Dated: August 2, 2007.

John Howard,

Director, National Institute for Occupational Safety and Health.

[FR Doc. 07–3845 Filed 8–6–07; 8:45 am]

BILLING CODE 4163–19–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institute for Occupational Safety and Health; Final Effect of Designation of a Class of Employees for Addition to the Special Exposure Cohort

AGENCY: National Institute for Occupational Safety and Health (NIOSH), Department of Health and Human Services (HHS).

ACTION: Notice.

SUMMARY: The Department of Health and Human Services (HHS) gives notice concerning the final effect of the HHS decision to designate a class of employees at Los Alamos National Laboratory, Los Alamos, New Mexico, as an addition to the Special Exposure Cohort (SEC) under the Energy Employees Occupational Illness Compensation Program Act of 2000. On June 22, 2007, as provided for under 42 U.S.C. 7384q(b), the Secretary of HHS designated the following class of employees as an addition to the SEC:

Employees of the Department of Energy (DOE), its predecessor agencies, or DOE contractors or subcontractors who were monitored or should have been monitored for radiological exposure while working in operational Technical Areas with a history of radioactive material use at the Los Alamos National Laboratory (LANL) for a number of work days aggregating at least 250 work days from March 15, 1943 through December 31, 1975, or in combination with work day as within parameters established for one or more other classes of employees in the Special Exposure Cohort.

This designation became effective on July 22, 2007, as provided for under 42 U.S.C. 7384*l*(14)(C). Hence, beginning on July 22, 2007, members of this class of employees, defined as reported in this notice, became members of the Special Exposure Cohort.

FOR FURTHER INFORMATION CONTACT: Larry Elliott, Director, Office of Compensation Analysis and Support, National Institute for Occupational Safety and Health (NIOSH), 4676 Columbia Parkway, MS C–46, Cincinnati, OH 45226, Telephone 513–533–6800 (this is not a toll-free number). Information requests can also be submitted by e-mail to *OCAS@CDC.GOV.*

Dated: August 2, 2007.

John Howard,

Director, National Institute for Occupational Safety and Health.

[FR Doc. 07–3843 Filed 8–6–07; 8:45 am]

BILLING CODE 4163–19–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institute for Occupational Safety and Health; Final Effect of Designation of a Class of Employees for Addition to the Special Exposure Cohort

AGENCY: National Institute for Occupational Safety and Health (NIOSH), Department of Health and Human Services (HHS).

ACTION: Notice.

SUMMARY: The Department of Health and Human Services (HHS) gives notice concerning the final effect of the HHS decision to designate a class of employees at W.R. Grace, Erwin, Tennessee, as an addition to the Special Exposure Cohort (SEC) under the Energy Employees Occupational Illness Compensation Program Act of 2000. On June 22, 2007, as provided for under 42 U.S.C. 7384q(b), the Secretary of HHS designated the following class of employees as an addition to the SEC:

Atomic Weapons Employer (AWE) employees who were monitored or should have been monitored for potential exposure to thorium while working in any of the 100 series buildings or Buildings 220, 230, 233, 234, 301, or 310 at the W.R. Grace site at Erwin, Tennessee for a number of work days aggregating at least 250 work days from January 1, 1958, through December 31, 1970, or in combination with work days within the parameters established for one or more other classes of employees in the Special Exposure Cohort.

This designation became effective on July 22, 2007, as provided for under 42 U.S.C. 7384*l*(14)(C). Hence, beginning on July 22, 2007, members of this class of employees, define as reported in this notice, became members of the Special Exposure Cohort.

FOR FURTHER INFORMATION CONTACT: Larry Elliott, Director, Office of Compensation Analysis and Support, National Institute for Occupational Safety and Health (NIOSH), 4676 Columbia Parkway, MS C–46, Cincinnati, OH 45226, Telephone 513–533–6800 (this is not a toll-free number). Information requests can also be submitted by e-mail to *OCAS@CDC.GOV.*

Dated: August 2, 2007.

John Howard,

Director, National Institute for Occupational Safety and Health.

[FR Doc. 07–3844 Filed 8–6–07; 8:45 am]

BILLING CODE 4163–19–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–3188–NC]

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

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

ACTION: Notice with comment period.

SUMMARY: This notice with comment period describes the criteria we intend to use to evaluate the efficiency and effectiveness of Quality Improvement Organizations (QIOs) currently under contract with CMS 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 8th SOW includes Tasks 1, 3, and 4 (Task 2 is reserved) with subtasks included under Tasks 1 and 3. QIOs were awarded contracts for the 8th SOW, or 8th Round, for 3 years, with staggered starting dates beginning August 2005, November 2005, and February 2006. Comments on this notice will also be considered in the development of the 9th SOW.

DATES: To be assured of consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on September 6, 2007.

ADDRESSES: In commenting, please refer to file code CMS–3188–NC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (no duplicates, please):

1. *Electronically.* You may submit electronic comments on specific issues in this regulation to *http://www.cms.hhs.gov/eRulemaking.* Click on the link ''Submit electronic comments on CMS regulations with an open comment period.'' (Attachments should be in Microsoft Word, WordPerfect, or Excel; however, we prefer Microsoft Word.)

2. *By regular mail.* You may mail written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid

Services, Department of Health and Human Services, Attention: CMS–3188–NC, P.O. Box 8010, Baltimore, MD 21244–8010.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments (one original and two copies) to the following address only: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–3188–NC, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–8010.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to one of the following addresses. If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786–9994 in advance to schedule your arrival with one of our staff members. Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201; or 7500 Security Boulevard, Baltimore, MD 21244–8010.

(Because access to the interior of the HHH Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Terry Lied (410) 786–8973.

SUPPLEMENTARY INFORMATION:

Submitting Comments: We welcome comments from the public on all issues set forth in this notice with comment period to assist us in fully considering issues and developing policies. You can assist us by referencing the file code CMS–3188–NC and the specific ''issue identifier'' that precedes the section on which you choose to comment.

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: *http://www.cms.hhs.gov/eRulemaking*. Click on the link ''*Electronic Comments on CMS Regulations*'' on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

I. Background

[If you choose to comment on issues in this section, please include the caption ''BACKGROUND'' at the beginning of your comments.]

The Peer Review Improvement Act of 1982 (Title I, Subtitle C of Pub. L. 97–248) amended Part B of Title XI of the Social Security Act (the Act) to establish the Peer Review Organization (PRO) programs. 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, 1153(b), and 1153(c) 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 pays only 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, 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), Public Law 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.

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 8th SOW were awarded for 3 years with starting dates staggered into three approximately equal groups (rounds) starting August 2005, November 2005, and February 2006, respectively. Comments on this notice will also be considered in the development of the 9th scope of work.

II. Measuring QIO Performance & Criteria for Non-Competitive Renewal of Contracts

[If you choose to comment on issues in this section, please include the caption ''MEASURING QIO PERFORMANCE'' at the beginning of your comments.]

Under the 8th Round contracts, QIOs are responsible for completing the requirements of the following specific tasks and subtasks:

Task 1: Assisting Providers in Developing the Capacity for and Achieving Excellence.

a. Subtask 1a: Nursing Home.
b. Subtask 1b: Home Health.
c. Subtask 1c1: Hospital.
d. Subtask 1c2: Critical Access Hospital/Rural Hospital.
e. Subtask 1d1: Physician Practice.
f. Subtask 1d2: Physician Practice: Underserved Populations.
g. Subtask 1d3: Physician Practice/Pharmacy: Part D Benefit.

Task 2: Reserved.

Task 3: Protecting Beneficiaries and the Medicare Program.

a. Subtask 3a: Beneficiary Protection.
b. Subtask 3b: Hospital Payment Monitoring Program

Task 4: Special Studies and Projects (Special Studies defined as work that CMS directs a QIO to perform or work that a QIO elects to perform with CMS approval which is not currently defined

under Tasks 1–3 of the SOW but falls within the scope of the contract and section 1154 of the Act).

Under this SOW, to merit having its contract renewed non-competitively, the QIO must meet the performance criteria on the tasks and subtasks. For Tasks 1 and 3, the QIO will be scored using the following four classifications:

- Excellent Pass
- Full Pass
- Conditional Pass
- Not Pass

For all nine subtasks related to tasks 1 and 3, the QIO must achieve at least a Conditional Pass to be eligible to have its contract renewed non-competitively. A QIO that receives a ''Not Pass'' on any subtask will be invited to our evaluation panel (subject to CMS approval). In addition, the QIO must achieve at least a ''Full Pass'' or ''Excellent Pass'' on seven of the nine subtasks to be eligible to have its contract renewed non-competitively. A QIO that receives a ''Conditional Pass'' on three or more subtasks will be invited to our evaluation panel (subject to CMS approval). However, an ''Excellent Pass'' on one or more subtasks may negate a ''Conditional Pass'' on one subtask. That is, a QIO that receives an ''Excellent Pass'' on one or more subtasks and receives a ''Conditional Pass'' on no more than three subtasks and does not receive a ''Not Pass'' on any subtasks may be eligible to have its contract renewed non-competitively. A QIO working only seven or eight subtasks due to valid exemptions as specified in the SOW will be treated as though it has received a ''Full Pass'' in the subtasks from which it is exempt. The QIO must still achieve at least a ''Full Pass'' or ''Excellent Pass'' on seven of the nine subtasks in order to have its contract non-competitively renewed.

We may revise the performance criteria for a QIO before signing a contract with that QIO. The target performance levels for individual tasks and subtasks may vary across QIOs. We will provide these specific performance criteria during the Request for Proposal (RFP) process.

We will assess the QIO's task and subtask-specific performance in November 2007 based on the data available at that time. The specific evaluation criteria are described below for each task and subtask. Task 4 (special projects) will not be subject to these evaluation criteria. Projects funded to reduce hospital payment error under Task 4 will affect QIOs evaluation as specified in Task 3b. The assessment of performance on all other special projects under Task 4 will affect the QIO's eligibility to receive funding for additional special projects under the current or subsequent QIO contracts, but will not affect eligibility for non-competitive renewal of the QIO contract.

For the 9th SOW, we intend to revise the criteria required for non-competitive renewal of contracts. For the 9th SOW, we are considering a requirement that QIOs achieve a ''full pass'' or an ''excellent pass'' on all tasks and sub-tasks for the non-competitive renewal of their contracts for the 10th SOW. We are also reviewing the process by which a QIO contract can be terminated, during the course of a SOW, on performance grounds.

III. Standards for Minimum Performance

[If you choose to comment on issues in this section, please include the caption ''STANDARDS FOR MINIMUM PERFORMANCE'' at the beginning of your comments.]

Task 1: Assisting Providers in Developing the Capacity for and Achieving Excellence

Subtasks of Task 1 will include statewide and identified participant components. (The term ''statewide'' is used for activities directed toward a QIO's entire State/jurisdiction—that is, one of the 50 States, the District of Columbia, Puerto Rico, or the Virgin Islands.) Subtask evaluation will be based on the following five dimensions of performance:

- Performance measure results (changes and improvements in rates).
- Clinical performance reporting (increases in number of measures reported).
- Providers' adoption and use of systems.
- Implementation of key process changes.
- Changes in organizational culture.

Each subtask of Task 1 will include a requirement to meet Satisfaction and Knowledge/Perception performance criteria for provider identified participants (IPG) and non-identified participants (Non-IPG). Satisfaction and knowledge/perception surveys and stakeholder knowledge/perception surveys will be used to measure performance. ''Identified Participants'' are providers that received focused assistance on at least one quality measure from QIOs. ''Non-Identified Participants'' are providers that received no focused assistance from QIOs.

Task 1a: Nursing Home

Under Task 1a, the QIO will focus on the following:

- Improving clinical performance.
- Setting improvement targets.
- Measuring the nursing home experience.

The QIO will focus on decreasing the rate of pressure ulcers among high risk individuals, decreasing the use of physical restraints, improving the management of depressive symptoms, and improving the management of pain in chronic (long stay) residents among a select group of identified participant nursing homes (IPG1) as well as other nursing homes requesting assistance from the QIO. The QIO must also work with a second select group of identified participants (IPG2) that focuses on decreasing the rate of pressure ulcers among high risk individuals and decreasing the use of physical restraints.

The QIO will set statewide targets for (at a minimum) pressure ulcers among high-risk residents and physical restraints. In addition, the QIO will work with all nursing homes throughout the State/jurisdiction to set quality improvement targets for (at a minimum) pressure ulcers and physical restraints on an annual basis.

In the area of organizational culture, the QIO must work with both groups of identified participants (IPG1 and IPG2) to collect information on resident and staff experience/satisfaction with care and staff turnover by engaging in activity that is likely to improve organizational culture. (**Note:** In four States/jurisdictions (WY, AK, DC, and PR), the QIO must work with its Project Officer to develop alternative Task 1a evaluation criteria for this SOW. The QIO must receive approval from its Project Officer and the Task 1a Government Task Leader (GTL) on its alternative Task 1a evaluation criteria).

Task 1b: Home Health

QIO work in the home health setting will focus at the statewide level on meeting or exceeding the statewide targets on the Outcome and Assessment Information Set (OASIS). Information on OASIS can be found at *http://www.cms.hhs.gov/OASIS/*. In addition, the QIO must work with home health agencies (HHAs) in setting targets for acute care hospitalization and other publicly reported OASIS measures to be determined by CMS. The QIO must also work to increase the number of HHAs that incorporate an assessment of influenza and pneumococcal vaccination status into the patient comprehensive assessment, offer these vaccinations, and provide follow-up. The QIO must also work with two groups of identified participants: A Clinical Performance Identified Participant Group (IPG) and a Systems Improvement and Organizational

Culture Change (SIOC) IPG. The QIO will focus in the Clinical Performance IPG on meeting or exceeding the IPG target on the OASIS measure for acute care hospitalization and one additional HHA-selected publicly reported OASIS measure through the Outcome Based Quality Improvement (OBQI) process. Information on OBQI can be found at: *http://www.cms.hhs.gov/HomeHealthQualityInits/16_HHQIOASISOBQI.asp.* With the SIOC IPG, the QIO will work to implement and/or use emerging telehealth technologies to help reduce acute care hospitalization and work to build capacity within these HHAs to evaluate and improve organizational culture. Both at the statewide level and with a Clinical Performance IPG, the QIO must improve clinical performance measure results. The QIO will be evaluated on its ability to work with HHAs to incorporate influenza and pneumococcal immunizations into the comprehensive patient assessment. The QIO will also be evaluated on the following:

- Implementation of a CMS survey tool that measures specific dimensions of organizational culture change.
- Submission by an HHA of a Plan of Action (POA) based on the results of the organizational culture change survey and implementation of a quality improvement activity.
- The QIO will have extra credit added to its total Task 1b evaluation score for improving results on both the OASIS acute care hospitalization measure and the selected publicly reported OASIS outcome measure.

The QIO may receive extra credit for one or more of the following:

- Improving results for the identified participant OASIS measure.
- Improving results for the statewide and identified participant Acute Care Hospitalization measure.
- Improving the statewide immunization assessment rate beyond the target rate.
- Working with HHAs to set targets.

Task 1c1: Hospital

For Task 1c1, the QIO must work with hospitals to achieve system-level changes through the use of four strategies: Increasing clinical performance measurement and reporting; process improvement; systems improvement; and organizational culture change. The QIO will work to improve quality of care in hospitals through several distinct efforts aligned with each strategy. For clinical performance measure results, the QIO will assist an IPG, including both rural and urban Prospective Payment System (PPS) hospitals, in improving performance on an Appropriate Care Measure (ACM). (The ACM is defined as a composite measure of care at the patient level for three clinical topics—AMI, HF, and PNE.) The QIO will work at the statewide level to encourage hospitals to submit data on the full Hospital Quality Alliance (HQA) measure set of 22 measures (*http://www.cms.hhs.gov/HospitalQualityInits/15_HospitalQualityAlliance.asp.*). The QIO will also work to increase the validity of all data the hospitals submit to the QIO Clinical Data Warehouse.

With a major focus on process improvement in this SOW, the QIO will work through statewide and identified participant efforts to get hospitals to adopt standard processes of care in five different areas: Prevention of surgical site infections, cardiovascular complications, venous thromboembolism, ventilator-associated pneumonia, and promotion of the use of fistulas for hemodialysis.

To encourage systems improvement and organizational culture change, the QIO will work with identified participants (including both PPS and Critical Access Hospitals (CAHs)) to engage senior hospital leadership in the use of Computerized Physician Order Entry (CPOE), barcoding, and/or telehealth systems.

Task 1c2: Critical Access Hospital/Rural PPS Hospital

The QIO must promote transformational change in CAHs and rural PPS hospitals by working on clinical performance quality measures and organizational safety culture relevant to the care provided in these hospitals. For purposes of Task 1c2, a rural PPS hospital is defined as a PPS hospital located in a non-Metropolitan Statistical Area (non-MSA) county. The QIO must assist identified participant CAHs/rural PPS hospitals in assessing their organizational safety culture. The QIO must also assist these hospitals in selecting, testing, and implementing changes that will demonstrate improvement in the organization's safety culture.

Task 1d1: Physician Practice

The QIO will work with physician practice sites statewide and with an IPG. With an IPG, the QIO will focus on more reliable delivery of preventive services and effective management of patients with chronic conditions, in particular diabetes and heart disease. Working with their IPG, the QIO will seek to demonstrate improvement in clinical performance measures through the production and effective use of electronic clinical information (ECI) in conjunction with redesign of patient care processes within the physician practice sites.

In addition to executing the work described for Task 1d1, the QIO will work with other organizations and agencies that have similar goals. The QIO must be actively involved with or promote the convening of local multi-stakeholder organizations that seek to promote the production and use of electronic clinical information and healthcare information exchange necessary for improving clinical performance. The QIO may work with these organizations to:

- Provide information on products, functionality, value, and costs of ECI systems;
- Promote production and use of ECI;
- Promote ECI sharing in accordance with the Health Insurance Portability and Accountability Act standards (including the Privacy and Security Rules) and QIO confidentiality requirements, as applicable; and
- Promote improved healthcare through use of and reporting of performance on the clinical quality measures specified for this Task.

The QIO must work with physician practice sites and others to improve care for Medicare beneficiaries on a statewide basis. The QIO must support quality initiatives including the Physician Voluntary Reporting Program (PVRP) by activities that include providing information to physicians on participation in the initiative and on physician performance and improvement for those that report.

The QIO must promote statewide quality improvement by working with public health, provider groups, and other broad-based agencies to support the use of appropriate preventive and disease-based care processes.

Medicare Advantage

The Project Officer will evaluate performance based on the assistance provided to Medicare Advantage Organizations. The Medicare Advantage part of Task 1d1 will be waived for States/jurisdictions that had low MA enrollment among the eligible Medicare beneficiaries during calendar year 2004. Clinical Performance Measurement and Reporting:

The objective of this element is to encourage physician practice sites to submit data on the DOQ clinical measures to the QIO Data Warehouse for all Medicare patients. Practice sites must demonstrate an ability to submit data to the Data Warehouse.

The QIO must collaborate with the Medicare Care Management

Performance Demonstration (section 649 of MMA) contractors by providing them with physician practice information the QIO already has or will collect, acquire, or generate in performing its own QIO tasks, provided the individual practices have requested and agreed to these disclosures. The QIO will be evaluated using the criteria deemed acceptable by CMS as outlined in the QIO's proposal.

Task 1d2:

As part of QIO efforts in the physician practice setting, the QIO must, at the statewide level, work to improve clinical performance measure results for clinical quality indicators in the areas of diabetes, mammography, and adult immunizations for underserved racial/ethnic populations.

With one IPG, the QIO will work to promote systems improvement through DOQ activities with a representative underserved population under Task 1d1. With a Task 1d2-specific IPG, the QIO will work on practice site and practitioner system changes related to Culturally and Linguistically Appropriate Services (CLAS) standards and culturally competent care. For more information on CLAS standards refer to: *http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=15.*

Task 1d2 is composed of core and non-core tasks. The core tasks include satisfactory completion of the CLAS/Cultural Competency IPG at the practice site and practitioner level and the Satisfaction and Knowledge/Perception survey for the relevant respondents. The non-core task is statewide measure improvement. Satisfactory completion of the core tasks will achieve a Full Pass for Task 1d2.

Task 1d3: Physician Practice/Pharmacy: Part D Benefit

As part of QIO efforts in the physician practice setting in this SOW, the QIO must focus on improving safety in the delivery of prescription drugs. Widespread use of e-prescribing with comprehensive decision support tools is expected to improve the quality of prescription drug delivery. Until this broader use is in place, the QIO must implement quality improvement projects focusing on improved prescribing, using evidence-based guidelines.

Over the course of the 8th SOW contract, we will work with the QIO to develop and implement new methods to gather and disseminate better evidence for healthcare decision-making. This activity will include collection, linkage, and de-identification of Part D and other public and private administrative data; assisting in implementation of clinical registries and practical clinical trials; and other work necessary to support the development and use of better evidence for decisions.

A variety of methods are available to accomplish these activities. We support engaging physicians because improving prescribing begins with modifying physicians' behavior. This can be accomplished by providing data and information in ways that support behavior change. We also support working with dispensing pharmacists because they detect errors and problems with the medications they dispense, and they interact with beneficiaries. Pharmacy policies, procedures, and quality checks need to be implemented to be consistent with quality, safety, and cost-effectiveness goals.

By partnering with prescription drug plans (PDPs) and using the drug data available, the QIO can affect prescribing by physicians and improve delivery of services at the pharmacy level. Medicare Advantage PDPs will have similar goals as fee-for-service (FFS) Medicare PDPs and will have both more information and more direct control than FFS Medicare PDPs over the care that Medicare beneficiaries receive.

With the enactment of MMA, we are committed to providing a robust drug benefit to seniors, implementing responsible cost management provisions, as well as monitoring and improving drug therapies using current evidence-based guidelines. As authorized by section 109(b) of MMA, the QIO must offer quality improvement assistance pertaining to prescription drug therapy to the following:

- All Medicare providers and practitioners;
- Medicare Advantage organizations offering Medicare Advantage plans under Part C; and
- Organizations offering Prescription Drug Plans (PDPs) under Part D.

The Part D benefit was implemented January 1, 2006. The QIOs began to implement quality improvement projects starting August 2006. Before August 2006, we identified the set of quality measures for Task 1d3 which were derived from evidence-based guidelines and developed in collaboration with participating PDPs, physician societies, and other national leaders. The QIO will be held accountable for work with identified participants on clinical performance measure results.

Because of the relatively new nature of the work, the evaluation of this task is more process and customer satisfaction oriented than other tasks in the contract. The QIO earns a conditional pass if it designs and completes, to CMS satisfaction, a quality improvement project designed to improve care with its stakeholders. The QIO will receive a full pass if, in addition to completing the project, 80 percent of its surveyed project partners report that they are satisfied with their work with the QIO. The QIO will earn an excellent pass if, in addition to the above two criteria, the project achieves improvement in the measures targeted by its project.

Task 2: (Reserved)

Task 3a: Beneficiary Protection

This task involves all case review activities, including mediation, that are necessary to conduct statutorily mandated review of beneficiary complaints about the quality of health care services. It also involves all activities associated with other required case reviews, including Emergency Medical Treatment and Active Labor Act (EMTALA) reviews, beneficiary appeals of discharge, and fiscal intermediary referrals. All case review activities must be conducted in accordance with our instructions. Additional required activities under this Task are physician acknowledgment monitoring; inter-rater reliability (IRR) assessment; procedures based on the result of a review or analysis of review data; development of an Annual Report; and maintenance of a Medicare Helpline.

Task 3b: Hospital Payment Monitoring Program

In the 8th SOW contract, we directed the QIOs to continue the Hospital Payment Monitoring Program (HPMP). The purpose of HPMP is to measure, monitor, and reduce the incidence of improper fee-for-service inpatient payments, including errors in: DRG coding; provision of medically necessary services; and appropriateness of setting, billing, and prepayment denial.

The basis for HPMP is statutory and regulatory. Section 1154 of the Act statutorily mandates utilization review of professional activities subject to the requirements of subsection (d). In accordance with 42 CFR 412.508(a), QIO review must include long-term acute care services. For FFS inpatient hospital claims (paid and denied), HPMP fulfills our requirement to comply with the Improper Payment Information Act of 2002 (Pub. L. 107–300).

The QIO will be judged successful if, at remeasurement, the absolute (gross total of under- and overpayments) and net (difference between over- and underpayments) payment error rates are

no greater than 1.5 standard errors above the respective absolute and net baseline payment error rate.

The QIOs will also be judged in terms of timeliness of reviews. Monitoring activities must be summarized for payment error rates and hospital admission, coding, and billing patterns for short-term acute care inpatient FFS reimbursements in the QIO's State/jurisdiction including hospital profiling and trend monitoring. The QIO must submit its summary electronically to the Project Officer via a designated database as directed by CMS. Whether demonstrations of reductions in dollars or percent dollars paid in error and whether substantive knowledge are gained in the project will be determined by the Task 3b GTL and the QIO's Project Officer.

Task 4: Special Studies and Projects

A Special Project is defined as work that we direct a QIO to perform or work that a QIO elects to perform with our approval that is not defined under Tasks 1–3 of the contract. The Special Project work must fall within the scope of the contract and of section 1154 of the Act. The Special Project must be conducted in accordance with contract sections B.4, Task 4 Special Projects; G.18, Procedures for Special Projects; and H.12, CMS-Directed Subcontracts/Special Project Lead QIOs. The term ''Special Project'' is a more accurate term for the type of activities and requirements characteristically implemented under Task 4. Other terms, previously commonly used, for activities under this task include ''special study'', ''special study project'', and ''special work.''

All Special Projects awarded/approved under Task 4 will be evaluated individually. The QIO's success or failure on a Special Project will not be factored into the evaluation of the QIO's work under Tasks 1–3 of the contract, except for projects funded to meet the requirements of Task 3b: Hospital Payment Monitoring Program. The assessment of performance on all other special projects under Task 4 will affect the QIO's eligibility to receive funding for additional special projects under the current or subsequent QIO contracts, but will not affect eligibility for non-competitive renewal of the QIO contract. Although individual projects may include additional project-specific assessment criteria and performance measures, every project awarded/approved under Task 4 is subject to evaluation on at least the following dimensions of performance, which apply to any and all projects awarded/approved under Task 4:

- Completion of specific tasks (deliverables) required in the special project.
- Financials.
- Appropriateness of QIO staffing for this special project including number of staff as well as skill sets of staff.
- Performance in meeting the needs of QIOs, other Quality Improvement Organization Support Centers, GTLs, etc., and the quality of activities to improve performance.
- Participation in other improvement activities.
- Efforts to address issues/barriers identified.

Performance assessment for each project will be conducted jointly by the QIO's regularly assigned CMS Project Officer and the specific Special Project GTL (SPGTL).

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 8, 2007.

Leslie Norwalk,

Acting Administrator, Centers for Medicare & Medicaid Services.

Editorial Note: The Office of the Federal Register received this document on August 2, 2007.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Privacy Act of 1974; Report of a New System of Records

AGENCY: Department of Health and Human Services (HHS) Centers for Medicare & Medicaid Services (CMS).

ACTION: Notice of a New System of Records (SOR).

SUMMARY: In accordance with the requirements of the Privacy Act of 1974, we are proposing to establish a new system titled, ''Healthcare Common Procedure Coding System (HCPCS) Level II, System No. 09–70–0576.'' In October 2003, the Secretary of HHS delegated authority under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to CMS to maintain and distribute HCPCS Level II Codes. Level II of the HCPCS is a standardized coding system that is used primarily to identify products and services not included in the HCPCS Level I Current Procedural Terminology (CPT) codes, such as: Injectable drugs administered in a physician office; durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office; and ambulance services. HCPCS Level II codes were established to identify these products on insurance claims. There are about 4000 HCPCS Level II codes available for assignment by insurers in accordance with their policies.

The primary purpose of this system is to facilitate the management and maintenance of the HCPCS Level II code set. Information in this system will also be used to: (1) Support regulatory and policy functions performed within the Agency or by a contractor, consultant, or grantee; (2) assist another Federal or state agency; (3) support litigation involving the Agency related to this system; and (4) combat fraud, waste, and abuse in certain health benefits programs. We have provided background information about the proposed system in the **SUPPLEMENTARY INFORMATION** section below. Although the Privacy Act requires only that the ''routine use'' portion of the system be published for comment, CMS invites comments on all portions of this notice. See *Effective Dates* section for comment period.

DATES: *Effective Dates:* CMS filed a new SOR report with the Chair of the House Committee on Oversight and Government Reform, the Chair of the Senate Committee on Homeland Security & Governmental Affairs, and the Administrator, Office of Information and Regulatory Affairs, Office of Management and Budget (OMB) on August 1, 2007. To ensure that all parties have adequate time in which to comment, the new system will become effective 30 days from the publication of the notice, or 40 days from the date it was submitted to OMB and the Congress, whichever is later. We may defer implementation of this system or one or more of the routine use statements listed below if we receive comments that persuade us to defer implementation.

ADDRESSES: The public should address comments to: CMS Privacy Officer, Division of Privacy Compliance, Enterprise Architecture and Strategy Group, CMS, Mail Stop N2–04–27, 7500 Security Boulevard, Baltimore, Maryland 21244–1850. Comments received will be available for review at this location, by appointment, during regular business hours, Monday through Friday from 9 a.m.–3 p.m., eastern daylight time.

FOR FURTHER INFORMATION CONTACT: Trish Brooks, Division of Home Health, Hospice, and HCPCS, Chronic Care