was not reviewed by the Office of Management and Budget.

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

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

Dated: January 9, 2006.

Mark B. McClellan,

Administrator, Centers for Medicare and Medicaid Services.

[FR Doc. E6–1049 Filed 1–25–06; 4:00 pm]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–3162–N]

Medicare Program; Meeting of the Medicare Coverage Advisory Committee—March 30, 2006

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

ACTION: Notice.

SUMMARY: This notice announces a public meeting of the Medicare Coverage Advisory Committee (MCAC). The Committee generally provides advice and recommendations about whether scientific evidence is adequate to determine whether certain medical items and services are reasonable and necessary under the Medicare statute. The charter also permits the MCAC to develop recommendations about other specific issues of Medicare coverage. This meeting concerns authoritative drug compendia that may be used in determining the medically accepted indications of drugs and biologicals used in an anti-cancer chemotherapeutic regimen under Part B of the Medicare program. Notice of this meeting is given under the Federal Advisory Committee Act (5 U.S.C. App. 2, section 10(a)).

DATES: The public meeting will be held on Thursday, March 30, 2006 from 7:30 a.m. until 4:30 p.m. e.s.t.

Deadlines: Deadline for Presentations and Comments: Written comments and presentations must be received by February 27, 2006, 5 p.m., e.s.t.

Deadline for Registration To Attend Meeting: For security reasons, individuals wishing to attend this meeting must register by close of business on March 23, 2006.

Special Accommodations: Persons attending the meeting who are hearing or visually impaired, or have a condition that requires special assistance or accommodations, are asked to notify the Executive Secretary by March 23, 2006 (see **FOR FURTHER INFORMATION CONTACT**).

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

FOR FURTHER INFORMATION CONTACT: Michelle Atkinson, Executive Secretary, by telephone at 410–786–2881 or by e-mail at *Michelle.Atkinson@cms.hhs.gov.*

Web site: You may access up-to-date information on this meeting at *http://www.cms.hhs.gov/FACA/02_MCAC.asp#TopOfPage.*

Presentations and Comments: Interested persons may present data, information, or views orally or in writing on issues pending before the Committee. Please submit written comments to Michelle Atkinson, by e-mail at *Michelle.Atkinson@cms.hhs.gov* or by mail to the Executive Secretary for MCAC, Coverage and Analysis Group, Office of Clinical Standards and Quality, Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Mail Stop C1–09–06, Baltimore, MD 21244.

SUPPLEMENTARY INFORMATION:

I. Background

On December 14, 1998, we published a notice in the **Federal Register** (63 FR 68780) to describe the Medicare Coverage Advisory Committee (MCAC), which provides advice and recommendations to us about clinical issues. This notice announces a public meeting of the Committee.

Meeting Topic: The Committee will discuss evidence and hear presentations and public comments regarding the desired characteristics of published authoritative compendia that may be used by CMS to determine the medically accepted indications of drugs and biologicals employed in an anti-cancer chemotherapeutic regimen under Part B of the Medicare program, section 1861(t)(2) of the Social Security Act.

Background information about this topic, including panel materials, is available on the Internet at *http://www.cms.hhs.gov/coverage/.*

II. Procedure

This meeting is open to the public. The Committee will hear oral presentations from the public for approximately 45 minutes. The Committee may limit the number and duration of oral presentations to the time available. If you wish to make formal presentations, you must notify the Executive Secretary named in the **FOR FURTHER INFORMATION CONTACT** section and submit the following by the *Deadline for Presentations and Comments* date listed in the **DATES** section of this notice: a brief statement of the general nature of the evidence or arguments you wish to present, the names and addresses of proposed participants, and a written copy of your presentation. Your presentation should consider the questions we have posed to the Committee and focus on the issues specific to the topic. The questions will be available on our Web site at *http://www.cms.hhs.gov/FACA/02_MCAC.asp#TopOfPage.* We require that you declare at the meeting whether or not you have any financial involvement with manufacturers of any items or services being discussed (or with their competitors).

After the public and CMS presentations, the Committee will deliberate openly on the topic. Interested persons may observe the deliberations, but the Committee will not hear further comments during this time except at the request of the chairperson. The Committee will also allow a 15 minute unscheduled open public session for any attendee to address issues specific to the topic. At the conclusion of the day, the members will vote, and the Committee will make its recommendation.

III. Registration Instructions

The Coverage and Analysis Group is coordinating meeting registration. While there is no registration fee, individuals must register to attend. You may register by contacting Maria Ellis at 410–786–0309, mailing address: Coverage and Analysis Group, OCSQ; Centers for Medicare & Medicaid Services; 7500 Security Blvd, Mailstop: C1–09–06; Baltimore, MD 21244, or by e-mail at *Maria.Ellis@cms.hhs.gov.* Please provide your name, address, organization, telephone and fax number, and e-mail address.

You will receive a registration confirmation with instructions for your arrival at the CMS complex. You will be notified if the seating capacity has been reached.

This meeting is located on Federal property; therefore, for security reasons, any individuals wishing to attend this meeting must register by close of business on March 23, 2006.

IV. Security, Building, and Parking Guidelines

This meeting will be held in a Federal Government building; therefore, Federal security measures are applicable. In planning your arrival time, we

recommend allowing additional time to clear security.

In order to gain access to the building and grounds, individuals must present photographic identification to the Federal Protective Service or Guard Service personnel before being allowed entrance.

Security measures also include inspection of vehicles, inside and out, at the entrance to the grounds. In addition, all individuals entering the building must pass through a metal detector. All items brought to CMS, whether personal or for the purpose of demonstration or to support a demonstration, are subject to inspection. We cannot assume responsibility for coordinating the receipt, transfer, transport, storage, set-up, safety, or timely arrival of any personal belongings or items used for demonstration or to support a demonstration.

Parking permits and instructions will be issued upon arrival.

Note: Individuals who are not registered in advance will not be permitted to enter the building and will be unable to attend the meeting.

The public may not enter the building earlier than 30 to 45 minutes prior to the convening of the meeting.

All visitors must be escorted in areas other than the lower and first floor levels in the Central Building.

Authority: 5 U.S.C. App. 2, section 10(a).

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

Dated: December 12, 2005.

Barry M. Straube,

Acting Chief Medical Officer and Acting Director, Office of Clinical Standards and Quality, Centers for Medicare and Medicaid Services.

[FR Doc. E6–704 Filed 1–26–06; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare and Medicaid Services

[CMS–1328–N]

Medicare Program; February 15, 2006 Town Hall Meeting on the Practice Expense Methodology Including the Proposal From the Physician Fee Schedule Proposed Rule for Calendar Year 2006

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

ACTION: Notice of meeting.

SUMMARY: This notice announces a Town Hall meeting on our methodology for establishing practice expense (PE) values for services paid under the physician fee schedule (PFS). The purpose of this meeting is to: (1) Clarify our proposed revisions to the PE methodology contained in the PFS calendar year (CY) 2006 proposed rule; and (2) receive comments and opinions from individuals of the medical community regarding ideas for the CY 2007 PFS proposed rule. This meeting is open to the public, but attendance is limited to space available.

DATES: The Town Hall meeting is scheduled for Tuesday, February 15, 2006 from 1:30 p.m. to 4:30 p.m. e.s.t.

ADDRESSES: The Town Hall meeting will be held at the Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244–1850 in the auditorium in the central building.

Meeting Registration: Persons wishing to attend this meeting must register by contacting Debbie Cooley at Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Mail stop C4–03–06, Baltimore, MD 21244–1850, or, by FAX at 410–786–4490 to the attention of Debbie Cooley. Please include the name of the attendee and the organization he or she represents, if applicable. This information must be received by 5 p.m., e.s.t, on Friday, February 10, 2006.

This meeting will be held in a Federal Government building, the Centers for Medicare and Medicaid Services; therefore, persons attending this meeting will be required to show a government-issued photo identification and a copy of their confirmation of registration for the meeting. Access may be denied to persons without proper identification. In planning your arrival time, we recommend allowing additional time to clear security.

Security measures include: Inspection of vehicles, inside and out, at the entrance to the grounds; passing through a metal detector; and, the inspection of all items brought into the building. Laptops and other computer equipment must be registered with the security desk upon entry. Please note that CMS headquarters is a smoke-free complex.

FOR FURTHER INFORMATION CONTACT: Debbie Cooley, (410)786–0007 or Dorothy Shannon, (410)786–3396.

SUPPLEMENTARY INFORMATION:

I. Background

Since January 1, 1992, Medicare has paid for services of physicians and other practitioners under a physician fee schedule. This schedule sets payment rates for 7,000 services based on the resources used to provide those services and is updated annually. To construct the fee schedule, we assign values called relative value units (RVUs) to each service. The total RVUs for a service are the sum of the work RVUs (which include the physician's time and effort); the practice expense RVUs (which cover expenses such as overhead, staff, and supplies); and the malpractice expense RVUs (which cover malpractice premiums).

In the CY 2006 PFS proposed rule (70 FR 45764), we outlined our plans to revise the practice expense (PE) methodology. There were three major parts to our proposal:

1. Changing from a ''top-down'' methodology for calculating direct PE to a ''bottom-up'' approach. Currently, on a specialty-specific basis, we derive a PE per physician hour from aggregate survey data, create a cost pool using Medicare utilization data, and then allocate the pool to all the services performed by the specialty. This methodology is complex, often not intuitive, and produces some PE values that can change significantly from year-to-year. The proposed bottom-up approach would use the sum of the typical resource costs for clinical staff, supplies, and equipment required for each service. These typical costs for each service would be determined based primarily on recommendations we reviewed and accepted from the American Medical Association's Relative Value Update Committee (RUC). We would then convert these costs into direct cost PE RVUs. We believe this methodology is easier to understand and more intuitive than the current top-down approach, and should also improve the stability of the PE RVUs over time. In addition, because most of the inputs that would be used in the bottom-up calculation have been approved by the multi-specialty RUC, the medical community has already agreed to their accuracy.

2. Accepting the supplementary PE surveys from seven specialties—allergy, dermatology, urology, gastrointestinal, cardiology, radiology, and radiation oncology—and using these in the calculation of indirect PE.

3. Calculating, on a code-specific basis, the higher of the current portion of the PE RVU for indirect costs (the indirect PE RVU) or the indirect PE RVU resulting from acceptance of the supplementary surveys.

This proposal was to have the effect of mitigating the redistributive effects of accepting the seven supplementary surveys by ensuring that, before application of PE budget neutrality, the indirect PE RVUs for each service were