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. Provisions of the Final Notice

No comments were received in response to the proposed notice published October 27, 2006. Therefore, based on the review and observations described in section III of this final notice, we have determined that AAAHC's requirements for HMOs and local PPOs continue to meet or exceed our requirements. We recognize AAAHC as a national accreditation organization for HMOs and PPOs that request participation in the Medicare program, and we approve AAAHC's deeming program effective July 12, 2006 through July 11, 2012.

V. Collection of Information Requirements

This final notice does not impose any information collection and record keeping requirements subject to the Paperwork Reduction Act (PRA). Consequently, it does not need to be reviewed by the Office of Management and Budget (OMB) under the authority of the PRA. The requirements associated with granting and withdrawal of deeming authority to national accreditation organizations, codified in 42 CFR part 488, ''Survey, Certification, and Enforcement Procedures,'' are currently approved by OMB under OMB approval number 0938–0690.

VI. 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 will 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 will 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 will 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 will not have a 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 will 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: December 14, 2006.

Leslie V. Norwalk,

Acting Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. E7–1274 Filed 1–25–07; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–15357–CN2]

RIN 0938–AO26

Medicare Program; Hospice Wage Index for Fiscal Year 2007; Correction

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

ACTION: Correction notice.

SUMMARY: This document corrects a technical error that appeared in the

wage index table in the September 1, 2006 **Federal Register**, entitled ''Hospice Wage Index for Fiscal Year 2007.''

DATES: *Effective Date:* This correction notice is effective October 1, 2006.

FOR FURTHER INFORMATION CONTACT: Terri Deutsch, (410) 786–9462.

SUPPLEMENTARY INFORMATION:

I. Background

In FR Doc. 06–7293, of September 1, 2006 (71 FR 52080) entitled, ''Hospice Wage Index for Fiscal Year 2007,'' there were errors that we identified and corrected in a correction notice published October 3, 2006 (71 FR 58415). Based on further review of the September 1, 2006 notice, we are correcting an additional typographical error in section I.B of this notice. Accordingly, the correction is effective retroactive to October 1, 2006, the effective date of the September 1, 2006 notice.

A. Summary of Errors

In the September 1, 2006 notice, on page 52102, we published an Addendum that list the updated urban and rural wage index values for hospices utilizing the Core-Based Statistical Areas (CBSA) designations. To ensure that hospice providers were able to identify their current wage index, the table contains the CBSA codes, CBSA county name, and CBSA wage index. However, we made a typographical error when we entered the wage index value for Kalamazoo-Portage, MI.

This correction notice is consistent with the published hospice wage index values used to make payment as of October 1, 2006. In section I.B. of this notice, we are correcting this error.

B. Correction of Error

In the September 1, 2006, **Federal Register** notice (71 FR 52080) on page 52102, in the third column, in line 5, for CBSA code 28020, the wage index value ''1.0140'' is corrected to read ''1.1040.''

C. Waiver of Proposed Rulemaking and Delay in Effective Date

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** to provide a period for public comment before the provisions of a rule take effect in accordance with section 553(b) of the Administrative Procedure Act (APA) (5 U.S.C. section 553(b)). However, we can waive this notice and comment procedure if the Secretary finds that the notice and comment process is impracticable, unnecessary, or contrary to the public interest, and incorporates a statement of the finding and the reasons therefore in the notice.

The revision contained in this document merely corrects a typographical error in the addendum for Table A. This correction is necessary to ensure that the notice accurately reflects the correct hospice wage index value. Since it is not substantive, but merely technical, we find that public comments on this revision are unnecessary. Therefore, we find good cause to waive notice and comment procedures.

In addition, the Administrative Procedure Act (APA) normally requires a 30-day delay in the effective date of a notice. Since this notice simply corrects a technical error to a notice that has previously gone through notice-and-comment rulemaking, we believe good cause also exists under the APA to waive the 30-day delay in the effective date and that a delay in the correction's effective date is also unnecessary.

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

Dated: January 18, 2007.

Ashley Files Flory,

Deputy Executive Secretary to the Department.

[FR Doc. E7–1111 Filed 1–25–07; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1386–N]

Medicare Program; Meeting of the Practicing Physicians Advisory Council, March 5, 2007

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

ACTION: Notice.

SUMMARY: This notice announces a quarterly meeting of the Practicing Physicians Advisory Council (the Council). The Council will meet to discuss certain proposed changes in regulations and manual instructions related to physicians' services, as identified by the Secretary of Health and Human Services (the Secretary). This meeting is open to the public.

DATES: *Meeting Date:* Monday, March 5, 2007, from 8:30 a.m. to 5 p.m. e.s.t.

Deadline for Registration without Oral Presentation: Friday, March 2, 2007, 12 noon, e.s.t.

Deadline for Registration of Oral Presentations: Friday, February 16, 2007, 12 noon, e.s.t.

Deadline for Submission of Oral Remarks and Written Comments: Wednesday, February 21, 2007, 12 noon, e.s.t.

Deadline for Requesting Special Accommodations: Monday, February 26, 2007, 12 noon, e.s.t.

ADDRESSES: *Meeting Location:* The meeting will be held in Room 705A, 7th floor, in the Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201.

Submission of Presentations: Presentations should be mailed to Kelly Buchanan, DFO, Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Mail stop C4–13–07, Baltimore, MD 21244–1850, or contact the DFO via e-mail at *PPAC@cms.hhs.gov.*

FOR FURTHER INFORMATION CONTACT: Kelly Buchanan, the Designated Federal Official (DFO), (410) 786–6132, or e-mail *PPAC@cms.hhs.gov.* News media representatives must contact the CMS Press Office, (202) 690–6145. Please refer to the CMS Advisory Committees' Information Line (1–877–449–5659 toll free), (410) 786–9379 local) or the Internet at *http://www.cms.hhs.gov/home/regsguidance.asp* for additional information and updates on committee activities.

SUPPLEMENTARY INFORMATION:

I. Background

In accordance with section 10(a) of the Federal Advisory Committee Act, this notice announces the quarterly meeting of the Practicing Physicians Advisory Council (the Council). The Secretary is mandated by section 1868(a)(1) of the Social Security Act (the Act) to appoint a Practicing Physicians Advisory Council based on nominations submitted by medical organizations representing physicians. The Council meets quarterly to discuss certain proposed changes in regulations and manual instructions related to physicians' services, as identified by the Secretary. To the extent feasible and consistent with statutory deadlines, the Council's consultation must occur before **Federal Register** publication of the proposed changes. The Council submits an annual report on its recommendations to the Secretary and the Administrator of the Centers for Medicare & Medicaid Services (CMS) not later than December 31 of each year.

The Council consists of 15 physicians, including the Chair. Members of the Council include both participating and nonparticipating physicians, and