if they propose plans to adopt the features of a FESC. To be eligible for the Frontier Extended Stay Clinic demonstration, a clinic must be located in a community which is at least 75 miles from the nearest acute care hospital or critical access hospital, or which is inaccessible by public road. Mileage is measured in terms of the shortest distance by road.

B. Conditions of Participation

This notice solicits applications for demonstration projects to enable participating remote clinics to provide services to seriously or critically ill or injured patients who, due to adverse weather conditions, or other reasons, cannot be transferred quickly to an acute care hospital, and to patients who do not meet hospital admission criteria but who need monitoring and observation for a limited period of time.

FESCs may vary as far as their architectural design and original type of clinic. At a minimum, an interested clinic must be able to provide primary care, ambulatory care, and extended stay services, but there are no requirements that an interested clinic be of any particular type. For example, Rural Health Clinics (RHCs) and federally qualified health centers (FQHCs), which are separately certified under Medicare, are especially appropriate for the FESC model. We will require each such clinic to explain how its staff and equipment will meet the needs of emergency and overnight patients.

Given the wide variety of clinical conditions that a clinic will face, it is vital that each FESC maintain stable, effective transfer relationships with acute care hospitals. All clinics participating in the FESC demonstration will be required to keep all billable items under the demonstration separate from those of the existing outpatient clinic. The FESC portion of a clinic participating in the demonstration will be able to share staff and resources with its non-FESC portion as long as billing for staff and resources is kept distinct during discrete blocks of time. An applicant must also describe its transfer agreements with acute care hospitals.

In addition, we expect all participants in the demonstration to have a physically separate area dedicated to extended stay FESC patients. A more specific listing of the FESC requirements are found in the application package at Web address identified above.

C. Evaluation Process and Criteria

If the application meets the basic eligibility requirements and responds to all components of the application, it will be referred to a technical review panel for evaluation and scoring for an independent review. The comments and evaluations of the panelists will be transcribed into a summary statement that will serve as the basis for award decisions. The evaluations of the panelists will contain numerical ratings based on the rating criteria specified in this section, the ranking of all applications, and a written assessment of each application. In addition, we will conduct a financial analysis of the recommended proposals and evaluate the proposed projects to ensure that they are budget neutral. CMS will make the final selection.

The evaluation criteria and weights are detailed in the complete application package. These criteria will be used to evaluate the applications for the FESC demonstration. Applications will be scored on an absolute basis. The application package, as well as the Medicare Waiver Demonstration Application, are available on the CMS Web site.

III. Requirements for Submission of Applications

Individual clinics or consortia that represent several clinics may submit applications. Each applicant organization is to submit one application, regardless of the number of proposed demonstration sites. The application is to be coordinated and submitted by an organizational component that has the authority to determine the financial and clinical service policy of an applicant body. If applicable, variations related to proposed sites should be outlined in the application text or supplemental materials. Applications should be a maximum of 40 typewritten pages, excluding appendices. The complete application package is at the CMS Web site at *http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS061689.* Hard copies can be obtained by calling Sid Mazumdar (410) 786–6673 or by e-mail at *Siddhartha.Mazumdar@cms.hhs.gov.*

In order to be considered for review by the technical review panel, applicants must complete, sign, date and return the Medicare Waiver Demonstration Applicant Data Sheet found on this Web page. The Medicare Waiver Demonstration Application, on the Web page, serves as the required outline for submitting information in the application. The required narrative portion is to consist of responses to the questions under ''Evaluation Process and Criteria.'' Queries for the narrative portion of the application may be submitted in writing by mail, fax, or e-mail. (Please see the **ADDRESSES** section of this notice for necessary information.)

IV. Collection of Information Requirements

This information collection requirement is subject to the Paperwork Reduction Act of 1995 (PRA); however, the collection is currently approved under OMB control number 0938–0880 entitled ''Medicare Demonstration Waiver Application'' with a current expiration date of July 31, 2006.

Authority : Section 434 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 Pub. L. 108–173.

Dated: May 18, 2006.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. E6–14176 Filed 8–24–06; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–4122–N]

Medicare Program; Town Hall Meeting on Proposed Collection and Request for Comments on the Skilled Nursing Facility Advance Beneficiary Notice

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

ACTION: Notice of meeting.

SUMMARY: This notice announces a Town Hall meeting to solicit input from the public on the proposed use of, and revisions to, the Skilled Nursing Facility Advance Beneficiary Notice (SNFABN), CMS–10055 (2006), and accompanying instructions. All interested parties are invited to comment on the proposed SNFABN collection instrument and instructions, including any of the following subjects: (1) The associated time and administrative burden, (2) the ability of the proposed notice to fulfill existing CMS requirements, and (3) ways to enhance the quality and clarity of the information to be collected. The opinions and alternatives provided during this meeting will assist us as we evaluate our policy on issuing notices in skilled nursing facilities. The meeting is open to the public, but attendance is limited to space available.

DATES: *Meeting Date:* The Town Hall meeting announced in this notice will be held on Tuesday, September 26, 2006 from 1 p.m. to 4 p.m. e.s.t.

ADDRESSES: The Town Hall meeting will be held in the main auditorium of the Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244. Interested parties attending the meeting must enter the building at the main entrance on the first floor of the Central Building.

Written Questions or Statements: Any interested party may send written comments by mail, fax, or electronically. We will accept written testimony, questions, or other statements until September 20, 2006. Send written testimony, questions, or other statements to Centers for Medicare & Medicaid Services, Medicare Enrollment Appeals Group, Division of Consumer Protection, Mail Stop C2–12–16, 7500 Security Boulevard, Baltimore, Maryland 21244–1850. Attention: Charlayne Van. Fax: (410) 786–8883. E-mail: *charlayne.van@cms.hhs.gov*.

Although written submissions will be accepted in advance of the meeting, they may not be read during the meeting due to time constraints.

FOR FURTHER INFORMATION CONTACT: Charlayne Van,(410) 786–8659, *charlayne.van@cms.hhs.gov.*

SUPPLEMENTARY INFORMATION:

Background

The current Skilled Nursing Facility Advance Beneficiary Notice (SNFABN), CMS–10055 (2006), is a notice that the Skilled Nursing Facility (SNF) gives to a Medicare beneficiary, or to his or her authorized representative, before extended care items or services are reduced or terminated, or before non-covered care is initiated. This notice is issued when the SNF, the utilization review entity, the quality improvement organization, or the Medicare contractor believes that Medicare will not pay for or will not continue to pay for extended care items and/or services that the SNF furnishes. Currently, SNFs may also use official denial letters for the same purpose, and must use the general Advance Beneficiary Notice (ABN–G) for Part B services.

In February of 2004, we held a Town Hall meeting to solicit comments on the SNFABN. In response to the questions and comments arising from the 2004 Town Hall meeting, we revised the SNFABN and instructions for its use when delivered by a SNF and paid by Part A or Part B. In July of 2006, we consumer tested the revised form and instructions with Medicare beneficiaries, caregivers, and professional SNF staff members.

In an effort to streamline the notice process and to alleviate confusion for beneficiaries, the new form will replace the current SNFABN for Part A services and the ABN for Part B items and/or services. In addition, we are also considering voluntary uses of the SNFABN so that alternatives, like the Notice of Exclusion from Medicare Benefits (NEMB), will no longer be necessary.

II. Meeting Format

The initial portion of the meeting will be a presentation to provide background on the evolution of the SNFABN and the current notice structure. The remainder of the meeting will be reserved for individual statements from interested parties.

The time for each participant to make statements may be limited according to the number of registered participants. Therefore, individuals who wish to make statements must contact the individual identified in the **FOR FURTHER INFORMATION CONTACT** section above, at the time of registration to sign up to make a statement. Participants will be permitted to speak in the order in which they sign up. If time permits, comments from individuals not registered to speak will be heard after scheduled statements.

III. Registration Instructions

Anyone who wishes to participate in the public meeting must notify us, in advance, of their interest in attending, and also if they wish to make a statement. Interested parties may register through the Town Hall meeting Web site at *SNF_06_Town_Hall@cms.hhs.gov.* Please submit the following information when registering: name, company name, address, telephone number and e-mail address. Individuals requiring sign language interpretation or other special accommodations must provide that information upon registration for the meeting. If you have trouble registering over the Internet, you may contact Charlayne Van at (410) 786–8659 or by e-mail at *charlayne.van@cms.hhs.gov*.

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 close of business on September 20, 2006. Individuals who have not registered in advance will not be allowed to enter the building to attend the meeting. Seating capacity is limited to the first 250 registrants.

The on-site check-in for visitors will be held from 12 noon until 1 p.m. Please allow sufficient time to go through the security checkpoints. It is suggested that you arrive at 7500 Security Boulevard no later than 12 noon so that you will be able to arrive promptly at the meeting by 1 p.m. All items brought to the building, whether personal or for the purpose of demonstration or to support a presentation, are subject to inspection.

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 CMS, including personal items such as desktops, cell phones, and palm pilots, are subject to physical inspection.

Authority : Section 1879 of the Social Security Act, 42 U.S.C. 1395pp.

(Catalog of Federal Domestic Assistance Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: August 18, 2006.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services. CMS–4122–N 2

[FR Doc. E6–14147 Filed 8–24–06; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–3166–N]

Medicare Program; Meeting of the Medicare Coverage Advisory Committee—November 30, 2006

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

ACTION: Notice of meeting.

SUMMARY: This notice announces a public meeting of the Medicare Coverage Advisory Committee (MCAC) (''Committee''). The Committee provides guidance and advice to CMS on specific clinical topics under review for Medicare coverage. This meeting concerns spinal fusion for the treatment of low back pain secondary to lumbar degenerative disc disease (DDD), generally, and to identify areas where current data is deficient and additional research is necessary.

Notice of this meeting is given under the Federal Advisory Committee Act (5 U.S.C. App. 2, section 10(a)).

DATES: *Meeting Date:* The public meeting will be held on Thursday, November 30, 2006 from 7:30 a.m. until 4:30 p.m., e.s.t.

Registration Deadline: For security reasons, individuals must register by the close of business on November 23, 2006. In addition, request for special