Atlanta, GA 30341, Telephone: 770–488–1515, E-mail: *Swynn@cdc.gov.*

VIII. Other Information

Applicants can find this and other HHS funding opportunity announcements on the HHS/CDC Web site, Internet address: *www.cdc.gov* (Click on ''Funding'' then ''Grants and Cooperative Agreements''), and on the web site of the HHS Office of Global Health Affairs, Internet address: *www.globalhealth.gov.*

Dated: August 22, 2005.

William P. Nichols,

Director, Procurement and Grants Office, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services.

[FR Doc. 05–16990 Filed 8–25–05; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10166]

Agency Information Collection Activities: Submission for OMB Review; Comment Request

AGENCY: Centers for Medicare & Medicaid Services, HHS.

In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services, is publishing the following summary of proposed collections for public comment. Interested persons are invited to send comments regarding this burden estimate or any other aspect of this collection of information, including any of the following subjects: (1) The necessity and utility of the proposed information collection for the proper performance of the Agency's function; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

1. *Type of Information Collection Request:* New Collection; Title of Information Collection: Payment Error Rate Measurement in Medicaid and State Children's Health Insurance Program (SCHIP); Form No.: CMS–10166 (OMB # 0938–NEW); Use: The information collected will be used by CMS for, among other purposes, estimating improper payments in Medicaid and SCHIP as required by the Improper Payments Information Act (IPIA) of 2002. To implement the IPIA in Medicaid and SCHIP, CMS will use a national contracting strategy to produce Medicaid and SCHIP error rates. CMS plans to adopt this approach based on a recommendation that CMS hire a Federal contractor to perform payment error rate measurement. This recommendation was made during public comment on the proposed rule entitled ''Medicaid Program and State Children's Health Insurance Program (SCHIP): Payment Error Rate Measurement'' which published on August 27, 2004 (69 FR 52620), that contained provisions for all states to produce error rates in Medicaid and SCHIP.

The new error measurement methodology will rely on a Federal contractor to conduct medical and data processing reviews using generally the same methodologies developed during the past pilot projects and produce State-specific and national Medicaid and SCHIP error rates based on reviews conducted each Federal fiscal year (FY). We expect to begin measuring improper payments made in Medicaid fee-for-service in FY 2006. We have not yet determined the best method to measure improper payments made in Medicaid and SCHIP managed care. However, under the national contracting strategy, we expect the Federal contractor will implement these reviews and States will submit the same information listed below except for medical policies. (Managed care claims are not subject to medical reviews so there is no burden to providers to submit medical records.) Similarly, we are considering the best approach to measure improper payments based on eligibility errors within the confines of current law and with minimal budgetary impact. It is possible that States will be required to conduct at least part of the eligibility tests. However, this notice is not intended to address the cost or burden estimates associated with either the managed care or eligibility reviews in Medicaid or SCHIP.

Initially, based on States' annual medical expenditures from the previous year, the Federal contractor will group all States into three equal strata of small, medium and large and select a random sample of an estimated 18 States to be reviewed for each program. (However, CMS may revise its sampling methodology in the future and may use a methodology to select States that will ensure each State is selected at least every three years but that no State is sampled more than once every three years. The error rates produced by this selection methodology will provide the State with a State-specific error rate estimated to be within 3% precision at the 95% confidence level.) The States selected for review would submit to the Federal contractor, annual expenditures, quarterly stratified claims data, medical policies (which include State statutes, regulations, individual Medicaid Provider Manual and Administrative Directives as well as other information that the contractor may need to determine errors in the medical reviews), and other information so that the contractor can determine the specific State sample sizes and conduct medical and data processing reviews on the sampled claims. In addition, the contractor will request medical records from providers whose claims were sampled; the medical records are needed to support the medical reviews. CMS is not requiring States and providers to use a specific form, *e.g.*, facsimile, or electronic to transmit the information. Based on the reviews, the contractor will calculate State-specific error rates which will serve as the basis for calculating national Medicaid and SCHIP error rates. Each State reviewed also will submit a corrective action plan to CMS that outlines its plans to develop, implement and monitor corrective actions designed to address error causes for purposes of reducing the State's error rate. *Frequency:* Reporting—On occasion and quarterly; *Affected Public:* State, Local or Tribal Government; *Number of Respondents:* 36; *Total Annual Responses:* 5076; *Total Annual Hours:* 58,680.

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.

Written comments and recommendations for the proposed information collections must be mailed within 30 days of this notice directly to the OMB desk officer: OMB Human Resources and Housing Branch, Attention: Katherine Astrich, New Executive Office Building, Room 10235, Washington, DC 20503.

Dated: August 24, 2005.

Michelle Shortt,

Director, Regulations Development Group, Office of Strategic Operations and Regulatory Affairs.

[FR Doc. 05–17100 Filed 8–25–05; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1486–N]

Medicare Program; Announcement of New Members of the Advisory Panel on Ambulatory Payment Classification (APC) Groups

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

ACTION: Notice.

SUMMARY: The purpose of the Advisory Panel on Ambulatory Payment Classification (APC) Groups (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 (HHS) and the Administrator of the Centers for Medicare and Medicaid Services (CMS) 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. This notice announces the new members selected to serve on the Panel.

FOR FURTHER INFORMATION CONTACT: For inquiries about the Panel, please contact the Designated Federal Officer (DFO): Shirl Ackerman-Ross, DFO, CMS, CMM, HAPG, DOC, 7500 Security Boulevard, Mail Stop C4–05–17, Baltimore, MD 21244–1850. Phone (410) 786–4474.

E-mail Address for comments is: *APCPanel@cms.hhs.gov.* News media representatives must contact our Public Affairs Office at (202) 690–6145.

Advisory Committees' Information Lines: The CMS Advisory Committees' Information Line is 1–877–449–5659 (toll free) and (410) 786–9379 (local).

Web Sites: For additional information on APC meeting agendas and updates to the Panel's activities, search our Web site at: *http://www.cms.hhs.gov/faca/apc/default.asp.* To obtain Charter copies, search our Web site at *http://www.cms.hhs.gov/faca* or e-mail the Panel DFO.

SUPPLEMENTARY INFORMATION:

I. Background

The Secretary of the Department of Health and Human Services (HHS) (the Secretary) is required by section 1833(t)(9)(A) of the Social Security 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 (Pub. L. 106–113), respectively, to establish and consult with an expert, outside advisory panel on APC groups. The APC Panel meets up to three times annually to review the APC groups and to provide technical advice to the Secretary and the Administrator of the Centers for Medicare and Medicaid Services (CMS) (the Administrator) concerning the clinical integrity of the groups and their associated weights. All members must have technical expertise that will enable them to participate fully in the work of the Panel. The expertise encompasses hospital payment systems, hospital medical-care delivery systems, outpatient payment requirements, APCs, 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 that any one member be an expert in all areas.

We will consider the technical advice provided by the Panel as we prepare the final rule that updates the OPPS payment rates for the next calendar year. The Secretary re-chartered the Panel on November 1, 2004.

II. Announcement of New Members

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

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.

The Panel presently consists of the following members and a Chair:

- Edith Hambrick, M.D., J.D., Chair.
- Marilyn Bedell, M.S., R.N., O.C.N.
- Albert Brooks Einstein, Jr., M.D.
- Sandra J. Metzler, M.B.A., R.H.I.A., C.P.H.Q.
- Frank G. Opelka, M.D., F.A.C.S.
- Louis Potters, M.D., F.A.C.R.
- Lou Ann Schraffenberger, M.B.A., R.H.I.A., C.C.S.-P.
- Judie S. Snipes, R.N., M.B.A., F.A.C.H.E.
- Lynn R. Tomascik, R.N., M.S.N., C.N.A.A.
- Timothy Gene Tyler, Pharm.D.

On February 25, 2005, we published a notice in the **Federal Register** (70 FR 9336) requesting nominations to the Panel to replace the six Panel members whose terms expired on March 31, 2005. In order to obtain additional nominees whose expertise matched the needs of the Panel, we published a second notice in the **Federal Register** on April 8, 2005 (70 FR 18028) extending the deadline. As a result of these two notices, the six new 4-year appointments to the APC Panel effective August 17, 2005, and ending August 16, 2009, are as follows:

- Gloryanne Bryant, B.S., R.H.I.A., R.H.I.T., C.C.S.
- Hazel Kimmel, R.N., C.C.S., C.P.C.
- Thomas M. Munger, M.D., F.A.C.C.
- James V. Rawson, M.D.
- Kim Allan Williams, M.D., F.A.C.C., F.A.B.C.
- Robert Matthew Zwolak, M.D., Ph.D., F.A.C.S.

Authority: Section 1833(t) of the Act (42 U.S.C. 1395l(t)). 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: August 9, 2005.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 05–16798 Filed 8–25–05; 8:45 am]

BILLING CODE 4120–03–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–2209–N]

RIN 0938–AJ74

Medicaid Program; Fiscal Year Disproportionate Share Hospital Allotments and Disproportionate Share Hospital Institutions for Mental Disease Limits

AGENCY: Notice.

SUMMARY: This notice announces the final Federal share disproportionate share hospital (DSH) allotments for Federal fiscal years (FFYs) 2003 and