## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Centers for Medicare & Medicaid Services

**[CMS–3155–N]**

**RIN 0938–AN67**

### Medicare Program; Quality Improvement Organization Contracts: Solicitation of Statements of Interest From In-State Organizations—Alaska, Hawaii, Idaho, Maine, South Carolina, Vermont, and Wyoming

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

**ACTION:** Notice.

**SUMMARY:** This notice, in accordance with Section 1153(i) of the Social Security Act, gives at least 6-months' advance notice of the expiration dates of contracts with out-of-State Utilization and Quality Control Peer Review Organizations. It also specifies the period of time in which in-State organizations may submit a statement of interest so that they may be eligible to compete for these contracts.

**DATES:** Written statements of interest must be received at the address specified no later than 5 p.m. EST February 22, 2005. Due to staffing and resource limitations, we cannot accept statements submitted by facsimile (FAX) transmission.

**ADDRESSES:** Statements of interest must be submitted to the Centers for Medicare & Medicaid Services, Acquisitions and Grants Groups, OOM, Attn.: Carol G. Sevel, 7500 Security Boulevard, Mail Stop C2–21–15, Baltimore, Maryland 21244–1850.

**FOR FURTHER INFORMATION CONTACT:** Udo Nwachukwu, (410) 786–7234.

**SUPPLEMENTARY INFORMATION:**

## I. Background

The Peer Review Improvement Act of 1982 (Title I, subtitle C of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Pub. L. 97–248) amended Part B of Title XI of the Social Security Act (the Act) by establishing the Utilization and Quality Control Peer Review Organization program.

Utilization and Quality Control Peer Review Organizations, now known as Quality Improvement Organizations (QIOs), currently review certain health care services furnished under Title XVIII of the Act (Medicare) and certain other Federal programs to determine whether those services are reasonable, medically necessary, provided in the appropriate setting, and are of a quality that meet professionally recognized standards. QIO activities are a part of the Health Care Quality Improvement Program (HCQIP), a program that supports our mission to ensure health care security for our beneficiaries. The HCQIP rests on the belief that a plan's, provider's, or practitioner's own internal quality management system is key to good performance. The HCQIP is carried out locally by the QIO in each State. Under the HCQIP, QIOs provide critical tools (for example, quality indicators and information) for plans, providers, and practitioners to improve the quality of care provided to Medicare beneficiaries. The Congress created the QIO program in part to redirect, simplify, and enhance the cost-effectiveness and efficiency of the peer review process.

In June 1984, we began awarding contracts to QIOs. We currently maintain 53 QIO contracts with organizations that provide medical review activities for the 50 States, the District of Columbia, Puerto Rico, and the Virgin Islands. The organizations that are eligible to contract as QIOs have satisfactorily demonstrated that they are either physician-sponsored or physician-access organizations in accordance with sections 1152 and 1153 of the Act and our regulations at 42 CFR 475.102 and 475.103. A physician-sponsored organization is one that is both composed of a substantial number of the licensed doctors of medicine and osteopathy practicing medicine or surgery in the respective review area and who are representative of the physicians practicing in the review area. A physician-access organization is one that has available to it, by arrangement, the services of a sufficient number of licensed doctors of medicine or osteopathy practicing medicine or surgery in the review area to ensure adequate peer review of the services furnished by the various medical specialties and subspecialties. In addition, the organization must not be a health care facility, health care facility association, a health care facility affiliate, or in most cases a payor organization. (Statutes and regulations provide that, in the event CMS determines no otherwise qualified non-payor organization is available to undertake a given QIO contract, CMS may select a payor organization which otherwise meets requirements to conduct QIO Utilization and Quality Control Peer Review as specified in Part B of Title XI of the Social Security Act and implementing regulations.) The selected organization must have a consumer representative on its governing board.

The Omnibus Budget Reconciliation Act of 1987 (Pub. L. 100–203) amended section 1153 of the Act by adding new paragraph (i) that prohibits us from renewing the contract of any QIO that is not an in-State organization without first publishing in the **Federal Register** a notice announcing when the contract will expire. This notice must be published no later than 6-months before the date the contract expires and must specify the period of time during which an in-State organization may submit a proposal for the contract. If one or more qualified in-State organizations submit a proposal within the specified period of time, we cannot automatically renew the contract on a noncompetitive basis, but must instead provide for competition for the contract in the same manner used for a new contract. An in-State organization is defined as an organization that has its primary place of business in the State in which review will be conducted (or, that is owned by a parent corporation, the headquarters of which is located in that State).

There are currently 7 QIO contracts with entities that do not meet the statutory definition of an in-State organization. The areas affected for purposes of this notice along with their respective expiration dates are as follows: Vermont, July 31, 2005; Wyoming, July 31, 2005; Maine, July 31, 2005; Alaska, October 31, 2005; Idaho, October 31, 2005; Hawaii, January 31, 2006; South Carolina, January 31, 2006.

## II. Provisions of the Notice

This notice announces the scheduled expiration dates of the current contracts between CMS and out-of-State QIOs responsible for review in the areas mentioned above.

Interested in-State organizations may submit statements of interest in competing to become the QIO for these States. We must receive the statements no later than February 22, 2005, and in its statement of interest, the organization must furnish materials that demonstrate that it meets the definition of an in-State organization. Specifically, the organization must have its primary place of business in the State in which review will be conducted or be a subsidiary of a parent corporation, whose headquarters is located in that State. In its statement, each interested organization must further demonstrate that it meets the following requirements:

### *A. Be Either a Physician-Sponsored or a Physician-Access Organization*

1. Physician-Sponsored Organization

To be eligible as a physician-sponsored organization, the

organization must meet the following requirements:

a. Be composed (have physicians as owners or members) of at least 20 percent of the licensed doctors of medicine and osteopathy practicing medicine or surgery in the State (that is, at least 20 percent of the practicing physicians in the State are owners of the QIO, or the QIO is owned by an entity which includes at least 20 percent of the practicing physicians in the State as members); or

b. Be composed (have physicians as owners or members) of at least 10 percent of the licensed doctors of medicine and osteopathy practicing medicine or surgery in the State, and demonstrate through means (for example, letters of support from physicians or physician organizations) acceptable to CMS that the organization is representative of an additional 10 percent of the practicing physicians in the State; and

c. Not be a health care facility, health care facility association, or health care facility affiliate.

2. Physician-Access Organization

To be eligible as a physician-access organization, the organization must meet the following requirements:

a. Have arrangements with doctors of medicine or osteopathy, licensed and practicing in the State, to conduct review for the organization;

b. Have available at least one physician, licensed in the State, from every generally recognized specialty and subspecialty who is in active practice in the review area; and

c. Not be a health care facility, health care facility association, or health care facility affiliate.

*B. Have at Least One Individual Who Is a Representative of Consumers on Its Governing Board*

If one or more organizations meet the above requirements in one of the 7 QIO areas in this notice and submit statements of interest in accordance with this notice, we will consider those organizations to be potential sources for contract upon its expiration. These organizations will be entitled to participate in a full and open competition for the QIO contract to perform the QIO statement of work.

## III. Information Collection Requirements

This notice contains information collection requirements that have been approved by the Office of Management and Budget (OMB) under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35) and assigned OMB Control Number 0938–0526 entitled ''Quality Improvement (formerly Peer Review) Organization, Contracts: Solicitation of Statements of Interest from In-State Organization, General Notice and Supporting Regulations.''

**Authority:** Section 1153 of the Social Security Act (42 U.S.C. 1320c-2).

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

Dated: January 26, 2005.

**Mark B. McClellan,**

*Administrator, Centers for Medicare & Medicaid Services.*

[FR Doc. 05–1878 Filed 1–27–05; 5:06 pm]

BILLING CODE 4120–01–P

---

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

## Centers for Medicare & Medicaid Services

**[CMS–1299–N]**

## Medicare Program; Monthly Payment Amounts for Oxygen and Oxygen Equipment for 2005, in Accordance with Section 302(c) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003

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

**ACTION:** Notice.

**SUMMARY:** This notice discusses a reduction in the 2005 monthly payment amounts for oxygen and oxygen equipment based on the percentage difference between Medicare's 2002 monthly payment amounts for each State and the median 2002 Federal Employee Health Benefit plan price reported by the Office of Inspector General. This reduction is required by section 302(c) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

**FOR FURTHER INFORMATION CONTACT:** Joel Kaiser, (410) 786–4499, *jkaiser@cms.hhs.gov.*

**SUPPLEMENTARY INFORMATION:**

## I. Background

In accordance with section 302(c) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108–173, enacted on December 8, 2003), Medicare's monthly payment amounts for oxygen and oxygen equipment for 2005 are to include a reduction based on the percentage difference between Medicare's 2002 monthly payment amounts for each State and the median 2002 Federal Employee Health Benefit (FEHB) plan price reported by the Office of Inspector General (OIG). The OIG has alerted us that they will need to collect additional information before the FEHB medians for oxygen and oxygen equipment and portable oxygen equipment are finalized. Therefore, Medicare claims for oxygen and oxygen equipment and portable oxygen equipment furnished on or after January 1, 2005, and identified by the Healthcare Common Procedure Coding System codes listed below, will be temporarily paid based on the 2004 monthly payment amounts. In accordance with the authority provided by section 1871(e)(1)(A)(ii) of the Social Security Act, we are making this change retroactive for items and services furnished on or after January 1, 2005, because we have determined that it would be contrary to the public interest to implement 2005 payment amounts based on preliminary and potentially erroneous data.

- E0424—Stationary Compressed Gaseous Oxygen System, Rental: Includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing;
- E0439—Stationary Liquid Oxygen System, Rental: Includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing;
- E1390—Oxygen Concentrator, Single delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate;
- E1391—Oxygen Concentrator, Dual delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate;
- E0431—Portable Gaseous Oxygen System, Rental: Includes portable container, regulator, flowmeter, humidifier, cannula or mask, and tubing;
- E0434—Portable Liquid Oxygen System, Rental: Includes portable container, supply reservoir, humidifier, flowmeter, refill adaptor, contents gauge, cannula or mask, and tubing.

Once we receive the FEHB medians from the OIG, we will calculate and implement the 2005 monthly payment amounts and will begin paying claims using these amounts. These amounts will apply prospectively only. This is explained at *http://www.cms.hhs.gov/suppliers/dmepos/.* Any future updates will also be published at this website.