designated OPO (for the service area in which it is located) of potential organ donors. Under section 1138(a)(1)(C) of the Act, every participating hospital must have an agreement only with its designated OPO to identify potential donors.

However, section 1138(a)(2)(A) of the Act provides that a hospital may obtain a waiver of the above requirements from the Secretary under certain specified conditions. A waiver allows the hospital to have an agreement with an OPO other than the one initially designated by CMS, if the hospital meets certain conditions specified in section 1138(a)(2)(A) of the Act. In addition, the Secretary may review additional criteria described in section 1138(a)(2)(B) of the Act to evaluate the hospital's request for a waiver.

Section 1138(a)(2)(A) of the Act states that in granting a waiver, the Secretary must determine that the waiver—(1) is expected to increase organ donations; and (2) will ensure equitable treatment of patients referred for transplants within the service area served by the designated OPO and within the service area served by the OPO with which the hospital seeks to enter into an agreement under the waiver. In making a waiver determination, section 1138(a)(2)(B) of the Act provides that the Secretary may consider, among other factors: (1) Cost-effectiveness; (2) improvements in quality; (3) whether there has been any change in a hospital's designated OPO due to the changes made in definitions for metropolitan statistical areas; and (4) the length and continuity of a hospital's relationship with an OPO other than the hospital's designated OPO. Under section 1138(a)(2)(D) of the Act, the Secretary is required to publish a notice of any waiver application received from a hospital within 30 days of receiving the application, and to offer interested parties an opportunity to submit comments during the 60-day comment period beginning on the publication date in the **Federal Register**.

The criteria that the Secretary uses to evaluate the waiver in these cases are the same as those described above under sections 1138(a)(2)(A) and (B) of the Act and have been incorporated into the regulations at § 486.308(e) and (f).

II. Waiver Request Procedures

On October 1995, we issued a Program Memorandum (Transmittal No. A–95–11) detailing the waiver process and discussing the information hospitals must provide in requesting a waiver. We indicated that upon receipt of a waiver request, we would publish a **Federal Register** notice to solicit public comments, as required by section 1138(a)(2)(D) of the Act.

According to these requirements, we will review the comments received. During the review process, we may consult on an as-needed basis with the Health Resources and Services Administration's Division of Transplantation, the United Network for Organ Sharing, and our regional offices. If necessary, we may request additional clarifying information from the applying hospital or others. We will then make a final determination on the waiver request and notify the hospital and the designated and requested OPOs.

III. Hospital Waiver Request

As permitted by 42 CFR 486.308(e), the following hospital has requested a waiver in order to enter into an agreement with a designated OPO other than the OPO designated for the service area in which the hospital is located:

Tri-Lakes Medical Center in Batesville, Mississippi, is requesting a waiver to work with: Mississippi Organ Recovery Agency, 12 River Bend Pl., Flowood, MS 39232.

The Hospital's Designated OPO is: Mid-South Transplant Foundation, Inc., 8001 Centerview Parkway, Suite 302, Memphis, TN 38018.

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).

IV. Response to 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.

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

Dated: August 20, 2012.

Marilyn Tavenner,

Acting Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2012–20920 Filed 8–23–12; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–4166–FN]

Medicare Program; Approved Renewal of Deeming Authority of the Accreditation Association for Ambulatory Health Care, Inc. 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 Accreditation Association for Ambulatory Health Care, Inc. (AAAHC) for Health Maintenance Organizations and Preferred Provider Organizations for a term of 6 years.

DATES: This final notice is effective through July 10, 2018.

FOR FURTHER INFORMATION CONTACT: Abraham Weinschneider, (410) 786–5688; 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 risk-bearing 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 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 Accreditation Association for Ambulatory Health Care, Inc. (AAAHC) was approved by CMS as an accreditation organization for MA HMOs and PPOs on July 12, 2006, and that term will expire on July 11, 2012. On December 14, 2011, AAAHC submitted an application to renew its deeming authority. On that same date, AAAHC 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 AAAHC 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** (76 FR 19290), we published a proposed notice announcing AAAHC'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 AAAHC'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 AAAHC'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 (76 FR 19290) also solicited public comments regarding whether AAAHC'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 AAAHC's Standards and Requirements for Accreditation and Medicare's Conditions and Survey Requirements

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

- To meet the requirements at § 488.10(b), AAAHC modified its policies to include ''person(s) receiving hospice benefits prior to completing an enrollment request for an MSA plan'' as an exception where an MAO may deny enrollment based on medical status.
- AAAHC amended its crosswalk to ensure current AAAHC standards are clearly crosswalked to the following regulatory requirements: §§ 422.112(a)(7); 422.118(d); 422.202(d)(1); and 422.204(b)(2).
- To meet the amendments made at § 422.156 by the final rule published in the April 15, 2011 **Federal Register** (76 CFR 21498), AAAHC 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 AAAHC's accreditation program requirements meet or exceed our requirements. Therefore, we approve AAAHC as a national accreditation organization with deeming authority for MA HMOs and PPOs, effective July 11, 2012 through July 10, 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: August 9, 2012.

Marilyn Tavenner,

Acting Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2012–20195 Filed 8–23–12; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1596–N]

Medicare Program; Solicitation of Two Nominations to the Advisory Panel on Hospital Outpatient Payment

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

ACTION: Notice.

SUMMARY: This notice solicits nominations for two new members to the Advisory Panel on Hospital Outpatient Payment (HOP, the Panel). There will be two vacancies on the Panel beginning September 30, 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 Ambulatory Payment Classification (APC) groups and their associated weights, and supervision of hospital outpatient services.

The Secretary rechartered the Panel in 2011 for a 2-year period effective through November 15, 2013.

DATES: *Submission of Nominations:* We will consider nominations if they are received no later than 5 p.m. (e.s.t.) October 23, 2012.

ADDRESSES: Please mail or hand deliver nominations to the following address: Centers for Medicare & Medicaid Services; Attn: Raymond Bulls, Advisory Panel on HOP; Center for Medicare, Hospital & Ambulatory Policy Group, Division of Outpatient Care; 7500 Security Boulevard, Mail Stop C4–05–17; Baltimore, MD 21244–1850.

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

FOR FURTHER INFORMATION CONTACT:

Contact: Persons wishing to nominate individuals to serve on the Panel or to obtain further information may also contact Raymond Bulls at the following email address: *APCPanel@cms.hhs.gov* or call 410–786–7267.

Advisory Committees' Information Lines: You may also refer to the CMS Federal Advisory Committee Hotlines at 1–877–449–5659 (toll-free) or 410–786–3985 (local) for additional information.

News Media: Representatives should contact the CMS Press Office at 202–690–6145.

SUPPLEMENTARY INFORMATION:

I. Background

The Secretary is required by section 1833(t)(9)(A) of the Social Security Act (the Act), and section 222 of the Public Health Service Act (PHS Act) to consult with an expert outside advisory panel regarding the clinical integrity of the APC groups and relative payment weights that are components of the Medicare Hospital Outpatient Prospective Payment System (OPPS), and the appropriate supervision level for hospital outpatient services. The panel may use data collected or developed by entities and organizations (other than DHHS) in conducting the review. The Panel is governed by the provisions of the Federal Advisory Committee Act (FACA) (Public Law 92–463), as amended (5 U.S.C. Appendix 2), which sets forth standards for the formation and use of advisory panels.

The Charter requires that the Panel meet up to three times annually. CMS considers the technical advice provided by the Panel as we prepare the proposed and final rules to update the OPPS for the following calendar year.

The Panel shall consist of a chair and up to 19 members who are full-time employees of hospitals, hospital systems, or other Medicare providers that are subject to the OPPS. (For purposes of the Panel, consultants or independent contractors are not considered to be full-time employees in these organizations.)

The current Panel members are as follows: (**Note:** The asterisk [*] indicates the Panel members whose terms end on September 30, 2012.)

- E. L. Hambrick, M.D., J.D., Chair, a CMS Medical Officer
- Karen Borman, M.D.
- Ruth L. Bush, M.D., M.P.H.
- Lanny Copeland, M.D.
- Kari S. Cornicelli, C.P.A., FHFMA
- Dawn L. Francis, M.D., M.H.S.
- David A. Halsey, M.D.
- Brain D. Kavanagh, M.D., M.P.H.
- Judith T. Kelly, B.S.H.A., RHIT, RHIA, CCS*
- Scott Manaker, M.D., Ph.D.
- John Marshall, CRA, RCC, RT
- Jim Nelson