

submission are included in the hospice cost report instructions on page 43–3.

CMS requires the Form CMS–1984–14 to determine a hospice’s reasonable costs incurred in furnishing medical services to Medicare beneficiaries. CMS uses the Form CMS–1984–14 for rate setting; payment refinement activities, including developing a market basket; Medicare Trust Fund projections; and program operations support. Additionally, the Medicare Payment Advisory Commission (MedPAC) uses the hospice cost report data to calculate Medicare margins (a measure of the relationship between Medicare’s payments and providers’ Medicare costs) and analyze data to formulate Medicare Program recommendations to Congress. *Form Number:* CMS–1984–14 (OMB control number: 0938–0758); *Frequency:* Yearly; *Affected Public:* Private Sector, Business or other for-profits, Not for profits institutions; *Number of Respondents:* 6,430; *Total Annual Responses:* 6,430; *Total Annual Hours:* 1,208,840. (For policy questions regarding this collection contact Duncan Gail at 410–786–7278.)

William N. Parham, III,

Director, Division of Information Collections and Regulatory Impacts, Office of Strategic Operations and Regulatory Affairs.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–3461–PN]

Medicare and Medicaid Programs: Application by the Accreditation Association for Ambulatory Health Care for Continued CMS-Approval of Ambulatory Surgical Center Accreditation Program

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

ACTION: Proposed notice.

SUMMARY: This proposed notice announces the receipt of an application from the Accreditation Association for Ambulatory Health Care for continued recognition as a national accrediting organization for Ambulatory Surgical Centers 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 29, 2024.

ADDRESSES: In commenting, refer to file code CMS–3461–PN. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

Comments, including mass comment submissions, must be submitted in one of the following three 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–3461–PN, P.O. Box 8010, 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–3461–PN, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

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

FOR FURTHER INFORMATION CONTACT: Joy Webb, (410) 786–1667, Joann Fitzell, (410) 786–4280.

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 website as soon as possible after they have been received: <http://www.regulations.gov>. Follow the search instructions on that website to view public comments. CMS will not post on [Regulations.gov](http://www.regulations.gov) public comments that make threats to individuals or institutions or suggest that the commenter will take actions to harm an individual. CMS continues to encourage individuals not to submit duplicative comments. We will post acceptable comments from multiple unique commenters even if the content is identical or nearly identical to other comments.

I. Background

Ambulatory Surgical Centers (ASCs) are distinct entities that operate exclusively for the purpose of

furnishing outpatient surgical services to patients. Under the Medicare program, eligible beneficiaries may receive covered services from an ASC provided certain requirements are met. Section 1832(a)(2)(F)(i) of the Social Security Act (the Act) establishes distinct criteria for a facility 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 conditions that an ASC must meet in order to participate in the Medicare program, the scope of covered services, and the conditions for Medicare payment for ASCs.

Generally, to enter into an agreement, an ASC must first be certified by a state survey agency (SA) as complying with the conditions or requirements set forth in part 416 of our Medicare regulations. Thereafter, the ASC is subject to regular surveys by an SA 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 a Centers for Medicare & Medicaid Services (CMS) approved national accrediting organization (AO) that all applicable Medicare conditions are met or exceeded, we may deem that provider entity as having met the requirements. Accreditation by an AO is voluntary and is not required for Medicare participation.

If an AO is recognized by the Secretary of the Department of Health and Human Services as having standards for accreditation that meet or exceed Medicare requirements, any provider entity accredited by the national accrediting body’s approved program may be deemed to meet the Medicare conditions. The AO applying for approval of its accreditation program under part 488, subpart A, must provide CMS 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 the approval of AOs are set forth at §§ 488.4 and 488.5.

The Accreditation Association for Ambulatory Health Care’s (AAAHC’s) current term of approval for its ASC program expires December 20, 2024.

II. Approval of Deeming Organization

Section 1865(a)(2) of the Act and our regulations at § 488.5 require that our findings concerning review and approval of an AO’s requirements consider, among other factors, the applying AO’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 that identifies the national accrediting body making the request, describes the nature of the request, and provides 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 AAAHC's request for continued CMS-approval of its ASC accreditation program. This notice also solicits public comment on whether AAAHC's requirements meet or exceed the Medicare conditions for coverage (CfCs) for ASCs.

III. Evaluation of Deeming Authority Request

AAAHC submitted all the necessary materials to enable us to make a determination concerning its request for continued CMS-approval of its ASC accreditation program. This application was determined to be complete on May 24, 2024. Under section 1865(a)(2) of the Act and § 488.5, our review and evaluation of AAAHC will be conducted in accordance with, but not necessarily limited to, the following factors:

- The equivalency of AAAHC's standards for ASCs as compared with Medicare's CfCs for ASCs.

- AAAHC'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 AAAHC's processes to those of State agencies, including survey frequency, and the ability to investigate and respond appropriately to complaints against accredited facilities.

- ++ AAAHC's processes and procedures for monitoring an ASC found out of compliance with AAAHC's program requirements. These monitoring procedures are used only when AAAHC identifies noncompliance. If noncompliance is identified through validation reviews or complaint surveys, the State survey agency monitors corrections as specified at § 488.9(c)(1).

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

- ++ AAAHC's capacity to provide CMS with electronic data and reports necessary for the effective validation and assessment of the organization's survey process.

- ++ The adequacy of AAAHC's staff and other resources, and its financial viability.

- ++ AAAHC's capacity to adequately fund required surveys.

- ++ AAAHC's policies with respect to whether surveys are announced or unannounced, to ensure that surveys are unannounced.

- ++ AAAHC's policies and procedures to avoid conflicts of interest, including the appearance of conflicts of interest, involving individuals who conduct surveys or participate in accreditation decisions.

- ++ AAAHC'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 requirements, that is, reporting, recordkeeping, or third-party disclosure requirements. Consequently, there is no need for review by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

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.

The Administrator of the Centers for Medicare & Medicaid Services (CMS), Chiquita Brooks-LaSure, having reviewed and approved this document, authorizes Vanessa Garcia, who is the Federal Register Liaison, to electronically sign this document for purposes of publication in the **Federal Register**.

Vanessa Garcia,

Federal Register Liaison, Centers for Medicare & Medicaid Service.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Center for Scientific Review; Notice of Closed Meetings

Pursuant to section 1009 of the Federal Advisory Committee Act, as amended, notice is hereby given of the following meetings.

The meetings will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: Center for Scientific Review Special Emphasis Panel; Small Business: Cancer Diagnosis and Treatments (CDT).

Date: July 19, 2024.

Time: 9:00 a.m. to 7:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892 (Virtual Meeting).

Contact Person: Victor A. Panchenko, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 802B2, Bethesda, MD 20892, (301) 867-5309, victor.panchenko@nih.gov.

Name of Committee: Center for Scientific Review Special Emphasis Panel; Member Conflict: Health Services and Systems.

Date: July 22-23, 2024.

Time: 9:00 a.m. to 8:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892 (Virtual Meeting).

Contact Person: Thomas Beres, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 5148, MSC 7840, Bethesda, MD 20892, 301-435-1175, berestm@mail.nih.gov.

Name of Committee: Center for Scientific Review Special Emphasis Panel; Overflow SEP: Innate Immunity and Inflammation.

Date: July 22, 2024.

Time: 9:30 a.m. to 6:30 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892 (Virtual Meeting).

Contact Person: Neerja Kaushik-Basu, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 3198, MSC 7808, Bethesda, MD 20892, (301) 435-1742, kaushikbasun@csr.nih.gov.