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.

II. Provisions of the Notice

The purpose of this notice is to notify the public that the OIG has informed us of their need for additional information before the provision may be used and implemented to reduce 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 OIG.

III. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995.

IV. Regulatory Impact Statement

We have examined the impact of this notice as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). This notice does not reach the economic threshold and thus is not considered a major rule.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $6 million to $29 million in any 1 year. Individuals and States are not included in the definition of a small entity. We are not preparing an analysis for the RFA because we have determined that this notice will not have a significant economic impact on a substantial number of small entities. In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. We are not preparing an analysis for section 1102(b) of the Act because we have determined that this notice will not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditure in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. This notice will have no consequential effect on the governments mentioned or on the private sector.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. Since this regulation does not impose any costs on State or local governments, the requirements of E.O. 13132 are not applicable.

In accordance with the provisions of Executive Order 12866, this document was not reviewed by the Office of Management and Budget.

Authority: Section 302(c) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).

(Catalog of Federal Domestic Assistance Program No. 93.774, Medicare-Supplemental Medical Insurance Program)

Dated: January 19, 2005.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 05–2176 Filed 2–3–05; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1366–N]

Medicare Program; Meeting of the Practicing Physicians Advisory Council—March 7, 2005

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

ACTION: Notice.

SUMMARY: In accordance with section 10(a) of the Federal Advisory Committee Act, this notice announces a meeting of the Practicing Physicians Advisory Council (the Council). The Council will be meeting to discuss certain proposed changes in regulations and carrier manual instructions related to physicians' services, as identified by the Secretary of the Department of Health and Human Services (the Secretary). This meeting is open to the public.

DATES: The meeting is scheduled for Monday, March 7, 2005, from 8:30 a.m. until 5 p.m. e.s.t.

ADDRESSES: The meeting will be held in Room 705A 7th floor, in the Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201.

Meeting Registration: Persons wishing to attend this meeting must contact John P. Lanigan, the Designated Federal Official (DFO) by e-mail at *JLanigan@cms.hhs.gov* or by telephone at (410) 786–2312, at least 72 hours in advance of the meeting to register. Persons not registered in advance will not be permitted to enter the Hubert H. Humphrey Building and will not be permitted to attend the Council meeting. Persons attending the meeting will be required to show a photographic identification, preferably a valid driver's license, before entering the building.

FOR FURTHER INFORMATION CONTACT: Kenneth Simon, M.D., Executive Director, Practicing Physicians Advisory Council, 7500 Security Blvd., Mail Stop C4–10–07, Baltimore, MD, 21244–1850, telephone (410) 786–2312,or e-mail *Ksimon@cms.hhs.gov.* News media representatives must contact the CMS Press Office, (202) 690–6145. Please refer to the CMS Advisory Committees Information Line (1–877–449–5659 toll free)/(410)786–9379 local) or the Internet at *http://www.cms.hhs.gov/faca/ppac/default.asp* for additional information and updates on committee activities.

SUPPLEMENTARY INFORMATION: The Secretary is mandated by section 1868(a) of the Social Security Act (the