Dutchess Hospital's Designated OPO is: New York Organ Donor Network, 132 West 31st Street, 11th Floor, New York, NY 10001.

Methodist University Hospital of Memphis, Tennessee has requested a waiver in order to enter into an agreement with a designated OPO other than the OPO designated for the service area in which the hospital is located. Methodist University Hospital is requesting a waiver to work with: Tennessee Donor Services, 1600 Hayes Street, Nashville, Tennessee 37203.

Methodist University Hospital's Designated OPO is: Mid-South Transplant Foundation, Inc., 8001 Centerview Parkway, Suite 302, Memphis, Tennessee 38018.

Le Bonheur Children's Medical Center of Memphis, Tennessee has requested a waiver in order to enter into an agreement with a designated OPO other than the OPO designated for the service area in which the hospital is located. Le Bonheur Children's Medical Center is requesting a waiver to work with: Tennessee Donor Services, 1600 Hayes Street, Nashville, Tennessee 37203.

Methodist University Hospital's Designated OPO is: Mid-South Transplant Foundation, Inc., 8001 Centerview Parkway, Suite 302, Memphis, Tennessee 38018.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; Program No. 93.774, Medicare—Supplementary Medical Insurance, and Program No. 93.778, Medical Assistance Program)

Dated: August 8, 2008.

Kerry Weems,

Acting Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. E8–18970 Filed 8–21–08; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare and Medicaid Services

[CMS–2899–PN]

Medicare and Medicaid Programs; Application by the Accreditation Commission for Health Care for Continued Deeming Authority for Home Health Agencies

AGENCY: Centers for Medicare and Medicaid Services, HHS.

ACTION: Proposed notice.

SUMMARY: This proposed notice acknowledges the receipt of a deeming application from the Accreditation Commission for Health Care (ACHC) for continued recognition as a national accrediting organization for home health agencies (HHAs) 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: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. d.s.t. on September 21, 2008.

ADDRESSES: In commenting, please refer to file code CMS–2899–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 this regulation to *http://www.regulations.gov.* Follow the instructions for ''Comment or Submission'' and enter the file code 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–2899–PN, P.O. Box 8013, Baltimore, MD 21244–8013.

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–2899–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.

(Because access to the interior of the Hubert H. Humphrey (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.)

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: Lillian Williams, (410) 786–8636; 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 home health agency (HHA) provided certain requirements are met. Sections 1861(m) and (o), and 1891 of the Social Security Act (the Act) authorize the Secretary to establish distinct criteria for facilities seeking designation as an HHA. 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 part 488. The regulations at part 484 specify the conditions that an HHA must meet in order to participate in the Medicare

program, the scope of covered services and the conditions for Medicare payment for home health care.

Generally, in order to enter into an agreement with the Medicare program, an HHA must first be certified by a State survey agency as complying with the conditions or requirements set forth in part 484. Thereafter, the HHA is subject to regular surveys by a State survey agency to determine whether it continues to meet these requirements. There is an alternative to surveys by State agencies, which is accreditation.

Section 1865(b)(1) of the Act provides that, if an HHA demonstrates through accreditation by an approved national accrediting organization that all applicable Medicare conditions are met or exceeded, we will deem those HHAs 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). Section 488.8(d)(3) requires accrediting organizations to reapply for continued deeming authority every 6 years or sooner as determined by us.

In the February 24, 2006 **Federal Register** (71 FR 9564), we published a final notice announcing our decision to approve the Accreditation Commission for Health Care (ACHC) as a recognized accreditation program for HHA's. ACHC's term of approval expires February 24, 2009.

II. Approval of Deeming Organizations

Section 1865(b)(2) of the Act and § 488.8(a) of the regulations 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 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 ACHC's request for continued deeming authority for HHAs. This notice also solicits public comment on whether ACHC's requirements meet or exceed the Medicare conditions of participation for HHAs.

III. Evaluation of Deeming Authority Request

ACHC submitted all the necessary materials to enable us to make a determination concerning its request for reapproval as a deeming organization for HHAs. This application was determined to be complete on June 27, 2008. Under section 1865(b)(2) of the Act and § 488.8 of the regulations (Federal review of accrediting organizations), our review and evaluation of ACHC will be conducted in accordance with, but not necessarily limited to, the following factors:

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

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

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

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

++ ACHC's capacity to adequately fund required surveys.

++ ACHC's policies with respect to whether surveys are announced or unannounced, to assure that surveys are unannounced.

++ ACHC'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 *et seq.*).

VI. Regulatory Impact Statement

In accordance with the provisions of Executive Order 12866 (September 1993, Regulatory Planning and Review, the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), 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.

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: August 7, 2008.

Kerry Weems,

Acting Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. E8–18971 Filed 8–21–08; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1405–N]

Medicare Program; Medicare Provider Feedback Group Town Hall Meeting—September 22, 2008

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

ACTION: Notice of meeting.

SUMMARY: This notice announces the annual Medicare Provider Feedback Group (MPFG) Town Hall meeting. This meeting is open to all Medicare fee-for-service (FFS) providers and suppliers that participate in the Medicare program, including physicians, hospitals, home health agencies, third-party billers, and interested parties, to present their individual views and opinions on selected FFS Medicare topics. In addition, we will be soliciting input on how we can improve communications to better serve the Medicare providers and suppliers.

DATES: *Meeting Date:* The Town Hall meeting announced in this notice will be held on Monday, September 22, 2008 from 2 p.m. to 4 p.m. EDT.

ADDRESSES: *Meeting Location:* The Town Hall meeting will be held in the main auditorium of the central building of the Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244. The meeting will also be available by teleconference.

FOR FURTHER INFORMATION CONTACT: Colette Shatto, (410) 786–6932. You may also send inquiries about this meeting via e-mail to *MFG@cms.hhs.gov.*

SUPPLEMENTARY INFORMATION:

I. Background

Since 2005, CMS has held four Medicare Provider Feedback Group (MPFG) Town Hall meetings. The purpose of these meetings is to capture individual provider and supplier feedback on relevant Fee-For-Service (FFS) Medicare policy and operational issues. These meetings allow us to further advance our efforts to strengthen the Medicare program and enhance our relationship with providers and suppliers. The meetings also provide a venue to allow us to continue a process of communication with individual providers and suppliers through the following year.

II. Meeting Format and Agenda

The meeting will begin with an overview of the goals and objectives of the MPFG efforts to gather feedback from individual Medicare providers and suppliers. This meeting will be held on-site at CMS and by teleconference. The meeting agenda and discussion materials will be available to download by September 19, 2008. These materials can be located at *http://www.cms.hhs.gov/center/provider.asp.*

The feedback provided during this meeting will assist us as we evaluate FFS Medicare policy, operational issues, and CMS' provider and supplier communication activities. Topics to be discussed include, but are not limited to, 5010 (possible next version of HIPAA standards for claims and other transactions), Medicare Administrative Contract Transitions, and Recovery Auditing.

There will be a question and answer session that offers meeting participants an opportunity to provide feedback on how CMS services physicians, providers and suppliers, as well as make suggestions on how this process can be improved. Time for participants to ask questions or provide feedback will be limited according to the number of registered participants; however, written submissions will be accepted. Individuals who wish to provide written feedback should e-mail that feedback to Colette Shatto at *MFG@cms.hhs.gov.* Written feedback will be accepted through September 30, 2008.

Consideration will be given to feedback received on the topics discussed at the meeting, but written responses will not be provided. The meeting is open to the public, but on-site attendance is limited to space available. Registered participants from the meeting will be included in the MPFG and may be contacted throughout the year for follow-up meetings to solicit additional opinions or clarify any issues that may arise from the September 22, 2008 meeting.

III. Registration Instructions

The Division of Provider Relations and Evaluations, Provider Communications Group, Center for Medicare Management is coordinating the meeting registration. While there is no registration fee, individuals, providers, and suppliers must register to participate both on-site and by teleconference. Individuals must complete the on-line registration located at *http://registration.intercall.com/go/cms2.*

The on-line registration system will capture contact information and practice characteristics (for example, names, e-mail addresses, and provider, and supplier types). Registration will be open beginning August 29, 2008 and will close on September 17, 2008. Registration after 5 p.m. EDT on September 17, 2008 will not be accepted.

The on-line registration system will generate a confirmation page to indicate the completion of your registration. Participants should print this page as his or her registration receipt. Teleconference instructions will be issued as part of the confirmation page once participants have registered through the on-line registration instrument. If seating capacity has been reached for on-site participants, notification will be sent that the meeting has reached capacity; however, those wishing to participate may still do so by teleconference.

IV. Security, Building, and Parking Guidelines

Because this meeting will be located on Federal property, for security reasons, any persons wishing to attend this meeting must register by 5 p.m. EDT on September 17, 2008. Individuals who have not registered by the registration deadline will not be allowed to enter the building to attend the meeting or attend the meeting by teleconference. Seating capacity is limited to the first 250 registrants.

The on-site check-in for visitors will be held from 12:30 p.m. to 1:30 p.m. EDT. Participants should allow sufficient time to go through the security checkpoints. It is suggested that participants arrive at 7500 Security Boulevard no later than 1:30 p.m. EDT in order to arrive promptly at the meeting by 2 p.m.

Security measures will include inspection of vehicles, inside and out, at the entrance to the grounds. In addition, all persons entering the building must pass through a metal detector. All items brought to the building, whether personal or for the purpose of demonstration or to support a presentation, are subject to inspection. In order to gain access to the building, participants will be required to show a government-issued photo identification (for example, driver's license, or