at § 485.647, including a crosswalk addressing the Medicare hospital CoPs at § 482, as part of its application for renewal of CAH deeming authority. Given the Joint Commission's unique statutory deeming authority for hospitals as set forth in former section 1865(a) of the Act, the Joint Commission had previously not been subject to a comparability review of its hospital accreditation program in accordance with the requirements at §§ 488.4 and 488.8. Review of the Joint Commission revised accreditation standards for hospitals revealed that significant gaps remain between the Joint Commission standards and the Medicare hospital CoPs.

In accordance with § 488.8(d)(3), every six years, or sooner as determined by CMS, an approved accreditation organization must reapply for continued approval of deeming authority. CMS notifies the organization of the materials the organization must submit as part of the reapplication procedure. An accreditation organization that is not meeting the requirements of this subpart, as determined through a comparability review, must furnish CMS, upon request and at any time, with the reapplication materials CMS requests. CMS will establish a deadline by which the materials are to be submitted.

In accordance with § 488.8(f)(3)(i), if we determine that an AO has failed to adopt requirements comparable to CMS requirements, we may grant a conditional approval of the AO's deeming authority for a period of up to 180 days to adopt comparable requirements. Within 60 days after the end of this period, CMS will make a final determination as to whether or not the Joint Commission's CAH accreditation requirements are comparable to CMS requirements and issue an appropriate notice that includes reasons for our determination no later than July 19, 2009. If the Joint Commission has not made improvements acceptable to CMS during this period, CMS may remove recognition of deemed authority for its CAH program effective up to 30 days from the date we provide written notice to the Joint Commission that its CAH deeming authority will be removed. In addition, because of our concern about DPU standards, once the Joint Commission has implemented their revised CAH DPU standards, we will conduct a survey observation at the next available opportunity to validate proper application of the standards.

B. Term of Approval

Based on the review and observations described in section III of this final notice, specifically remaining significant gaps between the Joint Commission hospital standards for DPUs and Medicare hospital CoPs. We have determined that the Joint Commission's accreditation standards for CAH DPUs require further revision and subsequent review. We are confident that with additional time, the Joint Commission will make the necessary revisions to their DPU standards and implement these revised standards to ensure that the Joint Commission's accreditation program for CAH DPUs meets or exceeds the Medicare requirements as stated at § 485. Therefore, we conditionally approve the Joint Commission as a national accreditation organization for CAHs that request participation in the Medicare program, effective November 21, 2008 through November 21, 2011, with a 180 day probationary period through May 20, 2009.

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: September 11, 2008.

Kerry Weems,

Acting Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. E8–25193 Filed 10–23–08; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–3205–PN]

Medicare Program; Application by the American Association of Diabetes Educators (AADE) for Recognition as a National Accreditation Organization for Accrediting Entities To Furnish Outpatient Diabetes Self-Management Training

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

ACTION: Proposed notice.

SUMMARY: This proposed notice announces the receipt of an application from the American Association of Diabetes Educators (AADE) for recognition as a national accreditation program for accrediting entities that wish to furnish outpatient diabetes self-management training to Medicare beneficiaries. The statute requires that the Secretary publish 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.

DATES: To be assured consideration, comments must be received at one of the addresses provided below no later than 5 p.m. on November 24, 2008.

ADDRESSES: In commenting, please refer to file code CMS–3205–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 specific issues in this regulation to *http://www.regulations.gov*. Follow the instructions under the more search options tab.

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–3205–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 to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–3205–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) before the close of the comment period to one of the following addresses:

a. 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. 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: Joan A. Moliki, (410) 786–5526.

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 outpatient diabetes self-management training when ordered by the physician (or qualified non-physician practitioner) treating the beneficiary's diabetes, provided certain requirements are met. We sometimes use national accrediting organizations to determine whether an entity meets some or all of the Medicare requirements when providing services for which Medicare payment is made.

Under section 1865(a)(1) of the Social Security Act (the Act), a national accreditation organization must have an agreement in effect with the Secretary and meet the standards and requirements specified by the Secretary in 42 CFR 410, subpart H to qualify for deeming authority. The regulations pertaining to application procedures for national accreditation organizations for diabetes self-management training are specified at § 410.142 (CMS process for approving national accreditation organizations). One of the regulations requires national accreditation organizations applying for deeming authority to provide us with reasonable assurance that the accrediting organization requires accredited entities to meet requirements that are at least as stringent as our requirements.

We may approve and recognize a nonprofit or not-for-profit organization with demonstrated experience in representing the interests of individuals with diabetes to accredit entities to furnish training. The accreditation organization, after being approved and recognized by us, may accredit an entity to meet one of the sets of quality standards in § 410.144 (Quality standards for deemed entities).

Section 1865(a)(2) of the Act further requires that we review the applying accreditation organization as follows:

- The organization's requirements for accreditation,
- Survey procedures,
- Ability to provide adequate resources for conducting required surveys,
- Ability to supply information for use in enforcement activities,
- Monitoring procedures for providers found out of compliance with the conditions or requirements, and
- Ability to provide us with necessary data for validation.

We then examine the national accreditation organization's accreditation requirements to determine if they meet or exceed the Medicare conditions as we would have applied them. Section 1865(a)(3)(A) of the Act requires that we publish a notice identifying the national accreditation body making the request within 30 days of receipt of a completed application. The notice must describe the nature of the request and provide at least a 30-day public comment period. We have 210 days from receipt of the request to publish a finding of approval or denial of the application. If we recognize an accreditation organization in this manner, any entity accredited by the national accreditation body's CMS-approved program for that service will be ''deemed'' to meet the Medicare conditions for coverage.

II. Provisions of the Proposed Notice

The purpose of this notice is to notify the public of the American Association of Diabetes Educators (AADE's) request for the Secretary's approval of its accreditation program for outpatient diabetes self-management training services. This notice also solicits public comments on the ability of the AADE to develop standards that meet or exceed the Medicare conditions for coverage, and apply them to entities furnishing outpatient diabetes self-management training.

Conditions for Coverage and Requirements for Outpatient Diabetes Self-Management Training Services

The regulations specifying the Medicare conditions for coverage for outpatient diabetes self-management training services are located in 42 CFR parts 410, subpart H. These conditions implement section 1861(qq) of the Act, which provides for Medicare Part B coverage of outpatient diabetes self-management training services specified by the Secretary.

Under section 1865(a)(2) of the Act and our regulations at § 410.142 (CMS process for approving national accreditation organizations) and § 410.143 (Requirements for approved accreditation organizations), we review and evaluate a national accreditation organization based on (but not necessarily limited to) the criteria set forth in § 410.142(b).

We may conduct on-site inspections of a national accreditation organization's operations and office to verify information in the organization's application and assess the organization's compliance with its own policies and procedures. The onsite inspection may include, but is not limited to, reviewing documents, auditing documentation of meetings concerning the accreditation process, evaluating accreditation results or the accreditation status decisionmaking process, and interviewing the organization's staff.

Notice Upon Completion of Evaluation

Upon completion of our evaluation, including evaluation of comments received as a result of this notice, we will publish a notice in the **Federal**

Register announcing the result of our evaluation.

III. 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. Chapter 35)

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.

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

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

Dated: October 9, 2008.

Kerry Weems,

Acting Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. E8–25195 Filed 10–23–08; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1421–N]

Medicare Program; Plan To Transition to a Medicare Value-Based Purchasing Program for Physician and Other Professional Services: Listening Session, December 9, 2008

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

ACTION: Notice of meeting.

SUMMARY: This notice announces a listening session being conducted as part of the development of a plan for the transition to a value-based purchasing program for physician and other professional services as required by section 131(d) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). The purpose of the listening session is to solicit comments on an issues paper that will present the range of issues being considered for plan development. Physicians, physician associations, and all others interested in the pursuit of new payment approaches to enhance the quality and efficiency of physician and other professional services are invited to participate, in person or by calling in to the teleconference. The issues paper will be posted on the CMS Web site Physician Center Spotlights at *http://www.cms.hhs.gov/center/physician.asp* no later than November 28, 2008. The issues identified and discussed during this meeting will assist us in developing options for the plan. The meeting is open to the public, but attendance is limited to space and teleconference lines available.

DATES: *Meeting Date:* The listening session will be held on Tuesday, December 9, 2008 from 10 a.m. until 4 p.m. e.s.t.

Deadline for Meeting Registration and Request for Special Accommodations: Registration opens on Monday, October 27, 2008. Registration must be completed by 5 p.m. e.s.t. Tuesday, December 2, 2008. Requests for special accommodations must be received by 5 p.m. e.s.t. on Tuesday, December 2, 2008.

Deadline for Submission of Written Comments or Statements: Written comments or statements on the issues paper may be sent via mail, fax, or electronically to the address specified in the **ADDRESSES** section of this notice and must be received by 5 p.m. e.s.t. on Tuesday, December 16, 2008.

ADDRESSES: *Meeting Location:* The listening session will be held in the main auditorium of the Central Building of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Registration and Special Accommodations: Persons interested in attending the meeting or participating by teleconference must register by completing the on-line registration via the CMS Web site at *http://registration.intercall.com/go/cms2.* Individuals who require special accommodations should send an e-mail request to *mpf@cms.hhs.gov* or via regular mail to Robin Phillips at the address specified in the **FOR FURTHER INFORMATION** section of this notice.

Written Comments or Statements: Written comments or statements may be sent via e-mail to *PhysicianVBP@cms.hhs.gov,* faxed to 410–786–8005; or sent via regular mail to: Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244–1850, Mail Stop C5–15–02, Attn: Physician VBP comments.

All persons planning to make a statement in person at the listening session are urged to submit statements in writing during the listening session and should subsequently submit the information electronically by the timeframe specified in the **DATES** section of this notice.

FOR FURTHER INFORMATION CONTACT: For further information regarding the December 9, 2008 listening session contact Robin Phillips, 410–786–3010 in the Provider Communications Group. You may also send inquiries about this listening session via e-mail to *mpf@cms.hhs.gov* or via regular mail at Centers for Medicare & Medicaid Services, Mail Stop C4–13–07, 7500 Security Boulevard, Baltimore, MD 21244–1850.

I. Background

Section 131(d) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), enacted on July 15, 2008, requires the Secretary of the Department of Health and Human Services to develop a plan to transition to a value-based purchasing (VBP) program for Medicare payment for covered professional services. It also requires the Secretary to submit a Report to Congress no later than May 1, 2010, containing the plan with recommendations for legislation and administrative action that the Secretary deems appropriate.

We have created an internal Physician VBP Workgroup that is charged with developing the plan. The workgroup is organized into four subgroups to address the major components of the plan: (1) Measures; (2) data infrastructure and reporting; (3) incentive methodology; and (4) public reporting. The CMS workgroup will identify key issues in each component to create the issues paper, prepare a set of design options that take into consideration the findings from the listening session and comments on the issues paper, narrow the set of design options to prepare a draft plan, and develop the final plan that will be submitted in a Report to Congress. The process of plan development began in September 2008 and is intended to be completed in time for submission of the Report to Congress (which is due no later than May 1, 2010). The December listening session and perhaps other sessions will be hosted to solicit comments from physicians and other health professionals on outstanding design questions associated with development of the plan.