CBA providers will be required to submit CBA Trimester Progress Reports (form A). The purpose of the CBA Trimester Progress Report is to describe CBA undertaken during the previous four months. The Trimester Progress Report will be a narrative on the programs' successes and barriers; process and outcome monitoring data; collaborative and cooperative activities with other organizations; and plans for future activities.

To effectively track and monitor all requests for capacity-building assistance, CBA providers will be required to submit a CBA Notification Form (form B) following each contact with a community based organization (CBO) or HIV prevention stakeholder for CBA services. The purpose of this form is to track all requests for services from CBOs, health departments and stakeholders. Requests for CBA from these CBOs and stakeholders are received by CBA providers on an on-going basis.

CBA providers will also be required to submit a CBA Completion Form (form C) following each episode of CBA service delivered to all CBOs and stakeholders. The purpose of this form is to provide feedback and follow-up information to CDC Project Officers on the types of CBA services and quality of services that were delivered to all CBOs by CBA providers. CBA requests from CBOs, health departments, and stakeholders are received by CBA providers on an on-going basis. Information collection will be on-going throughout the duration of the cooperative agreements.

In addition, CBA providers will be required to submit pre-planned CBA training events on a CBA Training Events Report (form D). The CBA Training Events Report is used to disseminate planned capacity building assistance activities delivered by CBA providers, the CDC and other organizations providing training and technical assistance. The calendar is also used as a marketing tool to let CBOs, health departments and stakeholders know what types of technical assistance and training activities are available. There are no costs to respondents other than their participation in the collection of information. The estimated annualized burden is 1,462 hours.

Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hours)
Form A: CBA Trimester Report	34 CBA Provider Grantees	3	2
Form B: CBA Notification Form	34 CBA Provider Grantees	50	15/60
Form C: CBA Completion Form	34 CBA Provider Grantees	25	30/60
Form D: CBA Training Events Form	34 CBA Provider Grantees	12	1

Dated: September 30, 2004.

Alvin Hall,

Director, Management Analysis and Services Office Centers for Disease Control and Prevention.

[FR Doc. 04–22454 Filed 10–5–04; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–5015–N]

Medicare Program; Care Management for High-Cost Beneficiaries (CMHCB) Demonstration

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

ACTION: Notice.

SUMMARY: This notice informs eligible health care organizations of an opportunity to apply to implement and operate a care management demonstration serving high-cost beneficiaries in the original Medicare fee-for-service (FFS) program. This voluntary demonstration is part of an effort to develop and test multiple strategies to improve the coordination of Medicare services for high-cost FFS beneficiaries. The notice contains information on how to obtain the complete solicitation and supporting information.

DATES: Applications will be considered timely if we receive them on or before January 4, 2005.

ADDRESSES: Mail applications to—Centers for Medicare & Medicaid Services, Attention: Cynthia Mason, Mail Stop: C4–17–27, 7500 Security Boulevard, Baltimore, Maryland 21244.

Because of staff and resource limitations, we cannot accept applications by facsimile (FAX) transmission or by e-mail.

FOR FURTHER INFORMATION CONTACT: Cynthia Mason at (410) 786–6680 or *cmhcbdemo@cms.hhs.gov.*

SUPPLEMENTARY INFORMATION:

I. Background

The Department of Health and Human Services is developing and testing multiple strategies to improve the coordination of Medicare services for beneficiaries with high-cost conditions. However, one approach that remains to be studied is intensive management for high-cost beneficiaries with various medical conditions to reduce cost as well as improve quality of care and quality of life for those beneficiaries. Therefore, we are interested in proposals to restructure care or enhance the management of care for beneficiaries with costly medical conditions. It is anticipated that organizations will serve high-risk beneficiaries with a variety of medical conditions and that the vast majority of beneficiaries participating in the demonstration will have multiple conditions. One organization will be selected per area to offer services to eligible beneficiaries. Beneficiary participation in the programs will be voluntary and will not change the amount, duration or scope of participants' fee-for-service (FFS) Medicare benefits. FFS Medicare benefits will continue to be covered, administered, and paid under the traditional Medicare FFS program. Programs will be offered at no charge to the beneficiary. Organizations chosen for the demonstration will not be able to restrict beneficiary access to care (for example, there can be no utilization review or gatekeeper function) or restrict beneficiaries to a limited number of physicians in a network.

Applicants may propose to serve one or more areas, but their proposed service areas must be adjusted to ensure that the population is of an appropriate size that would ensure statistically significant results. Also, to avoid any overlap between the current FFS care management demonstrations or the Chronic Care Improvement Programs (CCIP), it will be necessary to exclude from the Care Management for High-Cost Beneficiaries (CMHCB) demonstration population any

beneficiaries who meet the criteria to participate in existing demonstrations or CCIP.

Organizations may be paid a monthly fee per participant or participate under a gain-sharing arrangement based on Medicare savings; however, fee and gain-sharing payments will be contingent on improvements in clinical quality of care, beneficiary and provider satisfaction, and savings to Medicare in the intervention groups compared to control groups.

II. Provisions of This Notice

This demonstration is intended to test models of care management for high-cost beneficiaries under the Medicare FFS program, incorporating relevant features from traditional disease management programs, but allowing sufficient flexibility for us and the awardees to adapt the design of CMHCB programs to meet the unique needs of the high-cost Medicare population. For some beneficiaries with high-cost conditions, the restructuring of the care management plan to integrate provider services in the program and to deliver those services in non-acute care locations such as the beneficiary's home could significantly improve the beneficiary's quality of life while simultaneously reducing costs. Under the CMHCB demonstration, we hope to test a variety of models such as intensive case management, increased provider availability, structured chronic care programs, restructured physician practices, and expanded flexibility in care settings to deliver care to high-cost beneficiaries with multiple conditions.

The organization(s) that are awarded the demonstration project will be required to agree to assume financial risk in the event of failure to meet agreed upon performance guarantees for clinical quality, beneficiary and provider satisfaction and savings targets. That financial risk will include all fees and gain-sharing payments.

Organizations eligible to apply to implement and operate care management programs under CMHCB include—

- Physician groups;
- Hospitals; or
- Integrated delivery systems.

Other organizations may apply, but only as part of a consortium that includes physician groups, hospitals, or integrated delivery systems that would play a major role in the operation of the proposed CMHCB demonstration. Eligible organizations must be capable of providing ambulatory health care services.

We plan to make approximately four to six awards. Interested parties can obtain complete solicitation and supporting information on the CMS Web site at *http://www.cms.hhs.gov/researchers/demos/cmhcb.asp.* Paper copies can be obtained by writing to Cynthia Mason at the address listed in the **ADDRESSES** section of this notice.

III. Collection of Information Requirements

This information collection requirement is subject to the Paperwork Reduction Act of 1995 (PRA); however, the collection is currently approved under OMB control number 0938–0880 entitled ''Medicare Demonstration Waiver Application'' with a current expiration date of 7/31/2006.

Authority: Section 402(a)(1)(B) and (a)(2) of the Social Security Amendments of 1967, Pub. L. 90–248, as amended, 42 U.S.C. 1395b–1(a)(1)(B) and (a)(2).

(Catalog of Federal Domestic Assistance No. 93.773 Medicare-Hospital Insurance Program; and No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: September 15, 2004.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 04–22459 Filed 10–1–04; 4:00 pm]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Notice of Hearing: Reconsideration of Disapproval of New Hampshire State Plan Amendment (04–001A)

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

ACTION: Notice of hearing.

SUMMARY: This notice announces an administrative hearing on November 19, 2004, at 10 a.m., JFK Federal Building, Room E275A, Boston, Massachusetts 02203–0003, to reconsider the decision to disapprove New Hampshire State Plan Amendment (SPA) 04–001A.

DATES: Requests to participate in the hearing as a party must be received by the presiding officer by October 21, 2004.

FOR FURTHER INFORMATION CONTACT: Kathleen Scully-Hayes, Presiding Officer, CMS, LB–23–20, Lord Baltimore Drive, Baltimore, Maryland 21244, telephone: (410) 786–2055.

SUPPLEMENTARY INFORMATION: This notice announces an administrative hearing to reconsider the decision to disapprove New Hampshire State Plan Amendment (SPA) 04–001A, which New Hampshire submitted on March 31, 2004. SPA 04–001A sought to reduce the Estimated Acquisition Cost (EAC) for prescription drugs from Average Wholesale Price (AWP) minus 12 percent to AWP minus 16 percent and the dispensing fee from $2.50 to $1.75 per prescription, effective for the period from January 12, 2004, to March 11, 2004. The CMS reviewed this proposal and for the reasons set forth below, was unable to approve SPA 04–001A as submitted.

At issue is whether the requested effective date of January 12, 2004, is consistent with statutory and regulatory requirements. In a separate action, CMS approved SPA 04–001B, which made the same changes in the EAC and dispensing fee calculations, effective March 12, 2004. Section 1902(a)(30) of the Social Security Act (the Act) requires a state's Medicaid state plan to provide such methods and procedures as may be necessary to ensure that payments are consistent with efficiency, economy, and quality of care. Under that authority, the Secretary has issued regulations prescribing state rate-setting procedures. Federal regulations at 42 CFR 447.205(d) require public notice to be issued prior to the effective date of a significant change in any methods and standards for setting payment rates for services. The state did not issue a public notice for the proposed changes in payment methodology until March 11, 2004. Therefore, the earliest that such changes could be effective is March 12, 2004.

Based on the above, and after consultation with the Secretary as required under 42 CFR 430.15(c)(2), CMS disapproved New Hampshire SPA 04–001A.

Section 1116 of the Act and 42 CFR part 430 establish Departmental procedures that provide an administrative hearing for reconsideration of a disapproval of a State plan or plan amendment. The CMS is required to publish a copy of the notice to a state Medicaid agency that informs the agency of the time and place of the hearing and the issues to be considered. If we subsequently notify the agency of additional issues that will be considered at the hearing, we also will publish that notice.

Any interested individual or group that wants to participate in the hearing as a party must petition the presiding officer within 15 days after publication of this notice, in accordance with the requirements contained at 42 CFR 430.76(b)(2). Any person or organization that wants to participate as *amicus*