Health Care Financing Administration (HCFA), Department of Health and Human Services (HHS), is publishing the following summaries of proposed collections for public comment.

1. *Type of Information Collection Request:* New collection; *Title of Information Collection:* National Provider Identifier (NPI); *Form No.:* HCFA R–182; *Use:* HHS is consolidating Provider Enumeration across agencies. The NPI will be used in program operations and management to assign provider identification numbers; i.e., billing numbers for claims processing and payment. It will replace the current Medicare Physician and Eligibility System and Unique Physician Identifier Number. It will replace the enumeration functions of the Medicare Oscar, Clinical Laboratories Improvement Amendments of 1988, and National Supplier Clearing House systems and Civilian Health and Medical Program of the Uniformed Services provider numbering systems. *Frequency:* On occasion; *Affected Public:* Federal Government, State, local, or tribal government, individuals or households, business or other for profit, not-for-profit institutions; *Number of Respondents:* 45,000; *Total Annual Hours:* 23,000.

2. *Type of Information Collection Request:* Reinstatement, without change, of a previously approved collection for which approval has expired; *Title of Information Collection:* Request for Medicare Payment Ambulance; *Form No.:* HCFA 1491; *Use:* This form is completed on an ''occasion'' basis by beneficiaries and/or ambulance services. It is submitted to the Medicare carrier to request payment for ambulance services. *Frequency:* On occasion; *Affected Public:* Business or other for profit, not-for-profit institutions, individuals or households; *Number of Respondents:* 8,513,000; *Total Annual Hours:* 1,362,128.

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: Zaneta Davis, 7500 Security Boulevard, Room C2–26–17, Baltimore, Maryland 21244–1850.

Dated: August 9, 1995.

Kathleen B. Larson,

Director, Management Planning and Analysis Staff.

[FR Doc. 95–20325 Filed 8–16–95; 8:45 am]

BILLING CODE 4120–03–P

Public Information Collection Requirements Submitted for Public Comment and Recommendations

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 (HHS), is publishing the following summaries of proposed collections for public comment.

1. *Type of Information Collection Request:* Revision of a currently aproved collection; *Title of Information Collection:* Evaluation of the Medicare Cataract Surgery Allternate Payment Demonstration; *Form No.:* HCFA–R–154; *Use:* This survey will be implemented in an effort to estimate the effects of a bundled payment for cataract surgery on Medicare beneficiaries. Effects of the packaged payment on the nature of services, quality, and satisfaction will be measured. *Frequency:* Annually; *Affected Public:* Individuals or households, business or other for profit, not for profit; *Number of Respondents:* 1,686; *Total Annual Hours:* 506.

2. *Type of Information Collection Request:* Reinstatement, without change, of a previously approved collection for which approval has expired; *Title of Information Collection:* Corrective Action Plan (Medicaid Eligibility Quality Control); *Form No.:* HCFA–320; *Use:* Medicaid Eligibility Quality Control is a State administered management system designed to improve the administration of the Medicaid program. States are required to submit a corrective action plan annually. The plan must detail the initiatives the State will implement in order to reduce the type of errors found. *Frequency:* Annually; *Affected Public:* State, local, or tribal government; *Number of Respondents:* 51; *Total Annual Hours:* 20,400.

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: August 8, 1995.

Kathleen B. Larson,

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

[FR Doc. 95–20452 Filed 8–16–95; 8:45 am]

BILLING CODE 4120–03–P

Statement of Organization, Functions, and Delegations of Authority; Substructure for the Bureau of Program Operations

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. 14648–14654, dated Tuesday, March 29, 1994, and **Federal Register**, Vol. 60, No.12, pg. 3869, dated Thursday, January 19, 1995) is amended to reflect a change to the subordinate structure of the Bureau of Program Operations (BPO).

BPO is streamlining their organization by eliminating one entire organizational layer and realigning functions that supports the bureau in moving toward and into the Medicare Transaction System.

The specific amendments to part F are described below:

Section F.10.D., Health Care Financing Administration, Associate Administrator for Operations and Resource Management (FL) (Organization), paragraphs 4.a. through g. and all the associated subparagraphs are deleted and replaced with the following new organizational structure and administrative codes:

4. Bureau of Program Operations (FLG)

a. Management & Program Support Staff (FLG–1)
b. Office of Analysis and Systems (FLG1)
   (1) Analysis (FLG11)
   (2) Operational Systems (FLG12)
   (3) Systems Testing (FLG13)
   (4) Systems Design (FLG14)
c. Office of Benefits Integrity (FLG2)
   (1) Medical Review (FLG21)
   (2) Program Integrity (FLG22)
   (3) Audit/CMP (FLG23)
   (4) Overpayment & MSP Collections (FLG24)
d. Office of Program Requirements (FLG3)

(1) Institutional Claims Processing Requirements (FLG31)
(2) Practitioner Claims Processing Requirements (FLG32)
(3) Supplier Claims Processing Requirements (FLG33)
(4) Standards Setting (FLG34)
(5) Provider Enrollment (FLG35)
(6) Benefit Coordination (FLG36)

e. Office of Contract Administration (FLG4)
(1) Acquisitions & Contracts (FLG41)
(2) Financial Management (FLG42)
(3) Transition Management (FLG43)
(4) Contract Management (FLG44)
(5) Planning (FLG45)

f. Office of Customer Communications (FLG5)
(1) Appeals (FLG51)
(2) Entitlement & Premium Billing (FLG52)
(3) Issuances (FLG53)
(4) Medicare Customer Assistance (FLG54)
(5) Communications (FLG55)

g. Medicare Transaction System Initiative Task Force (FLG6)
(1) Medicare Transaction System Quality Assurance (FLG61)
(2) Medicare Transaction System Development (FLG62)
(3) Medicare Transaction System Program Planning & Needs Analysis (FLG63)

Section F.20.D, Health Care Financing Administration Associate Administrator for Operations and Resource Management (FL) (Functions), paragraphs 4.a. through g. and all the associated subparagraphs are deleted and replaced with the following new functional statements and administrative codes:

a. Management & Program Support Staff (FLG–1)

- Plans and directs a comprehensive bureau-wide human resource management program including manpower selection and placement, organizational analysis, training and employee development (including ADP and Medicare program related training), position control, manpower utilization, employee counseling, equal employment opportunity, and labor relations activities.
- Plans, directs, and coordinates bureau-wide employee appraisal programs including SES performance monitoring programs and the administration of mandatory performance award system.
- Plans and manages the bureau's financial management program, interprets administrative budgetary policies and limitations, and issues bureau-wide guidelines and instructions for budget formulation and execution.
- Executes the budget through the issuance of staff and dollar controls, budget allowances for administrative expenditures, and employee ceilings to BPO sub-components.
- Plans and monitors all BPO administrative contracts and procurement and conducts management evaluations to assure the effectiveness of the bureau's overall financial operations.
- Directs the bureau's ADP activities which includes providing technical assistance to bureau components in mainframe and microcomputer applications, developing BPO automation strategy based on long-term needs and new initiatives, identifying bureau ADP needs and requirements, and coordinating with the Bureau of Data Management and Strategy the necessary implementation activities.
- Serves as a focus for information and analysis to support both short and long-range planning for the bureau, identifying trends in the findings of external monitoring organizations (i.e, the General Accounting Office) as well as internal reviews. Recommends changes in operating procedures, policies, strategies, and organizational structure as appropriate.
- Conducts studies and analyses of the bureau's work processes and procedures, workload and production data, material and staff resources, budgetary data and expenditures trends, and physical layout. Recommends changes in operating procedures, policies, strategies, and organizational structure as appropriate.
- Develops and implements all bureau programs and administrative delegations of authority and serves as a focal point for all delegations of authority issues affecting the bureau. Serves as the focal point in leading negotiations with other HCFA components to resolve conflicts over central or regional office responsibilities.
- Serves as the bureau's primary source for management consultation and advice on management policies and issues including highly sensitive and complex actions involving inter-bureau coordination. Develops and implements bureau-wide management policies.

b. Office of Analysis and Systems (FLG1)

- Provides requirements and specifications for the design, development, and maintenance of reporting and information management systems that generate data reflecting on Medicare program operations.
- Identifies reporting and information needs for data relating to Medicare contractor operations and initiates appropriate action for establishing or modifying the reporting and information systems to satisfy these needs.
- Analyzes a broad range of information, including computer stored data, on operations performed in support of the Medicare program; prepares interpretive reports and recommendations on findings to internal bureau components for purposes of conducting program and performance evaluations.
- Provides overall support to other staff in analyzing and interpreting program and operational data to better understand the program.
- Provides requirements and specifications for the design, development, and management at the national level, activities required to enhance systems for improvement of the Medicare eligibility systems, Part A and Part B claims processing systems, and the Medicare program database.
- Provides direction and guidance to HCFA staff (central office and regional) on improving contractor systems.
- Prepares systems plans and develops policies for the design, implementation, and evaluation of shared systems and standardized modules for use by Medicare carriers, intermediaries, and hosts.
- Directs the design, development testing, and implementation of innovative system enhancements to the Common Working File (CWF) shared claims processing systems resulting in improvements to the national Medicare claims payment process.
- Provides requirements and specifications for the development, implementation, execution, and monitoring of a procedure to provide ongoing testing of national claims processing and information system to detect flaws in the operation of software, hardware, and related operations.
- Provides requirements and specifications for the development and implementation of systems that provide for the creation and maintenance of databases and test files that are required to conduct comprehensive system acceptance testing of a national claims processing and information system.

(1) Analysis (FLG11)

- Provides requirements and specifications for the design, establishment, and maintenance of reporting and information management systems that generate data reflecting on Medicare program operations.
- Reviews contractors' reporting systems for consistency and the ability to transmit the required information and

prepares the appropriate reporting requirements.

- Develops the specifications for an automated operational data system for Medicare.
- Prepares recurring reports on the status and trends in program administration and operational effectiveness.
- Provides technical assistance to regional offices and contractors on reporting requirements.
- Identifies reporting and information needs for data relating to Medicare contractor operations and initiates appropriate action for establishing or modifying the reporting and information systems to satisfy these needs.
- Analyzes a broad range of information, including computer stored data, on operations performed in support of the Medicare program; prepares interpretive reports and recommendations for the findings to other bureau components for purposes of conducting program and performance evaluations.
- Provides overall support to other staff in analyzing and interpreting program and operational data to better understand the program.
- Develops and publishes national reports on Medicare utilization patterns by procedure, beneficiary, etc.
- Analyzes patterns to determine contractor differences, changes in patterns, relationships between procedures, etc.
- Serves as the bureau focal point for support and liaison with other HCFA and non-HCFA components involved in data and information analyses.
- Utilizes the National Claims History Database to analyze and compare utilization patterns and to assess national trends in the provision of care to the Medicare population.
- Uses statistical databases and applications to analyze, evaluate, and make recommendations towards improving program operations, including operational efficiency.
- Provides statistical support to program studies and to analytical studies throughout the bureau.
- Evaluates and monitors proposals for new analytic methods to identify fraud, abuse and over utilization from claims data (Medicare Parts A and B).
- Responds to ad-hoc data requests for management information data.
- Acts as a liaison with the Bureau of Data Management and Strategy staff to enhance data available to BPO components.
- Directs workgroups to promote the continuous improvement in the use of data to conduct effective analysis in support of BPO component activities.
- Develops procedures and requirements for data analysis in the Medicare Transaction System environment.

(2) Operational Systems (FLG12)

- Prepares systems plans and develops policies for the design, implementation, and evaluation of shared systems and standardized modules for use by Medicare carriers, intermediaries, and hosts.
- Directs the design, development testing and implementation of innovative system enhancements to the Common Working File (CWF) shared claims processing systems resulting in improvements to the national Medicare claims payment process.
- Evaluates HCFA-wide systems plans for their impact on functions related to Part A and Part B of Medicare.
- Integrates systems changes within the framework of HCFA policies, goals, and objectives in an efficient and cost effective manner and coordinates system changes with other HCFA components, the Social Security Administration, HCFA regional offices, provider groups, and other affected organizations.
- Provides direction to the national CWF Maintenance Contractor and establishes priorities and schedules for all changes to CWF software and procedures and monitors progress in the release of these changes to all CWF users.
- Conducts and reviews national system impact analysis assessments relating to Medicare legislative mandates and oversees development of CWF specifications for national implementation of mandates.
- Develops and controls activities associated with the development of standard systems and standard modules and assists other HCFA components in preparing contract modifications associated with standard systems activities.
- Develops, monitors, and evaluates budgets and the budget forecasts for CWF, shared systems, and other contractor based operations including participation in long-range procurement planning support to procurement officials.
- Develops comprehensive systems security instructions in the Medicare Intermediary and Carrier Manuals.
- Provides regional offices with methods of reviews of contractor safeguards which include providing checklists for such initiatives as contingency planning and safeguarding the integrity of the Internal Revenue Service data used in the Medicare Secondary Payer data match and applying internal control sampling techniques to make sure that reviews have been performed adequately.
- Prepares quarterly listings of all significant tasks for carriers and intermediaries with special emphasis on those involving standard systems maintenance.

(3) Systems Testing (FLG13)

- Develops, implements, executes, and monitors a procedure to provide ongoing testing of national claims processing and information system to detect flaws in the operation of software, hardware, and related operations.
- Develops and implements systems that provide for the creation and maintenance of databases and test files that are required to conduct comprehensive system acceptance testing of a national claims processing and information system.
- Develops system test designs and test requirements for accomplishing system testing (hardware and software, etc.).
- Designs, develops, and maintains system software to accomplish testing requirements and processes.
- Performs system analyses and studies to develop testing strategies, procedures, and methodologies.
- Develops requirements and monitors implementation of corrective action plans for claims processing and information system that have failed to meet HCFA system testing requirements.
- Develops processes to monitor the implementation of new changed hardware and software that impact HCFA's claims processing and information system.
- Provides training and technical guidance to regional office and contractor staffs for implementing and operating national programs for assessing system testing activities.
- Consults and maintains working relations with contractors, HCFA components, and outside organizations for effective interchange of information and resolution of problems.
- Plans, develops, tests, and maintains a system to support Medicare claim and remittance electronic standardization enforcement and other front-end system testing activities.

(4) Systems Design (FLG14)

- Designs, develops, and manages, at the national level, activities required to enhance systems for improvement of the Medicare eligibility systems, Part A and Part B claims processing systems, and the Medicare program database.

• Provides direction and guidance to HCFA staff (central office and regional) on improving contractor systems.

• Designs, develops, and manages at the national level activities required to support the acquisition, establishment, and operation of the operating sites for the Medicare Transaction System (MTS).

• Coordinates and plans for the establishment of a test facility to ensure the system fully meets expectations of customers.

• Plans, develops, establishes, and maintains the processes necessary to manage all levels of change to the MTS.

• Plans, coordinates, and supports activities necessary to support the ongoing development and maintenance of system and program requirements for the MTS.

• Plans, supports, and participates in system activities to support transition to MTS.

• Serves as a technical specialist in the data telecommunications field and performs a broad variety of systems, software and hardware related tasks for major networks related to HCFA/BPO's nationwide Medicare claims processing telecommunications networks.

• Plans, designs, organizes, and leads studies to develop long-range Medicare operational systems telecommunications strategies and advises senior program managers on applying advances in telecommunications technologies to the Medicare operational systems.

c. Office of Benefits Integrity (FLG2)

• Oversees the administration of Medicare program audit and payment management, benefit integrity, Medicare Secondary Payer (MSP), other overpayment collections, and medical review.

• Plans and develops methods to improve and enhance the audit and payment management functions and makes recommendations for improvements in the management of the audit program. Analyzes regulations, executive orders, policies, and legislative proposals and assesses their financial impact on the audit budget.

• Develops, implements, and maintains programs and systems to ensure that Medicare benefits are paid within the meaning of applicable law, regulations, and program policy and to ensure that internal or external allegations of fraudulent or abusive behavior are promptly acknowledged, developed, and disposed of including referral to the Office of Inspector General.

• Directs the development and issuance of specifications, requirements, procedures, forms, and instructional material to implement and maintain operational systems for Part A and Part B medical review and utilization analysis.

• Develops the national budget for intermediary and carrier payment safeguard activities, linking programmatic expectations with funding requirements and available resources. Implements new legislation impacting on payment safeguard processes and/or Medicare covered services.

• Supports MSP litigation and post pay activities.

• Reviews regional office and contractor performance in determining the correct amount of provider, physician, and supplier overpayments and assists contractors in negotiations related to the acceptability of techniques for determining the amount of an overpayment and the methods of recovery.

• Prepares cases when compromises are not appropriate and overpayments are collectable and assists the HCFA Claims Collection Officer in preparing such cases for disposition.

• Prepares manual instructions concerning the procedures for the recovery of provider, physician, and supplier overpayments.

• Designs, implements, and maintains a Medicare overpayment tracking system.

• Conducts in-depth evaluations of selected programmatic areas to determine whether established policy and operational criteria are effectively and accurately met.

• Develops and implements requirements for payment safeguard activities in the Medicare Transaction System environment.

(1) Medical Review (FLG21)

• Directs the development and issuance of specifications, requirements, procedures, forms, and instructional material to implement and maintain operational systems for carrier and fiscal intermediary medical review and utilization analysis.

• Reviews proposed payment and coverage policy and legislative proposals to evaluate the operational impact on the Medical Review and Utilization Review (MR/UR) program. Implements new legislation affecting MR/UR and develops program safeguards for new and revised procedures.

• Oversees and evaluates contractor development and implementation of local medical review policy and procedures. Provides support to contractor medical directors and develop tools and instructions that enhance the consistency local MR policy. Coordinates and generally oversees the Carrier Advisory Committee activities.

• Assists with the development of contractor performance standards to promote improvement and assess the effectiveness of the contractor's MR/UR program.

• Provides technical support and assistance to bureau, other HCFA, and non-HCFA components. Serves as liaison with representatives of the health care industry to obtain expert input, promote understanding of the MR/UR program, and to ensure that HCFA's processes are compatible with health practices.

• Recommends legislative, regulatory, and programmatic changes to implement utilization controls in problematic areas.

• Develops the national budget for intermediary and carrier medical review activities, linking programmatic expectations with funding requirements.

• Develops and implements procedures and requirements for medical review procedures in the Medicare Transaction System environment.

• Participates in the development of analytical studies, tools, methodologies, etc., to assist in identifying patterns and trends in health care utilization that indicate over utilization or abuse.

(2) Program Integrity (FLG22)

• Develops, implements, and maintains programs and systems to ensure that Medicare benefits are paid within the meaning of applicable law, regulations, and program policy.

• Develops, implements, and maintains programs and systems to ensure that internal or external allegations of fraudulent or abusive behavior against the Medicare program are promptly acknowledged, developed and corrective action taken including referral to Office of Inspector General.

• Coordinates the development, budgeting, and institutionalization of Medicare dedicated program integrity units in Medicare carriers and fiscal intermediaries and monitors their activities. Develop regulations, legislative proposals, contract amendments, and operating procedures for these units.

• Plans, conducts, and evaluates studies and recommends actions aimed at short and long-range improvements in methods and procedures, legislative and policy proposals to prevent and detect fraud, abuse, waste, and other violations of billing requirements of the Medicare program.

• Provides bureau liaison with the Office of Inspector General, the Federal Bureau of Investigations, and the Department of Justice on program integrity issues, particularly on fraud and abuse issues and to improve the detection, development, and referral of fraud cases. Prepares and assists in preparation of reports to Congress. Develops and monitors relationships between Medicare contractors, and the State, local and private organizations, which are responsible for the detection and prevention of health care fraud including Medicaid State Agencies and fraud units. Ensures sharing of fraud information.

• Directs the development of analytical studies, tools, and other methodologies, etc., to detect potential fraudulent and abusive practices and patterns of over utilization.

• Develops procedures and requirements for program integrity activities in Medicare Transaction System environment.

• Issues national Medicare fraud alerts to notify contractors and public of fraudulent schemes. Coordinates at national level the review of proposed settlements negotiated by Office of the Inspector General, AUSA.

(3) Audit/CMP (FLG23)

• Analyzes regulations, executive orders, policies, and legislative proposals and assesses their financial impact on the audit budget. Develops the plan, necessary audit programs, guidelines, and instructions for the implementation of current and future legislation, regulations, and court orders.

• Plans and develops methods to improve and enhance the audit function and makes recommendations for improvements in management of the audit program. This includes the identification and implementation of ADP programs in the desk review, audit, and settlement activities.

• Develops rationale for the audit and payment management portion of the current and future national contractor budgets; monitors return ratios for provider audits to assure maximum return on investment expenditures.

• Reviews and analyzes Contractor Auditing and Settlement Reports to determine the effectiveness of contractor audit and payment performance and compliance with established audit guidelines, priorities, funding limitations, and workload objectives.

• Researches and responds to all Office of Inspector General and General Accounting Office reimbursement and financial audit reports and studies. Prepares position papers and reports offering alternative methods of resolution.

• Analyzes System Tracking for Audit and Reimbursement (STAR) data to assess effectiveness of audit policy and procedures and contractors compliance with such policy and procedures.

• Evaluates contractor requests for supplemental audit and payment management funding at the current operating budget level and makes recommendations based on available funding and defined program objectives.

• Develops, tests, and updates desk reviews, audit guidelines, and audit programs for use by the intermediaries to ensure that program objectives are achieved. Maintains contact with fiscal intermediaries through the regional office for resolution of audit problems.

• Reviews and evaluates existing audit and payment revisions with other components to resolve current and prevent potential problems. Analyzes and comments on proposed policy revisions, regulations, and legislation regarding provider payments.

• Plans, monitors, reports on, and develops guidelines for implementation of legislative special audit projects; e.g., the Wage Data Survey mandated by Section 4004 of OBRA and the implementation of the Capital Prospective Payment System.

• Manages the successful implementation of various negotiated agreements, court orders, special project activities, and Blue Cross/Blue Shield Association provider audit activities.

• Establishes audit protocols, priorities, and procedures for all intermediaries to follow in utilizing their audit resources.

• Assures optimum use of audit resources through the ADP processes.

• Directs the resolution of provider appeals assigned to the bureau. Analyzes and summarizes the payment issues and recommends a course of action.

• Develops guidelines and procedures for identifying appropriate civil monetary penalty cases under provisions for which HCFA has authority.

• Works with contractors and regional offices to document and develop specific cases.

• Oversees final adjudication of cases and collection of penalties.

• Negotiates settlement and compromises of selected penalty cases.

• Develops procedures and requirements for audit and reimbursement activities in Medicare Transaction System environment.

(4) Overpayment & MSP Collections (FLG24)

• Directs the nationwide administration of the institutional and physician/supplier (provider) payment recovery activity.

• Develops regulations, policies, procedures, guidelines, and recommendations for regional offices and HCFA contractors to assure timely and accurate provider overpayment identification, interest assessment, collection, and reduction of incidences of overpayment.

• Assures that the accounting practices, recovery procedures, and collection activities of regional offices and contractors properly and sufficiently implement (with respect to providers) the overpayment recovery policies, procedures, and regulations of HCFA, the Department of Health and Human Services, the General Accounting Office, the Department of Justice, and all applicable Federal statutes.

• Directs regional offices and contractors in determining the correct amount of provider, physician, and supplier overpayments and assists contractors in negotiations related to the acceptability of techniques for determining the amount of an overpayment and the methods of recovery.

• Prepares cases when compromises are not appropriate and overpayments are collectable and assists the HCFA Claims Collection Officer in preparing such cases for disposition.

• Prepares manual instructions concerning the procedures for the recovery of provider, physician, and supplier overpayment.

• Designs, implements, and maintains a Medicare overpayment tracking system.

• Develops procedures and provides training and assistance to regional offices for the review and evaluation of the institutional provider, physician, supplier, and beneficiary overpayment recovery and third party systems.

• Enforces Medicare Secondary Payer (MSP) provisions and supports MSP litigation and post pay activities. Monitors regional office and contractor operations on negotiation, waiver, and compromise of liability settlements where Medicare has a claim for recovery of prior conditional payments.

• Directs, oversees, and manages the contract for IRS/HCFA/SSA data match activities. Oversees contractor activities for demands and collection of mistaken payments identified by data match.

• Oversees regional office and contractor identification of liability

situations where Medicare has an interest in collection of monies paid on behalf of a Medicare beneficiary.

• Develops procedures and requirements for MSP and other overpayment activities in Medicare Transaction System environment.

• Coordinates and cooperates with medical review, audit, and program integrity units on use of overpayment recovery as a payment safeguard tool and to coordinate relationship between established overpayments and fraud cases.

d. Office of Program Requirements (FLG3)

• Develops, issues, and administers the specifications, requirements, methods, standards, procedures, and budget guidelines for Medicare claims processing related activities, including detailed definitions of the relative responsibilities of providers, contractors, HCFA, other third-party payers, and the beneficiaries of the Medicare program.

• Develops specifications and recommends budget necessary for more effective methods to process Medicare claims.

• Develops and maintains standards, including forms and electronic formats, used by contractors to process claims.

Represents the Medicare program before the health care industry with regard to standards for administrative health care transactions.

• Develops and implements requirements for provider enrollment in the Medicare program and assures the safeguard of program payments through effective enrollment processes and procedures.

• Ensures effective program compliance in areas related to Medicare claims processing and provider enrollment. Implements and manages requirements related to prohibited physician referrals and provider billings resulting from prohibited referrals.

• Develops and implements procedures for capturing information related to Medicare Secondary Payer situations and Medigap insurance to insure appropriate program payment and effective coordination of claims information with other insurers.

• Reviews and evaluates the processes and procedures used in the receipt, review, and payment/denial of Medicare claims.

• Recommends alternatives to existing processes and procedures, as well as, methods of improvement.

• Manages experiments that incorporate proposed alternatives to existing processes and procedures.

• Coordinates modifications to existing operational procedures, contracts, reporting mechanisms, and related materials as required.

• Identifies vulnerabilities in Medicare claims processing requirements and implements instructions and guidelines for safeguarding program expenditures (administrative and benefit).

• Conducts in-depth evaluations of selected programmatic areas to determine whether established policy and operational criteria are effectively and accurately met.

• Maintains liaison with beneficiaries, providers, contractors, and other partners for purposes of ensuring that continuous improvements are made to HCFA processes and that the interests of customers and partners are considered.

(1) Institutional Claims Processing Requirements (FLG31)

• Develops and issues specifications, requirements, procedures, and instructional material to process claims from Medicare institutional providers and defines their applications to these providers (hospitals, skilled nursing facilities, home health agencies, hospices, rural health clinics, comprehensive outpatient rehabilitation facilities, End Stage Renal Disease facilities) and Medicare contractors.

• Develops and issues instructions for, as well as monitors, implementation of institutional provider pricers.

• Develops applicable bill processing edits for contractors and the Common Working File (CWF) processing of Medicare provider claims and works with the Office of Analysis and Systems to implement these edits at contractor and CWF sites.

• Identifies vulnerabilities in Medicare claims processing requirements and implements instructions and guidelines for safeguarding program expenditures (administrative and benefit).

• Maintains the contractor/provider instructional manuals including CWF interface instructions for processing claims from Medicare institutional providers.

• Implements new legislation impacting on the provider payment process.

• Reviews proposed policy, reimbursement, and legislative proposals to evaluate the operational impact on claims processing operations, including the development of cost estimates for the implementation of such proposals.

• Maintains liaison with representatives of the health care industry to ensure that HCFA processes are compatible with provider administration practices.

• Maintains liaison with beneficiaries, providers, contractors, and other partners for purposes of ensuring that continuous improvements are made to HCFA processes and that the interests of customers and partners are considered.

(2) Practitioner Claims Processing Requirements (FLG32)

• Develops and issues specifications, requirements, procedures, and instructional material to process claims from physicians and other independent medical professionals and defines their application to these physicians and other independent medical professionals (Certified Registered Nurse Anesthetists, clinical psychologist and clinical social workers) as well as Medicare contractors and beneficiaries.

• Develops and issues instructions for, as well as monitors, implementation of practitioner provider pricers.

• Develops applicable bill processing edits for contractor and Common Working File (CWF) processing of claims from physicians and other independent medical professionals. Coordinates with the Office of Analysis and Systems to implement these changes at contractors.

• Identifies vulnerabilities in Medicare claims processing requirements and implements instructions and guidelines for safeguarding program expenditures (administrative and benefit).

• Maintains the contractor/provider instructional manuals including CWF interface instructions for processing bills from physicians and other independent medical professionals contractor payment program for physicians and other independent medical professionals.

• Reviews proposed changes in Medicare policy, regulations, and law to evaluate the operational impact on practitioner claims processing operations including the development of cost estimates for the implementation of such proposals.

• Maintains liaison with representatives of the health care industry to ensure that HCFA processes are compatible with professional medical field administrative practices.

• Maintains liaison with beneficiaries, providers, contractors, and other partners for purposes of ensuring that continuous improvements are made to HCFA processes and that the interests of customers and partners are considered.

(3) Supplier Claims Processing Requirements (FLG33)

- Develops and issues specifications, requirements, procedures, and instructional material to process claims from Medicare suppliers of services and defines their applications to these suppliers (durable medical equipment, ambulance, labs, orthotics and prosthetics, oxygen and parental and enteral nutrition), Medicare contractors, and beneficiaries.
- Develops and issues instructions for, as well as monitors, implementation of supplier provider pricers.
- Develops applicable processing edits for contractor and Common Working File (CWF) processing of claims from physicians and other independent medical professionals. Coordinates with the Office of Analysis and Systems to implement these changes at contractors.
- Identifies vulnerabilities in Medicare claims processing requirements and implements instructions and guidelines for safeguarding program expenditures (administrative and benefit).
- Maintains the contractor/provider instructional manuals including CWF interface instructions for processing bills from physicians and other independent medical professionals.
- Implements new legislation impacting on the contractor payment program for physicians and other independent medical professionals.
- Reviews proposed policy, reimbursement, and legislative proposals to evaluate the operational impact on supplier claims processing operations including the development of cost estimates for implementation of such proposals.
- Maintains liaison with representatives of the health care industry to ensure that HCFA processes are compatible with the professional medical field administrative practices.
- Maintains liaison with beneficiaries, providers, contractors, and other partners for purposes of ensuring that continuous improvements are made to HCFA processes and that the interests of customers and partners are considered.

(4) Standards Setting (FLG34)

- Develops and issues specifications, requirements, procedures, and instructional material related to electronic formats for claims, electronic funds transfer, remittance advice, eligibility, coordination of benefits, and any other claims processing items related to electronic transactions.
- Develops and maintains billing forms and formats used by contractors including the HCFA–1450 (UB–82) and the HCFA–1500.
- Develops, monitors, and approves all aspects of the notice of utilization.
- Develops programs to promote acceptance and usage of electronic claims processing, electronic funds transfer, and electronic remittance advice.
- Coordinates with stakeholders (providers, contractors, and HCFA components) to develop standardized data content for paper and electronic administrative transactions, such as claims, attachments, remittance advice, and eligibility inquiries.
- Serves as BPO focal point with the American National Standards Institute (ANSI) on electronic information formats used by the health insurance industry.
- Represents HCFA at the National Uniform Billing Committee and other established standards organizations to ascertain that HCFA's requirements are met.
- Reviews proposed changes in Medicare policy, regulations, and law to evaluate the operational impact on claims processing activities, including the development of cost estimates for the implementation of such proposals.
- Maintains liaison with beneficiaries, providers, contractors, and other partners for purposes of ensuring that continuous improvements are made to HCFA processes and that the interests of customers and partners are considered.
- Identifies vulnerabilities in Medicare claims processing requirements and implements instructions and guidelines for safeguarding program expenditures (administrative and benefit).

(5) Provider Enrollment (FLG35)

- Develops and issues specifications, requirements, procedures, and instructional material for provider enrollment and enumeration. Provides for the maintenance of the provider data base.
- Develops and issues general provider operating policy and procedures for the processing of Medicare claims that relate to any facet of provider applications and enumeration of provider applicants including standardizing the format(s), identifying data to be furnished by providers, and contractor validation/verification of application data submitted by non-institutional providers.
- Develops applicable bill processing edits for contractor and Common Working File (CWF) processing of claims from Medicare providers.
- Develops budget guidelines and cost estimates for Medicare claims processing activities.
- Develops instructions and maintains the contractor and provider instructional manuals applicable to provider enrollment, enumeration, and requirements.
- Oversees the National Supplier Clearinghouse and the Uniform Provider Identification Number (UPIN) Registry activities which include monitoring carrier ongoing maintenance of UPIN Registry, managing the printing of UPIN Directory, and overseeing UPIN data cleanup to resolve issues involving missing/discrepant UPIN data.
- Works with the Bureau of Data Management and Strategy in developing and implementing the National Provider File and enumerating providers with the National Provider Identifier.
- Reviews proposed changes in Medicare policy, regulations, and law to evaluate the operational impact on provider qualification and enumeration including the development of cost estimates for the implementation of such proposals.
- Maintains liaison with representatives of the health care industry to ensure that HCFA processes are compatible with their administrative practices.
- Maintains liaison with providers, contractors, and other partners for purposes of ensuring that continuous improvements are made to HCFA processes and that the interests of customers and partners are considered.
- Identifies vulnerabilities in Medicare claims processing requirements and implements instructions and guidelines for safeguarding program expenditures (administrative and benefit).

(6) Benefit Coordination (FLG36)

- Develops, implements, and administers Medicare Secondary Payer (MSP) operational policy for coordinating Medicare benefits with other health insurance benefits. Analyzes and evaluates specific operating policy and procedural problems in the benefit coordination program and initiates proposals to better achieve program objectives as they relate to claims processing.
- Develops applicable bill processing edits for contractors and the Common Working File (CWF) for application of MSP claim processing policy and works with the Office of Analysis and Systems to implement these edits at contractor and CWF sites.
- Develops, implements, and administers Medigap operational policy

(Section 1882 of the Social Security Act).

- Develops and implements a unique national payer identifier.
- Maintains the contractor and provider instructional manuals including CWF interface instructions for MSP claims processing policy.
- Implements new legislation impacting on the provider MSP payment process.
- Plans and directs operational liaison and outreach activities including public relations, publications, conferences, and presentations.
- Participates in the design, performance, and analysis of evaluations of contractor MSP pre-pay performance assessment.
- Analyzes State laws and regulations for Medicare supplemental health insurance to ensure compliance with Section 1882 of the Social Security Act. Prepares recommendations regarding approval or disapproval, or other appropriate actions, to the appropriate HCFA official.
- Develops national MSP budget and annual performance objectives for pre-pay activities. Analyzes contractors' MSP expenditures and goal performance.
- Reviews proposed changes in Medicare policy, regulations, and law to evaluate the operational impact on claims processing activities related to MSP and Medigap including the development of cost estimates for the implementation of such proposals.
- Maintains liaison with representatives of the health care industry to ensure that HCFA processes are compatible with provider administration practices.
- Maintains liaison with beneficiaries, providers, contractors, and other partners for purposes of ensuring that continuous improvements are made to HCFA processes and that the interests of customers and partners are considered.

e. Office of Contract Administration (FLG4)

- Administers contracts with private organizations to perform various aspects of Medicare program operations.
- Develops, negotiates, maintains, and modifies primary contracts and agreements with intermediaries, carriers, and other organizations authorized under Title XVIII of the Social Security Act.
- Provides direction and guidance to central office and regional office staff on Medicare intermediary and carrier contracts and procurement activities.
- Establishes policies and procedures to be used by Medicare intermediary and carrier contractors in the procurement of personnel, equipment, facilities management, software, and other services.
- Establishes financial management policies and procedures by which Medicare contractors prepare and submit periodic budget estimates.
- In consultation with other HCFA and bureau components, develops and negotiates the national budget for Medicare contractors.
- Controls and manages the Medicare cash flow and related banking activities. Monitors benefit payment expenditures.
- Reviews periodic contractor expenditure reports to evaluate Medicare budget execution and determines the allowability of costs. Prepares analysis of Medicare intermediary and carrier expenditure trends and patterns.
- Serves as bureau-wide support for participation in agency and department strategic planning and information resource management planning. Evaluates Medicare operational contracting arrangements, formulates recommendations for improvements, and develops appropriate implementation plans.
- Develops plans for possible transitions between new and current contractors and manages transition activities in coordination with the regional offices and HCFA components. Evaluates the impact of contractor transitions on HCFA's customers and strives for process improvements and responsiveness to customer needs.
- Plans, develops, and directs Medicare intermediary and carrier operating contracting experiments.
- Makes recommendations to agency management on proposed contract management actions for Medicare contractors determined to have serious performance deficiencies.
- Develops, implements, and monitors national performance evaluation programs to assess and improve overall effectiveness and quality of Medicare contractor operations.

(1) Acquisitions and Contracts (FLG41)

- Develops, maintains, negotiates, and modifies all agreements with intermediaries and contracts with carriers, as authorized under Title XVIII of the Social Security Act, and related contracts necessary to the Medicare program.
- Develops procedures for the award, non-renewal, termination, extension, and amendment of Medicare contracts.
- Represents the Contracting Officer in processing contractor claims resulting from changes in contract requirements and litigation activities related to contract disputes or protests involving selection or non-selection of contractors.
- Directs contract-related surveys requested by both the Executive and Legislative Branches of the Federal Government.
- Directs, coordinates, and serves as the HCFA resource in regard to technical contracting and procurement issues and maintains oversight on regional activity regarding Medicare contracting.
- Reviews contractors' requests for change orders and adjustments in price, determines where liquidated damages should be assessed against contractor, and takes appropriate action.
- Develops Medicare acquisition policy, providing technical acquisition guidance, and maintains Medicare contractor procurement procedures.
- Serves as bureau coordinator with the Office of Research and Demonstration on demonstration projects that impact Medicare contractor operations.
- Serves as the bureau focal point on the Small and Disadvantaged Business Subcontracting Program (SADBUS) requirements. Reviews and approves contractors' SADBUS plans and oversees related regional office monitoring.
- Provides liaison with contractor management.

(2) Financial Management (FLG42)

- Provides leadership in developing, implementing, and evaluating policies and procedures for the Medicare contractor budget formulation and execution process.
- Formulates and approves the national budget for Medicare contractor administrative costs.
- Develops, implements, and monitors cash management letter-of-credit procedures for contractors and servicing banks.
- Develops, implements, and monitors fund control for the Medicare contractor administrative costs.
- Sets requirements and procedures for contractors and regional offices to prepare and submit periodic budget estimates and reports.
- Participates and/or monitors negotiations and approval of all budgets and budget adjustments. Reviews periodic contractor expenditure reports to evaluate budget execution and to determine the appropriateness of costs.
- Designs, maintains, and as necessary, prepares specifications to revise the Contractor Administrative Budget and Financial Management System.
- Analyzes contractor administrative cost data and trends.

• Directs and prepares instructions to guide regional office performance to assure consistency implementation of financial policy.

• Develops procedures and monitors regional office actions related to the contractor administrative cost settlement process, interprets cost principles, and makes recommendations on final determinations of allowability of costs.

• Develops, implements, and monitors a process for reporting Medicare benefit payments.

• Develops and maintains policy, procedures, and systems for contractor reporting consistent with the Chief Financial Officer's Act.

(3) Transition Management (FLG43)

• Manages, monitors, and provides oversight of contractor transition activities including replacement of departing contractors and the resulting transfer of workload, major pre-Medicare Transaction System (MTS) electronic data processing (EDP) systems conversions, functional re-alignments, geographic workload carve-outs, and MTS operating site transitions, in coordination with the regional offices.

• Develops and implements contingency plans including replacement strategies for contractors at risk of leaving the Medicare program.

• Evaluates implementation proposals associated with contractor transitions, major pre-MTS EDP systems transitions, functional re-alignments, geographic workload carve-outs, and MTS operating site readiness testing and transitions.

• Provides technical expertise and support to HCFA central and regional office staffs regarding transition activities.

• Evaluates the impact of transitions on HCFA's customers and strives for continuous process improvements and responsiveness to customer needs.

• Incorporates current procurement and operating policy as well as lessons learned from prior transitions into the *Transition Handbook.*

• Conducts training for central and regional office staff on successful transition management and monitoring techniques and strategies.

(4) Contract Management (FLG44)

• Works in partnership with regional offices, central office components, and Medicare customers in identifying and arriving at proposed performance expectations of Medicare contractors.

• Develops, implements, and monitors national performance evaluation programs to assess and improve the overall effectiveness and quality of Medicare contractor operations.

• Develops, conducts, directs, and monitors HCFA operational component(s) participation in quality assurance reviews and studies of selected areas of contractor operations.

• Initiates, interprets, evaluates, and maintains data on each Medicare contractor in terms of compliance with performance requirements and expectations.

• Analyzes information and data on inaccurate or inconsistent Medicare contractor performance and reviews and approves corrective action planning and monitoring including, where applicable, recovery of any misspent Trust Fund dollars.

• In response to program needs, works in cooperation with other HCFA components to design, develop, and conduct special internal/external reviews, studies, projects and/or surveys which have an impact on contractor performance evaluation (includes development and implementation of the Medicare Transaction System).

• Reviews program instructions and evaluates policy and operations to improve Medicare program operations and implement policy and legislative directives.

• Provides information and makes recommendations to HCFA management concerning proposed contract management actions for Medicare contractors determined to have serious performance deficiencies.

• Designs and develops oversight requirements for Medicare contractors to assess their internal controls for assuring effective safeguard of program expenditures in compliance with the Federal Managers' Fiscal Integrity Act.

• Advises contractors on weaknesses identified in their internal controls and provides guidance on corrective action.

• Develops proposals and conducts needed analysis for benchmarking strategies for the Medicare Transaction System.

(5) Planning (FLG45)

• Provides support to HCFA staff in identifying opportunities for the achievement of Medicare program improvements and efficiencies through innovation in infrastructure support; including contracting, technology, and information resources.

• Provides bureau-wide guidance and provides planning support for those program office initiatives that relate to strategic planning and information resource planning objectives.

• Evaluates Medicare operational contracting arrangements, including provision of information and technological support, formulates recommendations for improvements and develops appropriate implementation plans.

• Evaluates contractor configurations and recommends contracting arrangements to perform or support specific functions or to serve in specified geographic areas.

• Provides planning assistance to HCFA staff in developing operational and contracting experiments to achieve program improvements and efficiencies.

f. Office of Customer Communications (FLG5)

• Serves as the primary bureau focal point for various Agency-wide communication programs dealing with direct interaction with our customers, e.g. beneficiary provider groups, regional offices, carriers, and fiscal intermediaries.

• Serves as the primary focal point for the bureau on operational as well as administrative inquiries including telephone inquiries from Presidential staffs, congressional offices, other government agencies, private institutions, and individuals seeking information concerning the various regulations and policies related to the administration of the Medicare program.

• Plans, develops, and issues operating policy, specifications, procedural requirements, and other materials to implement, maintain, and oversee the appeals process for Medicare Part A and Part B claims. Issues instructions to regional offices as well as intermediaries and carriers.

• Plans, directs, and issues operational policy and procedures for the establishment and maintenance of premium billing and collection and Medicare entitlement activities.

• Develops standard language for use by Medicare contractors in communicating with beneficiaries and providers.

• Coordinates policy and procedures concerning Privacy Act and Freedom of Information Act issues.

• Coordinates the preparation of manuals and other policy issuances required to meet the instructional and informational needs of providers, contractors, State agencies, regional offices, Peer Review Organizations, the Social Security Administration, and other audiences directly involved in the administration of HCFA programs.

• Participates in Medicare Transaction System workgroups and reviews deliverables that impact on the Office of Customer Communications program functions.

• Serves as bureau lead on special communications projects and serves as bureau focal point for agency-wide communications initiatives.

• Serves as bureau focal point on interaction with the Social Security Administration relative to Medicare program operational issues.

(1) Appeals (FLG51)

• Plans, develops, and issues operating policy, specifications, procedural requirements, and other materials to implement, maintain, or refine the appeals process for Part A and Part B claims. This includes instructions to the regional offices as well as intermediaries and carriers.

• Plans, conducts, and evaluates studies and implements changes to streamline and make more effective the appeals process.

• Develops, plans, implements, and oversees procedures and activities to reduce unnecessary appeals.

• Reviews proposed policy, reimbursement, and legislative proposals to evaluate the operational impact of such proposals on the appeals process for Part A and Part B claims.

• Evaluates and makes recommendations concerning the impact of claims processing policy and procedures on appeals. Evaluates impact of the appeals program on Medicare claims.

• Identifies management's information needs for data relating to Administrative Law Judge's (ALJ) decisions concerning both Part A and B claims and initiates appropriate actions for establishing or modifying the reporting and information systems to satisfy these needs (i.e., ALJ database, reversal reports, decision reports, etc.).

• Implements new legislation impacting on the appeals process.

• Maintains liaison with Part A and Part B contractors, HCFA components, and all other customers (including beneficiaries, institutional providers, physicians/suppliers, and advocacy groups) which use and implement the appeals process.

• Provides direction to regional offices and contractors (including Hearing Officers) on appeals procedures and in developing solutions to specific appeals issues as they arise during contractor processing of claims or appeals (or during Social Security Administration (SSA), Office of Hearing and Appeals processing of appeals).

• Participates in cross-functional efforts with claims processing and particularly with benefits integrity efforts for medical review, overpayments, and some aspects of fraud and abuse.

• Participates in the budgeting for and monitoring of the appeals process.

• Acts as HCFA's liaison with SSA's Office of Hearings and Appeals (ALJ level and Appeals Council level) to resolve issues affecting the Medicare appeals process.

• Maintains and evaluates data on the volume and qualitative aspects of the appeals process.

• Participates in the development of requirements, design, and implementation of appeals activities in the Medicare Transaction System environment.

(2) Entitlement & Premium Billing (FLG52)

• Plans, develops, and issues operational policy, specifications, requirements, procedures, and instructional material for the establishment and maintenance of three major systems: Enrollment Database (EDB) for Medicare Entitlement, Separate Operations for Billing, Entitlement, and Remittances (SOBER) for direct billed beneficiaries, and the SMI and HI Premium Accounting Collection and Enrollment System (SPACE) for third-party arrangements for States, the Office of Personnel Management (OPM), and formal groups.

• Plans, develops, issues operational policies, systems specifications, systems requirements, procedures and instructional material to administer the Medicare Lock-box premium collection operations for the direct billing operation and premium collections authorized by State Buy-In agreements, formal third-party group arrangements, and OPM.

• Develops contracts and negotiates agreements and modifications to efficiently administer the collection activities of the direct billing operations and production of the Carrier Alphabet State File and Beneficiary State File (CASF/BEST) for contractors, Peer Review Organizations, Railroad Retirement Board, and State agencies.

• Maintains liaison and works closely with the Social Security Administration (SSA) operational components, HCFA central and regional office components, State Agencies, the Railroad Retirement Board, and third-party groups on premium collection issues and beneficiary services related matters.

• Maintains liaison activities and works closely with SSA components, HCFA components, Medicare contractors, and the Railroad Retirement Board on entitlement issues.

• Resolves entitlement problems that cannot be done by the regional offices. Monitors the process and develops procedures for issuing and reissuing health insurance (HI) cards and monitors the Bureau of Data Management and Strategy (BDMS) records maintenance and correction.

• Oversees and reviews the processing of voluntary withdrawals, the identification of entitlement problems from the Medicare claim process and the Common Working File, and the process of providing direct input facilities with the date of death, name, and rejects from field offices. Develops SSA district office instructions on entitlement, HI cards, withdrawals, and premiums.

• Resolves premium billing and collection problems for States, OPM, the Railroad Retirement Board, third-party groups, and beneficiaries in direct billing status.

• Provides training and technical assistance to HCFA regional and central office personnel, State Agencies, and SSA personnel on enrollment, entitlement, HI cards, and premium billing and collection activities.

• Plans, conducts, and evaluates studies to improve systems methods and procedures pertaining to entitlement and premium collections.

• Develops, analyses, and recommends legislative and policy proposals pertaining to entitlement and premium collection issues.

• Validates BDMS initiated systems changes in entitlement.

(3) Issuances (FLG53)

• Plans, directs, develops and coordinates the preparation of manuals and other instructional materials to meet the instructional and informational needs of contractors, providers, State agencies, regional offices, Peer Review Organizations, the Social Security Administration, and other audiences directly involved in the administration of the Medicare and Medicaid programs.

• Prepares and coordinates preparation of written documents that assists the Director, Bureau of Program Operations, in resolving program and administrative policy issues.

• Manages the HCFA-wide system for developing instructions, setting instructions priorities, and coordinating work schedules related to instructions.

• Maintains an ongoing review system, including clearance of instructions, to ensure clarity and consistency. Identifies instructional needs and initiates development of instructions by HCFA components.

• Reviews instructional materials prepared by regional offices, contractors, and others that impact on HCFA instructions for conformance with national policies and procedures.

- Represents HCFA on issues involving instructions issued by the Social Security Administration and the Office of the Inspector General dealing with the Medicare and Medicaid programs.
- Initiates and develops plans for changes to the manual issuances system as it is impacted by the Medicare Transaction System.
- Prepares the quarterly **Federal Register** notice of instructional and informational materials issued by HCFA.
- Manages the manual issuances database (Text Information Management System) and the preparation of manual issuance database material for production of CD–ROM.

(4) Medicare Customer Assistance (FLG54)

- Develops and coordinates responses to all inquiries, both written and telephone, directed to the Bureau of Program Operations on the operational aspects of the Medicare Program received from a wide range of customers including beneficiaries, providers, Congressional Staffs, public interest groups, White House Staff, etc.
- Conducts analyses and studies to identify trends in customer needs and alerts appropriate bureau staff. Works in partnership with bureau staff to identify and resolve areas of customer concern with the Medicare program.
- Directs the management of the bureau's assignment control system including the receipt, review, coordination, and control of all correspondence and assignments. Prepares or coordinates the preparation of responsive replies for signature of the Secretary of the Department of Health and Human Services, the Administrator of HCFA, the Director of the Bureau of Program Operations, and other high level management officials.
- Establishes and maintains contact with HCFA's Executive Secretariat, the Office of Legislative and Inter-Governmental Affairs, the Freedom of Information and Privacy Office, the Office of the General Counsel, and other HCFA components and federal departments and agencies, to coordinate correspondence replies.
- Coordinates policy and procedures concerning Privacy Act and Freedom of Information Act issues for the bureau.
- Provides guidance and technical assistance to bureau and HCFA regional office staff on procedures and standards for content of memoranda and correspondence.
- Provides management reports to senior bureau staff on the quality and timeliness of the customer assistance and assignment coordination processes.

(5) Communications (FLG55)

- Develops, monitors, and approves formats and messages for the Explanation of Medicare Benefits.
- Initiates improvements and develops procedures for providing beneficiary and provider services for telephone, written, and personal contacts by Medicare contractors and other field facilities.
- Develops standard language for use by Medicare contractors in communicating with beneficiaries and providers.
- Plans, conducts, and evaluates studies and pilots to develop both long-range and short-range improvements in system requirements, methods, and procedures relating to beneficiary and provider communications.
- Approves funding requests and monitors contractor project plans for beneficiary and provider outreach activities.
- Works in direct partnership with HCFA customers in order to improve the communications process between HCFA and its customers.
- Validates and analyzes data relating to beneficiary and provider communications (e.g., telephone usage, pilot trends and findings) and prepares statistical reports for distribution to HCFA Senior Staff, BPO components, and the regional offices.

g. Medicare Transaction System Initiative Task Force (FLG6)

- Serves as the Agency focal point for the management and coordination of the Medicare Transaction System initiative (MTSI). Represents HCFA to the Department, other Federal Agencies, and outside organizations.
- Provides direction and technical guidance for the design, development, implementation, verification and validation, and maintenance of the Medicare Transaction System (MTS) to integrate Medicare Part A and Part B claims processing systems.
- Provides technical management, oversight, coordination, and day-to-day monitoring of contract(s) for the MTS design and the independent verification and validation of the MTS design, development, validation, implementation, and maintenance activities.
- Recommends alternatives to existing requirements, operational priorities, processes, procedures, and methods for improvement which will enhance the quality and cost-effectiveness of Medicare operational and administrative procedures and meet the needs of HCFA's internal and external customers.
- Develops, implements, and directs project planning, control, and administrative procedures, processes, and methods used to determine MTSI program status, assess performance, report progress, and implement changes.
- Develops, implements, directs, and operates activities to assure the quality of the MTSI development throughout the system development life cycle.
- Provides direction and technical guidance for the transition of Medicare claims processing from the current Part A and Part B systems to the integrated MTS, operating sites, and local contractor operations.
- Oversees the development of specifications for, and management of, any procurements that are necessary to conduct experiments incorporating approved alternatives to existing processes and procedures.
- Coordinates with HCFA components in the planning, development, and implementation of projects which impact on or are impacted by the MTSI.

(1) Medicare Transaction System Quality Assurance (FLG61)

- Develops, implements, directs, and operates activities to assure the quality of Medicare Transaction System (MTS) development throughout the system development life cycle.
- Provides technical management, oversight, coordination and day-to-day monitoring of contract(s) for the independent verification and validation of MTS analysis, design, development, validation, implementation, and maintenance activities.
- Reviews and evaluates the effectiveness of the processes and procedures used to analyze, design, develop, implement, and maintain the MTS.
- Provides the documentation and analysis necessary to initiate and support corrective action resulting from findings of the MTS quality assurance activities.
- Reviews and evaluates quality assurance programs maintained by the MTS design contractor, the independent verification and validation contractor and HCFA to ensure integration of quality assurance activities throughout the MTS development process.
- Recommends alternatives to proposed methodologies for the analysis, design, development, validation, implementation and maintenance of the MTS.

(2) Medicare Transaction System Development (FLG62)

- Develops, implements, and directs activities to assure the development of the Medicare Transaction System (MTS) throughout the system development life cycle.
- Provides technical management, oversight and coordination and day-to-day monitoring of the contract(s) for performing the Medicare Transaction System (MTS) analysis, design, development, validation, implementation, and maintenance activities.
- Provides the inter- and intra-component coordination required to insure appropriate and timely review and dissemination of the contract work products and other pertinent information.
- Reviews and evaluates the effectiveness of the processes and procedures used to coordinate and facilitate the review of the contract work products.
- Develops, conducts, and coordinates modifications to existing operational procedures, contracts, reporting mechanisms and related materials as required.
- Provides the documentation and analysis necessary to initiate and support corrective action resulting from the findings of the MTS development activities.

(3) Medicare Transaction System Program Planning & Needs Analysis (FLG63)

- Recommends alternatives to existing requirements, operational priorities, processes, procedures, and methods for improvement which will enhance the quality and cost-effectiveness of Medicare operational and administrative procedures and meet the needs of HCFA's internal and external customers.
- Develops, implements, and directs project planning, control and administration procedures, processes, and methods used to determine Medicare Transaction System initiative (MTSI) program status, assess performance, report progress, and implement changes.
- Maintains the MTSI program schedule and MTSI program management plan and various program management databases.
- Provides advisory and consultative services on project planning to HCFA central and regional office staff and key officials responsible for planning and implementing projects in support of the development and implementation of the Medicare Transaction System.
- Conducts project planning training to HCFA staff responsible for MTSI projects.

Dated: July 31, 1995.

Bruce C. Vladeck,

Administrator, Health Care Financing Administration.

[FR Doc. 95–20317 Filed 8–16–95; 8:45 am]

BILLING CODE 4120–01–P

National Institutes of Health

National Institute of Mental Health; 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 meeting of the National Institute of Mental Health Special Emphasis Panel:

Agenda /Purpose: To review and evaluate grant applications.

Committee Name: National Institute of Mental Health Special Emphasis Panel.

Date: August 24, 1995.

Time: 10:30 a.m.

Place: Parklawn Building, Room 9C–18, 5600 Fishers Lane, Rockville, MD 20857.

Contact Person: Angela L. Redlingshafer, Parklawn Building, Room 9C–18, 5600 Fishers Lane, Rockville, MD 20857, Telephone: 301, 443–1367.

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

This notice is being published less than fifteen days prior to the meeting due to the urgent need to meet timing limitations imposed by the grant review cycle.

(Catalog of Federal Domestic Assistance Program Numbers 93.242, 93.281, 93.282)

Dated: August 10, 1995.

Susan K. Feldman,

Committee Management Officer, NIH.

[FR Doc. 95–20323 Filed 8–16–95; 8:45 am]

BILLING CODE 4140–01–M

Substance Abuse and Mental Health Services Administration

Cooperative Agreement With the National Association of State Mental Health Program Directors

AGENCY: Center for Mental Health Services, SAMHSA, HHS.

ACTION: Cooperative agreement to support a technical assistance center for States in planning mental health services.

SUMMARY: This notice is to provide information to the public concerning a planned grant from the Center for Mental Health Services to the National Association of State Mental Health Program Directors to fund the Technical Assistance Center (TA Center) for State Mental Health Planning. If the application is recommended for approval by the Initial Review Group, and the CMHS National Advisory Council concurs, funds will be made available. This is not a formal request for applications. Assistance will be provided only to the National Association of State Mental Health Program Directors.

AUTHORITY/JUSTIFICATION: The cooperative agreement will be made under the authority of section 1948(a) of the Public Health Service Act, as amended (42 USC 300x–58). A single source award will be made to the National Association of State Mental Health Program Directors (NASMHPD) based on its close relationship with the single State mental health authorities (SMHAs). This relationship provides NASMHPD with a unique qualification to carry out the activities of this cooperative agreement, which require such an affiliation with the State agencies. As the organization representing all State mental health agencies, NASMHPD is the only organization whose membership is composed of the persons directly responsible for the administration of public mental health policies in the respective States. NASMHPD enjoys a full 59–State membership of the Mental Health Services Block Grant recipients, as well as a full, continuous, and fruitful communication with the leadership and staff of these agencies. It thus has staff who are uniquely knowledgeable about the needs of the States, and is in a unique position to assess the actual and verified needs of States for technical assistance.

Background

One of the primary goals of the Community Mental Health Services Block Grant is to assist States in the creation of a comprehensive, community-based system of care for adults with severe mental illness and children with serious emotional disturbances. The burden of providing for mental health services lies primarily with the States. Block grant legislation requires CMHS to collaborate with the States in meeting this obligation by helping them to determine their needs and by cooperating with them in identifying appropriate technical assistance to help them in planning