Factor 3—Estimated Real Gross Domestic Product Per Capita Growth in Fiscal Year 2000

Section 1848(f)(2)(C) of the Act, as amended by section 4503 of the BBA, requires the Secretary to project real gross domestic product per capita growth for the coming fiscal year. In calculating the SGR, we estimate that this growth will be 1.8 percent in fiscal year 2000.

Factor 4—Percentage Change in Expenditures for Physicians' Services Resulting From Changes in Law or Regulations in Fiscal Year 2000 Compared With Fiscal Year 1999

Legislative changes contained in the BBA will have some residual effects on expenditures for physicians' services in fiscal year 2000. In addition, there are some miscellaneous provisions that will have a small impact.

Taking into account all of the changes in law or regulation that may affect expenditures for physicians' services, the decrease in expenditures for physicians' services is estimated to be −0.2 percent.

IV. The Use of Estimates in Computing the Sustainable Growth Rate

Section 1848(f) of the Act clearly requires that each year, the Secretary establish the SGR for the upcoming fiscal year beginning October 1 based on the Secretary's estimate[s] of four factors: The percentage increase in physicians' fees, the percentage increase in fee-for-service enrollment, the projected percentage growth in per capita gross domestic product, and the percentage change in expenditures for physicians' services resulting from changes in law or regulations. Because the calculation of the SGR for a given year is based on projected values, updates may be either lower or higher than they would have been if we had used later data. Thus, we initially considered revising estimates of the factors used in setting the SGR when later data had become available. However, as we indicated in the notice with comment period published in the **Federal Register** (63 FR 59188) on November 2, 1998, we had concerns about whether we had the statutory authority to make these revisions under current law and invited comments regarding how an adjustment could be made consistent with the law. The comments we received and our response are discussed below.

Comment: The American Medical Association and numerous physician organizations suggested that congressional intent should be interpreted to authorize adjustments for projection error. These commenters also suggested a number of different approaches for making such adjustments. The various approaches suggested rely on later data.

Response: We do not believe that we have the authority to make adjustments based on Congressional intent because the statutory language clearly requires that estimated values be used for computing the SGR and there is no provision for revising the estimates to reflect later data. Our actions are controlled by the clear statutory language. Thus, we will not be able to make adjustments to the SGR based on later data.

However, the Administration's legislative package for fiscal year 2000, released in February 1999, contains a legislative proposal to adjust the SGR if later data are different from earlier estimates, as well as to address issues relating to the instability of the SGR discussed below. The changes proposed are all budget neutral. If Congress enacts this proposal for fiscal year 2000, we would revise the SGR for fiscal year 2000 as appropriate.

V. Technical Problems With the Sustainable Growth Rate System

We have begun to forecast the SGR for future years, and it appears that there is some instability in the SGR system. In the long-term, updates could oscillate between the maximum increase and decrease adjustments due to the use of mismatched time periods and the lag between measurement periods. The solution would be technical and would involve the matching of time periods for the SGR calculation, the actual versus target measurement, and the update adjustment. As discussed above the Administration has submitted a legislative proposal to the Congress that will address these factors and result in less oscillation in the physician fee schedule update.

VI. Regulatory Impact Statement

Consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612), we prepare a regulatory flexibility analysis unless we certify that a notice will not have a significant economic impact on a substantial number of small entities. For purposes of the RFA, we treat all physicians and suppliers as small entities. Individuals and States are not included in the definition of a small entity.

Also, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a notice may have a significant impact on the operations of a substantial number of small rural hospitals. That analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 50 beds.

Legislative changes contained in the BBA will affect expenditures for physicians' services in fiscal year 2000, although the impact will be slight, and residual effects will result in fiscal year 2000 from the calendar year implementation of these changes.

We are not preparing an analysis for either the RFA or section 1102(b) of the Act because we have determined, and the Secretary certifies, that this notice will not have a significant economic impact on a substantial number of small entities or on the operations of a substantial number of small rural hospitals.

In accordance with the provisions of Executive Order 12866, this notice was reviewed by the Office of Management and Budget.

We have reviewed this final notice under the threshold criteria of Executive Order 13132 of August 4, 1999, and have determined that it does not significantly affect the rights, roles, and responsibilities of States.

(Sections 1848(d) and (f) of the Social Security Act) (42 U.S.C. 1395w–4(d) and (f))

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

Dated: September 1, 1999.

Michael M. Hash,

Deputy Administrator, Health Care Financing Administration.

Approved: September 20, 1999.

Donna E. Shalala,

Secretary.

[FR Doc. 99–25527 Filed 9–28–99; 9:58 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources And Services Administration

Agency Information Collection Activities: Proposed Collection: Comment Request

In compliance with the requirement for opportunity for public comment on proposed data collection projects (section 3506(c)(2)(A) of Title 44, United States Code, as amended by the Paperwork Reduction Act of 1995, Public Law 104–13), the Health Resources and Services Administration (HRSA) publishes periodic summaries of proposed projects being developed

for submission to OMB under the Paperwork Reduction Act of 1995. To request more information on the proposed project or to obtain a copy of the data collection plans and draft instruments, call the HRSA Reports Clearance Officer on (301) 443–1891.

Comments are invited on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology.

Proposed Project: Uniform Reporting System Client Demonstration Project (URS): NEW

The Uniform Reporting System Client Demonstration Project (URS) was established in 1994 to collect information from several Title I and Title II grantees and their subcontracted service providers about their individual clients. Demographic information, service utilization, and health indicators of all clients receiving services at providers funded by the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act are collected twice each year. A unique identifier is used to protect the anonymity of the clients, and as a further safeguard, this unique identifier is encrypted before it is sent to HRSA.

HRSA initiated the URS to demonstrate (1) the feasibility of collecting client level demographic and service data on HIV/AIDS infected/affected clients across a network of service providers and (2) the usefulness of these data for planning and evaluation purposes at both the local and national levels. Through this system, HRSA sought to overcome the limitations of the Annual Administrative Report (AAR), the national reporting system for the Ryan White CARE Act. The AAR collects data aggregated at the grantee level and has duplicated counts of clients. The number of clients reported in the AAR overestimates by approximately the true number of clients. In addition, AAR data are not tied to any clinical or service outcome information at the client level. The feasibility of collecting client data has been demonstrated. The usefulness of these data for planning and evaluation purposes at both the local and national level has become increasingly evident. A number of client level analyses that were not possible with the AAR have been undertaken.

In addition to meeting the goal of accountability to Congress, clients, advocacy groups, and the general public, the URS supports critical efforts by HRSA, state and local grantees, and providers to assess the health outcomes and the service utilization patterns of the individuals at these sites who are infected or affected by HIV/AIDS and receive care at a provider funded by the Ryan White CARE Act.

Outcome specific and treatment measures are collected in the data system; these will be asked only of medical providers. These data elements seek to document whether current standards of care as established by the Public Health Service are being adhered to at these Ryan White CARE Act facilities. The core set of data elements are largely unchanged from the AAR. Minor changes in the demographic data elements have been made as a result of meetings and input from the current URS grantees and their providers.

The estimated response burden is as follows:

Medical records source	Number of respondents	Responses per respondent	Burden hour	Total burden hours
Medical Providers	27,000	1	4	108,000
Case Managers, Mental Health, Substance Abuse Providers	32,000	1	1	32,000
Other Providers	35,000	1	.5	17,500
Total	94,000			157,500

Send comments to Susan G. Queen, Ph.D., HRSA Reports Clearance Officer, Room 14–33, Parklawn Building, 5600 Fishers Lane, Rockville, MD 20857. Written comments should be received within 60 days of this notice.

Dated: September 24, 1999.

Jane Harrison,

Director, Division of Policy Review and Coordination.

[FR Doc. 99–25555 Filed 9–30–99; 8:45 am]

BILLING CODE 4160–15–P

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

[Docket No. FR–4446–N–07]

Announcement of OMB Approval Number for Community Development Block Grant (CDBG) Urban Country and New York Towns Qualification/Requalification Processes

AGENCY: Office of the Assistant Secretary for Community Planning and Development, HUD.

ACTION: Announcement of OMB Approval Number.

SUMMARY: The purpose of this notice is to announce the OMB approval number for the collection of information pertaining to Community Development Block Grant (CDBG) Urban Country and New York Towns Qualification/Requalification Processes.

FOR FURTHER INFORMATION CONTACT: Ms. Sue Miller, Department of Housing and Urban Development, 451 7th Street, Southwest, Washington, DC 20410, telephone (202) 708–1577. This is not a toll-free number.

SUPPLEMENTARY INFORMATION: In accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35, as amended), this notice advises that OMB has responded to the Department's request for approval of the information collection pertaining to Community Development Block Grant (CDBG) Urban Country and New York Towns Qualification/Requalification Processes. The OMB approval number for this information collection is 2506–0170, which expires on September 30, 2002.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information,