DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–5017–N]

Medicare Program; Medicare Health Care Quality (MHCQ) Demonstration Programs

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Notice.

SUMMARY: This notice informs eligible health care groups of an opportunity to apply to participate in the Medicare Health Care Quality demonstration. The goal of the demonstration is to improve the quality of care and services delivered to Medicare beneficiaries through a major system redesign that fosters best practice guideline usage, continuous quality and patient safety improvement, shared decision making between providers and patients, and the delivery of culturally and ethnically appropriate care. This notice contains information on how to obtain the complete solicitation and supporting information.

A competitive process will be used to select 8 to 12 health care organizations (that is, physician group practices, integrated delivery systems, and regional coalitions of physician group practices and integrated delivery systems) to participate in the 5-year demonstration. The application solicitation will be conducted in two phases.

DATES: For the initial solicitation, applications will be considered if received at the appropriate address, provided in the **ADDRESSES** section, no later than 5 p.m. e.s.t., on January 30, 2006. For the second solicitation phase, applications will be considered if we receive them no later than 5 p.m. e.d.t., on September 29, 2006. Applicants intending to submit a proposal for the second phase review should forward a letter of intent to the same address listed in the **ADDRESSES** section of this notice, no later than January 30, 2006.

LETTER OF INTENT REQUIREMENTS: The letter of intent should include the following:

- An outline of the demonstration proposal.
- A description of the proposed organizational structure.
- A timeline for development and implementation of the proposed model.
- A projected or desired date for submission of the application.

This will enable us to—

1. Better plan for the second phase of the solicitation;
2. Keep prospective applicants apprised of any new developments over the course of the solicitation process; and
3. Ensure that they have the latest information for preparing their applications.

ADDRESSES: Mail or deliver applications to the following address: Centers for Medicare & Medicaid Services, Attention: Cynthia Mason, Mail Stop: C4–17–27, 7500 Security Boulevard, Baltimore, Maryland 21244.

Because of staff and resource limitations, we cannot accept applications by facsimile (FAX) transmission or by e-mail.

FOR FURTHER INFORMATION CONTACT: Cynthia Mason at (410) 786–6680 or *mma646@cms.hhs.gov.* Interested parties can obtain complete solicitation and supporting information on the CMS Web site at *http://www.cms.hhs.gov/researchers/demos/mma646/.* Paper copies can be obtained by writing to Cynthia Mason at the address listed in the **ADDRESSES** section of this notice.

SUPPLEMENTARY INFORMATION:

I. Background

Section 646 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108–173) amends title XVIII (42 U.S.C. 1395 *et seq.*) of the Social Security Act (the Act) by establishing the Medicare Health Care Quality (MHCQ) Demonstration Programs. The MHCQ demonstration will test major changes to improve quality of care while increasing efficiency across an entire health care system. Broadly stated, the goals of the Medicare Health Care Quality demonstration are to—

- Improve patient safety;
- Enhance quality;
- Increase efficiency; and
- Reduce scientific uncertainty and the unwarranted variation in medical practice that results in both lower quality and higher costs.

The legislation anticipates that we can facilitate these overarching goals by providing incentives for system redesigns built on adoption and use of decision support tools by physicians and their patients, such as evidence-based medicine guidelines, best practice guidelines, and shared decision-making programs; reform of payment methodologies; measurement of outcomes; and enhanced cultural competence in the delivery of care.

II. Provisions of This Notice

The MHCQ demonstration will test the ability of health care groups to implement major system changes that reallocate resources to improve quality and reduce costs of Medicare Parts A, B, and C. Each proposal is expected to address all of the Institute of Medicine's ''Six Aims for Improvement.'' The proposed system redesign should:

- Include steps to improve patient safety in the delivery of care,
- Increase the effectiveness of the health care delivered, minimizing the over- and under-utilization of services Through the use of best practice guidelines and other measures,
- Prioritize patient-centeredness in the delivery of care with primary focus on patients' needs and comfort, Including increased emphasis on patient education and development of self-care skills,
- Improve the timeliness of care, significantly reducing delay in the delivery of needed health care services,
- Emphasize ways of improving efficiency in care delivery and thus improving quality, and
- Assure equity of care for all persons.

Further, we are persuaded that such system redesign should include the integration of health information technology consistent with the national health information infrastructure strategy and that—

- Informs clinical practice;
- Interconnects clinicians;
- Personalizes health care; and
- Improves population health.

We intend to use this demonstration to identify, develop, test, and disseminate major and multi-faceted improvements to the entire health care system. The focus will be on redesign projects that ''bundle'' multiple delivery improvements so as to introduce ''system-ness'' across the spectrum of care delivery—changes across and even between organizations. The redesign must make the system patient-focused and must undo the effects of a payment methodology that systematically fragments care while encouraging both omissions and duplication of care. At its ''grandest,'' particularly if a demonstration project is conducted by a regional coalition and entails the participation of other payers besides Medicare, this demonstration affords us and the awardees an opportunity to reinvent the health care delivery system.

In keeping with our view that this demonstration authority is intended to test models of basic health care system redesign, including payment reform, we note that the statute provides broad authority for us to waive both payment and non-payment provisions of the Medicare program. Therefore, we are

not specifying particular models of health care systems that demonstration applicants must propose and test, but are looking to applicants to specify the models they believe they can successfully put into practice for the patients they serve in their communities.

As provided by applicable Federal statute, physician groups, integrated delivery systems, and organizations representing regional coalitions of physician groups or integrated delivery systems are eligible to apply. Integrated delivery systems must include a full range of health care providers including hospitals, clinics, home health agencies, ambulatory surgery centers, skilled nursing facilities, rehabilitation facilities and clinics, and employed, independent or contracted physicians. Eligible organizations and coalitions may form a new corporate entity for the purpose of representing provider organizations or eligible organizations may designate an existing entity as their representative. However, the entity organizing the coalition and developing the demonstration proposal must be an eligible provider organization.

Payments under the MHCQ demonstration will be made for services furnished to Medicare beneficiaries and will be tied to cost savings, as well as improvements in process and outcome measures, increases in efficiencies, and reductions in costs in the targeted population compared to a similar group or sample. Eligible organizations may propose a variety of payment methodologies as long as those methodologies are amenable to an evaluation methodology based upon Medicare claims data. In addition, all proposals must assure budget neutrality and no duplication of payments for existing Medicare benefits. We will not be providing funding for start-up or other costs.

III. Collection of Information Requirements

This information collection requirement is subject to the Paperwork Reduction Act of 1995 (PRA); however, the collection is currently approved under OMB control number 0938–0880 entitled ''Medicare Demonstration Waiver Application'' with a current expiration date of July 31, 2006.

Authority: Section 646 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).

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

Dated: May 19, 2005.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 05–18144 Filed 9–9–05; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Proposed Information Collection Activity; Comment Request

Title: Annual Statistical Report on Children in Foster Homes and Children in Families Receiving Payment in Excess of the Poverty Income Level from a State Program Funded Under Part A of Title IV of the Social Security Act.

OMB No.: 0970–0004.

Description: The Department of Health and Human Services is required to collect these data under section 1124 of Title I of the Elementary and Secondary Education Act, as amended by Pub. L. 103–382. The data are used by the U.S. Department of Education for allocation of funds for programs to aid disadvantaged elementary and secondary students. Respondents include various components of State Human Service agencies.

Respondents: The 52 respondents include the 50 States, the District of Columbia and Puerto Rico.

ANNUAL BURDEN ESTIMATES

Instrument	Number of respondents	Number of responses per respondent	Average burden hours per response	Total burden hours
Annual Statistical Report on Children in Foster Homes and Children Receiving Payments in Excess of the Poverty Level from a State Program Funded Under Part A of Title IV of the Social Security Act	52	1	264.35	13,746

Estimated Total Annual Burden Hours: 13,746.

Additional Information: Copies of the proposed collection may be obtained by writing to the Administration for Children and Families, Office of Administration, Office of Information Services, 370 L'Enfant Promenade, SW., Washington, DC 20447, Attn: ACF Reports Clearance Officer. All requests should be identified by the title of the information collection. E-mail address: *grjohnson@acf.hhs.gov*.

OMB Comment: OMB is required to make a decision concerning the collection of information between 30 and 60 days after publication of this document in the **Federal Register**. Therefore, a comment is best assured of having its full effect if OMB receives it within 30 days of publication. Written comments and recommendations for the proposed information collection should be sent directly to the following: Office of Management and Budget, Paperwork Reduction Project, Attn: Desk Officer for ACF, E-mail address: *Katherine_T._Astrich@omb.eop.gov.*

Dated: September 12, 2005.

Robert Sargis,

Reports Clearance, Officer.

[FR Doc. 05–18442 Filed 9–15–05; 8:45 am]

BILLING CODE 4184–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General

Program Exclusions: August 2005

AGENCY: Office of Inspector General, HHS.

ACTION: Notice of program exclusions.

During the month of August 2005, the HHS Office of Inspector General imposed exclusions in the cases set forth below. When an exclusions is imposed, no program payment is made to anyone for any items or services (other than an emergency item or service not provided in a hospital emergency room) furnished, ordered or prescribed by an excluded party under