medical staff and the person directly responsible for operation of the facility approve contractual agreements.

- To meet the requirements at § 485.623(b)(2), the Joint Commission revised its crosswalk and survey process to address the proper routine storage and prompt disposal of trash.
- To meet the requirements at § 485.631(c)(2), the Joint Commission revised its crosswalk to address the requirement that physician assistants, nurse practitioners, or clinical nurse specialists provide services in accordance with the CAH's policies.
- To meet the requirements at § 485.635(a)(3)(iii), the Joint Commission revised its standards to include guidelines for the maintenance of health care records, and procedures for the periodic review and evaluation of the services furnished by the CAH.
- To meet the requirements at § 485.635(f) through (f)(2), the Joint Commission revised its crosswalk to include the patient visitation right standards and related survey process revisions.
- To meet the requirements at § 485.638(a)(2), the Joint Commission revised its crosswalk to address the requirement that medical records are readily accessible.
- To meet the requirements at § 485.639(b)(1), the Joint Commission revised its standards to include the requirement that a qualified practitioner must examine the patient immediately before surgery to evaluate the risk of the procedure to be performed.
- To meet the requirements at § 485.639(b)(2), the Joint Commission revised its standards to include the requirement that a qualified practitioner examine each patient before surgery to evaluate the risk of anesthesia.
- To meet the requirements at § 485.639(b)(3), the Joint Commission revised its standards to address the requirement that a qualified practitioner must evaluate each patient for proper anesthesia recovery before discharge from the CAH.
- To meet the requirements at § 485.643(f), the Joint Commission revised its glossary to ensure that the definition of organ includes ''intestines (or multivisceral organs).''
- To meet the requirements at § 485.645(d)(1), the Joint Commission revised its crosswalk to include standards which address the residents' right to send and receive mail that is not opened.
- To meet the requirements at § 412.27(d)(6)(i), the Joint Commission revised its crosswalk to include the requirement that programs be directed toward restoring and maintaining optimal levels of physical and psychosocial functioning.
- To meet the requirements at § 412.29(c), the Joint Commission revised it crosswalk to include standards to ensure patients receive social services, psychological services (including neuropsychological services), orthotic and prosthetic services, as needed.
- To meet the requirements at § 482.13(h) through (h)(4), the Joint Commission revised its crosswalk to include the patient visitation right standards and related survey process revisions.
- To meet the requirements at § 482.30(d)(3), the Joint Commission revised its standards to ensure that written notification regarding the admission to or continued stay in the hospital when it is not medically necessary, is given no later than 2 days after this determination has been made.
- To meet the requirements at § 482.41(b)(1)(i), the Joint Commission revised its standards to require quarterly testing of tamper and water flow devices.
- To meet the requirements at § 482.41(b)(8), the Joint Commission revised its standards to ensure the CAH maintains written evidence of regular inspections and approval by State or local fire control agencies for the entire CAH.
- To meet the requirements at § 482.51, the Joint Commission revised its standards to ensure that if the hospital provides surgical services, the services are well organized and provided in accordance with acceptable standards of practice and if outpatient surgical services are offered the services must be consistent in quality with inpatient care in accordance with the complexity of services offered.
- To meet the requirements at § 488.4(a)(7), the Joint Commission revised its survey process to include policies and procedures with respect to the withholding or removal of accreditation status or requirements, and other actions taken by the Joint Commission in response to noncompliance with standards and requirements.
- To meet the requirements at section 2728 of the State Operations Manual (SOM), the Joint Commission modified its policies regarding timeframes for sending and receiving a plan of correction (PoC).
- To meet the requirements at § 488.12, the Joint Commission modified its policies and procedures to ensure its survey files are complete.

B. Term of Approval

Based on the review and observations described in section III of this final notice, we have determined that the Joint Commission's requirements for CAHs meet or exceed our requirements. Therefore, we approve the Joint Commission as a national accreditation organization for CAHs that request participation in the Medicare program, effective November 21, 2011 through November 21, 2017.

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).

Authority: Section 1865 of the Social Security Act (42 U.S.C. 1395bb).

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

Dated: August 31, 2011.

Donald M. Berwick,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2011–24496 Filed 9–22–11; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–2377–PN]

Medicare and Medicaid Programs; Application by Community Health Accreditation Program for Continued Deeming Authority for Home Health Agencies

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

ACTION: Proposed notice.

SUMMARY: This proposed notice with comment period acknowledges the receipt of a deeming application from the Community Health Accreditation Program (CHAP) for continued recognition as a national accrediting organization for home health agencies (HHAs) that wish to participate in the Medicare or Medicaid programs. Section 1865(a)(3)(A) of the Social Security Act (the 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. on October 24, 2011.

ADDRESSES: In commenting, please refer to file code CMS–2377–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 ''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–2377–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–2377–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) 786–7195 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:

Lillian Williams, (410) 786–8636.
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 three 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 home health agency (HHA) provided certain requirements are met. Sections 1861(m) and (o), 1891 and 1895 of the Social Security Act (the Act) establish distinct criteria for facilities seeking designation as an HHA. 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 parts 409 and 484 specify the conditions that an HHA must meet to participate in the Medicare program, the scope of covered services and the conditions for Medicare payment for home health care.

Generally, to enter into a provider agreement with the Medicare program, an HHA must first be certified by a State survey agency as complying with the conditions or requirements set forth in 42 CFR part 484 of our regulations. Thereafter, the HHA is subject to regular surveys by a State survey agency to determine whether it continues to meet these requirements.

However, there is an alternative to surveys by State agencies. 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 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 42 CFR part 488, subpart A must provide CMS 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 CMS.

The CHAP'S term of approval as a recognized accreditation program for HHA's expires March 31, 2012.

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 CHAP's request for continued deeming authority for HHAs. This notice also solicits public comment on whether CHAP's requirements meet or exceed the Medicare conditions for participation for HHAs.

III. Evaluation of Deeming Authority Request

CHAP submitted all the necessary materials to enable us to make a determination concerning its request for reapproval as a deeming organization for HHAs. This application was determined to be complete on August 26, 2011. Under section 1865(a)(2) of the Act and our regulations at § 488.8 (Federal review of accrediting organizations), our review and evaluation of CHAP will be conducted in accordance with, but not necessarily limited to, the following factors:

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

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

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

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

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

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

++ CHAP'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 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 notice, and, we will respond to the comments in a subsequent document.

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: August 31, 2011.

Donald M. Berwick,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2011–24547 Filed 9–22–11; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–4152–N]

Medicare Program; Medicare Appeals; Adjustment to the Amount in Controversy Threshold Amounts for Calendar Year 2012

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

ACTION: Notice.

SUMMARY: This notice announces the annual adjustment in the amount in controversy (AIC) threshold amounts for Administrative Law Judge (ALJ) hearings and judicial review under the Medicare appeals process. The adjustment to the AIC threshold amounts will be effective for requests for ALJ hearings and judicial review filed on or after January 1, 2012. The calendar year 2012 AIC threshold amounts are $130 for ALJ hearings and $1,350 for judicial review.

DATES: *Effective Date:* This notice is effective on January 1, 2012.

FOR FURTHER INFORMATION CONTACT: Liz Hosna (*Katherine.Hosna@cms.hhs.gov*), (410) 786–4993.

SUPPLEMENTARY INFORMATION:

I. Background

Section 1869(b)(1)(E) of the Social Security Act (the Act), as amended by section 521 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), established the amount in controversy (AIC) threshold amounts for Administrative Law Judge (ALJ) hearing requests and judicial review at $100 and $1000, respectively, for Medicare Part A and Part B appeals. Section 940 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), amended section 1869(b)(1)(E) of the Act to require the AIC threshold amounts for ALJ hearings and judicial review to be adjusted annually. The AIC threshold amounts are to be adjusted, as of January 2005, by the percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) for July 2003 to July of the year preceding the year involved and rounded to the nearest multiple of $10. Section 940(b)(2) of the MMA provided conforming amendments to apply the AIC adjustment requirement to Medicare Part C Medicare Advantage (MA) appeals and certain health maintenance organization and competitive health plan appeals. Health care prepayment plans are also subject to MA appeals rules, including the AIC adjustment requirement. Section 101 of the MMA provides for the application of the AIC adjustment requirement to Medicare Part D appeals.

A. Medicare Part A and Part B Appeals

The statutory formula for the annual adjustment to the AIC threshold amounts for ALJ hearings and judicial review of Medicare Part A and Part B appeals, set forth at section 1869(b)(1)(E) of the Act, is included in the applicable implementing regulations, 42 CFR 405.1006(b) and (c). The regulations require the Secretary of the Department of Health and Human Services (the Secretary) to publish changes to the AIC threshold amounts in the **Federal Register** (405.1006(b)(2)). In order to be entitled to a hearing before an ALJ, a party to a proceeding must meet the AIC requirements at §405.1006(b). Similarly, a party must meet the AIC requirements at 405.1006(c) at the time judicial review