coordination through links between chronic care case-management and acute care providers; (3) provision of long-term-benefits; and (4) an adjusted average per capita costs based risk-adjusted payment methodology. *Form Number:* CMS–R–204 (OMB#: 0938–0709); *Frequency:* Reporting—yearly; *Affected Public:* Individuals or households; *Number of Respondents:* 17,624; *Total Annual Responses:* 17,624; *Total Annual Hours:* 3,425.

2. *Type of Information Collection Request:* New collection; *Title of Information Collection:* Assessing Degrees of Health Care Involvement Survey; *Use:* It is not sufficient to merely mail information about the Medicare program to each beneficiary. CMS needs to know that the beneficiaries received the information, understood the information and found the information useful in making choices about their Medicare participation. To this end, CMS must have measure(s) over time of what beneficiaries know and understand about the Medicare program now to be able to quantify and attribute any changes to their understanding or behavior to information/education initiatives. Measuring beneficiary information needs and knowledge over time will help CMS to evaluate the impact of information/education and other initiatives, as well as to understand how the population is changing separate from such initiatives. *Form Number:* CMS–10208 (OMB#: 0938—NEW); *Frequency:* Reporting—weekly; *Affected Public:* Individuals or households; *Number of Respondents:* 4,000; *Total Annual Responses:* 3,500; *Total Annual Hours:* 1,200.

3. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Certification of Medicaid Eligibility Control (MEQC) Payment Error Rates and Supporting Regulations at 42 CFR 431.800–431.865; *Use:* Medicaid Eligibility Quality Control (MEQC) is operated by Title XIX agencies to monitor and improve the administration of its Medicaid program. The traditional MEQC program is based on State reviews of Medicaid beneficiaries identified through a statistically reliable statewide sample of cases selected from the eligibility files. These reviews are conducted to determine whether the sampled cases meet applicable Title XIX eligibility requirements. State agencies are required to submit the Payment Error Rate form to their respective CMS Regional Office. Regional Office staff will review these forms for completeness and will forward these forms to central office for compilation of error rate charts for projected quarterly withholdings and/or fiscal disallowances. *Form Number:* CMS–301 (OMB#: 0938–0246); *Frequency:* Recordkeeping and reporting—semi-annually; *Affected Public:* State, local or tribal governments; *Number of Respondents:* 51; *Total Annual Responses:* 102; *Total Annual Hours:* 22,515.

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access CMS' Web site address at *http://www.cms.hhs.gov/PaperworkReductionActof1995*, or e-mail your request, including your address, phone number, OMB number, and CMS document identifier, to *Paperwork@cms.hhs.gov*, or call the Reports Clearance Office on (410) 786–1326.

To be assured consideration, comments and recommendations for the proposed information collections must be received at the address below, no later than 5 p.m. on December 26, 2006. CMS, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development—C, Attention: Bonnie L Harkless, Room C4–26–05, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

Dated October 19, 2006.

Michelle Shortt,

Director, Regulations Development Group, Office of Strategic Operations and Regulatory Affairs.

[FR Doc. E6–17910 Filed 10–26–06; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–4126–PN]

Medicare and Medicaid Programs; Reapproval of Deeming Authority of the Accreditation Association for Ambulatory Health Care, Inc. for Medicare Advantage Health Maintenance Organizations and Local Preferred Provider Organizations

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

ACTION: Proposed notice.

SUMMARY: This notice announces our proposal to reapprove Medicare Advantage Deeming Authority of the Accreditation Association for Ambulatory Health Care, Inc. for health maintenance organizations and local preferred provider organizations for a term of 6 years. This new term of approval begins July 12, 2006, and ends July 11, 2012. This notice also announces a 30-day period for public comments on 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 November 27, 2006.

ADDRESSES: In commenting, please refer to file code CMS–4126–PN. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of three ways (no duplicates, please):

1. *Electronically.* You may submit electronic comments on specific issues in this regulation to *http://www.cms.hhs.gov/regulations/ecomments.* (Attachments should be in Microsoft Word, WordPerfect, or Excel; however, we prefer Microsoft Word.)

2. *By 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–4126–PN, P.O. Box 8017, Baltimore, MD 21244–8017.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *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 one of the following addresses. 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. Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201; or 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 addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

FOR FURTHER INFORMATION CONTACT: Shaheen Halim, (410) 786–0641.

SUPPLEMENTARY INFORMATION:

I. Background

Under the Medicare program, eligible beneficiaries may receive covered services through a managed care organization (MCO) that has a Medicare Advantage (MA) (formerly, Medicare+Choice) contract with the Centers for Medicare & Medicaid Services (CMS). The regulations specifying the Medicare requirements that must be met in order for an MCO to enter into an MA 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 MCO 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 MCO to be an MA organization, the MCO must be licensed by the State as a risk bearing organization as set forth in part 422 of our regulations. Additionally, the MCO must file an application demonstrating that it meets other Medicare requirements in part 422 of our regulations.

Following approval of the MA contract, we engage in routine monitoring and oversight audits of the MA organization to ensure continuing compliance. The monitoring and oversight audit process is comprehensive and uses a written protocol that itemizes the Medicare requirements the MA organization must meet. As an alternative for meeting some Medicare requirements, an MA organization may be exempt from CMS monitoring of certain requirements in subsets listed in section 1852(e)(4)(B) of the Social Security Act (the Act) as a result of an MA organization's accreditation by a CMS-approved accrediting organization (AO). In essence, the Secretary ''deems'' that the Medicare requirements are met based on a determination that the AO's standards are at least as stringent as Medicare requirements. Therefore, 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 the MA requirements in the following six areas: Quality Improvement, Information on Advance Directives, Antidiscrimination, Confidentiality and Accuracy of Enrollee Records, Access to Services, and Provider Participation Rules. At this time, Deeming does not include the Part D areas of review listed in § 422.156(b).

Organizations that apply for MA deeming authority are generally recognized by the industry as entities that accredit MCOs that are licensed as an HMO or a PPO. As we specify at § 422.157(b)(2) of our regulations, the term for which an AO may be approved by CMS may not exceed 6 years. For continuing approval, the AO must re-apply to CMS.

Accreditation Association for Ambulatory Health Care, Inc. (AAAHC) was approved as an authorized AO for Medicare Advantage deeming on June 15, 2002. AAAHC was granted a term of approval of 4 years beginning June 15, 2002, and ending on June 14, 2006. On June 13, 2006, we issued a letter to AAAHC with instructions regarding application for a renewal of term. On June 14, 2006, AAAHC submitted a letter of intent to renew its MA deeming authority, and subsequently submitted all materials requested by CMS for a complete renewal application. The materials requested by CMS included updates and/or changes to items listed in Federal regulations at 42 CFR 422.158(a) that are prerequisites for receiving deeming program approval by CMS, and which were furnished to CMS by AAAHC as part of its initial application for deeming authority in 2002.

II. Deeming Applications Approval Process

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. Deeming Approval Review and Evaluation

As set forth in section 1852(e)(4) of the Act and our regulations at § 422.158, the review and evaluation of the AAAHC's accreditation program (including its standards and monitoring protocol) were compared to the requirements set forth in part 422 for the MA program.

A. Components of the Review Process

The review of AAAHC's application for approval of MA deeming authority included the following components:

1. Desk-Top Review

We conducted a desk-top review of updated materials regarding AAAHC's managed care accreditation program, including—

- A description of AAAHC's survey process for managed care plans, including the frequency of surveys performed, whether the surveys are announced or unannounced, surveyor instructions, the review and accreditation status decision-making process, procedures used to notify accredited MA organizations of deficiencies and monitoring of the correction of deficiencies, and the procedures used to enforce compliance with accreditation requirements;
- Information about the individuals who perform network accreditation reviews, including the size and composition of the survey team, the methods of compensation, the education and experience requirements, the content and frequency of the in-service training, the evaluation system used to monitor performance, and conflict of interest requirements governing AAAHC staff and surveyors;
- A description of the data management and analysis system, the types (full, partial, or denial) and categories (provisional, conditional, temporary) of accreditation offered by AAAHC, the duration of each category of accreditation, and a statement identifying the types and categories that would serve as a basis for accreditation, if we grant AAAHC organization deeming authority;
- The procedures used to respond to and investigate complaints or identify other problems with accredited organizations, including coordination of these activities with licensing bodies and ombudsmen programs;
- A description of how AAAHC provides accreditation information to the general public;
- The policies and procedures for (1) withholding, denying and removing accreditation status, and the other actions AAAHC may take in response to noncompliance with their standards and requirements, and (2) how AAAHC treats accreditation of organizations that are acquired by another organization, have merged with another organization, or that undergo a change of ownership or management;
- Lists of all AAAHC-accredited MA organizations, managed care plans surveyed by AAAHC in the past 3 years, and managed care plans that were scheduled to be surveyed by AAAHC within 3 months of submitting their application.

2. Assessment of AAAHC's Standards and Methods of Evaluation

As part of the application for renewal of term, AAAHC submitted a crosswalk that compared its standards and methods of evaluations with corresponding MA audit requirements in six areas: Quality Improvement, Access to Services, Antidiscrimination, Information on Advance Directives, Provider Participation Rules, and Confidentiality and Accuracy of Enrollee Records.

3. Past Performance and Results of Deeming Validation Review (Look-behind Audit)

We also considered AAAHC'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. Results of the Review Process

Using the information listed in section III.A. of this notice, we determined that AAAHC's current accreditation program for managed care plans continues to be at least as stringent as the MA requirements contained in the six categories set forth in section 1852(e)(4)(C) of the Act and our methods of evaluation for those areas.

IV. Term of Approval

Based on the review and observations described in section III of this proposed notice, we have determined that AAAHC's requirements for HMOs and local PPOs continue to meet or exceed our requirements. Therefore, we are proposing to recognize AAAHC as a national accreditation organization for HMOs and PPOs that request participation in the Medicare program. As a result, we are proposing to approve AAAHC's deeming program effective July 12, 2006 through July 11, 2012.

V. Regulatory Impact Statement

We have examined the impact of this notice as required by Executive Order 12866 (September 1993, Regulatory Planning and Review) and the Regulatory Flexibility Act (RFA) September 19, 1980 (Pub. L. 96–354).

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects; distributive impacts; and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). This notice would not reach the economic threshold and thus is not considered a major rule.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $6 million to $29 million in any 1 year. Individuals and States are not included in the definition of a small entity. We are not preparing an analysis for the RFA because we have determined that this notice would not have a significant economic impact on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. We are not preparing an analysis for section 1102(b) of the Act because we have determined that this notice would not have a significant impact on the operations of a substantial number of small rural hospitals.

This notice merely recognizes AAAHC as a national accreditation organization that has approval for deeming authority for HMOs or PPOs that are participating in the MA program.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. That threshold level is currently approximately $120 million. This notice would have no consequential effect on State, local, or tribal governments or on the private sector.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. Since this notice would not impose any costs on State or local governments, the requirements of E.O. 13132 are not applicable.

In accordance with the provisions of Executive Order 12866, this notice was not reviewed by the Office of Management and Budget.

Authority: Secs. 1851 and 1855 of the Social Security Act (42 U.S.C. 1395w–21 and 42 U.S.C. 1395w–25).

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

Dated: October 20, 2006.

Leslie V. Norwalk,

Acting Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. E6–18044 Filed 10–26–06; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–3174–N]

Medicare Program; Meeting of the Medicare Coverage Advisory Committee—December 13, 2006

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

ACTION: Notice.

SUMMARY: This notice announces a public meeting of the Medicare Coverage Advisory Committee (''MCAC'' or ''the Committee''). MCAC provides guidance and advice to CMS on specific clinical topics under review for Medicare coverage. This meeting concerns reconsideration of the Medicare clinical trial policy.

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 Wednesday, December 13, 2006 from 8 a.m. until 4:30 p.m., e.s.t.

Registration Deadline: For security reasons, registration must be made no later than 5 p.m. on November 29, 2006. Requests for special accommodations must be received by 5 p.m. on November 29, 2006.

Presentation and Written Comments Deadline: Written comments and presentations must be received by November 13, 2006, e.s.t. Presentations once submitted are final. No further changes to the presentation can be accepted after submission.

ADDRESSES: *Meeting Location:* The meeting will be held in the main