of patients referred for transplants within the service area served by the designated OPO and within the service area served by the OPO with which the hospital seeks to enter into an agreement under the waiver. In making a waiver determination, section 1138(a)(2)(B) of the Act provides that the Secretary may consider, among other factors: (1) Cost-effectiveness; (2) improvements in quality; (3) whether there has been any change in a hospital's designated OPO due to the changes made in definitions for metropolitan statistical areas (MSAs); and (4) the length and continuity of a hospital's relationship with an OPO other than the hospital's designated OPO. Under section 1138(a)(2)(D) of the Act, the Secretary is required to publish a notice of any waiver application within 30 days of receiving the application, and to offer interested parties an opportunity to comment in writing during the 60-day period beginning on the publication date in the **Federal Register**.

The criteria that the Secretary uses to evaluate the waiver in these cases are the same as those described above under sections 1138(a)(2)(A) and (B) of the Act and have been incorporated into the regulations at 42 CFR 486.316(e) and (f).

II. Waiver Request Procedures

In October 1995, we issued a Program Memorandum (Transmittal No. A–95–11) detailing the waiver process and discussing the information that hospitals must provide in requesting a waiver. We indicated that upon receipt of a waiver request, we would publish a **Federal Register** notice to solicit public comments, as required by section 1138(a)(2)(D) of the Act.

According to these requirements, we will review the request and comments received. During the review process, we may consult on an as-needed basis with the Public Health Service's Division of Transplantation, the United Network for Organ Sharing, and our regional offices. If necessary, we may request additional clarifying information from the applying hospital or others. We will then make a final determination on the waiver request and notify the hospital and the designated and requested OPOs.

III. Hospital Waiver Request

As permitted by 42 CFR 486.316(e), Rockford Health System of Rockford, Illinois has requested a waiver in order to enter into an agreement with an alternative, out-of-area OPO. Rockford Health System is requesting a waiver to work with: University of Wisconsin OPO, University of Wisconsin Hospital and Clinic, 600 Highland Avenue, Madison, Wisconsin 53792. Rockford Health System's designated OPO is: Gift of Hope Organ and Tissue Donor Network, 660 North Industrial Drive, Elmhurst, Il 60126–1520. Rockford Health System must continue to work with its designated OPO until the completion of our review.

Authority: Section 1138 of the Social Security Act (42 U.S.C. 1320b–8).

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; Program No. 93.774, Medicare-Supplementary Medical Insurance, and Program No. 93.778, Medical Assistance Program)

Dated: August 9, 2005.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 05–16796 Filed 8–25–05; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–4106–PN]

Medicare Program; Changes in Medicare Advantage Deeming Authority

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

ACTION: Proposed notice.

SUMMARY: This proposed notice announces that on September 26, 2005, we will begin to accept revisions from private accrediting organizations (AOs) who seek to modify their deeming authority.

EFFECTIVE DATE: This proposed notice is effective on September 26, 2005.

FOR FURTHER INFORMATION CONTACT: Shaheen Halim, 410–786–0641.

SUPPLEMENTARY INFORMATION:

I. Background

Section 4001 of the Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33), enacted on August 5, 1987, added section 1852(e)(4) to the Social Security Act (the Act), which gives us the authority to determine that a Medicare Advantage (MA) organization is deemed to be in compliance with certain Medicare requirements if the MA organization has been accredited (and is periodically reaccredited) by an accrediting organization that we have determined applies and enforces requirements at least as stringent as those the MA organization would be deemed to meet. Section 518 of the Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106–113), enacted on November 29, 1999, amended section 1852(e)(4) of the Act to expand the scope of deeming from two to six areas. Accrediting organizations may seek authority for any of the categories. The BBRA specified that we cannot require an accrediting entity to be able to certify plans for all the deeming categories. It also required us to determine, within 210 days from the day the application is determined to be complete, the eligibility of the accrediting organizations to be granted deeming authority. Conditions and procedures for granting deeming authority to accrediting organizations are outlined in § 422.157 and § 422.158 of title 42 of the Code of Federal Regulations.

Since the start of the Medicare Deeming program, we have approved three organizations to be AOs. These consist of the National Committee for Quality Assurance, the Joint Commission on the Accreditation of Healthcare Organizations, and Accreditation Association for Ambulatory Health Care (AAAHC).

Section 722 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108–173) revised section 1852(e)(4) of the Act. When we published the final rule of the Medicare Advantage program on January 28, 2005 (70 FR 4588), we made further changes to several sections of the rules that apply to the AOs. These changes consisted of the addition of the Chronic Care Improvement Program requirements (§ 422.152), and the deletion of some requirements in the areas of access and quality improvement projects. (§ 422.112 and § 422.152). Furthermore, it added prescription drug program requirements to the deemable areas. These areas include:

- Access to covered drugs, as provided under § 423.120 and § 423.124.
- Drug utilization management programs, quality assurance measures and systems, and Medication Therapy Management Programs as provided under § 423.153.
- Privacy, confidentiality, and accuracy of enrollee records, as provided under § 423.136.
- A program to protect against fraud, waste and abuse, as described in § 423.504(b)(4)(vi)(H).

II. Provisions of the Proposed Notice

This proposed notice announces that 30 days after publication, we will begin to accept applications from national private AOs who seek to modify their deeming authority. The application will consist of a letter stating how the applicant will modify their

accreditation program to address the changes to the Medicare Advantage rule. At this time, we will not be adding the prescription drug program requirements to the deemable areas. Those requirements will be added at a later time. The letters should be sent to Shaheen Halim, Centers for Medicare & Medicaid Services, Mailstop C4–23–07, 7500 Security Blvd, Baltimore, MD 21244.

Authority: Section 1852(e)(4) of the Social Security Act

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance Program; and No. 93.774, Medicare—Supplementary Medical Insurance Program (42 U.S.C. 1395w–22(e)(4)).

Dated: July 6, 2005.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 05–16799 Filed 8–25–05; 8:45 am]

BILLING CODE 4121–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1330–N]

Medicare Program; Town Hall Meeting on the Medicare Provider Feedback Group (MPFG)—September 12, 2005

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

ACTION: Notice of meeting.

SUMMARY: This notice announces a Town Hall meeting on the Medicare Provider Feedback Group (MPFG). The purpose of the meeting is to solicit facts and opinions from individual Medicare providers and suppliers on a variety of Medicare policy and operational issues. All Medicare providers and suppliers that participate in the Medicare program, including physicians, hospitals, home health agencies, and other third-party billers, are invited to attend this meeting. We will consider facts and opinions obtained from individual Medicare providers and suppliers. The meeting is open to the public, but attendance is limited to space available.

DATES: *Meeting Date:* The Town Hall meeting announced in this notice will be held on September 12, 2005 from 2 p.m. to 4 p.m. EST.

ADDRESSES: The Town Hall meeting will be held in the Auditorium in the central building of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

FOR FURTHER INFORMATION CONTACT: Eva Tetteyfio, (410) 786–3136. You may also send e-mail inquiries about this meeting to *MFG@cms.hhs.gov*.

SUPPLEMENTARY INFORMATION:

I. Background

On November 16, 2004, we held the first Medicare Provider Feedback Town Hall meeting to solicit the facts and opinions of individual Medicare providers and suppliers. Topics discussed during the November 16, 2004 meeting included Medicare Fee-for-Service (FFS) Chronic Care Improvement Programs, CMS electronic medical records, CMS Provider Outreach, and consolidated billing. After the meeting, we conducted follow-up meetings to clarify information received and solicited additional comments.

At the September 12, 2005 meeting, we will explain our design for gathering individual provider and supplier information and present topics for provider and supplier input. We will also solicit facts and opinions on how we can better serve the Medicare provider and supplier community.

II. Meeting Format

This meeting will begin with an overview of the goals and objectives of the meeting that includes a discussion of our efforts to gather feedback from individual Medicare providers and suppliers. We will introduce the meeting moderator. We will also introduce members of the Provider Communications Group, Center for Medicare Management, who will provide background information on the Medicare Provider Feedback Group initiative. Topics to be discussed during the meeting include:

- The important information for individual providers and suppliers on our implementation of the National Provider Identifier (NPI).
- The elimination of the Standard Paper Remittance (SPR) advice notices and their effect on individual provider and supplier practices.
- The impact of the implementation and procurement of Medicare Contracting Reform on individual providers and suppliers.
- A discussion and summary of the proposed rule for the 2006 physician fee-schedule.
- The effect of a revised payment system for Ambulatory Surgical Center (ASC) facility services.
- Individual perspectives from hospitals on how Medicare pays for new technologies.

We will hold a question and answer session that offers meeting attendees an opportunity to provide feedback on the topics discussed. We will also solicit suggestions on how this process can be improved.

III. Registration Instructions

The Provider Communications Group, Center for Medicare Management, Division of Provider Relations and Evaluations is the coordinator for this meeting. *On-line Registration:* An on-line registration tool is available for interested individuals who wish to participate in the meeting in person, by teleconference, or listen to a digital recording of the meeting. The on-line registration system will capture contact information and practice characteristics such as names, e-mail addresses, and provider and supplier types.

Registration will begin on August 19, 2005. Persons interested in attending the meeting and providing feedback must complete the on-line registration located at *http://registration.mshow.com/cms2/*. The on-line registration system will generate a confirmation page to indicate the completion of your registration. Interested parties, who will attend the meeting in person, must print the confirmation page and bring it with them to the meeting. We encourage all interested parties to complete the registration as soon as possible. Registration after 12 p.m. on September 9, 2005 will delay confirmation, and individuals may not be permitted entrance to the building. However, registrations received after September 12 will enable individuals to listen to a digital recording of the meeting that will be available beginning 2 hours after the meeting through midnight on September 14, 2005. The online registration will close on September 16, 2005.

Teleconference Participation: Individuals may participate in the public meeting by teleconference. The dial-in number is 877–357–7851 and the conference identification number is 7970566. Physicians and other interested parties may speak or ask questions during the question and answer period facilitated by the moderator. Parties may also submit written comments to Eva Tetteyfio at *MFG@cms.hhs.gov*.

IV. Security Information

Since this meeting will be held in a Federal government building, Federal security measures are applicable. In planning your arrival time, we recommend allowing additional time to clear security. In order to gain access to the building and grounds, participants