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). The regulations at § 488.8(d)(3) require accrediting organizations to reapply for continued deeming authority every 6 years or sooner as determined by us. The American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF) term of approval as a recognized accreditation program for ASCs expires November 26, 2009.

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 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(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 AAAASF's request for continued deeming authority for ASCs. This notice also solicits public comment on whether AAAASF's requirements meet or exceed the Medicare conditions for coverage for ASCs.

III. Evaluation of Deeming Authority Request

The AAAASF submitted all the necessary materials to enable us to determine its application to be complete on May 1, 2009. Under Section 1865(a)(2) of the Act and our regulations at § 488.8 (Federal review of accreditation organizations), our review and evaluation of AAAASF will be conducted in accordance with, but not necessarily limited to, the following factors:

- The equivalency of AAAASF's standards for an ASC as compared with CMS' ASC conditions for coverage.
- AAAASF'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 AAAASF's processes to those of State agencies, including survey frequency, and the ability to investigate and respond appropriately to complaints against accredited facilities.

—AAAASF's processes and procedures for monitoring ASCs found out of compliance with AAAASF's program requirements. These monitoring procedures are used only when AAAASF identifies noncompliance. If noncompliance is identified through validation reviews, the State survey agency monitors corrections as specified at § 488.7(d).

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

—AAAASF's capacity to provide us with electronic data and reports necessary for effective validation and assessment of the organization's survey process.

—The adequacy of AAAASF's staff and other resources, and its financial viability.

—AAAASF's capacity to adequately fund required surveys.

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

—AAAASF'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. 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.

V. 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. 93.778, Medical Assistance Program; No. 93.773 Medicare—Hospital Insurance Program; and No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: June 11, 2009.

Charlene Frizzera,

Acting Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. E9–15186 Filed 6–25–09; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–2302–PN]

Medicare and Medicaid Programs; Application by the Joint Commission for Continued Deeming Authority for Hospitals

AGENCY: Centers for Medicare & Medicaid Services, HHS.

ACTION: Proposed notice.

SUMMARY: This proposed notice acknowledges the receipt of a deeming application from the Joint Commission for continued recognition as a national accrediting organization for hospitals that wish to participate in the Medicare or Medicaid programs. The statute 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.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on July 27, 2009.

ADDRESSES: In commenting, please refer to file code CMS–2302–PN. 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 under the ''More Search Options'' tab.

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–2302–PN, 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–2302–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 before the close of the comment period to either of 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, 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 FURTHER INFORMATION CONTACT: Cindy Melanson, (410) 786–0310. 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 a hospital provided certain requirements are met. Section 1861(e) of the Social Security Act (the Act) establishes distinct criteria for facilities seeking designation as a hospital. 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 482 specify the conditions that a hospital must meet in order to participate in the Medicare program, the scope of covered services and the conditions for Medicare payment for hospitals.

Generally, in order to enter into a provider agreement with the Medicare program, a hospital must first be certified by a State survey agency as complying with the conditions or requirements set forth in part 482 of our regulations. Thereafter, the hospital is subject to regular surveys by a State survey agency to determine whether it continues to meet these requirements. There is an alternative, however, to surveys by State agencies.

Section 1865(a)(1) of the Act (as re-designated under section 125 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (Pub. L. 110–275)) 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. (We note that section 125 of MIPPA redesignated subsections (b) and (e) of subsection 1865 of the Act as (a) and (d), respectively.) 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). The regulations at § 488.8(d)(3) require accrediting organizations to reapply for continued deeming authority every 6 years or as we determine.

Section 125 of MIPPA revoked the Joint Commission's statutory deeming status for their hospital program and required the Joint Commission to apply to be recognized as a national accreditation body for hospitals, based on terms and conditions required by the Secretary. These terms and conditions are outlined under part 488, subpart A, as described above. Based on the 24-month transition period allowed by section 125 of MIPPA, the Joint Commission's term of approval as a recognized accreditation program for hospitals expires July 15, 2010.

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 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(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 a 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 hospitals. This notice also solicits public comment on whether the Joint Commission's requirements meet or exceed the Medicare conditions for participation for hospitals.

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 hospitals. This application was determined to be complete on May 1, 2009. 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 a hospital as compared with CMS' hospital conditions of participation.

• 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 hospitals 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, 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 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).

(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: May 14, 2009.

Charlene Frizzera,

Acting Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. E9–15183 Filed 6–25–09; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Eunice Kennedy Shriver National Institute of Child Health and Human Development; Notice of Closed Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. App.), notice is hereby given of the following meeting.

The meeting 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: National Institute of Child Health and Human Development Special Emphasis Panel; Mechanisms of Practice-Induced Reaching Improvement after Stroke.

Date: July 17, 2009.

Time: 11:30 a.m. to 3:30 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, 6100 Executive Boulevard, Room 5B01, Rockville, MD 20852 (Telephone Conference Call).

Contact Person: Peter Zelazowski, PhD, Scientific Review Officer, Division of Scientific Review, Eunice Kennedy Shriver National Institute of Child Health and Human Development, NIH, 6100 Executive Boulevard, Rm. 5B01, Bethesda, MD 20892–7510, 301–435–6902, *peter.zelazowski@nih.gov.*

(Catalogue of Federal Domestic Assistance Program Nos. 93.864, Population Research; 93.865, Research for Mothers and Children; 93.929, Center for Medical Rehabilitation Research; 93.209, Contraception and Infertility Loan Repayment Program, National Institutes of Health, HHS)

Dated: June 18, 2009.

Jennifer Spaeth,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. E9–15053 Filed 6–25–09; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of Diabetes and Digestive and Kidney Diseases; Amended Notice of Meeting

Notice is hereby given of a change in the meeting of the National Institute of Diabetes and Digestive and Kidney Diseases Special Emphasis Panel, June 25, 2009, 6 p.m. to June 26, 2009, 5 p.m., Embassy Suites, 1250 22nd Street NW., Washington, DC 20037 which was published in the **Federal Register** on May 27, 2009, 74 FR 25261.

This meeting will be held on August 3, 2009 from 8:30 a.m. until 5 p.m. The meeting is closed to the public.