officers, and others, and will be available on the JFMIP Web site.

Karen Cleary Alderman.

Executive Director, Joint Financial Management Improvement Program.

[FR Doc. 03–10246 Filed 4–24–03; 8:45 am]

BILLING CODE 1610–02–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare and Medicaid Services

[Document Identifier: CMS–1514, CMS–643, CMS–462A–B, CMS–588]

Agency Information Collection Activities: Proposed Collection; 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 (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 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:* Extension of a currently approved collection.

Title of Information Collection: Hospital Request for Certification in the Medicare/Medicaid Program.

Form No.: CMS–1514 (OMB# 0938–0380).

Use: Section 1861 of the Social Security Act requires hospitals and critical access hospitals to be certified to participate in the Medicare/Medicaid program. These providers must complete the ''Hospital Request for Certification in the Medicare/Medicaid Program'' form in order to be certified or recertified.

Frequency: Annually.

Affected Public: Business or other for-profit, Not-for-profit institutions.

Number of Respondents: 6,300.

Total Annual Responses: 2,000.

Total Annual Hours: 500.

2. *Type of Information Collection Request:* Extension of a currently approved request.

Title of Information Collection: Hospice Survey and Deficiencies Report Form and Supporting Regulations at 42 CFR 418.1—418.405.

Form No.: CMS–643 (OMB# 0938–0379).

Use: In order to participate in the Medicare program, a hospice must meet certain Federal health and safety conditions of participation. This form will be used by State surveyors to record data about a hospice's compliance with these conditions of participation in order to initiate the certification or recertification process.

Frequency: Annually.

Affected Public: State, local or tribal government.

Number of Respondents: 2,339.

Total Annual Responses: 475.

Total Annual Hours: 1,188.

3. *Type of Information Collection Request:* Extension of a currently approved collection.

Title of Information Collection: Clinical Laboratory Improvement Amendments (CLIA) Adverse Action Extract and Supporting Regulations at 42 CFR 483.1840.

Form No.: CMS–462A/B (OMB 0938–0655).

Use: The CLIA Adverse Action Extract will be used by CMS surveyors (State health department, and other CMS agents) to report to regional staff and record the adverse actions imposed against a laboratory. The form will also serve to track dates of the imposition of adverse actions, date on which a laboratory corrects deficiencies, and all appeals activity.

Frequency: On occasion, Biennially.

Affected Public: State, local, or tribal government.

Number of Respondents: 52.

Total Annual Responses: 1573.

Total Annual Hours: 786.

4. *Type of Information Collection Request:* Revision of a currently approved collection.

Title of Information Collection: Authorization agreement for electronic forms transfer.

Form No.: CMS–0588 (OMB# 0938–0626).

Use: The information is needed to allow providers to receive funds electronically in their bank accounts.

Frequency: On occasion.

Affected Public: Business or other for-profit, Not-for-profit institutions.

Number of Respondents: 10,000.

Total Annual Responses: 10,000.

Total Annual Hours: 1,250.

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access CMS's Web site address at *http://cms.hhs.gov/regulations/pra/default.asp*, 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. Written comments and recommendations for the proposed information collections must be mailed within 60 days of this notice directly to the CMS Paperwork Clearance Officer designated at the following address: CMS, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development and Issuances, Attention: Dawn Willinghan, Room: C5–14–03, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

Dated: April 17, 2003.

Dawn Willinghan,

Acting, Paperwork Reduction Act Team Leader, CMS Reports Clearance Officer, Office of Strategic Operations and Strategic Affairs, Division of Regulations Development and Issuances.

[FR Doc. 03–10245 Filed 4–24–03; 8:45 am]

BILLING CODE 4120–03–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–2182–PN]

Medicare and Medicaid Programs; Application by the Community Health Accreditation Program (CHAP) for Continued Approval of Deeming Authority for Hospices

AGENCY: Centers for Medicare & Medicaid Services, HHS.

ACTION: Proposed notice.

SUMMARY: This proposed notice acknowledges the receipt of an application from the Community Health Accreditation Program (CHAP) for continued recognition as a national accreditation program for hospice facilities that wish to participate in the Medicare or Medicaid programs. Section 1865(b)(3)(A) of the Social Security Act (the Act) requires that within 60 days of receipt of an organization's complete application, we publish a notice that identifies the national accrediting body making the request, describes the nature of the request, and provides at least a 30-day public comment period.

DATES: We will consider comments if we receive them at the appropriate address, as provided below, no later than 5 p.m. on May 27, 2003.

ADDRESSES: In commenting, please refer to file code CMS–2182–PN. Due to staff and resource limitations, we cannot accept comments by facsimile (fax). Mail written comments (one original and three copies) to the following address: Centers for Medicare and Medicaid Services, Department of Health and Human Services, Attention: CMS–2182–PN, P.O. Box 8013, Baltimore, MD 21244–8013.

Please allow sufficient time for mailed comments to be received in the event of delivery delays.

If you prefer, you may deliver (by hand or courier) your written comments (one original and three copies) to one of the following addresses: Room 443–G, Hubert H. Humphrey (HHH) Building, 200 Independence Avenue, SW., Washington, DC 20201, or Room C5–14–03, 7500 Security Boulevard, Baltimore, MD 21244–1850.

(Because access to the interior of the HHH Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

Comments mailed to the above addresses indicated as appropriate for hand or courier delivery may be delayed and received too late for us to consider them.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Cindy Melanson, (410) 785–0310.

SUPPLEMENTARY INFORMATION: *Inspection of Public Comments:* Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers of Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. Top schedule an appointment to view public comments, phone (410) 786–7195.

I. Background

Under the Medicare program, eligible beneficiaries may receive covered services in a hospice, provided certain requirements are met. Section 1861(dd) of the Social Security Act (the Act) establishes distinct criteria for facilities seeking designation as a hospice provider. Provider agreement regulations are located in 42 CFR part 489, and regulations pertaining to activities relating to the survey and certification of facilities are located in 42 CFR part 488. The regulations at 42 CFR part 418 specify the conditions that a hospice facility must meet in order to participate in the Medicare program, the scope of covered services, and the conditions for Medicare payment for hospice care. Section 1905(O)(1)(A) of the Act generally extends their requirements to payments for hospice services under the Medicaid program.

Generally, in order to enter into an agreement, a hospice facility must first be certified by a State survey agency as complying with the conditions or requirements set forth in part 418 of our regulations. Then, the hospice facility is subject to regular surveys by a State survey agency to determine whether it continues to meet these requirements. There is an alternate, however to surveys by State agencies.

Section 1865(b)(1) of the Act provides that, if a provider entity demonstrates through accreditation by an approved national accreditation organization that all applicable Medicare conditions are met or exceeded, we would ''deem'' those provider entities as having met the requirements. Accreditation by an accreditation organization is voluntary and is not required for Medicare participation.

If an accreditation organization is recognized by the Secretary as having standards for accreditation that meet or exceed Medicare requirements, any provider entity accredited by the national accrediting body's approved program would be deemed to meet the Medicare conditions. A national accreditation organization applying for approval of deeming authority under part 486, subpart A must provide us with reasonable assurance that the accreditation organization requires the accredited provider entities to meet requirements that are at least as stringent as the Medicare conditions. Our regulations concerning reapproval of accrediting organizations are set forth at § 488.4 and § 488.8(d)(3). The regulations at § 488.8(d)(3) require accreditation organizations to reapply for continued approval of deeming authority every 6 years or sooner as determined by us. The Community Health Accreditation Program's (CHAP's) term of approval as a recognized accreditation program for hospice facilities expires November 20, 2003.

II. Approval of Deeming Organizations

Section 1965(b)(2) of the Act and our regulations at § 488.8(a) require that our findings concerning review and reapproval of a national accrediting organization's requirements consider, among other factors, the reapplying accreditation organization's: Requirements for accreditation; survey procedures; resources for conducting required surveys; capacity to furnish information to use in enforcement activities; monitoring procedures for provider entities found not in compliance with the conditions or requirements; and ability to provide us with the necessary data for validation.

Section 1865(b)(3)(A) of the Act further requires that we publish, within 60 days of receipt of an accreditation organization's complete application, a notice identifying the national accreditation body making the request, describing the nature of the request, and providing at least a 30-day public comment period. In addition, we must publish a notice in the **Federal Register** or our approval or denial of the application within 210 days from the receipt of the application.

The purpose of this proposed notice is to inform the public of our consideration of CHAP's request for approval of continued deeming authority for hospice facilities. This notice also solicits public comment on whether CHAP requirements meet or exceed the Medicare conditions for participation for hospice facilities.

III. Evaluation of Deeming Authority Request

On February 21, 2003, CHAP submitted all the necessary materials to enable us to make a determination concerning its request for reapproval as a deeming organization for hospice facilities. Under section 1865(b)(2) of the Act and our regulations at § 488.8 (Federal review of accreditation organizations), our review and evaluation of CHAP will be conducted in accordance with, but not necessarily limited to, the following factors:

- The equivalency of CHAP standards for hospice care as compared with our comparable hospice conditions of participation.
- CHAP's survey process to determine the following:

—The composition of the survey team, surveyor qualifications, and the ability of the organization to provide continuing surveyor training.

—The comparability of CHAP processes to that of State agencies, including survey frequency, and the ability to investigate and respond appropriately

to complaints against accredited facilities.

—CHAP's processes and procedures for monitoring providers or suppliers found out of compliance with CHAP program requirements. These monitoring procedures are used only when CHAP identifies noncompliance. If noncompliance is identified through validation reviews, the survey agency monitors corrections as specified at § 488.7(d).

—CHAP's capacity to report deficiencies to the surveyed facilities and respond to the facility's plan of correction in a timely manner.

—CHAP capacity to provide us with electronic data in ASCII comparable code, and reports necessary for effective validation and assessment of the organization's survey process.

—The adequacy of CHAP's staff and other resources, and its financial viability.

—CHAP's capacity to fund required surveys.

—CHAP's policies with respect to whether surveys are announced or unannounced.

—CHAP's agreement to provide us with a copy of the most current accreditation survey together with any other information relate to the survey as we may require (including corrective action plans).

IV. Response to Public Comments and Notice Upon Completion of Evaluation

Due to the large number of items of correspondence we normally receive a **Federal Register** documents published for comment, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble and will respond to the public comments in the preamble to that document.

Upon completion of our evaluation, including evaluation of comments received as a result of this notice, we will publish a final notice in the **Federal Register** announcing the result of our evaluation.

In accordance with the provisions of Executive Order 12866, this notice was not reviewed by the Office of Management and Budget.

Authority: Section 1965 of the Social Security Act (42 U.S.C. 1395bb) (Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program; No. 93.773 Medicare—Hospital Insurance Program; and No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: April 8, 2003.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 03–9496 Filed 4–24–03; 8:45 am]

BILLING CODE 4120–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare and Medicaid Services

[CMS–4052–N]

Medicare Program: Meeting of the Advisory Panel on Medicare Education—May 21, 2003

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

ACTION: Notice of meeting.

SUMMARY: In accordance with section 10(a) of the Federal Advisory Committee Act (5 U.S.C. App. 2), this notice announces a meeting of the Advisory Panel on Medicare Education (the Panel) on May 21, 2003. The Panel advises and makes recommendations to the Secretary of the Department of Health and Human Services (HHS) and the Administrator of the Centers for Medicare & Medicaid Services (CMS) on opportunities to enhance the effectiveness of consumer education strategies concerning the Medicare program. This meeting is open to the public. This meeting replaces the February 27, 2003 meeting that was canceled due to snow.

DATES: The meeting is scheduled for May 21, 2003, from 9:15 a.m. to 4 p.m., e.s.t.

Deadline for Presentations and Comments: May 14, 2003, 12 noon, e.s.t.

ADDRESSES: The meeting will be held at the Wyndham Washington Hotel, 1400 M Street, NW., Washington, DC, 20005, (202) 429–1700.

FOR FURTHER INFORMATION CONTACT: Lynne Johnson, Health Insurance Specialist, Division of Partnership Development, Center for Beneficiary Choices, Centers for Medicare & Medicaid Services, 7500 Security Boulevard, S2–23–05, Baltimore, MD, 21244–1850, (410) 786–0090. Please refer to the CMS Advisory Committees Information Line (1–877–449–5659 toll free)/(410–786–9379 local) or the Internet *(http://www.cms.hhs.gov/faca/apme/default.asp)* for additional information and updates on committee activities, or contact Ms. Johnson via e-mail at *ljohnson3@cms.hhs.gov.* Press inquiries are handled through the CMS Press Office at (202) 690–6145.

SUPPLEMENTARY INFORMATION: Section 222 of the Public Health Service Act (42 U.S.C. 217a), as amended, grants to the Secretary the authority to establish an advisory panel if the Secretary finds the panel necessary and in the public interest. The Secretary signed the charter establishing this Panel on January 21, 1999 (64 FR 7849) and approved the renewal of the charter on January 21, 2003. The Panel advises and makes recommendations to the Secretary and the Administrator of the Centers for Medicare & Medicaid Services on opportunities to enhance the effectiveness of consumer education strategies concerning the Medicare program.

The goals of the Panel are as follows:

- To develop and implement a national Medicare education program that describes the options for selecting a health plan under Medicare.
- To enhance the Federal government's effectiveness in informing the Medicare consumer, including the appropriate use of public-private partnerships.
- To expand outreach to vulnerable and underserved communities, including racial and ethnic minorities, in the context of a national Medicare education program.
- To assemble an information base of best practices for helping consumers evaluate health plan options and build a community infrastructure for information, counseling, and assistance.

The current members of the Panel are: Dr. Jane Delgado, Chief Executive Officer, National Alliance for Hispanic Health; Joyce Dubow, Senior Policy Advisor, Public Policy Institute, AARP; Clayton Fong, President and Chief Executive Officer, National Asian Pacific Center on Aging; Timothy Fuller, Executive Director, National Gray Panthers; John Graham IV, Chief Executive Officer, American Diabetes Association; Dr. William Haggett, Senior Vice President, Government Programs, Independence Blue Cross; Thomas Hall, Chairman and Chief Executive Officer, Cardio-Kinetics, Inc.; David Knutson, Director, Health System Studies, Park Nicollet Institute for Research and Education; Brian Lindberg, Executive Director, Consumer Coalition for Quality Health Care; Katherine Metzger, Director, Medicare and Medicaid Programs, Fallon Community Health Plan; Dr. Laurie Powers, Co-Director, Center on Self-Determination, Oregon Health Sciences University; Dr. Marlon Priest, Professor of Emergency Medicine, University of Alabama at Birmingham; Dr. Susan Reinhard, Co-Director, Center for State Health Policy, Rutgers University and Chairperson of