days before the meeting. In addition, oral statements at the meeting by parties or entities not represented on the NANC will be permitted to the extent time permits. Such statements will be limited to five minutes in length by any one party or entity, and requests to make an oral statement must be received two business days before the meeting. Requests to make an oral statement or provide written comments to the NANC should be sent to Deborah Blue at the address under **FOR FURTHER INFORMATION CONTACT**, stated above.

Proposed Agenda—Tuesday, March 12, 2002

1. Announcements and Recent News
2. Approve Minutes
   —Meeting of January 15, 2002
   —Updated NANC Directory
3. Report of North American Numbering Plan Administrator (NANPA)
4. Report of NANPA Oversight Working Group
   —Initial evaluation of survey results
   —Industry associations to report on efforts to encourage members to complete surveys
5. Status of Industry Numbering Committee activities
   —Identifying ''policy'' issues
   —Summary ''walk through'' of NANP Expansion Plan
   —INC Regular Report
6. Report of National Thousands-Block Pooling Administrator
7. Report of NANP Expansion/ Optimization IMG
8. Report of the Local Number Portability Administration (LNPA) Working Group

Wireless Number Portability Operations (WNPO) Subcommittee
   —Native Block Pooling status
   —WNPO/CTIA: Status and risks to November 24, 2002 pooling and porting deadline
9. Report of NAPM LLC
10. Report from NBANC
11. Report of Cost Recovery Working Group
12. Report of E-Conferencing Subcommittee
13. Steering Committee
   —Table of NANC Projects
14. Report of Steering Committee
15. Action Items
16. Public Participation (5 minutes each)
17. Other Business

Adjourn (No later than 5 p.m.)

Wednesday, March 13, 2002 (If Required)

18. Complete any unfinished Agenda Items
19. Other Business

Adjourn (No later than 12:00 Noon)

Federal Communications Commission.

Diane L. Griffin,

Acting Chief, Network Services Division, Common Carrier Bureau.

[FR Doc. 02–4216 Filed 2–21–02; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Agency for Toxic Substances and Disease Registry

[ATSDR–179]

Public Health Assessments Completed

AGENCY: Agency for Toxic Substances and Disease Registry (ATSDR), Department of Health and Human Services (HHS).

ACTION: Notice.

SUMMARY: This notice announces those sites for which ATSDR has completed public health assessments during the period from September 2001 through December 2001. This list includes sites that are on or proposed for inclusion on the National Priorities List (NPL), and includes sites for which assessments were prepared in response to requests from the public.

FOR FURTHER INFORMATION CONTACT: Robert C. Williams, P.E., DEE, Assistant Surgeon General, Director, Division of Health Assessment and Consultation, Agency for Toxic Substances and Disease Registry, 1600 Clifton Road, NE, Mailstop E–32, Atlanta, Georgia 30333, telephone (404) 498–0007.

SUPPLEMENTARY INFORMATION: The most recent list of completed public health assessments was published in the **Federal Register** on November 16, 2001 (66 FR 57719). This announcement is the responsibility of ATSDR under the regulation, Public Health Assessments and Health Effects Studies of Hazardous Substances Releases and Facilities (42 CFR part 90). This rule sets forth ATSDR's procedures for the conduct of public health assessments under section 104(i) of the Comprehensive Environmental Response, Compensation, and Liability Act (CERCLA), as amended by the Superfund Amendments and Reauthorization Act (SARA) (42 U.S.C. 9604(i)).

Availability

The completed public health assessments and addenda are available for public inspection at the Division of Health Assessment and Consultation, Agency for Toxic Substances and Disease Registry, Building 33, Executive Park Drive, Atlanta, Georgia (not a mailing address), between 8 a.m. and 4:30 p.m., Monday through Friday except legal holidays. The completed public health assessments are also available by mail through the U.S. Department of Commerce, National Technical Information Service (NTIS), 5285 Port Royal Road, Springfield, Virginia 22161, or by telephone at (703) 605–6000. NTIS charges for copies of public health assessments and addenda. The NTIS order numbers are listed in parentheses following the site names.

Public Health Assessments Completed or Issued

Between September 10, 2001, and December 13, 2001, public health assessments were issued for the sites listed below:

NPL Sites

California

Omega Chemical Site (a/k/a Omega Chemical Corporation) (PB2002–100351).

Georgia

Marine Corps Logistics Base (PB2002–100526).

Illinois

Joliet Army Ammunition Plant (Manufacturing Area) and Joliet Army Ammunition Plant (Lap Area) (PB2002–100352).

Maryland

Andrews Air Force Base (PB2002–100354).

Beltsville Agricultural Research Center (PB2002–101482).

Massachusetts

Atlas Tack Site (a/k/a Atlas Tack Corporation) (PB2002–101491).

North Carolina

Petitioned Public Health Assessment (a/k/a Carolina Solite Corporation/ Aquadale) (PB2002–100417).

Puerto Rico

Isla de Vieques Bombing Site (PB2002–100532).

Utah

International Smelting and Refining (PB2002–100928).

Washington

Naval Undersea Warfare Center (NUWC) Division (a/k/a Naval Undersea Warfare Engineering Station) (PB2002–100405).

Boomsnub/Airco Superfund Site (a/k/a Boomsnub/Airco) (PB2002–100353).

Non NPL Petitioned Sites

None.

Dated: February 14, 2002.

Georgi Jones,

Director, Office of Policy and External Affairs, Agency for Toxic Substances and Disease Registry.

[FR Doc. 02–4318 Filed 2–21–02; 8:45 am]

BILLING CODE 4163–70–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–4030–N]

Medicare Program; Solicitation for Proposals for the Demonstration Project for Disease Management for Severely Chronically Ill Medicare Beneficiaries With Congestive Heart Failure, Diabetes, and Coronary Heart Disease

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

ACTION: Notice for solicitation of proposals.

SUMMARY: This notice informs interested parties of an opportunity to apply for a cooperative agreement for the Medicare Disease Management Demonstration. This demonstration uses disease management interventions to (1) improve the quality of services furnished to specific beneficiaries, (2) introduce full prescription drug coverage to encourage compliance with medical instructions and requirements, and (3) 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, namely, congestive heart failure, diabetes, or coronary heart disease. We intend to use a competitive application process to select up to three existing disease management organizations to participate in this demonstration.

Potentially qualified applicants are existing providers of disease management services applicable to the Medicare population specific to the three targeted chronic conditions.

DATES: Applications will be considered timely if we receive them on or before May 23, 2002.

ADDRESSES: Applications should be mailed to the following address: Department of Health and Human Services, Centers for Medicare & Medicaid Services, Attention: Tamara Jackson-Douglas, Project Officer, Center for Beneficiary Choices, Mail Stop: C4–17–27, 7500 Security Boulevard, Baltimore, Maryland 21244.

Please refer to the file code CMS–4030–N on the application. 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: Tamara Jackson-Douglas at (410) 786–9417, or by e-mail at *TJackson2@cms.hhs.gov.*

SUPPLEMENTARY INFORMATION: Our Disease Management Demonstration website (*www.hcfa.gov/research/dmdemo.htm*) contains additional information about these demonstrations and specific submission requirements for applications.

I. Background

A. Statutory Requirements

Section 121 of the Medicare, Medicaid, and State Child Health Insurance Program Benefits Improvement and Protection Act of 2000 (BIPA) requires the Secretary of Health and Human Services (the Secretary) to conduct a demonstration project for the Medicare fee-for-service population to demonstrate the impact on costs and health outcomes of applying disease management services, supplemented with coverage for prescription drugs, to specific Medicare beneficiaries with diagnosed, advanced-stage congestive heart failure, diabetes, or coronary heart disease. This demonstration project should result in a net reduction in aggregate Medicare expenditures. This project may include up to three organizations and cover up to 30,000 beneficiaries at a time. The project will last for 3 years.

B. Problem

Historically, a small proportion of Medicare beneficiaries has accounted for a major proportion of Medicare expenditures. For example, in 1996, 12.1 percent of all Medicare enrollees accounted for 75.5 percent ($126.1 billion) of all Medicare fee-for-service program payments. Many of these high-cost beneficiaries are chronically ill with certain common diagnoses, and most of the Medicare expenditures for their care are for repeated hospitalizations. During the next 30 years, as the population ages, the number of individuals and estimated cost of care for high-cost beneficiaries is expected to grow dramatically.

In the fee-for-service environment, health care for individuals with chronic illness has often been fragmented and poorly coordinated across multiple health care providers and multiple sites of care. Evidence-based practice guidelines have not always been followed, nor have patients always been taught how best to care for themselves. These shortcomings are particularly true for patients served under reimbursement systems in which providers lack incentives for controlling the frequency, mix, and intensity of services, and in which providers have limited accountability for the outcomes of care.

The vast majority of disease management patients' issues center around a single disease or condition and fall into fundamental problems with their own behavior, access to appropriate prescription drugs, or the disease-specific care they receive. Patient behavior-based problems include poor medication compliance, lack of self-care skills, and lack of adherence to recommended lifestyle changes. Patients' general reluctance to make major adjustments to their ways of life tends to be reinforced when patients are unable to see the direct or immediate benefits resulting from these changes.

Further compounding this problem for Medicare beneficiaries is the fact that Medicare generally does not cover outpatient prescription drugs. Beneficiaries wanting drug benefits have to purchase supplemental insurance, or join a Medicare+Choice plan if they are not already covered under an employer-sponsored retirement plan or a publicly-funded program, such as Medicaid or the Department of Veterans Affairs. Our research shows that, as of 1998, a majority (73 percent) of Medicare beneficiaries had some drug coverage at one point or another within a given year, and that fewer than half have had uninterrupted coverage for 2 consecutive years. Furthermore, questions remain regarding extent, quality, and comparability of coverage across different programs. Appropriate, effective pharmaceuticals are a key part of a comprehensive treatment program, and effective disease management must include access to appropriate medications.

Provider-related problems include failure to prescribe the most effective medications, poor coordination of care across providers and settings, lack of adherence to disease-specific guidelines based on evidence or expert panels, and inadequate follow-up and monitoring.