statement in understandable language of the reasons for the denial and a description of the reconsideration and appeals processes. These notices fulfill the regulatory requirement. *Form Number:* CMS–10003 (OMB#: 0938–0829); *Frequency:* Reporting: Yearly; *Affected Public:* Business or other for-profit and Not-for-profit institutions; *Number of Respondents:* 454; *Total Annual Responses:* 105,138; *Total Annual Hours:* 26285.

2. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* CMS Application for Federal Qualification (901A); CMS Medicare Agreement Application (901D) and Supporting Regulations in 42 CFR Section 417.143 and 422.6; *Use:* Prepaid health plans must meet certain regulatory requirements to be federally qualified health maintenance organizations or to enter into a contract with CMS to provide health benefits to Medicare beneficiaries. The application forms are used by CMS to collect information about a health plan to determine their compliance with federal regulations. *Form Number:* CMS–901A and D (OMB#: 0938–0470); *Frequency:* Reporting: Once; *Affected Public:* Business or other for-profit and Not-for-profit institutions; *Number of Respondents:* 55; *Total Annual Responses:* 55; *Total Annual Hours:* 2,200.

3. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Medicare ESRD Exceptions; *Use:* This information is collected in accordance with section 2145 of the Omnibus Budget Reconciliation Act of 1981 and section 623 of the Medicare Prescription Drug Improvement and Modernization Act of 2003. End Stage Renal Disease (ESRD) facilities can file for an exception to its composite payment rate. CMS uses the information submitted to determine whether an ESRD facility qualifies for a rate increase and the amount of the increase. *Form Number:* CMS–9044 (OMB#: 0938–0296); *Frequency:* Reporting: Occasionally; *Affected Public:* Business or other for-profit and Not-for-profit institutions; *Number of Respondents:* 10; *Total Annual Responses:* 10; *Total Annual Hours:* 400.

4. *Type of Information Collection Request:* Extension of a currently approved information collection; *Title of Information Collection:* Review of National Coverage Determinations and Local Coverage Determinations and Supporting Regulations in 42 CFR 426.400 and 42 CFR 426.500; *Use:* Section 522 of the Benefits Improvement and Protection Act (BIPA) of 2000 requires the implementation of a process for the appeal of National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs). Sections 426.400 and 426.500, state that an aggrieved party may initiate a review of an LCD or NCD, respectively, by filing a written complaint. These sections also identify the information required in the complaint to qualify as an aggrieved party as defined in § 426.110, as well as the process and information needed for an aggrieved party to withdraw a complaint. The required documentation includes a copy of the written authorization to represent the beneficiary, if the beneficiary has a representative, and a copy of a written statement from the treating physician that the beneficiary needs a service that is the subject of the LCD. *Form Number:* CMS–10099 (OMB#: 0938–0911); *Frequency:* Reporting—On occasion; *Affected Public:* Individuals or Households; *Number of Respondents:* 1,040; *Total Annual Responses:* 1,040; *Total Annual Hours:* 4,160.

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 *March 27, 2007*. CMS, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development—C, *Attention:* Bonnie L. Harkless, Room C4–26–05, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

Dated: January 19, 2007.

Michelle Shortt,

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

[FR Doc. E7–1124 Filed 1–25–07; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–3169–N]

Medicare Program; Renewal and Renaming of the Medicare Coverage Advisory Committee (MCAC) to Medicare Evidence Development Coverage Advisory Committee (MedCAC) and a Request for Nominations for Members for the Medicare Evidence Development & Coverage Advisory Committee

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

ACTION: Notice.

SUMMARY: This notice announces the renewal and name change of the Medicare Coverage Advisory Committee (MCAC) to Medicare Evidence Development Coverage Advisory Committee (MedCAC). It also requests nominations for consideration for membership on the Medicare Evidence Development & Coverage Advisory Committee (MedCAC).

DATES: Nominations will be considered if postmarked by March 12, 2007.

ADDRESSES: Nominations for membership must be sent by mail, fax, or e-mail, to one of the following addresses: Centers for Medicare & Medicaid Services, Office of Clinical Standards and Quality, Mail Stop: C1–09–06, 7500 Security Boulevard, Baltimore, MD 21244, Attention: Michelle Atkinson; via fax to (410) 786–9286; or e-mail to *michelle.atkinson@cms.hhs.gov.*

Copies of the Charter: To obtain a copy of the Secretary's Charter for the MedCAC submit a request to: Centers for Medicare & Medicaid Service, Office of Clinical Standards and Quality, Mail Stop C1–09–06, 7500 Security Boulevard, Baltimore, MD 21244, Attention: Maria Ellis or via e-mail to *maria.ellis@cms.hhs.gov.*

FOR FURTHER INFORMATION CONTACT: Michelle Atkinson, (410) 786–2881, Nominations; Marie Ellis, (410) 786–0309, Copies of the charter.

SUPPLEMENTARY INFORMATION:

I. Background

On December 14, 1998, we published a notice in the **Federal Register** (63 FR 68780) announcing the establishment of the Medicare Coverage Advisory Committee (MCAC). The Secretary signed the initial charter for the Medicare Coverage Advisory Committee on November 24, 1998. The MCAC

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.