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 deeming authority for ASCs. This notice also solicits public comment on whether the Joint Commission's requirements meet or exceed the Medicare conditions for coverage 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 reapproval as a deeming organization for ASCs. This application was determined to be complete on May 2, 2008. Under section 1865(b)(2) of the Act and § 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 an ASC as compared with CMS' ASC conditions for coverage.
- 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 ASCs 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 us with electronic data in ASCII comparable code, 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 us with a copy of the most current accreditation survey together with any other information related to the survey as we may require (including corrective action plans).

IV. Response to Public Comments and Notice Upon Completion of Evaluation

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.

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 *et seq.*).

VI. Regulatory Impact Statement

In accordance with the provisions of Executive Order 12866 (September 1993, Regulatory Planning and Review, the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), the Office of Management and Budget did not review this proposed notice.

In accordance with Executive Order 13132, we have determined that this proposed notice would not have a significant effect on the rights of States, local or tribal governments.

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: June 10, 2008.

Kerry Weems,

Acting Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. E8–14679 Filed 6–26–08; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare and Medicaid Services

[CMS–2897–PN]

Medicare and Medicaid Programs; Application by the Accreditation Association for Ambulatory Health Care for Continued Deeming Authority for Ambulatory Surgical Centers

AGENCY: Centers for Medicare and Medicaid Services, HHS.

ACTION: Proposed notice.

SUMMARY: This proposed notice acknowledges the receipt of a deeming application from the Accreditation Association for Ambulatory Health Care (AAAHC) for continued recognition as a national accrediting organization for ambulatory surgical centers (ASCs) that wish to participate in the Medicare or Medicaid programs. Section 1865(b)(3)(A) of the Social Security Act requires that within 60 days of receipt of an organization's complete application, we publish 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.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. e.s.t. on July 27, 2008.

ADDRESSES: In commenting, please refer to file code CMS–2897–PN. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (no duplicates, please):

1. Electronically. You may submit electronic comments on this regulation to *http://www.regulations.gov.* Follow the instructions for ''Comment or Submission'' and enter the file code to find the document accepting comments.

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–2897–PN, P.O. Box 8013, Baltimore, MD 21244____.

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 (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–2897–PN, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to either of the following addresses:

a. Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201

(Because access to the interior of the Hubert H. Humphrey (HHH) 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. 7500 Security Boulevard, Baltimore, MD 21244–1850.

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

Comments 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: Aviva Walker-Sicard, (410) 786–8648, Patricia Chmielewski, (410) 786–6899

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

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) authorizes the Secretary to establish 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 part 488. Part 416 specifies 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, in order to enter into an agreement with the Medicare program, an ASC must first be certified by a State survey agency as complying with the conditions or requirements set forth in part 416. Thereafter, the ASC is subject to regular surveys by a State survey agency to determine whether it continues to meet these requirements. There is an alternative to surveys by State agencies, which is accreditation.

Section 1865(b)(1) of the Act provides that, if an ASC demonstrates through accreditation by an approved national accrediting organization that all applicable Medicare conditions are met or exceeded, we will deem those ASCs 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 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 deeming authority 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 reapproval of accrediting organizations are set forth at § 488.4 and § 488.8(d)(3). Section 488.8(d)(3) requires accrediting organizations to reapply for continued deeming authority every 6 years or sooner as determined by us.

AAAHC's term of approval as a recognized accreditation program for ASCs expires December 20, 2008.

II. Approval of Deeming Organizations

Section 1865(b)(2) of the Act and § 488.8(a) of the regulations require that our findings concerning review and reapproval 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(b)(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 AAAHC's request for continued deeming authority for ASCs. This notice also solicits public comment on whether AAAHC's requirements meet or exceed the Medicare conditions for coverage 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 reapproval as a deeming organization for ASCs. This application was determined to be complete on May 2, 2008. Under section 1865(b)(2) of the Act and § 488.8 (Federal review of accrediting organizations), 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 an ASC as compared with CMS' ASC conditions for coverage.
- 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 ASCs 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 § 488.7(d).

++ 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 us with electronic data in ASCII comparable code, and reports necessary for 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 assure that surveys are unannounced.

++ AAAHC's agreement to provide us with a copy of the most current accreditation survey together with any other information related to the survey as we may require (including corrective action plans).

IV. Response to Public Comments and Notice Upon Completion of Evaluation

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.

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 *et seq.*).

VI. Regulatory Impact Statement

In accordance with the provisions of Executive Order 12866 (September 1993, Regulatory Planning and Review, the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354)), the Office of Management and Budget did not review this proposed notice.

In accordance with Executive Order 13132, we have determined that this proposed notice would not have a significant effect on the rights of States, local or tribal governments.

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: June 10, 2008.

Kerry Weems,

Acting Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. E8–14647 Filed 6–26–08; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1400–GNC]

RIN 0938–AP34

Medicare Program; Criteria and Standards for Evaluating Intermediary and Carrier Performance During Fiscal Year 2009

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

ACTION: General notice with comment period.

SUMMARY: This general notice with comment period describes the criteria and standards to be used for evaluating the performance of fiscal intermediaries (FIs) and carriers in the administration of the Medicare program. The results of these evaluations are considered whenever we enter into, renew, or terminate a FI agreement, carrier contract, or take other contract actions, for example, assigning or reassigning providers or services to a FI or designating regional or national intermediaries. We are requesting public comment on these criteria and standards.

DATES: *Effective Date:* The criteria and standards are effective on October 1, 2008.

Comment Date: To be assured consideration, comments must be received no later than 5 p.m. on August 26, 2008.

ADDRESSES: In commenting, please refer to file code CMS–1400–GNC. 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 instructions for ''Comment or Submission'' and enter the filecode to find the document accepting comments.

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–1400–GNC, P.O. Box 8013, Baltimore, MD 21244–8013.

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 (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1400–GNC, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to either of the following addresses:

a. Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201. (Because access to the interior of the HHH 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. 7500 Security Boulevard, Baltimore, MD 21244–1850.

If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786–7195 in advance to schedule your arrival with one of our staff members.