The purpose of this proposed notice is to inform the public of our consideration of CHAP's request for approval of 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

[If you choose to comment on issues in this section, please include the caption ''Evaluation of Deeming Authority Request'' at the beginning of your comments.]

On June 30, 2004, CHAP submitted all the necessary materials to enable us to make a determination concerning its request for reapproval as a deeming organization for HHAs. Under section 1865(b)(2) of the Act and our regulations at § 488.8 (Federal review of accreditation 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 standards for HHAs as compared with our comparable 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 processes to that 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 providers or suppliers found out of compliance with CHAP program requirements. These monitoring procedures are used only when CHAP identifies noncompliance. If noncompliance is identified through validation reviews, the 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 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 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.

+ 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 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. Regulatory Impact Statement

In accordance with the provisions of Executive Order 12866, this regulation was not reviewed by the Office of Management and Budget.

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)

Dated: September 10, 2004.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 04–21194 Filed 9–23–04; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–2208–PN]

RIN 0938–AZ59

Medicare and Medicaid Programs; Application by the American Osteopathic Association for Continued Approval of Deeming Authority for Hospitals

AGENCY: Centers for Medicare & Medicaid Services, HHS.

ACTION: Proposed notice.

SUMMARY: This proposed notice with comment period acknowledges the receipt of an application from the American Osteopathic Association (AOA) for continued recognition as a national accreditation program for hospitals that wish to participate in the Medicare or Medicaid programs. Section 1865(b)(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: We will consider comments if we receive them at the appropriate address, as provided below, no later than 5 p.m. on October 25, 2004.

ADDRESSES: In commenting, please refer to file code CMS–2208–PN. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

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

1. *Electronically*. You may submit electronic comments on specific issues in this regulation to *http://www.cms.hhs.gov/regulations/ecomments*. (Attachments should be in Microsoft Word, WordPerfect, or Excel; however, we prefer Microsoft Word.)

2. *By 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–2208–PN, P.O. Box 8016, Baltimore, MD 21244–8016.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *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 one of the following addresses. 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; Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201; or 7500 Security Boulevard, Baltimore, MD 21244–1850.

(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.)

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: Marjorie Eddinger (410) 786–0375.

I. Background

[If you choose to comment on issues in this section, please include the caption ''Background'' at the beginning of your comments.]

Under the Medicare program, eligible beneficiaries may receive covered services in a hospital facility provided certain requirements are met. Sections 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 to participate in the Medicare program.

Generally, to enter into an agreement, a hospital provider must first be certified by a State survey agency as complying with the conditions or standards set forth in part 482 of our regulations. Then, 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(b)(1) of the Act provides that, if a provider entity demonstrates through accreditation by an approved national accreditation organization that all applicable Medicare conditions are met or exceeded, we would ''deem'' those provider entities as having met the requirements. Accreditation by an accreditation organization is voluntary and is not required for Medicare participation.

If an accreditation 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 accreditation organization applying for approval of deeming authority under 42 CFR part 488, subpart A must provide us with reasonable assurance that the accreditation organization requires the accredited provider entities to meet requirements that are at least as stringent as the Medicare conditions. Our regulations concerning reapproval of accrediting organizations are set forth at § 488.4 and § 488.8(d)(3). The regulations at § 488.8(d)(3) require accreditation organizations to reapply for continued approval of deeming authority every 6 years or sooner as determined by CMS.

The AOA's term of approval as a recognized accreditation program for hospitals expires March 31, 2005.

II. Approval of Deeming Organizations

[If you choose to comment on issues in this section, please include the caption ''Approval of Deeming Organizations'' at the beginning of your comments.]

Section 1865(b)(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 reapplying accreditation 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 CMS 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 accreditation organization's complete application, a notice identifying the national accreditation 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 our receipt of a completed application to publish approval or denial of the application.

The purpose of this proposed notice is to inform the public of our consideration of AOA's request for approval of continued deeming authority for hospitals. This notice also solicits public comment on whether AOA requirements meet or exceed the Medicare conditions for participation for hospitals.

III.Evaluation of Deeming Authority Request

[If you choose to comment on issues in this section, please include the caption ''Evaluation of Deeming Request'' at the beginning of your comments.]

On June 30, 2004, AOA submitted all the necessary materials to enable us to make a determination concerning its request for reapproval as a deeming organization for hospitals. Under section 1865(b)(2) of the Act and our regulations at § 488.8 (Federal review of accreditation organizations), our review and evaluation of AOA will be conducted in accordance with, but not necessarily limited to, the following factors:

- The equivalency of AOA standards for hospitals as compared with our comparable hospital conditions of participation.
- AOA'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 AOA processes to those of State agencies, including survey frequency, and the ability to investigate and respond appropriately to complaints against accredited facilities.

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

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

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

+ AOA's capacity to adequately fund required surveys.

+ AOA's policies with respect to whether surveys are announced or unannounced.

+ AOA'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 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 will respond to the public 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. In accordance with the provisions of Executive Order 12866, the Office of Management and Budget did not review this proposed notice.

V. Regulatory Impact Statement

In accordance with Executive Order 12866, this notice was not reviewed by the Office of Management and Budget.

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: September 10, 2004.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 04–21196 Filed 9–23–04; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–4077–PN]

RIN 0928–ZA59

Medicare and Medicaid Programs; Application by the National Committee for Quality Assurance Preferred Provider Organization for Deeming Authority for Medicare Advantage

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

ACTION: Proposed notice.

SUMMARY: This proposed notice announces the receipt of an application from the National Committee for Quality Assurance for recognition as a national accreditation program for preferred provider organizations that wish to participate in the Medicare Advantage program. The statute requires that within 60 days of receipt of an organization's complete application, we 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: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on October 25, 2004.

ADDRESSES: In commenting, please refer to file code CMS–4077–PN. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

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

1. *Electronically.* You may submit electronic comments on specific issues in this regulation to *http://www.cms.hhs.gov/regulations/ecomments.* (Attachments should be in Microsoft Word, WordPerfect, or Excel; however, we prefer Microsoft Word.)

2. *By 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–4077–PN, P.O. Box 8016, Baltimore, MD 21244–8016.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *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 one of the following addresses. If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786–3159 in advance to schedule your arrival with one of our staff members; Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201; or 7500 Security Boulevard, Baltimore, MD 21244–1850.

(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.)

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: Heidi Adams, (410) 786–1094.

SUPPLEMENTARY INFORMATION:

Submitting Comments: We welcome comments from the public on all issues set forth in this proposed notice to assist us in fully considering issues and developing policies. You can assist us by referencing the file code CMS–4077–PN and the specific ''issue identifier'' that precedes the section on which you choose to comment.

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. After the close of the comment period, CMS posts all electronic comments received before the close of the comment period on its public website. 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) 786–7195.

This **Federal Register** document is available from the **Federal Register** online database through *GPO Access,* a service of the U.S. Government Printing Office. The web site address is: *http://www.gpoaccess.gov/fr/index.html.*

I. Background

[If you choose to comment on issues in this section, please include the caption ''Background'' at the beginning of your comments.]

Under the Medicare program, eligible beneficiaries may receive covered services through a managed care organization (MCO) that has a Medicare Advantage (MA) (formerly, Medicare+Choice) 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 MA 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 MA 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 MA contract, the organization must be licensed by the State as a risk bearing organization as set forth in part 422 of our regulations. Additionally, the organization must file an application demonstrating that it meets other Medicare requirements in part 422 of our regulations. Following approval of the contract, we engage in routine monitoring and oversight audits of the MA organization to ensure continuing compliance. The monitoring and