.

IV. Collection of Information Requirements

This document does not impose information collection requirements, that is, reporting, recordkeeping or third-party disclosure requirements. Consequently, there is no need for review by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

V. 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. 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.

Dated: April 7, 2015.

Andrew M. Slavitt,

Acting Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2015–09610 Filed 4–23–15; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10392 and CMS–10418]

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

ACTION: Notice.

SUMMARY: The Centers for Medicare & Medicaid Services (CMS) is announcing an opportunity for the public to comment on CMS' intention to collect information from the public. Under the Paperwork Reduction Act of 1995 (PRA), federal agencies are required to publish notice in the **Federal Register** concerning each proposed collection of information, including each proposed extension or reinstatement of an existing collection of information, and to allow a second opportunity for public comment on the notice. Interested persons are invited to send comments regarding the 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 functions; (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.

DATES: Comments on the collection(s) of information must be received by the OMB desk officer by May 26, 2015.

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:* Revision of a currently approved information collection; *Title of Information Collection:* Consumer Operated and Oriented (CO–OP) Program; *Use:* The Consumer Operated and Oriented Plan (CO–OP) program was established by Section 1322 of the Affordable Care Act. This program provides for loans to establish at least one consumer-operated, qualified nonprofit health insurance issuer in each State. Issuers supported by the