DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10161]

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

AGENCY: Centers for Medicare & Medicaid Services, HHS.

In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services, is publishing the following summary of proposed collections for public comment. Interested persons are invited to send comments regarding this 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 function; (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.

1. *Type of Information Collection Request:* Reinstatement without change of a previously approved collection. *Title of Information Collection:* New Freedom Initiative—Web-based Reporting System for Grantees. *Use:* CMS awards competitive grants to states and other eligible entities for the purpose of designing and implementing effective and enduring improvements in community-based long-term services and support systems. CMS requires that grantees report on a quarterly, semi-annual, and/or annual basis depending upon the grant type. CMS requires the information obtained through web-based grantee reporting for two reasons: To effectively monitor the grants and to report to Congress and other interested stakeholders the progress and obstacles experienced by the grantees. The grantees are the respondents to the web-based reporting system. *Form Number:* CMS–10161 (OCN 0938–0979). *Frequency:* Annually, semi-annually, and quarterly. *Affected Public:* State, Local or Tribal Governments. *Number of Respondents:* 171. *Total Annual Responses:* 428. *Total Annual Hours:* 3,764. (For policy questions regarding this collection contact Effie George at 410–786–8639. For all other issues call 410–786–1326.)

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access CMS Web Site address at *http://www.cms.hhs.gov/PaperworkReductionActof1995,* or Email your request, including your address, phone number, OMB number, and CMS document identifier, to *Paperwork@cms.hhs.gov,* or call the Reports Clearance Office on (410) 786–1326.

To be assured consideration, comments and recommendations for the proposed information collections must be received by the OMB desk officer at the address below, no later than 5 p.m. on October 29, 2012.

OMB, Office of Information and Regulatory Affairs, Attention: CMS Desk Officer, Fax Number: (202) 395–6974, Email: *OIRA_submission@omb.eop.gov.*

Dated: September 25, 2012.

Martique Jones,

Director, Regulations Development Group, Division-B, Office of Strategic Operations and Regulatory Affairs.

[FR Doc. 2012–23899 Filed 9–27–12; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–3264–FN]

Medicare and Medicaid Programs; Approval of the American Osteopathic Association/Healthcare Facilities Accreditation Program (AOA/HFAP) Application for Continuing CMS-Approval of Its Ambulatory Surgical Center (ASC) Accreditation Program

AGENCY: Centers for Medicare and Medicaid Services, HHS.

ACTION: Final notice.

SUMMARY: This final notice announces our decision to approve the American Osteopathic Healthcare Facilities Accreditation Program (AOA/HFAP) for continued recognition as a national accrediting organization for ambulatory surgical centers (ASCs) that wish to participate in the Medicare and/or Medicaid programs.

DATES: *Effective Date:* This final notice is effective October 23, 2013 through October 23, 2017.

FOR FURTHER INFORMATION CONTACT:

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Patricia Chmielewski, (410) 786–6899.

SUPPLEMENTARY INFORMATION:

I. Background

Under the Medicare program, eligible beneficiaries may receive covered services in an ASC provided certain health, safety, and other requirements are met. Section 1832(a)(2)(F)(i) of the Act permits the Secretary to establish distinct criteria for facilities seeking designation as an ASC. The regulations at 42 CFR part 416 specify the conditions that an ASC must meet in order to participate in the Medicare program, the scope of covered services, and the conditions for Medicare payment for ASCs. Regulations pertaining to activities relating to the survey and certification of facilities are at 42 CFR part 488.

Generally, in order to enter into an agreement, an ASC must first be certified by a State survey agency as complying with the conditions or requirements set forth in Part 416. Thereafter, the ASC is subject to regular surveys by a State survey agency to determine whether it continues to meet these requirements. There is an alternative, however, 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. In accordance with the requirements at 416.26, an ASC may be deemed to meet conditions for coverage if it is accredited by a national accrediting body.

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 us 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 of accrediting organizations are set forth at 488.4 and 488.8. The regulations at 488.8(d)(3) require accrediting organizations to reapply for continued approval of its accreditation program