require an average of 95 hours of professional staff time and 30 hours of support staff time per application. Estimates of annual activity and burden for foreign sponsor nomination of a resident, agent, change in ownership or designation, and inadequate supplies of drug in exclusivity, are based on total experience by FDA with such requests since 1983.

Dated: April 24, 2001.

William K. Hubbard,

Senior Associate Commissioner for Policy, Planning, and Legislation.

[FR Doc. 01–10711 Filed 4–30–01; 8:45 am]

BILLING CODE 4160–01–S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

[Document Identifier: HCFA–1450]

Agency Information Collection Activities: Submission for OMB Review; Comment Request

AGENCY: Health Care Financing Administration, HHS.

In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, 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.

Type of Information Request: Extension of a currently approved collection; *Title of Information Collection*: Medicare Uniform Institutional Provider Bill and Supporting Regulations in 42 CFR 424.5; *Form Number*: HCFA–1450 (OMB approval #: 0938–0247); *Use*: This standardized form is used in the Medicare/Medicaid program to apply for reimbursement of covered services by all providers that accept Medicare/Medicaid assigned claims; *Frequency*: On occasion; Affected Public: Business or other for-profit, Not-for-profit institutions; *Number of Respondents*: 46,708; *Total Annual Responses*: 147,343,290; *Total Annual Hours Requested*: 1,854,070.

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access HCFA's Web Site address at *http://www.hcfa.gov/regs/prdact95.htm*, or E-mail your request, including your address, phone number, OMB number, and HCFA 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 30 days of this notice directly to the OMB desk officer: OMB Human Resources and Housing Branch, Attention: Wendy Taylor, New Executive Office Building, Room 10235, Washington, DC 20503.

Dated: March 19, 2001.

John P. Burke, III,

HCFA Office of Information Services, Security and Standards Group, Division of HCFA Enterprise Standards.

[FR Doc. 01–10814 Filed 4–30–01; 8:45 am]

BILLING CODE 4120–03–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

[HCFA–1182–PN]

RIN 0938–AK75

Medicare Program; Revision of Payment Rates for End-Stage Renal Disease (ESRD) Patients Enrolled in Medicare+Choice Plans

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Proposed notice.

SUMMARY: This notice proposes a new payment methodology, effective January 2002, for beneficiaries with End-Stage Renal Disease (ESRD) who are enrolled in Medicare+Choice (M+C) plans. The proposed methodology would implement section 605 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). Section 605 requires the Secretary to increase ESRD M+C payment rates, using appropriate adjustments, to reflect the demonstration rates (including the risk adjustment methodology associated with those rates) of the social health maintenance organization ESRD capitation demonstrations. Briefly, the approach that we propose follows:

- Base State-level per capita rates on 100 percent of estimated State per capita ESRD fee-for-service expenditures in a base year.
- Adjust State per capita rates by age and sex factors, in order to pay more accurately, given differences in costs among ESRD patients.

The effect of the new ESRD M+C payment methodology would be to increase Medicare's Fiscal Year (FY) 2002 ESRD payments by an estimated $25 million (for 9 months of costs, given the effective date of January 2002). Total ESRD M+C payment increases for FY 2003 through FY 2005 are estimated to be $40 million annually.

The payment methodology proposed in this notice would govern M+C payments for enrollees with ESRD in 2002. M+C organizations are required to submit Adjusted Community Rate (ACR) proposals setting forth their M+C plan benefits, premiums, and cost-sharing for 2002 by July 1, 2001. M+C organizations need information on the payments they will receive for ESRD enrollees to prepare their ACR submissions. Section 605(c) of BIPA provided that this notice had to be published no later than 6 months after the enactment of BIPA or June 20, 2001. Yet section 605(c) also requires that the ''final'' ESRD methodology be published no later than July 1, 2001. In light of these deadlines, and the need of M+C organizations for final information on ESRD payment rates to prepare the ACR proposals, we find that affording the public a full 60-day comment period would be ''impracticable'' and ''contrary to the public interest,'' and that there is ''good cause'' for shortening the 60-day comment period we normally provide to 30 days.

DATES: We will consider comments if we receive them at the appropriate address, as provided below, no later than 5 p.m. on May 31, 2001.

ADDRESSES: Mail written comments (1 original and 3 copies) to the following address ONLY: Health Care Financing Administration, Department of Health and Human Services, Attention: HCFA–1182–PN, P.O. Box 8013, Baltimore, MD 21244–8013.

To ensure that mailed comments are received in time for us to consider them, please allow for possible delays in delivering them.

If you prefer, you may deliver your written comments (1 original and 3 copies) to one of the following addresses: Room 443–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or

Room C5–16–03, 7500 Security Boulevard, Baltimore, MD 21244–8013.

Comments mailed to the above addresses may be delayed and received too late for us to consider them.

Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code HCFA–1182-PN. Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, in Room C5–12–08 of the Health Care Financing Administration, 7500 Security Blvd., Baltimore, MD, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. Please call (410) 786–7197 to view these comments.

For information on ordering copies of the **Federal Register** containing this document and electronic access, see the beginning of the **SUPPLEMENTARY INFORMATION**.

FOR FURTHER INFORMATION CONTACT: Anne Hornsby, (410) 786–1181.

SUPPLEMENTARY INFORMATION:

Copies: To order copies of the **Federal Register** containing this document, send your request to: New Orders, Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250–7954. Specify the date of the issue requested and enclose a check or money order payable to the Superintendent of Documents, or enclose your Visa or Master Card number and expiration date. Credit card orders can also be placed by calling the order desk at (202) 512–1800 or by faxing to (202) 512–2250. The cost for each copy is $9. As an alternative, you can view and photocopy the **Federal Register** document at most libraries designated as Federal Depository Libraries and at many other public and academic libraries throughout the country that receive the **Federal Register**.

This **Federal Register** document is also available from the **Federal Register** online database through GPO Access, a service of the U.S. Government Printing Office. The Website address is: *http://www.access.gpo.gov/nara/index.html.*

I. Background

Section 605 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) amends section 1853(a)(1)(B) of the Social Security Act (the Act) by adding the following sentence at the end: ''In establishing such rates, the Secretary shall provide for appropriate adjustments to increase each rate to reflect the demonstration rate (including the risk adjustment methodology associated with such rate) of the social health maintenance organization end-stage renal disease capitation demonstrations (established by section 2355 of the Deficit Reduction Act of 1984, as amended by section 13567(b) of the Omnibus Budget Reconciliation Act of 1993), and shall compute such rates by taking into account such factors as renal treatment modality, age, and the underlying cause of the end-stage renal disease.'' The amendment will apply to payments for months beginning with January 2002.

Currently, M+C ESRD capitation payments are based on State-level rates that are not risk-adjusted. ESRD M+C base payment rates are set at 95 percent of State average fee-for-service costs in a base year (1997), which is consistent with other M+C rates. ESRD rates include the costs of beneficiaries with Medicare as Secondary Payer and the costs of beneficiaries who have functioning grafts 3 years or less from date of transplant. Note that for the purpose of M+C payment, ''ESRD beneficiaries'' includes beneficiaries with ESRD, whether entitled to Medicare because of ESRD, disability, or age.

A. ESRD Managed Care Demonstration Project

Beneficiaries with ESRD are the only group prohibited from enrolling in Medicare risk HMOs and M+C organizations, although a beneficiary who develops ESRD after enrolling with an organization that offers an M+C plan may remain enrolled with the organization under an M+C plan. In 1996, the Congress required the Secretary to conduct an ESRD Managed Care Demonstration Project to assess whether it is feasible to allow year-round open enrollment in managed care for Medicare ESRD patients of all ages. As of December 2000, there were two such Demonstration sites, one in California with approximately 1,200 enrollees and a second in Florida with approximately 600 enrollees.

The ESRD Demonstration introduced 100 percent risk-adjustment into ESRD capitation payments. We calculated separate monthly capitation rates by treatment modality (dialysis, transplant, or functioning graft), and then adjusted the dialysis and functioning graft rates for age (0–19, 20–64, or 65+ years old) and original cause of renal failure (diabetes or other cause).

Further, the Demonstration tested whether offering additional benefits not covered by Medicare enhanced effective treatment of this population. The statute mandated that we pay ESRD Demonstration sites 100 percent of estimated per capita fee-for-service expenditures in that State, rather than the 95 percent paid to managed care plans outside the Demonstration. To justify the extra 5 percent, ESRD Demonstration sites agreed to provide additional benefits, for example, nutritional supplements.

Finally, the Demonstration did not allow ESRD patients with Medicare as Secondary Payer to enroll in the sites. Therefore, we excluded fee-for-service beneficiaries with Medicare as Secondary Payer from calculation of the base payment rates. Excluding Medicare as Secondary Payer beneficiaries increased the Demonstration rates about 20 percent over rates paid outside the Demonstration.

B. ESRD Demonstration Experience With the Capitated Payment System

Preliminary assessments reveal that the administrative demands of implementing the methodology employed in the ESRD Demonstration were substantial and complex. HCFA and the Demonstration sites experienced difficulty with ensuring accurate and timely collection of data on treatment modality; data problems also occurred with the original cause adjuster. In large part, this was because to determine payment status, we had to rely on nonbilling documents. For example, the documentation of a transplant involves a detailed medical form that must travel from transplant center to organ transplant network to us. Often we did not receive these forms timely. Working with the Demonstration sites, we have had to create complex processes for retroactive adjustments and reconciliations because of delays in receipt of the appropriate documentation.

This assessment is based on our preliminary analysis of issues that have arisen during the ESRD Demonstration. The final evaluation of the ESRD Demonstration is forthcoming. Meanwhile, we are pursuing further improvements to the payment system for ESRD beneficiaries enrolled in managed care. Given our ongoing discussion with the Demonstration sites about system problems affecting payment, however, we are prospectively changing the ESRD Demonstration payment methodology. Demonstration payments will no longer be risk-adjusted. We will pay the unadjusted base capitation rate until this interim approach is superseded by implementation of the risk-adjusted ESRD M+C payment methodology proposed in this notice.

II. Provisions of the Proposed Notice

A. Calculation of State-Level Per Capita ESRD Rates at 100 Percent of State Fee-for-Service Costs

As noted above, BIPA requires that ESRD Managed Care Demonstration rates be increased ''to reflect'' the Demonstration rate, ''including'' the risk adjustment methodology used under the Demonstration. We discuss our approach to reflecting the Demonstration risk adjustment methodology in section II.B below. To increase the base rate to ''reflect'' the ESRD Demonstration rate, we propose to calculate ESRD M+C payment rates based on 100 percent of our current best estimate of actual 1997 State per capita ESRD fee-for-service costs, which is consistent with the approach provided for in the statutory provisions establishing the ESRD Demonstration. To bring the per capita ESRD rates forward to CY 2002, we will apply the M+C methodology under the Balanced Budget Act of 1997 (BBA), whereby the annual State capitation rate is the largest of the blended capitation rate, the minimum amount rate, and the minimum percentage increase rate. Our reasons for selecting this approach follow.

Increasing the original 1997 ESRD M+C payment rates to an amount representing 100 percent of our current estimates of actual 1997 State per capita ESRD fee-for-service costs results in an increase in the original 1997 rates of approximately 1 percent. To determine monthly per capita rates that are 100 percent of State fee-for-service costs in 1997, we returned to the 1997 rates, since that was selected as the base year for payments under the BBA payment methodology. To illustrate why paying 100 percent of a rate based on our current estimate of 1997 costs only increases the original 1997 rates by 1 percent, we have conducted preliminary analysis of the 1997 rates using average per capita costs for the nation. (To calculate the new ESRD rates, we will use fee-for-service costs on a State-by-State basis.)

Our analysis of the 1997 rates reveals that the national per capita rate promulgated in 1997 (based on September 1996 calculations) is about 4.1 percent higher than our current best estimate of the actual 1997 fee-for-service costs on which the rates are to be based.

- The basis for the 1997 monthly per capita ESRD rates was the monthly U.S. Per Capita Costs (USPCC) for ESRD of $3,861.
- In contrast, our best estimate in 2001 of actual monthly ESRD per capita cost for 1997 is $3,710. The difference is approximately 4.1 percent.

Under the M+C methodology set forth in the BBA, the original 1997 rates were the basis for all future rates, with no provision for correcting over or under estimates. This means that on average, in 1997 we paid managed care organizations an amount representing about 99 percent of the actual Medicare Average Annual Per Capita Cost (AAPCC) for 1997, rather than the assumed 95 percent of the AAPCC. To pay M+C organizations 100 percent of estimated State per capita ESRD fee-for-service costs for 1997, therefore, we will increase the 1997 rates by approximately 1 percent.[1] As noted above, this approach is fully consistent with the legislation providing for the ESRD Demonstration, which provided for payment at 100 percent of the AAPCC, and did not link this to a particular rate book or at any point to M+C payment rates.

Post-1997 ESRD Demonstration payment rates were updated using the BBA methodology, which resulted in the minimum 2 percent increase each year. To further ''reflect the Demonstration rate,'' we propose to do the same under the new ESRD methodology, notwithstanding the fact that actual fee-for-service costs did not increase at this rate, but actually decreased (see footnote 1). ESRD M+C payment rates outside the Demonstration also were increased 2 percent under the BBA methodology.

In summary, we propose to increase the 1997 payment rate produced by the pre-BIPA M+C payment methodology by approximately 1 percent to get to 100 percent of actual fee-for-service costs for 1997, thus fulfilling the BIPA mandate that new ESRD rates be increased to ''reflect'' the Demonstration rates, which are based on a 100 percent standard.

B. Risk Adjust the Base Payment Rates By Age and Sex

As noted above, section 605 of BIPA requires that the increase in ESRD rates to reflect Demonstration rates include the risk adjustment methodology associated with such rates. The methodology in place at the time BIPA was enacted was set forth above in section I.A. While the Demonstration methodology included several components, the bulk of the effect of risk adjustment is attributable to adjustment for age. For the reasons that follow, after taking into account the possibility of other categories of risk adjustment used in the ESRD Demonstration, we are proposing to adjust M+C ESRD rates only for age and sex. We believe that this ''reflects'' the most significant effects of the ESRD Demonstration methodology. To increase the power of the age adjustment compared to the ESRD Demonstration age adjustment, we will change from a 3-category age classification to the 10-category classification currently used in the M+C payment methodology.

We decided not to create separate rates for treatment modality or adjust for original cause of kidney failure for several reasons. First, when we implement the comprehensive risk adjustment model (adding ambulatory and outpatient diagnoses to the existing hospital-diagnosis system), we expect to incorporate ESRD M+C enrollees into the single risk-adjusted payment system. This will allow us to capture co-morbidity information in addition to demographic information and basic disease markers for ESRD beneficiaries.

In addition, research indicates that increased age is the single best correlate of ESRD mortality. The ESRD population enrolled in managed care is on average older than the ESRD fee-for-service population (see table below). (This is due to the current restrictions on ESRD enrollment in M+C organizations.) Our research comparing the 1998 Medicare HMO ESRD population with the fee-for-service population reveals the following contrasts (Eggers 2000).

Age	Percent of ESRD HMO population (percent)	Percent of ESRD fee-for-service population (percent)
Age 75+	28	15
65–74	41	22
45–64	24	39
0–44	7	24

We reviewed other evidence before selecting an interim risk adjustment methodology based on age and sex, including the following:

- Eggers *et al.* (2001) found that when taking age into account, M+C organizations were transplanting at the

[1] Note 4: the 4 percent differential in 1997 (between the national per capital rate promulgated in 1997 and our best estimate in 2001 of 1997 costs) is projected to grow to almost 25 percent by 2002. This is because the underlying growth trends for ESRD fee-for-service costs from 1997 to 2002 are negative, while the M+C payment rates have increased at a minimum of 2 percent per year, as provided in the BBA. Current estimates of the actual ESRD fee-for-service cost trends from 1997 to 2002 project a decrease of approximately 7 percent. In contrast, the guaranteed 2 percent increase per year (3 percent in 2001 under BIPA) equates to an increase of approximately 11.5 percent. The result is a differential of almost 25 percent by 2002.

same rates as fee-for-service organizations in 1998.

• A detailed study of capitation models for ESRD (The Lewin Group and URREA 2000) shows that age is a much more important factor predicting 1996 fee-for-service spending for within-year transplant patients, functioning graft patients, and pediatric dialysis patients than it is for adult hemodialysis patients. The study notes, however, that ESRD patients enrolled in Medicare HMOs with Medicare as primary payer are not included in the sample of patients analyzed, so we do not know whether the study findings are accurate for the M+C ESRD population, which is on average older than the fee-for-service ESRD population.

Taking into consideration the current enrollment restrictions in the M+C program and the resulting age distribution of ESRD M+C enrollees, we have concluded that adjusting for age and sex and using a more detailed age categorization obviates the need to include treatment modality and original cause as factors in this interim methodology.

HCFA's Office of the Actuary developed the following age/sex factors for ESRD beneficiaries enrolled in M+C plans. These factors will be used in making payments for ESRD beneficiaries starting in January 1, 2002. For a given ESRD enrollee, the appropriate age/sex factor will be multiplied by the standardized statewide payment rates in the M+C ratebook. Prior to January 2002, there are no adjustments for age and sex for M+C ESRD beneficiaries.

AGE/SEX DEMOGRAPHIC FACTORS FOR M+C ESRD ENROLLEES

Age	Part A		Part B	
	Male	Female	Male	Female
0–34	.55	.70	.70	.75
35–44	.65	.70	.80	.80
45–54	.70	.85	.85	.90
55–59	.80	.95	.90	1.00
60–64	.90	1.10	.90	1.10
65–69	1.15	1.35	1.10	1.20
70–74	1.25	1.45	1.15	1.25
75–79	1.30	1.55	1.20	1.25
80–84	1.40	1.60	1.20	1.25
85+	1.45	1.60	1.20	1.25

Given current enrollment restrictions, we estimate that, under the proposed methodology, the age- and sex-adjusted average ESRD payment per beneficiary will result in a significant increase in payments to M+C organizations for their ESRD enrollees.

When ESRD M+C enrollees are incorporated into the comprehensive risk adjustment system (adding ambulatory and outpatient diagnoses to the existing hospital-diagnosis system), payments for ESRD patients will be adjusted using the same adjusters used for other enrollees, thus incorporating information on basic disease markers and co-morbidities into calculations of ESRD payments.

Preliminary findings from the ESRD Demonstration, which allowed ESRD beneficiaries of all ages to enroll, indicate that the age distributions at the Demonstration sites were very similar to the ESRD age distribution in fee-for-service Medicare. A change in the law to allow ESRD beneficiaries of all ages to enroll in M+C plans would result in moderation of the average payment increases expected from the proposed methodology, because we would expect a shift in the age distribution of the M+C ESRD population toward younger enrollees.

Although the ESRD Managed Care Demonstration did not enroll beneficiaries with Medicare as Secondary Payer, we are unable to exclude from the M+C program any beneficiaries with Medicare as Secondary Payer who develop ESRD. Therefore, these ESRD beneficiaries with Medicare as Secondary Payer will be included in the program and payment rates. Due to data limitations, we do not expect to make separate payment adjustments.

III. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 35).

IV. Response to Comments

Because of the large number of items of correspondence we normally receive on **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, if we proceed with a subsequent document, we will respond to the major comments in the preamble to that document.

V. Regulatory Impact Statement

We have examined the impacts of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review) and the Regulatory Flexibility Act (RFA) (September 19, 1980 Public Law 96–354). Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more annually).

We have determined that this proposed notice is not a major rule with economically significant effects. There are approximately 18,000 ESRD beneficiaries enrolled in M+C plans. The additional cash expenditures for these ESRD M+C beneficiaries under this BIPA provision are estimated to be: $25 million in 2002; $40 million in 2003; $40 million in 2004; $40 million in 2005; and $45 million in 2006. These estimates assume continuation of the current restrictions on enrollment in the M+C program for ESRD beneficiaries. These estimates include the impact of adjusting for age and sex and the impact

of raising the ESRD base rates by 1 percent. Since the proposed notice results in increases in total expenditures of less than $100 million per year, this notice is not a major rule as defined in Title 5, United States Code, section 804(2) and is not an economically significant rule under Executive Order 12866.

The RFA requires agencies to analyze the economic impact on small entities, and if an agency finds that a regulation imposes a significant burden on a substantial number of small entities, it must explore options for reducing the burden. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $7.5 million or less annually. For purposes of the RFA, most managed care organizations are not considered to be small entities. Individuals and States are not included in the definition of a small entity.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditure in anyone year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. This proposed notice would have no consequential effect on State, local, or tribal governments, and the private sector cost of this rule falls below these thresholds as well.

We have reviewed this proposed notice under the threshold criteria of E.O. 13132, Federalism. We have determined that the proposed notice would not significantly affect the rights, roles, and responsibilities of the States.

We have examined the economic impact of this notice on M+C organizations and find that the overall impact is positive. However, because the number of ESRD patients enrolled in M+C organizations represents a very small fraction of M+C organizations' annual receipts and because a small number of M+C organizations qualify as small entities under the RFA, the Secretary is initially certifying that this notice will not have a significant impact on a substantial number of small entities. To our knowledge, no small rural hospitals will be affected by this notice, so the Secretary is also initially certifying that this notice will not have a significant impact on a substantial number of small rural hospitals.

In accordance with the provisions of E.O. 12866, this proposed notice was reviewed by OMB.

Works Cited

Eggers, Paul W., Diane L. Frankenfield, Joel W. Greer, William McClellan, William F. Owen, Jr., and Michael V. Rocco, ''Comparison of Mortality and Intermediate Outcomes between Dialysis Patients Enrolled in HMO and Fee for Service,'' February 2001. Under review at the American Journal of Kidney Disease.

Eggers, Paul. ''Outcome of ESRD Patients in HMOs.'' RPA/REF 2000 Annual Meeting. Washington DC March 25–27, 2000.

The Lewin Group and University Renal Research and Education Association (URREA). ''Capitation Models for ESRD: Methodology and Results.'' Prepared for Renal Physicians Association, American Society of Nephrology, American Society of Transplant Physicians, American Society for Pediatric Nephrology, and Amgen. January 7, 2000.

Section 1853(a)(1)(B) of the Social Security Act (42 U.S.C. 1395w–23(a)(1)(B))

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

Dated: March 19, 2001.

Michael McMullan,

Acting Deputy Administrator, Health Care Financing Administration.

Dated: April 12, 2001.

Tommy G. Thompson,

Secretary.

[FR Doc. 01–10865 Filed 4–26–01; 3:48 pm]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Postponement of Meeting of the Advisory Committee on Organ Transplantation

AGENCY: Health Resources and Services Administration, HHS.

ACTION: Notice; postponement.

SUMMARY: A notice announcing the first meeting of the Advisory Committee on Organ Transplantation (ACOT), Department of Health and Human Services (HHS), was published in the **Federal Register** dated April 12, 2001 (66 FR, page 18962). This meeting, scheduled for May 1–2, 2001, has been postponed.

SUPPLEMENTARY INFORMATION: This notice is to inform the public that the first meeting of the Advisory Committee on Organ Transplantation (ACOT), Department of Health and Human Services (HHS), which was scheduled for May 1–2, 2001, has been postponed. The Secretary of HHS will publish a notice in the **Federal Register** once the date for the rescheduled ACOT meeting is determined. Individuals with questions should contact the ACOT Executive Director, Ms. Lynn Rothberg Wegman, M.P.A., by telephone at (301)–443–7577, by e-mail at *Lwegman@hrsa.gov*, or in writing at the Division of Transplantation, Office of Special Programs, Health Resources and Services Administration, Room 7C–22, Parklawn Building, 5600 Fishers Lane, Rockville, MD 20857.

Dated: April 27, 2001.

Elizabeth M. Duke,

Acting Administrator, Health Resources and Services Administration.

[FR Doc. 01–11004 Filed 4–27–01; 3:10 pm]

BILLING CODE 4180–15–P

DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

Information Collection Renewal and Revision to be Submitted to the Office of Management and Budget (OMB) for Approval under the Paperwork Reduction Act

AGENCY: Fish and Wildlife Service, Interior.

ACTION: Proposed information collection; request for comments.

SUMMARY: The collection of information described below will be submitted to OMB for approval under the provisions of the Paperwork Reduction Act of 1995. Copies of specific information collection requirements, related forms and explanatory material may be obtained by contacting the Information Collection Clearance Officer of the U.S. Fish and Wildlife Service at the address and/or phone numbers listed below.

DATES: Consideration will be given to all comments received on or before July 2, 2001.

ADDRESSES: Comments and suggestions on specific requirements should be sent to Rebecca A. Mullin, Information Collection Clearance Officer, U.S. Fish and Wildlife Service, 4401 North Fairfax