CHART—2004 DEMONSTRATION TO IMPROVE THE DIRECT SERVICE COMMUNITY WORKFORCE GRANT AWARDS—Continued

State or other entity	Grant amount
Home Care Quality Authority, Olympia, Washington	1,403,000
Seven Counties Services, Inc., Louisville, Kentucky	680,000
Virginia Department of Medical Assistance Services, Richmond, Virginia	1,403,000

IX. Collection of Information Requirements

This notice informs applicants of the ''Demonstration to Improve the Direct Service Community'' that CMS has awarded 5 grants in FY 2003. Due to the extraordinary response received, CMS will not accept any new applications in FY 2004, but will continue to process the ranked applications submitted in FY 2003, beginning with the highest-ranked applications that were not funded in FY 2003.

This information collection requirement is subject to the PRA; however, it has already been approved under OMB control number 0938–0836 entitled ''Real Choice Systems Grants; Nursing Facility Transition/Access Housing Grants; Community Personal Assistance Service and Supports Grants, National Technical Assistance and Learning Collaborative Grants to Support Systems Change for Community Living'' with a current expiration date of 1/31/2007.

Dated: March 12, 2004.

Dennis G. Smith,

Acting Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 04–12172 Filed 5–27–04; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1266–N]

Medicare Program; Public Meeting in Calendar Year 2004 for New Clinical Laboratory Tests Payment Determinations

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

ACTION: Notice of meeting.

SUMMARY: This notice announces a public meeting to discuss payment determinations for specific new Physicians' Current Procedural Terminology (CPT) codes for clinical laboratory tests. The meeting provides a forum for interested individuals to make oral presentations and submit written comments on the new codes that will be included in Medicare's Clinical Laboratory Fee Schedule for calendar year 2005 that will be effective on January 1, 2005. Discussion is directed toward technical issues relating to payment determinations for a specified list of new clinical laboratory codes. The development of the codes for clinical laboratory tests is largely performed by the CPT Editorial Panel and will not be discussed at the CMS meeting.

DATES: The public meeting is scheduled for Monday, July 26, 2004 from 10 a.m. to 4 p.m., e.s.t.

ADDRESSES: The meeting will be held at the Centers for Medicare & Medicaid Services (CMS) Auditorium located at 7500 Security Boulevard, Baltimore, Maryland 21244.

Registration: Registration Procedures: Beginning June 28, 2004 registration may be completed on-line at *http://www.cms.hhs.gov/paymentsystems*. The following information must be submitted when registering: name, company name, address, telephone number, and e-mail address. When registering, individuals who want to make a presentation must also specify for which new clinical laboratory test code(s) they will be presenting. A confirmation will be sent upon receipt of the registration. Registration Deadline: Individuals must register by July 22, 2004. If on-line registration is not used, individuals may register by phone at (410) 786–4601 or fax to the attention of Anita Greenberg at (410) 786–0169.

FOR FURTHER INFORMATION CONTACT: Anita Greenberg (410) 786–4601.

SUPPLEMENTARY INFORMATION:

I. Background

Section 531(b) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), Pub. L. 106–554, mandated procedures that permit public consultation for payment determinations for new clinical laboratory tests under Part B of title XVIII of the Social Security Act (the Act) in a manner consistent with the procedures established for implementing coding modifications for International Classification of Diseases. The procedures and public meeting announced in this notice for new clinical laboratory tests are in accordance with the procedures published to implement section 531(b) of BIPA in the **Federal Register** at 66 FR 58743 on November 23, 2001. Also, section 942(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108–173, amended section 1833(h)(8)(B)(iii) of the Act to require that we convene a public meeting to receive comments and recommendations (and data on which recommendations are based) for establishing payment amounts for new clinical laboratory tests. The public meeting is intended to provide expert input on the nature of new clinical laboratory tests and receive recommendations to either crosswalk or gap-fill for payment. Decisions regarding payment for the newly created Physicians' Current Procedural Terminology (CPT) codes will not be made at this meeting. A summary of the new codes and the payment recommendations that are presented during the public meeting will be posted on our Web site by September 10, 2004 and can be accessed at *http://www.cms.hhs.gov/paymentsystems*. The summary will also display our tentative payment determinations, and interested parties may submit written comments on the tentative payment determinations by September 24, 2004 to the address specified in the summary.

II. Presentations

This meeting is open to the public. The on-site check-in for visitors will be held from 9:30 a.m. to 10 a.m., followed by opening remarks. Registered presenters may discuss and recommend payment determinations for specific new CPT codes for the 2004 Clinical Laboratory Fee Schedule. A newly created CPT code can either represent a refinement or modification of existing test methods or a substantially new test method. The newly created CPT codes for the calendar year 2004 will be listed at the following Web site *http://www.cms.hhs.gov/paymentsystems* on or after June 28, 2004.

Oral presentations must be brief, and must be accompanied by three written

copies. Presenters may also make copies available for approximately 50 meeting participants. Presenters must address the new test code(s) and descriptor, the test purpose and method, costs, charges, and a recommendation with rationale for one of two methods (crosswalking or gap-fill) for determining payment for new clinical laboratory codes. The first method, called crosswalking, a new test is determined to be similar to an existing test, multiple existing test codes, or a portion of an existing test code. The new test code is then assigned the related existing local fee schedule amounts and resulting national limitation amount. The second method, called gap-filling, is used when no comparable, existing test is available. When using this method, instructions are provided to each Medicare carrier to determine a payment amount for its geographic area(s) for use in the first year, and the carrier-specific amounts are used to establish a national limitation amount for following years. For each new clinical laboratory test code, a determination must be made to either crosswalk or to gap-fill, and, if crosswalking is appropriate, to know what tests to which to crosswalk.

III. General Information

The meeting will be held in a Federal government building; therefore, Federal security measures are applicable. In order to gain access to the building and grounds, participants must bring a government-issued photo identification and a copy of their registration confirmation. Security measures include inspection of vehicles, at entrance to the grounds, and the requirement for persons to pass through a metal detector when entering the building. All items brought to CMS, whether personal or for the purpose of demonstration or to support a presentation, are subject to inspection.

Special Accommodation: Persons attending the meeting who are hearing or visually impaired and have special requirements, or who have a condition that requires special assistance, must provide this information upon registering for the meeting.

Authority: Section 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 42 U.S.C. 1395hh)

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

Dated: May 10, 2004.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 04–11240 Filed 5–27–04; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–4069–N]

Medicare Program; Open Public Meeting To Discuss Definitions of Regions for Regional Medicare Preferred Provider Organizations and Prescription Drug Plans Under the Medicare Modernization Act—July 21, 2004

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

ACTION: Notice of meeting.

SUMMARY: This notice announces a public meeting to provide beneficiaries, advocacy groups, managed care organizations, trade associations, potential prescription drug plans (PDPs), pharmacy benefit managers, providers, practitioners, and other interested parties an opportunity to ask questions and raise issues regarding options for the definition of regions for Medicare Advantage (MA) regional plans and PDPs under provisions of the Medicare, Prescription Drug, Improvement and Medicare Modernization Act of 2003 (MMA). The legislation requires that we implement these MMA provisions in 2006. The purpose of the meeting is to provide information about a variety of region definition options being considered both for regional MA plans and PDPs and to allow for public comment on these options.

DATES: *Meeting Date:* The meeting is scheduled for Wednesday, July 21, 2004 from 9 a.m. until 4 p.m., c.d.s.t. *Comment Deadline:* Written comments must be received by 5 p.m., August 5, 2004.

ADDRESSES: The meeting will be held in Chicago, IL, at the Rosemont Conference Center/Donald E. Stephens Convention Center, (located on the grounds of O'Hare airport) at 555 North River Road, Rosemont, IL. The phone number for the Rosemont Conference Center is (847) 692–2220. The meeting will be organized by CMS' contractor, RTI International.

Written Statements and Requests: We will accept written questions about meeting logistics or requests for meeting materials either before the meeting or up to 14 days after the meeting. Written submissions must be sent to: RTI International, ATTN: Nathan West, MPA, RTI Health Services and Social Policy Research, 3040 Cornwallis Rd. Research Triangle Park, North Carolina 27709, Telephone Number: (919) 485–2661, Fax Number: (919) 990–8454, e-mail: *medicaremeeting@rti.org*.

Public Comments: Public comments should be sent to Angela Porter via e-mail to *APorter@cms.hhs.gov* or fax to Angela Porter at (410) 786–9963; or you may mail public comments to her at the Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Mailstop S1–05–06, Baltimore, Maryland 21244.

FOR FURTHER INFORMATION CONTACT: RTI International staff at *medicaremeeting@rti.org*, or Nathan West at (919) 485–2661.

SUPPLEMENTARY INFORMATION:

I. Background

The Medicare, Prescription Drug, Improvement and Modernization Act (MMA) of 2003 (Pub. L. 108–173, enacted on December 8, 2003) requires a number of changes to the Medicare program including the addition of Medicare prescription drug insurance plans (PDPs), as well as the addition of new regional Medicare Advantage (MA) plans. To implement both new programs, we must define appropriate regions for MA regional plans under section 1858(a)(2)(D) of the Social Security Act (the Act) added by section 221 of the MMA, and for PDPs under section 1860(D)–(11)(a) of the Act, added by section 101 of the MMA.

A. Medicare Advantage Regions

Title II of the MMA makes changes to the Medicare+Choice (M+C) program under Part C, which it renames as the Medicare Advantage program. Existing M+C plans, now known as MA plans, are now referred to as ''local MA plans''. Title II of MMA also establishes new MA regional plans, which would encourage private plans to serve Medicare beneficiaries in larger regions.

The new MA regional plan program will begin in 2006. The legislation calls for the creation of between 10 and 50 MA regions within the 50 States and the District of Columbia by January 1, 2005. Plans that opt to participate in the program are required to serve an entire MA region and are encouraged to offer services in more than one region. The legislation states that MA regions should maximize the availability of regional plans to all eligible individuals regardless of health status. The MMA conference report further clarifies these requirements by providing additional considerations for configuring the regions. To the extent possible, each MA region should include at least one State and not divide a State across regions.