four to five conference calls with some pre and post evaluation time (approximately 13 hours). Results from this process will influence the development of risk-adjustment and hierarchical modeling approaches for the AHRQ Quality Indicators. Beginning in late June through September, selected nominees will be asked to participate in the following activities:

Workgroup Activities

1. Provide evaluative comments on current methodology for risk-adjustment and hierarchical modeling (2.0 hours) and participate in subsequent Workgroup call (1.0 hour);
2. Participate in second Workgroup conference call to discuss suggested changes to the current modeling methodology, including the adoption of hierarchical methods (1.5 hour);
3. Provide evaluative comments on AHRQ's new draft or revised methodology (1.5 hour);
4. Participate in third Workgroup call to respond to each others' comments and questions or provide additional clarifications regarding draft methodology (1.5 hours);
5. Review draft summary document (1.5 hour);
6. Participate in fourth Workgroup call. Provide suggestions for summary document for public comment (2.0 hours); and,
7. Participate in final Workgroup call. Discuss and respond to public comments (2.0 hours).

Please note that should additional conference calls be necessary, Workgroup members are expected to make every effort to participate. The Workgroup will conduct business by telephone, e-mail, or other electronic means as needed.

FOR FURTHER INFORMATION CONTACT:

Mamatha Pancholi, Center for Delivery, Organization, and Markets, Agency for Healthcare Research and Quality, 540 Gaither Road, Rockville, MD 20850; Phone: (301) 427–1470; Fax: (301) 427–1430; E-mail: *mamatha.pancholi@ahrq.hhs.gov*

Marybeth Farquhar, Center for Delivery, Organization, and Markets, Agency for Healthcare Research and Quality, 540 Gaither Road, Rockville, MD 20850; Phone: (301) 427–1317; Fax: (301) 427–1430; E-mail: *marybeth.farquhar@ahrq.hhs.gov.*

SUPPLEMENTARY INFORMATION:

Background

The AHRQ Quality Indicators (AHRQ QIs) are a unique set of measures of health care quality that make use of readily available hospital inpatient administrative data. The QIs have been used for various purposes. Some of these include tracking, hospital self-assessment, reporting of hospital-specific quality or pay for performance. The AHRQ QIs are provider- and area-level quality indicators and currently consist of four modules: the Prevention Quality Indicators (PQI), the Inpatient Quality Indicators, the Patient Safety Indicators (PSI), and the Pediatric Quality Indicators (PedQIs). In response to feedback from the AHRQ QI user community, AHRQ is committed to developing risk adjustment approaches in an effort to provide an overall view of quality that is complete, useful and easily understandable to consumers and others with the health care field.

Dated: May 8, 2006.

Carolyn M. Clancy,

Director.

[FR Doc. 06–4574 Filed 5–15–06; 8:45am]

BILLING CODE 4160–90–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Proposed Criteria for Removing Chemicals From Future Editions of CDC's National Report on Human Exposure to Environmental Chemicals

AGENCY: Centers for Disease Control and Prevention (CDC), Health and Human Services (HHS).

ACTION: Notice.

SUMMARY: On Monday, October 7, 2002, CDC published final criteria for consideration of chemicals or categories of chemicals for possible inclusion in future releases of CDC's ''National Report on Human Exposure to Environmental Chemicals (the ''Report'') and also solicited chemicals for possible inclusion in future editions of the ''Report'' (See **Federal Register,** 67 FR 62477). The final selection criteria have remained the same since the issuance of the 2002 notice. They are as follows: (1) Independent scientific data which suggest that the potential for exposure of the U.S. population to a particular chemical is changing (*i.e.*, increasing or decreasing) or persisting; (2) seriousness of health effects known or suspected to result from exposure to the chemical (for example, cancer, birth defects, or other serious health effects); (3) proportion of the U.S. population likely to be exposed to levels of chemicals of known or potential health significance; (4) need to assess the efficacy of public health actions to reduce exposure to a chemical in the U.S. population or a large component of the U.S. population (for example, among children, women of childbearing age, the elderly); (5) existence of an analytical method that can measure the chemical or its metabolite in blood or urine with adequate accuracy, precision, sensitivity, and speed; and (6) incremental analytical cost (in dollars and personnel) to perform the analyses (preference is given to chemicals that can be added readily to existing analytical methods).

On Tuesday, September 30, 2003, CDC published a record of the nominated chemicals of interest that were scored by a panel of experts in accordance with the published selection criteria. (See **Federal Register**, 68 FR 56296.) All of this information is available on CDC's Web site at *http://www.cdc.gov/exposurereport/chemical_nominations.htm.* Past and future nominations do not result in obligatory laboratory analysis or inclusion of nominated chemicals in the ''Report,'' but rather serve to better inform CDC about which chemicals are of concern to the public.

CDC now requests public comment on proposed criteria for removing chemicals from future editions of the ''Report.'' These removal criteria (given below) will become part of a combined process of nominating chemicals for inclusion in or removal from the ''Report.'' This process will include (a) nominations from the public of chemicals to include or remove from the ''Report,''(b) an external scoring of nominations in accord with the published nomination and removal criteria, and (c) assistance from the Board of Scientific Counselors of CDC's National Center for Environmental Health/Agency for Toxic Substances and Disease Registry in reviewing plans for including or removing chemicals and identifying alternatives for monitoring specific at-risk population subgroups. This combined process for nomination and removal would occur periodically (*e.g.*, every six years). The criteria for selecting and removing chemicals apply only to those chemicals published in the ''Report,'' not those merely nominated.

The proposed removal criteria are as follows: A chemical may be removed from the ''Report'': (1) If a new replacement chemical (*i.e.*, a metabolite) is more representative of exposure than the chemical currently being measured or; (2) if after three survey periods (or not less than six years), detection rates for all chemicals within a methodological and chemically-related group* are less than 5 percent for all

population subgroups (two sexes, three race/ethnicity, and three age groups) or; (3) if after three survey periods (or not less than six years), levels of chemicals within a methodological and chemically-related group are unchanged or declining in all the specific subgroups as documented in the ''Report.''

A chemical would continue to be measured and not be removed from the ''Report'' if it met either of two proposed exceptions to these criteria: (a) It is a chemical for which there is an established biomonitoring health threshold (*e.g.*, CDC's level of concern for blood lead levels in children) or any chemical for which there is widespread public health concern (*e.g.*, mercury) or (b) three survey periods (or not less than six years) have passed, which constitute the minimum time before a chemical could be removed; a longer period may be necessary to account for the half-life of a particular chemical or to account for a recent change (*e.g.*, the removal of a chemical from commerce) that would necessitate monitoring of the population.

Note that the criteria for removing a chemical from the ''Report'' are not the corollaries of the criteria for adding chemicals to the ''Report.'' After reviewing and incorporating public comments from this announcement, CDC will publish the criteria in their final form in the **Federal Register.**

*Chemicals within a methodological and chemically related group are those which are detected and identified by a single test or analytic procedure, such that individual chemicals in the group cannot easily be dropped from analysis while others in the group continue to be monitored.

DATES: Submit comments on or before May 31, 2006, to the below address.

ADDRESSES: Address all comments concerning this notice to Dorothy Sussman, Centers for Disease Control and Prevention, National Center for Environmental Health, Division of Laboratory Sciences, Mail Stop F–20, 4770 Buford Highway, Atlanta, Georgia 30341.

FOR FURTHER INFORMATION CONTACT: Dorothy Sussman, Telephone 770–488–7950.

SUPPLEMENTARY INFORMATION: CDC publishes the ''Report'' under the authorities 42 U.S.C. 241 and 42 U.S.C. 242k. The ''Report'' provides ongoing assessment using biomonitoring of the exposure of the noninstitutionalized, civilian population to environmental chemicals. Biomonitoring assesses human exposure to chemicals by measuring the chemicals or their metabolites in human specimens such as blood or urine. For the ''Report,'' an environmental chemical means a chemical compound or chemical element present in air, water, soil, dust, food, or other environmental medium. The ''Report'' provides exposure information about participants in an ongoing national survey known as the National Health and Nutrition Examination Survey (NHANES). This survey is conducted by CDC's National Center for Health Statistics; measurements are conducted by CDC's National Center for Environmental Health. The first ''Report,'' published in March 2001, gave information about levels of 27 chemicals found in the U.S. population; the second ''Report,'' published in January 2003, contained exposure information on 116 chemicals, including the 27 chemicals in the first ''Report.'' The third ''Report,'' published in July 2005, contained exposure information on 148 chemicals, including data on the chemicals published in the second ''Report.'' This ''Report'' can be obtained in the following ways: access *http://www.cdc.gov/exposurereport;* e-mail *ncehdls @cdc.gov;* or telephone 1–866–670–6052. Over time, CDC will be able to track trends in exposure levels. The ''Report'' is published every 2 years; the fourth ''Report'' is slated for publication in 2007.

James D. Seligman,

Chief Information Officer, Centers for Disease Control and Prevention (CDC).

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BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Privacy Act of 1974; Report of a New System of Records

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Notice of a New System of Records (SOR).

SUMMARY: In accordance with the requirements of the Privacy Act of 1974, we are proposing to establish a new system titled, ''Medicaid Program and State Children's Health Insurance Program (SCHIP) Payment Error Rate Measurement (PERM), System No. 09–70–0578.'' The Improper Payments Information Act (IPIA) of 2002 (Pub. L. 107–300) requires heads of Federal agencies to annually estimate and report to the Congress national error rates for the programs they oversee. The Medicaid and SCHIP programs were identified by the Office of Management and Budget (OMB) as programs at risk for significant erroneous payments. OMB has directed HHS to report the estimated error rate for the Medicaid and SCHIP programs to OMB. Since Medicaid and SCHIP are administered by state agencies according to each state's unique program characteristics, state assistance in estimating improper payments is critical and continues to be necessary and important for the Secretary to comply with the requirements of the IPIA. CMS will use a national contracting strategy to calculate a state-by-state, comprehensive error rate for both the Medicaid and SCHIP programs. Implementing regulations set forth state requirements to: (1) Provide claims information to CMS for the purposes of estimating improper payment in Medicaid and SCHIP; and (2) measure improper payments in the Medicaid and SCHIP based on eligibility errors.

The primary purpose of this system is to collect and maintain individually identifiable claims information to calculate payment error rates for Medicaid and SCHIP programs. Information in this system will also be used to: (1) Support regulatory and policy functions performed within the Agency or by a contractor, consultant or grantee; (2) assist another Federal or state agency in the proper administration of the Medicare program, enable such agency to administer a Federal health benefits program, and/or assist Federal/state Medicaid programs within the state; (3) support constituent requests made to a Congressional representative; (4) to support litigation involving the Agency related to this system; and (5) combat fraud and abuse in certain health benefits programs. We have provided background information about the proposed system in the **SUPPLEMENTARY INFORMATION** section below. Although the Privacy Act requires only that the ''routine use'' portion of the system be published for comment, CMS invites comments on all portions of this notice. See ''Effective Dates'' section for comment period.

EFFECTIVE DATES: CMS filed a new SOR report with the Chair of the House Committee on Government Reform and Oversight, the Chair of the Senate Committee on Homeland Security & Governmental Affairs, and the Administrator, Office of Information and Regulatory Affairs, OMB on May 9, 2006. To ensure that all parties have adequate time in which to comment, the new system will become effective 30