requirements is necessary to determine whether the ambulance qualifies for reimbursement under Medicare. Carriers require ambulances providing service to Medicare beneficiaries to submit documentation showing that they have the required equipment. *Frequency:* On occasion; *Affected Public:* Business or other for-profit; *Number of Respondents:* 100; *Total Annual Hours:* 25.

2. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Cost Report for Electronic Filing for Hospital and Hospital Health Care Complex Cost Report and Supporting Regulations in 42 CFR 413.20 and 413.24; *Form No.:* HCFA–2552–96; *Use:* This form is required by statute and regulation for participation in the Medicare program. The information is used to determine final payment for Medicare. Hospitals and related complexes are the main users. *Frequency:* Annually; *Affected Public:* Business or other for-profit, Not-for profit institutions, and State, Local or Tribal Government; *Number of Respondents:* 7,000; *Total Annual Responses:* 7,000; *Total Annual Hours Requested:* 4,599,000.

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 to obtain the supporting statement and any related forms, 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 30 days of this notice directly to the HCFA Paperwork Clearance 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: June 24, 1997.

Edwin J. Glatzel,

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

[FR Doc. 97–17243 Filed 7–1–97; 8:45 am]

BILLING CODE 4120–03–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

[HSQ–207–NC]

RIN 0938–AG32

Medicare Program; Description of the Health Care Financing Administration's Evaluation Methodology for the Peer Review Organization 5th Scope of Work Contracts

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

ACTION: General notice with comment period.

SUMMARY: This notice describes how HCFA intends to evaluate the Peer Review Organizations (PROs) for quality improvement activities, under their 5th Scope of Work (SOW) contracts, for efficiency and effectiveness in accordance with the Social Security Act. In accordance with the provisions of the Government Performance and Results Act of 1993, the 5th SOW contracts with the PROs are performance-based contracts.

DATES: This notice is effective on July 2, 1997. Written comments will be considered if we receive them at the appropriate address, as provided below, no later than 5 p.m. on September 2, 1997.

ADDRESSES: Mail written comments (an original and 3 copies) to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: HSQ–207–NC, P.O. Box 26676, Baltimore, MD 21207–0476.

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

Room 309–G, Hubert H. Humphrey Building, 200 Independence Avenue, S.W., Washington, DC 20201–0001.
or
Room C5–09–26, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Because of staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code HSQ–207–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, S.W., Washington DC 20201–0001, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (phone: (202) 690–7890).

Comments may also be submitted electronically to the following e-mail address: HSQ207NC@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. Electronically submitted comments will also be available for public inspection at the Independence Avenue address shown above.

FOR FURTHER INFORMATION CONTACT: Henry Koehler, (410) 786–6850.

SUPPLEMENTARY INFORMATION:

I. Background

A. Program Description

The Peer Review Improvement Act of 1982 (title I, subtitle C of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Pub. L. 97–248) amended part B of title XI of the Social Security Act (the Act), establishing the PRO program. The PRO program was established in order to redirect, simplify, and enhance the cost-effectiveness and efficiency of the medical peer review process. Sections 1153 (b) and (c) of the Act define the types of organizations eligible to become PROs and establish certain limitations and priorities regarding PRO contracting. In 42 CFR part 462, subpart C, of our regulations, we describe the types of organizations eligible to become PROs. In § 462.101, we require they: (a) Be either a physician-sponsored organization as described in § 462.102, or a physician-access organization as described in § 462.103; and (b) demonstrate their ability to perform the review requirements set forth in § 462.104.

Under section 1153(h)(2) of the Act, the Secretary is required to publish in the **Federal Register** the general criteria and standards that will be used to evaluate the efficient and effective performance of contract obligations by PROs, and provide the opportunity for public comment. This notice sets forth the criteria that will be used to monitor PRO performance of quality improvement activities.

Section 1154 of the Act requires that PROs review those services furnished by physicians, other health care practitioners, and institutional and non-institutional providers of health care services, including health maintenance organizations and competitive medical plans, as specified in their contract with the Secretary. The Secretary enters into

contracts with PROs to perform the following two broad functions:

- To promote quality health care services for Medicare beneficiaries; and
- To determine whether those services are reasonable, medically necessary, furnished in the appropriate setting, and of a quality that meets professionally recognized standards of health care.

These functions, which include quality improvement projects, are central elements of the Health Care Quality Improvement Program (HCQIP). PRO contracts are awarded for three years with starting dates staggered into three approximately equal groups starting on April 1, July 1, and October 1.

B. Development of Evaluation Standards

Using the conceptual groundwork of a 1990 Institute of Medicine report (''Medicare: A strategy for quality assurance,'' Volumes 1 & 2, Committee to Design a Strategy for Quality Review and Assurance in Medicare, Division of Health Care Services, Institute of Medicine, KN Lohr, editor, National Academy Press, Washington, DC, 1990), we reinvented and modernized our quality assurance and improvement activities under the HCQIP. We launched the HCQIP in April 1993, reorienting the PRO program from a random sample case-by-case review to a system designed to encourage providers to maintain and strengthen their own internal quality management systems. The PROs monitor the quality of care provided in both fee-for-service and managed care settings using both a data-driven approach to monitor care and outcomes and a cooperative approach of working with the health care community to improve care.

The agency changed the focus of the PRO contracts in recognition that the case review approach as the principal means of monitoring did not give providers adequate information on systemic health care delivery problems and methods for improving service delivery systems and health outcomes. The HCQIP approach addresses these weaknesses, combining providers' internal quality management systems, driven by clinically-reliable data, with external monitoring and educational support from the PROs. Central to the monitoring system is the identification of patterns of care. The goal of these data analyses is to identify treatment patterns for individuals and populations that are consistent with current professional knowledge and that are likely to improve outcomes. The PROs educate physicians about best practices and assist hospitals and other institutional and noninstitutional providers in developing internal quality monitoring systems that will lead to quality improvement.

In our recently modified 5th Scope of Work contracts with the PROs, we specified four objectives that PROs should maximize as they design and implement quality improvement projects. The PROs are directed to implement quality improvement projects that—

1. Result in measurable improvements;
2. Involve as many beneficiaries, providers and provider types as possible;
3. Focus on important clinical topics; and
4. Build internal and external capacity to improve care.

C. Measuring PRO Performance

The most important activity for the PROs in their 5th Scope of Work contracts is implementing quality improvement projects that lead to measurable improvements in quality of care and health status. The second objective, involving as many beneficiaries, providers, and provider types as possible, will be accomplished as a result of PROs implementing a broad portfolio of successful improvement projects. The measurements for evaluating progress towards achieving objectives 3 and 4 will not be part of the evaluation strategy at this time. Due to the complexity involved in developing measures for those objectives, we will pilot test them before we make implementation decisions.

We define below the first two objectives concretely and unambiguously and we will assess each PRO's progress in achieving the objectives using explicit and quantifiable measures. We will feed back to the PROs information about their success in achieving the contract objectives. We will use this process to identify the successfully performing PROs, to learn what characteristics are associated with success, and to disseminate this information to the PRO community. We will also use this feedback process to encourage average and poorly performing PROs and to give them a mechanism by which they can gauge the success of any remedial actions they might initiate.

We will use the data reported via the Standard Data Processing System quality improvement project reporting system to evaluate each PRO's progress in achieving objectives 1 and 2 of the 5th Scope of Work contract. We reserve the right to ask for additional information and to use alternate reporting channels should the data we require not be present in the quality improvement project reporting system.

Specifically, to assess the PRO's ability to implement quality improvement projects that result in measurable improvements, we will:

- Monitor the achievement of key project steps for all projects undertaken by the PRO. (These project steps include: documenting the baseline opportunity to improve care, intervening directly or in conjunction with appropriate health care providers to improve care, and measuring the effect of these interventions.)
- Monitor the number of projects the PRO reports as having achieved some measurable improvement.
- Assess the amount of improvement each project has achieved.

With respect to objective 2, to assess the PRO's ability to ''implement quality improvement projects that involve as many beneficiaries, providers and provider types as possible'', we will:

- Determine the percentage of beneficiaries who might be impacted by the project by measuring the number of beneficiaries in the State who have the targeted clinical condition and measuring the number of eligible beneficiaries who might be affected by the project.
- Determine the percentage of acute care hospitals in each State that actively collaborate with the PRO in one or more projects.
- Measure the number of other providers and practitioners who participate in the PROs' projects.

In addition to these performance measures, we may choose to use other data sources, such as surveys or focus groups, in order to assess and improve the validity of the evaluation process.

We will design a standard content and format for our evaluation reports and will issue the reports at regularly scheduled intervals. In addition, we will periodically issue special evaluation reports as new issues become pertinent.

We plan to use this evaluation system as a basis for decisions regarding future special PRO projects, awards, and competitive and noncompetitive contract renewals. At the time that each of these decisions is to be made, we will identify the pertinent criteria and use the evaluation system to determine which PROs are eligible. In addition, we will use the evaluation system to assure that the PROs' 5th Scope of Work performance does not deteriorate as their special project activities are implemented.

As the end of the 5th Scope of Work contracts approaches, we will use the

evaluation system to set a threshold for eligibility for noncompetitive renewal of the PRO contract. We are issuing the following standards for minimum performance to inform the PROs about what we consider to be a minimum level of PRO performance during the 5th Scope of Work.

II. Standards For Minimum Performance

To be eligible for a noncompetitive renewal of its 6th round contract, a PRO must meet, at a minimum, the performance standards listed below by the end of its 18th contract month. However, meeting these minimum performance standards does not guarantee a noncompetitive renewal of its contract. We will make a final decision on renewal/nonrenewal by the end of the 28th month of the 5th Scope of Work contract.

We will issue a ''Notice of Intent to Non-renew the PRO Contract'' letter to all PROs that do not meet the minimum performance standards by the end of their 18th contract month. A PRO will be considered to have met the minimum performance standards if:

A. The PRO initiated quality improvement projects in at least the five clinical topic areas to include acute myocardial infarction, diabetes, prevention (flu vaccination, pneumonia vaccination, or mammography), and two topic areas of a PRO's choice.

B. Each PRO quality improvement project is sufficiently broad enough in scope to involve a specified percentage of beneficiaries in the PRO's geographic area (a percentage of beneficiaries with the condition or percentage for whom the prevention service is indicated) as follows:

Topic Area	Scope (Percentage of beneficiaries involved)
Acute Myocardial Infarction	10
Diabetes	5
Prevention (flu vaccination, pneumonia vaccination, or mammography)	10
Topic of PRO's choice	10
Topic of PRO's choice	10

C. The PRO demonstrates that a sufficient number of providers in its contractually specified geographic area have actively attempted to improve care through participation in the PRO's quality improvement projects. Specifically, the PRO must have enlisted the participation of:

- At least 25 percent of all acute care hospitals; and
- One of the following:

* In States with a high managed care penetration (defined to include California, Florida, Oregon, Washington, Arizona, Massachusetts, New York and Pennsylvania), at least one managed care plan; or

* In all remaining states, at least 10 community-based practitioners.

D. A PRO will demonstrate that at least one of the five prescribed projects has achieved a measured improvement on one or more of the targeted project indicators. In other words, the PRO must demonstrate that the gap between the ''expected'' indicator level (for example, the YEAR 2000 goal, practice guideline, clinical control trials recommendation) and the ''actual'' level, as documented in the baseline measurement, will have been lessened, as shown in the project's evaluation (for example, remeasurement step).

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

III. Response to Comments

Although we are not able to acknowledge or respond to all items of correspondence individually, we will consider all written comments that we receive by the date and time specified in the **DATES** section of this preamble.

Authority: Sections 1102 and 1881 of the Social Security Act (42 U.S.C. 1302 and 1395rr).

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

Dated: May 29, 1997.

Bruce C. Vladeck,

Administrator, Health Care Financing Administration.

[FR Doc. 97–17234 Filed 7–1–97; 8:45 am]

BILLING CODE 4120–03–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of General Medical Sciences; Notice of Closed Meeting

Pursuant to Section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of the following advisory committee meeting of the National Institute of General Medical Sciences Special Emphasis Panel:

Committee Name: Trauma and Burn.
Date: July 21, 1997.
Time: 2:00 p.m.—until conclusion.
Place: The Copley Plaza Hotel, 138 St. James Avenue, Boston, MA 02116.
Contact Person: Bruce K. Wetzel, Ph.D., Scientific Review Administrator, NIGMS, Office of Scientific Review, 45 Center Drive, Room 2AS–19, Bethesda, MD 20892–6200, 301–594–3907.
Purpose: To review and evaluate program project applications.

This meeting will be closed in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6). Title 5 U.S.C. The discussions of these applications could reveal confidential trade secrets or commercial property such as patentable material and personal information concerning individuals associated with the applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

(Catalog of Federal Domestic Assistance Program Nos. 93.821, Biophysics and Physiological Sciences; 93.859, Pharmacological Sciences; 93.862, Genetics Research: 93.863, Cellular and Molecular Basis of Disease Research; 93.880, Minority Access Research Careers [MARC]; and 93.375, Minority Biomedical Research Support [MBRS])

Dated: June 26, 1997.

LaVerne Y. Stringfield,

Committee Management Officer, NIH.

[FR Doc. 97–17380 Filed 7–1–97; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

Agency Information Collection Activities: Proposed Collection; Comment Request

In compliance with section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 for opportunity for public comment on proposed data collection projects, the Substance Abuse and Mental Health Services Administration will publish periodic summaries of proposed projects. To request more information on the proposed projects or to obtain a copy of the data collection plans and instruments, the SAMHSA Reports Clearance Officer on (301) 443–8005.

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