Fairview, 2450 Riverside Avenue, Minneapolis, MN 55424
Medicare Provider #240080
Wyoming Medical Center, 1233 E. 2nd Street, Casper, WY 82601
Medicare Provider #530012

12/12/05

Chesapeake General Hospital, 736 Battlefield Boulevard, North, Chesapeake, VA 23320
Medicare Provider #490120
Exempla Lutheran Medical Center, 8300 West 38th Avenue, Wheat Ridge, CO 80033
Medicare Provider #060009
Gaston Memorial Hospital, 2525 Court Drive, Gastonia, NC 28054, Medicare Provider #340032
Parkridge Medical Center, 2333 McCallie Avenue, Chattanooga, TN 37404, Medicare Provider #440156

12/19/05

Baton Rouge General Medical Center, 3600 Florida Boulevard, Baton Rouge, LA 70806, Medicare Provider #190065
Broward General Medical Center, 1600 South Andrews Avenue, Ft. Lauderdale, FL 33316, Medicare Provider #100039
Good Samaritan Medical Center, 1309 Flagler Drive, West Palm Beach, FL 33401, Medicare Provider #100287
Largo Medical Center, 201 14th Street SW, Mail P.O. Box 2905, Largo, FL 33770, Medicare Provider #100248
Memorial Hermann Baptist Hospital-Beaumont, 3080 College Street, Beaumont, TX 77701, Medicare Provider #450346
The Nebraska Medical Center, 987400 Nebraska Medical Center, Omaha, NE 68198–7400, Medicare Provider #280013
Providence Everett Medical Center, 1321 Colby Avenue, Everett, WA 98201, Medicare Provider #500014
Roper Hospital, 316 Calhoun Street, Charleston, SC 29401, Medicare Provider #420087
Santa Clara Valley Medical Center, 751 South Bascom Avenue, San Jose, CA 95128, Medicare Provider #050038
Stanford Hospital & Clinics, 300 Pasteur Drive, Stanford, CA 94305, Medicare Provider #050441
The University of Chicago Hospitals, AMB W–606 MC 6091, 5841 South Maryland Avenue, Chicago, IL 60637–1470, Medicare Provider #140088
University of Utah Hospitals and Clinics, 50 North Medical Drive, Salt Lake City, UT 84132, Medicare Provider #460009

12/21/05

Community Medical Center Healthcare System, 1800 Mulberry Street, Scranton, PA 18510, Medicare Provider #390001
Mercy General Health Partners in Muskegon, Michigan, 1500 East Sherman Boulevard, Muskegon, MI 49444, Medicare Provider #230004
St. Luke's Medical Center, 190 East Bannock Street, Boise, ID 83712, Medicare Provider #130006

12/28/05

Riverside Healthcare Systems, LP, Dba Riverside Community Hospital, 4445 Magnolia Avenue, Riverside, CA 92501, Medicare Provider #050022
Santa Rosa Memorial Hospital, 1165 Montgomery Drive, Santa Rosa, CA 95405–4801, Medicare Provider #050174
San Joaquin Community Hospital, 2615 Eye Street, P.O. Box 2615, Bakersfield, CA 93303–2615, Medicare Provider #050455
United Hospital, 333 North Smith Avenue, St. Paul, MN 55102, Medicare Provider #240038

12/30/05

Georgetown University Hospital, 3800 Reservoir Road, NW, Washington, DC 20007–2113, Medicare Provider #090004
Memorial Health Care System, 2525 de Sales Avenue, Chattanooga, TN 37404–1102, Medicare Provider #440091
Mercy Medical Center, 1343 Fountain Boulevard, P.O. Box 1380, Springfield, OH 45501–1380, Medicare Provider #360086
Munson Medical Center, 1105 Sixth Street, Traverse City, MI 49684–2386, Medicare Provider #230097
Salem Hospital, 665 Winter Street SE, Post Office Box 14001, Salem, OR 97309–5014, Medicare Provider #380051
University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216, Medicare Provider #250001

[FR Doc. 06–2807 Filed 3–23–06; 8:45 am]
BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–4117–PN]

Medicare Program; Application for Deeming Authority for Medicare Advantage Health Maintenance Organizations and Local Preferred Provider Organizations Submitted by URAC

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

ACTION: Proposed notice.

SUMMARY: This proposed notice announces URAC's submission of an application for deeming authority as a national accreditation organization for health maintenance organizations and local preferred provider organizations participating in the Medicare Advantage program. This announcement describes the criteria to be used in evaluating the application and provides information for submitting comments during a public comment period that will span at least 30 days.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on April 28, 2006.

ADDRESSES: In commenting, please refer to file code CMS–4117–PN. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission. You may submit comments in one of three 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 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–4117–PN, P.O. Box 8016, Baltimore, MD 21244–8016. Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *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) 786–3159 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 HHS 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: Shaheen Halim, PhD, (410) 786–0641.

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–4117–PN.

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.

I. Background

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 422. 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.

Generally, for an organization to enter into an MA contract, the organization must be licensed by the State as a risk bearing organization as set forth in part 422 of our regulations. Additionally, the organization must file an application demonstrating that it meets other Medicare requirements in part 422 of our regulations. Following approval of the contract, we engage in routine monitoring and oversight audits of the MA organization to ensure continuing 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). In essence, the Secretary ''deems'' that the Medicare requirements are met based on a determination that the AO's standards are at least as stringent as Medicare requirements. 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 will have to re-apply to CMS.

An organization that applies for Medicare Advantage deeming authority is generally recognized by the industry as an entity that accredits MCOs 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. Section 1852(e)(4)(C) of the Act requires that within 210 days of receipt of an application, the Secretary shall determine whether the applicant meets criteria specified in section 1865(b)(2) of the Act.

On June 4, 2004 URAC submitted to CMS an application for deeming authority that was later withdrawn. On October 12, 2005, URAC submitted an application for approval as an accrediting organization for Medicare Advantage HMOs and local PPOs in the following six areas:

- Quality improvement.
- Antidiscrimination.
- Access to services.
- Confidentiality and accuracy of enrollee records.
- Information on advance directives.
- Provider participation rules.

To be approved for deeming authority, an accrediting organization must demonstrate that its accreditation program requirements meet or exceed the Medicare requirements for which it is seeking the authority to deem compliance.

II. Deeming Application Approval Process

The application process for deeming authority includes a review of URAC's application in accordance with the criteria specified by our regulations at § 422.158(a). This includes, but is not limited to, the following:

- The equivalency of URAC's requirements for HMOs and PPOs to CMS' comparable MA organization requirements.
- URAC's survey process, to determine the following:
- The frequency of surveys.
- The types of forms, guidelines, and instructions used by surveyors.
- Descriptions of the accreditation decision making process, deficiency notification and monitoring process, and compliance enforcement process.
- Detailed information about individuals who perform accreditation surveys including:
- Size and composition of the survey team;
- Education and experience requirements for the surveyors;
- In-service training required for surveyor personnel;
- Surveyor performance evaluation systems; and
- Conflict of interest policies relating to individuals in the survey and accreditation decision process.
- Descriptions of the organization's:
- Data management and analysis system;
- Policies and procedures for investigating and responding to complaints against accredited organizations;
- Types and categories of accreditation offered and MA organizations currently accredited within those types and categories.

In accordance with § 422.158(b) of our regulations, the applicant must provide documentation relating to:

- Its ability to provide data in a CMS compatible format;
- The adequacy of personnel and other resources necessary to perform the required surveys and other activities; and
- Assurances that it will comply with ongoing responsibility requirements specified in § 422.157(c) of our regulations.

In accordance with section 1865(b)(3)(A) of the Act, this proposed notice solicits public comment on the ability of URAC's accreditation program to meet or exceed the Medicare requirements for which it seeks authority to deem.

III. Evaluation of Application for Deeming Authority

On October 12, 2005, URAC submitted all the necessary information to permit us to make a determination concerning its request for approval as a deeming authority for MA organizations that are licensed as either HMOs or PPOs. Under § 422.158(a) of the regulations, our review and evaluation of a national accreditation organization will consider, but not necessarily be limited to, the following information and criteria:

- The equivalency of URAC's requirements for HMOs and PPOs to CMS' comparable MA organization requirements.
- URAC's survey process, to determine the following:
- The frequency of surveys.

- The types of forms, guidelines, and instructions used by surveyors.
- Descriptions of the accreditation decision making process, deficiency notification and monitoring process, and compliance enforcement process.
- Detailed information about individuals who perform accreditation surveys including:
- Size and composition of the survey team;
- Education and experience requirements for the surveyors;
- In-service training required for surveyor personnel;
- Surveyor performance evaluation systems; and
- Conflict of interest policies relating to individuals in the survey and accreditation decision process.
- Descriptions of the organization's:
- Data management and analysis system;
- Policies and procedures for investigating and responding to complaints against accredited organizations; and
- Types and categories of accreditation offered and MA organizations currently accredited within those types and categories.

In accordance with § 422.158(b) of our regulations, the applicant must provide documentation relating to—

- Its ability to provide data in a CMS compatible format;
- The adequacy of personnel and other resources necessary to perform the required surveys and other activities; and
- Assurances that it will comply with ongoing responsibility requirements specified in § 422.157(c) of our regulations.

Additionally, the accrediting organization must provide CMS the opportunity to observe its accreditation process on site at a managed care organization and must provide any other information that CMS requires to prepare for an onsite visit. These site visits will help to verify that the information presented in the application is correct and to make a determination on the application.

IV. Response to Comments

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 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. Regulatory Impact Statement

In accordance with the provisions of Executive Order 12866, this regulation was not reviewed by the Office of Management and Budget.

Authority: Sections 1852 and 1865 of the Social Security Act (42 U.S.C. 1395w–22 and 1395bb).

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

Dated: March 8, 2006.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicare Services.

[FR Doc. 06–2567 Filed 3–23–06; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1281–N]

Medicare Program; Public Meetings in Calendar Year 2006 for All New Public Requests for Revisions to the Healthcare Common Procedure Coding System (HCPCS) Coding and Payment Determinations

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

ACTION: Notice.

SUMMARY: This notice announces the dates, time, and location of the Healthcare Common Procedure Coding System (HCPCS) public meetings to be held in calendar year 2006 to discuss our preliminary coding and payment determinations for all new public requests for revisions to the HCPCS.

These meetings provide a forum for interested parties to make oral presentations or to submit written comments in response to preliminary coding and payment determinations. Discussion will be directed toward responses to our specific preliminary recommendations and will include all items on the public meeting agenda.

DATES: *Meeting Dates:* The following are the 2006 HCPCS public meeting dates:

1. Tuesday, April 25, 2006, 9 a.m. to 5 p.m., e.d.s.t. (Durable Medical Equipment (DME) and Accessories).
2. Wednesday, April 26, 2006, 9 a.m. to 5 p.m., e.d.s.t. (Orthotics and Prosthetics).
3. Thursday, April 27, 2006, 9 a.m. to 12 p.m., e.d.s.t. (Orthotics and Prosthetics).
4. Thursday, May 4, 2006, 9 a.m. to 5 p.m., e.d.s.t. (Supplies and Other).
5. Friday, May 5, 2006, 9 a.m. to 5 p.m., e.d.s.t. (Supplies and Other).
6. Thursday, May 11, 2006, 9 a.m. to 5 p.m., e.d.s.t. (Drugs/Biologicals/Radiopharmaceuticals/Radiologic Imaging Agents).
7. Friday, May 12, 2006, 9 a.m. to 5 p.m., e.d.s.t. (Drugs/Biologicals/Radiopharmaceuticals/Radiologic Imaging Agents).

The product category reported by the meeting participant may not be the same as that assigned by CMS. All meeting participants are advised to review the public meeting agenda at *http://www.cms.hhs.gov/medhcpcsgeninfo* which identifies our category determinations, and the dates each item will be discussed. Draft agendas, including a summary of each request and CMS' preliminary decision will be posted on our HCPCS Web site at *http://www.cms.hhs.gov/medhcpcsgeninfo* at least one month before each meeting.

Each meeting day will begin at 9 a.m. and end at 5 p.m., e.d.s.t., except for Thursday, April 27, 2006, the meeting will begin at 9 a.m. and end at 12 p.m., e.d.s.t.

ADDRESSES: The public meetings will be held in the auditorium at the Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244.

Meeting Registration

Registration Procedures: Registration can be completed online at *http://www.cms.hhs.gov/medhcpcsgeninfo*. To register by telephone or e-mail, for the April 25, April 26, and April 27, 2006 meetings, contact Felicia Eggleston at *Eggleston.Felicia@cms.hhs.gov* or telephone (410) 786–9287; or Trish Brooks at *Brooks.Trish@cms.hhs.gov* or telephone (410) 786–4561.

For the May 4, May 5, May 11, and May 12, 2006 meetings, contact Jennifer Carver at *Carver.Jennifer@cms.hhs.gov* or telephone (410) 786–6610; or Gloria Knight at *Knight.Gloria@cms.hhs.gov* or telephone (410) 786–4598.

The following information must be provided when registering: Name, company name and address, telephone and fax numbers, e-mail address, and special needs information. A CMS staff member will confirm your registration by mail, e-mail, or fax.

Registration Deadlines: Individuals must register for each date they plan either to attend or to provide a presentation. For the April 25, 26, and