comparing the intervention group and a contrast group. To view the specific criteria for this task, go to *www.cms.hhs.gov/qio/2.asp* for a copy of the J–7.

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. CMS 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. CMS 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.

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

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 provided by CMS as well as any other feedback the QIO receives to refine its project activities to achieve the desired outcome.

Task 2b—Transitioning to Hospital-Generated Data—The evaluation for this task will be based on the following. CMS will determine the completeness of the assessment survey information for each hospital. CMS 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. CMS will review hospital satisfaction with the QIO data abstraction support. To view specific criteria for this task, go to *www.cms.hhs.gov/qio/2.asp* for a copy of the J–7.

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.

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

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, and beneficiary satisfaction with the complaint process.

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 any and all projects approved or directed by CMS.

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.

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: May 4, 2004.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 04–16432 Filed 7–22–04; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–4074–N]

Medicare Program; Meeting of the Advisory Panel on Medicare Education—September 9, 2004

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

ACTION: Notice of meeting.

SUMMARY: In accordance with the Federal Advisory Committee Act, 5 U.S.C. Appendix 2, section 10(a) (Pub. L. 92–463), this notice announces a meeting of the Advisory Panel on Medicare Education on September 9, 2004. The Panel advises and makes recommendations to the Secretary of the Department of Health and Human Services and the Administrator of the Centers for Medicare & Medicaid Services on opportunities to enhance the effectiveness of consumer education strategies concerning the Medicare program. This meeting is open to the public.

DATES: The meeting is scheduled for September 9, 2004 from 9 a.m. to 4 p.m., e.d.t.

Deadline for Presentations and Comments: September 2, 2004, 12 noon, e.d.t.

ADDRESSES: The meeting will be held at the Wyndham Washington Hotel, 1400 M Street, NW., Washington, DC 20005, (202) 429–1700.

FOR FURTHER INFORMATION CONTACT: Lynne Johnson, Health Insurance Specialist, Division of Partnership Development, Center for Beneficiary Choices, Centers for Medicare & Medicaid Services, 7500 Security Boulevard, mail stop S2–23–05, Baltimore, MD 21244–1850, (410) 786–0090. Please refer to the CMS Advisory Committees' Information Line (1–877–449–5659 toll free)/(410–786–9379 local) or the Internet (*http://www.cms.hhs.gov/faca/apme/default.asp*) for additional information and updates on committee activities, or contact Lynne Johnson by e-mail at *ljohnson3@cms.hhs.gov.* Press inquiries are handled through the CMS Press Office at (202) 690–6145.

SUPPLEMENTARY INFORMATION: Section 222 of the Public Health Service Act (42 U.S.C. 217a), as amended, grants to the Secretary of the Department of Health and Human Services (the Secretary) the authority to establish an advisory panel if the Secretary finds the panel necessary and in the public interest. The Secretary signed the charter establishing the Advisory Panel on Medicare Education (the Panel) on January 21, 1999 (64 FR 7849) and approved the renewal of the charter on January 21, 2003. The Panel advises and makes recommendations to the Secretary and the Administrator of the Centers for Medicare & Medicaid Services on opportunities to enhance the effectiveness of consumer education strategies concerning the Medicare program.

The goals of the Panel are as follows:

- To develop and implement a national Medicare education program that describes the options for selecting a health plan under Medicare.

• To enhance the Federal government's effectiveness in informing the Medicare consumer, including the appropriate use of public-private partnerships.

• To expand outreach to vulnerable and underserved communities, including racial and ethnic minorities, in the context of a national Medicare education program.

• To assemble an information base of best practices for helping consumers evaluate health plan options and build a community infrastructure for information, counseling, and assistance.

The current members of the Panel are: James L. Bildner, Chairman and Chief Executive Officer, New Horizons Partners, LLC; and Clayton Fong, President and Chief Executive Officer, National Asian Pacific Center on Aging. A list of new members will be announced in the **Federal Register** on August 27, 2004.

The agenda for the September 9, 2004 meeting will include the following:

• Recap of the previous meeting (May 11, 2004).

• Centers for Medicare & Medicaid Services Update.

• Medicare Program Overview.

• Medicare Modernization Act Outreach and Education.

• Public Comment.

• Listening Session with CMS Leadership.

• Next Steps.

Individuals or organizations that wish to make a 5-minute oral presentation on an agenda topic must submit a written copy of the oral presentation to Lynne Johnson, Health Insurance Specialist, Division of Partnership Development, Center for Beneficiary Choices, Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Mail stop S2–23–05, Baltimore, MD 21244–1850 or by e-mail at *ljohnson3@cms.hhs.gov* no later than 12 noon, e.d.t., September 2, 2004. The number of oral presentations may be limited by the time available. Individuals not wishing to make a presentation may submit written comments to Lynne Johnson by 12 noon, (e.d.t.), September 2, 2004. The meeting is open to the public, but attendance is limited to the space available.

Special Accommodation: Individuals requiring sign language interpretation or other special accommodations must contact Lynne Johnson at least 15 days before the meeting.

Authority: Sec. 222 of the Public Health Service Act (42 U.S.C. 217a) and sec. 10(a) of Pub. L. 92–463 (5 U.S.C. App. 2, sec. 10(a) and 41 CFR 102–3).

(Catalog of Federal Domestic Assistance Program No. 93.733, Medicare—Hospital Insurance Program; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: July 14, 2004.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 04–16433 Filed 7–22–04; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1364–N]

Medicare Program; August 30, 2004, Meeting of the Practicing Physicians Advisory Council and Request for Nominations

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

ACTION: Notice.

SUMMARY: In accordance with section 10(a) of the Federal Advisory Committee Act, this notice announces a meeting of the Practicing Physicians Advisory Council (the Council) and invites all organizations representing physicians to submit nominees for membership on the Council. There will be several vacancies on the Council as of February 28, 2005. The Council will be meeting to discuss certain proposed changes in regulations and carrier manual instructions related to physicians' services, as identified by the Secretary of the Department of Health and Human Services (the Secretary). This meeting is open to the public.

DATES: The meeting is scheduled for Monday, August 30, 2004, from 8:30 a.m. until 5 p.m. e.d.t.

ADDRESSES: The meeting will be held in Room 800, 8th floor, in the Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201.

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

Nominations: Nominations to fill vacancies on the Council will be considered if received at the appropriate address, no later than 5 p.m. e.d.t., September 15, 2004. Mail or deliver nominations to the following address: Centers for Medicare & Medicaid Services, Center for Medicare Management, Division of Provider Relations and Evaluations, Attention: John Lanigan, Designated Federal Official, Practicing Physicians Advisory Council, 7500 Security Boulevard, Mail Stop C4–10–07, Baltimore, Maryland 21244–1850.

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

SUPPLEMENTARY INFORMATION: The Secretary is mandated by section 1868 (a) of the Social Security Act (the Act) to appoint a Practicing Physicians Advisory Council (the Council) based on nominations submitted by medical organizations representing physicians. The Council meets quarterly to discuss certain proposed changes in regulations and carrier manual instructions related to physicians' services, as identified by the Secretary. To the extent feasible and consistent with statutory deadlines, the consultation must occur before publication of the proposed changes. The Council submits an annual report on its recommendations to the Secretary and the Administrator of the Centers for Medicare & Medicaid Services not later than December 31 of each year.

The Council consists of 15 physicians, each of whom must have submitted at least 250 claims for physicians' services under Medicare in the previous year. Members of the Council include both participating and nonparticipating physicians, and physicians practicing in rural and underserved urban areas. At least 11 members of the Council must be physicians as described in section 1861(r)(1) of the Act; that is, State-licensed doctors of medicine or osteopathy. The remaining 4 members may include dentists, podiatrists, optometrists and chiropractors. Members serve for overlapping 4-year terms; terms of more than 2 years are contingent upon the renewal of the Council by appropriate action prior to its termination. Section 1868(a)(1) of the