contact Shirl Ackerman-Ross, the DFO, at *APCPanel@cms.hhs.gov* or call 410–786–4474. News media representatives should contact the CMS Press Office at 202–690–6145.

SUPPLEMENTARY INFORMATION:

I. Background

The Secretary is required by section 1833(t)(9)(A) of the Social Security Act (the Act), as amended and redesignated by sections 201(h) and 202(a)(2) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106–113), respectively, to establish and consult with an expert, outside advisory panel on Ambulatory Payment Classification (APC) groups.

The Panel meets up to three times annually to review the APC groups and to provide technical advice to the Secretary and the Administrator concerning the clinical integrity of the groups and their associated weights. CMS considers the technical advice provided by the Panel as we prepare the proposed rule that proposes changes to the OPPS for the next calendar year.

The Panel may consist of up to 15 representatives who are full-time employees (not consultants) of Medicare providers, which are subject to the OPPS, and a Chair.

The Administrator selects the Panel membership based upon either self-nominations or nominations submitted by providers or interested organizations.

The current Panel members are: (The asterisk [*] indicates a Panel member whose term expires on March 31, 2005.)

- E. L. Hambrick, M.D., J.D., a CMS Medical Officer.
- Marilyn K. Bedell, M.S., R.N., O.C.N.*
- Albert Brooks Einstein, Jr., M.D.
- Lee H. Hilborne, M.D.*
- Stephen T. House, M.D.*
- Kathleen P. Kinslow, C.R.N.A., Ed.D.*
- Mike Metro, R.N.*
- Sandra J. Metzler, M.B.A., R.H.I.A.
- Gerald V. Naccarelli, M.D.*
- Frank G. Opelka, M.D.
- Louis Potters, M.D.
- Lou Ann Schraffenberger, M.B.A., R.H.I.A.
- Judie S. Snipes, R.N., M.B.A., C.H.E.
- Lynn R. Tomascik, R.N., M.S.N., C.N.A.A.
- Timothy Gene Tyler, Pharm.D.
- William A. Van Decker, M.D., J.D.*

Panel members serve without compensation, according to an advance written agreement; however, travel, meals, lodging, and related expenses are reimbursed in accordance with standard Government travel regulations. CMS has a special interest for ensuring that women, minorities, and the physically challenged are adequately represented on the Panel. CMS further encourages nominations of qualified candidates from those groups.

The Secretary, or his designee, appoints new members to the Panel from among those candidates determined to have the required expertise. New appointments are made in a manner that ensures a balanced membership.

II. Criteria for Nominees

All nominees must have technical expertise that enables them to participate fully in the work of the Panel. Such expertise encompasses hospital payment systems, hospital medical-care delivery systems, outpatient payment requirements, Ambulatory Payment Classification (APC) Groups, Physicians' Current Procedural Terminology Codes (CPTs), the use and payment of drugs and medical devices in the outpatient setting, and other forms of relevant expertise.

It is not necessary for a nominee to possess expertise in all of the areas listed, but each must have a minimum of 5 years experience and currently be employed full-time in his or her area of expertise. Members of the Panel serve overlapping 2, 3, and 4-year terms, contingent upon the rechartering of the Panel.

Any interested person may nominate one or more qualified individuals. Self-nominations will also be accepted. Each nomination must include a letter of nomination, the curriculum vita of the nominee, and a statement from the nominee that the nominee is willing to serve on the Panel under the conditions described in this notice and further specified in the Charter.

III. Copies of the Charter

To obtain a copy of the Panel's Charter, submit a written request to the DFO at the address provided or by e-mail at *APCPanel@cms.hhs.gov*, or call her at 410–786–4474. Copies of the Charter are also available on the Internet at *http://www.cms.hhs.gov/faca*.

Authority: Section 1833(t)(9)(A) of the Act (42 U.S.C. 1395l(t)(9)(A). The Panel is governed by the provisions of Pub. L. 92–463, as amended (5 U.S.C. Appendix 2).

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

Dated: February 18, 2005.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 05–3752 Filed 2–24–05; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–5011–WN2]

Medicare and Medicaid Programs; Solicitation of Proposals for the Private, For-Profit Demonstration Project for the Program of All-Inclusive Care for the Elderly (PACE); Cancellation of Withdrawal

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

ACTION: Cancellation of a withdrawal notice.

SUMMARY: This document cancels the withdrawal of the ''Notice for the Solicitation of Proposals for the Private, For-Profit Demonstration Project for the Program of All-Inclusive Care for the Elderly (PACE)'' published in the **Federal Register** on November 26, 2004. The November 26, 2004 notice was published in error, and we do not wish to withdraw the original notice of solicitation published on August 10, 2001.

The solicitation notice solicited proposals from private, for-profit organizations for a fully-capitated joint Medicare and Medicaid demonstration. The goal of the solicitation notice was to determine whether the risk-based long-term care model employed by the nonprofit PACE could be replicated successfully by for-profit organizations.

EFFECTIVE DATE: The notice announcing the withdrawal of solicitation is cancelled effective February 25, 2005.

FOR FURTHER INFORMATION CONTACT: Michael Henesch, (410) 786–6685.

SUPPLEMENTARY INFORMATION: Section 4804(a)(2) of the Balanced Budget Act of 1997 (BBA) requires us to conduct a study to compare the costs, quality, and access to services provided by for-profit entities to those of nonprofit Program of All-Inclusive Care for the Elderly (PACE) providers. Section 4801(h)(2)(A) of the BBA states that the terms and conditions for the for-profit PACE must be the same as those for PACE providers that are nonprofit, private organizations except that only 10 waivers may be granted.

On August 10, 2001, we published a notice in the **Federal Register** (66 FR

42229). The notice solicited proposals from for-profit entities to demonstrate that they could successfully provide comprehensive coordinated care for the frail elderly under a prepaid fully-capitated payment system.

On November 26, 2004, we published a notice in the **Federal Register** (69 FR 68931) withdrawing the August 10, 2001 solicitation. To date, we have received one application, and we do not want to foreclose the application process for other interested parties. Therefore, we are canceling the previously published notice of withdrawal.

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995.

Authority: Section 1894(h) and 1934(h) of the Social Security Act (42 U.S.C. 1395).

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program; No. 93.773 Medicare—Hospital Insurance Program; and No. 93.774, Medicare-Supplementary Medical Insurance Program)

Dated: February 17, 2005.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 05–3553 Filed 2–24–05; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–9025–N]

Medicare and Medicaid Programs; Quarterly Listing of Program Issuances—October Through December 2004

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

ACTION: Notice.

SUMMARY: This notice lists CMS manual instructions, substantive and interpretive regulations, and other **Federal Register** notices that were published from October 2004 through December 2004, relating to the Medicare and Medicaid programs. This notice provides information on national coverage determinations (NCDs) affecting specific medical and health care services under Medicare. Additionally, this notice identifies certain devices with investigational device exemption (IDE) numbers approved by the Food and Drug Administration (FDA) that potentially may be covered under Medicare. Finally, this notice also includes listings of all approval numbers from the Office of Management and Budget for collections of information in CMS regulations.

Section 1871(c) of the Social Security Act requires that we publish a list of Medicare issuances in the **Federal Register** at least every 3 months. Although we are not mandated to do so by statute, for the sake of completeness of the listing, and to foster more open and transparent collaboration efforts, we are also including all Medicaid issuances and Medicare and Medicaid substantive and interpretive regulations (proposed and final) published during this 3-month time frame.

FOR FURTHER INFORMATION CONTACT: It is possible that an interested party may have a specific information need and not be able to determine from the listed information whether the issuance or regulation would fulfill that need. Consequently, we are providing information contact persons to answer general questions concerning these items. Copies are not available through the contact persons. (See Section III of this notice for how to obtain listed material.)

Questions concerning items in Addendum III may be addressed to Timothy Jennings, Office of Strategic Operations and Regulatory Affairs, Centers for Medicare & Medicaid Services, C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850, or you can call (410) 786–2134.

Questions concerning Medicare NCDs in Addendum V may be addressed to Patricia Brocato-Simons, Office of Clinical Standards and Quality, Centers for Medicare & Medicaid Services, C1–09–06, 7500 Security Boulevard, Baltimore, MD 21244–1850, or you can call (410) 786–0261.

Questions concerning FDA-approved Category B IDE numbers listed in Addendum VI may be addressed to Eileen Davidson, Office of Clinical Standards and Quality, Centers for Medicare & Medicaid Services, S3–26–10, 7500 Security Boulevard, Baltimore, MD 21244–1850, or you can call (410) 786–6874.

Questions concerning approval numbers for collections of information in Addendum VII may be addressed to Dawn Willinghan, Office of Strategic Operations and Regulatory Affairs, Regulations Development and Issuances Group, Centers for Medicare & Medicaid Services, C5–09–26, 7500 Security Boulevard, Baltimore, MD 21244–1850, or you can call (410) 786–6141.

Questions concerning all other information may be addressed to Margaret Teeters, Office of Strategic Operations and Regulatory Affairs, Regulations Development Group, Centers for Medicare & Medicaid Services, C5–13–18, 7500 Security Boulevard, Baltimore, MD 21244–1850, or you can call (410) 786–4678.

SUPPLEMENTARY INFORMATION:

I. Program Issuances

The Centers for Medicare & Medicaid Services (CMS) is responsible for administering the Medicare and Medicaid programs. These programs pay for health care and related services for 39 million Medicare beneficiaries and 35 million Medicaid recipients. Administration of the two programs involves (1) furnishing information to Medicare beneficiaries and Medicaid recipients, health care providers, and the public and (2) maintaining effective communications with regional offices, State governments, State Medicaid agencies, State survey agencies, various providers of health care, all Medicare contractors that process claims and pay bills, and others. To implement the various statutes on which the programs are based, we issue regulations under the authority granted to the Secretary of the Department of Health and Human Services under sections 1102, 1871, 1902, and related provisions of the Social Security Act (the Act). We also issue various manuals, memoranda, and statements necessary to administer the programs efficiently.

Section 1871(c)(1) of the Act requires that we publish a list of all Medicare manual instructions, interpretive rules, statements of policy, and guidelines of general applicability not issued as regulations at least every 3 months in the **Federal Register**. We published our first notice June 9, 1988 (53 FR 21730). Although we are not mandated to do so by statute, for the sake of completeness of the listing of operational and policy statements, and to foster more open and transparent collaboration, we are continuing our practice of including Medicare substantive and interpretive regulations (proposed and final) published during the respective 3-month time frame.

II. How To Use the Addenda

This notice is organized so that a reader may review the subjects of manual issuances, memoranda, substantive and interpretive regulations, NCDs, and FDA-approved IDEs published during the subject quarter to determine whether any are of particular interest. We expect this notice to be used in concert with previously