DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–3187–N]

RIN 0938–Z

Medicare Program; Quality Improvement Organization (QIO) Contracts: Solicitation of Proposals From In-State QIOs—Alaska, 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 (the Act), gives at least 6 months advance notice of the expiration dates of contracts with out-of-State Quality Improvement Organizations (QIOs). It also specifies the period of time in which in-State QIOs may submit a proposal for those contracts.

DATES: Interested offerors may submit a proposal to perform the QIO work in any of the States listed in this announcement. The Request for Proposal (RFP) will be made available to all interested offerors through the Federal Business Opportunities (*http://www.fedbizopps.gov*) Web site. CMS anticipates that the RFP for the first group of QIO contracts will be released sometime during the month of February 2008. Interested offerors should monitor the Federal Business Opportunities Web site for all information relating to the RFP.

ADDRESSES: Proposals for the contracts must be submitted to the Centers for Medicare & Medicaid Services, Acquisitions and Grants Groups, OAGM, Attn.: Naomi Ceresa-Haney, 7500 Security Boulevard, Mail Stop C2–21–15, Baltimore, Maryland 21244–1850.

FOR FURTHER INFORMATION CONTACT: Alfreda Staton, (410) 786–4194.

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 Social Security Act (Medicare), to determine whether those services are reasonable, medically necessary, provided in the appropriate setting, and are of a quality that meets 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 quality 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 section 1152 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, a QIO cannot 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 certain requirements to be eligible to conduct Utilization and Quality Control Peer Review as specified in Part B of Title XI of the Act and its implementing regulations.) Section 1152(2) of the Act requires QIOs to perform review functions in an efficient and effective manner, and perform reviews of quality of care in an area of medical practice where actual performance is measured against objective criteria, which defines acceptable and adequate practice. The selected organization must have a consumer representative on its governing board.

Section 1153(i) of the Act prohibits us from renewing the contract of any QIO that is not an in-State QIO 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 QIO contract for that State. If one or more qualified in-State organizations submit a proposal for the QIO contract within the specified period of time, we cannot automatically renew the current contract on a noncompetitive basis, but must instead provide for competition for the contract in the same manner used for a new contract under section 1153(b) of the Act. An in-State QIO is defined at section 1153(i)(3) of the Act as a QIO 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 6 QIO contracts with entities that do not meet the statutory definition of an in-State QIO. The areas affected for purposes of this notice along with the respective contract expiration dates are as follows:

Vermont July 31, 2008
Wyoming July 31, 2008
Maine July 31, 2008
Alaska October 31, 2008
Idaho October 31, 2008
South Carolina January 31, 2009

II. Provisions of the Notice

The 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 offerors may submit a proposal to perform the QIO work in any of the States listed in this announcement. The Request for Proposal (RFP) will be made available to all interested offerors through the Federal Business Opportunities Web site. CMS anticipates that the RFP for the first group of QIOs will be released

sometime during the month of February 2008. Interested offerors should monitor the Federal Business Opportunities Web site for all information relating to the RFP.

Section 1153(i)(3) of the Act requires that an in-State QIO have its primary place of business in the State in which review will be conducted (or, if a QIO is owned by a parent corporation, the headquarters of which is located in that State).

In the proposal, each QIO must furnish, among other things, materials that demonstrate that it meets the following requirements under sections 1152(1)(A), (B), (2), and (3) of the Act and the regulations at § 475.102 and § 475.103:

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. 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, 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, payor organization, or affiliated with any of these entities. However, statutes and regulations provide that, in the event that we determine no otherwise qualified non-payor organization is available to undertake a given QIO contract, we may select a payor organization which otherwise meets requirements to be eligible to conduct Utilization and Quality Control Peer Review as specified in Part B of Title XI of the Act and its implementing regulations.

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

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

a. The organization must have 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.

b. The organization must not be a health facility, health care facility association, health care facility affiliate, payor organization, or be affiliated with any of these mentioned entities.

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 QIO area and submit proposals for the contracts in accordance with this notice, we will consider those organizations to be potential sources for the 6 contracts upon their 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 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 (44 U.S.C. 35).

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 6, 2007.

Kerry Weems,

Acting Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. E7–24477 Filed 12–27–07; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1323–N]

Medicare Program; Semi-Annual Winter Meeting of the Advisory Panel on Ambulatory Payment Classification Groups—March 5, 6, and 7, 2008

AGENCY: Centers for Medicare & Medicaid Services, Department of Health and Human Services.

ACTION: Notice.

SUMMARY: In accordance with section 10(a) of the Federal Advisory Committee Act (FACA) (5 U.S.C. Appendix 2), this notice announces the first semi-annual winter meeting of the Advisory Panel on Ambulatory Payment Classification (APC) Groups (the Panel) for 2008. The purpose of the Panel is to review the APC groups and their associated weights and to advise the Secretary of the Department of Health and Human Services (DHHS) (the Secretary) and the Administrator of the Centers for Medicare & Medicaid Services (CMS) (the Administrator) concerning the clinical integrity of the APC groups and their associated weights. We will consider the Panel's advice as we prepare the proposed rule that updates the hospital Outpatient Prospective Payment System (OPPS) for CY 2009.

DATES: *Meeting Dates:* We are scheduling the first semi-annual winter meeting in 2008 for the following dates and times:

- Wednesday, March 5, 2008, 1 p.m. to 5 p.m. (e.s.t.) [1]
- Thursday, March 6, 2008, 8 a.m. to 5 p.m. (e.s.t.) [1]
- Friday, March 7, 2008, 8 a.m. to 12 noon (e.s.t.) [2]

Deadlines:

Deadline for Hardcopy Comments/ Suggested Agenda Topics—5 p.m. (e.s.t.), Thursday, February 7, 2008.

[1] The times listed in this notice are approximate times; consequently, the meetings may last longer than listed in this notice—but will not begin before the posted times.

[2] If the business of the Panel concludes on Thursday, March 6, there will be no Friday meeting.