DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

[HCFA–1104–N]

RIN 0938–AI26

Medicare Program; Notice for the Solicitation for Proposals for a Case Management Demonstration Project Focused on Congestive Heart Failure or Diabetes Mellitus

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

ACTION: Notice.

SUMMARY: This notice announces HCFA's solicitation for proposals for a demonstration project that will use existing, innovative case management interventions to improve clinical outcomes and quality of life for beneficiaries with congestive heart failure or diabetes mellitus who are in the Medicare fee-for-service program under Parts A and B, and that will provide for Medicare program savings through efficient provision and utilization of services and the prevention of avoidable, costly medical complications (or consequences) that may require hospitalizations. HCFA requires that the proposed savings, at a minimum, be sufficient to cover the payments made for the case management services. This notice contains critical information for interested applicants, including the instructions for timely submission of the required letter of intent and the proposal. Interested applicants may propose projects focusing on case management of congestive heart failure, diabetes mellitus, or both.

HCFA intends to select a maximum of two proposed projects for this demonstration. The selected proposals will be those that best meet the evaluation criteria. HCFA intends to operate the demonstration project(s) for three years from implementation.

DATES: Letters of intent must be received by the HCFA project officer on or before July 13, 1998.

Proposals (original and 10 copies), each with a copy of the timely letter of intent, must be received by the HCFA project officer on or before September 9, 1998.

ADDRESSES: Mail letters of intent and proposals to: Department of Health and Human Services, Health Care Financing Administration, Attention: Catherine Jansto, Project Officer, Center for Health Plans and Providers, Mail Stop: C4–17–27, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

Letters of intent may also be submitted electronically to the following E-mail address: HCFA1104N@hcfa.gov. Electronically submitted letters of intent must be submitted to the referenced E-mail address in order to be considered. The complete letter of intent must be incorporated in the E-mail messages because we may not be able to access attachments. Proposals may not be submitted electronically.

Only proposals that are received timely, and for which a timely letter of intent is received, will be reviewed and considered by the technical review panel.

FOR FURTHER INFORMATION CONTACT: Catherine Jansto at (410) 786–7762, or CJansto@hcfa.gov.

SUPPLEMENTARY INFORMATION:

I. Background

A. Problem

Historically, a small proportion of Medicare beneficiaries have accounted for a major proportion of Medicare expenditures. For example, in 1993 roughly 10 percent of the Medicare beneficiaries accounted for 70 percent of the $129.4 billion in total Medicare expenditures. Hospital payments accounted for a major proportion of this expense.

We believe Medicare beneficiaries with congestive heart failure and diabetes mellitus are a population for whom innovations in care through effective case management interventions may improve clinical outcomes and the quality of life for the following reasons:

- Research suggests that some complications related to congestive heart failure and diabetes mellitus are avoidable; and
- Control of these diseases requires a complex treatment regimen.

Research also suggests that individuals with congestive heart failure or diabetes mellitus may suffer fewer adverse health outcomes and that additional more costly care might be avoided if these patients adhere to treatment regimens or receive adequate post-hospital care. Although neither congestive heart failure nor diabetes mellitus can be cured, careful adherence to recommended lifestyle changes and medication regimens can control symptoms, reduce complications, and improve the quality of life. These lifestyle changes and medication regimens may include restrictive diets, weight loss, exercise programs, careful self-monitoring of symptoms, and multiple medications that must be taken as prescribed, monitored with blood tests, and adjusted if indicated. However, both recommended lifestyle changes and medication regimens can be difficult for patients to understand and maintain. Indeed, among individuals with either congestive heart failure or diabetes mellitus, nonadherence to treatment regimens has been identified as a major contributor to exacerbations of symptoms and to preventable hospitalizations. The Agency for Health Care Policy and Research's 1994 clinical practice guidelines for congestive heart failure recommend, as a key element of comprehensive care, that ''after a diagnosis of heart failure * * * all patients should be counseled regarding the nature of heart failure, drug regimens, dietary restrictions, symptoms of worsening heart failure, what to do if these symptoms occur, and prognosis.'' Similarly, patients diagnosed with diabetes mellitus also should be counseled regarding appropriate measures for management of their disease. Recognizing the importance of patient education as a component of a comprehensive plan of care for diabetics, section 4105 of the Balanced Budget Act of 1997 (Pub. L. 105–33, enacted on August 5, 1997) expanded coverage for diabetes outpatient self-management training. Thus, at a minimum, individualized patient education and counseling to improve understanding of, and adherence to, complex self-care regimens should be basic features of case management models for patients with congestive heart failure or diabetes mellitus. However, models may be more complex, including frequent monitoring of patients' signs and symptoms, adherence to the prescribed treatment plan, as well as other sophisticated interventions.

While case management interventions may not result in the same level of measurable improvements in all beneficiaries with congestive heart failure or diabetes mellitus, properly identified patients have the potential to benefit significantly. Beneficiaries who are likely to experience avoidable hospitalizations are prime candidates for case management interventions that will identify medical problems early, improve treatment regimen compliance, and coordinate post-hospital care. The expectation is that a case management intervention that achieves these improvements will reduce overall costs substantially by reducing the frequency of hospital admissions and other costly aspects of treatment. The case management intervention is expected to maintain or improve the quality of care.

Based in part on the potential for chronic care case management to

improve beneficiary health status and to lower costs through reduced hospitalizations and disease complications, HCFA sponsored a series of case management demonstrations. These demonstrations, mandated by section 4207(g) of the Omnibus Budget Reconciliation Act of 1990 (OBRA '90), Pub. L. 101–508, included case management approaches aimed at a number of chronic illnesses, including congestive heart failure. Specifically, the legislation called for demonstrations to ''provide case management services to Medicare beneficiaries with selected catastrophic illnesses, particularly those with high costs of health care services.'' The resulting demonstrations were implemented in three sites, AdminaStar Solutions, Iowa Foundation for Medical Care (IFMC), and Providence Hospital. The projects began operation in October 1993 and continued through November 1995.

Although all three demonstration sites generally focused on increased education regarding proper patient monitoring and management of the specified chronic condition, the targeted conditions and case management protocols differed in each site. The AdminaStar site focused exclusively on congestive heart failure, the IFMC project focused on congestive heart failure and chronic obstructive pulmonary disease, and the Providence Hospital site case management intervention applied to a wider range of chronic conditions. None of the projects were aimed specifically at diabetes case management. Rather, these projects varied in the extent to which management of diabetes as a co-morbid condition was addressed. At the start of the project, all three sites anticipated sharply reduced hospitalizations and lower medical costs compared to the beneficiary control groups.

B. Evaluation and Findings

The legislation required a formal evaluation of the project. The evaluation (Costs and Consequences of Case Management for Medicare Beneficiaries, NTIS: PB98–103328), performed by Mathematica Policy Research, Inc., found the following:

- *The three demonstration projects successfully identified and enrolled populations of Medicare beneficiaries who were likely to incur much higher than average Medicare reimbursements during the demonstration period.* In all three sites, beneficiaries with chronic illnesses who were identified for the project used far greater resources than those in the general Medicare population.
- *Each project encountered unexpectedly low levels of enthusiasm for the demonstration from beneficiaries and their physicians.* For all three sites, recruiting volunteer beneficiaries was more difficult than anticipated, and refusal rates were sometimes as high as 90 percent. Although the project teams engaged in outreach activities, participation by and coordination with beneficiaries' physicians was difficult.
- *The projects failed to improve client self-care or health, or to reduce Medicare spending, despite engendering high levels of satisfaction among the high cost, chronically ill beneficiaries who eventually participated.* Comparisons of health status, functional status, and expenditures between the control and the intervention groups showed no improvements due to the case management intervention.

The evaluation report suggested the following primary reasons for the lack of outcome and cost impacts found in these case management demonstrations:

- *The clients' physicians were not involved in the interventions.* The evaluation study found that case managers received little or no cooperation from clients' physicians. Despite outreach by the case managers, most physicians provided little interaction with the case managers, and few opportunities for constructive rapport developed. The case managers at all three projects indicated that they would have been more effective if their activities had been coordinated with the clients' physicians' advice, and if these physicians had generally supported the case management efforts.
- *The projects did not have sufficiently focused interventions.* Even at the two demonstration sites that focused specifically on congestive heart failure, little guidance was built into the interventions regarding the types of activities to be emphasized, how often to contact and monitor clients at different levels of severity, or the content of the education provided.
- *The projects lacked staff with sufficient case management expertise and the specific clinical knowledge to generate the desired reductions in hospital use.* The case managers in these projects, virtually all of whom were nurses, received only a few days of initial training to review project procedures and clinical topics; however, some completed additional in-service training or attended seminars. This limited training may have been an inadequate substitute for more comprehensive experience or background in the specific target disease and in community-based care or case management.
- *The projects had no financial incentives to reduce Medicare spending.* In these projects, the case management intervention focused on providing education or arranging services, but had no target outcomes (for example, holding hospital readmission rates at or below a pre-determined level) upon which manager reimbursement was based. In addition, since the clients' physicians played almost no role in these interventions, there was no incentive for the providers of care to render services efficiently. If payment either for the case management services, or to the providers of care had been based in part on measurable outcome targets, the projects' personnel might have monitored patient outcomes more closely and focused efforts more consistently on activities that would increase the likelihood of improving outcomes or reducing costs.

C. Issues To Address in Future Studies

The results of this evaluation indicate that the following issues need to be addressed in any future work related to chronic illness case management:

- The importance of the involvement of the client's physicians;
- The need for focused interventions based upon the etiology of the disease, severity of the condition, co-morbid conditions, psychosocial factors, and other factors specific to the Medicare population;
- The need for staff specifically trained in case management; and
- The necessity for some incentives, particularly financial incentives, to control costs and improve outcomes. In addition, we expect that future studies will benefit from testing whether the added costs of modifying and intensifying case management interventions to address limitations identified by the prior demonstrations can be implemented in a fiscally responsible manner (both in terms of costs for the case management services and of the overall financing strategy). Specifically, we recommend that future studies clarify whether savings from reduced medical costs would be sufficient to cover the case management costs in the Medicare fee-for-service environment (where beneficiaries are not bound to primary care physicians for service approvals). The Mathematica evaluation estimated that the costs associated with providing the relatively generic case management interventions tested in the AdminaStar congestive heart failure demonstration reached about 14 percent of average client medical expenditures. Based on the most successful trial to date, if an estimate of the possible savings from

focused congestive heart failure interventions is about 23 percent of client medical expenditures, then the potential net savings could be up to 9 percent (23 percent minus 14 percent). Whether the cost of more focused case management interventions would be less than the savings provided by the interventions, and whether these interventions could lead to measurable improvement in beneficiary outcomes are unknown.

Another consideration for future studies is that HCFA's experience with case management demonstration projects has established, as a key element for success, the need for creative incentive arrangements that promote interdisciplinary collaboration to affect appropriate provision and substitution of services. In essence, development of a financing strategy that supports the goals of a Medicare fee-for-service case management demonstration is as important to the potential success of the project as is the design of the delivery model and specific interventions. However, given the nature of the Medicare fee-for-service program, HCFA recognizes that the feasibility of implementing a case management delivery model in the program may be complicated. Particularly challenging is that Medicare fee-for-service beneficiaries are able to seek services from any qualified provider (there are no lock-in provisions), the program does not offer an oral medication benefit, and that separate payment for non-face-to-face interventions is typically not allowed. Further, because Medicare fee-for-service providers receive payment for discrete units of service, physicians and other providers face direct incentives to increase volume and intensity of their services and to avoid the marginal costs of providing services that are not directly reimbursed.

In addition, there are other system-wide challenges to case management implementation in a fee-for-service environment. For example, a large proportion of Medicare beneficiaries have supplemental insurance that typically covers co-payments and deductibles, thereby leaving them little incentive to use the health care delivery system efficiently.

Despite these challenges, in the Medicare fee-for-service program, and in its payment demonstrations, there are numerous examples of alternative financing methodologies that have been developed and implemented successfully (such as the hospital prospective payment system). However, these experiences have indicated that careful attention to the efficient pricing of services, incentive and administrative arrangements, and the interaction between the provision of discrete services and the broader service delivery system is required. Therefore, a successful demonstration project to implement a case management delivery model in the Medicare fee-for-service program must efficiently provide and oversee well-integrated case management services, use a fiscally responsible financing strategy that involves appropriate, carefully crafted incentive arrangements, and address the challenges presented by the nature of the fee-for-service program.

D. Demonstration Authority

Our authority to engage in this proposed demonstration project is based upon section 402 of the Social Security Amendments of 1967, as amended (42 U.S.C. 1395b–1). Specifically, section 402(a)(1) of the Social Security Amendments of 1967, as amended (42 U.S.C. 1395b–1), authorizes the Secretary ''either directly or through grants to public or nonprofit private agencies, institutions and organizations or contracts with public or private agencies, institutions, and organizations, to develop and engage in experiments and demonstration projects'' for one of eleven specified purposes. Of these specific purposes, we believe that the most appropriate category for the demonstration announced in this notice is section 402(a)(1)(B). Specifically, the purpose given in section 402(a)(1)(B) is:

> to determine whether payments for services other than those for which payment may be made under such programs (and which are incidental to services for which payment may be made under such programs) would, in the judgement of the Secretary, result in more economical provision and more effective utilization of [Medicare covered services] where such services are furnished by organizations and institutions which have the capability of providing—
>
> (i) comprehensive health care services,
>
> (ii) mental health care services (as defined by section 2691(c) of [title 42],
>
> (iii) ambulatory health care services (including surgical services provided on an outpatient basis), or
>
> (iv) institutional services which may substitute, at lower cost, for hospital care.

Thus, for consideration, proposals must provide evidence that the applicant and the proposed project fall within the parameters of the demonstration authority of section 402(a)(1)(B).

II. Provisions of This Notice

A. Purpose

This notice announces HCFA's solicitation for proposals for demonstration projects that will use existing, innovative case management interventions to improve clinical outcomes and quality of life for beneficiaries diagnosed with congestive heart failure or diabetes mellitus who are in the Medicare fee-for-service program under Parts A and B, and that will provide savings to the Medicare program at least sufficient to cover the payment made for the case management services. These savings are to result from more efficient provision and utilization of services and the prevention of avoidable, costly medical complications. Under the demonstration, using a fiscally responsible payment methodology that, at a minimum, is budget neutral, HCFA will make payment for the proposed case management services. Thus, over the course of the project, the aggregate Medicare payment for the case management services may be no greater than the total expected program savings from the case management interventions.

Applicants must propose an all-inclusive payment amount (for example, per service, case rate, monthly fee, per diem) for their proposed unit of case management services. No separate payment will be made for capital investments, administrative, implementation, operating, data collection, research, evaluation, or any other costs incurred by the demonstration selectee(s) in the provision of the proposed case management services. The selectee(s) will be required to cooperate in a formal evaluation of the demonstration. No additional funding will be provided for this cooperation.

HCFA intends to award a maximum of two proposed projects that best meet the evaluation criteria, and plans to operate the demonstration project(s) for three years from implementation. The selected projects(s) will test congestive heart failure case management, diabetes case management, or both.

B. Requirements for Submissions

1. Innovative Proposals

In this solicitation, HCFA seeks innovative proposals that test whether case management interventions improve clinical outcomes and quality of life for Medicare fee-for-service beneficiaries with congestive heart failure or diabetes mellitus, while providing savings to the Medicare program at least sufficient to cover the expenditures for these services. HCFA is interested in case management models that are specifically targeted to the Medicare population and that take into account

the beneficiaries' relative health status, age, and other factors, rather than the application of generic clinical case management delivery system models. Of particular importance is the fact that many Medicare beneficiaries have multiple medical conditions. Case management interventions that focus exclusively on one condition may fail to address the interaction of various disease states. While a diagnosis of congestive heart failure or diabetes mellitus is a basic condition for beneficiary participation in the demonstration, HCFA is interested in and will give preference to proposals that focus on beneficiaries most likely to benefit from case management interventions that take patient co-morbidities into account in the case management interventions provided.

HCFA seeks to test existing case management delivery protocols and interventions that, at a minimum, have been pilot tested, thus, preventing the need for a long developmental time frame. Proposals must build upon lessons learned in HCFA's previous case management demonstrations and must address specifically the following issues in the context of the Medicare fee-for-service program under Parts A and B:

- Integration and involvement of the client's physicians in case management activities;
- Well-defined clinical case management delivery model protocols that focus on congestive heart failure or diabetes mellitus, and that demonstrate an individualized approach to patient education, counseling, and other services;
- Focused training and experience of the case management staff; and
- Budget neutral payment methodology and incentive arrangements that are administratively feasible, and that support measurable outcome targets, such as reduced medical spending and improved beneficiary clinical outcomes or health status.

Proposals must show clearly that the demonstration design incorporates the four issues described above. In addition, applicants must provide a scientific, clinically-based rationale for their design. We recommend that, at a minimum, the applicant include a detailed discussion of the following project elements:

- Process for a beneficiary participant's identification, selection, and discharge from the program;
- Definition and scope of services to be provided;
- Process for ensuring adequate post-hospital care and flow of patient information from setting to setting;
- Process for payment allocation across the proposed providers;
- Details of any risk or risk sharing arrangements;
- Existing quality improvement processes and study results;
- Description of the pertinent research questions related to cost and health outcomes;
- Proposed data elements that will be collected to support the measurement of these outcomes;
- Data system capabilities;
- Qualifications of staff and management;
- Scope of the project, including the number of beneficiaries, number and types of providers, location, and period of performance; and
- Implementation plan.

Proposals for models that rely on medication management regimens must address issues related to the cost of the medications, beneficiaries' ability to afford the medications, and implications for the applicant's protocols, and other pertinent information. In addition, applicants must provide clear evidence of actual net cost savings and outcomes achieved during prior pilot testing or implementation. Preference will be given to proposals that include the following:

- Evidence of cost effective clinical case management delivery model protocols, specific to the Medicare population;
- Clinically-based approach to identify patients with congestive heart failure or diabetes mellitus who are most likely to benefit from case management;
- Use of focused interventions and appropriateness screening, based upon the etiology of the disease, severity of the condition, and other relevant factors; and
- Protocols that have been tested specifically with a Medicare population diagnosed with congestive heart failure or diabetes mellitus.

2. Experimental Design and Implementation Plan

Many of the design elements of the proposed demonstration project will depend on the protocol offered by the applicant. At a minimum, for consideration, the proposed demonstration project must provide for voluntary participation for Medicare beneficiaries, a randomized experimental design, and budget neutrality (that is, no expected increase in Medicare program costs).

Proposals that include existing case management delivery protocols and interventions that have never been implemented on a Medicare population must detail the modifications to the protocols for application to the Medicare fee-for-service population. Proposals must include a detailed implementation strategy and plan, and provide evidence of how the plan supports the project's goals. In addition, proposals must include evidence of the feasibility of implementing the proposed payment model in a fee-for-service environment.

3. Replication of Models

HCFA's purpose in this solicitation is to identify clinical case management delivery system models for congestive heart failure or diabetes mellitus that, if evaluated as successful, could be replicated throughout the Medicare fee-for-service program under Parts A and B. Accordingly, the protocols tested in this demonstration cannot be proprietary in nature to the extent that the application of the intervention beyond the demonstration will require HCFA to contract only with the demonstration selectee.

4. Eligible Organizations and General Policy Considerations

HCFA is interested in proposals from a variety of qualified organizations. However, to be considered responsive, the applicant must satisfy all of the requirements described in sections I.D., II.A., and II.B. of this notice. Organizations that believe they meet these requirements may submit a letter of intent to submit a complete proposal.

5. Letter of Intent

A signed letter of intent must be received by the HCFA project officer as indicated in the **DATES** and **ADDRESSES** sections of this notice. The letter of intent must indicate the applicant's intention to submit a completed proposal for congestive heart failure case management, diabetes case management, or both. By submitting a letter of intent, the applicant is not obligated to submit a proposal. The letter must be signed by a duly authorized official and include the applicant's name, address, contact person, business telephone number, and all existing HCFA provider number(s) and an Employer Identification Number (EIN) for basic identification purposes.

For each timely submitted letter of intent, the HCFA project officer, or designee, will contact the specified representative (contact person) to discuss the application process. Organizations that submit a timely letter of intent may submit a completed proposal and 10 copies (along with a copy of the previously timely submitted letter of intent) to the HCFA project

officer as indicated in the **DATES** and **ADDRESSES** sections of this notice. Applicants submitting proposals for both congestive heart failure case management and diabetes case management should submit 2 completed proposals (one for congestive heart failure and one for diabetes) along with 10 copies of each proposal and a copy of the previously timely submitted letter of intent.

This notice is not covered by the Paperwork Reduction Act of 1995 and accordingly will not be reviewed by the Office of Management and Budget.

Authority: Sections 402(a)(1) and 402(a)(1)(B) of the Social Security Amendments of 1967, as amended (42 U.S.C. 1395b–1).

(Catalog of Federal Domestic Assistance Program No. 93.779; Health Financing, Demonstrations, and Experiments)

Dated: May 13, 1998.

Nancy-Ann Min DeParle,

Administrator, Health Care Financing Administration.

[FR Doc. 98–15509 Filed 6–10–98; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

[HCFA–1043–N]

Medicare Program; June 24 and 25, 1998, Meeting of the Competitive Pricing Advisory Committee

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

ACTION: Notice of meeting.

SUMMARY: In accordance with section 10(a) of the Federal Advisory Committee Act, this notice announces a meeting of the Competitive Pricing Advisory Committee. This meeting is open to the public.

DATES: The meeting is scheduled for June 24, 1998 from 9:00 a.m. until 5:30 p.m. and for June 25, 1998 from 9:00 a.m. until 1:00 p.m.

ADDRESSES: The meeting will be held at the Bethesda Ramada Hotel and Conference Center, 8400 Wisconsin Avenue, Bethesda, Maryland 20814.

FOR FURTHER INFORMATION CONTACT: Lu Zawistowich, Sc.D., Executive Director, Competitive Pricing Advisory Committee, Health Care Financing Administration, 7500 Security Boulevard C4–14–17, Baltimore, Maryland 21244–1850, (410) 786–6451.

SUPPLEMENTARY INFORMATION: Section 4011 of the Balanced Budget Act of 1997, (BBA) (Pub. L. 105–33) requires the Secretary of the Department of Health and Human Services (the Secretary) to establish a demonstration project under which payments to Medicare+Choice organizations in designated areas are determined in accordance with a competitive pricing methodology. Section 4012 of the BBA requires the Secretary to appoint a Competitive Pricing Advisory Committee (the CPAC). The CPAC will meet periodically to make recommendations to the Secretary concerning the designation of areas for inclusion in the project and appropriate research design for implementing the project.

The CPAC consists of 15 individuals who are independent actuaries, experts in competitive pricing and the administration of the Federal Employees Health Benefit Program, and representatives of health plans, insurers, employers, unions, and beneficiaries. In accordance with section 4012(a)(5) of the Balanced Budget Act, the CPAC shall terminate on December 31, 2004.

The CPAC held its first meeting on May 7, 1998. The CPAC members are: James Cubbin, Executive Director, General Motors Health Care Initiative; Robert Berenson, M.D., Director, Center for Health Plans and Providers, HCFA; John Bertko, CEO and Senior Actuary, PM-Squared Inc.; Dave Durenberger, Senior Health Policy Fellow, University of St. Thomas and Founder of Public Policy Partners; Gary Goldstein, M.D., CEO, The Oschner Clinic; Samuel Havens, Healthcare Consultant and Chairman of Health Scope/United; Margaret Jordan, Healthcare Consultant and CEO, The Margaret Jordan Group; Chip Kahn, CEO, The Health Insurance Association of America; Cleve Killingsworth, President, Health Alliance Plan; Nancy Kichak, Director, Office of Actuaries, Office of Personnel Management; Len Nichols, Principal Research Associate, The Urban Institute; Robert Reischauer, Senior Fellow, The Brookings Institute; John Rother, Director, Legislation and Public Policy, American Association of Retired Persons; Andrew Stern, President, Service Employees International Union, AFL–CIO; and Jay Wolfson, Director, The Florida Information Center, University of South Florida. The Chairperson is James Cubbin and the Co-Chairperson is Robert Berenson, M.D.

The agenda will include description and discussion of private/public sector experience with competitive pricing, the status of quality of care measurements, risk adjustment in the context of competitive pricing, and the desired criteria for demonstration site selection. The CPAC will also discuss additional information needed before selecting the recommended demonstration design.

Individuals or organizations that wish to make 5-minute oral presentations on the agenda issues should contact the Executive Director by 12 noon, June 11, 1998, to be scheduled. The number of oral presentations may be limited by the time available. A written copy of the oral remarks should be submitted to the Executive Director no later than 12 noon, June 18, 1998. Anyone who is not scheduled to speak may submit written comments to the Executive Director by 12:00 noon, June 18, 1998. The meeting is open to the public, but attendance is limited to the space available.

(Section 4012 of the Balanced Budget Act of 1997, Pub. L. 105–33 (42 U.S.C. 1395w–23 note) and section 10(a) Pub. L. 92–463 (5 U.S.C. App.2, section 10(a))

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

Dated: June 4, 1998.

Nancy-Ann Min DeParle,

Administrator, Health Care Financing Administration.

[FR Doc. 98–15600 Filed 6–8–98; 2:43 pm]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General

Program Exclusions: May 1998

AGENCY: Office of Inspector General, HHS.

ACTION: Notice of program exclusions.

During the month of May 1998, the HHS Office of Inspector General imposed exclusions in the cases set forth below. When an exclusion 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 the Medicare, Medicaid, and all Federal Health Care programs. In addition, no program payment is made to any business or facility, e.g., a hospital, that submits bills for payment for items or services provided by an excluded party. Program beneficiaries remain free to decide for themselves whether they will continue to use the services of an excluded party even though no program payments will be made for items and services provided by that excluded party. The exclusions have national