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:* New collection (Request for a new OMB control number); *Title of Information Collection:* Medicare and Medicaid Programs: Conditions of Participation for Home Health Agencies (HHA); Use: Home health services are covered for the elderly and disabled under the Hospital Insurance (Part A) and Supplemental Medical Insurance (Part B) benefits of the Medicare program, and are described in section 1861(m) of the Social Security Act (the Act) (42 U.S.C. 1395x). These services must be furnished by, or under arrangement with, an HHA that participates in the Medicare program, and be provided on a visiting basis in the beneficiary's home. They may include the following:

- Part-time or intermittent skilled nursing care furnished by or under the supervision of a registered nurse.
- Physical therapy, speech-language pathology, or occupational therapy.
- Medical social services under the direction of a physician.
- Part-time or intermittent home health aide services.
- Medical supplies (other than drugs and biologicals) and durable medical equipment.
- Services of interns and residents if the HHA is owned by or affiliated with a hospital that has an approved medical education program.
- Services at hospitals, SNFs, or rehabilitation centers when they involve equipment too cumbersome to bring to the home.

Section 1861(o) of the Act (42 U.S.C. 1395x) specifies certain requirements that a home health agency must meet to participate in the Medicare program. Existing regulations at 42 CFR 440.70(d) specify that HHAs participating in the Medicaid program must also meet the Medicare CoPs.) In particular, section 1861(o)(6) of the Act requires that an HHA must meet the CoPs specified in section 1891(a) of the Act and such other CoPs as the Secretary finds necessary in the interest of the health and safety of its patients. Section 1891(a) of the Act establishes specific requirements for HHAs in several areas, including patient rights, home health aide training and competency, and compliance with applicable Federal, State, and local laws.

Under the authority of sections 1861(o), 1871 and 1891 of the Act, the Secretary proposes to establish in regulations the requirements that an HHA must meet to participate in the Medicare program. These requirements would be set forth in 42 CFR part 484 as Conditions of Participation for Home Health Agencies. The CoPs apply to an HHA as an entity as well as the services furnished to each individual under the care of the HHA, unless a condition is specifically limited to Medicare beneficiaries.

Under section 1891(b) of the Act, the Secretary is responsible for assuring that the CoPs, and their enforcement, are adequate to protect the health and safety of individuals under the care of an HHA and to promote the effective and efficient use of Medicare funds. To implement this requirement, State survey agencies generally conduct surveys of HHAs to determine whether they are complying with the CoPs.

This information collection request is associated with Home Health Agency Conditions of Participation (0938–AG81) which published October 9, 2014. *Form Number:* CMS–10539 (OMB control number: 0938–NEW); *Frequency:* Annually; *Affected Public:* Business or other for-profits and not-for-profit institutions; *Number of Respondents:* 19,474; *Total Annual Responses:* 32,929,239; *Total Annual Hours:* 2,786,198. (For policy questions regarding this collection contact Danielle Shearer at 410–786–6617.)

Dated: April 21, 2015.

William N. Parham, III,

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

[FR Doc. 2015–09592 Filed 4–23–15; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–3320–N]

Medicare Program; Meeting of the Medicare Evidence Development and Coverage Advisory Committee—July 22, 2015

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

ACTION: Notice of meeting.

SUMMARY: This notice announces that a public meeting of the Medicare Evidence Development & Coverage Advisory Committee (MEDCAC) (''Committee'') will be held on Wednesday, July 22, 2015. This meeting will specifically focus on lower extremity peripheral artery disease. This meeting is open to the public in accordance with the Federal Advisory Committee Act (5 U.S.C. App. 2, section 10(a)).

DATES: *Meeting Date:* The public meeting will be held on Wednesday, July 22, 2015 from 7:30 a.m. until 4:30 p.m., Eastern Daylight Time (EDT).

Deadline for Submission of Written Comments: Written comments must be received at the address specified in the **ADDRESSES** section of this notice by 5 p.m., EDT, Monday, June 15, 2015. Once submitted, all comments are final.

Deadlines for Speaker Registration and Presentation Materials: The deadline to register to be a speaker and to submit PowerPoint presentation materials and writings that will be used in support of an oral presentation is 5:00 p.m., EDT on Monday, June 15, 2015. Speakers may register by phone or via email by contacting the person listed in the **FOR FURTHER INFORMATION CONTACT** section of this notice. Presentation materials must be received at the address specified in the **ADDRESSES** section of this notice.

Deadline for All Other Attendees Registration: Individuals may register online at *http://www.cms.gov/apps/events/upcomingevents.asp?strOrderBy=1&type=3* or by phone by contacting the person listed in the **FOR FURTHER INFORMATION CONTACT** section of this notice by 5 p.m. EDT, Wednesday, July 15, 2015. We will be broadcasting the meeting live via Webcast at *http://www.cms.gov/live/. Deadline for Submitting a Request for Special Accommodations:* Persons attending the meeting who are hearing or visually impaired, or have a condition that requires special assistance or accommodations, are asked to contact the Executive Secretary as specified in the **FOR FURTHER INFORMATION CONTACT** section of this notice no later than 5:00 p.m., EDT Friday, July 3, 2015.

ADDRESSES: *Meeting Location:* The meeting will be held in the main auditorium of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244.

Submission of Presentations and Comments: Presentation materials and written comments that will be presented at the meeting must be submitted via email to *MedCACpresentations@cms.hhs.gov* or by regular mail to the

contact listed in the **FOR FURTHER INFORMATION CONTACT** section of this notice by the date specified in the **DATES** section of this notice.

FOR FURTHER INFORMATION CONTACT: Maria Ellis, Executive Secretary for MEDCAC, Centers for Medicare & Medicaid Services, Center for Clinical Standards and Quality, Coverage and Analysis Group, S3–02–01, 7500 Security Boulevard, Baltimore, MD 21244 or contact Ms. Ellis by phone (410–786–0309) or via email at *Maria.Ellis@cms.hhs.gov.*

SUPPLEMENTARY INFORMATION:

I. Background

MEDCAC, formerly known as the Medicare Coverage Advisory Committee (MCAC), is advisory in nature, with all final coverage decisions resting with CMS. MEDCAC is used to supplement CMS' internal expertise. Accordingly, the advice rendered by the MEDCAC is most useful when it results from a process of full scientific inquiry and thoughtful discussion, in an open forum, with careful framing of recommendations and clear identification of the basis of those recommendations. MEDCAC members are valued for their background, education, and expertise in a wide variety of scientific, clinical, and other related fields. (For more information on MCAC, see the MEDCAC Charter (*http://www.cms.gov/Regulations-and-Guidance/Guidance/FACA/Downloads/medcaccharter.pdf*) and the CMS Guidance Document, *Factors CMS Considers in Referring Topics to the MEDCAC* (*http://www.cms.gov/medicare-coverage-database/details/medicare-coverage-document-details.aspx?MCDId=10*).

II. Meeting Topic and Format

This notice announces the Wednesday, July 22, 2015, public meeting of the Committee. During this meeting, the Committee will discuss lower extremity peripheral artery disease. Background information about this topic, including panel materials, is available at *http://www.cms.gov/medicare-coverage-database/indexes/medcac-meetings-index.aspx?bc=BAAAAAAAAAAA&.* We will no longer be providing paper copies of the handouts for the meeting. Electronic copies of all the meeting materials will be on the CMS Web site no later than 2 business days before the meeting. We encourage the participation of appropriate organizations with expertise in lower extremity peripheral artery disease.

This meeting is open to the public. The Committee will hear oral presentations from the public for approximately 45 minutes. Time allotted for each presentation may be limited. If the number of registrants requesting to speak is greater than can be reasonably accommodated during the scheduled open public hearing session, we may conduct a lottery to determine the speakers for the scheduled open public hearing session. The contact person will notify interested persons regarding their request to speak by June 22, 2015. Your comments should focus on issues specific to the list of topics that we have proposed to the Committee. The list of research topics to be discussed at the meeting will be available on the following Web site prior to the meeting: *http://www.cms.gov/medicare-coverage-database/indexes/medcac-meetings-index.aspx?bc=BAAAAAAAAAAA&.* We require that you declare at the meeting whether you have any financial involvement with manufacturers (or their competitors) of any items or services being discussed. Speakers presenting at the MEDCAC meeting must include a full disclosure slide as their second slide in their presentation for financial interests (for example, type of financial association—consultant, research support, advisory board, and an indication of level, such as minor association <$10,000 or major association >$10,000) as well as intellectual conflicts of interest (for example, involvement in a federal or nonfederal advisory committee that has discussed the issue) that may pertain in any way to the subject of this meeting. If you are representing an organization, we require that you also disclose conflict of interest information for that organization. If you do not have a PowerPoint presentation, you will need to present the full disclosure information requested previously at the beginning of your statement to the Committee.

The Committee will deliberate openly on the topics under consideration. Interested persons may observe the deliberations, but the Committee will not hear further comments during this time except at the request of the chairperson. The Committee will also allow a 15-minute unscheduled open public session for any attendee to address issues specific to the topics under consideration. At the conclusion of the day, the members will vote and the Committee will make its recommendation(s) to CMS.

III. Registration Instructions

CMS' Coverage and Analysis Group is coordinating meeting registration. While there is no registration fee, individuals must register to attend. You may register online at *http://www.cms.gov/apps/events/upcomingevents.asp?strOrderBy=1&type=3* or by phone by contacting the person listed in the **FOR FURTHER INFORMATION CONTACT** section of this notice by the deadline listed in the **DATES** section of this notice. Please provide your full name (as it appears on your state-issued driver's license), address, organization, telephone number(s), fax number, and email address. You will receive a registration confirmation with instructions for your arrival at the CMS complex or you will be notified that the seating capacity has been reached.

IV. Security, Building, and Parking Guidelines

This meeting will be held in a federal government building; therefore, federal security measures are applicable. We recommend that confirmed registrants arrive reasonably early, but no earlier than 45 minutes prior to the start of the meeting, to allow additional time to clear security. Security measures include the following:

- Presentation of government-issued photographic identification to the Federal Protective Service or Guard Service personnel.
- Inspection of vehicle's interior and exterior (this includes engine and trunk inspection) at the entrance to the grounds. Parking permits and instructions will be issued after the vehicle inspection.
- Inspection, via metal detector or other applicable means, of all persons entering the building. We note that all items brought into CMS, whether personal or for the purpose of presentation or to support a presentation, are subject to inspection. We cannot assume responsibility for coordinating the receipt, transfer, transport, storage, set-up, safety, or timely arrival of any personal belongings or items used for presentation or to support a presentation.

Note: Individuals who are not registered in advance will not be permitted to enter the building and will be unable to attend the meeting. The public may not enter the building earlier than 45 minutes prior to the convening of the meeting.

All visitors must be escorted in areas other than the lower and first floor levels in the Central Building.

V. Collection of Information

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).

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