implement the resource-based PE RVUs beginning January 1, 1998.

This discussion of our efforts to implement the requirement in the statute to develop a resource-based relative value scale for PEs is not a formal proposal. We are notifying the physician community and others about our progress to date and are providing other helpful information about the effort.

B. Primary Care Case Management and Other Managed Care Approaches

We are considering approaches to increasing managed care options under Medicare. One approach could be to apply primary care case management methods currently used by private payers and Medicaid programs to the Medicare fee-for-service system. There are many interpretations of primary care case management. The CPT defines case management as ''a process in which a physician is responsible for direct care of a patient, and for coordinating and controlling access to or initiating and/or supervising other health care services needed by the patient.'' The State of Maryland operates a primary care case management system known as Maryland Access to Care (MAC). Under the MAC program, Medicaid recipients are linked to a primary medical provider (PMP). Each PMP acts as a ''gatekeeper'' to the health care system, furnishing primary care and preventive services and making referrals to specialty care when necessary. Permutations of the gatekeeper approach are being used in many managed care arrangements. Under the physician fee schedule, we could construct fee arrangements with primary care physicians that would promote greater use of case management. We also are considering whether to undertake demonstrations of primary care case management that involve beneficiary enrollment or election and different approaches for a primary care option. We welcome comments on a possible framework for a Medicare primary care case management option either under current regulations or through a demonstration project.

We are already exploring case management options through several Medicare demonstration and developmental efforts that are underway. One demonstration is a voluntary program of Medicare case management for targeted high-cost illnesses such as congestive heart failure and cancer. The case management services consist of regular telephone calls to provide education and monitor treatment, assistance in arranging support services, caregiver support, and occasional in-person visits. These services are furnished by teams of nurses and social workers who coordinate their efforts with the beneficiary's physician. This demonstration tests whether the case management service will reduce the cost and aggravation incurred when patients with specific conditions are unnecessarily rehospitalized or must revisit a physician.

Other projects involve a new method for paying physicians that provides incentives for effective management of care to beneficiaries. Physician groups will be paid either on a capitated basis or incentive through payment for specified bundles of services associated with the treatment of chronic conditions and acute episodes of care.

The intent of these new payment arrangements is to transfer financial risk to the physician groups, thereby finding efficient ways to provide care and increasing incentives to the physician groups to contain costs. Five payment models will be evaluated that range from a model of full capitation that transfers the financial risk to the physician group furnishing all Medicare-covered services to models that reduce the amount of risk transferred to the group and limit the requirement for an enrolled population.

These approaches represent a sample of available options. We are not prepared to make a specific proposal now. Rather, our intent at this time is to solicit information, recommendations, and suggestions from the public on how we might apply primary care case management to the Medicare fee-for-service system. We are particularly interested in the following:

- Which physicians, providers, or other health care professionals should be designated as case managers?
- Which types of patients would benefit from case management?
- What evidence is there that case management is valuable to patients other than those with chronic illness or acute episodes?
- Should Medicare pay for case management services and how should they be paid?

V. Collection of Information Requirements

Sections 415.60(f)(1) (concerning determination and payment of allowable physician compensation costs), 415.60(g) (concerning recordkeeping requirements for allocation of physician compensation costs), and 415.70(e) (concerning limits on compensation for services of physicians in providers) of this document contain information collection requirements. The information collection requirements in § 415.60(f)(1) concern the amounts of time the physician spends in furnishing physician services to the provider, physician services to patients, and services that are not paid under either Part A or Part B of Medicare; and assurance that the compensation is reasonable in terms of the time devoted to these services. The information collection requirements in § 415.60(g) concern time records used to allocate physician compensation, information on which the physician compensation allocation is based, and retention of this information for a 4-year period after the end of each cost reporting period to which the allocation applies. The information collection requirements in § 415.70(e) concern an exception to the limits on compensation for services of physicians in providers if the provider can demonstrate to the intermediary that it is unable to recruit or maintain an adequate number of physicians at a compensation level within these limits. Respondents who will provide the information include providers, intermediaries, and physicians.

Organizations and individuals desiring to submit comments on the information collection and recordkeeping requirements should direct them to the OMB official whose name appears in the **ADDRESSES** section of this preamble.

VI. Response to Comments

Because of the large number of items of correspondence we normally receive on **Federal Register** documents published for comment, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, if we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

VII. Regulatory Impact Analysis

A. Regulatory Flexibility Act

Consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612), we prepare a regulatory flexibility analysis unless the Secretary certifies that a rule would not have a significant economic impact on a substantial number of small entities. For purposes of the RFA, all physicians are considered to be small entities.

This proposed rule would not have a significant economic impact on a substantial number of small entities. Nevertheless, we are preparing a regulatory flexibility analysis because the provisions of this rule are expected