advised the Secretary of the Department of Health and Human Services (DHHS) and the Administrator of the Centers for Medicare and Medicaid Services (CMS), as requested by the Secretary, whether medical items and services were reasonable and necessary under Title XVIII of the Social Security Act (the Act).

The MCAC consisted of a pool of 100 appointed members. Members were selected from among authorities in clinical medicine of all specialties, administrative medicine, public health, biologic and physical sciences, health care data and information management and analysis, patient advocacy, the economics of health care, medical ethics, and other related professions such as epidemiology and biostatistics, and methodology of trial design. A maximum of 88 members are standard voting members, 12 are nonvoting members, 6 of whom are representatives of consumer interests, and 6 of whom are representatives of industry interests.

II. Provisions of This Notice

A. Renewal of the Charter and the Renaming of the Committee

This notice announces the signing of the MedCAC charter renewal by the Secretary on November 24, 2006. The charter will terminate on November 24, 2008, unless renewed by the Secretary. The new charter makes the following changes:

- Redesignates the Committee from the MCAC to Medicare Evidence Development Coverage Advisory Committee.
- Gives the MedCAC an explicit responsibility to advise CMS as part of its coverage with evidence development (CED) activity. The CED initiative involves the issuance of national coverage determinations that include, a condition of payment, requirements for developing additional clinical data on a particular medical technology.
- Formalizes the role of patient advocates on the MedCAC role. By establishing the patient advocate as a permanent MedCAC role, CMS is ensuring that beneficiary community is represented on the panels. These advocates will identify issues most important to patients, communicate the patient perspective, and vote on the Committee's recommendations with patients' general interests in mind.

To accompany the changes in the MedCAC charter, we have issued a guidance document entitled, ''Factor CMS Considers in Referring Topics to the Medicare Evidence Development and Coverage Advisory Committee.'' This document is consistent with Section 731 of the Medicare Prescription Drug Improvement, and Modernization Act (MMA) of 2003, and is in line with our goal of continuing to develop a more open, transparent, and understandable national coverage process.

B. Request for Nominations

As of May 2007, there will be 28 terms of membership expiring, 2 of which are nonvoting consumer representatives, 1 of which is a nonvoting industry representative and 6 voting patient advocates. Accordingly, we are requesting nominations for both voting and nonvoting members to serve on the MedCAC. Members are invited to serve for overlapping 4 year terms. A member may serve after the expiration of the member's term until a successor takes office. Any interested person may nominate one or more qualified persons. Self-nominations are also accepted. We have a special interest in ensuring that women, minority groups, and physically challenged individuals are adequately represented on the MedCAC. Therefore, we encourage nominations of qualified candidates from these groups. Nominees are selected based upon their individual qualifications and not as representatives of professional associations or societies.

The MedCAC functions on a committee basis. The committee reviews and evaluates medical literature, reviews technology assessments, and examines data and information on the effectiveness and appropriateness of medical items and services that are covered or eligible for coverage under Medicare. The Committee works from an agenda provided by the designated Federal official that lists specific issues, and develops technical advice to assist us in determining reasonable and necessary applications of medical services and technology when we make national coverage decisions for Medicare.

1. Membership Criteria

Nominees for voting membership must have expertise and experience in one or more of the following fields: clinical medicine of all specialties, administrative medicine, public health, patient advocacy, biologic and physical sciences, health care data and information management and analysis, the economics of health care, medical ethics, and other related professions such as epidemiology and biostatistics, and methodology of trial design.

2. Submission of Nominations

All nominations must be accompanied by nomination letter and curricula vitae. Nomination packages must be sent to the address specified in the **ADDRESSES** section this notice. The nomination letter must include—(1) A statement that the nominee is willing to serve as a member of the MedCAC and believes that he or she does not have a conflict of interest that would preclude his or her committee membership; and (2) specify whether the nominee is applying for a voting position, consumer representative; industry representative or patient advocate. The curricula vitae must include the following: (1) Date of birth; (2) place of birth; (3) social security number; (4) title and current position; (5) professional affiliation; (6) home and business addresses; (7) telephone and fax numbers; (8) e-mail address; and (9) list of the nominee's areas of expertise. Potential candidates will be asked to provide detailed information concerning such matters as financial holdings, consultancies, and research grants or contracts in order to permit evaluation of possible sources of conflict of interest.

Authority: 5 U.S.C. App. 2, section 10(a)(1) and (a)(2).

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

Dated: January 11, 2007.

Barry M. Straube,

Chief Medical Officer, Director, Office of Clinical Standards and Quality, Centers for Medicare &Medicaid Services.

[FR Doc. E7–1113 Filed 1–25–07; 8:45 am]

BILLING CODE 4120–03–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–4126–FN]

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: Final notice.

SUMMARY: This notice announces our decision to approve 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.

DATES: *Effective Date:* This final notice is effective July 12, 2006 through July 11, 2012.

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 as described 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. Proposed Notice

On October 27, 2006, we published a proposed notice (71 FR 63019) announcing reapproval of Medicare Advantage Deeming Authority of the Accreditation Association for Ambulatory Health Care, Inc. In the proposed notice, we detailed our evaluation criteria. Under section 1852(e)(4) of the Act and our regulations at § 422.158, we conducted a review and evaluation of the AAAHC's accreditation program (including its standards and monitoring protocol) in accordance with the criteria specified by our regulation, which includes, but are not limited to the following:

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. 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