Jeffrey M. Zirger,

Lead, Information Collection Review Office, Office of Scientific Integrity, Office of Science, Centers for Disease Control and Prevention.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–3424–PN]

Medicare and Medicaid Programs: Application From Det Norske Veritas for Continued Approval of Its Hospital Accreditation Program

AGENCY: Centers for Medicare and Medicaid Services, HHS.

ACTION: Notice.

SUMMARY: This notice acknowledges the receipt of an application from Det Norske Veritas for continued recognition as a national accrediting organization for hospitals that wish to participate in the Medicare or Medicaid programs.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on May 18, 2022.

ADDRESSES: In commenting, please refer to file code CMS–3424–PN. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

Comments, including mass comment submissions, must be submitted in one of the following three 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–3424–PN, P.O. Box 8016, Baltimore, MD 21244–8010.

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–3424–PN, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

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

FOR FURTHER INFORMATION CONTACT: Joy Webb, (410) 786–1667. Lillian William, (410) 786–8636.

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 website as soon as possible after they have been received: *http://www.regulations.gov.* Follow the search instructions on that website to view public comments. CMS will not post on *Regulations.gov* public comments that make threats to individuals or institutions or suggest that the individual will take actions to harm the individual. CMS continues to encourage individuals not to submit duplicative comments. We will post acceptable comments from multiple unique commenters even if the content is identical or nearly identical to other comments.

I. Background

Under the Medicare program, eligible beneficiaries may receive covered services from a hospital provided certain requirements are met. Section 1861(e) of the Social Security Act (the Act), establishes distinct criteria for facilities seeking designation as a hospital. 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 482 specify the minimum conditions that a hospital must meet to participate in the Medicare program.

Generally, to enter into an agreement, a hospital must first be certified by a state survey agency (SA) as complying with the conditions or requirements set forth in part 482 of our regulations. Thereafter, the hospital is subject to regular surveys by a SA to determine whether it continues to meet these requirements.

Section 1865(a)(1) of the Act provides that, if a provider entity demonstrates through accreditation by a Centers for Medicare & Medicaid Services (CMS) approved national accrediting organization (AO) that all applicable Medicare conditions are met or exceeded, we will deem those provider entities as having met the requirements. Accreditation by an AO is voluntary and is not required for Medicare participation.

If an AO is recognized by the Secretary of the Department of Health and Human Services (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 AO applying for approval of its accreditation program under part 488, subpart A, must provide CMS with reasonable assurance that the AO requires the accredited provider entities to meet requirements that are at least as stringent as the Medicare conditions. Our regulations concerning the approval of AOs are set forth at §§ 488.4 and 488.5. The regulations at § 488.5(e)(2)(i) require AOs to reapply for continued approval of its accreditation program every 6 years or sooner as determined by CMS.

Det Norske Veritas' current term of approval for their hospital accreditation program expires September 26, 2022.

II. Approval of Deeming Organization

Section 1865(a)(2) of the Act and our regulations at § 488.5 require that our findings concerning review and approval of a national AO's requirements consider, among other factors, the applying AO'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 CMS with the necessary data for validation.

Section 1865(a)(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 Det Norske Veritas' request for continued approval of its hospital accreditation program. This notice also solicits public comment on whether Det Norske Veritas' requirements meet or exceed the Medicare conditions of participation (CoPs) for hospitals.

III. Evaluation of Deeming Authority Request

Det Norske Veritas submitted all the necessary materials to enable us to make a determination concerning its request

for continued approval of its hospital accreditation program. This application was determined to be complete on February 28, 2022. Under section 1865(a)(2) of the Act and our regulations at § 488.5 (Application and re-application procedures for national accrediting organizations), our review and evaluation of Det Norske Veritas will be conducted in accordance with, but not necessarily limited to, the following factors:

- The equivalency of Det Norske Veritas' standards for hospitals as compared with CMS' hospital CoPs.
- Det Norske Veritas' 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 Det Norske Veritas' processes to those of state agencies, including survey frequency, and the ability to investigate and respond appropriately to complaints against accredited facilities.

++ Det Norske Veritas' processes and procedures for monitoring a hospital found out of compliance with Det Norske Veritas' program requirements. These monitoring procedures are used only when Det Norske Veritas identifies noncompliance. If noncompliance is identified through validation reviews or complaint surveys, the SA monitors corrections as specified at § 488.9.

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

++ Det Norske Veritas' capacity to provide CMS with electronic data and reports necessary for effective validation and assessment of the organization's survey process.

++ The adequacy of Det Norske Veritas' staff and other resources, and its financial viability.

++ Det Norske Veritas' capacity to adequately fund required surveys.

++ Det Norske Veritas' policies with respect to whether surveys are announced or unannounced, to assure that surveys are unannounced.

++ Det Norske Veritas' policies and procedures to avoid conflicts of interest, including the appearance of conflicts of interest, involving individuals who conduct surveys or participate in accreditation decisions.

++ Det Norske Veritas' agreement to provide CMS 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. Collection of Information Requirements

This document does not impose information collection requirements, that is, reporting, recordkeeping or third-party disclosure requirements. Consequently, there is no need for review by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. chapter 35).

V. Response to Public 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.

The Administrator of the Centers for Medicare & Medicaid Services (CMS), Chiquita Brooks-LaSure, having reviewed and approved this document, authorizes Lynette Wilson, who is the Federal Register Liaison, to electronically sign this document for purposes of publication in the **Federal Register**.

Dated: April 13, 2022.

Lynette Wilson,

Federal Register Liaison, Centers for Medicare & Medicaid Services.

[FR Doc. 2022–08251 Filed 4–15–22; 8:45 am]

BILLING CODE P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1777–N]

Medicare Program; Meeting Announcement for the Medicare Advisory Panel on Clinical Diagnostic Laboratory Tests

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

ACTION: Notice.

SUMMARY: This notice announces the public meeting dates for the Medicare Advisory Panel on Clinical Diagnostic Laboratory Tests (the Panel) on Monday, July 18, 2022 and Tuesday, July 19, 2022. The purpose of the Panel is to advise the Secretary of the Department of Health and Human Services and the Administrator of the Centers for Medicare & Medicaid Services on issues related to clinical diagnostic laboratory tests.

DATES:

Meeting Dates: The virtual meeting of the Panel is scheduled for Monday, July 18, 2022 from 9:00 a.m. to 5:00 p.m., Eastern Daylight Time (E.D.T.) and Tuesday, July 19, 2022, from 9:00 a.m. to 5:00 p.m., E.D.T. The Panel is also expected to virtually participate in the Clinical Laboratory Fee Schedule (CLFS) Annual Public Meeting for Calendar Year (CY) 2023 on June 23, 2022 in order to gather information and ask questions to presenters. Notice of the CLFS Annual Public Meeting for CY 2023 is published elsewhere in this issue of the **Federal Register**.

Deadline Date for Registration: All stand-by speakers for the Panel meeting must register electronically to our CDLT Panel dedicated email box, *CDLTPanel@cms.hhs.gov* by June 27, 2022. Registration is not required for non-speakers. The public may view this meeting via webinar, or listen-only via teleconference.

Webinar and Teleconference Meeting Information: Teleconference dial-in instructions, and related webinar details will be posted on the meeting agenda, which will be available on the CMS website approximately 2 weeks prior to the meeting at *https://www.cms.gov/Regulations-and-Guidance/Guidance/FACA/AdvisoryPanelonClinicalDiagnosticLaboratoryTests.html.* A preliminary agenda is described in section II of this notice.

ADDRESSES: Due to the current COVID–19 public health emergency, the Panel meeting will be held virtually and will not occur at the campus of the Centers for Medicare & Medicaid Services (CMS), Central Building, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

FOR FURTHER INFORMATION CONTACT: Rasheeda Arthur, Ph.D., (410) 786–3434, email, *CDLTPanel@cms.hhs.gov.* Press inquiries are handled through the CMS Press Office at (202) 690–6145. For additional information on the Panel, we refer readers to the CMS website at *https://www.cms.gov/Regulations-and-Guidance/Guidance/FACA/AdvisoryPanelonClinicalDiagnosticLaboratoryTests.html.*

SUPPLEMENTARY INFORMATION:

I. Background

The Medicare Advisory Panel on Clinical Diagnostic Laboratory Tests (the Panel) is authorized by section 1834A(f)(1) of the Social Security Act (the Act) (42 U.S.C. 1395m–1), as established by section 216(a) of the Protecting Access to Medicare Act of 2014 (PAMA) (Pub. L. 113–93), enacted on April 1, 2014. The Panel is subject