CMS is requesting OMB review and approval of these collections by March 18, 2005, with a 180-day approval period. Written comments and recommendations will be accepted from the public if received by the individuals designated below by March 17, 2005.

1. *Type of Information Collection Request:* New collection; *Title of Information Collection:* Bid Pricing Tool (BPT) for Medicare Advantage Organizations (MAOs) and Prescription Drug Plans (PDPs) and Supporting Regulations in 42 CFR 422.250, 422.252 422.254, 422.256, 422.258, 422.262, 422.264, 422.266, 422.270, 422.300, 422.304, 422.306, 422.308, 422.310, 422.312, 422.314, 422.316, 422.318, 422.320, 422.322, 422.324, 423.251, 423.258, 423.265, 423.272, 423.279, 423.286, 423.293, 423.301, 423.308, 423.315, 423.322, 423.329, 423.336, 423.343, 423.346, and 423.350; *Use:* Under the Medicare Modernization Act (MMA), Medicare Advantage Organizations (MAOs) and Prescription Drug Plans (PDPs) are required to submit an actuarial pricing bid for each plan for approval by CMS. MAOs and PDPs use the Bid Pricing Tool (BPT) software to develop their actuarial pricing bid. CMS uses the BPT to review and approve the plan pricing proposed by each organization. CMS requires that MAOs and PDPs complete the BPT as part of the annual bid process. During this process, organizations prepare their proposed actuarial bid pricing for the upcoming contract year and submit them to CMS for review and approval. The purpose of the BPT is to collect the actuarial pricing for each plan. The BPT calculates the plan's bid, enrollee premium(s), and any rebates or savings; *Form Number:* CMS–10142 (OMB#: 0938–NEW); *Frequency:* On occasion, annually, and as required by new legislation; *Affected Public:* Business or other for-profit and not-for-profit institutions; *Number of Respondents:* 350; *Total Annual Responses:* 350; *Total Annual Hours:* 12,050.

2. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Plan Benefit Package (PBP) and Formulary Submission for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDPs); *Use:* Under the Medicare Modernization Act (MMA), Medicare Advantage (MA) and Prescription Drug Plan (PDPs) organizations are required to submit plan benefit packages for all Medicare beneficiaries residing in their service area. MA and PDP organizations will generate a formulary to illustrate their preferred list of drugs, including information on prior authorization, step therapy, tiering, and quantity limits. Additionally, the PBP software will be used to describe their organization's plan benefit packages, including information on premiums, cost sharing, authorization rules, and supplemental benefits. CMS uses the formulary and PBP data to review and approve the plan benefit packages proposed by each MA and PDP organization. The formulary is a new requirement under MMA; therefore, a revision to this currently approved information collection is necessary; *Form Number:* CMS–R–262 (OMB#: 0938–0763); *Frequency:* On occasion and as required by new legislation; *Affected Public:* Business or other for-profit and not-for-profit institutions; *Number of Respondents:* 470; *Total Annual Responses:* 2,092; *Total Annual Hours:* 5,546.

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/regulations/pra* 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.

Interested persons are invited to send comments regarding the burden or any other aspect of these collections of information requirements. However, as noted above, comments on these information collection and recordkeeping requirements must be mailed and/or faxed to the designees referenced below by March 17, 2005:

CMS, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development, 7500 Security Boulevard, Room C5–14–03, Baltimore, MD 21244–1850, Attn: Melissa Musotto, CMS–10142 and CMS–R–262, Fax Number: 410–786–3064; and,

OMB Human Resources and Housing Branch, New Executive Office Building, Room 10235, Washington, DC 20503, Attention: Christopher Martin, Desk Officer, Fax Number: 202–395–6974.

Dated: February 17, 2005.

John P. Burke, III,

CMS Paperwork Reduction Act Reports Clearance Officer, Office of Strategic Operations and Regulatory Affairs, Regulations Development Group.

[FR Doc. 05–3550 Filed 2–24–05; 8:45 am]

BILLING CODE 4120–03–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1296–N]

Medicare Program; Request for Nominations to the Advisory Panel on Ambulatory Payment Classification Groups

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

ACTION: Notice.

SUMMARY: This notice invites nominations of members to the Advisory Panel on Ambulatory Payment Classification (APC) Groups (the Panel). Seven vacancies will exist on the Panel as of March 31, 2005.

The purpose of the Panel is to review the APC groups and their associated weights and to advise the Secretary of the Department of Health and Human Services (the Secretary) and the Administrator of the Centers for Medicare & Medicaid Services (CMS) (the Administrator) concerning the clinical integrity of the APC groups and their associated weights. The advice provided by the Panel will be considered as CMS prepares its annual updates of the hospital Outpatient Prospective Payment System (OPPS) through rulemaking.

The panel was recently rechartered for a 2-year period through November 21, 2006.

Nominations: Nominations will be considered if received no later than March 15, 2005 at 5 p.m. e.s.t. Mail or deliver nominations to the following address: CMS; Attn: Shirl Ackerman-Ross, Designated Federal Officer (DFO), Advisory Panel on APC Groups; Center for Medicare Management (CMM), Hospital & Ambulatory Policy Group (HAPG), Division of Outpatient Care (DOC); 7500 Security Boulevard, Mail Stop C4–05–17; Baltimore, MD 21244–1850.

Web Site: For additional information on the APC Panel and updates to the Panel's activities, search our Web site at: *http://www.cms.hhs.gov/faca/apc/default.asp.*

Advisory Committees' Information Lines: You may also refer to the CMS Advisory Committee Information Hotlines at 1–877–449–5659 (toll-free) or 410–786–9379 (local) for additional information.

FOR FURTHER INFORMATION CONTACT: Persons wishing to nominate individuals to serve on the Panel or to obtain further information can also

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