1. *Type of Information Collection Request:* New collection; *Title of Information Collection:* Evaluation of the Medicare Care Management Performance Demonstration (MCMP) and the Electronic Health Records Demonstration (EHRD); *Use:* The MCMP demonstration was authorized under Section 649 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. This is a three year pay for performance demonstration with physicians to promote the adoption and use of health information technology (HIT) to improve the quality of care for eligible chronically ill Medicare beneficiaries. MCMP targets small to medium sized primary care practices with up to 10 physicians. Practices must provide care to at least 50 Medicare beneficiaries. Physicians will receive payments for meeting or exceeding performance standards for quality of care. They will also receive an additional incentive payment for electronic submission of performance measures via their electronic health record (EHR) system. These payments are in addition to their normal payments for providing service to Medicare beneficiaries. The Office System Survey (OSS) will be used to assess progress of physician practices in implementation and use of EHRs and related HIT functionalities.

The EHR demonstration is authorized under section 402 of the Medicare Waiver Authority. The goal of this six year pay for performance demonstration is to foster the implementation and adoption of EHRs and HIT in order to improve the quality of care provided by physician practices. The EHRD expands upon the MCMP Demonstration and will test whether performance-based financial incentives (1) increase physician practices' adoption and use of electronic health records (EHRs), and (2) improve the quality of care that practices deliver to chronically ill patients. The EHRD targets small to medium sized primary care practices with up to 20 physicians. Practices must provide care to at least 50 Medicare beneficiaries. Approximately 2,400 practices will be enrolled in the demonstration across 12 sites. Practices will be randomly assigned to a treatment and control group. The OSS will be used to assess progress of physician practices in implementation and use of EHRs and related HIT functionalities, and to determine incentive payments for treatment practices. In-person and telephone discussions with community partners and physician practices will be used to learn about practices' experiences and strategies in adopting and using EHRs, as well as the factors that help or hinder their efforts. *Form Number:* CMS–10273 (OMB# 0938—New); *Frequency:* Annually, Biennially and Once; *Affected Public:* Business or other for-profit; *Number of Respondents:* 3434; *Total Annual Responses:* 3434; *Total Annual Hours:* 2586.

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access CMS' Web site at *http://www.cms.hhs.gov/PaperworkReductionActof1995,* or E-mail your request, including your address, phone number, OMB number, and CMS document identifier, to *Paperwork@cms.hhs.gov,* or call the Reports Clearance Office on (410) 786–1326.

In commenting on the proposed information collections please reference the document identifier or OMB control number. To be assured consideration, comments and recommendations must be submitted in one of the following ways by *March 24, 2009:*

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/OMB Control Number __, Room C4–26–05, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

Dated: January 14, 2009.

Michelle Shortt,

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

[FR Doc. E9–1435 Filed 1–22–09; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–2899–FN]

Medicare and Medicaid Programs; Approval of the Accreditation Commission for Health Care, Incorporated for Continued Deeming Authority for Home Health Agencies

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

ACTION: Final notice.

SUMMARY: This notice announces our decision to approve the Accreditation Commission for Health Care, Incorporated (ACHC) for continued recognition as a national accreditation program for home health agencies (HHAs) seeking to participate in the Medicare or Medicaid programs.

DATES: *Effective Date:* This final notice is effective February 24, 2009 through February 24, 2015.

FOR FURTHER INFORMATION CONTACT: Lillian Williams, (410) 786–8636. Patricia Chmielewski, (410) 786–6899.

SUPPLEMENTARY INFORMATION:

I. Background

Under the Medicare program, eligible beneficiaries may receive selected covered services from a home health agency (HHA) provided certain requirements are met. Sections 1861(m) and (o), 1891, and 1895 of the Social Security Act (the Act) authorize the Secretary to establish distinct criteria for facilities seeking designation as an HHA. Under this authority, the minimum requirements that an HHA must meet to participate in Medicare are set forth in regulations at 42 CFR part 484 and 42 CFR part 409, which determine the basis and scope of HHA-covered services, and the conditions for Medicare payment for home health care. Regulations concerning provider agreements are at 42 CFR part 489 and those pertaining to activities relating to the survey and certification of facilities are at 42 CFR part 488.

Generally, to enter into an agreement, an HHA must first be certified by a State survey agency as complying with conditions or requirements set forth in part 484 of our regulations. Then, the HHA is subject to regular surveys by a State survey agency to determine whether it continues to meet those requirements. There is an alternative, however, to surveys by State agencies.

Section 1865(a)(1) of the Act (as redesignated under section 125 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (Pub. L. 110–275) provides that, if a provider entity demonstrates through accreditation by an approved national accreditation organization that all applicable Medicare conditions are met or exceeded, we may ''deem'' those provider entities as having met Medicare requirements. (We note that section 125 of MIPPA redesignated subsections (b) through (e) of subsection 1865 of the Act as (a) through (d) respectively.) Accreditation by an accreditation organization is voluntary

and is not required for Medicare participation.

If an accreditation organization is recognized by the Secretary as having standards for accreditation that meet or exceed Medicare requirements, a provider entity accredited by the national accrediting body's approved program may be deemed to meet the Medicare conditions. A national accreditation organization applying for approval of deeming authority under part 488, subpart A must provide us with reasonable assurance that the accreditation organization requires the accredited provider entities to meet requirements that are at least as stringent as the Medicare conditions. Our regulations concerning reapproval of accrediting organizations are set forth at § 488.4 and § 488.8(d)(3). The regulations at § 488.8(d)(3) require accreditation organizations to reapply for continued approval of deeming authority every 6 years, or sooner as we determine. The Accreditation Commission for Health Care, Incorporated's (ACHC) term of approval as a recognized accreditation program for HHAs expires February 24, 2009.

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 that 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. Provisions of the Proposed Notice

In the August 22, 2008 **Federal Register** (73 FR 49681), we published a proposed notice announcing the ACHC's request for reapproval as a deeming organization for HHAs. In the proposed notice, we detailed our evaluation criteria. Under section 1865(a)(2) of the Act and our regulations at § 488.4 (Application and reapplication procedures for accreditation organizations), we conducted a review of the ACHC application in accordance with the criteria specified by our regulation, which include, but are not limited to the following:

- An onsite administrative review of ACHC's (1) Corporate policies; (2) financial and human resources available to accomplish the proposed surveys; (3) procedures for training, monitoring, and evaluation of its surveyors; (4) ability to investigate and respond appropriately to complaints against accredited facilities; and (5) survey review and decision-making process for accreditation.
- A comparison of ACHC's HHA accreditation standards to our current Medicare HHA conditions of participation (COPs).
- A documentation review of ACHC's survey processes to—

++ Determine the composition of the survey team, surveyor qualifications, and the ability of ACHC to provide continuing surveyor training;

++ Compare ACHC's processes to those of State survey agencies, including survey frequency, and the ability to investigate and respond appropriately to complaints against accredited facilities;

++ Evaluate ACHC's procedures for monitoring providers or suppliers found to be out of compliance with ACHC program requirements. The monitoring procedures are used only when ACHC identifies noncompliance. If noncompliance is identified through validation reviews, the State survey agency monitors corrections as specified at § 488.7(d);

++ Assess ACHC's ability to report deficiencies to the surveyed facilities and respond to the facility's plan of correction in a timely manner;

++ Establish ACHC's ability to provide us with electronic data and reports necessary for effective validation and assessment of ACHC's survey process;

++ Determine the adequacy of staff and other resources;

++ Review ACHC's ability to provide adequate funding for performing required surveys;

++ Confirm ACHC's policies with respect to whether surveys are announced or unannounced; and,

++ Obtain ACHC's agreement to provide us 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.

In accordance with section 1865(a)(3)(A) of the Act, the August 22, 2008 proposed notice (73 FR 49681) solicited public comments regarding whether ACHC's requirements met or exceeded the Medicare conditions of coverage for HHAs. We received no public comments in response to our proposed notice.

IV. Provisions of the Final Notice

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

We compared the standards contained in ACHC's accreditation requirements for HHAs and its survey process in ACHC's application for renewal of deeming authority for HHAs with the Medicare HHA conditions for participation and our State Operations Manual (SOM). Our review and evaluation of ACHC's deeming application, which were conducted as described in section III. of this final notice, yielded the following:

- To meet the requirements at § 488.4(a)(3)(iii), ACHC revised their record retention policy to require all survey documentation be kept for a minimum of 3 years.
- To meet the requirements at § 484.4(a)(4), ACHC revised its surveyor training and evaluation policy to include a process for addressing unsatisfactory performance.
- To comply with the requirement at § 488.4(b)(3)(i), ACHC developed an action plan to resolve issues related to timely data submissions.
- ACHC modified its policies regarding timeframe for sending and receiving a plan of correction (PoC) to comply with the requirements of section 2728 of the SOM.
- To meet the Medicare requirements related to a plan of correction (PoC), ACHC amended its policies to ensure approved PoCs contain all the required elements specified in section 2728 of the SOM.
- ACHC revised its accreditation decision letters to ensure they are accurate and contain all the required elements necessary for the CMS Regional Office to render a decision regarding deemed status of a provider.

B. Term of Approval

Based on the review and observations described in section III. of this final notice, we have determined that the ACHC requirements for HHA meet or exceed our requirements. Therefore, we approve ACHC as a national accreditation organization for HHAs that request participation in the Medicare program, effective February 24, 2009 through February 24, 2015.

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

Dated: November 21, 2008.

Kerry Weems,

Acting Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. E9–684 Filed 1–22–09; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–2298–N]

Medicaid Program; Town Hall Forum on Access to Dental Care for Medicaid-Eligible Children; April 6, 2009

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

ACTION: Notice of meeting.

SUMMARY: This notice announces a town hall forum to discuss access to dental care for Medicaid eligible children. Beneficiaries, providers, dentists, industry representatives, and other interested parties are invited to this meeting to present their views, concerns, and recommendations related to oral health issues. The forum is open to the public, but attendance is limited to space available.

DATES: *Meeting Date:* The town hall forum will be held on Monday, April 6, 2009, from 1 p.m. to 4 p.m., eastern daylight time (e.d.t.).

Deadline for Meeting Registration: Registrations must be received by Wednesday, April 1, 2009, by 5 p.m., e.d.t.

Deadline for Requesting Special Accommodations: Participants requiring special accommodations should contact Cindy Ruff at the address specified in the **ADDRESSES** section of this notice by Friday, March 27, 2009, by 5 p.m., e.d.t.

ADDRESSES: Meeting Location: The town hall forum will be held in the auditorium at the Center for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244.

Meeting Registration: Participants may register via e-mail at *Cynthia.Ruff@cms.hhs.gov* or by regular mail at the Centers for Medicare and Medicaid Services, Center for Medicaid and State Operations, Family and Children's Health Programs Group, 7500 Security Boulevard, S2–01–16, Baltimore, MD 21244.

Inquires: Send inquiries about this meeting via email to *Cynthia.ruff@cms.hhs.gov.*

FOR FURTHER INFORMATION CONTACT: Cindy Ruff, 410–786–5916.

SUPPLEMENTARY INFORMATION:

I. Background

In response to Congressional hearings and Federal studies regarding access to dental care for Medicaid eligible children, we performed 16 State dental reviews in 2008. We recently published a National Summary of those State reviews and identified several opportunities for improving dental care for individuals eligible for Medicaid. We proposed to have a Town Hall Forum to discuss these opportunities. The Forum will provide a venue for participants to provide feedback to us on various oral health issues and to discuss best practices and innovative delivery models for dental care. We will work with co-facilitators, the National Association of State Medicaid Directors and the American Dental Association, in presenting the Forum.

II. Meeting Format

The meeting will begin with introductions of the individuals participating in the meeting and an overview of the goal and objectives of the meeting. There will be a brief overview of the role and functions of Federal and State programs in delivering dental care to individuals eligible for Medicaid. There will be an opportunity for several States to briefly present information on a promising oral health practice in their State. The third portion of the Forum will focus on discussion of delivery of dental services through managed care organizations, payment issues, best practices/innovative delivery models, and recommendations for education and outreach to dental providers and Medicaid enrollees.

Prior to the Town Hall Forum, we will distribute information via the CMS Web site including an agenda and a set of questions to be addressed at the Forum. The materials will be posted on the CMS web site at *http://www.cms.hhs.gov/MedicaidSCHIPQualPrac/02_whatsnewinquality.asp#TopOfPage.* Registered participants may submit additional questions/comments to be considered for discussion at the Forum.

III. Registration Instructions

There is no registration fee associated with attending the meeting. All individuals must register to attend. Because this meeting will be located on Federal property, for security reasons any persons wishing to attend must register at one of the addresses specified in the **ADDRESSES** section of this notice by the date specified 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, fax number(s), and e-mail address. You will receive a registration confirmation with instructions for your arrival at the CMS complex or you will be notified the seating capacity has been reached. The meeting is limited to registered persons, and seating capacity is limited to the first 250 registrants.

Individuals requiring sign language interpretation for the hearing impaired or other special accommodations should contact Cindy Ruff at the address listed in the **ADDRESSES** section of this notice by the date specified in the **DATES** section of this notice.

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 at CMS 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 brought 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