complies with sections 1902(a)(10) and 1902(a)(30) of the Act by limiting payment of medical assistance to payment of medical costs for individuals who lack sufficient income and resources to meet the cost of care; and

• Whether the State has provided adequate documentation to demonstrate that the State's rate methodology is consistent with the requirements of section 1902(a)(30) of the Act; specifically whether the rates paid to service providers are consistent with efficiency, economy, and quality of care.

Section 1116 of the Act and Federal regulations at 42 CFR Part 430, establish Department procedures that provide an administrative hearing for reconsideration of a disapproval of a State plan or plan amendment. CMS is required to publish a copy of the notice to a State Medicaid agency that informs the agency of the time and place of the hearing, and the issues to be considered. If we subsequently notify the agency of additional issues that will be considered at the hearing, we will also publish that notice.

Any individual or group that wants to participate in the hearing as a party must petition the presiding officer within 15 days after publication of this notice, in accordance with the requirements contained at 42 CFR 430.76(b)(2). Any interested person or organization that wants to participate as amicus curiae must petition the presiding officer before the hearing begins in accordance with the requirements contained at 42 CFR 430.76(c). If the hearing is later rescheduled, the presiding officer will notify all participants.

The notice to Pennsylvania announcing an administrative hearing to reconsider the disapproval of its SPA reads as follows:

Ms. Estelle B. Richman,
Secretary of Public Welfare, Commonwealth of Pennsylvania, Department of Public Welfare, Office of Medical Assistance Programs, Bureau of Policy, Budget and Planning,
P.O. Box 8046,
Harrisburg, PA 17105.

Dear Ms. Richman:

I am responding to your request for reconsideration of the decision to disapprove Pennsylvania State plan amendment (SPA) 06–007, which was submitted on September 27, 2006, and disapproved on June 29, 2007.

Under this SPA, the State requested the addition of targeted case management services for first-time, low-income expectant mothers who have, or are at risk of having, a high incidence of medical or social problems. The Centers for Medicare & Medicaid Services (CMS) disapproved the SPA because CMS found that it violated the statute for reasons set forth in the disapproval letter.

The CMS made a Request for Additional Information on December 22, 2006, to which the State responded on April 2, 2007. The information provided confirmed that the targeted case management services proposed in SPA 06–007 are currently provided to first-time expectant mothers without charge through State grant funding and private funds.

Section 1902(a)(10) of the Social Security Act (the Act) requires that States make available medical assistance, which is defined at section 1905(a) of the Act, and is limited to payment of medical costs for ''individuals whose income and resources are insufficient to meet all of such costs.'' The term ''medical assistance'' fundamentally excludes payment for medical services that are free to the general public, since where a service is provided without charge the individual is not in the circumstance of having insufficient income or resources to meet the cost of care. Hence, such services do not meet the definition of ''medical assistance.''

In addition, section 1902(a)(30) of the Act requires States to have methods and procedures in place to assure that payments are consistent with efficiency, economy, and quality of care. CMS did not find that Medicaid payments for case management for first-time expectant mothers were consistent with this requirement when these same services are available to non-Medicaid enrollees without charge. Furthermore, the State failed to provide documentation requested by CMS demonstrating that the rate methodology used to determine payments to service providers was consistent with section 1902(a)(30). The State failed to provide documentation of the various cost elements used to determine a fee-schedule amount or to submit provider surveys conducted by the State to determine whether its proposed indirect cost rate should be applied to direct costs to calculate the final fee paid to providers.

Based on the above, and after consultation with the Secretary of the Department of Health and Human Services as required under Federal regulations at 42 CFR 430.15(c)(2), CMS disapproved Pennsylvania Medicaid SPA 06–007.

The issues to be decided at the hearing are

• Whether Pennsylvania has demonstrated that its SPA 06–007 complies with sections 1902(a)(10) and 1902(a)(30) of the Act by limiting payment of medical assistance to payment of medical costs for individuals who lack sufficient income and resources to meet the cost of care; and

• Whether the State has provided adequate documentation to demonstrate that the State's rate methodology is consistent with the requirements of section 1902(a)(30) of the Act; specifically whether the rates paid to service providers are consistent with efficiency, economy, and quality of care.

I am scheduling a hearing on your request for reconsideration to be held on November 16, 2007, at Suite 216, The Public Ledger Building, 150 S. Independence Mall West, Conference Room 241, the Pennsylvania Room, Philadelphia, PA 19106, to reconsider the decision to disapprove SPA 06–007. 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.

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,
Kerry Weems,
Acting Administrator.

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

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

Kerry Weems,

Acting Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. E7–19141 Filed 9–27–07; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare and Medicaid Services

[CMS–3186–PN]

Medicare and Medicaid Programs; Application by the Indian Health Service (IHS) for Continued Recognition as a National Accreditation Organization for Accrediting American Indian and Alaska Native Entities To Furnish Outpatient Diabetes Self-Management Training

AGENCY: Centers for Medicare and Medicaid Services, HHS.

ACTION: Proposed notice.

SUMMARY: This proposed notice announces the receipt of an application from the Indian Health Service for continued recognition as a national accreditation organization for accrediting American Indian and Alaska Native entities that wish to furnish outpatient diabetes self-management training to Medicare beneficiaries. This notice also announces 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. October 29, 2007.

ADDRESSES: In commenting, please refer to file code CMS–3186–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–3186–PN, P.O. Box 3014, Baltimore, MD 21244–1850.

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–3186–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: Eva Fung, (410) 786–7539.

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–3186–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 outpatient diabetes self-management training when ordered by the physician or qualified nonphysician practitioner treating the beneficiary's diabetes, provided certain requirements are met. We sometimes use national accreditation organizations to determine whether a provider entity meets the Medicare requirements that are necessary in order for an entity to provide a service covered by Medicare.

Section 1865(b)(1) of the Social Security Act (the Act), provides that a national accreditation organization must have an agreement in effect with the Secretary and meet the standards and requirements as specified in 42 CFR part 410, subpart H. The regulations pertaining to application procedures for national accreditation organizations for diabetes self-management training services are specified in § 410.142 (CMS process for approving national accreditation organizations).

A national accreditation organization applying for deeming authority must provide us with reasonable assurance that it requires accredited entities to meet requirements that are at least as stringent as those set forth by CMS. Nonprofit or not-for-profit organizations with demonstrated experience in representing the interests of individuals with diabetes are eligible to request recognition as a national accreditation organization. The national accreditation organization, after being approved and recognized by CMS, evaluates the entity to determine if it meets one of the sets of quality standards as specified in § 410.144 (Quality standards for deemed entities). If the national accreditation organization finds that the entity meets or exceeds applicable requirements, the Secretary shall deem the entity as meeting the Medicare requirements.

Section 1865(b)(2) of the Act requires that the Secretary's findings relative to approving a national accreditation organization as a deeming authority consider the organization's requirements for accreditation, its survey procedures, its ability to provide adequate resources for conducting required surveys and its ability to supply information for use in enforcement activities, its monitoring procedures for entities found out of compliance with the conditions or requirements, and its ability to provide the Secretary with necessary data for validation. The Secretary evaluates the national accreditation organization's accreditation requirements to determine if they meet or exceed the Medicare conditions as we would have applied them.

Section 1865(b)(3)(A) of the Act requires that the Secretary publish within 60 days of receipt of a completed application, a notice identifying the national accreditation body making the request, describing the nature of the request, and providing at least a 30-day public comment period. In addition, the Secretary has 210 days from receipt of the request to publish a finding of approval or denial of the application. If the Secretary recognizes an accreditation organization in this manner, once an entity that furnishes diabetes training is accredited by a national accreditation organization, it can be ''deemed'' to meet the Medicare conditions of coverage for diabetes self-management training.

II. Provisions of the Proposed Notice

[If you choose to comment on issues in this section, please include the caption ''PROVISIONS OF THE PROPOSED NOTICE'' at the beginning of your comments.]

The purpose of this notice is to notify the public of the Indian Health Service's (IHS's) request for the approval for continued recognition as a national accrediting organization for accreditation of American Indian and Alaska Native entities to furnish outpatient diabetes self-management training services. The IHS proposes to continue to adopt the National Standards for Diabetes Self-Management Education as its quality standards. This notice also solicits public comments on the ability of the IHS to develop and apply its standards to entities furnishing outpatient diabetes self-management training services.

Outpatient Diabetes Self-Management Training Services

The regulations specifying the Medicare conditions for coverage for outpatient diabetes self-management training services are specified in 42 CFR parts 410, subpart H. These conditions implement section 1861(qq) of the Act, which provides for Medicare Part B coverage of outpatient diabetes self-management training services specified by the Secretary.

Under section 1865(b)(2) of the Act and our regulations at § 410.142 (CMS process for approving national accreditation organizations) and § 410.143 (Requirements for approved accreditation organizations), we review and evaluate a national accreditation organization based on (but not necessarily limited to) the criteria specified in § 410.142(b), and we review the ongoing responsibilities of an approved accreditation organization.

We may visit the prospective organization's offices to verify information in the organization's reapplication package, including, but not limited to, review of documents, and interviews with the organization's staff. We may conduct onsite inspection of a national accreditation organization's operations and office to verify information and assess the organization's compliance with its own policies and procedures. The onsite inspection may include, but is not limited to, reviewing documents, auditing documentation from meetings concerning the accreditation process, evaluating accreditation results or the accreditation status decision making process, and interviewing the organization's staff.

Notice Upon Completion of Evaluation

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

III. 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 the preamble to that document.

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

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

Dated: September 6, 2007.

Kerry Weems,

Acting Administrator, Centers for Medicare & Medicare Services.

[FR Doc. E7–18470 Filed 9–27–07; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1378–N]

Medicare Program; Medicare Provider Feedback Group Town Hall Meeting—October 16, 2007

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

ACTION: Notice of meeting.

SUMMARY: This notice announces the annual Medicare Provider Feedback Group (MPFG) Town Hall meeting. This meeting is open to all Medicare fee-for-service (FFS) providers and suppliers that participate in the Medicare program, including physicians, hospitals, home health agencies, other third-party billers and other interested parties, to present their individual views and opinions on selected FFS Medicare topics. In addition, we will be soliciting input on how we can improve communications to better serve the Medicare providers and suppliers. The meeting agenda and discussion materials will be available by October 12, 2007. The public can access these materials at *http://www.cms.hhs.gov/center/provider.asp.*

The feedback provided during this meeting will assist us as we evaluate FFS Medicare policy, operational issues and CMS' provider and supplier communication activities. The meeting is open to the public, but attendance is limited to space available. Registered participants from the meeting will be included in the Medicare Provider Feedback Group and may be contacted throughout the year for follow-up meetings to solicit additional opinions and clarify any issues that may arise from the October 16, 2007 meeting.

DATES: *Meeting Date:* The Town Hall meeting announced in this notice will be held on Tuesday, October 16, 2007, from 2 p.m. to 4 p.m. e.s.t.

ADDRESSES: The Town Hall meeting will be held in the main auditorium of the central building of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244.

Written Questions or Statements: Any interested party may send written comments electronically. We will give consideration to feedback received on the topics discussed at the Town Hall meeting, but written responses will not be provided. We will accept and take into consideration written feedback, questions, or other statements about the town hall meeting and agenda topics before the meeting, and up until October 26, 2007. Send written feedback, questions, or other statements to Colette Shatto at *MFG@cms.hhs.gov*.

FOR FURTHER INFORMATION CONTACT: Colette Shatto, 410–786–6932. You may also send inquires about this meeting by *MFG@cms.hhs.gov*.

SUPPLEMENTARY INFORMATION:

I. Background

CMS has held three Medicare Provider Feedback Group Town Hall Meetings beginning in 2005. The purpose of these meetings is to capture individual provider and supplier feedback on relevant FFS Medicare policy and operational issues. As a result, we are able to further advance our efforts to strengthen the Medicare program and enhance our relationship with providers and suppliers. The Town Hall meetings also provide a venue to allow us to continue a process of communicating with individual providers and suppliers through the following year.

II. Meeting Format

The meeting will begin with an overview of the goals and objectives of the MPFG efforts to gather feedback