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:* Extension of a previously approved collection; *Title of Information Collection:* Medicare Beneficiary and Family-Centered Satisfaction Survey; *Use:* The data collection methodology used to determine Beneficiary Satisfaction flows from the proposed sampling approach. Based on recent literature on survey methodology and response rates by mode, we recommend using a data collection that is done primarily by mail. A mail-based methodology will achieve the goals of being efficient, effective, and minimally burdensome for beneficiary respondents. We anticipate that a mail-based methodology could yield a response rate of approximately 60 percent. In order to achieve this response rate, we would recommend a 3 staged approach to data collection:

(1) Mailout of a covering letter, the paper survey questionnaire, and a postage-paid return envelope.

(2) Mailout of a post card that thanks respondents and reminds the non-respondents to please return their survey.

(3) Mailout of a follow-up covering letter, the paper survey questionnaire, and a postage-paid return envelope.

Through the pilot test, we will determine the response rate that can be achieved using this approach. If it is deemed necessary, a prenotification letter, additional mailout reminders and a telephone non-response step can be added to the protocol to achieve desired response rate.

Form Number: CMS–10393 (OMB Control number: 0938–1177); *Frequency:* Once; *Affected Public:* Individuals or households; *Number of Respondents:* 16,010; *Number of Responses:* 16,010; *Total Annual Hours:* 4,002. (For policy questions regarding this collection, contact Nekeshia McInnis at 410–786–4486.)

Dated: September 22, 2015.

William N. Parham,

Director, Paperwork Reduction Staff, Office of Strategic Operations and Regulatory Affairs.

[FR Doc. 2015–24471 Filed 9–24–15; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–3322–PN]

Medicare and Medicaid Programs: Application From the American Association for Accreditation of Ambulatory Surgery Facilities for Continued Approval of Its Rural Health 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 American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF) for continued recognition as a national accrediting organization for Rural Health Clinics (RHCs). The statute requires that within 60 days of receipt of an organization's complete application, the Centers for Medicare & Medicaid Services (CMS) publish a notice that identifies the national accrediting body making the request, describes the nature of the request, and provides at least 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 26, 2015.

ADDRESSES: In commenting, please refer to file code CMS–3322–PN. 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–3322–PN, 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–3322–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 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: Cindy Melanson, (410) 786–0310; 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–3322–PN 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) 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. The regulations at 42 CFR part 491, subpart A, specify the minimum conditions that an RHC must meet to participate in the Medicare program.

Generally, to enter into an agreement, an RHC must first be certified by a State survey agency as complying with the conditions or requirements set forth in part 491, subpart A of our Medicare regulations. Thereafter, the RHC is subject to regular surveys by a State survey agency to determine whether it continues to meet these requirements.

Section 1865(a)(1) of the Act provides that, if a provider entity demonstrates through accreditation by a Centers for Medicare & Medicaid Services (CMS) approved national accrediting organization that all applicable Medicare conditions are met or exceeded, we may 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 of the Department of Health and Human Services (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 may 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. Our regulations concerning the approval and re-approval of accrediting organizations are set forth at § 488.5. The regulations at § 488.5(i) require accrediting organizations to reapply for continued approval of its accreditation program every 6 years or sooner as determined by CMS.

American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF's) current term of approval for their RHC accreditation program expires March 23, 2016.

II. Approval of Deeming Organizations

Section 1865(a)(2) of the Act and our regulations at § 488.5 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 AAAASF's request for continued approval of its RHC accreditation program. This notice also solicits public comment on whether AAAASF's requirements meet or exceed the Medicare conditions for certification for RHCs.

III. Evaluation of Deeming Authority Request

AAAASF submitted all the necessary materials to enable us to make a determination concerning its request for continued approval of its RHC accreditation program. This application was determined to be complete on July 31, 2015. Under section 1865(a)(2) of the Act and our regulations at § 488.5 (Application and re-application procedures for national accrediting organizations), our review and evaluation of AAAASF will be conducted in accordance with, but not necessarily limited to, the following factors:

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

++ AAAASF's processes and procedures for monitoring a RHC found out of compliance with AAAASF's program requirements. These monitoring procedures are used only when AAAASF identifies noncompliance. If noncompliance is

identified through validation reviews or complaint surveys, the State survey agency monitors corrections as specified at § 488.9(c).

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

++ AAAASF'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 AAAASF's staff and other resources, and its financial viability.

++ AAAASF's capacity to adequately fund required surveys.

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

++ AAAASF'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 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 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.

Dated: September 16, 2015.

Andrew M. Slavitt,

Acting Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2015–24356 Filed 9–24–15; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–3315–FN]

Medicare and Medicaid Programs; Continued Approval of the American Association of Diabetes Educators as an Accrediting Organization for Diabetes Self-Management Training Programs

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

ACTION: Final notice.

SUMMARY: This final notice announces our decision to approve the American Association of Diabetes Educators (AADE) for continued recognition as a national accreditation program for accrediting entities that wish to furnish outpatient diabetes self-management training (DSMT) to Medicare beneficiaries.

DATES: This final notice is effective September 25, 2015 through September 27, 2021.

FOR FURTHER INFORMATION CONTACT: Kristin Shifflett, (410) 786–4133; Jacqueline Leach, (410) 786–4282.

SUPPLEMENTARY INFORMATION:

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 by the provider. Pursuant to our regulations at 42 CFR 410.141 (e)(3), we use national accrediting organizations (NAOs) to assess whether provider entities meet Medicare requirements when providing DSMT 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.

A NAO must meet the standards and requirements specified by the Secretary of the Department of Health and Human Services in our regulations under part 410, subpart H, to qualify for deeming authority. The regulations pertaining to application procedures for NAOs for DSMT are specified at § 410.142 (CMS process for approving national accreditation organizations).

A NAO applying for deeming authority must provide us with reasonable assurance that the accrediting organization requires accredited entities to meet requirements that are at least as stringent as our 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 DSMT. 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).

Section 1865(a)(2) of the Social Security Act (the Act) 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.
- Ability to provide CMS with necessary data for validation.

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 days after the date of receipt of a complete application, with any documentation necessary to make the 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 accrediting 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 April 24, 2015, we published a proposed notice in the **Federal Register** (80 FR 23009) entitled ''Application by the American Association of Diabetes Educators for Continued Deeming Authority for Diabetes Self-Management Training,'' announcing the receipt of an application from AADE for continued recognition as a national accreditation program for accrediting entities that wish to furnish outpatient diabetes self-management training to Medicare beneficiaries.

In that notice, we detailed our evaluation criteria. Under section