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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS-4164-PN]

Medicare Program; Renewal of Deeming Authority of the Utilization Review

Accreditation Commission for Medicare Advantage Health Maintenance

Organizations and Local Preferred Provider Organizations

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

ACTION: Proposed notice.

SUMMARY: This notice announces our proposal to renew the Medicare Advantage “deeming authority” of the Utilization Review Accreditation Commission (URAC) for Health Maintenance Organizations and Preferred Provider Organizations for a term of 6 years. This new term of approval would begin May 26, 2012 and end May 25, 2018. This notice announces a 30-day period for public comments on the renewal of the application.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on **[insert date 30 days after date of publication in the Federal Register]**.

ADDRESSES: In commenting, please refer to file code CMS-4164-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 "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-4164-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-4164-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 before the close of the comment period to either of the following addresses:

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, please call telephone number (410) 786-7195 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 FURTHER INFORMATION CONTACT: Caroline Baker, (410) 786-0116 or Edgar Gallardo, (410) 786-0361.

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 through a Medicare Advantage (MA) organization that contracts with CMS. The regulations specifying the Medicare requirements that must be met for a Medicare Advantage Organization (MAO) to enter into a contract with CMS are located at 42 CFR part 422. These regulations implement Part C of Title XVIII of the Social Security Act (the Act), which specifies the services that an MAO must provide and the requirements that the organization must meet to be an MA contractor. Other relevant sections of the Act are Parts A and B of Title XVIII and Part A of Title XI pertaining to the provision of

services by Medicare certified providers and suppliers. Generally, for an entity to be an MA organization, the organization must be licensed by the State as a risk bearing organization as set forth in part 422.

As a method of assuring compliance with certain Medicare requirements, an MA organization may choose to become accredited by a CMS approved accrediting organization (AO). By virtue of its accreditation by a CMS-approved AO, the MA organization can be “deemed” compliant in one or more of six requirements set forth in section 1852(e)(4)(B) of the Act. For CMS to recognize an AO’s accreditation program as establishing an MA plan’s compliance with our requirements, the AO must prove to CMS that their standards are at least as stringent as Medicare requirements. MA organizations that are licensed as health maintenance organizations (HMOs) or preferred provider organizations (PPOs) and are accredited by an approved accrediting organization may receive, at their request, “deemed” status for CMS requirements with respect to the following six MA criteria: Quality Improvement; Antidiscrimination; Access to Services; Confidentiality and Accuracy of Enrollee Records; Information on Advanced Directives; and Provider Participation Rules. (See §422.156(b)). At this time, recognition of accreditation does not include the Part D areas of review set out at §423.165(b). AOs that apply for MA deeming authority are generally recognized by the health care industry as entities that accredit HMOs and PPOs. As we specify at §422.157(b)(2)(ii) the term for which an AO may be approved by CMS may not exceed 6 years. For continuing approval, the AO must apply to CMS to renew their “deeming authority” for a subsequent approval period.

The Utilization Review Accreditation Commission (URAC) was approved as a CMS approved accreditation organization for MA deeming of HMOs on May 26, 2006, and that term will expire on May 26, 2012. On December 9, 2011, URAC submitted an application to renew its deeming authority. On that same date, URAC submitted materials requested from CMS which included updates and/or changes to items set out in Federal regulations at §422.158(a) that are prerequisites for receiving approval of its accreditation program from CMS, and which were furnished to CMS by URAC as a part of their renewal applications for HMOs and PPOs.

II. Provisions of the Proposed Notice

The purpose of this notice is to notify the public of URAC's request to renew its Medicare Advantage "deeming authority" for HMOs and PPOs. URAC submitted all the necessary materials (including its standards and monitoring protocol) to enable us to make a determination concerning its request for approval as an accreditation organization for CMS. This renewal application was determined to be complete on February 6, 2012. Under section 1852(e)(4) of the Act and §422.158 (Federal review of accrediting organizations), our review and evaluation of URAC will be conducted in accordance with our regulations, and will include but not necessarily be limited to the following components:

A. Components of the Review Process

- The types of MA plans that it would review as part of its accreditation process.
- A detailed comparison of the organization's accreditation requirements and standards with the Medicare requirements (for example, a crosswalk).

- Detailed information about the organization’s survey process, including the following—
 - ++ Frequency of surveys and whether surveys are announced or unannounced.
 - ++ Copies of survey forms, and guidelines and instructions to surveyors.
 - ++ Descriptions of—
 - The survey review process and the accreditation status decision making process;
 - The procedures used to notify accredited MA organizations of deficiencies and to monitor the correction of those deficiencies; and
 - The procedures used to enforce compliance with accreditation requirements.
- Detailed information about the individuals who perform surveys for the accreditation organization, including the following—
 - ++ The size and composition of accreditation survey teams for each type of plan reviewed as part of the accreditation process;
 - ++ The education and experience requirements surveyors must meet;
 - ++ The content and frequency of the in-service training provided to survey personnel;
 - ++ The evaluation systems used to monitor the performance of individual surveyors and survey teams; and
 - ++ The organization’s policies and practice with respect to the participation, in surveys or in the accreditation decision process by an individual who is professionally or financially affiliated with the entity being surveyed.

- A description of the organization's data management and analysis system with respect to its surveys and accreditation decisions, including the kinds of reports, tables, and other displays generated by that system.

- A description of the organization's procedures for responding to and investigating complaints against accredited organizations, including policies and procedures regarding coordination of these activities with appropriate licensing bodies and ombudsmen programs.

- A description of the organization's policies and procedures with respect to the withholding or removal of accreditation for failure to meet the accreditation organization's standards or requirements, and other actions the organization takes in response to noncompliance with its standards and requirements.

- A description of all types (for example, full, partial) and categories (for example, provisional, conditional, temporary) of accreditation offered by the organization, the duration of each type and category of accreditation and a statement identifying the types and categories that would serve as a basis for accreditation if CMS approves the accreditation organization.

- A list of all currently accredited MA organizations and the type, category, and expiration date of the accreditation held by each of them.

- A list of all full and partial accreditation surveys scheduled to be performed by the accreditation organization as requested by CMS.

- The name and address of each person with an ownership or control interest in the accreditation organization.

- We will also consider URAC's past performance in the deeming program and results of recent deeming validation reviews, or look-behind audits conducted as part of continuing Federal oversight of the deeming program under §422.157(d).

B. 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.

Section 1852(e)(4)(C) of the Act provides a statutory timetable to ensure that our review of deeming applications is conducted in a timely manner. The Act provides us with 210 calendar days after the date of receipt of an application to complete our survey activities and application review process. At the end of the 210 day period, we must publish an approval or denial of the application in the **Federal Register**.

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.

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.

CMS-4164-PN

Authority: Section 1865 of the Social Security Act (42 U.S.C. 1395bb)

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

Dated: March 23, 2012.

Marilyn Tavenner,

Acting CMS Administrator,

Centers for Medicare & Medicaid Services.

BILLING CODE: 4120-01-P

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