LIST OF PUMPOUTS IN THE BAY NDZ PROPOSED AREA AVAILABLE FOR RECREATIONAL VESSELS—Continued

Number	Name	Location	Contact information	Dates/days/hours of operation	Water depth (feet)	Cost
2	Coney Island WWTP	Shellbank Creek	718–743–0990; Channel 13.	May 1–Oct 31; 24 hrs	8–10	Free.
3	Rockaway WWTP	Jamaica Bay	718–474–3663; Channel 68.	May 1–Oct 31; 24 hrs	10–14	Free.
4	NY/NJ Baykeeper's 24 foot sewage-pumpout vessel.	Jamaica Bay	732–337–9262; Channel 9.	Memorial Day to Labor Day; Sunrise to sunset.	N/A	Free.

Based on the above, EPA hereby makes a final affirmative determination that adequate facilities for the safe and sanitary removal and treatment of sewage from all vessels are available for the open waters and tributaries of the Bay of the New York City metropolitan area.

Dated: September 30, 2011.

Judith A. Enck,

Regional Administrator, Region 2.

[FR Doc. 2011–27990 Filed 10–27–11; 8:45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare and Medicaid Services

[CMS–2901–PN]

Medicare and Medicaid Programs; The American Association for Accreditation of Ambulatory Surgery Facilities for Approval of Deeming Authority for Rural Health Clinics

AGENCY: Centers for Medicare and Medicaid Services, HHS.

ACTION: Proposed notice.

SUMMARY: This proposed notice with comment period acknowledges the receipt of a deeming application from the American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF) for recognition as a national accrediting organization for rural health clinics (RHCs) that wish to participate in the Medicare or Medicaid programs. The statute 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 November 28, 2011.

ADDRESSES: In commenting, please refer to file code CMS–2901–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 notice 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–2901–PN, P.O. Box 8010, 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–2901–PN, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* Alternatively, you may deliver (by hand or courier) your written comments *only* to the following addresses prior to the close of the comment period:

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, call telephone number (410) 786–9994 in advance to schedule your arrival with one of our staff members.

Comments erroneously 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: L. Tyler Whitaker, (410) 786–5236. 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 rural health clinic (RHC) provided certain requirements are met. Sections 1861(aa) of the Social Security Act (the Act) establish distinct criteria for facilities seeking designation as RHCs. 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 491, subpart A, specify the conditions that an RHC must meet in order to participate in the Medicare program, the scope of covered services, and the conditions for Medicare payment for RHCs.

Generally, in order to enter into a provider agreement with the Medicare program, an RHC must first be certified by a State survey agency as complying with the conditions or requirements set forth in part 42 CFR part 491, subpart A, of our regulations. Thereafter, the RHC 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 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 would 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 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. The regulations at § 488.8(d)(3) require accrediting organizations to reapply for continued deeming authority every 6 years or as we determine.

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 approval 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 American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF's) request for deeming authority for RHCs. This notice also solicits public comment on whether AAAASF's requirements meet or exceed the Medicare conditions for coverage for RHCs.

III. Evaluation of Deeming Authority Request

AAAASF submitted all the necessary materials to enable us to make a determination concerning its request for approval as a deeming organization for RHCs. This application was determined to be complete on August 29, 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 the AAAASF would be conducted in accordance with, but not necessarily limited to, the following factors:

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

—The processes and procedures AAAASF uses for monitoring RHCs 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).

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

—The capacity AAAASF uses 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.

—The capacity AAAASF uses to adequately fund required surveys.

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

—The agreement AAAASF uses 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 received 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: October 13, 2011.

Donald M. Berwick,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2011–27962 Filed 10–27–11; 8:45 am]

BILLING CODE 4120–01–P