++ The composition of the survey team, surveyor qualifications, and the ability of the organization to provide continuing surveyor training.

++ The comparability of the Joint Commission's processes to those of State Survey Agencies, including survey frequency, and the ability to investigate and respond appropriately to complaints against accredited facilities.

++ The Joint Commission's processes and procedures for monitoring a psychiatric hospital found out of compliance with the Joint Commission's program requirements. These monitoring procedures are used only when the Joint Commission identifies noncompliance. If noncompliance is identified through validation reviews or complaint surveys, the State Survey Agency monitors corrections as specified at § 488.7(d).

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

++ The Joint Commission'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 the Joint Commission's staff and other resources, and its financial viability.

++ The Joint Commission's capacity to adequately fund required surveys.

++ The Joint Commission's policies to assure that surveys are unannounced.

++ The Joint Commission's agreement to provide CMS with a copy of a facility's most current accreditation survey together with any survey information that CMS may request (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.

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.

Dated: September 11, 2014.

Marilyn Tavenner,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2014–22632 Filed 9–22–14; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1626–N]

Medicare Program; Solicitation of Nominations to the Advisory Panel on Hospital Outpatient Payment

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

ACTION: Notice.

SUMMARY: This notice solicits nominations for up to four new members to the Advisory Panel on Hospital Outpatient Payment (HOP, the Panel). There are vacancies on the Panel effective September 30, 2014.

The purpose of the Panel is to advise the Secretary of the Department of Health and Human Services and the Administrator of the Centers for Medicare & Medicaid Services on the clinical integrity of the Ambulatory Payment Classification (APC) groups and their associated weights, and supervision of hospital outpatient services.

The Secretary rechartered the Panel in 2012 for a 2-year period effective through November 19, 2014. CMS intends to recharter the Panel for another 2-year period prior to expiration of the current charter.

DATES: *Submission of Nominations:* We will consider nominations if they are received no later than 5 p.m. (e.s.t.) November 24, 2014.

ADDRESSES: Please submit nominations electronically to the following email address: *APCPanel@cms.hhs.gov.*

Web site: For additional information on the Panel and updates to the Panel's activities, we refer readers to our Web site at the following address: *http://www.cms.gov/Regulations-and-Guidance/Guidance/FACA/AdvisoryPanelonAmbulatoryPaymentClassificationGroups.html.*

FOR FURTHER INFORMATION CONTACT: Persons wishing to nominate individuals to serve on the Panel or to obtain further information may contact Carol Schwartz at the following email address: *APCPanel@cms.hhs.gov* or call (410) 786–3985.

News Media: Representatives should contact the CMS Press Office at (202) 690–6145.

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), and section 222 of the Public Health Service Act (PHS Act) to consult with an expert outside advisory panel regarding the clinical integrity of the Ambulatory Payment Classification (APC) groups and relative payment weights that are components 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 may consider data collected or developed by entities and organizations (other than the Department of Health and Human Services) as part of their deliberations.

The Charter provides that the Panel shall meet up to three 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.

The Panel shall consist of a chair and up to 19 members who are full-time employees of hospitals, hospital systems, or other Medicare providers that are subject to the OPPS. (For purposes of the Panel, consultants or independent contractors are not considered to be representatives of providers.)

The current Panel members are as follows: (**Note:** The asterisk [*] indicates the Panel members whose terms end effective September 30, 2014.)

- E. L. Hambrick, M.D., J.D., Chair, a CMS Medical Officer.
- Karen Borman, M.D.
- Kari S. Cornicelli, C.P.A., FHFMA.*
- Brain D. Kavanagh, M.D., M.P.H.*
- Scott Manaker, M.D., Ph.D.*
- John Marshall, CRA, RCC, RT.*
- Jim Nelson
- Leah Osbahr
- Jacqueline Phillips
- Johnathan Pregler, M.D.
- Traci Rabine
- Wendy Resnick, FHFMA
- Michael Rabovsky, M.D.
- Marianna V. Spanki-Varelas M.D., Ph.D., M.B.A.
- Gale Walker
- Kris Zimmer

Panel members serve on a voluntary basis, without compensation, according

to an advance written agreement; however, for the meetings, CMS reimburses travel, meals, lodging, and related expenses in accordance with standard Government travel regulations. CMS has a special interest in ensuring, while taking into account the nominee pool, that the Panel is diverse in all respects of the following: Geography; rural or urban practice; race, ethnicity, sex, and disability; medical or technical specialty; and type of hospital, hospital health system, or other Medicare provider subject to the OPPS.

Based upon either self-nominations or nominations submitted by providers or interested organizations, the Secretary, or her designee, appoints new members to the Panel from among those candidates determined to have the required expertise. New appointments are made in a manner that ensures a balanced membership under the FACA guidelines.

II. Criteria for Nominees

The Panel must be fairly balanced in its membership in terms of the points of view represented and the functions to be performed. Each Panel member must be employed full-time by a hospital, hospital system, or other Medicare provider subject to payment under the OPPS. All members must have technical expertise to enable them to participate fully in the Panel's work. Such expertise encompasses hospital payment systems; hospital medical care delivery systems; provider billing systems; APC groups; Current Procedural Terminology codes; and alpha-numeric Health Care Common Procedure Coding System codes; and the use of, and payment for, drugs, medical devices, and other services in the outpatient setting, as well as other forms of relevant expertise. For supervision deliberations, the Panel shall have members that represent the interests of Critical Access Hospitals (CAHs), who advise CMS only regarding the level of supervision for hospital outpatient services.

It is not necessary for a nominee to possess expertise in all of the areas listed, but each must have a minimum of 5 years experience and currently have full-time employment in his or her area of expertise. Generally, members of the Panel serve overlapping terms up to 4 years, based on the needs of the Panel and contingent upon the rechartering of the Panel. A member may serve after the expiration of his or her term until a successor has been sworn in.

Any interested person or organization may nominate one or more qualified individuals. Self-nominations will also be accepted. Each nomination must include the following:

- Letter of Nomination stating the reasons why the nominee should be considered.
- Curriculum vitae or resume of the nominee that includes an email address where the nominee can be contacted.
- Written and signed statement from the nominee that the nominee is willing to serve on the Panel under the conditions described in this notice and further specified in the Charter.
- The hospital or hospital system name and address, or CAH name and address, as well as all Medicare hospital and or Medicare CAH billing numbers of the facility where the nominee is employed.

III. Copies of the Charter

To obtain a copy of the Panel's Charter, we refer readers to our Web site at the following: *http://www.cms.gov/Regulations-and-Guidance/Guidance/FACA/AdvisoryPanelonAmbulatoryPaymentClassificationGroups.html.*

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.

Dated: September 15, 2014.

Marilyn Tavenner,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2014–22634 Filed 9–22–14; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Submission for OMB Review; Comment Request

Title: Annual Statistical Report on Children in Foster Homes and Children in Families Receiving Payment in Excess of the Poverty Income Level from a State Program Funded Under Part A of Title IV of the Social Security Act.

OMB No.: 0970–0004.

Description

The Department of Health and Human Services is required to collect these data under section 1124 of Title I of the Elementary and Secondary Education Act, as amended by Public Law 103–382. The data are used by the U.S. Department of Education for allocation of funds for programs to aid disadvantaged elementary and secondary students. Respondents include various components of State Human Service agencies.

Respondents

The 52 respondents include the 50 States, the District of Columbia, and Puerto Rico.

ANNUAL BURDEN ESTIMATES

Instrument	Number of respondents	Number of responses per respondent	Average burden hours per response	Total burden hours
Annual Statistical Report on Children in Foster Homes and Children Receiving Payments in Excess of the Poverty Level From a State Program Funded Under Part A of Title IV of the Social Security Act	52	1	264.35	13,746.20

Estimated Total Annual Burden Hours: 13,746.20

Additional Information

Copies of the proposed collection may be obtained by writing to the Administration for Children and Families, Office of Planning, Research and Evaluation, 370 L'Enfant Promenade SW., Washington, DC 20447, Attn: ACF Reports Clearance Officer. All requests should be identified by the title of the information collection. Email address: *infocollection@acf.hhs.gov.*

OMB Comment

OMB is required to make a decision concerning the collection of information between 30 and 60 days after publication of this document in the **Federal Register**. Therefore, a comment is best assured of having its full effect