misconduct and administrative actions in response to allegations of research misconduct involving research conducted or supported by the Public Health Service (PHS) OPDIVs, including reversal of an institution's no misconduct finding or opening of a new investigation; (14) responsible for management and oversight of human research subjects protections functions and related activities where research involves human subjects; (15) provides oversight and direction to the Regional Health Administrators (I–X) and their associated staff; (16) directs and manages the PHS Commissioned Corps, which includes a cadre of health professionals, and the associated personnel systems in support of the missions of the Department of Health and Human Services, U.S. Public Health Service, and agencies in which officers are assigned or detailed to, and provides oversight and direction for officer assignments and professional development; (17) provides policy and related oversight of the Commissioned Corps: and (18) manages the vaccine and immunization related activities for the Secretary.

2. At the end of Paragraph L, insert the following new component: ''*M. National Vaccine Program Office (ACP)'': The Office:* (1) Advises the Assistant Secretary for Health (the Director of the National Vaccine Program) regarding issues and concerns identified with the implementation of the responsibilities of the National Vaccine Program; (2) develops and provides the Assistant Secretary for Health an annual plan for the implementation of the responsibilities of the NVPO; (3) develops data and conducts analyses of Federal spending on vaccines and vaccine-related activities; (4) provides executive-secretary, staff and administrative support to the National Vaccine Advisory Committee; and (5) coordinates preparation and submission of the annual National Vaccine Report for transmittal by the Assistant Secretary for Health.

III. Delegation for Authority: All delegations and redelegations of authority made by officials and employees of affected organizational components will continue in them or their successors pending further redelegation, provided they are consistent with this reorganization.

Effective Date: This reorganization is effective on the date of signature.

Dated: December 22, 2003.

Tommy G. Thompson,

Secretary.

[FR Doc. 04–120 Filed 1–5–04; 8:45 am]

BILLING CODE 4150–28–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1373–N]

RIN 0938–AN00

Medicare Program; Notice of One-Time Appeal Process for Hospital Wage Index Classification

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

ACTION: Notice.

SUMMARY: In accordance with section 508(a) of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, this notice establishes a one-time appeal process by which a hospital may appeal the wage index classification otherwise applicable to the hospital.

DATES: *Effective Date:* This notice is effective January 1, 2004.

Deadline for Submission of Appeal Requests: Appeal requests will be considered if the Medicare Geographic Classification Review Board receives them, at the appropriate address, no later than 5 p.m. EDT on February 15, 2004.

Applicability: Geographic redesignations granted under this process are applicable to discharges occurring during the 3-year period beginning with discharges on or after April 1, 2004 and before April 1, 2007.

FOR FURTHER INFORMATION CONTACT: Stephen Phillips, (410) 786–4548.

SUPPLEMENTARY INFORMATION:

I. Background

Under section 1886(d)(10) of the Act, the Medicare Geographic Classification Review Board (MGCRB) considers applications by hospitals for geographic reclassification for purposes of payment under the inpatient prospective payment system (IPPS). Hospitals can elect to reclassify for the wage index or the standardized amount, or both, and as individual hospitals or as groups. Generally, hospitals must be proximate to the labor market area to which they are seeking reclassification and must demonstrate characteristics similar to hospitals located in that area. Hospitals must apply for reclassification to the MGCRB. The MGCRB issues its decisions by the end of February for reclassifications to become effective for the following fiscal year (beginning October 1). The regulations applicable to reclassifications by the MGCRB are located in §§ 412.230 through 412.280.

Section 1886(d)(10)(D)(v) of the Act provides that, beginning with FY 2001, an MGCRB decision on a hospital reclassification for purposes of the wage index is effective for 3 fiscal years, unless the hospital elects to terminate the reclassification. Section 1886(d)(10)(D)(vi) of the Act provides that the MGCRB must use the 3 most recent years' average hourly wage data in evaluating a hospital's reclassification application for FY 2003 and any succeeding fiscal year.

Section 304(b) of Public Law (Pub. L.) 106–554 provides that the Secretary must establish a mechanism under which a statewide entity may apply to have all of the geographic areas in the State treated as a single geographic area for purposes of computing and applying a single wage index, for reclassifications beginning in FY 2003. The implementing regulations for this provision are located at § 412.235.

Section 1886(d)(8)(B) of the Act permits a hospital located in a rural county adjacent to one or more urban areas to be designated as being located in the Metropolitan Statistical Areas (MSA) to which the greatest number of workers in the county commute if—(1) the rural county would otherwise be considered part of an urban area under the standards published in the **Federal Register** for designating MSAs (and for designating New England County Metropolitan Areas (NECMAs)), and (2) if the commuting rates used in determining outlying counties (or, for New England, similarly recognized areas) were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or counties of all contiguous MSAs (or NECMAs). Hospitals that meet these criteria are deemed urban for purposes of the standardized amounts and for purposes of assigning the wage index.

On June 6, 2003, the Office of Management and Budget (OMB) issued OMB Bulletin No. 03–04, announcing revised definitions of MSAs and new definitions of Micropolitan Statistical Areas and Combined Statistical Areas. The new definitions recognize 49 new Metropolitan Statistical Areas and 565 new Micropolitan Statistical Areas, as well as extensively revising the construct of many of the existing Metropolitan Areas. We are in the process of evaluating these new MSA

definitions. At this time, however, we have not adopted these revised MSA definitions for purposes of the wage index. Therefore, references to MSAs (and, by inference, NECMAs) in this notice refer to the MSAs currently used for the wage index, those in place prior to the new definitions announced in June 2003 by OMB.

II. Provisions of the Notice

Section 508(a) of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MPDIMA) (Pub. L. 108–173) provides that, by January 1, 2004, the Secretary must establish by instruction or otherwise, a process for hospitals to appeal their wage index classification. This notice establishes that process.

A. One-Time Appeal Process Requirements

Under this process, a qualifying hospital may appeal the wage index classification otherwise applicable to the hospital and apply for reclassification to another area of the State in which the hospital is located (or, at the discretion of the Secretary, to an area within a contiguous State). Such reclassifications are applicable to discharges occurring during the 3-year period beginning April 1, 2004 and ending March 31, 2007.

The process requirements under section 508(a)(2) and (a)(3) of Pub. L. 108–173 are as follows:

- A hospital must file an appeal request no later than February 15, 2004.
- The MGCRB will consider the request of any qualifying hospital to change its geographic classification for purposes of determining the hospital's area wage index. The MGCRB will issue a decision on the requests. There shall be no further administrative review or judicial appeal of the MGCRB's decision.
- If the MGCRB determines that the hospital is a qualifying hospital, the hospital shall be reclassified to the selected area within the State where the hospital is located (or, at the discretion of the Secretary, to an area within a contiguous State). The approved reclassification will be effective for 3 years beginning with discharges occurring on April 1, 2004.

Under section 508(c) of Pub. L. 108–173, a ''qualifying hospital'' is defined as a subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Act) that—

- Does not qualify for a change in wage index classification under paragraphs (8) or (10) of section 1886(d) of the Act on the basis of requirements relating to distance or commuting. Current distance and commuting criteria for individual hospitals seeking reclassification are set forth in § 412.230(b) of the regulations. Rural referral center and sole community hospital distance requirements are at § 412.230(a)(3)(ii). Generally, hospitals must demonstrate a close proximity to the labor market area to which they are seeking reclassification. The proximity criteria are met if—(1) for an urban hospital the distance from the hospital to the area to which the hospital is reclassifying is no more than 15 miles; and (2) for a rural hospital, the distance from the hospital to the area to which the hospital is reclassifying is no more than 35 miles (§ 412.230(b)(1)) or; at least 50 percent of the hospital's employees reside in the area (§ 412.230(b)(2)). Rural referral centers and sole community hospitals are required to reclassify to the urban or another rural area closest to the hospital. (§ 412.230(a)(3)(ii)); and,
- Meets such other criteria, such as quality, as the Secretary may specify by instruction or otherwise.

Section 508(b) specifies that approved requests under this process must not affect the wage index computation for any area or any other hospital and shall not be budget neutral. The provisions of this section shall not affect payment for discharges occurring after the end of the 3-year period, which ends March 31, 2007. Finally, as specified, the total additional expenditures of this section shall not exceed $900 million.

Under § 412.273(b), a hospital may terminate an approved 3-year reclassification for purposes of the wage index within 45 days of publication of CMS's annual notice of proposed rulemaking concerning changes and updates to the IPPS for the fiscal year for which the termination is to apply. That is, a hospital may terminate its wage index reclassification during either the first, second, or third year of that reclassification. In order to terminate a reclassification under this one-time process, a hospital should follow the process at § 412.273(b). Terminations will be effective with discharges during the following Federal fiscal year (beginning October 1). Hospitals whose applications under the one-time process are approved will not be able to terminate such a reclassification prior to October 1, 2004.

B. One-Time Appeal Process Criteria

All hospitals seeking reclassification under this one-time process *must submit an application consistent with the process described in section II.D. of this notice.* Hospitals that have submitted an application under the routine MGCRB application process must still submit a separate application for consideration by the MGCRB under this process. The MGCRB must approve a request, from any subsection (d) hospital, for geographic reclassification for purposes of wage index under this process if both of the following criteria are met (*see* section II.C. of this notice for a discussion of the rationale for the criteria). For purposes of applying these criteria, average hourly wages (AHW) refers to the 3-year average AHWs published in the August 1, 2003 final rule (68 FR 45345) for hospitals (Table 2) and MSAs and rural areas (Tables 3A and 3B, respectively), as corrected in the October 6, 2003 **Federal Register** (68 FR 57732). As noted above, references to MSAs refer to the MSA definitions currently employed for the wage index, those in place prior to OMB's announcement of revised MSAs in June 2003. Note that *both* of the following criteria must be met in all reclassifications under this process:

1. A hospital meets neither the distance requirement set forth in § 412.230(b)(1) nor the commuting requirement set forth in § 412.230(b)(2) (or fails to meet § 412.230(a)(3)(ii) in the case of a rural referral center or sole community hospital) to be reclassified into the MSA for which the request under the process established by this notice is submitted.

2. The hospital does not otherwise qualify for reclassification effective for discharges on or after October 1, 2004 (except in the case of criteria 2(b) and 2(g) below), under the reclassification process at 42 CFR part 412 subpart L, and one of the following criteria is met:

a. The hospital is an urban hospital located in a State with fewer than 10 people per square mile. The hospital may only reclassify under the process established by this notice to another MSA within its State (Based on the 2000 Census data, only urban hospitals in the States of Montana, North Dakota, South Dakota, and Wyoming meet this criteria.)

b. The hospital is currently (for FY 2004) reclassified into another MSA and the hospital's 3-year AHW is at least 108 percent of the AHW of the hospitals geographically located in the MSA to which the hospital is currently reclassified. The hospital may only reclassify under this process to an MSA within the hospital's State that has an area AHW nearest to, but not less than, the hospital's AHW. If there is no such MSA, the hospital will receive a wage index calculated based upon its own AHW. If a hospital that otherwise would be reclassified effective for discharges on or after October 1, 2004 is approved

for reclassification under this one-time appeal process based upon this criterion, any other reclassifications shall be considered to have been terminated effective for discharges on or after April 1, 2004.

c. The hospital is currently (for FY 2004) reclassified by the MGCRB to another MSA but, upon applying to the MGCRB for FY 2005, is ineligible for reclassification because its AHW is now less than 84 percent (but greater than 82 percent) of the AHW of the hospitals geographically located in the MSA to which the hospital applied for reclassification for FY 2005. The hospital may only reclassify under this process to an MSA within its State with an FY 2004 wage index value that is nearest to the FY 2004 wage index the hospital currently receives.

d. The hospital was part of an urban county group reclassification application to the MGCRB for FY 2004 or FY 2005 in accordance with § 412.234, but the application did not meet the standardized amount criteria set forth in § 412.234(c). Individual hospitals that were part of the urban county group reclassification application may reclassify under this process only to the MSA specified in the group application.

e. The hospital is located in an MSA that experiences at least a 6 percent decrease in its FY 2004 wage index compared to its FY 2003 wage index; and a hospital with an AHW at least 10 percent higher than the MSA's AHW that reclassified into the MSA during FY 2003 has reclassified elsewhere for FY 2004. The hospital may only reclassify under this process to an MSA within its State with an FY 2004 area wage index value that is nearest to what it would have received if the hospital that previously reclassified into the MSA had continued to reclassify into the MSA for FY 2004.

f. One of the following criteria are met:

(1) The hospital is located in an MSA that is adjacent to an MSA (or urban county) that was reclassified under section 152 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, Pub. L. 106–113 and the hospital's FY 2004 wage index is at least 10 percent less than the FY 2004 wage index of the adjacent MSA (or urban county) that was reclassified under section 152 of Pub. L. 106–113.

(2) The hospital is located in an MSA that is adjacent to an MSA identified in sections 153 or 154(a) of Pub. L. 106–113, and the hospitals' FY 2004 wage index is at least 10 percent less than the FY 2004 wage index of the adjacent MSA identified in section 153 or 154(a) of Pub. L. 106–113.

In both cases, the hospital may only reclassify under this process to the adjacent MSA (or urban county) identified in the applicable section of Pub. L. 106–113.

g. The hospital received reclassification by act of Congress that expired on September 30, 2003. The hospital may only reclassify under this process to the MSA to which it was reclassified by act of Congress, unless it would not qualify to reclassify under this process into such MSA because it fails to meet criterion 1 above. If the later situation applies, the hospital may reclassify to another MSA in its State, where it would meet criterion 1 above, with a FY 2004 wage index that most closely approximates the FY 2004 wage index of the area to which the hospital was reclassified by statute. Nothing in this criterion shall be viewed as superseding the reclassifications extended by section 508(f) of Pub. L. 108–173.

h. After decisions by the MGCRB based on hospitals meeting criteria 2(a) through 2(g) above, as well as our implementation of section 508(f) of Pub. L. 108–173, the MGCRB may approve a hospital to be reclassified if the hospital's 3-year AHW is at least 106 percent of the 3-year AHW of the hospitals geographically located in the area in which the hospital is located. The MGCRB will reclassify a hospital under this process to the MSA within the hospital's State (in the case of a rural hospital, or the nearest Statewide rural area of a contiguous State) that has an area 3-year AHW nearest to the hospital's 3-year AHW. However, to be classified to that area, the hospital's 3-year AHW must be at least 82 percent of the 3-year AHW of the area to which it would be reclassified. The requests submitted under this criterion will be considered and approved by the MGCRB in rank order. Ranking will be based on the percentage difference between the hospital's 3-year AHW and the 3-year AHW of the area where the hospital is geographically located. A hospital application received under criterion 2(h) will receive a 2.5 percentage point increase in its ranking for each of the following two criteria that are met—

(1) The hospital has either:

• By January 23, 2004, submitted performance data on any of the 10 measures that were in the National Voluntary Hospital Reporting Initiative on November 15, 2003 meeting the sample size specifications of either the Joint Commission on Accreditation of Healthcare Organizations or CMS, or

• Pledged in a form dated before December 15, 2003 to submit such data; or

(2) The hospital is a rural hospital.

For example, an urban hospital with a 3-year AHW that is 110 percent higher than the 3-year AHW for the area where it is located would be ranked as though its 3-year AHW were 112.5 percent if that hospital had submitted quality data by January 23, 2004. If the hospital were a rural hospital, it would be ranked as though its 3-year AHW were 115 percent of its area's 3-year AHW. Hospitals applying in accordance with criterion 2(h) will only be approved after the MGCRB decides upon all applications meeting the criteria specified in 2(a) through 2(g) and section 508(f) of Pub. L. 108–173.

C. Rationale for Criteria

Criteria 2(a) through 2(g) above are designed to assist categories of hospitals that fall just beyond the current reclassification criteria. Although we generally believe our current reclassification process appropriately balances the requirement at section 1886(d)(3)(E) of the Act to adjust payments to reflect the ''relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level'' and the provisions for geographic reclassification at section 1886(d)(8) and (10) of the Act, section 508 of Pub. L. 108–173 was intended to address, on a one-time basis, situations that do not meet the established criteria. Specific rationale for each criterion follows:

a. In States with low population densities, employees are likely to commute greater distances to work. Dispersed urban areas are therefore more likely to compete for employees than are urban areas in more densely populated States. We established the population density and number of MSAs based on our analysis indicating these criteria best captured such a Statewide urban labor market situation. We did not include rural hospitals under this criterion because we already employ Statewide rural labor markets.

b. This criterion recognizes that some reclassified hospitals have an AHW much higher even than a nearby MSA into they have already reclassified. We believe it is appropriate to provide some relief for these situations under this one-time appeals process. Because, in some cases, the AHW of hospitals meeting this criterion are likely to exceed those of any labor market area within the State, we are providing under this one-time appeal process that a hospital qualifying under this criterion may receive a wage index based on its own

AHW if there is no MSA AHW at least equal to the hospital's AHW.

c. This criterion recognizes anomalous situations where previously reclassified urban hospitals would meet the lower criterion for rural hospitals to reclassify, but, for FY 2005, fail to meet the urban hospital wage comparability criterion.

d. This criterion recognizes situations where hospitals have been denied reclassification because they failed to meet the standardized amount criterion, even though the hospital would have received no benefit from a standardized amount reclassification because section 501 of Pub. L. 108–173 eliminated the differential in the standardized amounts.

e. This criterion would protect hospitals from the negative impact on an MSA's wage index resulting from a hospital with a significantly higher AHW that no longer reclassifies into the MSA. The wage index decrease standard and the AHW difference standard are designed to focus this criterion upon situations where the reclassification elsewhere of a particular hospital has a truly negative impact on the MSA's wage index.

f. This criterion would alleviate large disparities in wage indexes resulting from statutory reclassifications. It is limited to adjacent MSAs because these are the labor market areas most impacted by the statutory reclassifications (that is, rather than Statewide rural labor market areas).

g. These statutory reclassifications would have expired on September 30, 2003 but were extended by section 508(f) of Pub. L. 108–173 and would otherwise expire on September 30, 2004. Because of the special circumstances of these hospitals as recognized by Congress, we believe it is appropriate to allow them to reclassify under this one-time appeal process. However, like other hospitals, these hospitals must meet criterion 1 in order to be considered qualifying hospitals under the statute. Therefore, if a hospital would not meet criterion 1 with regard to the MSA to which Congress reclassified it, then the hospital must reclassify to another MSA in its State where it would meet criterion 1 and with a FY 2004 wage index that most closely approximates the FY 2004 wage index of the area to which Congress reclassified it.

h. This criterion would permit other hospitals that are not currently reclassified to be reclassified based upon the relationship between their AHW and the AHW of the area where they are geographically located. We believe it is appropriate to give priority to hospitals whose AHW exceeds the area's AHW by the largest percentage and demonstrate a significant disparity (that is at least 106 percent of the AHW of the area in which they are located) between the hospital's current AHW and the area AHW. Furthermore, rural hospitals tend to have lower AHWs in general than urban hospitals. Therefore, we believe it is appropriate to provide a bonus under this criterion to rural hospitals. Finally, we believe in light of Congress' mention of the submission of quality data in section 508(c)(2), and the importance for the future of health care quality to have performance measures that allow the Government to evaluate quality, it is appropriate to give preferential treatment to hospitals that have submitted these data.

D. One-Time Appeal Request Procedure

We are providing that a hospital seeking reclassification under section 508 of Pub. L. 108–173 must submit a request in writing by February 15, 2004, to the MGCRB, with a copy to CMS. The request must be mailed. Facsimile or other electronic means are not acceptable.

The request must contain the following information:

- The hospital's name and street address.
- The hospital's Medicare provider number.
- For all communications regarding the appeals request, provide the name, title, and telephone number of a contact person.
- Name of the area/county (include the MSA/identification number) where the hospital is located.
- Name of the area/county (refer to the criteria) where the hospital wishes to be reclassified.
- A statement of which criterion is applicable.

A hospital's appeal request must be received by the MGCRB no later than 5 p.m. EDT on February 15, 2004. The request must be typed or clearly printed in ink.

Hospitals must mail or deliver an original copy of their appeal request to the MGCRB's at the following address: Medicare Geographic Classification Review Board, 2520 Lord Baltimore Drive, Suite L, Baltimore, Maryland 21244–2670.

Hospitals must simultaneously send an informational copy of their completed appeal request to the following address: Centers for Medicare and Medicaid Services, Center for Medicare Management, Hospital and Ambulatory Policy Group, Division of Acute Care, Attention: One-Time Appeals Process, Mail Stop C4–08–06, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

Hospitals may want to send their application by a delivery method that guarantees a signed receipt, which indicates delivery and date of delivery of their appeal request to the MGCRB. The MGCRB and CMS addresses listed above are applicable for both United States mail and courier service delivery.

III. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

However, the collection requirements associated with section II.B. of this notice are currently approved under OMB PRA approval number 0938–0573, ''Medicare Geographic Classification Review Board,'' with a current expiration date of October 31, 2005. In addition, we believe that any information collected subsequent to an administrative action, such as an appeal of a geographic classification, are exempt from the PRA as stipulated under 5 CFR 1320.4(a)(2).

Consequently, this document does not impose any new information collection and recordkeeping requirements that would require a review by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 35).

IV. Waiver of the Delay in Effective Date

Section 903 of Pub. L. 108–173 amended section 1871(e)(1) of the Act to specify that a substantive change shall not become effective before the end of the 30-day period that begins on the date that the Secretary has issued or published the substantive change. Section 903 of Pub. L. 108–173 also states the substantive change can take

effect on a date that precedes the 30-day period if the Secretary finds that waiver of this period is necessary to comply with statutory requirements, or is contrary to the public interest. In addition, it specifies that the issuance or publication must include a brief statement of the reasons for such finding.

This notice meets the waiver criteria described in section 1871(e)(1)(B)(ii) of the Act, since section 508 of Pub. L. 108–173 requires the Secretary to establish a one-time appeal process by January 1, 2004 and directs that the appeals be ''filed as soon as possible after the date of enactment of the Act.'' In order for the process to be established and for appeals to be filed as soon as possible, the process must be in effect, and there can be no delay in the effective date.

V. Regulatory Impact Statement

We have examined the impact of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), 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 would increase payments to hospitals by up to $900 million, and thus is considered a major rule.

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 notice does not impose any costs on State or local governments, the requirements of E.O. 13132 are not applicable.

We estimate the impact of this provision will be to increase payments to hospitals by up to $900 million. As noted above, section 508 of Pub. L. 108–173 specifies that the aggregate amount of additional expenditures resulting from the application of this section shall not exceed $900 million. Section 508(f) requires that hospitals previously reclassified by an act of Congress, but such reclassification expired effective with discharges on or after October 1, 2003, shall have their reclassifications reinstated effective April 1, 2004 through September 30, 2004. The extra payments for these reclassification extensions under section 508(f) are also subject to the $900 million limit.

We estimate the increased payments under section 508(f) will total approximately $33 million. The higher payments associated with reclassifications under this one-time appeals process are not expected to exceed a total of $867 million (during the 3-year period covered by the provision).

In accordance with the provisions of Executive Order 12866, this notice was reviewed by the Office of Management and Budget.

Authority: Section 508(a) of the Public Law 108–173.

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

Dated: December 19, 2003.

Dennis G. Smith,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: December 29, 2003.

Tommy G. Thompson,

Secretary.

[FR Doc. 03–32337 Filed 12–31–03; 2:18 pm]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–4065–N]

Medicare Program: Meeting of the Advisory Panel on Medicare Education

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

ACTION: Notice of meeting.

SUMMARY: In accordance with the Federal Advisory Committee Act, 5 U.S.C. Appendix 2, section 10(a) (Pub. L. 92–463), this notice announces a meeting of the Advisory Panel on Medicare Education (the Panel) on February 5, 2004. The Panel advises and makes recommendations to the Secretary of the Department of Health and Human Services and the Administrator of the Centers for Medicare & Medicaid Services on opportunities to enhance the effectiveness of consumer education strategies concerning the Medicare program. This meeting is open to the public.

DATES: The meeting is scheduled for February 5, 2004, from 9:15 a.m. to 4 p.m. e.s.t.

Deadline for Presentations and Comments: January 29, 2004, 12 noon e.s.t.

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: Lynne Johnson, Health Insurance Specialist, Division of Partnership Development, Center for Beneficiary Choices, Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Mail Stop S2–23–05, Baltimore, MD 21244–1850, (410) 786–0090. Please refer to the CMS Advisory Committees' Information Line (1–877–449–5659 toll free)/(410–786–9379 local) or the Internet (*http://www.cms.hhs.gov/faca/apme/default.asp*) for additional information and updates on committee activities, or contact Ms. Johnson via e-mail at *ljohnson3@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 of the Department of Health and Human Services (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 (64 FR 7899), and approved the renewal of the charter on January 21, 2003. The panel advises and makes recommendations to the Secretary and the Administrator of the Centers for Medicare & Medicaid Services (CMS) on opportunities to enhance the effectiveness of consumer education strategies concerning the Medicare program.

The goals of the panel are as follows:

- To develop and implement a national Medicare education program that describes the options for selecting a health plan under Medicare.
- To enhance the Federal government's effectiveness in informing the Medicare consumer, including the appropriate use of public-private partnerships.
- To expand outreach to vulnerable and underserved communities, including racial and ethnic minorities, in the context of a national Medicare education program.
- To assemble an information base of best practices for helping consumers evaluate health plan options and build a community infrastructure for information, counseling, and assistance.