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.