

coverage of the order, and the order does nothing to prevent future violations at those systems. If, after the order is issued, Summit enters an identical market allocation agreement at a cable system outside these fourteen counties, the Commission's only recourse will be to initiate an administrative proceeding to obtain still another order.

Market allocation, like price fixing, has long been deemed *per se* unlawful, and no proof of market power is necessary to condemn the conduct. Nothing about the fourteen Georgia counties renders them uniquely susceptible to market allocation schemes. Since market allocation is unlawful whenever and wherever it occurs, I see no reason to limit the prohibition in the order to a tiny geographic region.

The complaint and order set forth no rationale for drawing a line around these fourteen counties as the geographic metes and bounds of the order's coverage. The actual agreements alleged in paragraphs six through eleven of the complaint relate to the provision of cable television service to the Asbury Village apartment complex and specific housing subdivisions. As alleged in paragraph thirteen of the complaint, the restraint of trade had its anticompetitive effect only in these unincorporated areas of Cobb County, Georgia. The absence of any apparent rationale is troubling. In future cases, it opens the door to unguided negotiations regarding the geographic scope of conduct orders.

This is the second consent agreement involving allegations of market allocation in which the Commission has limited the coverage of the order to a narrow geographic area. In *B & J School Bus Service, Inc.*, Docket No. C-3425 (April 22, 1993), I dissented from the limitation on the geographic coverage of the order on the ground that in the rare case in which the Commission uncovers a flagrant *per se* violation such as bid rigging, price fixing or market allocation, it should take strong action to prohibit the participants in conspiracy from repeating the violation. I expressed concern that the Commission was signalling a new leniency toward *per se* antitrust violations. In accepting this second order with such a weak and limited remedy, the Commission appears to eliminate the possibility that the school bus order can be disregarded as an aberration.

**Benjamin I. Berman,**

*Acting Secretary.*

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Health Care Financing Administration

#### Public Information Collection Requirements Submitted for Public Comment and Recommendations

In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Health Care Financing Administration

(HCFA), Department of Health and Human Services (HHS), is publishing the following summaries of proposed collections for public comment.

1. *Type of Information Collection Request:* Reinstatement, with change, of a previously approved collection for which approval has expired; *Title of Information Collection:* Peer Review Organization (PRO) Reporting Forms; *Form Nos.:* HCFA 613-627; *Use:* PROs are authorized to review inpatient and outpatient services for quality of care provided and to eliminate unreasonable, unnecessary, and inappropriate care provided to Medicare beneficiaries. The PROs are required to report the results of the review to HCFA. *Frequency:* Monthly, quarterly; *Affected Public:* Business or other for profit; *Number of Respondents:* 53; *Total Annual Hours:* 10,759.

2. *Type of Information Collection Request:* New Collection; *Title of Information Collection:* Evaluation of the Oregon Medicaid Reform Demonstration, Baseline Survey; *Form No.:* HCFA R-179; *Use:* The baseline survey is one component in the evaluation of the Oregon Medicaid Reform Demonstration (OMRD), a demonstration authorized under section 115 of the Social Security Act. The purpose of the survey is to gather information on the health status, past utilization, and level of satisfaction of a sample of newly enrolled OMRD recipients, in a way that allows followup contact, and maximizes the likelihood of preenrollment recall. *Frequency:* Annually; *Affected Public:* Individuals or households; *Number of Respondents:* 2,667; *Total Annual Hours:* 500.

3. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Information Collection Requirements in HSQ 108-F, Assumption of Responsibilities; *Form No.:* HCFA R-71; *Use:* Rule establishes the review functions to be performed by the PRO and outlines the relationships among PROs, providers, practitioners, beneficiaries, fiscal intermediaries, and carriers. *Frequency:* Monthly, quarterly; *Affected Public:* Business or other for profit; *Number of Respondents:* 53; *Total Annual Hours:* 46,653.

4. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Medical Records Review Under Prospective Payment System (PPS); *Form No.:* HCFA R-50; *Use:* PROs are authorized to conduct medical review activities under the PPS. In order to conduct medical review activities, we depend upon hospitals to

make available specific records.

*Frequency:* Annually; *Affected Public:* Business or other for profit; *Number of Respondents:* 6,412; *Total Annual Hours:* 22,400.

5. *Type of Information Collection Request:* New Collection; *Title of Information Collection:* Evaluation of the Medicare Cataract Surgery Alternate Payment Demonstration; *Form No.:* HCFA-R-177; *Use:* To test the feasibility of a negotiated bundled payment for the entire episode of cataract surgery with an intraocular lens implant and, provide insight into appropriateness indicators and effective quality assurance and utilization review mechanisms for cataract surgery. *Frequency:* Annually; *Affected Public:* Business or other for profit institutions; *Number of Respondents:* 1,686; *Total Annual Hours:* 506.

6. *Type of Information Collection Request:* Reinstatement, without change, of a previously approved collection for which approval has expired; *Title of Information Collection:* Home Health Agency Survey and Deficiencies Report, Home Health Functional Assessment Instrument; *Form Nos.:* HCFA-1572, HCFA-1515; *Use:* In order to participate in the Medicare program as a home health agency (HHA) provider, the HHA must meet Federal standards. These forms are used to record information about patients' health and provider compliance with requirement and report information to the Federal Government. *Frequency:* Annually; *Affected Public:* Business or other for profit; *Number of Respondents:* 8,622; *Total Annual Hours:* 129,330.

7. *Type of Information Collection Request:* Reinstatement, without change, of a previously approved collection for which approval has expired; *Title of Information Collection:* Survey Team Composition and Workload Report; *Form No.:* HCFA-670; *Use:* This form will provide information on resource utilization applicable to survey activity in the Medicare/Medicaid provider/supplier types and Clinical Laboratory Improvement Amendment (CLIA) laboratories. This information will assist HCFA in determining Federal reimbursement for surveys conducted. *Frequency:* Annually; *Affected Public:* State, local, or tribal governments; *Number of Respondents:* 53; *Total Annual Hours:* 71,667.

8. *Type of Information Collection Request:* New collection; *Title of Information Collection:* Field Testing of the Uniform Needs Assessment Instrument; *Form No.:* HCFA-R-180; *Use:* The validity, reliability, and administrative feasibility of the Uniform Needs Assessment instrument will be

tested in a small-scale trial. Also, a high risk screener will be developed to identify hospital patients in need of extensive discharge planning. Testing will be done in two phases approximately 1 year apart. Each phase will involve 12 provider sites, 420 patients, and 840 total assessments. *Frequency:* Annually; *Affected Public:* Individuals or households, business or other for profit, and not-for-profit institutions; *Number of Respondents:* 420; *Total Annual Hours:* 1,050.

To request copies of the proposed paperwork collections referenced above, call the Reports Clearance Office on (410) 786-1326. Written comments and recommendations for the proposed information collections should be sent within 60 days of this notice directly to the HCFA Paperwork Clearance Officer designated at the following address: HCFA, Office of Financial and Human Resources, Management Planning and Analysis Staff, Attention: John Burke, Room C2-26-17, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

Dated: July 24, 1995.

**Kathleen B. Larson,**

*Director, Management Planning and Analysis Staff, Office of Financial and Human Resources, Health Care Financing Administration.*

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**Statement of Organization, Functions, and Delegations of Authority; Update of Regional Office Division Level Functional Statements**

Part F of the Statement of Organization, Functions, and Delegations of Authority for the Department of Health and Human Services, Health Care Financing Administration (HCFA), (**Federal Register**, Vol. 59, No. 60, pp. 14658-14659, dated Tuesday, March 29, 1994) is being amended to reflect changes to the functional statements to the Division level components within the HCFA Regional Offices (ROs). Eight of the ROs propose to streamline their organizational structure in accordance with HCFA's Strategic Plan (SP) and the recommendations contained in the National Performance Review. Seattle plans to streamline as a demonstration project to last up to 18 months. Seattle will establish seven organizations, called Clusters, that will report to the Office of the Regional Administrator (ORA). The other ROs will retain the basic three division structure, including the Division of Health Standards and Quality (DHSQ), the Division of

Medicaid, and the Division of Medicare, in each of the ROs affected by this proposal. The changes to the functional statements at the division level are minor and can best be characterized as updates and clarifications of functional responsibilities. The primary changes occur at the branch level where the ROs propose to realign components to improve services to beneficiaries, streamline their functions, to reduce the number of supervisory positions, enhance employee empowerment and meet the goals of the HCFA SP. The functional responsibilities of the Division of Medicare and the Division of Medicaid are the same in all regions, except Seattle, with minor variations indicated in the functional statements.

The functional statements for DHSQ and the Divisions of Medicaid and Medicare in Denver and San Francisco are being republished. The functional statements for these two ROs will remain operational until revised by a proposal later in the year. There are thus four distinct functional statements for the DHSQ due to variations caused by the concentration of primary responsibility for medical review activities in three regions (Boston, Dallas, and Kansas City). The other ROs will continue to have responsibility for some aspects of medical review but will not have the primary responsibility for the function. The first statement applies to those ROs (New York, Philadelphia, Atlanta, and Chicago) that do not have primary responsibility for the medical review function. The second statement applies to two of the ROs that have primary medical review responsibility, Boston and Dallas. In both of these regions, the medical review function will be assigned to DHSQ. The third DHSQ statement applies to Kansas City, where the medical review function will be assigned to the immediate ORA rather than DHSQ. The fourth statement applies to the Denver and San Francisco which retain the current DHSQ functional responsibility until revised by a streamlining proposal later this year.

The functional statements for DHSQ and the Division of Medicaid and the Division of Medicare in Denver and San Francisco are being republished to avoid confusion.

The specific amendments to Part F. are as follows:

- Section F.10.D.6 (Organization) is amended to read as follows:
  6. Office of the Regional Administrator
    - a1. Division of Health Standards and Quality (FLD(2-5)A)
    - a2. Division of Health Standards and Quality (FLD(1,6)A)

- a3. Division of Health Standards and Quality (FLD(7)A)
- a4. Division of Health Standards and Quality (FLD(8,9)A)
  - b1. Division of Medicaid (FLD(1-4, 6-7)B)
  - b2. Division of Medicaid and Managed Care (FLD(5)B)
  - b3. Division of Medicaid (FLD(8-9)B)
  - c1. Division of Medicare (FLD(1-7)C)
  - c2. Division of Medicare (FLD(8-9)C)
  - d1. Medicare Operations and Policy Cluster (FLDXD)
  - d2. Medicaid Operations and Policy Cluster (FLDXE)
  - d3. Program Fiscal Integrity Cluster (FLDXF)
  - d4. Consumer Services and Information Cluster (FLDXG)
  - d5. Managed Care Operations Cluster (FLDXH)
  - d6. Health Care Quality Improvement Cluster (FLSXI)
  - d7. Certification Improvement Cluster (FLDXK)

Section F.20.D.6.a (Functions) is amended to read as follows:

- a1. Division of Health Standards and Quality (FLD(2-5)A)
  - Assures that health care services provided under the Medicare, Medicaid, and CLIA programs are furnished in the most effective and efficient manner consistent with recognized professional standards of care.
    - Interprets and implements health safety standards and evaluates their impact on utilization and quality of health care services.
      - Determines approval and denial of all provider and supplier certification actions under the Medicare program.
        - Initiates and implements remedial actions, including termination of agreements or alternative sanctions against health care facilities not in compliance with Medicare requirements.
          - Makes final determination on all initial and supplemental budget requests submitted by State survey agencies.
            - Monitors and evaluates State activities related to Medicare and Medicaid survey and certification.
              - Oversees and monitors joint State survey agency/ESRD Network activities.
                - Authorizes investigation of complaints received from the public, the Congress, the media, and other sources which allege deficiencies in the quality of care rendered by certified health care providers.
                  - Coordinates State survey agency activities related to COBRA dumping, sanctions and civil money penalties.
                    - Actively participates in and takes a lead role in training, outreach and