Dated: May 8, 1998.

William B. Schultz,

Deputy Commissioner for Policy.

[FR Doc. 98–12831 Filed 5–13–98; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

[Document Identifier: HCFA–R–229]

Agency Information Collection Activities: Proposed Collection; Comment Request

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, is publishing the following summary of proposed collections for public comment. Interested persons are invited to send comments regarding the burden estimate or any other aspect of this collection of information, including any of the following subjects: (1) the necessity and utility of the proposed information collection for the proper performance of the agency's functions; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility,and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

Type of Information Collection Request: Extension of a currently approved collection; *Title of Information Collection:* Development of an Assessment System for post Acute Care; *Form No.:* HCFA–R–229, OMB #0938–0720; *Use:* The Minimum Data Set- Post Acute Care (MDS–PAC) will be used to establish patient case mix groups including classes of patients in the rehabilitation facility for the payment system. It will also provide data and seek input from the rehabilitation industry for HCFA to formulate policy and promulgate regulations. *Frequency:* On occasion; *Affected Public:* Individuals or Households, Business or other for-profit, Not-for-profit; *Number of Respondents:* 10,465; *Total Annual Responses:* 10,465; *Total Annual Hours:* 23,301.

To obtain copies of the supporting statement for the proposed paperwork collections referenced above, E-mail your request, including your address and phone number, to 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 60 days of this notice directly to the HCFA Paperwork Clearance Officer designated at the following address: HCFA, Office of Information Services, Information Technology Investment Management Group, Division of HCFA Enterprise Standards, Attention: John Rudolph, Room C2–26–17, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

Dated: May 5, 1998.

John P. Burke III,

HCFA Reports Clearance Officer, Division of HCFA Enterprise Standards, Health Care Financing Administration.

[FR Doc. 98–12766 Filed 5–13–98; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

[Document Identifier: HCFA–250 through HCFA–254]

Emergency Clearance: Public Information Collection Requirements Submitted to the Office of Management and Budget (OMB)

AGENCY: Health Care Financing Administration, HHS

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, is publishing the following summary of proposed collections for public comment. Interested persons are invited to send comments regarding this burden estimate or any other aspect of this collection of information, including any of the following subjects: (1) The necessity and utility of the proposed information collection for the proper performance of the agency's functions; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

We are, however, requesting an emergency review of the information collections referenced below. In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, we have submitted to the Office of Management and Budget (OMB) the following requirements for emergency review. We are requesting an emergency review because the collection of this information is needed before the expiration of the normal time limits under OMB's regulations at 5 CFR, Part 1320. This is necessary to collect information from beneficiaries on health insurance coverage that is primary to Medicare. Collection of this information allows HCFA to identify those Medicare beneficiaries who have other group health insurance that would pay before Medicare, resulting in savings to the Medicare Trust Fund. The annual savings from the Medicare Secondary Payer (MSP) program are more than $3 billion per year. Emergency approval is needed to prevent a disruption in the information collection and to continue the savings to the Medicare Trust Fund. We cannot reasonably comply with the normal clearance procedures because public harm is likely to result because eligible individuals may not receive the health insurance protections under the statute.

HCFA is requesting OMB review and approval of this collection 15 working days after the publication of this **Federal Register** notice, with a 180-day approval period. Written comments and recommendations will be accepted from the public if received by the individuals designated below 14 working days after the publication of this notice. During this 180-day period, we will publish a separate **Federal Register** notice announcing the initiation of an extensive 60-day agency review and public comment period on these requirements. We will submit the requirements for OMB review and an extension of this emergency approval.

Type of Information Request: Reinstatement, without change, of a previously approved collection for which approval has expired;

Title of Information Collection: Medicare Secondary Payer Information Collection and Supporting Regulations in 42 CFR 489.20;

Form Number: HCFA–250 through HCFA–2545 (OMB approval #: 0938–0214);

Use: Medicare Secondary Payer (MSP) is essentially the same concept known in the private insurance industry as coordination of benefits, and refers to those situations where Medicare does not have primary responsibility for paying the medical expenses of a Medicare beneficiary. HCFA contracts with health insuring organizations, herein referred to as intermediaries and carriers, to process Medicare claims. HCFA charges its Medicare intermediaries and carriers with various tasks to detect MSP cases; develops and disseminates tools to enable them to

better perform their tasks; and monitors their performance in achievement of their assigned MSP functions. Because intermediaries and carriers are also marketing health insurance products that may have liability when Medicare is secondary, the MSP provisions create the potential for conflict of interest. Recognizing this inherent conflict, HCFA has taken steps to ensure that its intermediaries and carriers process claims in accordance with the MSP provisions, regardless of what other insurer is primary. These information collection requirements describe the MSP requirements.

Frequency: One time only;
Affected Public: Individuals or Households;
Number of Respondents: 14,204,000;
Total Annual Responses: 14,204,000;
Total Annual Hours Requested: 773,240.

• *42 CFR 489.20(f)—Third Party Identification.*

Identification and collection of information concerning proper payers during the admission process is a common business practice in the health care field. HCFA hospital reviews indicate that only one additional question is required as compared with the normal admissions process for non-Medicare patients. In addition, many hospitals have and will continue to reap significant benefits due to identification of primary payers during the admission process. This relates to the fact that a private payer's rate of payment is normally based on a percentage of charges, whereas for Medicare patients the hospital receives the Medicare payment, which is generally an amount paid under the prospective payment system.

• *Initial Enrollment Questionnaire (IEQ)—P.L. 103–432 Sec. 151*

The IEQ contractor states that the average number of IEQs mailed each calendar year is 1,903,960. The time required to complete the IEQ is approximately 15 minutes per beneficiary. Therefore, the burden is 1,903,960 × 15 minutes = 475,990 of burden hours per year. The total burden is 773,240 hours (297,250 + 475,990).

We have submitted a copy of this notice to OMB for its review of these information collections. A notice will be published in the **Federal Register** when approval is obtained.

To obtain copies of the supporting statement and any related forms 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, phone number, OMB number, and HCFA document identifier, to Paperwork@hcfa.gov, or call the Reports Clearance Office on (410) 786–1326.

Interested persons are invited to send comments regarding the burden or any other aspect of these collections of information requirements. However, as noted above, comments on these information collection requirements must be mailed and/or faxed to the designees referenced below fourteen days after the publication of this **Federal Register** notice:

Health Care Financing Administration, Office of Information Services, Information Technology Investment Management Group, Division of HCFA Enterprise Standards, Room C2–26–17, 7500 Security Boulevard, Baltimore, MD 21244–1850. Fax Number: (410) 786–1415. Attn: Louis Blank HCFA–250 through HCFA–254 and,

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Fax Number: (202) 395–6974 or (202) 395–5167. Attn: Allison Herron Eydt, HCFA Desk Officer.

Dated: May 6, 1998.

John P. Burke III,

HCFA Reports Clearance Officer, HCFA, Office of Information Services, Information Technology Investment Management Group, Division of HCFA Enterprise Standards.

[FR Doc. 98–12802 Filed 5–13–98; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

[HCFA–3888–NC]

Medicare and Medicaid Programs: Request for Public Comments on the Quality Improvement System for Managed Care

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

ACTION: Solicitation of comments; notice of public meeting.

SUMMARY: The Quality Improvement System for Managed Care (QISMC) is a document that represents the best thinking on what managed care organizations contracting with Medicare and Medicaid should do to protect and improve the health and satisfaction of enrolled beneficiaries. This notice solicits comments on the review draft of the QISMC document, and informs the public of a meeting to discuss the quality improvement system initiative.

DATES: We request that comments be submitted on or before May 26, 1998.

Public Meeting: In addition to seeking written comments from the public, we will hold a public meeting on Tuesday, May 26, 1998, from 8:30 a.m. to 3:30 p.m. e.d.t.

ADDRESSES: The May 26, 1998 public meeting will be held in the Health Care Financing Administration Auditorium at 7500 Security Boulevard, Baltimore, Maryland 21207. (For details, see section III of this notice.)

Mail written comments (1 original and 3 copies) to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: HCFA–3888–NC, P.O. Box 26688, Baltimore, MD 21207.

If you prefer, you may deliver your written comments (1 original and 3 copies) to one of the following addresses:

Room 309–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201,

or

Room C5–09–26, 7500 Security Boulevard, Baltimore, MD 21244–1850

Comments may also be submitted electronically to the following e-mail address: hcfa3888nc.hcfa.gov. E-mail comments must include the full name and address of the sender and must be submitted to the referenced address in order to be considered. All comments must be incorporated in the e-mail message because we may not be able to access attachments. Because of staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code HCFA–3888–NC. Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, in Room 309–G of the Department's offices at 200 Independence Avenue, SW., Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (phone: (202) 690–7890).

FOR FURTHER INFORMATION CONTACT: Brian Agnew, (410) 786–5964.

SUPPLEMENTARY INFORMATION:

I. Background

The QISMC initiative began in 1996 with the following basic goals:

• To develop a coordinated Medicare and Medicaid quality oversight system that would reduce duplicative or conflicting efforts and send a uniform