and submits a variety of cash management and travel reports required by the Department of the Treasury and various other outside agencies; (6) acts as liaison with the CIOs and outside customers to provide financial information, resolve problems and provide training and advice on payment, travel and disbursement issues; (7) serves as the CDC subject matter expert on all financial matters dealing with international travel, assignments and payments; and (8) analyzes internal reports to provide management information on topics such as interest expenses, workload, and various other performance indicators.

Cash Management and Quality Control Section (HCAC62). (1) Overall responsibility for policies, procedures, internal controls and systems related to section payment and disbursement activities; (2) analyzes and reconciles disbursements made for CDC by other Federal activities, and insures that disbursements are consistent with Federal Appropriations Law requirements, GAO policies, interagency elimination entry requirements, and other governing financial regulations; (3) overall responsibility for all financial matters dealing with international travel, assignments and payments; (4) serves as the focal point at CDC for vendor, employee and CIO payment and disbursement questions and resolution of payment and disbursement problems; (5) acts as CDC liaison on all payment issues related to the implementation of the Government Purchase Card Program; (6) maintains contract advance records and coordinates the recording and reconciling of subsidiary records to general ledger advance accounts; (7) serves as the CDC focal point for cashier and imprest fund issues; (8) analyzes year-end liquidated obligations for compliance with Federal Appropriations Laws and the Economy Act, and recommends funding changes to CIO's; and (9) prepares and reconciles all U.S. Treasury Department reports and transmissions and serves as the primary point of contact for all U.S. Treasury issues; (10) performs ongoing quality control reviews of various payment and disbursement processes and systems in the Financial Services Branch, including reviews to ensure compliance with the Prompt Payment Act and to validate the legality, propriety and accounting treatment of travel and non-travel payments at CDC, including reviews of payments processed by the Cincinnati office; (11) identifies recurring problems in payment processes and recommends corrective actions or identifies required training to correct the deficiency; (12) serves as the focal point for all Federal Income Tax issues for CDC payments, reconciles tax withholding general ledger accounts, and prepares all monthly, quarterly and annual reports to the Internal Revenue Service; and (13) establishes local policy and procedures on electronic payments and maintains the automated file containing vendor payment address and banking information.

Payment and Travel Services Section (HCAC63). (1) Develops and implements policies and procedures related to payment processes and systems and ensures appropriate internal controls are in place and functioning to ensure the integrity and legality of CDC payments; (2) analyzes and approves payment for all equipment, supplies, travel, transportation and services procured by CDC, and ensures the validity, legality and proper accounting treatment of expenditures processed through the Accounts Payable module of the CDC Financial Management System; (3) provides expert level guidance, oversight, and interpretation of policies, laws, rules and regulations for the CIO's on all aspects of travel procedures and policies at CDC, including the use of the automated travel system, local travel, domestic and foreign temporary duty travel, and change of station travel for civil service employees, foreign service employees, commissioned officers, CDC fellows, etc.; (4) serves as the Subject Matter Expert and focal point for the development of new financial systems to automate accounts payable operations and serves as the focal point for payment system issues for CDC; (5) researches and analysis appropriations law issues at CDC and provides guidance consistent with legal and regulatory guidelines; (6) complies and submits a variety of management and payment performance reports required by various outside agencies; (7) analyzes various internal reports to provide management information on topics such as interest expenses, workload, and various other performance indicators; (8) coordinates all aspects of CDC's Electronic Commerce Program in the Financial Services Branch; and (9) analyzes a variety of accounting and travel system reports to ensure that obligations are liquidated in a timely manner.

Dated: March 13, 2002.

David Fleming,

Acting Director.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–4026–FN]

RIN 0938–ZA21

Medicare Program; Medicare+Choice Organizations—Approval of the Joint Commission on Accreditation of Healthcare Organizations for Medicare+Choice (M+C) Deeming Authority for Managed Care Organizations That Are Licensed as Health Maintenance Organizations (HMOs) or Preferred Provider Organizations (PPOs)

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

ACTION: Final notice.

SUMMARY: This final notice announces the approval of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) for deeming authority of Medicare+Choice (M+C) organizations that are licensed as health maintenance organizations (HMOs) or preferred provider organizations (PPOs). We have found that the JCAHO's standards for managed care plans/integrated delivery networks/provider-sponsored organizations (networks) submitted to us and amended during the application process, meet or exceed those established by the Medicare program. Therefore, M+C organizations that are licensed as HMOs or PPOs and are accredited by JCAHO, may receive, at their request, deemed status for the M+C requirements in the six areas—Quality Assurance, Information on Advance Directives, Antidiscrimination, Access to Services, Provider Participation Rules, and Confidentiality and Accuracy of Enrollee Records—that are specified in section 1852(e)(4)(B) of the Social Security Act (the Act).

Regulations set forth in 42 CFR 422.157(b)(2) specify that the Secretary will publish a **Federal Register** notice that indicates whether an accreditation organization's request for approval has been granted and the effective date and term of the approval, which may not exceed 6 years.

FOR FURTHER INFORMATION CONTACT: Trisha Kurtz, (410) 786–4670.

I. Background

Under the Medicare program, eligible beneficiaries may receive covered services through a managed care organization that has a Medicare+Choice (M+C) contract with us. To enter into an M+C contract, the

organization must be licensed by the State as a risk-bearing entity and must meet the requirements that are set forth in 42 CFR part 422. Those regulations implement part C of title XVIII of the Social Security Act (the Act), which specifies the services that a managed care organization must provide and the requirements that the organization must meet to be an M+C contractor. Other relevant sections of the Act are parts A and B of title XVIII and part A of title XI pertaining to the provision of services by Medicare certified providers and suppliers.

Following approval of the M+C contract, we engage in routine monitoring of the M+C organization to ensure continuing compliance. The monitoring process is comprehensive and uses a written protocol that specifies the Medicare requirements the M+C organization must meet.

An M+C organization may be exempt from our monitoring of the requirements that are in the areas listed in section 1852(e)(4)(B) of the Act if the organization is accredited by a CMS-approved accrediting organization. In essence, the Secretary ''deems'' that the Medicare requirements are met based on a determination that the accrediting organization's standards are at least as stringent as Medicare requirements. Regulations for the M+C deeming program are set forth in §§ 422.156, 422.157, and 422.158. The term for which we may approve an accrediting organization may not exceed 6 years as stated in § 422.157(b)(2). For continuing approval, the accrediting organization will have to re-apply to us.

II. Provisions of the Proposed Notice

On September 18, 2001, we published a proposed notice in the **Federal Register** (66 FR 48147) announcing the receipt of an application from JCAHO for approval of deeming authority for M+C organizations that are licensed as health maintenance organizations (HMOs) or preferred provider organizations (PPOs). In the proposed notice, we provided the factors on which we would base our evaluation. In accordance with § 422.157(b)(1)(iii) of the M+C regulations, we provided a 30-day public comment period. We did not receive any public comments in response to that proposed notice.

III. Deeming Approval Review and Evaluation

As set forth in section 1852(e)(4) of the Act and our regulations at § 422.158, the review and evaluation of the JCAHO's accreditation program (including their standards and monitoring protocol) was compared to the requirements set forth in part 422 for the M+C program.

A. Components of the Review Process

The review of JCAHO's application for approval of M+C deeming authority included the following components.

1. Site Visit

A site visit to JCAHO's headquarters was conducted to assess—

- The corporate policies and procedures that relate to the network accreditation program;
- The survey, decision-making, and report-writing processes used in JCAHO's network accreditation program;
- The resources available for accreditation reviews and JCAHO's ability to financially sustain an M+C deeming program;
- The staff and surveyor training and evaluation programs;
- The communication, customer support and release of accreditation information to the public; and
- JCAHO's ability to investigate and respond appropriately to complaints against accredited networks.

2. Desk-Top Review

A desk-top review of JCAHO's network accreditation program, included the following items—

- A description of JCAHO's survey process for networks, including the frequency of surveys performed, whether the surveys are announced or unannounced, surveyor instructions, the review and accreditation status decision-making process, procedures used to notify accredited M+C organizations of deficiencies and monitoring of the correction of deficiencies, and the procedures used to enforce compliance with accreditation requirements;
- Information about the individuals who perform network accreditation reviews, including the size and composition of the survey team, the methods of compensation, the education and experience required of them, the content and frequency of the in-service training, the evaluation system used to monitor performance, and the conflict of interest requirements governing JCAHO staff;
- A description of the data management and analysis system, the types (full, partial, or denial) and categories (provisional, conditional, temporary) of accreditation offered by JCAHO, the duration of each category of accreditation, and a statement identifying the types and categories that would serve as a basis for accreditation, if we grant JCAHO M+C organization deeming authority;
- The procedures used to respond to and investigate complaints or identify other problems with accredited organizations, including any coordination of these activities with licensing bodies and ombudsmen programs;
- A description of how JCAHO provides accreditation information to the general public;
- The policies and procedures for (1) withholding, denying and removing accreditation status, and the other actions JCAHO may take in response to noncompliance with their standards and requirements; and (2) how JCAHO treats accreditation of organizations that are acquired by another organization, have merged with another organization, or that undergo a change of ownership or management;
- Lists of all (1) JCAHO-accredited M+C organizations, (2) networks surveyed by JCAHO in the past 3 years, and (3) networks that were scheduled to be surveyed by JCAHO within 3 months of submitting their application;
- A written presentation of JCAHO's ability to furnish data electronically, via telecommunications;
- A resource analysis that included financial statements for the past 3 years (audited, if possible) and the projected number of deemed status surveys for the upcoming year; and
- A statement acknowledging that, as a condition of approval, JCAHO agreed to comply with the ongoing responsibility requirements stated in § 422.157(c).

3. Assessment of JCAHO's Standards and Methods of Evaluation

As part of the application, JCAHO submitted a crosswalk that compared its standards and methods of evaluations with corresponding M+C requirements. A multicomponent team of our regional and central office staff then reviewed and evaluated JCAHO's standards and processes and compared them to the M+C requirements in six areas: Quality Assurance, Access to Services, Antidiscrimination, Information on Advance Directives, Provider Participation Rules, and Confidentiality and Accuracy of Enrollee Records.

4. Observation of a JCAHO Accreditation Survey

An observation of a JCAHO accreditation survey of a network organization allowed our staff to (1) validate that the accreditation review methods described in JCAHO's application were equal to (or exceeded) the corresponding Medicare requirements, and (2) resolve outstanding issues that were identified

during the review of JCAHO's application materials.

B. Results of the Review Process

We determined that JCAHO's current accreditation program for networks either did not address or did not ''meet or exceed'' several of the M+C requirements contained in the six categories set forth in section 1852(e)(4)(B) of the Act. To address this issue, JCAHO agreed to complement their current network accreditation program. Thus, when assessing M+C organizations (including their subcontractors and affiliates, as applicable) that seek deemed status for the Medicare requirements contained in the six categories established in the Act, JCAHO will add the requirements described below.

1. Quality Assurance (§ 422.152)

JCAHO will add to its accreditation standards requirements for M+C organizations to do the following—

- Achieve and report minimum performance levels when we establish them;
- Assess enrollee satisfaction;
- Correct significant systemic problems that come to their attention through internal surveillance, complaints or other mechanisms, such as the use of appeals and grievances;
- Conduct quality improvement projects that meet or exceed the requirements specified in § 422.152.
- Collect data related to (1) both acute and chronic conditions as related to preventive services and care outcomes, (2) the use of clinical resources for high volume services, and (3) the availability, accessibility, and cultural competency of services;
- Select quality indicators that are objective, clearly defined, based upon current research, and generally used in the public health community. Indicators must be measured over time, monitored for at least 1 year after the desired level of performance is achieved (sustained improvement), and benchmarked to targets if we specify targets;
- Designate a policymaking body and a senior official that are accountable for the quality assurance program and that encourage providers and consumers to participate actively;
- Evaluate the effectiveness of the quality assurance program strategy on an annual basis and modify as necessary.

2. Provider Participation Rules (42 CFR part 422 subpart E)

JCAHO will add to its accreditation standards requirements for M+C organizations to do the following—

- Provide physicians with (1) written notice of material changes in participation rules before the changes are put into effect, (2) written notice of participation decisions that are adverse to physicians, and (3) a process for appealing adverse participation decisions, including (a) having a majority of the members of the hearing panel be peers of the affected physician, and (b) allowing the physician the opportunity to present information on the decision;
- Provide that the participation guidelines, procedures, and Federal requirements apply equally and consistently to all physicians, and do not allow for employment or contracts with individuals excluded from the Medicare program;
- Provide (1) written notification (with specific content) when suspending or terminating an agreement under which the physician provides services to the M+C plan enrollees, and (2) notification to licensing and disciplinary bodies on quality-related suspensions or terminations;
- Provide at least 60 days written notice (applies to provider as well) before terminating a contract without cause;
- Make information available to us and to enrollees on counseling or referral services to which the M+C organization objects on moral or religious grounds;
- Distribute to each enrollee, at the time of enrollment and at least annually thereafter, a written statement that includes information on his or her right to obtain a summary description of the method of physician compensation;
- Ensure that participating providers and suppliers who provide services to Medicare enrollees are approved for participation in Medicare and that the M+C organization does not employ or contract with providers who have opted out of Medicare participation;
- Address the limitation on provider indemnification that is stated in § 422.212.

JCAHO agreed to a Physician Incentive Plan (PIP) review strategy that we proposed. M+C organizations will continue to provide PIP information directly to us. We will notify JCAHO when a M+C organization that they have deemed is ''noncompliant'' for any of the PIP requirements; JCAHO will then contact the M+C organization to inform it that it must comply with the PIP provisions. If, at the end of the accrediting organization's corrective action process, the M+C organization continues to be noncompliant, the accrediting organization will refer the case to us.

3. Information on Advance Directives (§ 422.128)

JCAHO will add to its accreditation standards requirements for M+C organizations to do the following—

- Implement written policies and procedures for advance directives for all adult patients served, and share those policies and procedures with each enrollee at the time of enrollment;
- Comply with State laws that (1) allow the provider to conscientiously object to certain types of care (including a statement of limitation, if the M+C organization cannot implement the advance directive), and (2) require information concerning health care decision-making rights to be reflected within 90 days after the effective date of the law;
- Inform individuals that complaints concerning noncompliance with the advance directive requirements may be filed with the State survey and certification agency.

4. Antidiscrimination (§ 422.110 and § 422.502(h))

JCAHO will add to its accreditation standards requirements for M+C organizations to do the following—

- Prohibit the denial, limitation or conditioning of coverage or benefits to eligible enrollees on the basis of any factor that relates to health status, except in the case of an individual with end-stage renal disease;
- Comply with all applicable laws and regulations related to discrimination and payment sources.

5. Access to Services (§ 422.112)

JCAHO will add to its accreditation standards requirements for M+C organizations to do the following—

- Instruct enrollees regarding their right to (1) access emergency services without prior authorization, (2) choose a personal provider from a panel of primary care providers accepting new enrollees, and (3) refuse care from specific providers;
- Provide information regarding treatment options in a language that the enrollee understands;
- Provide services, both clinical and nonclinical, that are readily available, accessible, and appropriate, when medically necessary (24 hours a day/7 days a week) to all enrollees, including those with limited English proficiency or reading skills and those with diverse cultural and ethnic backgrounds. Services include access to specialty care such as women's health services;
- Provide coordination-of-care programs that include (1) an initial health care needs assessment and a

follow-up process, (2) policies regarding ongoing coordination of care by primary care providers or other means, (3) procedures for the identification of, and treatment plans for, individuals with complex or serious needs, and (4) coordination of plan services with community and social services;

• Establish, monitor, and improve performance regarding standards for timeliness of access to care and member services that meet or exceed our standards;

• Conduct an ongoing program to monitor compliance with policies and procedures that ensure that information for patient care and quality review is available;

• Transmit information to the enrollee's primary care provider regarding services used under a point-of-service (POS) benefit by an enrollee.

6. Confidentiality and Accuracy of Enrollee Records (§ 422.118)

JCAHO will add to its accreditation standards requirements for M+C organizations to release original medical records only in accordance with Federal or State laws, court orders, or subpoenas; however, when permitted by law, the records must be made available to treatment providers and to organizations involved in assessing quality of care or investigating enrollee grievances.

7. Delegation Requirements (Contained in Five of Six Deeming Categories)

JCAHO will add to its accreditation standards requirements for M+C organizations to do the following—

• Oversee and be accountable for any functions or responsibilities that are described in the standards for which JCAHO received deeming authority, if that area (or standard) is delegated to another entity;

• Specify in a written agreement the delegated activities and reporting responsibilities of the entity and provide for the revocation of the delegation or other remedies for inadequate performance;

• Monitor the performance of the entity on an ongoing basis and formally review the organization at least annually.

C. Term of Approval

Regulations at § 422.157(b)(2) permit us to grant a term of approval for deeming authority for accreditation organizations of up to 6 years. We are granting this deeming authority through March 24, 2008.

IV. Paperwork Reduction Act

The requirements associated with granting and withdrawal of deeming authority to national accreditation organizations, codified in part 422, Medicare+Choice Program, are currently approved by OMB under OMB approval number 0938–0690, with an expiration date of June 30, 2002. Consequently, this notice does not need to be reviewed by the Office of Management and Budget (OMB) under the authority of the PRA.

V. Regulatory Impact Statement

We have examined the impact of this notice as required by Executive Order 12866 (September 1993, Regulatory Planning and Review) and the Regulatory Flexibility Act (RFA) September 19, 1980 (Pub. L. 96–354). Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects; distributive impacts; and equity).

The RFA requires agencies to analyze options for regulatory relief for small businesses, nonprofit organizations and government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $5 million to $25 million or less in any 1 year (for details, see the Small Business Administration's publication that set forth size standards for health care industries at 65 FR 69432). For purposes of the RFA, States and individuals are not considered small entities.

Also, section 1102(b) of the Act requires the Secretary to prepare a regulatory impact analysis for any notice that may have a significant impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we consider a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds.

This notice merely recognizes JCAHO as a national accreditation organization that has approval for deeming authority for HMOs or PPOs that are participating in the M+C program. Since M+C organizations are monitored every 2 years by our regional office staff to determine compliance with M+C requirements, we believe that the M+C deeming program has the potential to reduce both the regulatory and administrative burdens associated with the Medicare+Choice program. In FY 2001, there were 179 M+C contracts and 5,578,605 enrollees. Approximately eight of those M+C organizations were accredited by JCAHO.

This notice is not a major rule as defined in Title 5, United States Code, section 804(2) and is not an economically significant rule under Executive Order 12866.

Therefore, we have determined, and the Secretary certifies, that this notice will not result in a significant impact on small entities and will not have an effect on the operations of small rural hospitals. Therefore, we are not preparing analyses for either the RFA or section 1102(b) of the Act.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditure in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. This notice has no consequential effect on State, local, or tribal governments. We believe the private sector costs of this notice fall below this threshold as well.

In accordance with Executive Order 13132, this notice will not significantly affect the rights of States and does not significantly affect State authority. This regulation describes only processes that must be undertaken to fulfill our obligation to enforce our regulations as required by the April 8, 1997 (62 FR 16985) regulation.

In accordance with the provisions of Executive Order 12866, this notice was not reviewed by OMB.

Authority: Secs. 1851 and 1855 of the Social Security Act (42 U.S.C. 1395w–21 and 42 U.S.C. 1395w–25)

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: March 14, 2002.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 02–7123 Filed 3–21–02; 8:45 am]

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