

March 30, 2012. Under section 1865(a)(2) of the Act and our regulations at § 488.8 (Federal review of accrediting organizations), our review and evaluation of CHAP will be conducted in accordance with, but not necessarily limited to, the following factors:

- The equivalency of CHAP's standards for a hospice as compared with CMS' hospice conditions of participation.
- CHAP's survey process to determine the following:
 - + The composition of the survey team, surveyor qualifications, and the ability of the organization to provide continuing surveyor training.
 - + The comparability of CHAP's processes to those of State agencies, including survey frequency, and the ability to investigate and respond appropriately to complaints against accredited facilities.
- CHAP's processes and procedures for monitoring a hospice found out of compliance with CHAP's program requirements. These monitoring procedures are used only when CHAP identifies noncompliance. If noncompliance is identified through validation reviews or complaint surveys, the State survey agency monitors corrections as specified at § 488.7(d).
- CHAP's capacity to report deficiencies to the surveyed facilities and respond to the facility's plan of correction in a timely manner.
- CHAP'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 CHAP's staff and other resources, and its financial viability.
- CHAP's capacity to adequately fund required surveys.
- CHAP's policies with respect to whether surveys are announced or unannounced, to assure that surveys are unannounced.
- CHAP's agreement to provide CMS with a copy of the most current accreditation survey, together with any other information related to the survey as we may require (including corrective action plans).

IV. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 35).

V. Response to Public 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.

Upon completion of our evaluation, including evaluation of comments received as a result of this notice, we will publish a final notice in the **Federal Register** announcing the result of our evaluation.

V. Regulatory Impact Statement

In accordance with the provisions of Executive Order 12866, this proposed notice was not reviewed by the Office of Management and Budget.

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program; No. 93.773 Medicare—Hospital Insurance Program; and No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: May 21, 2012.

Marilyn Tavenner,

Acting Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2012-12816 Filed 5-24-12; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS-4164-FN]

Medicare Program; Approved Renewal of Deeming Authority of the Utilization Review Accreditation Commission for Medicare Advantage Health Maintenance Organizations and Local Preferred Provider Organizations

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

ACTION: Final notice.

SUMMARY: This notice announces our decision to renew the Medicare Advantage “deeming authority” of the Utilization Review Accreditation Commission (URAC) for Health Maintenance Organizations and Preferred Provider Organizations for a term of 6 years. This new term of approval would begin May 26, 2012, and end May 25, 2018.

DATES: This final notice is effective May 26, 2012 through May 25, 2018.

FOR FURTHER INFORMATION CONTACT:

Caroline Baker, (410) 786-0116; or Edgar Gallardo, (410) 786-0361.

SUPPLEMENTARY INFORMATION:

I. Background

Under the Medicare program, eligible beneficiaries may receive covered services through a Medicare Advantage (MA) organization that contracts with CMS. The regulations specifying the Medicare requirements that must be met for a Medicare Advantage Organization (MAO) to enter into a contract with CMS are located at 42 CFR part 422. These regulations implement Part C of Title XVIII of the Social Security Act (the Act), which specifies the services that an MAO must provide and the requirements that the organization must meet to be an MA 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. Generally, for an entity to be an MA organization, the organization must be licensed by the State as a riskbearing organization as set forth in part 422.

As a method of assuring compliance with certain Medicare requirements, an MA organization may choose to become accredited by a CMS-approved accrediting organization (AO). Once accredited by such a CMS-approved AO, we deem the MA organization to be compliant in one or more of six requirements set forth in section 1852(e)(4)(B) of the Act. For an AO to be able to “deem” an MA plan as compliant with these MA requirements, the AO must prove to CMS that its standards are at least as stringent as Medicare requirements. Health maintenance organizations (HMOs) or preferred provider organizations (PPOs) accredited by an approved AO may receive, at their request, “deemed” status for CMS requirements with respect to the following six MA criteria: Quality Improvement; Antidiscrimination; Access to Services; Confidentiality and Accuracy of Enrollee Records; Information on Advanced Directives; and Provider Participation Rules. (See 42 CFR 422.156(b)). At this time, recognition of accreditation does not include the Part D areas of review set out at § 423.165(b). AOs that apply for MA deeming authority are generally recognized by the health care industry as entities that accredit HMOs and PPOs. As we specify at § 422.157(b)(2)(ii), the term for which an AO may be approved by CMS may not exceed 6 years. For continuing approval, the AO must apply to CMS to

renew its “deeming authority” for a subsequent approval period.

The Utilization Review Accreditation Commission (URAC) was approved as a CMS approved accreditation organization for MA deeming of HMOs on May 26, 2006, and that term will expire on May 26, 2012. On December 9, 2011, URAC submitted an application to renew its deeming authority. On that same date, URAC submitted materials requested from CMS which included updates and/or changes to items set out in Federal regulations at § 422.158(a) that are prerequisites for receiving approval of its accreditation program from CMS, and which were furnished to CMS by URAC as a part of their renewal applications for HMOs and PPOs.

II. Deeming Applications Approval Process

Section 1865(a)(3)(A) of the Act provides a statutory timetable to ensure that our review of deeming applications is conducted in a timely manner. The Act provides us with 210 calendar days after the date of receipt of an application to complete our survey activities and application review process. Within 60 days of receiving a completed application, we must publish a notice in the **Federal Register** that identifies the national accreditation 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 an approval or denial of the application.

III. Proposed Notice

In the March 30, 2012, **Federal Register** (77 FR 19288), we published a proposed notice announcing URAC's request for continued CMS approval of its deeming authority for MA HMOs and PPOs. In the proposed notice, we detailed our evaluation criteria. Under section 1852(e)(4) of the Act and our regulations at § 422.158 (Federal review of accrediting organizations), we conducted a review of URAC's application in accordance with the criteria specified by our regulations, which include, but are not limited to the following:

- The types of MA plans that it would review as part of its accreditation process.
- A detailed comparison of the organization's accreditation requirements and standards with the Medicare requirements (for example, a crosswalk).
- Detailed information about the organization's survey process, including the following—
 - ++ Frequency of surveys and whether surveys are announced or unannounced.

++ Copies of survey forms, and guidelines and instructions to surveyors.

++ Descriptions of—

—The survey review process and the accreditation status decision making process;

—The procedures used to notify accredited MA organizations of deficiencies and to monitor the correction of those deficiencies; and

—The procedures used to enforce compliance with accreditation requirements.

• Detailed information about the individuals who perform surveys for the accreditation organization, including the following—

++ The size and composition of accreditation survey teams for each type of plan reviewed as part of the accreditation process;

++ The education and experience requirements surveyors must meet;

++ The content and frequency of the in-service training provided to survey personnel;

++ The evaluation systems used to monitor the performance of individual surveyors and survey teams; and

++ The organization's policies and practice with respect to the participation, in surveys or in the accreditation decision process by an individual who is professionally or financially affiliated with the entity being surveyed.

• A description of the organization's data management and analysis system with respect to its surveys and accreditation decisions, including the kinds of reports, tables, and other displays generated by that system.

• A description of the organization's procedures for responding to and investigating complaints against accredited organizations, including policies and procedures regarding coordination of these activities with appropriate licensing bodies and ombudsmen programs.

• A description of the organization's policies and procedures with respect to the withholding or removal of accreditation for failure to meet the accreditation organization's standards or requirements, and other actions the organization takes in response to noncompliance with its standards and requirements.

• A description of all types (for example, full, partial) and categories (for example, provisional, conditional, temporary) of accreditation offered by the organization, the duration of each type and category of accreditation and a statement identifying the types and categories that would serve as a basis for

accreditation if CMS approves the accreditation organization.

• A list of all currently accredited MA organizations and the type, category, and expiration date of the accreditation held by each of them.

• A list of all full and partial accreditation surveys scheduled to be performed by the accreditation organization as requested by CMS.

• The name and address of each person with an ownership or control interest in the accreditation organization.

• CMS also considers URAC's past performance in the deeming program and results of recent deeming validation reviews, or look-behind audits conducted as part of continuing Federal oversight of the deeming program under § 422.157(d).

In accordance with section 1865(a)(3)(A) of the Act, the March 30, 2012 proposed notice (77 FR 19288) also solicited public comments regarding whether URAC's requirements met or exceeded the Medicare conditions of participation as an accrediting organization for MA HMOs and PPOs. We received no public comments in response to our proposed notice.

IV. Provisions of the Final Notice

A. Differences Between URAC's Standards and Requirements for Accreditation and Medicare's Conditions and Survey Requirements

We compared the standards and survey process contained in URAC's application with the Medicare conditions for accreditation. Our review and evaluation of URAC's application for continued CMS-approval were conducted as described in section III of this final notice, and yielded the following:

• URAC amended its crosswalk to ensure current URAC standards are clearly crosswalked to the following regulatory requirements: §§ 422.128; 422.206(b)(2); 422.112(a)(1); 422.112(a)(2); 422.112(a)(8); 422.112(b)(3); 422.112(b)(4)(iii); 422.112(b)(5); 422.118; 422.152; 422.202(b); and 422.202(c).

• To meet the amendments made at § 422.156 by the final rule published in the April 15, 2011 **Federal Register** (76 CFR 21432), URAC removed Quality Improvement Projects and Chronic Care Improvement Programs from its deeming process.

B. Term of Approval

Based on the review and observations described in section III of this final notice, we have determined that URAC's accreditation program requirements

meet or exceed our requirements. Therefore, we approve URAC as a national accreditation organization with deeming authority for MA HMOs and PPOs, effective May 26, 2012 through May 25, 2018.

V. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 35).

Authority: Section 1865 of the Social Security Act (42 U.S.C. 1395bb).

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program; No. 93.773 Medicare—Hospital Insurance Program; and No. 93.774, Medicare—Supplemental Medical Insurance Program)

Dated: May 21, 2012.

Marilyn Tavenner,

Acting Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2012–12812 Filed 5–24–12; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1595–N]

Medicare Program; Semi-Annual Meeting of the Advisory Panel on Hospital Outpatient Payment (HOP Panel)—August 27, 28, and 29, 2012

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

ACTION: Notice.

SUMMARY: This notice announces the second semi-annual meeting of the Advisory Panel on Hospital Outpatient Payment (HOP, the Panel), (the Ambulatory Payment Classification (APC) Panel) for 2012. The purpose of the Panel is to advise the Secretary of the Department of Health and Human Services (DHHS) (the Secretary) and the Administrator of the Centers for Medicare & Medicaid Services (CMS) (the Administrator) on the clinical integrity of the APC groups and their associated weights, and hospital outpatient therapeutic supervision issues.

DATES: *Meeting Date:* The second semi-annual meeting in 2012 is scheduled for the following dates and times. **Note:** The

times listed in this notice are Eastern Daylight Time (EDT) and are approximate times; consequently, the meetings may last longer than listed in this notice, but will not begin before the posted times:

- Monday, August 27, 2012, 1 p.m. to 5 p.m. EDT.
- Tuesday, August 28, 2012, 9 a.m. to 5 p.m. EDT.
- Wednesday, August 29, 2012, 9 a.m. to 5 p.m. EDT.

Deadlines

Deadline for Presentations and Comments—5 p.m. EDT, Friday, July 27, 2012. (See below for submission instructions for both hardcopy and electronic submissions.)

Deadline for Meeting Registration—5 p.m. EDT, Friday, August 17, 2012.

(Note: Those who do not preregister may not be able to attend the meeting since seating space is limited).

Deadline for Requests for Special Accommodations—5 p.m. EDT, Friday, August 17, 2012.

Submission Instructions for Presentations and Comments

Because of staffing and resource limitations, we cannot accept written comments and/or presentations by FAX, nor can we print written comments and presentations received by email for dissemination at the meeting.

Presentations

Presentations must be based on the scope of the Panel designated in the Charter. Any presentations outside of the scope of this Panel will be returned and/or amendments requested. Unrelated topics include, but are not limited to, the conversion factor, charge compression, revisions to the cost report, pass-through payments, correct coding, new technology applications (including supporting information/documentation), provider payment adjustments, supervision of hospital outpatient diagnostic services and the types of practitioners that are permitted to supervise hospital outpatient services. The Panel may not recommend that services be designated as nonsurgical extended duration therapeutic services.

All presentations will be considered public information and may be posted on the CMS web site and will be shared with the public. Presenters should not send pictures of patients in any of the documents (unless their faces have been blocked out) or include any examples with patient identifiable information.

In order to consider presentation and/or comment requests, we will need to receive the following information:

1. A hardcopy of your presentation; only hardcopy comments and presentations can be reproduced for public dissemination. We note that all presentations are limited to 5 minutes per individual or organization.

2. An email copy of your presentations sent to the Designated Federal Official's (DFO) mailbox, Raymond.Bulls@cms.hhs.gov.

3. Form CMS–20017 with complete contact information that includes name, address, phone, and email addresses for all presenters and a contact that can answer any questions and or provide revisions that are requested for the presentation.

○ Presenters must clearly explain the action(s) that they are requesting CMS to take in the appropriate section of the form. A presenter's relationship to the organization that they represent must also be clearly listed.

○ The form is now available through the CMS Forms Web site. The Uniform Resource Locator (URL) for linking to this form is as follows: <http://www.cms.hhs.gov/cmsforms/downloads/cms20017.pdf>.

ADDRESSES: *Meeting Location:* The meeting will be held in the Auditorium, CMS Central Office, 7500 Security Boulevard, Woodlawn, Maryland 21244–1850.

FOR FURTHER INFORMATION CONTACT: For inquiries about the Panel, contact the DFO: Raymond Bulls, 7500 Security Boulevard, Mail Stop C4–03–12, Woodlawn, MD 21244–1850. Phone: (410) 786–7267.

Mail hardcopies and email copies to the following addresses: Raymond Bulls, DFO, CMS, CM, HAPC, DOC—HOPS Panel, 7500 Security Blvd., Woodlawn, MD 21244–1850, Mail Stop C4–03–12, Raymond.Bulls@cms.hhs.gov.

Note: We recommend that you advise couriers of the following information: When delivering hardcopies of presentations to CMS, if no one answers at the above phone number, call (410) 786–4532 or (410) 786–7267.

News Media: Representatives must contact our Public Affairs Office at (202) 690–6145.

Advisory Committees' Information Lines: The phone numbers for the CMS Federal Advisory Committee Hotline are 1–877–449–5659 (toll free) and (410) 786–9379 (local).

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