ESTIMATED ANNUALIZED BURDEN HOURS—Continued

Type of respondents	Form name	No. of respondents	No. of responses per respondent	Average burden per response (in hours)	Total burden (in hours)
	Refresher Course Application	10	1	8	80
	One-Time Customer Satisfaction Survey.	23	1	12/60	5
Total					201

Leroy Richardson,

Chief, Information Collection Review Office, Office of Scientific Integrity, Office of the Associate Director for Science, Office of the Director, Centers for Disease Control and Prevention.

[FR Doc. 2013–30365 Filed 12–20–13; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10510]

Emergency Clearance: Public Information Collection Requirements Submitted to the Office of Management and Budget (OMB)

AGENCY: Centers for Medicare & Medicaid Services, HHS.

In compliance with 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 a summary of this proposed information collection for public comment. Interested persons are invited to send comments regarding this collection's proposed 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.

In compliance with section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, we have also submitted to the Office of Management and Budget (OMB) the proposed information collection for their emergency review. While the collection is necessary to ensure compliance with an initiative of the Administration, we are requesting emergency review under 5 CFR 1320(a)(2)(i) because public harm is reasonably likely to result if the regular clearance procedures are followed.

Without emergency approval, we will need to delay by approximately 4 months the release of Basic Health Program (BHP) federal payment rates beyond the March 2014 timeframe that was published in the BHP proposed regulation released on September 25, 2013 (78 FR 59122). Instead, we would release rates in early summer 2014 to accommodate the normal PRA approval process. Rates are needed in March 2014 to support state decisions to implement BHP on January 1, 2015, and to provide the necessary time for states to do their planning, contracting with issuers, and conducting open enrollment. Providing rates in the summer 2014 will likely postpone interested states' decisions and their implementation dates by as much as a year. This could result in as many as 1.3 million low income people not having access to BHP in early 2015, thereby prohibiting them from availing continuity of providers and health care that BHP is intended to provide. That is, BHP is a bridge program for low income people who today move in and out of health programs as their eligibility changes based on fluctuations in income and other factors, and such movements disrupt their access to the providers and services that they need. This delay in access to BHP benefits would likely cause public harm.

1. *Type of Information Collection Request:* New collection (request for a new OMB control number); *Title of Information Collection:* Basic Health Program Report for Health Insurance Exchange Premium; *Use:* In accordance with section 1331 of the Affordable Care Act, the Basic Health Program (BHP) is federally funded by determining the amount of payments that the federal government would have made through premium tax credits (PTCs) and cost sharing reductions (CSRs) for people enrolled in BHP had they instead been enrolled in an Exchange.

To calculate these amounts for each state, we need the reference premiums for the second lowest cost silver plans (SLCSPs) in each geographic area in a state, as SLCSPs are a basic unit in the calculation of PTCs and CSRs under the Exchanges. Relatedly, the reference premiums for these SLCSPs are critical components in the BHP payment methodology in order to estimate what PTCs and CSRs would have been paid. Similarly, we also need to collect reference premiums for the lowest cost bronze plans to appropriately account for CSR calculations for American Indians and Alaskan Natives. Reference premiums are foundational inputs into the BHP payment methodology.

We have the necessary information to determine these reference premiums for states whose Exchanges are operated by the Federally Facilitated Exchange (FFE) or in Partnership with the FFE. Therefore, this collection only pertains to the 17 states who are operating State Based Exchanges. A related notice, issued under CMS–2380–PN, is also publishing in today's **Federal Register**; *Form Number:* CMS–10510 (OCN: 0938–New); *Frequency:* Yearly; *Affected Public:* State, Local or Tribal Governments; *Number of Respondents:* 17; *Total Annual Responses:* 17; *Total Annual Hours:* 68. (For policy questions regarding this collection contact Jessica Schubel at 410–786–3032.)

We are requesting OMB review and approval of this collection by December 23, 2013, with a 180-day approval period. Written comments and recommendations will be considered from the public if received by the date and address noted below.

Copies of the supporting statement and any related forms can be found at: *http://www.cms.hhs.gov/PaperworkReductionActof1995* or can be obtained by emailing your request, including your address, phone number, OMB number, and CMS document identifier, to: *Paperwork@cms.hhs.gov,* or by calling the Reports Clearance Office at: 410–786–1326.

When commenting on this proposed information collection, please reference the CMS document identifier and the OMB control number (OCN). To be assured consideration, comments and

recommendations must be received in one of the following ways by January 2, 2014:

1. *Electronically.* You may submit 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) 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 (CMS–10510), Room C4–26–05, 7500 Security Boulevard, Baltimore, Maryland 21244–1850 and, OMB Office of Information and Regulatory Affairs, Attention: CMS Desk Officer, New Executive Office Building, Room 10235, Washington, DC 20503, Fax Number: 202–395–6974.

Dated: December 17, 2013.

Martique Jones,

Deputy Director, Regulations Development Group, Office of Strategic Operations and Regulatory Affairs.

[FR Doc. 2013–30434 Filed 12–18–13; 4:15 pm]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–9953–FN]

Health Insurance Exchanges; Approval of an Application by the Accreditation Association for Ambulatory Health Care (AAAHC) To Be a Recognized Accrediting Entity for the Accreditation of Qualified Health Plans

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

ACTION: Final notice.

SUMMARY: This final notice announces our decision to approve the Accreditation Association for Ambulatory Health Care (AAAHC) for recognition as an accrediting entity for the purposes of fulfilling the accreditation requirement as part of qualified health plan (QHP) certification.

DATE: This notice is effective on December 23, 2013.

FOR FURTHER INFORMATION CONTACT: Rebecca Zimmermann, (301) 492–4396.

SUPPLEMENTARY INFORMATION:

I. Background

Regulations at 45 CFR 156.275(c) require qualified health plan (QHP) issuers to be accredited on the basis of local performance of its QHPs by an accrediting entity recognized by the Secretary (the Secretary) of the Department of Health and Human Services (HHS). In a final rule published on July 20, 2012 titled, ''Data Collection To Support Standards Related to Essential Health Benefits; Recognition of Entities for the Accreditation of Qualified Health Plans (77 FR 42658),'' we established the first phase of an intended two-phase approach to recognize accrediting entities and proposed both the National Committee for Quality Assurance (NCQA) and URAC as recognized accrediting entities. On November 23, 2012, we notified the public that NCQA and URAC had both met the requirements in the July 2012 final rule to be recognized as accrediting entities (§ 156.275(c)(1)(iv)) and were recognized by the Secretary [1] as accrediting entities for the purposes of QHP certification.

On February 25, 2013, we published a subsequent final rule, titled, ''Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation'' (78 FR 12834),[2] which amended § 156.275(c) to establish an application and review process to allow additional accrediting entities to seek recognition. The application submitted by an accrediting entity must include documentation described in § 156.275(c)(4) and demonstrate, in a concise and organized fashion, how the accrediting entity meets the requirements of § 156.275(c)(2) and (3). Specifically, to be recognized, an accrediting entity must provide current accreditation standards and requirements, processes, and measure specifications for performance measures to demonstrate via a crosswalk that it meets the conditions described in § 156.275(c)(2) and (c)(3). Further, once recognized, § 156.275(c)(4)(ii) requires accrediting entities to provide the Secretary with any proposed changes or updates to the accreditation standards and requirements, processes, and measure specifications for performance measures with 60 days' notice prior to public notification. Lastly, § 156.275(c)(5) requires recognized accrediting entities, when authorized by an accredited QHP issuer, to provide specific QHP issuer accreditation survey data elements, other than personally identifiable information, to the Exchange in which the issuer plans to operate one or more QHPs during the annual certification or as changes occur in the data elements throughout the coverage year.

II. Provisions of the Proposed Notice

On September 13, 2013, we published in the **Federal Register** a proposed notice [3] announcing the receipt of an application from the Accreditation Association for Ambulatory Health Care (AAAHC) to be a recognized accrediting entity for the purposes of fulfilling the accreditation requirement as part of qualified health plan certification. In the proposed notice, we provided a detailed analysis of whether AAAHC meet the requirements as specified in our regulations at § 156.275. In addition, we solicited public comments on whether it was appropriate to recognize AAAHC as an accrediting entity for the purpose of QHP certification; AAAHC's accreditation standards for QHP issuers including whether or not AAAHC's standards meet the requirements in § 156.275; whether AAAHC had any deficiencies in its standards; the content of the proposed clinical quality measures and their appropriateness for use in QHP accreditation; the rigor of the scoring methodology; and if the network adequacy standards will ensure sufficient network of providers for QHP enrollees.

III. Analysis of and Response to Public Comments on the Proposed Notice

We received nine public comments in response to the September 13, 2013 proposed notice. Five commenters supported the recommendation to recognize AAAHC as an accrediting entity for the purposes of QHP accreditation; whereas two commenters did not support the proposal to recognize AAAHC as an accrediting entity. Two commenters provided comments that were outside the scope of the proposed notice.

One commenter questioned the comparability of AAAHC's standards to other HHS-recognized accrediting entities. Another commenter requested that more child measures be included in the clinical quality metrics. Both of these commenters thought that the accreditation standards were not sufficiently transparent.

[1] Certain authority under the Affordable Care Act has been delegated from the Secretary to the Administrator of CMS. 76 FR 53903 through 53906, (August 30, 2011).

[2] Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation; Final Rule, 78 FR 12834, 12854–12855 (February 25, 2013) (45 CFR 156.275(c)).

[3] Health Insurance Exchanges; Application by the Accreditation Association for Ambulatory Health Care To Be a Recognized Accrediting Entity for the Accreditation of Qualified Health Plans; 78 FR 56711–56714 (September 13, 2013).