e-mail address and current curriculum vitae.

Nominations should be accompanied with a letter of recommendation stating the qualifications of the nominee and postmarked by December 18, 2006 to: Demetria Gardner, Immunization Service Division, National Center for Immunization and Respiratory Diseases, Centers for Disease Control and Prevention, 1600 Clifton Road, NE, Mailstop E–05, Atlanta, Georgia 30333, telephone (404) 639–8836.

The Director, Management Analysis and Services Office, has been delegated the authority to sign **Federal Register** notices pertaining to announcements of meetings and other committee management activities for both CDC and the Agency for Toxic Substances and Disease Registry.

Dated: November 17, 2006.

Alvin Hall,

Director, Management Analysis and Services Office, Centers for Disease Control and Prevention.

[FR Doc. E6–19842 Filed 11–22–06; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10053, CMS–P–0015A, and CMS–367]

Agency Information Collection Activities: Proposed Collection; Comment Request

AGENCY: Centers for Medicare & Medicaid Services, HHS.

In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Centers for Medicare & Medicaid Services (CMS) is publishing the following summary of proposed collections for public comment. Interested persons are invited to send comments regarding this burden estimate or any other aspect of this collection of information, including any of the following subjects: (1) The necessity and utility of the proposed information collection for the proper performance of the agency's functions; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

1. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Paid Feeding Assistants in Long Term Care Facilities and Supporting Regulations at 42 CFR 483.160. *Use:* 42 CFR 483 permits long-term care facilities to use paid feeding assistants to supplement the services of certified nurse aides. If facilities choose this option, feeding assistants must complete a specified training program. In addition, a facility must maintain a record of all individuals, used by the facility as feeding assistants, who have successfully completed the training course for paid feeding assistants. This information is used as part of the process to determine facility compliance with this requirement. *Form Number:* CMS–10053 (OMB#: 0938–0916); *Frequency:* Recordkeeping—Once; *Affected Public:* Business or other for-profit and not-for-profit institutions; *Number of Respondents:* 8,772; *Total Annual Responses:* 3,509; *Total Annual Hours:* 21,054.

2. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Medicare Current Beneficiary Survey (MCBS): Rounds 48–56. *Use:* The Medicare Current Beneficiary Survey (MCBS) is a continuous, multipurpose survey of a nationally representative sample of aged, disabled, and institutionalized Medicare beneficiaries. MCBS, which is sponsored by the Centers for Medicare & Medicaid Services, is the only comprehensive source of information on the health status, health care use and expenditures, health insurance coverage, and socioeconomic and demographic characteristics of the entire spectrum of Medicare beneficiaries. MCBS data users can assess the impact of major policy innovations and health care reform on Medicare beneficiaries. They can monitor delivery of services, sources of payment for Medicare covered and non-covered services, beneficiary cost sharing and financial protection, and satisfaction with and the access to health care services. *Form Number:* CMS–P–0015A (OMB#: 0938–0568); *Frequency:* Third Party Disclosure, Recordkeeping, and Reporting—Yearly; *Affected Public:* Individuals or households, Business or other for-profit and not-for-profit institutions; *Number of Respondents:* 49,500; *Total Annual Responses:* 49,500; *Total Annual Hours:* 50,325.

3. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Medicaid Drug Program Monthly Quarterly Drug Reporting Format. *Use:* Section 1927 of the Social Security Act requires drug manufacturers to enter into and have in effect a rebate agreement with the Federal government for States to receive funding for drugs dispensed to Medicaid beneficiaries. The Deficit Reduction Act (DRA) of 2005 modified Section 1927 to require additional reporting requirements beyond the quarterly data currently collected. CMS form 367 identifies the data fields that manufacturers must submit to CMS on both a monthly and quarterly basis. *Form Number:* CMS–367 (OMB#: 0938–0578); *Frequency:* Reporting: Monthly and quarterly; *Affected Public:* Business or other for-profit; *Number of Respondents:* 540; *Total Annual Responses:* 8,460; *Total Annual Hours:* 112,320.

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access CMS' Web Site address at *http://www.cms.hhs.gov/PaperworkReductionActof1995*, or E-mail your request, including your address, phone number, OMB number, and CMS document identifier, to *Paperwork@cms.hhs.gov*, or call the Reports Clearance Office on (410) 786–1326.

To be assured consideration, comments and recommendations for the proposed information collections must be received at the address below, no later than 5 p.m. on January 23, 2007. CMS, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development—B, Attention: William N. Parham, III, Room C4–26–05, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

Dated: November 15, 2006.

Michelle Shortt,

Director, Regulations Development Group, Office of Strategic Operations and Regulatory Affairs.

[FR Doc. E6–19779 Filed 11–22–06; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1305–N]

Medicare Program; Request for Nominations to 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 invites nominations of members to the Advisory Panel on Ambulatory Payment Classification (APC) Groups (the Panel). One vacancy presently exists on the Panel due to a Panel member's retirement in June 2006. There will be six more vacancies on the Panel between January 1 and September 30, 2007. Consequently, this solicitation is for seven new members.

The purpose of the Panel is to review the APC groups and their associated weights and to advise the Secretary, DHHS, (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 we prepare our annual updates of the hospital Outpatient Prospective Payment System (OPPS) through rulemaking.

The Secretary rechartered the Panel in 2004 for a 2-year period through November 21, 2006. The new Panel Charter will be effective through November 21, 2008.

Nominations: We will consider nominations if they are received no later than 5 p.m. on December 18, 2006. Please mail or deliver nominations to the following address: CMS; Attn: Shirl Ackerman-Ross, Designated Federal Official (DFO), Advisory Panel on APC Groups; Center for Medicare Management, Hospital & Ambulatory Policy Group, Division of Outpatient Care; 7500 Security Boulevard, Mail Stop C4–05–17; Baltimore, MD 21244–1850.

Web Site: For additional information on the APC Panel and updates to the Panel's activities, search our Web site at the following: *http://www.cms.hhs.gov/FACA/05_AdvisoryPanelonAmbulatoryPaymentClassificationGroups.asp#TopOfPage.*

Advisory Committees' Information Lines: You may also refer to the CMS Federal Advisory Committee Hotlines at 1–877–449–5659 (toll-free) or 410–786–9379 (local) for additional information.

FOR FURTHER INFORMATION CONTACT: Persons wishing to nominate individuals to serve on the Panel or to obtain further information may also contact Shirl Ackerman-Ross, the DFO, at *CMS_APCPanel@cms.hhs.gov* or call 410–786–4474. 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), as amended and redesignated by sections 201(h) and 202(a)(2) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106–113), to consult with an expert, outside advisory panel regarding the clinical integrity of the APC groups and relative payment weights that are components of the hospital OPPS.

The Panel meets up to three times annually to review the APC groups and to provide technical advice to the Secretary and the Administrator. We consider the technical advice provided by the Panel in preparing the proposed rule to update the OPPS for the next calendar year.

The Panel may consist of a chair and up to 15 members who are full-time employees of hospitals, hospital systems, or other Medicare providers that are subject to the OPPS. (For purposes of the Panel, consultants or independent contractors are not considered to be full-time employees in these organizations.)

The Administrator selects the Panel membership based upon either self-nominations or nominations submitted by providers or interested organizations.

The current Panel members are as follows: (The asterisk [*] indicates a Panel member who will retire or whose term expires within 2007.)

- E.L. Hambrick, M.D., J.D., Chair, a CMS Medical Officer.
- *Marilyn K. Bedell, M.S., R.N., O.C.N.
- Gloryanne Bryant, B.S., R.H.I.A., R.H.I.T., C.C.S.
- *Albert Brooks Einstein, Jr., M.D.
- Hazel Kimmel, R.N., C.C.S., C.P.C.
- *Sandra J. Metzler, M.B.A., R.H.I.A.
- Thomas M. Munger, M.D.
- *Frank G. Opelka, M.D.
- Louis Potters, M.D.
- James V. Rawson, M.D.
- *Lou Ann Schraffenberger, M.B.A., R.H.I.A.
- Judie S. Snipes, R.N., M.B.A., C.H.E.
- *Timothy Gene Tyler, Pharm.D.
- Kim Allen Williams, M.D.
- Robert M. Zwolak, M.D.

Panel members serve without compensation, according to an advance written agreement; however, for the meetings, we reimburse travel, meals, lodging, and related expenses in accordance with standard Government travel regulations.

We have a special interest in attempting to ensure, while taking into account the nominee pool, that the Panel is diverse in all respects to the following: Geography; rural or urban practice; race; ethnicity; sex; disability; medical or technical specialty; and type of hospital, hospital health system, or other Medicare provider.

The Secretary, or his designee, appoints new members to the Panel from among those candidates determined to have the required expertise. New appointments are made in a manner that attempts to ensure a balanced membership under the guidelines of the Federal Advisory Committee Act.

II. Criteria for Nominees

All nominees must have technical expertise that enables them to participate fully in the work of the Panel. Such expertise encompasses hospital payment systems, hospital medical-care delivery systems, outpatient payment requirements, APC Groups, Physicians' Current Procedural Terminology Codes, the use and payment of drugs and medical devices in the outpatient setting, and other forms of relevant expertise.

It is not necessary for a nominee to possess expertise in all of the areas listed, but each must have a minimum of 5 years experience and currently have full-time employment in his or her area of expertise. Members of the Panel serve overlapping terms of up to 4 years based on the needs of the Panel and contingent upon the rechartering of the Panel.

Any interested person or organization may nominate one or more qualified individuals. Self-nominations will also be accepted. Each nomination must include the following:

- Letter of Nomination;
- Curriculum Vita of the nominee; and
- Written statement from the nominee that the nominee is willing to serve on the Panel under the conditions described in this notice and further specified in the Charter.

III. Copies of the Charter

To obtain a copy of the Panel's Charter, submit a written request to the DFO at the address provided or by e-mail at *CMS_APCPanel@cms.hhs.gov,* or call her at 410–786–4474. Copies of the Charter are also available on the Internet at the following: *http://www.cms.hhs.gov/FACA/05_AdvisoryPanelonAmbulatoryPaymentClassificationGroups.asp#TopOfPage.*

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 Pub. L. 92–463, as amended (5 U.S.C. Appendix 2).

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]

BILLING CODE 4120–01–P

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]

BILLING CODE 4120–01–P

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.