Dated: October 31, 2006.

Leslie V. Norwalk,

Acting Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. E6–19432 Filed 11–22–06; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1326–N]

Medicare Program; Rechartering of the Advisory Panel on Ambulatory Payment Classification Groups

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (DHHS).

ACTION: Notice.

SUMMARY: This notice announces the rechartering of the Advisory Panel on Ambulatory Payment Classification (APC) Groups (the Panel) by the Secretary of DHHS (the Secretary) for a 2-year period with the new Charter effective until November 21, 2008.

FOR FURTHER INFORMATION CONTACT: Shirl Ackerman-Ross, Designated Federal Official (DFO), Advisory Panel on APC Groups; Center for Medicare Management, Hospital and Ambulatory Policy Group, Division of Outpatient Care; 7500 Security Boulevard, Mail Stop C4–05–17; Baltimore, MD 21244–1850. You may also contact the DFO by phone at 410–786–4474 or by e-mail at *CMS_ APCPanel@cms.hhs.gov.*

For additional information on the APC Panel and updates to the Panel's activities, please search our Web site at: *http://www.cms.hhs.gov/FACA/05_AdvisoryPanelonAmbulatoryPaymentClassificationGroups.asp#TopOfPage.* You may also refer to the CMS Federal Advisory Committee Hotline at 1–877–449–5659 (toll-free) or call 410–786–9379 (local) for additional information. News media representatives should contact the CMS Press Office at 202–690–6145.

SUPPLEMENTARY INFORMATION:

I. Background

The Secretary is required by section 1833(t)(9)(A) of the Social Security Act (the Act) to consult with an expert, outside advisory panel on the ambulatory payment classification (APC) groups established under the Medicare hospital Outpatient Prospective Payment System (OPPS).

The purpose of the Panel is to review the APC groups and their associated weights and to advise the Secretary and the Administrator, CMS, (the Administrator) concerning the clinical integrity of the APC groups and their associated weights. The advice provided by the Panel will be considered as CMS prepares its annual updates of the hospital OPPS through rulemaking.

The Panel membership must be fairly balanced in terms of the points of view represented and the functions to be performed. The Panel consists of up to 15 members. Each Panel member must be employed full-time by a hospital or other Medicare provider subject to the OPPS; have technical expertise to enable him or her to fully participate in the work of the Panel; and have a minimum of 5 years experience in his/her area(s) of expertise. For purposes of this Panel, consultants or independent contractors are not considered to be full-time employees of providers.

A Federal official serves as the Chair and facilitates the Panel meetings. A DFO is appointed to the Panel as provided by the Federal Advisory Committee Act (FACA).

Meetings are held up to three times a year at the call of the DFO, and are open to the public, except as determined otherwise by the Secretary or other official to whom the authority has been delegated in accordance with the Government in the Sunshine Act (5 U.S.C. 552b(c)). Advance notice of all meetings is published in the **Federal Register,** as required by applicable laws and Departmental regulations, stating reasonably accessible and convenient locations and times.

II. Provisions of this Notice

The effective date of the APC Panel Charter renewal is November 21, 2006. The Charter will terminate on November 21, 2008, unless rechartered by the Secretary before the expiration date.

III. Copies of the Charter

You may obtain a copy of the APC Panel's Charter by submitting a request to the DFO at the street or e-mail addresses listed above or by calling her at 410–786–4474.

Authority: Section 1833(t)(9)(A) of the Act (42 U.S.C. 1395l(t)(9)(A)). The Panel is governed by the provisions of Public Law 92–463, as amended (5 U.S.C. Appendix 2).

The Panel was established by statute and has functions that are of a continuing nature. Therefore, its duration is not governed by section 14(a) of FACA, but rather it is otherwise provided by law. The Panel is rechartered in accordance with section 14(b)(2) of FACA.

Dated: October 31, 2006.

Leslie V. Norwalk,

Acting Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. E6–19761 Filed 11–22–06; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–4128–N]

Medicare Program; Decisions Affecting Medicare Advantage Plans Deemed by Joint Commission for the Accreditation of Health Care Organizations

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

ACTION: Notice.

SUMMARY: This notice announces our decisions regarding deemed status of Joint Commission for the Accreditation of Health Care Organization-accredited Medicare Advantage plans. These decisions follow business decisions made by Joint Commission for the Accreditation of Health Care Organization in late 2005 which affect its deeming operations beginning January 1, 2006 and continue until Joint Commission for the Accreditation of Health Care Organization's deeming authority expires on March 24, 2008.

DATES: Effective January 1, 2006 through March 24, 2008.

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

I. Background on Medicare Advantage Deeming Program

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 22. 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 continued 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 Act as a result of an MA organization's accreditation by a CMS-approved accrediting organization (AO). We ''deem'' that the Medicare requirements are met based on a determination that the AO's standards are at least as stringent as Medicare requirements.

Organizations that apply for MA deeming authority are generally recognized by the industry as entities that accredit MCO's that are licensed as a health maintenance organization (HMO) or a preferred provider organization (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. The Joint Commission for the Accreditation of Health Care Organizations (JCAHO) was granted deeming authority for Medicare Advantage HMOs and PPOs on March 22, 2002 in all six of the deemable areas set forth in 42 CFR 422.156(b) at the time. JCAHO was granted approval for deeming authority through March 24, 2008, and to date JCAHO has deemed 2 MA plans via accreditation.

II. JCAHO Termination of Deeming Activities

On November 9, 2005, JCAHO notified us of its decision to discontinue its network accreditation program and that, beginning January 1, 2006, it would not provide new accreditation to any MA organizations. JCAHO indicated that it intended to continue to provide technical support and monitoring for the two MA organizations that received JCAHO accreditation prior to January 1, 2006, until each plan's current term of JCAHO accreditation expires.

III. CMS Decisions Regarding JCAHO and its Deemed MA Plans

We decided to allow JCAHO's deeming authority to expire, as it normally would, on March 24, 2008. Thus, MA plans currently accredited by JCAHO under its network accreditation program will retain their deemed status until their current terms of accreditation expire. However, the period of time between January 1, 2006 and March 24, 2008, JCAHO will not accept new requests to deem MA plans.

Authority: Section 1852(e)(4) of the Social Security Act.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program (42 U.S.C. 1395w–22(e)(4))

Dated: November 9, 2006.

Leslie V. Norwalk,

Acting Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. E6–19799 Filed 11–21–06; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1383–N]

Medicare Program; Listening Session on a Plan for Medicare Hospital Value-Based Purchasing—January 17, 2007

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

ACTION: Notice of meeting.

SUMMARY: This notice announces a listening session being conducted as part of the development of a plan for Medicare hospital value-based purchasing, as authorized by the section 5001(b) of the Deficit Reduction Act (DRA) of 2005. The purpose of the listening session is to solicit comments on the range of design issues being considered for plan development. Hospitals, hospital associations, and all interested parties are invited to attend and make comments in person. It will also be possible to participate by teleconference, although due to time constraints, telephone participants will not be able to make verbal comments. Written comments are welcomed. The perspectives expressed during this session and in writing will assist us in drafting the plan. An issues paper outlining the design questions to be discussed and further information about the January listening session will be posted no later than January 3, 2007 on the CMS Web site, Hospital Center, under Spotlights at *http://www.cms.hhs.gov/center/hospital.asp.*

DATES: *Meeting Date:* The listening session will be held on Wednesday, January 17, 2007 from 10 a.m. until 5 p.m., e.s.t.

Registration and Request for Special Accommodations Deadline: Registration must be completed no later than 5 p.m., e.s.t. on Wednesday, January 10, 2007. Requests for special accommodations must be received by 5 p.m., e.s.t. Wednesday, January 10, 2007.

Deadline for Submission of Written Comments or Statements: Written comments on the design questions posed in the issues paper may be sent by mail, fax, or electronically and must be received by 5 p.m., e.s.t. on January 24, 2007.

ADDRESSES: *Meeting Location:* The listening session will be held in the main auditorium of the central building of the Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Registration and Special Accommodations: Individuals wishing to participate or who need special accommodations or both must register by—completing the on-line registration located at *http://registration.mshow.com/cms2/;* contacting Robin Phillips at (410) 786–3010; e-mailing *robin.phillips@cms.hhs.gov;* or regular mail to Robin Phillips, Medicare Feedback Group, Center for Medicare Management, Centers for Medicare & Medicaid Services, Mail stop C4–13–07, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Written Comments or Statements: Written comments on design questions posed in the issues paper may be sent by mail, fax, or electronically and must be received by 5 p.m. January 24, 2007. Please send mail to Robin Phillips, Medicare Feedback Group, Center for Medicare Management, Centers for Medicare & Medicaid Services, Mail stop C4–13–07, 7500 Security Boulevard, Baltimore, MD 21244–1850; e-mail to *cmshospitalVBP@cms.hhs.gov;* or fax to 410–786–0330.

FOR FURTHER INFORMATION CONTACT: Robin Phillips, 410–786–3010 or via e-mail to *robin.phillips@cms.hhs.gov.* Press inquiries are handled through the CMS Press Office at (202) 690–6145.

SUPPLEMENTARY INFORMATION:

I. Background

Section 5001(b) of The Deficit Reduction Act (DRA) of 2005, specifies that we develop a plan to implement a