Assessment of Healthcare Providers and Systems (HCAHPS); *Use:* The HCAHPS (*Hospital Consumer Assessment of Healthcare Providers and Systems*) survey is the first national, standardized, publicly reported survey of patients' perspectives of hospital care. HCAHPS (pronounced ''*H-caps''*), also known as the CAHPS® Hospital Survey, is a survey instrument and data collection methodology for measuring patients' perceptions of their hospital experience. While many hospitals have collected information on patient satisfaction for their own internal use, until HCAHPS there was no national standard for collecting and publicly reporting information about patient experience of care that allowed valid comparisons to be made across hospitals locally, regionally and nationally.

Three broad goals have shaped HCAHPS. First, the survey is designed to produce data about patients' perspectives of care that allow objective and meaningful comparisons of hospitals on topics that are important to consumers. Second, public reporting of the survey results creates new incentives for hospitals to improve quality of care. Third, public reporting serves to enhance accountability in health care by increasing transparency of the quality of hospital care provided in return for the public investment. With these goals in mind, the Centers for Medicare & Medicaid Services (CMS) has taken substantial steps to assure that the survey is credible, useful, and practical. Hospitals implement HCAHPS under the auspices of the Hospital Quality Alliance (HQA), a private/public partnership that includes major hospital and medical associations, consumer groups, measurement and accrediting bodies, government, and other groups that share an interest in improving hospital quality. Both the HQA and the National Quality Forum have endorsed HCAHPS.

The enactment of the Deficit Reduction Act of 2005 created an additional incentive for acute care hospitals to participate in HCAHPS. Since July 2007, hospitals subject to the Inpatient Prospective Payment System (IPPS) annual payment update provisions (''subsection (d) hospitals'') must collect and submit HCAHPS data in order to receive their full IPPS annual payment update. IPPS hospitals that fail to publicly report the required quality measures, which include the HCAHPS survey, may receive an annual payment update that is reduced by 2.0 percentage points. Non-IPPS hospitals, such as Critical Access Hospitals, may voluntarily participate in HCAHPS.

The Patient Protection and Affordable Care Act of 2010 (Pub. L. 111–148) includes HCAHPS among the measures to be used to calculate value-based incentive payments in the Hospital Value-Based Purchasing program, beginning with discharges in October 2012.

Currently the HCAHPS survey asks discharged patients 27 questions about their recent hospital stay. The survey contains 18 core questions about critical aspects of patients' hospital experiences (communication with nurses and doctors, the responsiveness of hospital staff, the cleanliness and quietness of the hospital environment, pain management, communication about medicines, discharge information, overall rating of hospital, and would they recommend the hospital). The survey also includes four items to direct patients to relevant questions, three items to adjust for the mix of patients across hospitals, and two items that support Congressionally-mandated reports.

This revision is being submitted in order to add five new items to the survey: Three items that comprise a Care Transitions composite; one item that asks whether the patient was admitted through the emergency room; and one item that asks about the patient's overall mental health. This marks the first addition of items to the HCAHPS Survey since its national implementation in 2006. *Form Number:* CMS–10102 (OCN: 0938–0981); *Frequency:* Occasionally; *Affected Public:* Individuals or Households, Private Sector—Business or other for-profits and not-for-profit institutions. *Number of Respondents:* 2,713,812; *Total Annual Responses:* 2,713,812; *Total Annual Hours:* 365,136. (For policy questions regarding this collection contact William Lehrman at 410–786–1037. For all other issues call 410–786–1326.)

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access CMS' Web site address 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 *November 22, 2011:*

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: September 20, 2011.

Martique Jones,

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

[FR Doc. 2011–24522 Filed 9–22–11; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–2375–FN]

Medicare and Medicaid Programs; Approval of the Joint Commission's Continued Deeming Authority for Critical Access Hospitals

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

ACTION: Final notice.

SUMMARY: This notice announces our decision to approve the Joint Commission for continued recognition as a national accreditation program for critical access hospitals (CAHs) seeking to participate in the Medicare or Medicaid programs.

DATES: *Effective Date:* This final notice is effective November 21, 2011 through November 21, 2017.

FOR FURTHER INFORMATION CONTACT:

L. Tyler Whitaker, (410) 786–5236.

Patricia Chmielewski, (410) 786–6899.

SUPPLEMENTARY INFORMATION:

I. Background

Under the Medicare program, eligible beneficiaries may receive covered services in a critical access hospital (CAH) provided certain requirements are met. Sections 1820(c)(2)(B) and 1861(mm) of the Social Security Act (the Act) establish distinct criteria for facilities seeking designation as a CAH. The minimum requirements that a CAH must meet to participate in Medicare are set forth in regulations at 42 CFR part

485, subpart F. Conditions for Medicare payment for CAHs are set forth at § 413.70. Applicable regulations concerning provider agreements are located in 42 CFR part 489 and those pertaining to facility survey and certification are located in 42 CFR part 488, subparts A and B.

For a CAH to enter into a provider agreement with the Medicare program, a CAH must first be certified by a State survey agency as complying with the conditions or requirements set forth in section 1820 of the Act, and 42 CFR part 485 of the regulations. Subsequently, the CAH is subject to ongoing review by a State survey agency to determine whether it continues to meet the Medicare requirements. However, there is an alternative to State compliance surveys. Certification by a nationally recognized accreditation program can substitute for ongoing State review.

Section 1865(a)(1) of the Act stipulates that, if a provider entity demonstrates through accreditation by an approved national accreditation organization (AO) that all applicable Medicare conditions are met or exceeded, we may ''deem'' those provider entities as having met the requirements. Accreditation by an AO is voluntary and is not required for Medicare participation. A national AO applying for deeming authority under 42 CFR part 488, subpart A must provide us with reasonable assurance that the AO requires the accredited provider entities to meet requirements that are at least as stringent as the Medicare conditions.

Our regulations concerning reapproval of AO's are set forth at § 488.4 and § 488.8(d)(3). The regulations at § 488.8(d)(3) require AO's to reapply for continued approval of deeming authority every 6 years, or sooner as we determine. The Joint Commission's term of approval as a recognized accreditation program for CAHs expires November 21, 2011.

We received a complete application from the Joint Commission for continued recognition as a national accrediting organization for CAHs on April 1, 2011. In accordance with the requirements at § 488.4 and § 488.8(d)(3), we published a proposed notice on May 13, 2011 (76 FR 30107). This final notice is required to be published no later than November 21, 2011.

II. Deeming Application Approval Process

Section 1865(a)(3)(A) of the Act provides a statutory timetable to ensure that our review of applications for deeming authority is conducted in a timely manner. The statute provides us 210 calendar days after the date of receipt of a complete application, with any documentation necessary to make a determination, to complete our survey activities and application process. Within 60 days after receiving a complete 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 a notice in the **Federal Register** approving or denying the application.

III. Provisions of the Proposed Notice and Response to Comments

In the May 13, 2011 **Federal Register** (76 FR 28040), we published a proposed notice announcing the Joint Commission's request for continued approval as a deeming organization for critical access hospitals. In the proposed notice, we detailed our evaluation criteria. Under section 1865(a)(2) of the Act and in our regulations at § 488.4 we conducted a review of the Joint Commission's application in accordance with the criteria specified by our regulations, which include, but are not limited to, the following:

- An onsite administrative review of the Joint Commission's:

++ Corporate policies.

++ Financial and human resources available to accomplish the proposed surveys.

++ Procedures for training, monitoring, and evaluation of its surveyors.

++ Ability to investigate and respond appropriately to complaints against accredited facilities.

++ Survey review and decision-making process for accreditation.

- A comparison of the Joint Commission's CAH accreditation standards to our current Medicare CAH conditions of participation (CoPs).
- A documentation review of the Joint Commission's survey processes to:

++ Determine the composition of the survey team, surveyor qualifications, and the Joint Commission's ability to provide continuing surveyor training.

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

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

++ Establish the Joint Commission's ability to provide us with electronic data and reports necessary for effective validation and assessment of the Joint Commission's survey process.

++ Determine the adequacy of staff and other resources.

++ Review the Joint Commission's ability to provide adequate funding for performing required surveys.

++ Confirm the Joint Commission's policies with respect to whether surveys are announced or unannounced.

++ Obtain the Joint Commission'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 May 13, 2011 proposed notice also solicited public comments regarding whether the Joint Commission's requirements meet or exceed the Medicare CoPs for CAHs. We received one comment in response to our proposed notice.

The commenter expressed strong support for the Joint Commission's application for CAH deeming authority. The commenter stated that the Joint Commission's standards are clearly written and closely align with the Medicare CoPs, and that the Joint Commission's accreditation program provides CAHs with a viable alternative to other healthcare AOs.

IV. Provisions of the Final Notice

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

We compared the Joint Commission's CAH accreditation requirements and survey process with the Medicare CoPs and survey process as outlined in the State Operations Manual (SOM). Our review and evaluation of the Joint Commission's deeming application, which were conducted as described in section III of this final notice, yielded the following:

- To meet the requirements at § 485.618(c)(2), the Joint Commission revised its crosswalk to include the requirement that an organization's

medical staff and the person directly responsible for operation of the facility approve contractual agreements.

• To meet the requirements at § 485.623(b)(2), the Joint Commission revised its crosswalk and survey process to address the proper routine storage and prompt disposal of trash.

• To meet the requirements at § 485.631(c)(2), the Joint Commission revised its crosswalk to address the requirement that physician assistants, nurse practitioners, or clinical nurse specialists provide services in accordance with the CAH's policies.

• To meet the requirements at § 485.635(a)(3)(iii), the Joint Commission revised its standards to include guidelines for the maintenance of health care records, and procedures for the periodic review and evaluation of the services furnished by the CAH.

• To meet the requirements at § 485.635(f) through (f)(2), the Joint Commission revised its crosswalk to include the patient visitation right standards and related survey process revisions.

• To meet the requirements at § 485.638(a)(2), the Joint Commission revised its crosswalk to address the requirement that medical records are readily accessible.

• To meet the requirements at § 485.639(b)(1), the Joint Commission revised its standards to include the requirement that a qualified practitioner must examine the patient immediately before surgery to evaluate the risk of the procedure to be performed.

• To meet the requirements at § 485.639(b)(2), the Joint Commission revised its standards to include the requirement that a qualified practitioner examine each patient before surgery to evaluate the risk of anesthesia.

• To meet the requirements at § 485.639(b)(3), the Joint Commission revised its standards to address the requirement that a qualified practitioner must evaluate each patient for proper anesthesia recovery before discharge from the CAH.

• To meet the requirements at § 485.643(f), the Joint Commission revised its glossary to ensure that the definition of organ includes ''intestines (or multivisceral organs).''

• To meet the requirements at § 485.645(d)(1), the Joint Commission revised its crosswalk to include standards which address the residents' right to send and receive mail that is not opened.

• To meet the requirements at § 412.27(d)(6)(i), the Joint Commission revised its crosswalk to include the requirement that programs be directed toward restoring and maintaining optimal levels of physical and psychosocial functioning.

• To meet the requirements at § 412.29(c), the Joint Commission revised it crosswalk to include standards to ensure patients receive social services, psychological services (including neuropsychological services), orthotic and prosthetic services, as needed.

• To meet the requirements at § 482.13(h) through (h)(4), the Joint Commission revised its crosswalk to include the patient visitation right standards and related survey process revisions.

• To meet the requirements at § 482.30(d)(3), the Joint Commission revised its standards to ensure that written notification regarding the admission to or continued stay in the hospital when it is not medically necessary, is given no later than 2 days after this determination has been made.

• To meet the requirements at § 482.41(b)(1)(i), the Joint Commission revised its standards to require quarterly testing of tamper and water flow devices.

• To meet the requirements at § 482.41(b)(8), the Joint Commission revised its standards to ensure the CAH maintains written evidence of regular inspections and approval by State or local fire control agencies for the entire CAH.

• To meet the requirements at § 482.51, the Joint Commission revised its standards to ensure that if the hospital provides surgical services, the services are well organized and provided in accordance with acceptable standards of practice and if outpatient surgical services are offered the services must be consistent in quality with inpatient care in accordance with the complexity of services offered.

• To meet the requirements at § 488.4(a)(7), the Joint Commission revised its survey process to include policies and procedures with respect to the withholding or removal of accreditation status or requirements, and other actions taken by the Joint Commission in response to noncompliance with standards and requirements.

• To meet the requirements at section 2728 of the State Operations Manual (SOM), the Joint Commission modified its policies regarding timeframes for sending and receiving a plan of correction (PoC).

• To meet the requirements at § 488.12, the Joint Commission modified its policies and procedures to ensure its survey files are complete.

B. Term of Approval

Based on the review and observations described in section III of this final notice, we have determined that the Joint Commission's requirements for CAHs meet or exceed our requirements. Therefore, we approve the Joint Commission as a national accreditation organization for CAHs that request participation in the Medicare program, effective November 21, 2011 through November 21, 2017.

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. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: August 31, 2011.

Donald M. Berwick,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2011–24496 Filed 9–22–11; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–2377–PN]

Medicare and Medicaid Programs; Application by Community Health Accreditation Program for Continued Deeming Authority for Home Health Agencies

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

ACTION: Proposed notice.

SUMMARY: This proposed notice with comment period acknowledges the receipt of a deeming application from the Community Health Accreditation Program (CHAP) for continued recognition as a national accrediting organization for home health agencies (HHAs) that wish to participate in the Medicare or Medicaid programs. Section 1865(a)(3)(A) of the Social Security Act (the Act) requires that within 60 days of receipt of an organization's complete application, we publish a notice that