Other Matters
Discussion
9:30 a.m.—Invited Speakers
Peter Rowe, MD
Professor, Johns Hopkins Children's Center
General Pediatrics and Adolescent Medicine
Chronic Fatigue Syndrome
Discussion
Chelsa Morgan
Florida
CFS: A Dilemma Facing Young People
Discussion
10:30 a.m.—Break
10:45 a.m.—Invited Speakers
Betty McConnell
New Jersey Chronic Fatigue Syndrome, Inc.
CFS: Pediatric Education
Discussion
American Academy of Pediatrics (Invited)
CFS: The AAP Perspective
Discussion
11:30 a.m.—Public Comment
12 noon—Lunch Break
1 p.m.—Ex Officio Member Updates
Discussion
Recommendations Update
Discussion
Subcommittee Updates
Disabilities: Lyle Lieberman, Chair
Education: Dr. Robert Patarca, Chair
Research: Dr. Nahid Mohagheghpour, Chair
Discussion
2:45 p.m.—Break
3 p.m.—New and Other CFS-related Matters
4 p.m.—Public Comment
4:30 p.m.—Wrap-up
5 p.m.—Adjournment

Public attendance at the meeting is limited to space available. Individuals must provide a photo ID for entry into the meeting. Individuals who plan to attend and need special assistance, such as sign language interpretation or other reasonable accommodations, should notify the designated contact person. Members of the public will have the opportunity to provide comments at the meeting. Pre-registration is required for public comment by December 27, 2004. Any individual who wishes to participate in the public comment session should call the telephone number listed in the contact information to register. Public comment will be limited to five minutes per speaker. Any members of the public who wish to have printed material distributed to CFSAC members should submit materials to the Executive Secretary, CFSAC, whose contact information is listed above prior to close of business December 27, 2004.

Dated: November 24, 2004.

Larry E. Fields,

Executive Secretary, Chronic Fatigue Syndrome Advisory Committee.

[FR Doc. 04–27118 Filed 12–9–04; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare and Medicaid Services

[Document Identifier: CMS–10115, CMS–10123 & 10124, CMS–R–211, CMS–2552, and CMS–10048]

Agency Information Collection Activities: Proposed Collection; Comment Request.

AGENCY: Centers for Medicare and Medicaid Services.

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 (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.

1. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Federal Funding of Emergency Health Services (Section 1011): Enrollment Application; *Use:* These information collections will allow hospitals and other providers to enroll to receive payment for Section 1011 claim submissions. Section 1011 provides $250 million per year for fiscal years 2005–2008 for payments to eligible providers for emergency health services provided to undocumented aliens and other specified aliens; Form *Number:* CMS–10115 (OMB#: 0938–0929); *Frequency:* Other: as needed; *Affected Public:* Business or other for-profit, Not-for-profit institutions, and State, Local or Tribal Govt.; *Number of Respondents:* 62,500; *Total Annual Responses:* 62,500; *Total Annual Hours:* 31,250.

2. *Type of Information Collection Request:* New Collection; *Title of Information Collection:* Expedited Review Notices and Supporting Regulations contained in 42 CFR Sections 405.1200 and 405.1202; *Use:* These notices are used to inform beneficiaries that their provider services will end, and to provide beneficiaries who request an expedited determination with detailed information of why the services should end; *Form Numbers:* CMS–10123 & 10124 (OMB#: 0938–NEW); *Frequency:* On occasion; *Affected Public:* Individuals or Households, Business or other for-profit, and Not-for-profit institutions; *Number of Respondents:* 4,200,000; *Total Annual Responses:* 4,200,000; *Total Annual Hours:* 379,400.

3. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Model Application Template for State Child Health Plan Under Title XXI of the Social Security Act, State Children's Health Insurance Program, and Model Application Template and Instructions; *Use:* States are required to submit Title XXI plans and amendments for approval by the Secretary pursuant to section 2102 of the Social Security Act in order to receive funds for initiating and expanding health insurance coverage for uninsured children. The model application template is used to assist States in submitting a State Child Health Plan and amendments to that plan; *Form Number:* CMS–R–211 (OMB#: 0938–0707); *Frequency:* Quarterly and Annually; *Affected Public:* State, Local or Tribal Govt.; *Number of Respondents:* 40; *Total Annual Responses:* 40; *Total Annual Hours:* 3,200.

4. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Hospital and Health Care Complexes Cost Report and Supporting Regulations in 42 CFR 413.20 and 413.24; *Use:* This form is completed by Hospitals and Health Care Complexes participating in the Medicare program. Hospitals and Health Care Complexes use this form to report the health care costs for services they provide. The information reported on this form is used by CMS to determine the amount of reimbursable costs for services rendered to Medicare beneficiaries. The revisions to this form contain the provisions for implementing section 422 of the MMA. Section 422 deals with the calculation of GME and IME payments for redistribution of

unused resident slots; *Form Number:* CMS–2552–96 (OMB# 0938–0050); *Frequency:* Annually; *Affected Public:* Business or other for-profit, Not-for-profit institutions, and State, Local or Tribal Government; *Number of Respondents:* 6,111; *Total Annual Responses:* 6,111; *Total Annual Hours:* 4,046,782.

5. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Application Template for Health Insurance Flexibility and Accountability (HIFA) Section Demonstration Proposal; *Use:* The HIFA Initiative affords states an opportunity to expand coverage to the uninsured under Social Security Act Section 1115 demonstrations authority. States will be able to use Medicaid and State Child Health Insurance Program funds in concert with private insurance options to expand coverage to low-income uninsured individuals with a focus on those with income at or below 200 percent of the Federal poverty level. The model demonstration application will facilitate State efforts in designing programs to cover the uninsured; *Form Number:* CMS–10048 (OMB# 0938–0848); *Frequency:* Other: renewal every 5 yrs.; *Affected Public:* State, Local or Tribal Government; *Number of Respondents:* 10; *Total Annual Responses:* 9; *Total Annual Hours:* 42.

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access CMS' Web Site address at *http://www.cms.hhs.gov/regulations/pra/*, or E-mail your request, including your address, phone number, OMB number, and CMS document identifier, to *Paperwork@cms.hhs.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 Reduction Act Reports Clearance Officer designated at the address below: CMS, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development, Attention: Melissa Musotto, Room C5–14–03, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

Dated: December 3, 2004.

John P. Burke, III,

CMS Paperwork Reduction Act Reports Clearance Officer, Office of Strategic Operations and Regulatory Affairs, Regulations Development Group.

[FR Doc. 04–27145 Filed 12–9–04; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Notice of Hearing: Reconsideration of Disapproval of Oklahoma State Plan Amendment (SPA) 03–26

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

ACTION: Notice of hearing.

SUMMARY: This notice announces an administrative hearing on January 14, 2005, at 10 a.m., 1301 Young Street, Room 1113, Dallas, Texas 75202, to reconsider our decision to disapprove Oklahoma's Medicaid State Plan Amendment (SPA) 03–26.

DATES: Requests to participate in the hearing as a party must be received by the presiding officer by December 27, 2004.

FOR FURTHER INFORMATION CONTACT: Kathleen Scully-Hayes; Presiding Officer, CMS, Lord Baltimore Drive; Mail Stop LB–23–20, Baltimore, Maryland 21244, Telephone: 410–786–2055.

SUPPLEMENTARY INFORMATION: This notice announces an administrative hearing to reconsider CMS' decision to disapprove Oklahoma's Medicaid State Plan Amendment (SPA) 03–26.

Oklahoma submitted SPA 03–26 on January 2, 2004. This SPA would modify language regarding the rate-setting process for inpatient and outpatient hospital services. Specifically, this SPA would provide for supplemental payments to hospitals located in hospital districts pursuant to the Oklahoma Hospitals Public Trust and Authority Act.

The Centers for Medicare & Medicaid Services (CMS) was unable to approve SPA 03–26 because the SPA did not comply with sections 1902(a), 1902 (a)(19), 1903(w), and 1905(b) of the Social Security Act (the Act).

The payments proposed under SPA 03–26 would be funded through transfers from the Tulsa Hospital Public Trust Authority (THPTA) that CMS has determined are not consistent with the provisions of sections 1903(w)(1) and 1902(a) of the Act. Although the State has indicated that State law recognizes any such entity as a ''government entity * * * with powers of government,'' State law specifically withholds the governmental powers that are characteristic of a unit of government. THPTA is an association of hospitals (formed by the action of hospitals and with a board controlled by hospitals) that has no powers of taxation, or police or business regulation, and is not a sub-unit of the State government or any other local government that exercises such powers. While it has the power to impose assessments on member hospitals, the State has indicated that Oklahoma law specifically indicates that this power is not taxation. THPTA more closely resembles a private association that collects dues from its members. As a result, CMS has concluded that THPTA is not within the scope of a ''unit of government,'' and its assessments are not within the scope of ''state or local taxes'' as those terms are used under section 1903(w)(6) of the Act. Transfers of funds made by THPTA would thus not qualify for protected status under section 1903(w)(6)of the Act. Absent protected status, THPTA is within the definition of a provider-related entity under section 1903(w)(7) of the Act. As such, the transfers are subject to the provider-related donation requirements in section 1903(w)(l) of the Act and the implementing regulations in 42 CFR Part 433. Under those provisions, because payment of supplemental payments to member hospitals (the provider class) is contingent upon the receipt of donations from a provider-related entity, there is a hold harmless arrangement and the donation is not ''bona fide,'' as set forth in 42 CFR 433.54. Under section 1903(w)(l) of the Act, a donation that is not bona fide cannot be recognized as the non-Federal share of Medicaid expenditures that is required under section 1902(a) of the Act.

Nor is SPA 03–26 consistent with the requirement of section 1902(a)(19) of the Act that care and services will be provided consistent with ''simplicity of administration and the best interests of the recipients.'' The best interest of recipients is not served by a payment structure that is designed primarily to divert Medicaid payments from the providers to the State, and to shift financial burdens from the State to the Federal Government. The best interest of recipients requires that the full amount of Medicaid payments should be available to support access to quality care and services.

Finally, section 1905(b) of the Act specifies how the Federal medical assistance percentage (FMAP) will be calculated for states. This section clearly illustrates Congress' intentions as to how the financial partnership of the Medicaid program should operate. The formula in this cite clearly and explicitly states that the FMAP for any state shall be 100 per centum less the state percentage, and then further