DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–3081–N]

RIN 0938–ZA26

Medicare Program; Peer Review Organization Contracts: Solicitation of Statements of Interest From In-State Organizations—Alaska, Hawaii, Idaho, Illinois, Kentucky, Maine, Nebraska, 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 11, 2002. 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, OICS, Attn.: Edward L. Hughes, 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 (PRO) program.

PROs currently review certain health care services furnished under title XVIII of the Act (Medicare) and under certain other Federal programs to determine whether those services are reasonable, medically necessary, provided in the appropriate setting, and are of a quality that meets professionally recognized standards. PRO activities are a part of the Health Care Quality Improvement Program (HCQIP), a program which 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 PRO in each State. Under the HCQIP, PROs 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 PRO 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 PROs. We currently maintain 53 PRO 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 PROs 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 or otherwise, 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 nonpayor organization is available to undertake a given PRO contract, CMS may select a payor organization that otherwise meets requirements to be eligible to conduct PRO Utilization and Quality Control Peer Review.) 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 a new paragraph (i) that prohibits us from renewing the contract of any PRO 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 10 PRO 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:

Illinois, July 31, 2002
Vermont, July 31, 2002
Wyoming, July 31, 2002
Maine, July 31, 2002
Alaska, October 31, 2002
Idaho, October 31, 2002
Hawaii, January 31, 2003
Kentucky, January 31, 2003
Nebraska, January 31, 2003
South Carolina, January 31, 2003

II. Provisions of the Notice

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

Interested in-State organizations may submit statements of interest to be the PRO for these States. We must receive the statements no later than February 11, 2002, 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

a. The organization must be composed of a substantial number of the licensed

doctors of medicine and osteopathy practicing medicine or surgery in the review area, and who are representative of the physicians practicing in the review area.

b. The organization must not be a health care facility, health care facility association, health care facility affiliate, or in most cases a payor organization.

c. In order to meet the ''substantial number of doctors of medicine and osteopathy'' requirement of paragraph A.1.a of this section, an organization must be composed of at least 10 percent of the licensed doctors of medicine and osteopathy practicing medicine or surgery in the review area. In order to meet the representation requirement of paragraph A.1.a of this section, an organization must state and have documentation in its files demonstrating that it is composed of at least 20 percent of the licensed doctors of medicine and osteopathy practicing medicine or surgery in the review area. Alternatively, if the organization does not demonstrate that it is composed of at least 20 percent of the licensed doctors of medicine and osteopathy practicing medicine or surgery in the review area, the organization must demonstrate in its statement of interest through letters of support from physicians or physician organizations, or through other means, that it is representative of the area physicians.

2. Physician-Access Organization

a. The organization must have available to it, by arrangement or otherwise, the services of a sufficient number of the 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.

b. The organization must not be a health care facility, health care facility association, health care facility affiliate, or in most cases a payor organization.

c. An organization meets the requirements of paragraph A.2.a of this section if it demonstrates that it has available to it at least one physician in every generally recognized specialty and has an arrangement or arrangements with physicians under which the physicians would conduct review for the organization.

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 a PRO area and submit statements of interest in accordance with this notice, we will consider those organizations to be potential sources for the 10 contracts upon their expiration. These organizations will be entitled to participate in a full and open competition for the PRO contract to perform the PRO 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.

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: December 12, 2001.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 02–1066 Filed 1–24–02; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–4034–N]

Medicare Program: Meeting of the Advisory Panel on Medicare Education—February 13, 2002

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

ACTION: Notice of meeting.

SUMMARY: In accordance with section 10(a) of the Federal Advisory Committee Act (5 U.S.C. App. 2), this notice announces a meeting of the Advisory Panel on Medicare Education (the Panel) on Wednesday, February 13, 2002. This Panel advises and makes recommendations to the Secretary of the Department of Health and Human Services (HHS) and the Administrator of the Centers for Medicare & Medicaid Services (CMS), on opportunities for CMS to optimize the effectiveness of the National Medicare Education Program and other CMS programs that help Medicare beneficiaries understand Medicare and the range of Medicare options available with the passage of the Medicare+Choice program. The Panel meeting is open to the public.

DATES: The meeting is scheduled for Wednesday, February 13, 2002, from 9:00 am. to 5:00 pm.

ADDRESSES: The meeting will be held at the Wyndham Washington Hotel, 1400 M Street, NW., Washington, DC, 20005, (202) 429–1700.

FOR FURTHER INFORMATION CONTACT: Nancy Caliman, Health Insurance Specialist, Division of Partnership Development, Center for Beneficiary Choices, Centers for Medicare & Medicaid Services, 7500 Security Boulevard, S2–23–05, Baltimore, MD, 21244–1850, (410) 786–5052. Please refer to the CMS Advisory Committees Information Line (1–877–449–5659 toll free)/(410–786–9379 local) or the Internet (*http://www.hcfa.gov/events/apme/homepage.htm*) for additional information and updates on committee activities, or contact Ms. Caliman via e-mail at *APME@cms.hhs.gov*. Press inquiries are handled through the CMS Press Office at (202) 690–6145.

SUPPLEMENTARY INFORMATION: Section 222 of the Public Health Service Act (42 U.S.C. 217a), as amended, grants to the Secretary the authority to establish an advisory panel if the Secretary finds the panel necessary and in the public interest. The Secretary signed the charter establishing this Panel on January 21, 1999 and the charter renewing the Panel on January 18, 2001. The Advisory Panel on Medicare Education advises the Department of Health and Human Services and the Centers for Medicare & Medicaid Services on opportunities to enhance the effectiveness of consumer education strategies concerning the Medicare program.

The goals of the Panel are to provide advice concerning optimal strategies for:

- Developing and implementing a national Medicare education program that describes the options for selecting a health plan under Medicare;
- Enhancing the Federal government's effectiveness in informing the Medicare consumer, including the appropriate use of public-private partnerships;
- Expanding outreach to vulnerable and underserved communities, including racial and ethnic minorities, in the context of a national Medicare education program;
- Assembling an information base of best practices for helping consumers evaluate health plan options and building a community infrastructure for information, counseling, and assistance.

The current members of the Panel are: Diane Archer, J.D., President, Medicare Rights Center; David Baldridge, Executive Director, National Indian Council on Aging; Bruce Bradley, M.B.A., Director, Managed Care Plans, General Motors Corporation; Carol