accrediting organization requires the accredited provider entities to meet requirements that are at least as stringent as the Medicare conditions. Our regulations concerning the approval of accrediting organizations are set forth at § 488.4 and § 488.8(d)(3). The regulations at § 488.8(d)(3) require an accrediting organization to reapply for continued approval of its accreditation program every 6 years or as determined by CMS. Det Norske Veritas Healthcare's (DNVHC) current term of approval for its CAH accreditation program expires December 23, 2014.

II. Approval of Deeming Organizations

Section 1865(a)(2) of the Act and our regulations at § 488.8(a) require that our findings concerning review and approval of a national accrediting organization's requirements consider, among other factors, the applying accrediting organization's requirements for accreditation; survey procedures; resources for conducting required surveys; capacity to furnish information for use in enforcement activities; monitoring procedures for provider entities found not in compliance with the conditions or requirements; and ability to provide us with the necessary data for validation.

Section 1865(a)(3)(A) of the Act further requires that we publish, within 60 days of receipt of an organization's complete application, a notice identifying the national accrediting body making the request, describing the nature of the request, and providing at least a 30-day public comment period. We have 210 days from the receipt of a complete application to publish notice of approval or denial of the application.

The purpose of this proposed notice is to inform the public of DNVHC's request for continued CMS approval of its CAH accreditation program. This notice also solicits public comment on whether DNVHC's requirements meet or exceed the Medicare conditions of participation (CoPs) for CAHs.

III. Evaluation of Deeming Authority Request

DNVHC submitted all the necessary materials to enable us to make a determination concerning its request for continued approval of its CAH accreditation program. This application was determined to be complete on May 2, 2014. Under section 1865(a)(2) of the Act and our regulations at § 488.8 (federal review of accrediting organizations), our review and evaluation of DNVHC will be conducted in accordance with, but not necessarily limited to, the following factors:

- The equivalency of DNVHC's standards for CAHs as compared with CMS' CAH CoPs.
- DNVHC'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 DNVHC's processes to those of state agencies, including survey frequency, and the ability to investigate and respond appropriately to complaints against accredited facilities.

++ DNVHC's processes and procedures for monitoring a CAH found out of compliance with DNVHC's program requirements. These monitoring procedures are used only when DNVHC identifies noncompliance. If noncompliance is identified through validation reviews or complaint surveys, the state survey agency monitors corrections as specified at § 488.7(d).

++ DNVHC's capacity to report deficiencies to the surveyed facilities and respond to the facility's plan of correction in a timely manner.

++ DNVHC'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 DNVHC's staff and other resources, and its financial viability.

++ DNVHC's capacity to adequately fund required surveys.

++ DNVHC's policies with respect to whether surveys are announced or unannounced, to assure that surveys are unannounced.

++ DNVHC's agreement to provide CMS with a copy of the most current accreditation survey together with any other information related to the survey as CMS 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.

Dated: June 18, 2014.

Marilyn Tavenner,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2014–15100 Filed 6–26–14; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–3297–PN]

Medicare and Medicaid Programs: Application From the Joint Commission for Continued Approval of Its Ambulatory Surgical Center Accreditation Program

AGENCY: Centers for Medicare and Medicaid Services, HHS.

ACTION: Proposed notice.

SUMMARY: This proposed notice acknowledges the receipt of an application from the Joint Commission for continued recognition as a national accrediting organization for ambulatory surgical centers (ASCs) that wish to participate in the Medicare or Medicaid programs.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on July 28, 2014.

ADDRESSES: In commenting, please refer to file code CMS–3297–PN. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways:

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

2. *By regular mail.* You may mail written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–3297–PN, P.O. Box 8016, Baltimore, MD 21244–8010.

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–3297–PN, 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 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.)

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

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.

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

FOR FURTHER INFORMATION CONTACT: Monda Shaver, (410) 786–3410. Cindy Melanson, (410) 786–0310. Patricia Chmielewski, (410) 786–6899.

SUPPLEMENTARY INFORMATION:

Submitting Comments: We welcome comments from the public on all issues set forth in this proposed notice to assist us in fully considering issues and developing policies. Referencing the file code CMS–3297–PN and the specific ''issue identifier'' that precedes the section on which you choose to comment will assist us in fully considering issues and developing policies.

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

Under the Medicare program, eligible beneficiaries may receive covered services from an ambulatory surgical center (ASC) provided certain requirements are met. Section 1832 (a)(2)(F)(i) of the Social Security Act (the Act) establishes distinct criteria for facilities seeking designation as an ASC. 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. The regulations at 42 CFR part 416 specify the minimum conditions that an ASC must meet to participate in the Medicare program.

Generally, to enter into an agreement, an ASC must first be certified by a State survey agency as complying with the conditions or requirements set forth in part 416 of our regulations. Thereafter, the ASC is subject to regular surveys by a State survey agency to determine whether it continues to meet these requirements.

Section 1865(a)(1) of the Act provides that, if a provider entity demonstrates through accreditation by an approved national accrediting organization that all applicable Medicare conditions are met or exceeded, we will deem those provider entities as having met the requirements. Accreditation by an accrediting organization is voluntary and is not required for Medicare participation.

If an accrediting organization is recognized by the Secretary of the Department of Health and Human Services (the Secretary) as having standards for accreditation that meet or exceed Medicare requirements, any provider entity accredited by the national accrediting body's approved program would be deemed to meet the Medicare conditions. A national accrediting organization applying for approval of its accreditation program under part 488, subpart A, must provide us with reasonable assurance that the accrediting organization requires the accredited provider entities to meet requirements that are at least as stringent as the Medicare conditions. Our regulations concerning the approval of accrediting organizations are set forth at § 488.4 and § 488.8(d)(3). The regulations at § 488.8(d)(3) require accrediting organizations to reapply for continued approval of its accreditation program every 6 years or as determined by CMS.

The Joint Commission's current term of approval for their ASC accreditation program expires December 20, 2014.

II. Approval of Deeming Organizations

Section 1865(a)(2) of the Act and our regulations at § 488.8(a) require that our findings concerning review and approval of a national accrediting organization's requirements consider, among other factors, the applying accrediting organization's requirements for accreditation; survey procedures; resources for conducting required surveys; capacity to furnish information for use in enforcement activities; monitoring procedures for provider entities found not in compliance with the conditions or requirements; and ability to provide CMS with the necessary data for validation.

Section 1865(a)(3)(A) of the Act further requires that we publish, within 60 days of receipt of an organization's complete application, a notice identifying the national accrediting body making the request, describing the nature of the request, and providing at least a 30-day public comment period. We have 210 days from the receipt of a complete application to publish notice of approval or denial of the application.

The purpose of this proposed notice is to inform the public of the Joint Commission's request for continued approval of its ASC accreditation program. This notice also solicits public comment on whether the Joint Commission's requirements meet or exceed the Medicare conditions for coverage (CfCs) for ASCs.

III. Evaluation of Deeming Authority Request

The Joint Commission submitted all the necessary materials to enable us to make a determination concerning its request for continued approval of its ASC accreditation program. This application was determined to be

complete on May 2, 2014. Under Section 1865(a)(2) of the Act and our regulations at § 488.8 (Federal review of accrediting organizations), our review and evaluation of the Joint Commission will be conducted in accordance with, but not necessarily limited to, the following factors:

- The equivalency of the Joint Commission's standards for ASCs as compared with our ASC CfCs.
- The Joint Commission'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 the Joint Commission's processes to those of State agencies, including survey frequency, and the ability to investigate and respond appropriately to complaints against accredited facilities.

++ The Joint Commission's processes and procedures for monitoring an ASC found out of compliance with the Joint Commission's program requirements. These monitoring procedures are used only when the Joint Commission identifies noncompliance. If noncompliance is identified through validation reviews or complaint surveys, the State survey agency monitors corrections as specified at § 488.7(d).

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

++ The Joint Commission'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 the Joint Commission's staff and other resources, and its financial viability.

++ The Joint Commission's capacity to adequately fund required surveys.

++ The Joint Commission's policies with respect to whether surveys are announced or unannounced, to assure that surveys are unannounced.

++ The Joint Commission's agreement to provide CMS with a copy of the most current accreditation survey together with any other information related to the survey that we may require (including corrective action plans).

IV. Collection of Information Requirements

This document does not impose information collection requirements, that is, no reporting, recordkeeping or third-party disclosure 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.

Dated: June 18, 2014.

Marilyn Tavenner,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2014–15101 Filed 6–26–14; 8:45 am]

BILLING CODE P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–3290–FN]

Medicare and Medicaid Programs; Continued Approval of The Joint Commission's (TJC's) Hospital Accreditation Program

AGENCY: Centers for Medicare and Medicaid Services, HHS.

ACTION: Final notice.

SUMMARY: This final notice announces our decision to approve The Joint Commission (TJC) for continued recognition as a national accrediting organization for hospitals that wish to participate in the Medicare or Medicaid programs. A hospital that participates in Medicaid must also meet the Medicare conditions of participation (CoPs) as required under section 1905(a) of the Social Security Act (''Act'') and 42 CFR 482.1(a)(5). This approval is effective July 15, 2014 through July 15, 2020.

DATES: This final notice is effective July 15, 2014 through July 15, 2020.

FOR FURTHER INFORMATION CONTACT: Monda Shaver (410) 786–3410, Cindy Melanson, (410) 786–0310, or Patricia Chmielewski, (410) 786–6899.

SUPPLEMENTARY INFORMATION:

I. Background

A healthcare provider may enter into an agreement with Medicare to participate in the program as a hospital provided certain requirements are met. Section 1861(e) of the Social Security Act (the Act) establishes criteria for providers seeking participation as a hospital. Regulations concerning Medicare provider agreements in general are at 42 CFR part 489 and those pertaining to the survey and certification for Medicare participation of providers and certain types of suppliers are at part 488. The regulations at part 482 specify the specific conditions that a provider must meet to participate in the Medicare program as a hospital.

Generally, to enter into a Medicare hospital provider agreement, a facility must first be certified as complying with the conditions set forth in part 482 and recommended to us for participation by a state survey agency. Thereafter, the hospital is subject to periodic surveys by a state survey agency to determine whether it continues to meet these conditions. However, there is an alternative to certification surveys by state agencies. Accreditation by a nationally recognized Medicare accreditation program approved by us may substitute for both initial and ongoing state review.

Section 1865(a)(1) of the Act provides that, if the Secretary finds that accreditation of a provider entity by an approved national accrediting organization meets or exceeds all applicable Medicare conditions, we may treat the provider entity as having met those conditions, that is, we may ''deem'' the provider entity to be in compliance. Accreditation by an accrediting organization is voluntary and is not required for Medicare participation.

Part 488, subpart A, implements the provisions of section 1865 and requires that a national accrediting organization applying for approval of its Medicare accreditation program must provide us with reasonable assurance that the accrediting organization requires its accredited provider entities to meet requirements that are at least as stringent as the Medicare conditions. Our regulations concerning the approval of accrediting organizations are set forth at § 488.4 and § 488.8(d)(3). The regulations at § 488.8(d)(3) require an accrediting organization to reapply for continued approval of its Medicare accreditation program every 6 years or sooner as determined by us. TJC's current term of approval as a recognized