

Supporting Regulations in 42 CFR 420.200–420.206, 455.100–455.106;

Form No.: HCFA–1513 (OMB# 0938–0086);

*Use:* The Medicare/Medicaid Disclosure of Ownership and Control Interest Statement must be used by State agencies and HCFA regional offices to determine whether providers meet the eligibility requirements for Titles 18 and 19 (Medicare and Medicaid) and for grants under Titles V and XX. Review of ownership and control is particularly necessary to prohibit ownership and control for individuals excluded under Federal fraud statutes;

*Frequency:* Other (every 1 to 3 years);

*Affected Public:* Business or other for-profit, and Not-for-profit institutions;

*Number of Respondents:* 125,000;

*Total Annual Responses:* 125,000;

*Total Annual Hours:* 62,500.

To obtain copies of the supporting statement for the proposed paperwork collections referenced above, access HCFA's WEB SITE ADDRESS at <http://www.hcfa.gov/regs/prdact95.htm>, or E-mail your request, including your address and phone number, to [Paperwork@hcfa.gov](mailto:Paperwork@hcfa.gov), or call the Reports Clearance Office on (410) 786–1326. Written comments and recommendations for the proposed information collections must be mailed within 30 days of this notice directly to the OMB Desk Officer designated at the following address:

OMB Human Resources and Housing Branch, Attention: Allison Eydt, New Executive Office Building, Room 10235, Washington, D.C. 20503.

Dated: February 25, 1999.

**John P. Burke III,**

*HCFA Reports Clearance Officer, HCFA, Office of Information Services, Security and Standards Group, Division of HCFA Enterprise Standards.*

[FR Doc. 99–6968 Filed 3–22–99; 8:45 am]

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Health Care Financing Administration

[HCFA–1100–N]

RIN 0938–AJ49

### Medicare Program; Medicare Coordinated Care Demonstration Project and Request for Information on Potential Best Practices of Coordinated Care

**AGENCY:** Health Care Financing Administration (HCFA), HHS.

**ACTION:** Solicitation of information.

**SUMMARY:** This notice announces our intent to conduct the Medicare Coordinated Care Demonstration. It informs interested parties of the opportunity to submit information on examples of best practices of coordinated care, as well as comment on potential aspects of the overall Medicare Coordinated Care demonstration.

Section 4016 of the Balanced Budget Act of 1997 requires a review of best practices and, following this assessment, a Medicare Coordinated Care Demonstration to be launched by August 1999.

The purpose of the demonstration is to evaluate models of coordinated care that improve the quality of services furnished to specific beneficiaries and reduce expenditures under Parts A and B of the Medicare program.

**EFFECTIVE DATE:** Information and comments will be considered if we receive them at the address provided below, no later than 5 p.m., June 21, 1999.

**ADDRESSES:** Mail written comments (1 original and 3 copies) to the following address: Mathematica Policy Research, Inc., Attn: Ms. Kristin LaBounty, P.O. Box 2393, Princeton, NJ 08543–2393.

Comments may also be submitted electronically to Ms. LaBounty's e-mail address ([Klabounty@mathematica-mpr.com](mailto:Klabounty@mathematica-mpr.com)). Electronically submitted comments should not include attachments.

Because of staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code HCFA–1100–N.

**FOR FURTHER INFORMATION CONTACT:** Kathy Headen, Acting HCFA Project Officer, (410) 786–9253 or Kristin LaBounty, (609) 275–2263.

#### SUPPLEMENTARY INFORMATION:

##### I. Background

Section 4016 of the Balanced Budget Act of 1997 (Public Law 105–33) requires the Secretary of Health and Human Services (the Secretary) to evaluate best practices in the private sector for methods of coordinated care. The statute also directs the Secretary to design demonstration projects for the Medicare fee-for-service population based on the evaluation. The purpose of the demonstration is to evaluate models of coordinated care that improve the quality of services provided to specific beneficiaries who have a chronic illness and reduce expenditures under Parts A and B of the Medicare program.

We competitively awarded a task order for conducting a review of best practices in coordinated care and for

providing a recommendation of demonstration design options to Mathematica Policy Research, Inc. (MPR). We will perform the final assessment of best practices and select the demonstration design.

##### II. Provisions of This Notice

This notice announces our intent to conduct the Medicare Coordinated Care Demonstration and informs interested parties of the opportunity to submit information on potential best practices of coordinated care. In addition, this notice also requests comments on potential aspects of the overall demonstration. We are looking for information on successful models of coordinated care, disease management, or case management that are appropriate for the Medicare fee-for-service population.

Information about, and evidence of, successful models can be found in published literature; however, published literature is likely to be a limited resource and successful programs may not have been documented. Therefore, we would like to give interested parties the opportunity to submit information about models of coordinated care that are known to have achieved measurable success but may not have been discussed in published literature.

We anticipate this information will complement the review being conducted by MPR. Additional information regarding MPR's review can be found on their website ([www.mathematica-mpr.com/projects/bestpractices](http://www.mathematica-mpr.com/projects/bestpractices)).

Any person or organization may submit information about successful programs; however, the information must provide evidence of success in sufficient detail to be useful. Therefore, operators of programs may be in the best position to submit information regarding their approach. The following items of information should be submitted:

- The name and address of the program.
- The name, address, telephone number, facsimile number, and e-mail address of a contact person.
- Background on the program (including goals, history, relationship to larger organization(s), number of clients served, and length of time the program has been in operation).
- Special or innovative features of the program.
- Size and composition of the staff (number of RNs and number of social workers performing case management).

- Referral sources, targeting criteria, and selection criteria, if any, for participants.
- The patients served by the program (including age ranges, diagnoses or conditions, and functional impairments).
- Program intervention and how services differ from the usual care the patient would have received.
- How care plans are developed and monitored for each patient.
- Patient education efforts, if any.
- Patient monitoring efforts, if any.
- Feedback to providers, if any.
- Average length of time patient is in the program.
- Funding source(s) for the program.
- Financial incentives, if any, for providers and patients to participate.
- Outcome measures by which the program's performance is evaluated (including clinical, utilization, client-reported, and financial measures used).
- Program impacts on these measures.
- Cost savings due to the program (total and per person served per month).
- How program impacts and cost savings were calculated (for example, method of estimating reduction in use and costs, such as comparison to control group or prior year experience).
- Costs of operating the program (average per patient per month costs).
- Adaptability of the program to the Medicare fee-for-service setting.
- Program brochures or published articles, if any.

We are also interested in comments on potential aspects of the overall demonstration. Specifically, we are interested in comments that discuss and distinguish program characteristics known to be essential for positive outcomes in a fee-for-service setting. Commenters may also wish to address the types of providers, organizations, or entities capable of, and qualified to provide, coordinated care or case management services. Other aspects of importance include, but are not limited to:

- The relationship of the case management entity with other providers.
- The potential role of the case manager in authorizing or providing services beyond coordinating and educational activities.

- Appropriate incentives for the case management entity, beneficiaries, and other providers.
- Appropriate payment methodology.
- Potential risk bearing arrangements for the case management entity.

In addition, we seek comments regarding challenges to, and potential solutions for, implementing a coordinated care demonstration in rural sites.

We currently envision evaluating the data using a multi-tiered review process that will focus on structure, process, and outcomes. Review of individual programs will include the following review criteria:

- Programs that are currently functioning.
- Programs that decrease health care costs or utilization without adversely affecting health outcomes or that improve health outcomes without increasing health care costs or utilization.
- Programs that are suitable for the Medicare fee-for-service population.
- Programs that are targeted to common diseases in the Medicare population.

We will also examine a program's structural characteristics and specific features of its program interventions.

Responders should submit written information or comments to the above address. We encourage the public to submit information or comments as soon as possible to permit the maximum amount of time for consideration. Written information or comments received by 5 p.m., June 21, 1999, will be considered in drafting the demonstration design recommendations. Given the timeline for establishing this demonstration, there will not be sufficient time to consider information or comments received after this deadline.

**III. Collection of Information Requirements**

Section II of this notice contains information collection requirements that were approved by the Office of Management and Budget under the Paperwork Reduction Act of 1995 on January 5, 1999. The approval number is 0938-0750 and the expiration date is June 30, 1999.

**Authority:** Section 4016 of the Balanced Budget Act of 1997 (Public Law 105-33).

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

Dated: March 16, 1999.

**Nancy-Ann Min DeParle,**

*Administrator, Health Care Financing Administration.*

[FR Doc. 99-7079 Filed 3-22-99; 8:45 am]

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**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**Health Resources and Services Administration**

**Agency Information Collection Activities: Submission for OMB Review: Comment Request**

Periodically, the Health Resources and Services Administration (HRSA) publishes abstracts of information collection requests under review by the Office of Management and Budget, in compliance with the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35). To request a copy of the clearance requests submitted to OMB for review, call the HRSA Reports Clearance Office on (301) 443-1129.

The following request has been submitted to the Office of Management and Budget for review under the Paperwork Reduction Act of 1995:

**Proposed Project: National Health Service Corps Waiver Request Worksheets—In Use Without Approval**

The National Health Service Corps (NHSC) of HRSA's Bureau of Primary Health Care (BPHC) assists underserved communities through the development, recruitment and retention of primary health care clinicians dedicated to serving people in health professional shortage areas. The Public Health Service Act, Section 334 (b) contains provisions which permit a waiver of the reimbursement requirement for entities which are assigned Corps members. The Waiver Request Worksheets are used to collect the necessary information from sites which are requesting a waiver of the mandated reimbursable costs.

Estimates of the annualized reporting burden are as follows:

Form	Number of respondents	Responses per respondent	Total responses	Hours per response	Total hour burden
Billing form .....	750	1	750	15 minutes	188
Budget form .....	450	1	450	1	450
<b>Total .....</b>			<b>1,200</b>		<b>638</b>