relate to physicians' services, identified by the Secretary. Council members are expected to participate in all meetings. Section 1868(a)(3) of the Act provides for payment of expenses and a per diem allowance for Council members at a rate equal to payment provided members of other advisory committees. In addition to making these payments, the Department of Health and Human Services and CMS provide management and support services to the Council. The Secretary will appoint new members to the Council from among those candidates determined to have the expertise required to meet specific agency needs in a manner to ensure appropriate balance of the Council's membership.

The Council held its first meeting on May 11, 1992. The current members are: Ronald Castellanos, M.D. Chairperson; Jose Azocar, M.D.; M. Leroy Sprang, M.D.; Rebecca Gaughan, M.D.; Peter Grimm, D.O.; Carlos R. Hamilton, M.D.; Dennis K. Iglar, M.D.; Joe Johnson, D.C.; Christopher Leggett, M.D.; Barbara McAneny, M.D.; Geraldine O'Shea, D.O.; Laura B. Powers, M.D.; Gregory J. Przybylski, M.D.; Anthony Senagore, M.D.; and Robert L. Urata, M.D.

The meeting will commence with the swearing-in of one Council member. The Council's Executive Director will give a status report and the CMS responses to the recommendations made by the Council at the May 23, 2005 meeting and prior meeting recommendations. Additionally, an update will be provided on the Physician Regulatory Issues Team. In accordance with the Council charter, we are requesting assistance with the following agenda topics:

- Competitive Acquisition for Drugs.
- Physician Fee Schedule Proposed Rule.
- Part D Prescription Drug Program.
- Outpatient Proposed Rule.
- Surgical Care Improvement Partnership Program.
- Alliance for Cardiac Care Excellence Program.
- NPI-Outreach and Implementation.

For additional information and clarification on these topics, contact the DFO as provided in the **FOR FURTHER INFORMATION CONTACT** section of this notice. Individual physicians or medical organizations that represent physicians wishing to make a 5-minute oral presentation on agenda issues must contact the DFO by 12 noon, e.d.t., August 5, 2005, to be scheduled. Testimony is limited to agenda topics only. The number of oral presentations may be limited by the time available. A written copy of the presenter's oral remarks must be submitted to Kelly Buchanan, DFO, no later than 12 noon, e.d.t., August 5, 2005, for distribution to Council members for review prior to the meeting. Physicians and medical organizations not scheduled to speak may also submit written comments to the DFO for distribution no later than noon, e.d.t., August 5, 2005. The meeting is open to the public, but attendance is limited to the space available.

Special Accommodations: Individuals requiring sign language interpretation or other special accommodation must contact the DFO by e-mail at *PPAC@cms.hhs.gov* or by telephone at (410) 786–6132 at least 10 days before the meeting.

Authority: (Section 1868 of the Social Security Act (42 U.S.C. 1395ee) and section 10(a) of Pub. L. 92–463 (5 U.S.C. App. 2, section 10(a).)

Dated: July 11, 2005.

Mark McClellan,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 05–14154 Filed 7–21–05; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Statement of Organization, Functions, and Delegations of Authority

Part F., Section F.70. (Order of Succession) of the Statement of Organization, Functions, and Delegations of Authority for the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS), (**Federal Register**, Vol. 49, No. 174, p. 35251, dated September 6, 1984) is hereby rescinded and replaced by the following new Section F.70.

F.70. Order of Succession

During any period when the Administrator, Centers for Medicare & Medicaid Services (CMS), has died, resigned, or otherwise become unable to perform the functions and duties of the office of the Administrator, CMS, the following officers, in the order listed, shall act for and perform the functions and duties of the office of Administrator, CMS, until such time the Administrator, CMS, again becomes available, a permanent successor is appointed, or the temporary successor is otherwise relieved:

1. Deputy Administrator.
2. Chief Operating Officer.
3. Director, Center for Medicare Management.
4. Deputy Chief Operating Officer.
5. Director & Chief Financial Officer, Office of Financial Management.
6. Deputy Director, Center for Medicare Management.
7. Deputy Director, Office of Financial Management.

The authority to act as the Administrator, CMS, must be exercised in accordance with the provisions of the Federal Vacancies and Reform Act of 1998 (''the Vacancies Act''), 5 U.S.C. 3345 *et seq*. The ''Acting'' title is applicable and reserved only in instances in which the CMS Administrator position is vacant. In accordance with the Vacancies Act, the Deputy Administrator is herein designated as the first assistant for CMS.

During a planned absence, the Administrator, CMS, may designate an individual to serve as ''operationally in charge.'' No individual who is serving in an ''operationally in charge'' capacity shall exercise this authority unless he or she is herein designated as a delegatee.

This authority is limited to maintaining the Agency's essential functions and restoring the Agency's normal business functions under the CMS Continuity of Operations Plan (COOP).

Dated: June 16, 2005.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 05–14148 Filed 7–21–05; 8:45 am]

BILLING CODE 4120–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–3142–FN]

Medicare Program; Evaluation Criteria and Standards for Quality Improvement Program Contracts

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

ACTION: Final notice.

SUMMARY: This final notice describes the evaluation criteria we will use to evaluate the Quality Improvement Organizations (QIOs) under their contracts with us, for efficiency and effectiveness in accordance with the Social Security Act. These evaluation criteria are based on the tasks and related subtasks set forth in the QIO's Scope of Work (SOW). The current 7th SOW includes Tasks 1 through 4, with subtasks included under all tasks,

excluding Task 4. QIOs were awarded contracts for the 7th SOW, or 7th Round, for 3 years, with staggered starting dates beginning August 2002, November 2002, and February 2003. This final notice also responds to the public comments received regarding the evaluation criteria published in July 2004.

DATES: Effective August 22, 2005.

FOR FURTHER INFORMATION CONTACT: Maria Hammel, (410) 786–1775.

SUPPLEMENTARY INFORMATION:

I. Background

The Peer Review Improvement Act of 1982 (Title I, Subtitle C of Public Law 97–248) amended Part B of Title XI of the Social Security Act (the Act) to establish the Peer Review Organization (PRO) program. The PRO program (now called the Quality Improvement Organization (QIO) program) was established to redirect, simplify, and enhance the cost-effectiveness and efficiency of the medical peer review process. Sections 1152 and 1153 of the Act define the types of organizations eligible to become QIOs, and establish certain limitations and priorities regarding QIO contracting.

The Secretary enters into contracts with QIOs to perform three broad functions:

- Improve quality of care for beneficiaries by ensuring that beneficiary care meets professionally recognized standards of health care;
- Protect the integrity of the Medicare Trust Fund by ensuring that Medicare only pays for services and items that are reasonable and medically necessary and that are provided in the most economical setting;
- Protect beneficiaries by expeditiously addressing individual cases such as beneficiary quality of care complaints, contested hospital issued notices of noncoverage (HINNs), alleged Emergency Medical Treatment and Labor Act (EMTALA) violations (patient dumping), and other statutory responsibilities.

Section 1154 of the Act requires that QIOs review those services furnished by physicians; other health care practitioners; and institutional and non-institutional providers of health care services, including health maintenance organizations and competitive medical plans. Section 109 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Pub. L. 108–173, amended section 1154(a)(1) of the Act to expand the scope of review of QIOs to include Medicare Advantage Organizations and prescription drug sponsors. Section 109 of the MMA also created a new section 1154(a)(17) of the Act, which requires QIOs to offer to providers, practitioners, Medicare Advantage Plans, and prescription drug sponsors quality improvement assistance pertaining to prescription drug therapy. We will not evaluate QIOs on these provisions in the current Scope of Work (SOW) because these provisions of sections 1154(a)(1) and (a)(17) of the Act were not included in the contract.

Section 1153(h)(2) of the Act requires the Secretary to publish in the **Federal Register** the general criteria and standards that would be used to evaluate the efficient and effective performance of contract obligations by QIOs and to provide the opportunity for public comment. The QIO contracts for the 7th SOW were awarded for 3 years with starting dates staggered into three approximately equal groups (rounds) starting August 2002, November 2002, and February 2003, respectively.

II. Provisions of the Notice With Comment

On July 23, 2004, we published a notice with comment in the **Federal Register** titled ''Medicare Program; Evaluation Criteria and Standards for Quality Improvement Organizations.'' The comment period for this notice closed on August 23, 2004. The evaluation criteria published in the notice are currently being used to evaluate QIO performance on the 7th SOW. The evaluation criteria is listed here for the reader's convenience. No modifications were made to the evaluation criteria based on comments provided in response to the notice.

A. Measuring QIO Performance

Under the 7th Round contracts, QIOs are responsible for completing tasks in the following four areas, with additional subtasks contained in the first three areas:

Task 1—Improving Beneficiary Safety and Health Through Clinical Quality Improvement

a. Nursing Home
b. Home Health
c. Hospital
d. Physician Office
e. Underserved and Rural Beneficiaries
f. Medicare+Choice Organizations (M+COs), now called Medicare Advantage Organizations (MAs)

Task 2—Improving Beneficiary Safety and Health Through Information and Communications

a. Promoting the Use of Performance Data
b. Transitioning to Hospital-Generated Data
c. Other Mandated Communications Activities

Task 3—Improving Beneficiary Safety and Health Through Medicare Beneficiary Protection Activities

a. Beneficiary Complaint Response Program
b. Hospital Payment Monitoring Review Program
c. All Other Beneficiary Protection Activities

Task 4—Improving Beneficiary Safety and Health Through Developmental Activities (Special Studies defined as work that we direct a QIO to perform or work that a QIO elects to perform with our approval that is not currently defined in the Tasks, but falls within the scope of the contract and section 1154 of the Act).

Under this contract, to merit having its contract renewed non-competitively, the QIO must meet the performance criteria (including a score of 1.0 or greater for Tasks 1a through 1e and 2b) on 10 of 12 subtasks (9 of 11 for States with no MA plans) of Tasks 1 through 3 of the 7th SOW. To renew the QIO's contract non-competitively for both of the subtasks that do not meet the criteria, the QIO must have: (1) Achieved a score of 0.6 or better on all quantitative subtasks, and (2) for the remaining subtasks only, in the judgment of the Project Officer, the QIO expended a reasonable effort to address these subtasks, and developed and implemented an appropriate initial work plan. The work plan must have been assessed by the Project Officer during the contract period to determine if it was achieving results likely to lead to success in meeting contractual performance expectations and had made appropriate adjustments to its work plan based on these results.

To be considered successful (that is, meeting the criteria outlined in the J–7 found at *http://www.cms.hhs.gov/qio/2.asp*), though not meriting a non-competitive renewal, the QIO must meet the performance criteria (including a score of 1.0 or greater for Tasks 1a through 1e and 2b) on 9 of 12 subtasks (8 of 11 for States with no MA plans) of Tasks 1 through 3 of the 7th Round Contract. For the subtasks that do not meet the criteria, the QIO must—

- Achieve a score of 0.6 or better on all quantitative subtasks;
- For the remaining subtasks only, in the judgment of the Project Officer, the QIO has expended a reasonable effort to address these subtasks, developed and implemented an appropriate initial work plan that was assessed by the Project Officer during the contract period to determine if it was achieving

results likely to lead to success in meeting contractual performance expectations, and had made appropriate adjustments to its work plan based on these results; and

• Failed to meet the criteria in no more than two subtasks of any one task.

For Task 4, except as provided in Task 3b that is evaluated by the Task Leader, all special studies approved under this task will be evaluated individually, based on study-specific evaluation criteria. The QIO's success or failure on a special study will not be factored into the evaluation of the QIO's work under Tasks 1 through 3.

However, meeting the minimum performance standards does not guarantee a noncompetitive renewal of the QIO's contract. For example, an organization within a particular State meeting the definition of a QIO may express interest in competing for a contract currently held by a QIO from outside that State, according to section 1153(i) of the Act. In this case, we will compete the contract despite acceptable performance by the current QIO. We will make a final decision on renewal/non-renewal by the end of the 30th month of the 7th Round contract. We will issue a ''Notice of Intent to Non-renew the QIO Contract'' letter to all QIOs that do not meet the minimum performance standards no later than the end of the 33rd month of the contract. The QIO will be considered to have met minimum performance standards if the QIO had demonstrated acceptable performance in each Task area as specified in section III of this notice, Standards for Minimum Performance.

If the QIO has not met the criteria to merit a noncompetitive renewal, it will be notified of our intention not to renew its contract and will be informed of its right to request an opportunity to provide information about its performance under the contract to a CMS-wide panel. The panel includes representatives from each of the four QIO Regional Offices and the Central Office. The QIO's Project Officer will not be eligible to represent the Regional Office on the panel when it reviews the work of his or her QIO. However, the Project Officer will be available to answer any questions. Also, the QIO will be given the opportunity to provide additional information. The panel will have the right to create its own procedures, but must apply them consistently to all QIOs. At a minimum, the panel will use the criteria listed below for all Tasks:

• The degree of collaboration the QIO exhibited with the Quality Improvement Organization Support Centers (QIOSCs) and other QIOs, both by sharing the lessons and tools it developed and by adopting practices and tools developed by other QIOs.

• Whether the QIO was a new contractor in the 7th SOW.

• Whether specific identifiable circumstances uniquely interfered with the QIO's efforts.

• Evidence suggesting that the QIO has done exceptional work in one or more of the other Task areas.

• Any other issues that the panel may deem relevant.

Upon completion of its review, the panel will recommend a final disposition of the QIO's contract renewal to the Director of CMS' Office of Clinical Standards and Quality (OCSQ).

B. Standards for Minimum Performance

General Criteria

We will evaluate the QIO's performance on each sub-task by some combination of the following elements:

• Statewide improvement on the quality measure(s).

• Improvement on the quality of care measure(s) among a group of identified participants as defined within each subtask.

• Satisfaction among providers and practitioners regarding their interaction with the QIO.

Satisfaction will be assessed using a survey, the purpose of which will be to:

• Measure satisfaction as one component of the QIO's evaluation.

• Identify opportunities where the QIO can improve satisfaction.

Task 1 (including subtasks a through e) and subtask 2b will be evaluated quantitatively. The QIO's success will be measured by assessing its relative improvement on each evaluation criterion. The term ''improvement'' as used in the 7th Round Contract will be defined mathematically to mean the relative reduction in the failure rate. The expected minimum improvement level, as determined by our management and defined in the J–7 at *http:www.cms.hhs.gov/qio/2.asp*, will serve as the reference point for each calculated relative improvement.

In a number of the Task 1 subtasks, statewide improvement will be averaged with the improvement among a set of identified participant providers. In these cases, we have set a target percentage of identified participant providers. The relative weights of the statewide improvement and of identified participants' improvement will combine to equal 80 percent of the subtask's weight, and will be a function of the percentage of the target percentage (up to 150 percent) that the QIO identifies as participants. Tasks 1f, 2a, 2c and all of Task 3 will be evaluated by the Project Officer using qualitative measures based on information provided in reports developed from data provided by the QIOs on the QIO's status to date.

C. Task Specific Standards

1. Task 1—Improving Beneficiary Safety and Health Through Clinical Quality Improvement

a. Task 1a—Nursing Home Quality Improvement

The QIO will be held accountable for improvement in the quality of care measure rates for all nursing homes in the State and for identified participant nursing homes. QIOs will be evaluated based on the following components: Statewide improvement on the set of three to five publicly reported quality of care measures that the QIO has selected in consultation with stakeholders, improvement in the selected nursing home publicly reported quality of care measures for identified participants, and nursing home satisfaction based on a survey of identified participating nursing homes. To view the weighting criteria for each component, go to *http://www.cms.hhs.gov/qio/2.asp* for a copy of the J–7.

b. Task 1b—Home Health Quality Improvement

The QIO will be held accountable for improvement in the Outcome Based Quality Improvement (OBQI) quality of care measure rates for a set of home health agencies that are identified participants. The QIOs will be evaluated based on the following components: The extent to which the number of participating home health agencies, with significant improvement in a targeted outcome, equals or exceeds 30 percent of the total number of home health agencies in the State, and the identified participant satisfaction that will be measured by a survey of identified participant home health agencies using a composite measure of satisfaction that reflects the type of activities that QIOs are expected to have undertaken with these providers.

c. Task 1c—Hospital Quality Improvement

QIOs will be evaluated on the following criteria: Statewide improvement on the quality of care measures listed in the 7th Round Contract, and hospital satisfaction based on feedback from the hospitals in the State. To view the specific criteria, go to *http://www.cms.hhs.gov/qio/2.asp* for a copy of the J–7.

d. Task 1d—Physician Office Quality Improvement

QIOs will be evaluated based on the following general criteria: statewide improvement on quality of care measures, improvement on diabetes and cancer screening quality of care measures for identified participant physicians, and physician satisfaction based on feedback from physician designees in the State who participated with the QIO. To view the specific criteria for this task, go to *http://www.cms.hhs.gov/qio/2.asp* for a copy of the J–7.

e. Task 1e—Underserved and Rural Beneficiaries Quality Improvement

The QIO's work on this task will be primarily evaluated on the success of the QIO's efforts to reduce disparity between the targeted underserved group and their geographically relevant non-underserved reference group from baseline to re-measurement. To be judged to have performed minimally successful on this task, the QIO must demonstrate disparity reduction. QIOs will also be evaluated on three factors that collectively demonstrate knowledge generated by the QIO about the underserved target group, the interventions planned upon the basis of that knowledge, the use of literature on effective interventions, and by demonstrating the effectiveness of their interventions through analyses comparing the intervention group and a contrast group. To view the specific criteria for this task, go to *http://www.cms.hhs.gov/qio/2.asp* for a copy of the J–7.

f. Task 1f—Medicare + Choice Organizations (M+COs) (Now Called Medicare Advantage Organizations (MAs)) Quality Improvement

QIOs will be expected to have demonstrated appropriate activity to include MAs in Tasks 1a to 1e as determined by the Project Officer. We will survey MAs that have worked with the QIO using a composite measure of satisfaction that reflects the types of activities that QIOs are expected to have undertaken with these organizations. We will further use the results of the Medicare+Choice Quality Review Organizations (M+CQRO) or accreditation organization evaluation of the Quality Assessment and Performance Improvement (QAPI) projects to determine if expected improvement was demonstrated.

2. Task 2—Improving Beneficiary Safety and Health Through Information and Communications

a. Task 2a—Promoting the Use of Performance Data

QIO success will be assessed on the timely completion and submission of a project work plan, timely completion and submission of all required reports and deliverables, and the extent to which the QIO uses information we have provided as well as any other feedback the QIO receives to refine its project activities to achieve the desired outcome.

b. Task 2b—Transitioning to Hospital-Generated Data

The evaluation for this task will be based on the following elements:

- We will determine the completeness of the assessment survey information for each hospital.
- We will review hospital data submitted to the national repository via QualityNet Exchange to determine the proportion of hospitals within the State that have implemented a data abstraction system to abstract quality of care measures.
- We will review hospital satisfaction with the QIO data abstraction support.

To view specific criteria for this task, go to *http://www.cms.hhs.gov/qio/2.asp* for a copy of the J–7.

c. Task 2c—Other Mandated Communication Activities

QIO success on this task will be assessed on the following elements: The establishment and use of a Consumer Advisory Council to advise and provide guidance regarding consumer related activities, the QIO's success at broadening consumer representation on the QIO Board of Directors, the successful operation of a beneficiary helpline, and the publication and distribution of an annual report.

3. Task 3—Improving Beneficiary Safety and Health Through Medicare Beneficiary Protection Activities

a. Task 3a—Beneficiary Complaint Response Program

QIO success will be assessed by the timeliness of completed reviews, quality improvement activities as the result of beneficiary complaints, reliability of the review of cases as determined by QIO assessment of the review determinations, and beneficiary satisfaction with the complaint process.

b. Task 3b—Hospital Payment Monitoring Review Program

The QIO must complete reviews within the prescribed timeframes. The QIO must also meet one of the following criteria: with respect to the absolute payment error rate, the follow-up payment error rate must be no greater than 1.5 standard errors above the baseline error rate, or the QIO must have made acceptable progress in improving provider performance in relation to all projects approved or directed by us.

c. Task 3c—Other Beneficiary Protection Activities

The QIO will be assessed on the timeliness of reviews for HINN/NODMAR, EMTALA review, other case review activities and post review activities.

III. Analysis of and Responses to Public Comments and Provisions of the Final Notice

We received several public comments on the 2004 **Federal Register** notice with comment period.

Comment: One commenter expressed concern over the hospital satisfaction survey in Task 1c. The commenter noted that some hospitals have changed to acute care hospitals late in the SOW. The commenter believes this does not provide the QIO ample opportunity to work with the hospital before the hospital completes the satisfaction survey. The commenter recommended that we establish a cut-off date for new entries as acute care hospitals participating in the satisfaction survey.

Response: While we understand the concern that hospitals with only recent experience in acute care could have an impact on the hospital satisfaction survey, we do not believe that it would be a significant impact for the 7th SOW. The Task 1c satisfaction scores from the first two rounds appear to support our position. All QIOs in the first two rounds received scores that met or exceeded the 80 percent passing threshold. The suggestion to include a cut-off date is a reasonable one that we can consider for subsequent Scopes of Work. We intend to evaluate all rounds for the current SOW identically.

Comment: One commenter expressed concern about the project plan requirements in Task 2a. Specifically, the commenter stated that the task only required a project plan for the Nursing Home Quality Initiative. The commenter requested more specific language in the evaluation criteria to address this issue.

Response: For the 7th SOW, we are requiring only one formal project plan for the Nursing Home Quality Initiative. A deliverable has not been added for subsequent plans. QIOs will not be held accountable for failing to deliver project plans that are not required deliverables for the task.

Comment: One commenter stated that there are no historical data to demonstrate that nursing homes' thresholds and home health thresholds are achievable or realistic.

Response: We believe that the thresholds are achievable for most QIOs. The results of the 1st Round 28-month evaluations show that the majority of the QIOs (87 percent) achieved or exceeded the target performance. Therefore, there is no indication that these thresholds should be changed.

Comment: One commenter stated that the tasks to be evaluated subjectively would be less ambiguous if the components of the evaluation were known before the start of the SOW.

Response: We agree with this comment. However, QIOs were provided a copy of the J–7 before the start of the SOW. The tool used to do the actual evaluation was based on the materials provided in the J–7, and did not include any criteria or standards not in the SOW. We will produce the tool for the 8th SOW early in the contract period. It will be distributed to QIOs as soon as it is available.

Comment: Three commenters questioned how statistical significance could be calculated for home health agencies with a small number of episodes of care.

Response: We use the Fisher's exact test to calculate statistical significance for agency outcomes with 10 to 30 episodes of care. This test does not require a large sample to estimate statistical significance. More information on this test can be found in Categorical Data Analysis by Alan Agresti. Additionally, we tested the impact of small HHAs by recalculating evaluation results. Excluding all HHAs with fewer than 30 episodes of care did not substantively improve the overall evaluation results. Based on this information, we decided not to modify the 1b evaluation criteria.

Comment: One commenter questioned how we determined the home health task denominator for the 30 percent.

Response: The home health denominator is made up of two components. It includes identified participants and non-identified participants. Identified participants are defined as all home health agencies that submitted an OBQI plan of action (POA) and have at least a one 3-bar OBQI report for any reporting period ending at least 12 months after the POA submission date. A 3-bar report allows the HHA to compare current outcome rates to prior year outcome rates and national outcome rates. Non-identified participants are defined as having no OBQI plan of action submitted, but with a 3-bar OBQI report for the reporting period ending in the 24th month of the contract. This definition recognizes the dynamic nature of the home health industry, and counts only agencies with sufficient caseload during the 24 months included in the 3-bar report. We believe that this definition provides QIOs with the best opportunity to successfully pass the evaluation, while including all agencies operating with a sufficient caseload during a large part of the SOW.

Comment: One commenter stated that many of the Task 1c hospital indicators will have a small number in the denominator. The commenter stated that by collecting the same number of cases for all States, the precision and confidence interval is much smaller for a large State, thereby making the evaluation of the QIO less accurate.

Response: The assumption on the part of the commenter is not completely accurate. The evaluation score equally weights the four conditions for hospital public reporting (see *http://www.cms.hhs.gov/quality/hospital* for list of conditions) to provide a more robust estimate of quality improvement. Three of the four conditions have large enough samples so that sample size (not population size) is the primary determinant driving the precision of the estimates. Acute Myocardial Infarction measures, one of the four conditions, with systematically small samples are weighted accordingly to minimize the impact of any unreliable estimates on the overall evaluation. AMI is the only one of the four conditions with systematically small samples. It is weighted accordingly to minimize the impact of any unreliable estimates on the overall evaluation.

Comment: One commenter stated that the Task 2b evaluation should not be considered under the quantitative evaluation criteria. The commenter stated that the largest weighted criterion for this task is related to the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU), which does not have a quantitative measurement.

Response: The RHQDAPU criterion for this subtask is dichotomous in nature and requires that QIOs contact all hospitals in their State and assist them in their data submission into the Standard Data Processing System Clinical Warehouse. QIOs must also document their communication and assistance with all hospitals, participating and non-participating. Although this task does involve some activities that may be evaluated in a qualitative manner, the majority of the activities are quantitative in nature. Therefore, we have chosen to evaluate this task quantitatively.

Comment: One commenter expressed concern over the lateness of data for Task 1d. The commenter believes that this has made it nearly impossible to assess the effectiveness of the QIO interventions, or to identify other areas for intervention.

Response: We recognize that time lags can hinder the QIO's technical assistance to providers in the outpatient setting. We have set the baseline period to allow QIOs to work with providers during the transition period between SOWs. Much of this work is reflected in the next SOW's evaluation results. The relative stability of QIOs in their States lessens the impact of the time lag.

Comment: One commenter suggested that we change the evaluation criteria in the J–7 for Task 1e to make them the same as the evaluation criteria that were originally developed for their QIO's improvement project.

Response: We assume the commenter is referring to the use of sub-county targeting in the evaluation of this Task. We have already modified the evaluation on this Task to allow sub-county targeting. This modification to the evaluation was approved by the Project Officers in the beginning of the SOW. We do not anticipate any further changes at this point.

Comment: One commenter suggested that Task 3 activities be elevated to a higher position in the SOW. This commenter believes the current Task 3 should be Task 1 or Task 2 to increase its importance in the contract.

Response: We agree that all of the Tasks performed by the QIOs are important to foster quality improvement in the health care delivered to Medicare beneficiaries. The evaluation criteria reflect this belief. Task 3 comprises 3 out of 12 subtasks evaluated by us. QIOs must successfully perform Task 3 work in order to be granted non-competitive contract renewal. We believe that the stringent evaluation criteria in place for this task reflect the importance of the work.

Comment: One commenter asked about the provider satisfaction survey and how we plan to use the survey if the QIO does not have a sufficient sample size.

Response: Identifying opportunities for improvement is part of a quality improvement feedback cycle. We believe that the results of the satisfaction survey are useful to QIOs in identifying quality improvement opportunities. CMS and its statistical contractor have provided all QIOs with detailed information about their satisfaction survey results. The

statistical contractor will also write a national analysis of the survey results to identify opportunities for QIO program improvement as a whole. In the few instances with insufficient sample size, we use the actual satisfaction rate to evaluate QIO performance. However, we grant QIOs a passing evaluation score when the overall evaluation status (that is, pass vs. fail) is sensitive to this potentially unreliable rate. Usually this rate does not affect a QIO's overall evaluation status on a particular subtask, since its relative weight is small in a subtask's evaluation.

Comment: One commenter stated that, with the development of the Excel spreadsheet to evaluate the qualitative tasks, these tasks are no longer qualitative. They are now being evaluated in a quantitative way.

Response: The Excel tool allows Project Officers to subjectively evaluate QIO performance in the qualitative tasks. It was developed in response to concerns from QIOs about inter-region variation in the 6th SOW. It uses the same evaluation criterion provided in the J–7, and is not intended to make the evaluation quantitative in nature. Rather, it gives some consistency to the subjective review by the Project Officers. We agree that this tool should be provided to QIOs as early as possible in the contract cycle. We will strive to provide this tool to the QIOs as early as possible for the 8th SOW.

Comment: One commenter stated that a great deal of effort was put into the National Voluntary Hospital Reporting Initiative (NVHRI), but this effort was not included in the evaluation criteria.

Response: We appreciate the fact that the NVHRI did require some additional effort on the part of the hospitals. However, participation could not be included in the evaluation criteria because this was a voluntary program on the part of hospitals. The voluntary nature of the program requires a different approach by the QIO than is required by the other subtasks and deliverables of the contract.

Comment: One commenter stated that for those States with 100 percent participation in hospital public reporting, the Hospital Generated Data (HGD) Survey is redundant. The commenter stated that the same information may be obtained through both sources.

Response: We have been careful to avoid redundant activities for both providers and QIOs. The HGD Survey does not determine if a hospital is a reporting hospital. Instead, it assesses the hospital's ability to collect data. Therefore both the survey and the actual hospital reporting are necessary and provide different information to us.

Comment: One commenter questioned the evaluation criteria for Task 3b. In the J–7, the term ''reliability'' is used. The guidance document states that the QIO will be evaluated based on both ''reliability'' and ''validity of review.'' This commenter also requested clarification as to why Tasks 3a and 3b require reliability while Task 3c does not require validity for evaluation.

Response: The reliability of the review is the primary criterion for evaluating this component of the task. We will ensure consistency in documents released for the 8th SOW. The evaluation criteria were chosen for each subtask in Task 3 based on the appropriateness for the task.

Comment: One commenter expressed concern over using Medicare physician billing as the method to measure the rate of statewide and identified participants' improvement in quality care measures for Task 1d.

Response: We are investigating this method of measuring improvement for the Round 1 evaluations, and have so far found nothing large-scale or systematic that would alter evaluation results for Task 1d. We believe that the evaluation measures are relatively stable and reliable estimates, and that billing issues as a whole do not contribute significant bias to these estimates. We understand the limitations of using billing information to estimate quality improvement, and are working to minimize its impact by identifying these problems and reporting questionable billing issues to the appropriate parties.

We are adopting the provisions of the notice with comment as final.

IV. Executive Order 12866 Statement

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

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

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

Dated: March 14, 2005.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 05–14505 Filed 7–21–05; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Administration on Children, Youth and Families; Family and Youth Services Bureau; Notice of the Availability of Financial Assistance and Request for Applications To Establish and Operate the National Domestic Violence Hotline

Announcement Type: Grant.

Funding Opportunity Number: HHS–2005–ACF–ACYF–EV–0039.

CFDA Number: 93.592.

Due Date for Applications: August 22, 2005.

Executive Summary: The Administration for Children and Families (ACF), Administration on Children, Youth and Families (ACYF) announces the availability of funds in fiscal year 2005 for the award of one grant on a competitive basis to operate a national, toll-free telephone hotline to provide information and assistance to victims of domestic violence.

I. Funding Opportunity Description

Authorizing Statutes and Regulations: The Family Violence Prevention and Services Act (the Act) was originally enacted in sections 301–316 of Title III of the ''Child Abuse Amendments of 1984'' (Pub. L. 98–457, 10/9/84). The Act was most recently amended by the ''Keeping Children and Families Safe Act of 2003'' (Pub. L. 108–36).

Supplementary Information: In accordance with amendments to the Act enacted by Pub. L. 108–36, ACF will award grants to one or more private, non-profit entities to assist in the establishment and operation of a highly secure Internet website to provide information and assistance to victims of domestic violence. A separate announcement regarding these awards will be issued at a future date.

Program and Focus Area: The purpose of the National Domestic Violence Hotline (Hotline) is to provide information and referral services, counseling, and assistance to victims of domestic violence, their children and other family members, and others affected by such violence; and enable them to find safety and protection in crisis situations. The successful applicant will be required to provide telephonic assistance on a 24 hours-per-day, seven days-a-week basis throughout the continental United States, Alaska, Hawaii, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands.