Secretary to request information from providers which is necessary to properly administer the Medicare program. Quarterly credit balance reporting is needed to monitor and control the identification and timely collection of improper payments. The information obtained from Medicare credit balance reports will be used by the contractors to identify and recover outstanding Medicare credit balances and by Federal enforcement agencies to protect Federal funds. The information will also be used to identify the causes of credit balances and to take corrective action. *Form Number:* CMS–838 (OMB# 0938–0600); *Frequency:* Yearly; *Affected Public:* Private sector—business or other for-profits; *Number of Respondents:* 52,380; *Total Annual Responses:* 209,520; *Total Annual Hours:* 628,560.

3. *Type of Information Collection Request:* New collection; *Title of Information Collection:* CROWNWeb Authentication Service (CAS) Account Form; *Form Number:* CMS–10267 (OMB#: 0938–1050); *Use:* The CROWNWeb Authentication Service (CAS) application must be completed by any person needing access to the CROWNWeb system which include includes CMS employees, ESRD Network Organization staff and dialysis facilities staff. The CROWNWeb system is the system used as the collection point of data necessary for entitlement of ESRD patients to Medicare benefits and Federal Government monitoring and assessing of quality and type of care provided to renal patients. The data collected in CAS will provide the necessary security measures for creating and maintaining active CROWNWeb user accounts and collection of audit trail information required by the CMS Information Security Officers (ISSO). Frequency: Reporting—one-time; *Affected Public:* Business or other for-profit, not-for-profit; *Number of Respondents:* 15,600; *Total Annual Responses:* 15,600; Total Annual Hours: 7,800.

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access CMS' Web Site at *http://www.cms.hhs.gov/PaperworkReductionActof1995,* or e-mail your request, including your address, phone number, OMB number, and CMS document identifier, to *Paperwork@cms.hhs.gov,* or call the Reports Clearance Office on (410) 786–1326.

In commenting on the proposed information collections please reference the document identifier or OMB control number. To be assured consideration, comments and recommendations must be submitted in one of the following ways by January 27, 2009.

1. *Electronically.* You may submit your comments electronically to *http://www.regulations.gov.* Follow the instructions for ''Comment or Submission'' or ''More Search Options'' to find the information collection document(s) accepting comments.

2. *By regular mail.* You may mail written comments to the following address:

CMS, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development, Attention: Document Identifier/OMB Control Number_____, Room C4–26–05, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

Dated: *November 21, 2008.*

Michelle Shortt,

Director, Regulations Development Group, Office of Strategic Operations and Regulatory Affairs.

[FR Doc. E8–28380 Filed 11–26–08; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare and Medicaid Services

[CMS–2294–PN]

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

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 Joint Commission for continued recognition as a national accrediting organization for hospices that wish to participate in the Medicare or Medicaid programs. Section 1865(b)(3)(A) of the Act, recodified under the Medicare Improvement for Patients and Providers Act of 2008 (Pub. L. 110–275, July 15, 2008) (MIPPA) as section 1865(a)(3)(A) 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: *Comment Date:* To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on December 29, 2008.

ADDRESSES: In commenting, please refer to file code CMS–2294–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 specific issues in this regulation to *http://www.regulation.gov.* Follow the instructions for ''Comment or Submission'' and enter the filecode to find the document accepting comments.

2. *By regular 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–2294–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 express or overnight mail.* You may send 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–2294–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 (one original and two copies) before the close of the comment period to either of the following addresses.

a. Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201; or

(Because access to the interior of the HHS 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. 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 information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Alexis Prete, (410) 786–0375. 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 hospice provided certain requirements are met. Sections 1861(dd)(1) of the Social Security Act (the Act) establish distinct criteria for facilities seeking designation as a hospice. 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 418, specify the conditions that a hospice must meet in order to participate in the Medicare program, the scope of covered services and the conditions for Medicare payment for Hospice care.

Generally, in order to enter into a provider agreement with the Medicare program, a hospice must first be certified by a State survey agency as complying with the conditions or requirements set forth in part 418 of our CMS regulations. Thereafter, the hospice 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 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 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 six years or sooner as determined by CMS.

The Joint Commission's term of approval as a recognized accreditation program for hospice's expires March 31, 2009.

II. Approval of Deeming Organizations

Section 1865(b)(2) of the Act (now section 1865(a)(2)) 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(b)(3)(A) of the Act (now 1865(a)(3)(A)) 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 the Joint Commission's request for continued deeming authority for hospices. This notice also solicits public comment on whether the Joint Commission's requirements meet or exceed the Medicare conditions for participation for hospices.

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 hospices. This application was determined to be complete on October 24, 2008. Under section 1865(b)(2) of the Act (now 1865(a)(2)) 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 hospices as compared with CMS' hospice 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 hospices 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).

VI. Regulatory Impact Statement

In accordance with the provisions of Executive Order 12866, the Office of Management and Budget did not review this proposed notice.

In accordance with Executive Order 13132, we have determined that this proposed notice would not have a significant effect on the rights of States, local or tribal governments.

(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: November 7, 2008.

Kerry Weems,

Acting Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. E8–28178 Filed 11–26–08; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1397–N]

Medicare Program; Rechartering of the Advisory Panel on Ambulatory Payment Classification Groups

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (DHHS).

ACTION: Notice.

SUMMARY: This notice announces the Rechartering of the Advisory Panel on Ambulatory Payment Classification (APC) Groups (the Panel) by the Secretary, DHHS (the Secretary) for a 2-year period with the new charter effective through November 21, 2010.

FOR FURTHER INFORMATION CONTACT: Shirl Ackerman-Ross, Designated Federal Official (DFO), Advisory Panel on APC Groups; Center for Medicare Management, Hospital & Ambulatory Policy Group, Division of Outpatient Care; 7500 Security Boulevard, Mail Stop C4–05–17; Baltimore, MD 21244–1850. You may also contact the DFO by phone at 410–786–4474 or by e-mail at *CMS__APCPanel@cms.hhs.gov*.

For additional information on the APC Panel and updates to the Panel's activities, please search our Web site at: *http://www.cms.hhs.gov/FACA/05__AdvisoryPanelonAmbulatoryPaymentClassificationGroups.asp#TopOfPage.* You may also refer to the CMS Federal Advisory Committee Hotline at 1–877–449–5659 (toll-free) or call 410–786–9379 (local) for additional information. News media representatives should contact the CMS Press Office at 202–690–6145.

SUPPLEMENTARY INFORMATION:

I. Background

Purpose

The Secretary of the Department of Health and Human Services (DHHS) (the Secretary) is required by section 1833(t)(9)(A) of the Social Security Act (the Act), as amended by section 201(h) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA) (Public Law [Pub. L.] 106–113), and re-designated by section 202(a)(2) of the BBRA to establish and consult with an expert, outside advisory panel on the ambulatory payment classification (APC) groups established under the Medicare hospital Outpatient Prospective Payment System (OPPS).

Authority

Section 1833(t)(9)(A) of the Act (42 U.S.C. 1395l(t)), as amended by section 201(h) of the BBRA of 1999 (Pub. L. 106–113). The Advisory Panel on APC Groups (the Panel) is governed by the provisions of Pub. L. 92–463, the Federal Advisory Committee Act (FACA), as amended (5 U.S.C. Appendix 2), which sets forth standards for the formation and use of advisory panels.

The Panel was established by statute and has functions that are of a continuing nature. Therefore, its duration is not governed by section 14(a) of FACA, but rather it is otherwise provided by law. The Panel is rechartered in accordance with section 14(b)(2) of FACA.

Function

The Panel shall advise the Secretary and the Administrator, Centers for Medicare & Medicaid Services (CMS), about the clinical integrity of the APC groups and their associated weights, which are major elements of the Medicare hospital OPPS. The Panel is technical in nature, and it shall deal with the following issues:

- Addressing whether procedures within an APC group are similar both clinically and in terms of resource use.
- Evaluating APC group weights.
- Reviewing the packaging of OPPS services and costs, including the methodology and the impact on APC groups and payment.
- Removing procedures from the inpatient list for payment under the OPPS.
- Using single and multiple procedure claims data for determination of APC group payments.
- Addressing other technical issues concerning APC group structure.

The subject matter before the Panel shall be limited to these and related topics. Unrelated topics are not subjects for discussion. Unrelated topics include, but are not limited to, the conversion factor, charge compression, pass-through payments for medical devices and drugs, correct code usage, and wage adjustments.

The Panel may use data collected or developed by entities and organizations other than the DHHS and CMS in conducting its review. The Secretary and the Administrator shall be advised of all matters pertaining to the Panel (i.e., membership, recommendations, subcommittees, meetings, etc.).

Structure

The Panel must be fairly balanced in its membership in terms of the points of