IV. Provisions of the Final Notice

A. Differences Between AAAHC's Standards and Requirements for Accreditation and Medicare's Conditions and Survey Requirements

We compared the standards and survey process contained in AAAHC's application with the Medicare conditions for accreditation. Our review and evaluation of AAAHC's application for continued CMS-approval were conducted as described in section III of this final notice, and yielded the following:

- To meet the requirements at § 488.10(b), AAAHC modified its policies to include ''person(s) receiving hospice benefits prior to completing an enrollment request for an MSA plan'' as an exception where an MAO may deny enrollment based on medical status.
- AAAHC amended its crosswalk to ensure current AAAHC standards are clearly crosswalked to the following regulatory requirements: §§ 422.112(a)(7); 422.118(d); 422.202(d)(1); and 422.204(b)(2).
- To meet the amendments made at § 422.156 by the final rule published in the April 15, 2011 **Federal Register** (76 CFR 21498), AAAHC removed Quality Improvement Projects and Chronic Care Improvement Programs from its deeming process.

B. Term of Approval

Based on the review and observations described in section III of this final notice, we have determined that AAAHC's accreditation program requirements meet or exceed our requirements. Therefore, we approve AAAHC as a national accreditation organization with deeming authority for MA HMOs and PPOs, effective July 11, 2012 through July 10, 2018.

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

Dated: August 9, 2012.

Marilyn Tavenner,

Acting Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2012–20195 Filed 8–23–12; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1596–N]

Medicare Program; Solicitation of Two Nominations to the Advisory Panel on Hospital Outpatient Payment

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

ACTION: Notice.

SUMMARY: This notice solicits nominations for two new members to the Advisory Panel on Hospital Outpatient Payment (HOP, the Panel). There will be two vacancies on the Panel beginning September 30, 2012.

The purpose of the Panel is to advise the Secretary of the Department of Health and Human Services (DHHS) (the Secretary) and the Administrator of the Centers for Medicare & Medicaid Services (CMS) (the Administrator) on the clinical integrity of the Ambulatory Payment Classification (APC) groups and their associated weights, and supervision of hospital outpatient services.

The Secretary rechartered the Panel in 2011 for a 2-year period effective through November 15, 2013.

DATES: *Submission of Nominations:* We will consider nominations if they are received no later than 5 p.m. (e.s.t.) October 23, 2012.

ADDRESSES: Please mail or hand deliver nominations to the following address: Centers for Medicare & Medicaid Services; Attn: Raymond Bulls, Advisory Panel on HOP; Center for Medicare, Hospital & Ambulatory Policy Group, Division of Outpatient Care; 7500 Security Boulevard, Mail Stop C4–05–17; Baltimore, MD 21244–1850.

Web site: For additional information on the Panel and updates to the Panel's activities, we refer readers to our Web site at the following: *http://www.cms.gov/Regulations-andGuidance/Guidance/FACA/AdvisoryPanelonAmbulatoryPaymentClassificationGroups.html.*

FOR FURTHER INFORMATION CONTACT:

Contact: Persons wishing to nominate individuals to serve on the Panel or to obtain further information may also contact Raymond Bulls at the following email address: *APCPanel@cms.hhs.gov* or call 410–786–7267.

Advisory Committees' Information Lines: You may also refer to the CMS Federal Advisory Committee Hotlines at 1–877–449–5659 (toll-free) or 410–786–3985 (local) for additional information.

News Media: Representatives should contact the CMS Press Office at 202–690–6145.

SUPPLEMENTARY INFORMATION:

I. Background

The Secretary is required by section 1833(t)(9)(A) of the Social Security Act (the Act), and section 222 of the Public Health Service Act (PHS Act) to consult with an expert outside advisory panel regarding the clinical integrity of the APC groups and relative payment weights that are components of the Medicare Hospital Outpatient Prospective Payment System (OPPS), and the appropriate supervision level for hospital outpatient services. The panel may use data collected or developed by entities and organizations (other than DHHS) in conducting the review. The Panel is governed by the provisions of the Federal Advisory Committee Act (FACA) (Public Law 92–463), as amended (5 U.S.C. Appendix 2), which sets forth standards for the formation and use of advisory panels.

The Charter requires that the Panel meet up to three times annually. CMS considers the technical advice provided by the Panel as we prepare the proposed and final rules to update the OPPS for the following calendar year.

The Panel shall consist of a chair and up to 19 members who are full-time employees of hospitals, hospital systems, or other Medicare providers that are subject to the OPPS. (For purposes of the Panel, consultants or independent contractors are not considered to be full-time employees in these organizations.)

The current Panel members are as follows: (**Note:** The asterisk [*] indicates the Panel members whose terms end on September 30, 2012.)

- E. L. Hambrick, M.D., J.D., Chair, a CMS Medical Officer
- Karen Borman, M.D.
- Ruth L. Bush, M.D., M.P.H.
- Lanny Copeland, M.D.
- Kari S. Cornicelli, C.P.A., FHFMA
- Dawn L. Francis, M.D., M.H.S.
- David A. Halsey, M.D.
- Brain D. Kavanagh, M.D., M.P.H.
- Judith T. Kelly, B.S.H.A., RHIT, RHIA, CCS*
- Scott Manaker, M.D., Ph.D.
- John Marshall, CRA, RCC, RT
- Jim Nelson

- Leah Osbahr
- Randall A. Oyer, M.D.*
- Jacqueline Phillips
- Daniel J. Pothen, M.S., RHIA, CHPS, CPHIMS, CCS, CCS–P, CHC
- Gregory J. Przbylski, M.D.
- Traci Rabine
- Marianna V. Spanki-Varelas M.D., Ph.D., M.B.A.
- Gale Walker

Panel members serve without compensation, according to an advance written agreement; however, for the meetings, CMS reimburses travel, meals, lodging, and related expenses in accordance with standard Government travel regulations. CMS has a special interest in ensuring, while taking into account the nominee pool, that the Panel is diverse in all respects of the following: geography; rural or urban practice; race, ethnicity, sex, and disability; medical or technical specialty; and type of hospital, hospital health system, or other Medicare provider subject to the OPPS.

Based upon either self-nominations or nominations submitted by providers or interested organizations, the Secretary, or her designee, appoints new members to the Panel from among those candidates determined to have the required expertise. New appointments are made in a manner that ensures a balanced membership under the FACA guidelines.

II. Criteria for Nominees

The Panel must be fairly balanced in its membership in terms of the points of view represented and the functions to be performed. Each Panel member must be employed full-time by a hospital, hospital system, or other Medicare provider subject to payment under the OPPS. All members must have technical expertise to enable them to participate fully in the Panel's work. Such expertise encompasses hospital payment systems; hospital medical care delivery systems; provider billing systems; APC groups; Current Procedural Terminology codes; and alpha-numeric Health Care Common Procedure Coding System codes; and the use of, and payment for, drugs, medical devices, and other services in the outpatient setting, as well as other forms of relevant expertise. For supervision deliberations, the Panel shall have members that represent the interests of Critical Access Hospitals (CAHs), who advise CMS only regarding the level of supervision for hospital outpatient services.

It is not necessary for a nominee to possess expertise in all of the areas listed, but each must have a minimum of 5 years experience and currently have full-time employment in his or her area of expertise. Generally, members of the Panel serve overlapping terms up to 4 years, based on the needs of the Panel and contingent upon the rechartering of the Panel. A member may serve after the expiration of his or her term until a successor has been sworn in.

Any interested person or organization may nominate one or more qualified individuals. Self-nominations will also be accepted. Each nomination must include the following:

- Letter of Nomination stating the reasons why the nominee should be considered.
- Curriculum Vitae or resume of the nominee.
- Written and signed statement from the nominee that the nominee is willing to serve on the Panel under the conditions described in this notice and further specified in the Charter.
- The hospital or hospital system name and address, or CAH name and address, as well as all Medicare hospital and or Medicare CAH billing numbers of the facility where the nominee is employee.

III. Copies of the Charter

To obtain a copy of the Panel's Charter, we refer readers to our Web site at the following: *http://www.cms.gov/Regulations-and-Guidance/Guidance/FACA/AdvisoryPanelonAmbulatoryPaymentClassificationGroups.html.*

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 (44 U.S.C. 35).

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

Dated: August 8, 2012.

Marilyn Tavenner,

Acting Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2012–20069 Filed 8–23–12; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

National Advisory Committee on Rural Health and Human Services; Notice of Meeting

In accordance with section 10(a)(2) of the Federal Advisory Committee Act (Pub. L. 92–463), notice is hereby given that the following committee will convene its seventy-second meeting.

Name: National Advisory Committee on Rural Health and Human Services.

Dates and Times: September 26, 2012, 9:00 a.m.–5 p.m.; September 27, 2012, 9:00 a.m.–5 p.m.; September 28, 2012, 8:45 a.m.–11:15 a.m.

Place: Radisson Hotel & Suites Austin Downtown, 111 East Cesar Chavez Street, Austin, TX 78701.

Phone: (512) 478–9611.

Status: The meeting will be open to the public.

Purpose: The National Advisory Committee on Rural Health and Human Services provides advice and recommendations to the Secretary with respect to the delivery, research, development, and administration of health and human services in rural areas.

Agenda: Wednesday morning at 9:00 a.m., the meeting will be called to order by the Chairman of the Committee, the Honorable Ronnie Musgrove. The Committee will be examining the future of the rural health care infrastructure and the rural effects of recent changes to the Temporary Assistance for Needy Families (TANF) Program. The day will conclude with a period of public comment at approximately 5:00 p.m.

Thursday morning at approximately 9:00 a.m., the Committee will break into Subcommittees and depart for site visits to rural healthcare and human services providers in Texas. One panel from the Health Infrastructure Subcommittee will visit the Llano Memorial Hospital in Llano, TX. Another panel from the Health Infrastructure Subcommittee will visit Gonzales Healthcare System—Memorial Hospital, in Gonzales, TX. The day will conclude at the Radisson Hotel & Suites Austin Downtown with a period of public comment at approximately 5:00 p.m.

The final session will be convened on Friday morning at 9 a.m. The Committee will summarize key findings from the meeting and develop a work plan for the next quarter and the following meeting. The meeting will adjourn at 11:15 a.m.

FOR FURTHER INFORMATION CONTACT: Steve Hirsch, MSLS, Executive