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 continued 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 in subsets listed in section 1852(e)(4)(B) of the Act as a result of an MA organization's accreditation by a CMS-approved accrediting organization (AO). We ''deem'' that the Medicare requirements are met based on a determination that the AO's standards are at least as stringent as Medicare requirements.

Organizations that apply for MA deeming authority are generally recognized by the industry as entities that accredit MCO's that are licensed as a health maintenance organization (HMO) or a preferred provider organization (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. The Joint Commission for the Accreditation of Health Care Organizations (JCAHO) was granted deeming authority for Medicare Advantage HMOs and PPOs on March 22, 2002 in all six of the deemable areas set forth in 42 CFR 422.156(b) at the time. JCAHO was granted approval for deeming authority through March 24, 2008, and to date JCAHO has deemed 2 MA plans via accreditation.

## II. JCAHO Termination of Deeming Activities

On November 9, 2005, JCAHO notified us of its decision to discontinue its network accreditation program and that, beginning January 1, 2006, it would not provide new accreditation to any MA organizations. JCAHO indicated that it intended to continue to provide technical support and monitoring for the two MA organizations that received JCAHO accreditation prior to January 1, 2006, until each plan's current term of JCAHO accreditation expires.

## III. CMS Decisions Regarding JCAHO and its Deemed MA Plans

We decided to allow JCAHO's deeming authority to expire, as it normally would, on March 24, 2008. Thus, MA plans currently accredited by JCAHO under its network accreditation program will retain their deemed status until their current terms of accreditation expire. However, the period of time between January 1, 2006 and March 24, 2008, JCAHO will not accept new requests to deem MA plans.

**Authority:** Section 1852(e)(4) of the Social Security Act.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program (42 U.S.C. 1395w–22(e)(4))

Dated: November 9, 2006.

**Leslie V. Norwalk,**

*Acting Administrator, Centers for Medicare & Medicaid Services.*

[FR Doc. E6–19799 Filed 11–21–06; 8:45 am]

**BILLING CODE 4120–01–P**

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Centers for Medicare & Medicaid Services

**[CMS–1383–N]**

### Medicare Program; Listening Session on a Plan for Medicare Hospital Value-Based Purchasing—January 17, 2007

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

**ACTION:** Notice of meeting.

**SUMMARY:** This notice announces a listening session being conducted as part of the development of a plan for Medicare hospital value-based purchasing, as authorized by the section 5001(b) of the Deficit Reduction Act (DRA) of 2005. The purpose of the listening session is to solicit comments on the range of design issues being considered for plan development. Hospitals, hospital associations, and all interested parties are invited to attend and make comments in person. It will also be possible to participate by teleconference, although due to time constraints, telephone participants will not be able to make verbal comments. Written comments are welcomed. The perspectives expressed during this session and in writing will assist us in drafting the plan. An issues paper outlining the design questions to be discussed and further information about the January listening session will be posted no later than January 3, 2007 on the CMS Web site, Hospital Center, under Spotlights at *http://www.cms.hhs.gov/center/hospital.asp.*

**DATES:** *Meeting Date:* The listening session will be held on Wednesday, January 17, 2007 from 10 a.m. until 5 p.m., e.s.t.

*Registration and Request for Special Accommodations Deadline:* Registration must be completed no later than 5 p.m., e.s.t. on Wednesday, January 10, 2007. Requests for special accommodations must be received by 5 p.m., e.s.t. Wednesday, January 10, 2007.

*Deadline for Submission of Written Comments or Statements:* Written comments on the design questions posed in the issues paper may be sent by mail, fax, or electronically and must be received by 5 p.m., e.s.t. on January 24, 2007.

**ADDRESSES:** *Meeting Location:* The listening session will be held in the main auditorium of the central building of the Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244–1850.

*Registration and Special Accommodations:* Individuals wishing to participate or who need special accommodations or both must register by—completing the on-line registration located at *http://registration.mshow.com/cms2/;* contacting Robin Phillips at (410) 786–3010; e-mailing *robin.phillips@cms.hhs.gov;* or regular mail to Robin Phillips, Medicare Feedback Group, Center for Medicare Management, Centers for Medicare & Medicaid Services, Mail stop C4–13–07, 7500 Security Boulevard, Baltimore, MD 21244–1850.

*Written Comments or Statements:* Written comments on design questions posed in the issues paper may be sent by mail, fax, or electronically and must be received by 5 p.m. January 24, 2007. Please send mail to Robin Phillips, Medicare Feedback Group, Center for Medicare Management, Centers for Medicare & Medicaid Services, Mail stop C4–13–07, 7500 Security Boulevard, Baltimore, MD 21244–1850; e-mail to *cmshospitalVBP@cms.hhs.gov;* or fax to 410–786–0330.

**FOR FURTHER INFORMATION CONTACT:** Robin Phillips, 410–786–3010 or via e-mail to *robin.phillips@cms.hhs.gov.* Press inquiries are handled through the CMS Press Office at (202) 690–6145.

**SUPPLEMENTARY INFORMATION:**

## I. Background

Section 5001(b) of The Deficit Reduction Act (DRA) of 2005, specifies that we develop a plan to implement a

Value-Based Purchasing (VBP) Program for payments under the Medicare program for subsection (d) hospitals (as defined in section 1886(d)(1)(B) of the Social Security Act (the Act)) beginning with fiscal year (FY) 2009. Congress specified that the ''plan'' include consideration of the following issues:

- The ongoing development, selection, and modification process for measures of quality and efficiency in hospital inpatient settings.
- The reporting, collection, and validation of quality data.
- The structure of value-based payment adjustments, including the determination of thresholds or improvements in quality that would substantiate a payment adjustment, the size of such payments, and the sources of funding for the value-based payments.
- The disclosure of information on hospital performance.

In developing the plan, we must consult with relevant affected parties and consider experience with demonstrations that are relevant to the value-based purchasing program. CMS has created a workgroup that is charged with developing the VBP Plan for Medicare hospital services provided by subsection (d) hospitals. The Workgroup is organized into four subgroups to address each of the required planning issues: (1) Measures; (2) data collection and validation; (3) incentive structure; and (4) public reporting. The CMS Workgroup is charged with preparing a set of design options, narrowing the set of design options to prepare a draft plan, and preparing a report on the plan for implementing VBP for Medicare hospital services which will be provided to Congress as required under section 5001(b)(3) of the DRA. We are hosting two public listening sessions in early 2007 to solicit comments from relevant affected parties on outstanding design questions associated with development of the plan. The first is the listening session scheduled for January 17, 2007 to consider design questions posed in the issues paper. The second listening session is April 12, 2007 to consider the draft plan.

## II. Listening Session Format and Agenda

The January 17, 2007 listening session will begin at 10 a.m. with an overview of the objectives for the session and a presentation on the background on the Medicare Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program and the Value-Based Purchasing plan development. A brief review of the current state-of-the-art in hospital pay for performance will then be presented by consultants from RAND who are assisting the CMS Workgroup in plan development. Beginning at approximately 11 a.m., the remainder of the meeting will be devoted to addressing each of the following issue areas: measures; program and data infrastructure; incentives; and public reporting. Each area will be considered in turn, with the CMS Subgroup Leads first providing a brief presentation on key issues, followed by comments and questions from on-site session attendees. A lunch break will occur from approximately 12:30 to 1:30 p.m. The meeting will conclude by 5 p.m. with brief comments on ''next steps.''

## III. Registration Instructions

Persons interested in attending the meeting or listening by teleconference must register by the date specified in the **DATES** section of this notice in one of the following ways:

- Completing the on-line registration located at *http://registration.mshow.com/cms2/.* The on-line registration system will generate a confirmation page to indicate the completion of your registration. Please print this page as your registration confirmation.
- Contacting Robin Phillips via regular mail, e-mail or phone at the address listed in the **ADDRESSES** section of this notice. You will receive a registration confirmation with instructions for your arrival at the CMS complex. Persons will be notified if the seating capacity has been reached.

Individuals attending the meeting who are hearing or visually impaired, or have a condition that requires special assistance or accommodations, must submit their request with their registration information or to Robin Phillips at the address specified in the **ADDRESSES** section of this notice by the date specified in the **DATES** section of this notice.

Persons wishing to make comments at the meeting must indicate which section(s) of the issues paper they wish to address as part of their registration. Remarks will be limited to 2 minutes per person per section to assure that as many attendees as possible will have the opportunity to speak. The registration process will enable CMS to gauge relative interest in the four issue areas and to allocate comment time accordingly. This feedback on the issues paper will provide important input to development of the draft Medicare Hospital Value-based Purchasing Plan.

Individuals may also listen to the session by teleconference. Registration is required so that we may provide further communications as the plan is developed. The call-in number will be provided upon confirmation of registration. Persons participating by phone will not be able to make verbal comments due to time constraints. However, written comments are welcome.

An audio download of the listening session will be available through the CMS Hospital Center Web site within 72 hours after completion of the listening session.

## IV. Security, Building, and Parking Guidelines

Because this meeting will be located on Federal property, for security reasons, any persons wishing to attend this meeting must register by close of business on January 10, 2007. Individuals who have not registered in advance will not be allowed to enter the building to attend the meeting. Seating capacity is limited to the first 550 registrants.

The on-site check in for visitors will begin at 9 a.m. Please allow sufficient time to go through the security checkpoints. It is suggested that you arrive at central building by 9 a.m. so that you will have enough time to check in before the session begins. Security measures will include inspection of vehicles, inside and out, at the entrance to the grounds. In addition, all persons entering the building must check in by name, provide a government-issued identification, and pass through a metal detector. All items brought to CMS, whether personal or for the purpose of demonstration or to support a presentation, including items such as laptops, cell phones, and palm pilots, are subject to physical inspection.

**Authority:** Section 5001(b) the Deficit Reduction Act of 2005.

(Catalog of Federal Domestic Assistance Program No. 93.733, Medicare—Hospital Insurance Program; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: November 16, 2006.

**Leslie V. Norwalk,**

*Acting Administrator, Centers for Medicare & Medicaid Services.*

[FR Doc. E6–19804 Filed 11–22–06; 8:45 am]

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