photo ID, persons may not be permitted entry to the building.

- Security measures include inspection of vehicles, inside and out, at the entrance to the grounds.
- All persons entering the building must pass through a metal detector.
- All items brought into CMS including personal items, for example, laptops and cell phones are subject to physical inspection.
- The public may enter the building 30 to 45 minutes before the meeting convenes each day.
- All visitors must be escorted in areas other than the lower and first-floor levels in the Central Building.
- The main-entrance guards will issue parking permits and instructions upon arrival at the building.
- Foreign nationals visiting any CMS facility require prior approval. If you are a foreign national and wish to attend the meeting onsite, in addition to registering for the meeting, you must also send a separate email to *APCPanel@cms.hhs.gov* prior to the close of registration to request authorization to attend as a foreign national.

VII. Special Accommodations

Individuals requiring special accommodations must include the request for these services during registration.

VIII. Panel Recommendations and Discussions

The Panel's recommendations at any Panel meeting generally are not final until they have been reviewed and approved by the Panel on the last day of the meeting, before the final adjournment. These recommendations will be posted to our Web site after the meeting.

IX. 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.*).

Dated: May 5, 2015.

Andrew M. Slavitt,

Acting Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2015–12527 Filed 5–21–15; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifiers CMS–668B]

Agency Information Collection Activities: Proposed Collection; Comment Request

AGENCY: Centers for Medicare & Medicaid Services, HHS.

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 (the 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 60 days for public comment on the proposed action. Interested persons are invited to send comments regarding our burden estimates 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 must be received by *July 21, 2015.*

ADDRESSES: When commenting, please reference the document identifier or OMB control number. To be assured consideration, comments and recommendations must be submitted in any one of the following ways:

1. *Electronically.* You may send your comments electronically to *http://www.regulations.gov.* Follow the instructions for ''Comment or Submission'' or ''More Search Options'' to find the information collection document(s) that are accepting comments.

2. *By regular mail.* You may mail written comments to the following address: CMS, Office of Strategic Operations and Regulatory Affairs Division of Regulations Development Attention: Document Identifier/OMB Control Number _____, Room C4–26–05, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

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:

Contents

This notice sets out a summary of the use and burden associated with the following information collections. More detailed information can be found in each collection's supporting statement and associated materials (see **ADDRESSES**).

CMS–668B Post Clinical Laboratory Survey Questionnaire and Supporting Regulations

Under the 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 requires federal agencies to publish a 60-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.

Information Collection

1. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Post Clinical Laboratory Survey Questionnaire and Supporting Regulations; *Use:* Form CMS–668B is used by a Clinical Laboratory Improvement Amendments (CLIA) laboratory to express its satisfaction with the survey process and to make recommendations for improvement. Surveyors furnish this form to all laboratories that receive

either an onsite survey or the Alternate Quality Assessment Survey (*i.e.,* paper survey of quality indicators). We perform an overview evaluation of the completed forms. Each calendar year, a summary of the information collected is sent to the State and CMS Regional Offices. *Form Number:* CMS–668B (OMB Control Number 0938–0653); *Frequency:* Biennially; *Affected Public:* Private sector (Business or other for-profits and Not-for-profit institutions), State, Local, or Tribal Government; *Number of Respondents:* 19,051; *Total Annual Responses:* 9,526; *Total Annual Hours:* 2,382. (For policy questions regarding this collection contact Kathleen Todd at 410–786–3385.)

Dated: May 19, 2015.

William N. Parham, III,

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

[FR Doc. 2015–12498 Filed 5–21–15; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–3307–FN]

Medicare and Medicaid Programs; Continued Approval of The Joint Commission's Hospice Accreditation Program

AGENCY: Centers for Medicare & Medicaid Services, HHS.

ACTION: Final notice.

SUMMARY: This final notice announces our decision to approve The Joint Commission (TJC) for continued recognition as a national accrediting organization for hospices that wish to participate in the Medicare or Medicaid programs. A hospice that participates in Medicaid must also meet the Medicare Conditions of Participation (CoPs).

DATES: This final notice is effective June 18, 2015 through June 18, 2021.

FOR FURTHER INFORMATION CONTACT: Lillian Williams, (410) 786–8636, Cindy Melanson, (410) 786–0310, or Patricia Chmielewski, (410) 786–6899.

SUPPLEMENTARY INFORMATION:

I. Background

Under the Medicare program, eligible beneficiaries may receive covered services in a hospice provided certain requirements are met by the hospice. Section 1861(dd) of the Social Security Act (the Act) establishes distinct criteria for facilities seeking designation as a hospice. 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 418 specify the conditions that a hospice must meet in order to participate in the Medicare program, the scope of covered services and the conditions for Medicare payment for hospices.

Generally, to enter into an agreement, a hospice must first be certified as complying with the conditions set forth in part 418 and recommended to the Center for Medicare & Medicaid (CMS) for participation by a state survey agency. Thereafter, the hospice is subject to periodic surveys by a state survey agency to determine whether it continues to meet these conditions. However, there is an alternative to certification surveys by state agencies. Accreditation by a nationally recognized Medicare accreditation program approved by CMS may substitute for both initial and ongoing state review.

Section 1865(a)(1) of the Act provides that, if the Secretary of the Department of Health and Human Services (the Secretary) finds that accreditation of a provider entity by an approved national accrediting organization meets or exceeds all applicable Medicare conditions, CMS may treat the provider entity as having met those conditions, that is, we may ''deem'' the provider entity to be in compliance. Accreditation by an accrediting organization is voluntary and is not required for Medicare participation.

Part 488, subpart A, implements the provisions of section 1865 of the Act and requires that a national accrediting organization applying for approval of its Medicare accreditation program must provide CMS with reasonable assurance that the accrediting organization requires its 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(d)(3). The regulations at § 488.8(d)(3) require an accrediting organization to reapply for continued approval of its Medicare accreditation program every 6 years or sooner as determined by CMS. The Joint Commission's (TJC's) current term of approval for its hospice accreditation program expires June 18, 2015.

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

In the December 19, 2014 **Federal Register** (79 FR 75817), we published a proposed notice announcing TJC's request for continued approval of its Medicare hospice accreditation program. In the December 19, 2014 proposed notice, we detailed our evaluation criteria. Under section 1865(a)(2) of the Act and in our regulations at § 488.4 and § 488.8, we conducted a review of TJC's Medicare hospice accreditation application in accordance with the criteria specified by our regulations, which include, but are not limited to the following:

- An onsite administrative review of TJC's: (1) Corporate policies; (2) financial and human resources available to accomplish the proposed surveys; (3) procedures for training, monitoring, and evaluation of its hospice surveyors; (4) ability to investigate and respond appropriately to complaints against accredited hospices; and (5) survey review and decision-making process for accreditation.
- The comparison of TJC's Medicare hospice accreditation program standards to our current Medicare hospice CoPs.
- A documentation review of TJC's survey process to—

++ Determine the composition of the survey team, surveyor qualifications, and TJC's ability to provide continuing surveyor training.

++ Compare TJC's processes to those we require of state survey agencies, including periodic resurvey and the ability to investigate and respond appropriately to complaints against accredited hospices.

++ Evaluate TJC's procedures for monitoring hospices it has found to be out of compliance with TJC's program requirements. (This pertains only to monitoring procedures when TJC identifies non-compliance. If noncompliance is identified by a state survey agency through a validation survey, the state survey agency monitors corrections as specified at § 488.7(d)).