minimize the information collection burden.

Type of Information Collection Request: New collection; *Title of Information Collection:* Long Term Care Awareness Project; *Form No.:* CMS–10041 (OMB# 0938–NEW); *Use:* CMS needs to collect data to pilot test a national campaign to educate current and future Medicare beneficiaries and their families about long term health care needs, as requested in the Clinton Fiscal Year 2000 Budget, to design and implement a nationwide campaign. Respondents will be from two groups: 55–70 year-olds and 18–64 years old persons with disability; *Frequency:* Quarterly; *Affected Public:* Individuals or households; *Number of Respondents:* 7,800; *Total Annual Responses:* 3,900; *Total Annual Hours:* 800.

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.hcfa.gov/regs/prdact95.htm, or E-mail your request, including your address, phone number, OMB number, and CMS document identifier, to Paperwork@hcfa.gov, or call the Reports Clearance Office on (410) 786–1326. Written comments and recommendations for the proposed information collections must be mailed within 30 days of this notice directly to the OMB desk officer: OMB Human Resources and Housing Branch, Attention: Allison Eydt, New Executive Office Building, Room 10235, Washington, DC 20503.

Dated: July 20, 2001.

Julie Brown,

CMS Reports Clearance Officer, CMS Office of Information Services, Security and Standards Group, Division of CMS Enterprise Standards.

[FR Doc. 01–19153 Filed 7–31–01; 8:45 am]

BILLING CODE 4120–03–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–4023–PN]

ZRIN 0938–-ZA16

Medicare Program; Medicare+Choice Organizations—Application by the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC) for Approval of Deeming Authority for Medicare+Choice Organizations That Are Licensed as a Health Maintenance Organization (HMO) or a Preferred Provider Organization (PPO)

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, Inc. (AAAHC) for recognition as a national accreditation program for health maintenance organizations (HMOs) and Preferred Provider Organizations (PPOs) that wish to participate in the Medicare+Choice program. Regulations set forth at 42 CFR 422.157(b)(1) specify that a **Federal Register** notice will announce our receipt of the accreditation organization's application for approval, describe the criteria we will use in evaluating the application, and provide at least a 30-day public comment period.

DATES: We will consider comments if we receive them at the appropriate address, as provided below, no later than 5 p.m. on August 31, 2001.

ADDRESSES: In commenting, please refer to file code CMS–4023–PN. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission. Mail written comments (one original and three copies) to the following address ONLY:

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–4023–PN, P.O. Box 8013,Baltimore, MD 21244–8013.

Please allow sufficient time for mailed comments to be timely received in the event of delivery delays.

If you prefer, you may deliver (by hand or courier) your written comments (one original and three copies) to one of the following addresses:

Room 443–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or Room C5–16–03, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and could be considered late.

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

FOR FURTHER INFORMATION CONTACT: Patricia Kurtz, (410) 786–4670.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: Comments received timely will 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 (410) 786–7197.

Copies: To order copies of the **Federal Register** containing this document, send your request to: New Orders, Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250–7954. Specify the date of the issue requested and enclose a check or money order payable to the Superintendent of Documents, or enclose your Visa or Master Card number and expiration date. Credit card orders can also be placed by calling the order desk at (202) 512–1800 or by faxing to (202) 512–2250. The cost for each copy is $9. As an alternative, you can view and photocopy the **Federal Register** document at most libraries designated as Federal Depository Libraries and at many other public and academic libraries throughout the country that receive the **Federal Register**.

This **Federal Register** document is also available from the **Federal Register** online database through GPO Access, a service of the U.S. Government Printing Office. The Website address is: *http://www.access.gpo.gov/nara/index.html.*

I. Background

Under the Medicare program, eligible beneficiaries may receive covered services through a managed care organization (MCO) that has a Medicare+Choice (M+C) contract with the Centers for Medicare & Medicaid Services (CMS). The regulations specifying the Medicare requirements that must be met in order for an MCO to enter into an M+C 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 MCO must provide and the requirements that the organization must

meet to be an M+C 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 organization to enter into an M+C contract, the organization must be licensed by the State as a risk bearing organization as set forth in part 422. Additionally, the organization must file an application demonstrating that other Medicare requirements in part 422 are met. Following approval of the contract, CMS engages in routine monitoring of the M+C organization to ensure continuing compliance. The monitoring process is comprehensive and uses a written protocol that itemizes the Medicare requirements the M+C organization must meet.

As an alternative for meeting some Medicare requirements, an M+C organization may be exempt from CMS monitoring of certain requirements in subsets listed in section 1852(e)(4)(C) of the Act as a result of an M+C organization's accreditation by a CMS-approved accrediting organization (AO). In essence, the Secretary ''deems'' that the Medicare requirements are met based on a determination that the AO's standards are at least as stringent as Medicare requirements. The term for which an AO may be approved by CMS may not exceed 6 years as stated in § 422.157(b)(2). For continuing approval, the AO will have to re-apply to CMS.

The applicant organization is generally recognized as an entity that accredits MCOs that are licensed as an HMO or a PPO.

II. Approval of Deeming Organizations

Section 1852(e)(4)(C) of the Act requires that within 210 days of receipt of an application, the Secretary shall determine whether the applicant meets criteria specified in section 1852(e)(4) of the Act. Under these criteria, the Secretary will consider for a national accreditation body, its requirements for accreditation, its survey procedures, its ability to provide adequate resources for conducting required surveys and supplying information for use in enforcement activities, its monitoring procedures for provider entities found out of compliance with the conditions or requirements, and its ability to provide the Secretary with necessary data for validation.

The purpose of this proposed notice is to inform the public of our consideration of AAAHC's application for approval of deeming authority of M+C organizations that are licensed as HMOs or PPOs for the following six categories:

- Quality assurance.
- Access to services.
- Antidiscrimination.
- Information on advance directives.
- Provider participation rules.
- Confidentiality and accuracy of enrollees' records.

This notice also solicits public comment on the ability of the applicant's accreditation program to meet or exceed the Medicare requirements for which it seeks authority to deem.

III. Evaluation of Deeming Request

On June 20, 2001, AAAHC submitted all the necessary information to permit us to make a determination concerning its request for approval as a deeming authority for M+C organizations that are licensed as an HMO or a PPO. Under § 422.158(a), our review and evaluation of a national accreditation organization will consider, but not necessarily be limited to, the following information and criteria:

- The equivalency of AAAHC's requirements for HMOs and PPOs to CMS's comparable M+C organization requirements.
- AAAHC's survey process, to determine the following:
- The frequency of surveys.
- The types of forms, guidelines and instructions used by surveyors.
- Descriptions of the accreditation decision making process, deficiency notification and monitoring process, and compliance enforcement process.
- Detailed information about individuals who perform accreditation surveys including—
- Size and composition of the survey team;
- Education and experience requirements for the surveyors;
- In-service training required for surveyor personnel;
- Surveyor performance evaluation systems; and
- Conflict of interest policies relating to individuals in the survey and accreditation decision process.
- Descriptions of the organization's—
- Data management and analysis system;
- Policies and procedures for investigating and responding to complaints against accredited organizations;
- Types and categories of accreditation offered andM+C organizations currently accredited within those types and categories.

In accordance with § 422.158(b), the applicant must provide documentation relating to—

- Its ability to provide data in a CMS-compatible format;
- The adequacy of personnel and other resources necessary to perform the required surveys and other activities; and
- Assurances that it will comply with ongoing responsibility requirements specified in § 422.157(c).

Additionally, the accrediting organization must provide CMS the opportunity to observe its accreditation process for managed care organizations and must provide other information required by CMS to prepare for an onsite visit to the AO's offices to verify representations made in the application and to make a determination on the application.

IV. Response to Comments and Notice Upon Completion of Evaluation

Because of the large number of items of correspondence we normally receive on **Federal Register** documents published for comment, 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, if we proceed with a subsequent document, we will respond to the major 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 notice in the **Federal Register** announcing the result of our evaluation.

In accordance with the provisions of E.O. 12866, this proposed notice was not reviewed by the Office of Management and Budget.

Section 1853(a)(1)(B) of the Social Security Act (42 U.S.C. 1395w-23(a)(1)(B)).

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

Dated: July 26, 2001.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services

[FR Doc. 01–19189 Filed 7–31–01; 8:45 am]

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