REAL CHOICE SYSTEMS CHANGE GRANTS FOR COMMUNITY LIVING—FY 2003—Continued

Grant opportunity	Application deadline	Who may apply? [1]	Max. number of grant awards per State per type of grant	Maximum award	Anticipated average award	Maximum projected period	Percent allowable for direct services [2]	Estimated number of awards
10. Family-to-Family Health Care Information and Education Centers (CFDA 93.779).	July 29, 2003.	Any Nonprofit Organization [5].	1	150,000	145,000	36 mos	0	6–10

[1] The Single State Medicaid Agency or any other agency or instrumentality of a state (as determined under state law) may apply for any grant opportunity except the Technical Assistance for Consumer Task Forces Grant. By ''State'' we refer to the definition provided under 45 CFR 74.2 as ''any of the several States of the United States, the District of Columbia, the Commonwealth of Puerto Rico, any territory or possession of the United States, or any agency or instrumentality of a State exclusive of local governments.'' ''Territory or possession'' is defined as Guam, the United States Virgin Islands, American Samoa, and the Commonwealth of the Northern Mariana Islands. If an application is from an applicant that is not the Single State Medicaid Agency, a letter of endorsement from the Governor, State Medicaid Director, or Agency administering a relevant section of the 1915(c) home and community-based waiver must accompany the application; this requirement does not apply to applicants for the National State-to-State Technical Assistance Program for Community Living, the Technical Assistance for Consumer Task Forces Grants, or the Family-to-Family Health Care Information and Education Centers Grants.

[2] Direct Services do not include expenses budgeted for consumer task force member participation in Real Choice Systems Change for Community Living Conferences or technical assistance conferences sponsored by CMS or its national technical assistance providers for purposes of Real Choice Systems Change Grants for Community Living.

[3] For the Community-Integrated Personal Assistance Services and Supports Grants (C–PASS), states that received a C–PASS grant in FY 2001 or FY 2002 are ineligible to apply for FY 2003 C–PASS funding. FY 2001 C–PASS Grantees are: Alaska, Arkansas, Guam, Michigan, Minnesota, Montana, Nevada, New Hampshire, Oklahoma, and Rhode Island. FY 2002 C–PASS Grantees are: Colorado, District of Columbia, Hawaii, Indiana, Kansas, North Carolina, Tennessee, and West Virginia. Only states that did not receive a C–PASS grant in either FY 2001 or FY 2002 are eligible to apply.

[4] Consumer-controlled organization means an organization that is governed by individuals who have a disability or long-term illness. Individuals of any age, who rely upon long-term supports and services as a result of a disability or long-term illness, must represent more than half of such organization's Board of Directors or other controlling structure.

[5] Applicants for this type of grant must also have a letter of endorsement from the State Medicaid Director or the Governor or. In addition, states that currently operate Family-to-Family Family Health Care Information and Education Centers (funded through the Health Resources and Services Administration) are ineligible for funding under this initiative. Information and Education Centers application.

[FR Doc. 03–13582 Filed 5–27–03; 3:27 pm]

BILLING CODE 4120–03–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare and Medicaid Services

[Document Identifier: CMS–R–131]

Agency Information Collection Activities: Proposed Collection; Expedited Review and Clearance; Comment Request

AGENCY: Centers for Medicare and 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 and Medicaid Services (CMS) (formerly known as the Health Care Financing Administration (HCFA)), 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 functions; (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.

We are, however, requesting an expedited review of the information collection referenced below. In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, we are abbreviating the normal comment period of 60 days for the first notice to 30 days. We are requesting an expedited review because the collection of this information is needed before the expiration of the normal time limits under OMB's regulations at 5 CFR Part 1320. We cannot reasonably comply with the normal clearance procedures because to do so could have serious consequences for Medicare beneficiaries, health care providers, Medicare contractors and software vendors.

CMS is requesting OMB's expedited review and approval of this collection. Written comments and recommendations will be accepted from the public if received by the individual designated below by June 30, 2003. During this 180-day period, we will publish a separate **Federal Register** notice announcing the initiation of an extensive 60-day agency review and public comment period on these requirements. We will submit the requirements for OMB review and an extension of this emergency approval. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Advance Beneficiary Notice; *Form No.:* CMS–R–131 (OMB# 0938–0566); *Use:* Physicians, practitioners, suppliers, and providers furnishing Part A or Part B items or services may bill a patient for items or services denied by Medicare as not reasonable and necessary if they informed the patient, before furnishing the item or service, that Medicare was likely to deny payment for the items or services and the patient, after being informed, agreed to pay for the items or services; *Frequency:* On occasion; *Affected Public:* Businesses or other for-profit, Individuals or households, Not-for-profit institutions; *Number of Respondents:* 1,028,585; *Total Annual Responses:* 19,660,110; *Total Annual Hours:* 1,686,285.

We have submitted a copy of this notice to OMB for its review of these information collections. A notice will be published in the **Federal Register** when approval is obtained.

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.hcfa.gov/regs/prdact95.htm,* or e-mail your request, including your address, phone number, OMB number, and CMS document identifier, to *Paperwork@hcfa.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 June 30, 2003.

CMS, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development and Issuances, Attention: Melissa Musotto, Room: C5–14–03, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

Dated: May 12, 2003.

Julie Brown,

CMS Reports Clearance Officer, Division of Regulations Development and Issuances, Office of Strategic Operations and Strategic Affairs.

[FR Doc. 03–13664 Filed 5–28–03; 11:17 am]

BILLING CODE 4120–03–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–3116–N]

Medicare Program; Request for Nominations for Members for the Medicare Coverage Advisory Committee

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

ACTION: Notice.

SUMMARY: This notice requests nominations for consideration for membership on the Medicare Coverage Advisory Committee.

DATES: Nominations will be considered if received at the designated address, as provided below, no later than 5 p.m. on June 30, 2003.

ADDRESSES: You may mail nominations for membership to the following address: Centers for Medicare & Medicaid Services, Office of Clinical Standards and Quality, Attention: Michelle Atkinson, 7500 Security Blvd., Mail Stop: Central Building 1–09–06, Baltimore, MD 21244.

A copy of the Secretary's Charter for the Medicare Coverage Advisory Committee (MCAC) can be obtained from Maria Ellis, Office of Clinical Standards and Quality, Centers for Medicare & Medicaid Services, 7500 Security Blvd., Mail Stop: Central Building 1–09–06, Baltimore, MD 21244, or by e-mail to *mellis@cms.hhs.gov*. The charter is also posted on the Web at *http://www.cms.hhs.gov/mcac/default.asp*.

FOR FURTHER INFORMATION CONTACT: Michelle Atkinson, Centers for Medicare & Medicaid Services, Office of Clinical Standards and Quality, 7500 Security Blvd., Baltimore, MD 21244, 410–786–2881.

SUPPLEMENTARY INFORMATION:

Background

On December 14, 1998, we published a notice in the **Federal Register** (63 FR 68780) announcing establishment of the Medicare Coverage Advisory Committee (MCAC). The Secretary signed the initial charter for the MCAC on November 24, 1998. The charter has been renewed by the Secretary and will terminate on November 24, 2004, unless renewed again by the Secretary.

The Medicare Coverage Advisory Committee is governed by provisions of the Federal Advisory Committee Act, Public Law 92–463, as amended (5 U.S.C. App. 2), which sets forth standards for the formulation and use of advisory committees, and authorized by section 222 of the Public Health Service Act as amended (42 U.S.C. 217A).

The MCAC consists of a pool of 100 appointed members. Members are selected from among authorities in clinical medicine of all specialties, administrative medicine, public health, epidemiology and biostatistics, methodology of trial design, biologic and physical sciences, health care data and information management and analysis, the economics of health care, medical ethics, and other related professions. A maximum of 88 members are standard voting members, 12 are nonvoting members, 6 of which are representatives of consumer interests, and 6 of which are representatives of industry interests.

The MCAC functions on a committee basis. The committee reviews and evaluates medical literature, reviews technology assessments, and examines data and information on the effectiveness and appropriateness of medical items and services that are covered or eligible for coverage under Medicare. The Committee works from an agenda provided by the Designed Federal Official that lists specific issues, and develops technical advice to assist us in determining reasonable and necessary applications of medical services and technology when we make national coverage decisions for Medicare.

A few vacancies exist on the current MCAC roster, and terms for some members currently serving will expire in 2003. Accordingly, we are requesting nominations for both voting and nonvoting members to serve on the MCAC. Nominees are selected based upon their individual qualifications and not as representatives of professional associations or societies. We have a special interest in ensuring that women, minority groups, and physically challenged individuals are adequately represented on the MCAC. Therefore, we encourage nominations of qualified candidates from these groups.

All nominations must be accompanied by a curricula vitae. Nomination packages should be sent to Michelle Atkinson at the address above.

Criteria for Members

Nominees must have expertise and experience in one or more of the following fields: clinical medicine of all specialties, administrative medicine, public health, epidemiology and biostatistics, methodology of trial design, biologic and physical sciences, health care data and information management and analysis, the economics of health care, medical ethics, and other related professions.

We are also seeking nominations for nonvoting consumer and industry representatives. Nominees for these positions must possess appropriate qualifications to understand and contribute to the MCAC's work.

Nominations must state that the nominee is willing to serve as a member of the MCAC and appears to have no conflict of interest that would preclude membership. It would be very helpful if all curricula vitae included the following: date of birth, place of birth, social security number, title and current position, professional affiliation, home and business address, telephone and fax numbers, e-mail address, and list of expertise. In the nominations letter specify whether applying for voting member, industry representative, or consumer representative. Potential candidates will be asked to provide detailed information concerning such matters as financial holdings, consultancies, and research grants or contracts in order to permit evaluation of possible sources of conflict of interest.

Members are invited to serve for overlapping 4-year terms; terms of more than 2 years are contingent upon the renewal of the MCAC by appropriate action before its termination on November 24, 2004. A member may serve after the expiration of the member's term until a successor has taken office. Any interested person may nominate one or more qualified persons. Self-nominations are also accepted.

Authority: 5 U.S.C. App. 2, section 10(a)(1) and (a)(2).

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