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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BILLING CODE 4120–03–P

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 (FLSXJ)
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

collaborative activities involving providers, provider groups, and State survey agencies, relating to quality of health care services.

• Provides leadership in the development, implementation and continuation of Continuous Quality Improvement activities for the State survey agencies and providers.

• Directs RO activities in support of HCFA's National Managed Care Program.

a2. Division of Health Standards and Quality (FLD(1,6)A)

• Oversees, monitors, coordinates, and evaluates the State Survey agencies, Peer Review Organizations (PROs), and ESRD Networks.

• Assures that health care provided under the Medicare, Medicaid, and CLIA programs are appropriate, of high quality, and meet recognized professional standards of care.

• Improves the quality of care provided to Medicare beneficiaries by administration of the PROs and ESRD Network programs, hereafter referred to as Quality Improvement Programs (QIPs). Under the Health Care Quality Improvement Program (HCQIP), QIPs collaborate with providers to identify and act upon opportunities for the quality of health care services.

• Oversees the negotiation and award of contracts for QIPs.

• Interprets and implements health and safety standards and evaluates, through surveillance, and surveys, their impact on the utilization and quality of health care services.

• Evaluates services to ensure protection of beneficiaries receiving health care services under the Medicare, Medicaid, and CLIA programs.

• Provides leadership and direction in beneficiary information and outreach activities concerning health care services, including information to enable beneficiaries to make informed health care choices.

• Determines program eligibility for all providers and suppliers under the Medicare program, and executes required agreements.

• Initiates, implements, and coordinates State related adverse actions and alternative remedies, including civil money penalties, and Federal activities against health care facilities not in compliance with Medicare or CLIA requirements.

• Makes final determination on all budget request submitted by State survey agencies.

• Establishes and maintains an extensive data and information gathering system involving all aspects of the certification program, CLIA, and QIPs.

• Authorizes investigation of complaints received from beneficiaries, the public, the Congress, the media, and other sources which allege deficiencies in the quality of care rendered by certified health care providers.

• Actively participates in and takes a lead role in training, outreach and collaborative activities involving providers, provider groups, health care professionals, professional reorganizations, consumer groups, and State survey agencies, relating to quality of health care services.

• Provides leadership in the development, implementation and continuation of continuous Quality Improvement activities for the State survey agencies and providers.

• Provides leadership in the quality improvement aspects of HCFA's National Managed Care Program.

• Develops and conducts training programs for the State survey agencies.

• Provides clinical assistance and technical direction to QIPs in the selection and evaluation of project, and develops, executes and measures HCFA directed cooperative clinical projects.

a3. Division of Health Standards and Quality (FLD(7)A)

• Oversees, monitors, and evaluates the State survey agencies and Medicaid State agencies.

• Assures that health care services provided under the Medicare, Medicaid, and CLIA programs are furnished in the most effective manner consistent with recognized professional standards of care.

• Interprets and implements health and safety standards and evaluates, through surveillance, assessments and surveys, their impact on the utilization and quality of health care services.

• Determines approval, denial, or termination of all provider and supplier certification actions under the Medicare program.

• Implements and coordinates State, Contractor, and carrier activities related to adverse sanctions and alternative remedies.

• Makes final determination on all budget requests submitted by State survey agencies.

• Establishes and maintains an extensive data and information gathering system involving all aspects of the certification.

• 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.

• Actively participates in and takes a lead role in training, outreach and collaborative activities involving providers, provider groups, and State survey agencies, relating to quality of health care services.

• Provides leadership in the development, implementation and continuation of continuous Quality Improvement activities for the State survey agencies and providers.

a4. Division of Health Standards and Quality (FLD(8,9)A)

• Assures that health care services provided under the Medicare and Medicaid 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 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, monitors, and evaluates Peer Review Organizations (PROs), including recommendations for contract renewal, extension, and modification.

• Recommends approval or withholding of monthly voucher payments to PROs.

• 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 sanctions and civil money penalties.

b1. Division of Medicaid (FLD(1–4,6–7)B)

• Plans, manages and provides Federal leadership to State agencies in program development, implementation, maintenance, and the regulatory review of State Medicaid program management activities under title XIX of the Social Security Act.

• Plans, directs, coordinates, and approves Medicaid State agency data processing systems (including MMIS)), proposals, modifications, operations,

contracts, and reviews. Assists Medicaid State agencies in developing innovative automated data processing health care systems. Assures the propriety of Federal expenditures.

- Reviews, evaluates, and determines acceptability of audit findings and recommendations and takes necessary clearance and closure actions.
- Maintains day-to-day liaison with State agencies and monitors their Medicaid program activities and practices by conducting periodic program management and financial reviews to assure State adherence to Federal law and regulations.
- Reviews, approves, recommends disapproval, and maintains official State plans and plan amendments for medical assistance.
- Reviews, approves, and monitors State payment systems and determines the allowablity of claims for Federal financial participation. Takes action to disallow claims when expenditures are not in accordance with Federal requirements and defends such action before the Departmental Appeals Board and in court. Defers payment action on questionable State claims for allowability.
- Reviews States' Medicaid quarterly estimates and statement of expenditures and recommends the amount to be estimated and allowed in the quarterly grants.
- Implements title XIX special initiatives and special or experimental programs such as Maternal and Child Health, Acquired Immune Deficiency Syndrome, statewide 1115 waivers, Freedom of Choice Waivers (1915(b), Home and Community Based Services Waivers (1915c), and operations of major management initiatives.
- Provides consistent guidance, technical assistance, and policy interpretation to States on Medicaid program and financial issues.
- Responds to beneficiary, Congressional, provider, and public inquiries concerning Medicaid issues, including Freedom of Information Act requests.
- Conducts customer outreach and service initiatives.
- Reviews and approves managed care contracts and prepaid health plans.

b2. Division of Medicaid and Managed Care (FLD(5)B)

- Provides Federal leadership to State agencies in program implementation, maintenance, and regulatory review of State Medicaid program management activities under Title XIX of the Social Security Act.
- Assures the propriety of Federal Medicaid expenditures and, where appropriate, takes action to disallow claims.
- Consults with and provides guidance to States on appropriate matters including the interpretation of Federal requirements, options available to States under these requirements, and information on practices in other States.
- Provides consistent policy guidance to States on Medicaid program administration and the amount, duration, scope, and payment for health services under the State program.
- Monitors State agency Medicaid activities by conducting periodic program management and financial reviews to assure State adherence to Federal laws and regulations.
- Reviews, approves, and maintains official State plans and State plan amendments for medical assistance.
- Directs activities in support of the Medicare managed care program including technical support and oversight of these plans.
- Reviews, approves or recommends for disapproval, and monitors State institutional payment plans and systems (after CO concurrence for hospitals and long term care facilities).
- Reviews States' quarterly statements of expenditures and recommends appropriate action on amounts claimed.
- Defers payment action on questionable State claims for allowability.
- Issues orders suspending Federal financial participation on unallowable State Title XIX payments and defends disallowance actions at Departmental Appeals Board.
- Plans, directs, and coordinates the review and approval of Medicaid State agency data processing systems, proposals, modifications, operations, and contracts.
- Implements Title XIX special initiatives, such as maternal and child health, Acquired Immune Deficiency Syndrome, managed care plans, health maintenance organization contracts, and other special or experimental programs and operations of major management initiatives.
- Performs Medicaid eligibility quality control reviews over State Medicaid eligibility and inspection of care practices to assure their ongoing compliance with Medicaid laws and regulations.

b3. Division of Medicaid (FLD(8–9)B)

- Provides Federal leadership to State agencies in program implementation, maintenance, and regulatory review of State Medicaid program management activities under Title XIX of the Social Security Act.
- Assures the propriety of Federal Medicaid expenditures and, where appropriate, takes action to disallow claims.
- Consults with and provides guidance to States on appropriate matters including the interpretation of Federal requirements, options available to States under these requirements, and information on practices in other States.
- Provides consistent policy guidance to States on Medicaid program administration and the amount, duration, scope, and payment for health services under the State program.
- Monitors State agency Medicaid activities by conducting periodic program management and financial reviews to assure State adherence to Federal laws and regulations.
- Reviews, approves, and maintains official State plans and State plan amendments for medical assistance.
- Reviews, approves or recommends for disapproval, and monitors State institutional payment plans and systems (after CO concurrence for hospitals and long term care facilities).
- Reviews States' quarterly statements of expenditures and recommends appropriate action on amounts claimed.
- Defers payment action on questionable State claims for allowability.
- Issues orders suspending Federal financial participation on unallowable State Title XIX payments and defends disallowance actions at Departmental Appeals Board.
- Plans, directs, and coordinates the review and approval of Medicaid State agency data processing systems, proposals, modifications, operations, and contracts.
- Implements Title XIX special initiatives, such as Maternal and Child Health, Acquired Immune Deficiency Syndrome, prepaid health plans, health maintenance organization contracts, and other special or experimental programs and operations of major management initiatives.
- Performs Medicaid eligibility quality control reviews over State Medicaid eligibility and inspection of care practices to assure their ongoing compliance with Medicaid laws and regulations.

c1. Division of Medicare (FLD(1–7)C)

- Directs Medicare program administration through working relationship with contractors, providers, physicians, beneficiaries, the Social Security Administration district offices, the Administration on Aging, the Office of Inspector General, and other Federal agencies, as well as local and national

organizations and individuals, as required.

- Directs the review and revaluation of the effectiveness of the Medicare program.
- Directs activities in support of the Managed Care Program including technical support and oversight of Health Maintenance Organizations, and other prepaid contractors.
- Monitor all aspects of contractor performance including claims/bills processing; coverage decisions; Medical Review; the detection of fraud, abuse, and waste in the Medicare Program; overpayment identification and collection; Medicare Secondary Payer (MSP); provider payment and audit; payment to physicians and suppliers; and electronic media claims.
- Coordinates on-going contractor fiscal management activities, including subcontracting, cash management activities, and compliance with the Chief Financial Officers Act.
- Negotiates and approves Medicare contractor budget and budget modifications.
- Directs and coordinates Medicare contractor system and workload transaction activities. Provides advice in the development of the Medicare Transaction System (MTS).
- Evaluates Medicare contractor performance and prepares annual Report of Contractor Performance.
- Manages beneficiary, provider, and public information programs.
- Recommends renewals, non-renewals, rescissions, and terminations of Medicare contracts.
- Coordinates the ESRD program.

c2. Division of Medicare (FLD(8, 9)C)

- Directs Medicare program administration through working relationship with contractors, providers, physicians, the Social Security Administration regional offices, the Administration on Aging, the Office of Inspector General, and other local and national organizations and individuals, as required.
- Directs the review and evaluation of the effectiveness of the Medicare program.
- Directs activities in support of the Managed Care Program including technical support and oversight of health maintenance organizations, and other prepaid contractors.
- Monitors all aspects of contractor performance including claims processing, coverage decisions, overpayment identification and collection, Medicare secondary payor, provider payment and audit, payment to physicians and suppliers, and electronic media claims.
- Coordinates ongoing contractor fiscal management activities, including subcontracting.
- Negotiates and approves Medicare contractor budget modifications.
- Evaluates Medicare contractor performance and prepares annual contractor evaluation report.
- Manages beneficiary, provider, and public information programs.
- Recommends renewals, non-renewals, recessions, and terminations of Medicare contracts.

d1. Medicare Operations and Policy Cluster (FLDXD)

- Directs and coordinates the assessment of Medicare fiscal intermediary contractor performance to ensure compliance with their Medicare contracts. Oversees corrective action and resolution of operational problems.
- Integrates program integrity considerations into all aspects of contractor operations to manage trust fund and general fund expenditures in a responsible manner, referring potential fraud cases for development and action to the Program Fiscal Integrity Cluster.
- Applies data analysis to assess risk and/or vulnerability of payment policies to ensure appropriateness of program expenditures and recommends policy and procedure changes to CO as needed.
- Monitors, evaluates, and assesses Medicare contractors' performance.
- Recommends renewals, non-renewals, rescissions, and terminations of Medicare contracts.
- Monitors the Medicare Common Working File host contractor's performance and oversees the operations and interfaces of the host and satellites.
- Provides specialized technical support and expertise to Medicare contractors and other HCFA components in such areas as ESRD, rural health clinics, Part B payment, medical review, coverage, and coding issues.
- Oversees and evaluates Part B payment changes and Part A and Part B medical review activities.
- Directs the review of Medicare contractor data processing systems, proposals, and modifications.
- Reviews, negotiates, and recommends approval of contractor budgets, modifications to budget allotments, and final settlement of contractor costs.
- Monitors Medicare contractor banking activities and recommends approval of contractor banking agreements.
- Maintains letter of credit and allotment controls on Medicare contractors to monitor funds drawn for administrative purposes.
- Provides technical assistance to Medicare contractors in implementing corrective actions, resolving operational problems, improving their contract performance, and in implementing special HCFA initiatives.
- Conducts special studies of contractor's performance and identifies opportunities for improving contractor's effectiveness.
- Coordinates and provides guidance to Medicare contractors and providers/suppliers in resolving billing, payment, coverage, claims processing, and customer service issues.
- Evaluates proposed regulatory and policy changes to the Medicare program and makes recommendations for CO consideration.
- Provides specialized technical support and oversight in such areas as Part A and Part B appeals.

d2. Medicaid Operations and Policy Cluster (FLDXE)

- Directs and coordinates the assessment of Medicaid State agencies compliance with the Medicaid State plans, with the exception of institutional payment State plans.
- Provides specialized technical support and expertise to Medicaid State agencies and other HCFA components including those related to non-institutional payment; early and periodic screening, diagnosis, and treatment; third-party liability; eligibility, entitlement, and coverage of health services; the Vaccines for Children program, and maternal and infant health.
- Provides technical assistance to State agencies in implementing corrective actions, resolving problems, and improving the effectiveness of their performance.
- Negotiates compliance issues and other problems with State agency management.
- Reviews and approves Medicaid State plan amendments, except for institutional payment State plans.
- Oversees, coordinates, and assesses the operation of State Medicaid Home and Community-Based Services Waivers.
- Provides highly specialized technical direction and assistance to States regarding computer systems applications, particularly for the Medicaid Management Information System (MMIS) and the Family Assistance Management Information System procurement, development, and installations.

d3. Program Fiscal Integrity Cluster (FLDXF)

- Conducts annual System Performance Reviews on MMIS computer systems to validate their compliance with Federal specifications as well as to confirm their ongoing eligibility for enhanced Federal funding.
- Oversees fiscal operations of the Medicare and Medicaid programs.
- Provides leadership and technical assistance to Medicaid State agencies in the development and maintenance of their Medicaid financial management activities, including the recovery of Medicaid overpayments, Medicaid utilization control; and inspection of care reviews.
- Conducts periodic comprehensive on-site financial reviews to assure State adherence to Federal laws, regulations, and State plans. Provides technical expertise and guidance in the financial system and cost allocation areas.
- Reviews State quarterly statements of expenditures and recommends appropriate actions (including acceptance, deferral or disallowance) on amounts claimed; and in a case of disallowance, prepares HCFA position for Departmental Appeals Board.
- Reviews State Medicaid budget estimates projecting future Federal funding requirements and recommends appropriate State funding levels to CO.
- Reviews, approves, or recommends disapproval, and monitors State institutional payment plans and systems for hospitals and nursing facilities, and determines the allowability or nonallowability of claims for Federal financial participation (FFP); and where State expenditures have not been made in accordance with an approved plan or Federal requirements, takes action to disallow such claims.
- Reviews the effectiveness of specific Medicaid program areas operated by State agencies, using data analysis techniques to assess whether the State program meets intent.
- Together with State agency staff, develops studies to help the State assess its own effectiveness.
- Participates with CO components in the development and design of quality measurements of the Medicaid program's effectiveness.
- Evaluates Medicare contractor's activities involving Medicare Secondary Payor (MSP) performance and negotiates MSP subrogation cases.
- Monitors and negotiates the settlement and resolution of audit findings pertaining to the Medicare or Medicaid programs which originate from HHS' Office of Inspector General or the General Accounting Office.
- Conducts quality assurance reviews of Medicare contractor claims payment operations.
- Monitors Medicare contractor overpayment identification and collection activities, pursues collection of overpayments referred to the RO, authorizes extended repayment schedules, assists regional counsel in bankruptcy cases; prepares overpayment cases for offset against Medicaid payments and Internal Revenue Service refunds; and refers cases to the Department of Justice for possible litigation as appropriate.
- Provides technical assistance to Medicare contractors, Medicaid State agencies, and other HCFA components in the area of Medicare and Medicaid payment and fiscal administration.
- Performs special studies of Medicare institutional payment practices and recommends corrective action to close loopholes identified.
- Conducts the Medicare cost report evaluation program.
- Recommends approval or disapproval of common audit agreements, rural referral centers, and sole community provider exemption requests.
- Performs reviews of allowability of costs claimed by Medicare contractors on the Final Administrative Cost Reports.
- Monitors and reviews Medicare contractors compliance with the Chief Financial Officer's Act.
- Directs the region's efforts to develop and refer cases of suspected fraud in Medicare and Medicaid, maintaining close contact with OIG, Medicaid fraud units at State Agencies, and the Department of Justice.
- Coordinates fraud and abuse activities with other HCFA ROs, Medicare contractors, other third party payers, and CO.
- Reviews the effectiveness of specific Medicaid program areas operated by State agencies, using data analysis techniques to assess whether the State program meets intent.

d4. Consumer Services and Information Cluster (FLDXG)

- Ensures that Medicare and Medicaid beneficiaries are informed of HCFA program benefits, rights, and responsibilities through a comprehensive marketing strategy to varied audiences.
- Monitors, evaluates, and assesses the performance of Medicare contractors in their beneficiary outreach and service organizations.
- Coordinates the operation of a public information and outreach programs directed at beneficiary groups, professional organizations, advocacy organizations, other health care entities, and the media.
- Directs the implementation of HCFA beneficiary services initiatives, such as the Medigap, Retired Senior Volunteer Programs, Information Counseling Assistance grants, and Qualified Medicare Beneficiary (QMB) programs.
- Provides direction, technical assistance, and training to the Social Security Administration district offices concerning Medicare entitlement, post-entitlement, and beneficiary education functions, and monitors the performance of these functions.
- Coordinates and controls the processing of responses to all beneficiary, provider, and Congressional inquiries.
- Provides specialized technical support and oversight in such areas as QMB and buy in.
- Works closely with local congressional and Governor's offices to provide a full array of constituent services and support.

d5. Managed Care Operations Cluster (FLDXH)

- Conducts a broad range of activities to oversee the operation of Medicare and Medicaid managed care plans to protect access to care and to enhance access to care, especially in rural or other undeserved areas.
- Provides leadership and oversight of health care delivery systems in Medicare and Medicaid that depart from the traditional fee-for-service model.
- Provides technical advice to health care plans that want to enter into risk and cost contracts for Medicare.
- Evaluates applications from managed care plans to become Medicare risk or cost contractors and/or expand operations to assure compliance with applicable laws and regulations; recommends approval or denial of such applications.
- Reviews and approves managed care plan marketing materials to assure adherence to laws and regulations and to assure that Medicare beneficiaries receive appropriate and clear information about the plans' benefit package and consumer protection.
- Assures contract compliance through periodic monitoring of plan performance.
- In cases of non-compliance, approves corrective action plan from the managed care plans and monitors adherence to the corrective action plan.
- Maintains ongoing relations with managed care plans in the region and works with central office to resolve problems plans have with HCFA policy

or procedures; recommends changes to CO in policy and procedures as appropriate.

- Operates a program of beneficiary services that includes direct contact with the Medicare beneficiary to resolve problems with particular plans, contract through congressional offices concerning beneficiary problems, and contact plans to resolve beneficiary problems.
- Resolves systems problems that affect beneficiary eligibility/entitlement under a particular managed care plan.
- Receives and evaluates complaints from beneficiaries concerning quality of care and refers such complaints to PROS for further investigation as appropriate.
- Conducts data analysis of plan performance indicators to determine whether plans need technical assistance or corrective action.
- Through ongoing information gathering in the health care marketplace, provides early warning to CO on polices that might impede the risk contracting in Medicare as commercial/public member limits and rate setting.
- Provides leadership and technical support to States in designing and implementing Medicaid managed care programs.
- Evaluates requests for freedom of choice waivers for Medicaid managed care plans to assure that access to care is maintained or enhanced and that projected costs comply with applicable law and regulation.
- Reviews and approves contracts between States and providers to assure compliance with Federal law and regulation.
- Provides early technical assistance to States that plan to apply for Section 1115 waivers to implement Statewide health care reform.
- Works closely with CO to evaluate requests for Section 1115 waivers, assuming a lead role when the waiver is approved and implementation begins.
- Provides ongoing technical assistance to States with active statewide Section 1115 waivers to assure that conditions of the waiver are adhered to and that access to care is adequate.
- Provides technical assistance to States in finding creative and new methods of delivering Medicaid services through a variety of managed care arrangements.

d6. Health Care Quality Improvement Cluster (FLDXJ)

- Assures that medical care, paid for by Federal Medicare funds, is medically necessary and meets recognized professional standards and quality of care through funding and the monitoring of Peer Review Organizations (PROs) and ESRD Networks in a multi-regional geographic area.
- Provides leadership to PROs and networks to design projects that will improve care to Medicare beneficiaries.
- Maintains knowledge of HCFA data bases, as well as other large health related data bases, and uses these to evaluate care provided to the Medicare population.
- Oversees the PROs' development of local quality studies to assure scientific merit and program relevance.
- Encourages PROs and ESRD networks to work with providers to use the results of local quality studies to fashion interventions to improve care.
- Conducts special regionwide studies to evaluate care provided to Medicare beneficiaries, including beneficiary groups which may have special health care needs, and works through PROs to help providers design interventions to improve care.
- Disseminates useful information to providers and to beneficiaries to improve quality of care.
- Convenes groups at the local level to collaborate on studies involving the quality of care provided to the Medicare, Medicaid, and managed care populations; this includes bringing together variously funded sources such as universities, foundations, and State offices with similar interests in quality of care.
- Participates in the negotiation and award of contracts to PROs.
- Prepares technical and budget evaluations of contract proposals received from PROs, and makes judgments to commit Federal funds for program implementation.
- Monitors and assesses the overall quality performance of PROs including success in using local projects to improve care for Medicare beneficiaries.

d7. Certification Improvement Cluster (FLDXK)

- Manages the State agency evaluation program and assesses the performance of the State survey agency in their survey and certification review process for compliance with performance standards.
- Works with the States to design internal quality assurance programs.
- Negotiates State agency agreements and issues substantive regional guidelines containing policy and procedural interpretations relating to certification activities.
- Evaluates complaints from the public, media, Congress, and others alleging deficient standards in provider facilities, and instructs State agencies to investigate, as appropriate.
- Makes final recommendations on all initial budget and supplemental budget requests submitted by State agencies.
- Takes adverse actions against non-complying Medicare facilities.
- Establishes and maintains a data and information gathering system involving all aspects of the certification program.
- Conducts Federal surveys of providers and suppliers of health services to ensure that State monitoring is satisfactory.
- Performs or authorizes validation surveys in accredited institutions to determine their compliance with Federal standards.
- Conducts surveillance and assessment of State agency operations regarding quality of care, and assists them in developing the capability to provide direct assistance to providers and suppliers of health services in the improvement of their performance.
- Conducts studies, pilot projects, and experimental programs and assists in implementing techniques designed to improve the survey and certification process and peer review systems.
- Conducts training of State surveyors as needed and indicated by Federal monitoring.

Dated: July 19, 1995.

Bruce C. Vladeck,

Administrator, Health Care Financing Administration.

[FR Doc. 95–18977 Filed 8–1–95; 8:45 am]

BILLING CODE 4120–01–P

Substance Abuse and Mental Health Services Administration

Cooperative Agreement With the State of Hawaii

AGENCY: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration (SAMHSA), HHS.

ACTION: Notice of planned cooperative agreement award to the State of Hawaii to serve a rural area in the Hawaiian Islands with a focus on substance abuse among Native Hawaiians and other residents of rural Hawaii.

SUMMARY: The Center for Substance Abuse Treatment (CSAT), SAMHSA, is publishing this notice to provide information to the public of a planned single source cooperative agreement award to the State of Hawaii for the development and evaluation of systems of substance abuse and/or dependence intervention, treatment and recovery