Advisory Committees' Information Lines: Information Hotlines at 1–877–449–5659 (toll-free) or 410–786–9379 (local) for additional information.

FOR FURTHER INFORMATION CONTACT: Shirl Ackerman-Ross, at *SAckermanross@cms.hhs.gov* or call her on (410) 786–4474. News media representatives should contact the CMS Press Office, (202) 690–6145.

SUPPLEMENTARY INFORMATION:

I. Background

The Secretary of Health and Human Services (the Secretary) is required by section 1833(t)(9)(A) of the Social Security Act (the Act), as amended by section 201(h)(1)(B) and redesignated by section 202 (a)(2) of the Balanced Budget Refinement Act of 1999 (Pub. L. 106–113), to consult with an advisory panel on APC groups (the Panel). The Panel will meet up to three times annually to review the APC groups and provide technical advice to the Secretary and the Administrator of the Centers for Medicare & Medicaid Services (the Administrator) concerning the clinical integrity of the groups and their associated weights. The groups and their weights are major elements of the hospital outpatient prospective payment system (OPPS). The technical advice provided by the Panel will be considered as we prepare the annual Notice of Proposed Rulemaking that will propose changes to the OPPS for the next calendar year.

The current members of the Panel are: Michelle Burke, R.N.; Leslie Jane Collins, R.N.; Geneva Craig, R.N.; Lora A. DeWald, M.ED; Gretchen M. Evans, R.N.; Robert E. Henkin, M.D.; Lee H. Hilborne, M.D.; Stephen T. House, M.D.; Kathleen P. Kinslow, CRNA, Ed.D; Mike Metro, R.N.; Gerald V. Naccarelli, M.D; Beverly K. Philip, M.D.; Karen L. Rutledge, B.S.; William A. Van Decker, M.D., J.D., and Paul E. Wallner, D.O. The Panel Chairperson is Paul M. Rudolf, M.D, J.D., a CMS Medical officer.

The charter allows for up to 15 members plus a Chair, and we will have 6 openings as of March 31, 2003. Therefore, we are requesting nominations for members to serve on the Panel. Panel members serve without compensation, pursuant to advance written agreement; however, travel, meals, lodging, and related expenses will be reimbursed in accordance with standard government travel regulations. We have a special interest for ensuring that women, minorities, and the physically challenged are adequately represented on the Panel, and we encourage nominations of qualified candidates from those groups.

The Secretary, or his designee, will appoint new members to the Panel from among those candidates determined to have the required expertise; new appointments will be done in a manner that will ensure an appropriate balance of membership.

II. Criteria for Nominees

Qualified nominees will meet those requirements necessary to be a Panel member. Panel members must be representatives of Medicare providers (including Community Mental Health Centers) subject to the OPPS, with technical and/or clinical expertise in any of the following areas:

- Hospital payment systems.
- Hospital medical care delivery systems.
- Outpatient payment requirements.
- Ambulatory payment classification groups.
- Use of, and payment for, drugs and medical devices in an outpatient setting.
- Provision of, and payment for, partial hospitalization services.
- Any other relevant expertise.

It is not necessary that any nominee 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 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, a 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

You may obtain a copy of the charter for the Panel by submitting a request to Shirl Ackermann-Ross, CMS, CMM, HAPG, DOC, 7500 Security Boulevard, Mail Stop C4–05–17, Baltimore, MD 21244, (410) 786–4474, or e-mail the request to *SAckermanross@cms.hhs.gov*. A copy of the charter is also available on the Internet at *http://www.cms.hhs.gov/faca.*

Authority: Section 1833(t)(9)(A) of the Social Security Act (42 U.S.C. 13951(t)(9)(A)) and section 10(a) of Pub. L. 92–463 (5 U.S.C. App. 2).

Dated: February 25, 2003.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 03–4804 Filed 2–27–03; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare and Medicaid Services

[CMS–2165–N]

Medicaid Program; Infrastructure Grant Program To Support the Competitive Employment of People With Disabilities

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

ACTION: Notice.

SUMMARY: This notice announces the availability of funding, through grants, for eligible States under section 203 of the Ticket to Work and Work Incentives Improvement Act of 1999 (TWIIA). The grant program is designed to assist States in developing infrastructures to support the competitive employment of people with disabilities by extending necessary Medicaid coverage to these individuals. This notice also contains pertinent information where States may apply for the grant program.

A total of $35 million has been appropriated by the legislation for the infrastructure grant program for fiscal year 2004. In addition, amounts that were appropriated under section 203 of TWWIIA for previous fiscal years but which were not awarded to States are available for these awards in 2004.

We expect to award approximately 50 grants. This includes new as well as continuation grants. Award amounts will be between $500,000 and $1.5 million. There is no State match or cost sharing associated with this grant solicitation. Criteria for evaluating these applications will be listed in the grant solicitation (Web site address listed below).

Who May Apply: State Agencies.

DATES: *Deadline for Letter of Intent to Apply:* States are encouraged to submit a notice of intent to apply for a grant no later than May 2, 2003. Submission of your letter of intent is optional and will not affect the approval of your application.

Date of Applicant's Teleconference: States interested in participating in a teleconference regarding this grant solicitation should check the Ticket to Work Web site listed below for the date and time.

Deadline for Grant Submission: Grant applications must be submitted by July 15, 2003 to be considered under the 2004 annual funding cycle. Applications for these grants are not subject to review under Executive Order 12372—Intergovernmental Review by Federal Agencies (45 CFR part 100).

ADDRESSES: *Application Materials:* Standard application forms and related instructions are available from the Web site, *www.cms.hhs.gov/researchers/priorities/grants.asp* or from Judith Norris, Centers for Medicare & Medicaid Services, Office of Internal Customer Support, Acquisition and Grants Group, C2–21–15 Central Building, 7500 Security Boulevard, Baltimore, MD 21244–1850, (410) 786–5130, e-mail: *Jnorris1@cms.hhs.gov*. Application materials must be formally submitted to Judith Norris.

Please note: State agencies are only required to submit an original application and two copies.

Web site: You may access up-to-date information about the Medicaid Infrastructure Grants and obtain information from the full grant solicitation grant at: *http://www.cms.hhs.gov/twwiia*.

FOR FURTHER INFORMATION CONTACT: Questions about the grants may be directed to: Joe Razes, TWWIIA Program Manager, Disabled and Elderly Health Programs Group, Center for Medicaid and State Operations, Centers for Medicare & Medicaid Services, Room S2–14–26, 7500 Security Boulevard, Baltimore, MD 21244–1850, (410) 786–6126, e-mail: *Jrazes@cms.hhs.gov*.

SUPPLEMENTARY INFORMATION: This notice is the fourth such notice announcing the availability of funds for Medicaid infrastructure grants authorized by the Ticket to Work and Work Incentives Improvement Act. A total of 38 States currently have been awarded Medicaid infrastructure grants under the Ticket to Work legislation that provides Federal grant funding for 11 years through 2011. This notice is consistent with the three previous notices in soliciting States to apply for grants that will expand services and supports for workers with disabling conditions. States that wish to apply for these grants and desire further detailed information, such as application requirements, review procedures, an explanation of a timely submission, necessary forms, and other relevant information, should refer to the above listed Web sites.

Approval for Collection of Information: The collection of information requested in the application for grants funding has been approved by the Office of Management and Budget under the approval number 0938–0811. The current approval expires on November 30, 2003.

Authority: Section 203 of the Ticket to Work and Work Incentives Improvement Act of 1999, Pub. L. 106–170. (Catalog of Federal Domestic Assistance Program No. 93.768, Centers for Medicare and Medicaid Services Research, Demonstration, and Evaluations)

Dated: December 23, 2002.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 03–4733 Filed 2–27–03; 8:45am]

BILLING CODE: 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–5002–N]

RIN 0938–ZA39

Medicare Program; Demonstration: Capitated Disease Management for Beneficiaries With Chronic Illnesses

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

ACTION: Notice.

SUMMARY: This notice informs interested parties of an opportunity to apply for a cooperative agreement to participate in a Capitated Disease Management Demonstration. This demonstration uses disease management interventions and payment for services based on full capitation (with risk sharing options) to (1) improve the quality of services furnished to specific eligible beneficiaries, including dual eligibles and the frail elderly, and (2) manage expenditures under Parts A and B of the Medicare program. We are interested in testing models aimed at beneficiaries who have one or more chronic conditions that are related to high costs to the Medicare program, such as stroke, congestive heart failure, or diabetes. We intend to use a competitive application process to select organizations to participate in this demonstration.

DATES: Applications will be considered timely if we receive them on or before May 29, 2003.

ADDRESSES: Mail applications to: Department of Health and Human Services, Centers for Medicare & Medicaid Services, Office of Research Development and Information, Demonstration Program staff, Attn: Raymond Wedgeworth, Mail Stop: C4–17–27, 7500 Security Boulevard, Baltimore, Maryland 21244. Applications must be typed for clarity and should not exceed 40 double-spaced pages, exclusive of the executive summary, resumes, forms, and documentation supporting the cost proposal. Because of staffing and resource limitations, we cannot accept applications by facsimile (FAX) transmission. Applications postmarked after the closing date, or postmarked on or before the closing date but not received in time for panel review, will be considered late applications.

FOR FURTHER INFORMATION CONTACT: For information concerning this demonstration, contact Raymond Wedgeworth, CMS Project Officer, at (410) 786–6676, or *rwedgeworth@cms.hhs.gov.*

SUPPLEMENTARY INFORMATION:

Eligible Organizations

Potentially qualified applicants are provider sponsored organizations, academic medical centers, Medicare+Choice organizations, or disease management companies, who can demonstrate ability to effectively supply disease management services applicable to the Medicare population, which may include dual eligibles and frail elderly, specific to select chronic conditions.

Administrator Initiative

The clearest statement of the Administration's priorities for Medicare is found in the White House document, ''21st Century Medicare,'' issued on July 12, 2001. In that document, the Administration made a series of proposals for modernizing Medicare benefits so that they would better meet the needs of its beneficiaries. One of the important proposals in the document is to improve the current limits of the program on innovative treatment. The report notes that ''Medicare's traditional approach to paying only for discrete visits and services has denied many seniors the opportunity to take advantage of the advances that have been pioneered by integrated health delivery in coordinating care for complex conditions and chronic diseases. These programs can lead to better health outcomes and reduce total medical costs by avoiding complications.''

In line with the above goals, the Administration is undertaking a series of disease management demonstration projects to explore a variety of ways to improve beneficiary care in the traditional Medicare plan. These demonstrations provide beneficiaries with greater choices, enhance the quality of their care, and offer better