accordance with the requirements at SOM chapter five.

• DNVHC revised its policies and procedures to clarify that they do not have authority to advise facilities regarding certification issues. Instead, DNVHC must contact the CMS Regional Office on facility specific certification issues for consultation and direction.

B. Term of Approval

Based on our review and observations described in section III. of this final notice, we have determined that DNVHC's requirements for hospitals meet or exceed our requirements. Therefore, we approve DVNHC as a national accreditation organization for hospitals that request participation in the Medicare program, effective September 26, 2012, through September 26, 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—Supplementary Medical Insurance Program)

Dated: August 9, 2012.

Marilyn Tavenner,

Acting Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2012–20199 Filed 8–23–12; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1452–NC]

Medicare and Medicaid Programs; Announcement of Application From a Hospital Requesting Waiver for Organ Procurement Service Area

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

ACTION: Notice with comment period.

SUMMARY: This notice with comment period announces a hospital's request for a waiver from the requirement to have an agreement with its designated Organ Procurement Organization (OPO). The request was made in accordance with section 1138(a)(2) of the Social Security Act (the Act). In addition, this notice requests comments from OPOs and the general public for our consideration in determining whether we should grant the requested waiver.

DATES: *Comment Date:* To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on October 23, 2012.

ADDRESSES: In commenting, please refer to file code CMS–1452–NC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to *http://www.regulations.gov*. Follow the ''Submit a comment'' instructions.

2. *By regular mail.* You may mail written comments to the following address ONLY:

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1452–NC, P.O. Box 8010, Baltimore, MD 21244–1850.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY:

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1452–NC, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* Alternatively, you may deliver (by hand or courier) your written comments ONLY to the following addresses:

a. For delivery in Washington, DC—

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, DC 20201.

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD—

Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244–1850.

If you intend to deliver your comments to the Baltimore address, call telephone number (410) 786–9994 in advance to schedule your arrival with one of our staff members.

Comments erroneously mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Patricia Taft, (410) 786–4561.

SUPPLEMENTARY INFORMATION: *Inspection of Public Comments:* All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: *http://www.regulations.gov*. Follow the search instructions on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

I. Background

Organ Procurement Organizations (OPOs) are not-for-profit organizations that are responsible for the procurement, preservation, and transport of organs to transplant centers throughout the country. Qualified OPOs are designated by the Centers for Medicare & Medicaid Services (CMS) to recover or procure organs in CMS-defined exclusive geographic service areas, pursuant to section 371(b)(1) of the Public Health Service Act (42 U.S.C. 273(b)(1)) and our regulations at 42 CFR 486.306. Once an OPO has been designated for an area, hospitals in that area that participate in Medicare and Medicaid are required to work with that OPO in providing organs for transplant, pursuant to section 1138(a)(1)(C) of the Social Security Act (the Act) and our regulations at 42 CFR 482.45.

Section 1138(a)(1)(A)(iii) of the Act provides that a hospital must notify the

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