

DATES: We will consider comments if we receive them at the appropriate address, as provided below, no later than 5 p.m. on May 27, 2003.

ADDRESSES: In commenting, please refer to file code CMS-2182-PN. Due to staff and resource limitations, we cannot accept comments by facsimile (fax). Mail written comments (one original and three copies) to the following address: Centers for Medicare and Medicaid Services, Department of Health and Human Services, Attention: CMS-2182-PN, P.O. Box 8013, Baltimore, MD 21244-8013.

Please allow sufficient time for mailed comments to be received in the event of delivery delays.

If you prefer, you may deliver (by hand or courier) your written comments (one original and three copies) to one of the following addresses: Room 443-G, Hubert H. Humphrey (HHH) Building, 200 Independence Avenue, SW., Washington, DC 20201, or Room C5-14-03, 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 above addresses indicated as appropriate for hand or courier delivery may be delayed and received too late for us to consider them.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Cindy Melanson, (410) 785-0310.

SUPPLEMENTARY INFORMATION: *Inspection of Public Comments:* 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 of Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. Top schedule an appointment to view public comments, phone (410) 786-7195.

I. Background

Under the Medicare program, eligible beneficiaries may receive covered services in a hospice, provided certain requirements are met. Section 1861(dd)

of the Social Security Act (the Act) establishes distinct criteria for facilities seeking designation as a hospice provider. Provider agreement regulations are located in 42 CFR part 489, and regulations pertaining to activities relating to the survey and certification of facilities are located in 42 CFR part 488. The regulations at 42 CFR part 418 specify the conditions that a hospice facility must meet in order to participate in the Medicare program, the scope of covered services, and the conditions for Medicare payment for hospice care. Section 1905(O)(1)(A) of the Act generally extends their requirements to payments for hospice services under the Medicaid program.

Generally, in order to enter into an agreement, a hospice facility must first be certified by a State survey agency as complying with the conditions or requirements set forth in part 418 of our regulations. Then, the hospice facility is subject to regular surveys by a State survey agency to determine whether it continues to meet these requirements. There is an alternate, 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 part 486, 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 us. The Community Health Accreditation Program's (CHAP's) term of approval as a recognized accreditation program for hospice facilities expires November 20, 2003.

II. Approval of Deeming Organizations

Section 1965(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 to 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 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. In addition, we must publish a notice in the **Federal Register** or our approval or denial of the application within 210 days from the receipt of the application.

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 hospice facilities. This notice also solicits public comment on whether CHAP requirements meet or exceed the Medicare conditions for participation for hospice facilities.

III. Evaluation of Deeming Authority Request

On February 21, 2003, CHAP submitted all the necessary materials to enable us to make a determination concerning its request for reapproval as a deeming organization for hospice facilities. 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 hospice care as compared with our comparable hospice 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