(2) In the absence of such information, whether a disapproval was warranted when 950 days had passed after CMS had requested that information.

The Commonwealth of Virginia's title XXI SPA No. 6 was submitted to CMS on June 29, 2004, with a requested retroactive effective date of August 3, 2003. This amendment requested the addition of new school-based health services to the State's SCHIP FAMIS benefit package.

A request for additional information was submitted to the State on August 18, 2004, which stopped the 90-day review period. The request for information included questions concerning the nature of the proposed services, the qualifications of the providers, and the budgetary impact of the amendment.

To date, the State has not responded to this request for information.

I am scheduling a hearing on your request for reconsideration to be held on September 4, 2007, at 150 S. Independence Mall West, Suite 216, Conference Room #241 (Pennsylvania Room), The Public Ledger Building, Philadelphia, PA 19106–3499, to reconsider the decision to disapprove SPA No. 6. If this date is not acceptable, we would be glad to set another date that is mutually agreeable to the parties. The hearing will be governed by the procedures prescribed by Federal regulations at 42 CFR Part 430, Subpart D, and section 457.203.

I am designating Ms. Kathleen Scully-Hayes as the presiding officer. If these arrangements present any problems, please contact the presiding officer at (410) 786–2055. In order to facilitate any communication which may be necessary between the parties to the hearing, please notify the presiding officer to indicate acceptability of the hearing date that has been scheduled and provide names of the individuals who will represent the State at the hearing.

Sincerely,
Leslie V. Norwalk, Esq.,
Acting Administrator.

Section 1116 of the Social Security Act (42 U.S.C. section 1316); 42 CFR 430.18)

(Catalog of Federal Domestic Assistance program No. 13.714, Medicaid Assistance Program.)

Dated: July 20, 2007.

Leslie V. Norwalk,

Acting Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. E7–14607 Filed 7–26–07; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare and Medicaid Services

[CMS–2272–PN]

Medicare and Medicaid Programs; Application by the American Osteopathic Association (AOA) for Continued Deeming Authority for Critical Access Hospitals (CAHs)

AGENCY: Centers for Medicare and Medicaid Services, HHS.

ACTION: Proposed notice.

SUMMARY: This proposed notice with comment period acknowledges the receipt of a deeming application from the American Osteopathic Association (AOA) for continued recognition as a national accrediting organization for Critical Access Hospitals (CAH) that wish to participate in the Medicare or Medicaid programs. Section 1865(b)(3)(A) of the Social Security Act (the Act) requires that within 60 days of receipt of an organization's complete application, we publish a notice that identifies the national accrediting body making the request, describes the nature of the request, and provides at least a 30-day public comment period.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on August 27, 2007.

ADDRESSES: In commenting, please refer to file code CMS–2272–PN. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

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

1. *Electronically.* You may submit electronic comments on specific issues in this regulation to *http://www.cms.hhs.gov/eRulemaking.* Click on the link ''Submit electronic comments on CMS regulations with an open comment period.'' (Attachments should be in Microsoft Word, WordPerfect, or Excel; however, we prefer Microsoft Word.)

2. *By regular 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–2272–PN, P.O. Box 8015, Baltimore, MD 21244–8015.

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

3. *By express or overnight mail.* You may send 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–2272–PN, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *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 information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Cindy Melanson, (410) 786–0310. Patricia Chmielewski, (410) 786–6899.

SUPPLEMENTARY INFORMATION:

Submitting Comments: We welcome comments from the public on all issues set forth in this proposed notice to assist us in fully considering issues and developing policies. You can assist us by referencing the file code CMS–2272–PN and the specific ''issue identifier'' that precedes the section on which you choose to comment.

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: *http://www.cms.hhs.gov/eRulemaking.* Click on the link ''Electronic Comments on CMS Regulations'' on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

I. Background

Under the Medicare program, eligible beneficiaries may receive covered services in a CAH provided certain requirements are met. Sections 1820(c)(2)(B) and 1861(mm) of the Social Security Act (the Act) establish distinct criteria for facilities seeking designation as a CAH. Regulations concerning provider agreements are at 42 CFR part 489 and those pertaining to activities relating to the survey and certification of facilities are at 42 CFR part 488. The regulations at 42 CFR part 485, subpart F specify the conditions that a CAH must meet in order to participate in the Medicare program; the scope of covered services and the conditions for Medicare payment for CAHs are set out at 42 CFR 413.70.

Generally, in order to enter into a provider agreement with the Medicare program, a CAH must first be certified by a State survey agency as complying with the conditions or requirements set forth in part 485, subpart F of CMS regulations. Thereafter, the CAH is subject to regular surveys by a State survey agency to determine whether it continues to meet these requirements. There is an alternative, however, to surveys by State agencies.

Section 1865(b)(1) of the Act provides that, if a provider entity demonstrates through accreditation by an approved national accrediting organization that all applicable Medicare conditions are met or exceeded, we shall deem those provider entities as having met the requirements. Accreditation by an accrediting organization is voluntary and is not required for Medicare participation.

If an accrediting organization is recognized by the Secretary as having standards for accreditation that meet or exceed Medicare requirements, any provider entity accredited by the national accrediting body's approved program would be deemed to meet the Medicare conditions. A national accrediting organization applying for deeming authority under 42 CFR part 488, subpart A must provide us with reasonable assurance that the accrediting organization requires the accredited provider entities to meet requirements that are at least as stringent as the Medicare conditions. Our regulations concerning the reapproval of accrediting organizations are set forth at 42 CFR 488.4 and 488.8(d)(3). The regulations at 42 CFR 488.8(d)(3) require accrediting organizations to reapply for continued authority every six years or sooner as determined by us.

On September 28, 2001, we approved AOA as an accrediting organization for CAHs (66 FR 49677), effective December 27, 2001, for a six-year term. The AOA's term of approval as a recognized accrediting organization for CAHs expires December 27, 2007.

II. Approval of Deeming Organizations

Section 1865(b)(2) of the Act and our regulations at 42 CFR 488.8(a) require that our findings concerning review and reapproval of a national accrediting organization's requirements consider, among other factors, the applying accrediting organization's: Requirements for accreditation; survey procedures; resources for conducting required surveys; capacity to furnish information for use in enforcement activities; monitoring procedures for provider entities found not in compliance with the conditions or requirements; and ability to provide us with the necessary data for validation.

Section 1865(b)(3)(A) of the Act further requires that we publish, within 60 days of receipt of an organization's complete application, a notice that: identifies the national accrediting body making the request; describes the nature of the request; and provides at least a 30-day public comment period. We have 210 days from the receipt of a complete application to publish approval or denial of the application.

The purpose of this proposed notice is to inform the public of AOA's request for continued deeming authority for CAHs. This notice also solicits public comment on whether AOA's requirements meet or exceed the Medicare conditions for participation for CAHs.

III. Evaluation of Deeming Authority Request

AOA submitted all the necessary materials to enable us to make a determination concerning its request for reapproval as a deeming organization for CAHs. This application was determined to be complete on May 31, 2007. Under Section 1865(b)(2) of the Act and our regulations at 42 CFR 488.8 (Federal review of accrediting organizations), our review and evaluation of AOA will be conducted in accordance with, but not necessarily limited to, the following factors:

- The equivalency of AOA standards for a CAH as compared with CMS' CAH conditions of participation.
- AOA's survey process to determine the following:

—The composition of the survey team, surveyor qualifications, and the ability of the organization to provide continuing surveyor training.

—The comparability of AOA processes to that of State agencies, including survey frequency, and the ability to investigate and respond appropriately to complaints against accredited facilities.

—AOA's processes and procedures for monitoring CAHs found out of compliance with AOA program requirements. These monitoring procedures are used only when AOA identifies noncompliance. If noncompliance is identified through validation reviews, the State survey agency monitors corrections as specified at 42 CFR 488.7(d).

—AOA's capacity to report deficiencies to the surveyed facilities and respond to the facility's plan of correction in a timely manner.

—AOA's capacity to provide us with electronic data in ASCII comparable code, and reports necessary for effective validation and assessment of the organization's survey process.

—The adequacy of AOA's staff and other resources, and its financial viability.

—AOA's capacity to adequately fund required surveys.

—AOA's policies to assure that surveys are unannounced.

—AOA's agreement to provide us with a copy of the most current accreditation survey together with any other information related to the survey as we may require (including corrective action plans).

IV. Response to Public Comments and Notice Upon Completion of Evaluation

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

Upon completion of our evaluation, including evaluation of comments received as a result of this notice, we will publish a final notice in the **Federal Register** announcing the result of our evaluation.

V. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 35).

VI. Regulatory Impact Statement

In accordance with the provisions of Executive Order 12866, the Office of Management and Budget did not review this proposed notice.

In accordance with Executive Order 13132, we have determined that this proposed notice would not have a significant effect on the rights of States, local or tribal governments.

Authority: Section 1865 of the Social Security Act (42 U.S.C. 1395bb).

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program; No. 93.773 Medicare—Hospital Insurance Program; and No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: July 12, 2007.

Leslie V. Norwalk,

Acting Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. E7–14100 Filed 7–26–07; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1388–N]

Medicare Program; Request for Nominations and Meeting of the Practicing Physicians Advisory Council, August 27, 2007

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

ACTION: Notice.

SUMMARY: This notice invites all organizations representing physicians to submit nominations for consideration to fill four seats on the Practicing Physicians Advisory Council (the Council) that will be vacated by current Council members in 2008. This notice also announces a quarterly meeting of 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, August 27, 2007, from 8:30 a.m. to 5 p.m. e.d.t.

Deadline for Registration without Oral Presentation: Thursday, August 23, 2007, 12 noon, e.d.t.

Deadline for Registration of Oral Presentations: Friday, August 10, 2007, 12 noon, e.d.t.

Deadline for Submission of Oral Remarks and Written Comments: Wednesday, August 15, 2007, 12 noon, e.d.t.

Deadline for Requesting Special Accommodations: Monday, August 20, 2007, 12 noon, e.d.t.

Deadline for Submitting Nominations: Friday, September 14, 2007, 5 p.m. e.d.t.

ADDRESSES: *Meeting Location:* The meeting will be held in the Multi-purpose Room, 1st floor, at the CMS Central Office, 7500 Security Boulevard, Baltimore, Maryland 21244.

Submission of Testimony: Testimonies 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.*

Submission of Nominations: Mail or deliver nominations to the Centers for Medicare and Medicaid Services, Center for Medicare Management, Division of Provider Relations and Evaluations, Attention: Kelly Buchanan, Designated Federal Official, Practicing Physicians Advisory Council, 7500 Security Boulevard, Mail Stop C4–13–07, Baltimore, Maryland 21244–1850.

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 physicians practicing in rural and underserved urban areas. At least 11 members of the Council must be physicians as described in section 1861(r)(1) of the Act, that is, State-licensed doctors of medicine or osteopathy. The remaining 4 members may include dentists, podiatrists, optometrists, and chiropractors. Members serve for overlapping 4-year terms.

Section 1868(a)(2) of the Act provides that the Council meet quarterly to discuss certain proposed changes in regulations and manual issuances that relate to physicians' services, identified by the Secretary. Section 1868(a)(3) of the Act provides for payment of expenses and per diem for Council members in the same manner as members of other advisory committees appointed by the Secretary. In addition to making these payments, the Department of Health and Human Services and CMS provide management and support services to the Council. The Secretary will appoint new members to the Council from among those candidates determined to have the expertise required to meet specific agency needs in a manner to ensure appropriate balance of the Council's membership.

The Council held its first meeting on May 11, 1992. The current members are: Anthony Senagore, M.D., Chairperson; Jose Azocar, M.D.; M. Leroy Sprang, M.D.; Karen S. Williams, M.D.; Peter Grimm, D.O.; Jonathon E. Siff, M.D., MBA; John E. Arradondo, M.D., MPH; Helena Wachslicht Rodbard, M.D.; Vincent J. Bufalino, M.D.; Tye J. Ouzounian, M.D.; Geraldine O'Shea, D.O.; Arthur D. Snow, Jr., M.D.; Gregory J. Przybylski, M.D.; Jeffrey A. Ross, DPM, M.D.; and Roger L. Jordan, O.D.

II. Nomination Requirements

Nominations must be submitted by medical organizations representing physicians. Nominees must have submitted at least 250 claims for