TO: Heads of Federal Agencies

SUBJECT: Relocation Allowances—Standard Mileage Rate for Moving Purposes

1. **What is the purpose of this bulletin?** This bulletin informs agencies that on June 23, 2008, the IRS announced an eight cent increase in the Standard Mileage Rate for moving purposes from 19 cents to 27 cents per mile. This new Standard Mileage Rate for moving purposes is effective July 1, 2008, through December 31, 2008, and applies to relocations undertaken by Federal employees during this time period.

2. **What is the background of this bulletin?** On December 11, 2007, GSA published FTR Amendment 2007–06 in the **Federal Register** (72 FR 70234) specifying that the IRS Standard Mileage Rate for moving purposes would be the rate at which agencies will reimburse an employee for using a privately owned vehicle (POV) for relocation worldwide. The amendment indicated that the change to the IRS Standard Mileage Rate for moving purposes applied to relocations on and after September 25, 2007, and that GSA would publish a bulletin announcing any changes to that rate made by the IRS thereafter.

3. **Who should I call for further information?** For further information, contact Mr. Ed Davis, Office of Governmentwide Policy (M), Office of Travel, Transportation, and Asset Management (MT), General Services Administration at (202) 208–7638 or via e-mail at *ed.davis@gsa.gov*.

By delegation of the Administrator of General Services,

Kevin Messner,

Acting Associate Administrator, Office of Governmentwide Policy.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10166, CMS–10182, and CMS–846–849, 854, 10125, 10126, and 10269]

Agency Information Collection Activities: Proposed Collection; Comment Request

AGENCY: Centers for Medicare & Medicaid Services.

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) 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.

1. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Payment Error Rate Measurement in Medicaid and the State Children's Health Insurance Program (SCHIP); *Use:* The Improper Payments Information Act (IPIA) of 2002 requires CMS to produce national error rates for Medicaid and State Children's Health Insurance Program (SCHIP). To comply with the IPIA, CMS will engage a Federal contractor to produce the error rates in Medicaid and SCHIP.

The states will be requested to submit, at their option, test data which include full claims details to the contractor prior to the quarterly submissions to detect potential problems in the dataset to and ensure the quality of the data. These states will be required to submit quarterly claims data to the contractor who will pull a statistically valid random sample, each quarter, by strata, so that medical and data processing reviews can be performed. State-specific error rates will be based on these review results.

CMS needs to collect the claims data, medical policies, and other information from states as well as medical records from providers in order for the contractor to sample and review adjudicated claims in those states selected for review. Based on the reviews, state-specific error rates will be calculated which will serve as the basis for calculating national Medicaid and SCHIP error rates.

This revision of the currently approved collection contains minor revisions to the information collection requirements. There is a 10-hour increase in burden per state per program as part of a new process. Based on the past experience in PERM operation, the adjustment is made to ensure the quality of the data will comply with the data requirement during the measurement. *Form Number:* CMS–10166 (OMB# 0938–0974); *Frequency:* Quarterly, Yearly; *Affected Public:* State, Local or Tribal Governments; *Number of Respondents:* 34; *Total Annual Responses:* 4,080; *Total Annual Hours:* 28,560.

2. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Model Creditable Coverage Disclosure Notices; *Use:* Section 1860D–1 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) and implementing regulations at 42 CFR 423.56 require that entities that offer prescription drug benefits under any of the types of coverage described in 42 CFR 423.56(b) provide a disclosure of creditable coverage status to all Medicare Part D eligible individuals covered under the entity's plan informing them whether such coverage meets the actuarial requirements specified in guidelines provided by CMS.

These disclosure notices must be provided to Part D eligible individuals, at minimum, at the following times: (1) Prior to an individual's initial enrollment period for Part D, as described under § 423.38(a); (2) prior to the effective date of enrollment in the entity's coverage, and upon any change in creditable status; (3) prior to the commencement of the Part D Annual Coordinated Election Period (ACEP) which begins on November 15 of each year, as defined in § 423.38(b); and (4) upon request by the individual. In an effort to reduce the burden associated with providing these notices, our final regulations allow most entities to provide notices of creditable and non-creditable status with other information materials that these entities distribute to beneficiaries.

This collection has been updated by eliminating the separate Model Personalized Disclosure Notice. CMS has incorporated the personalized information into the Model Creditable Disclosure Notice and the Model Non-Creditable Disclosure Notice for use by the public. *Form Number:* CMS–10182 (OMB# 0938–0990); *Frequency:* Yearly and Semi-annually; *Affected Public:* Federal Government, Business or Other For-Profits and Not-for-Profit Institutions, and State, Local or Tribal Governments; *Number of Respondents:* 1,225,173; *Total Annual Responses:* 1,225,173; *Total Annual Hours:* 522,204.

3. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Durable Medical

Equipment Medicare Administrative Contractors (MAC), Certificates of Medical Necessity; *Use:* The certificate of medical necessity (CMN) collects information required to help determine the medical necessity of certain items. CMS requires CMNs where there may be a vulnerability to the Medicare program. Each initial claim for these items must have an associated CMN for the beneficiary. Suppliers (those who bill for the items) complete the administrative information (*e.g.*, patient's name and address, items ordered, etc.) on each CMN. The 1994 Amendments to the Social Security Act require that the supplier also provide a narrative description of the items ordered and all related accessories, their charge for each of these items, and the Medicare fee schedule allowance (where applicable). The supplier then sends the CMN to the treating physician or other clinicians (*e.g.*, physician assistant, LPN, etc.) who completes questions pertaining to the beneficiary's medical condition and signs the CMN. The physician or other clinician returns the CMN to the supplier who has the option to maintain a copy and then submits the CMN (paper or electronic) to CMS, along with a claim for reimbursement. *Form Number:* CMS–846–849, 854, 10125, 10126, 10269 (OMB# 0938–0679); *Frequency:* Occasionally; *Affected Public:* Business or other for-profit and Not-for-profit institutions; *Number of Respondents:* 59,200; *Total Annual Responses:* 6,480,000; *Total Annual Hours:* 1,296,000.

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access CMS' Web Site at *http://www.cms.hhs.gov/PaperworkReductionActof1995*, 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.

In commenting on the proposed information collections please reference the document identifier or OMB control number. To be assured consideration, comments and recommendations must be submitted in one of the following ways by *September 23, 2008:*

1. *Electronically.* You may submit your comments electronically to *http://www.regulations.gov*. Follow the instructions for ''Comment or Submission'' or ''More Search Options'' to find the information collection document(s) accepting comments.

2. *By regular mail.* You may mail written comments to the following address: CMS, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development, Attention: Document Identifier/OMB Control Number _____, Room C4–26–05, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

Dated: July 18, 2008.

Michelle Shortt,

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

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1396–N]

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

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (DHHS).

ACTION: Notice.

SUMMARY: This notice announces three new members selected to serve on the Advisory Panel on Ambulatory Payment Classification (APC) Groups (the Panel). The purpose of the Panel is to review the APC groups and their associated weights and to advise the Secretary, DHHS (the Secretary), and the Administrator, CMS (the Administrator), concerning the clinical integrity of the APC groups and their associated weights. We will consider the Panel's advice as we prepare the annual updates of the hospital outpatient prospective payment system (OPPS).

FOR FURTHER INFORMATION CONTACT: For inquiries about the Panel, please contact the Designated Federal Official (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.

APC Panel E-Mail Address: The E-mail address for the Panel is as follows: *CMS APCPanel@cms.hhs.gov.*

Note: There is NO underscore in this e-mail address; there is a SPACE between CMS and APCPanel.

News Media Contact: News media representatives must contact our Public Affairs Office at (202) 690–6145.

CMS Advisory Committees Hotlines: The CMS Federal Advisory Committee Hotline is 1–877–449–5659 (toll free) and (410) 786–9379 (local) for additional Panel information.

Web Sites: For additional information regarding the APC Panel membership, meetings, agendas, and updates to the Panel's activities, please search our Web site at the following Uniform Resource Locator (URL): *http://www.cms.hhs.gov/FACA/05_AdvisoryPanelonAmbulatoryPaymentClassificationGroups.asp#TopOfPage*.

Note: There is an underscore after FACA/05 (like this _); there is no space.

The public may also access the following URL for the Federal Advisory Committee Act Web site to obtain APC Panel information: *https://www.fido.gov/facadatabase/logon.asp*. A copy of the Panel's Charter and other pertinent information are on both Web sites mentioned above. You may also e-mail the Panel DFO at the above e-mail address for a copy of the Charter.

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), to consult with an expert outside advisory Panel regarding the clinical integrity of the APC groups and relative payment weights that are components of the Medicare hospital OPPS.

The APC Panel meets up to three times annually. The Charter requires that the Panel must be fairly balanced in its membership in terms of the points of view represented and the functions to be performed. The Panel consists of up to 15 members, who are representatives of providers, and a Chair. Each Panel member must be employed full-time by a hospital, hospital system, or other Medicare provider subject to payment under the OPPS. The Secretary or Administrator selects the Panel membership based upon either self-nominations or nominations submitted by Medicare providers and other interested organizations. All members must have technical expertise to enable them to participate fully in the work of the Panel. This expertise encompasses hospital payment systems; hospital medical-care delivery systems; provider billing systems; APC groups, Current Procedural Terminology codes, and alpha-numeric Healthcare Common Procedure Coding System codes; and the use and payment of drugs and medical devices in the outpatient setting, as well as other forms of relevant expertise.

The Charter requires that all members have a minimum of 5 years experience