

to the Chief Counsel for Advocacy of the Small Business Administration.

VIII. Submission to Congress and the General Accounting Office

Under 5 U.S.C. 801(a)(1)(A), as added by the Small Business Regulatory Enforcement Fairness Act of 1996, the Agency has submitted a report containing this rule and other required information to the U.S. Senate, the U.S. House of Representatives, and the Comptroller General of the General Accounting Office prior to publication of this rule in today's **Federal Register**. This is not a "major rule" as defined by 5 U.S.C. 804(2).

List of Subjects in 40 CFR Parts 180

Environmental protection, Administrative practice and procedure, Agricultural commodities, Pesticides and pest, Reporting and recordkeeping requirements.

Dated: November 21, 1997.

Linda A. Travers,

Acting Director, Office of Pesticide Programs.

Therefore, 40 CFR chapter I is amended as follows:

PART 180—[AMENDED]

a. The authority citation for part 180 continues to read as follows:

Authority: 21 U.S.C. 346a and 371

b. Section § 180.518 is added to read as follows:

§ 180.518 Pyrimethanil; tolerances for residues.

- (a) *General.* [Reserved]
- (b) *Section 18 emergency exemptions.* [Reserved]
- (c) *Tolerances with regional registrations.* [Reserved]
- (d) *Indirect or inadvertent residues.* [Reserved]
- (e) *Import.* Import tolerances are established for residues of the fungicide 4,6-dimethyl-N-phenyl-2-pyrimidinamine expressed as pyrimethanil in or on the following raw agricultural commodity:

Commodity	Parts per million
Wine grapes	5.0 ppm

[FR Doc. 97-31552 Filed 12-1-97; 8:45 am]

BILLING CODE 6560-50-F

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Part 417

[HCFA-1911-IFC]

RIN 0938-AI35

Medicare+Choice Program; Collection of User Fees From Medicare+Choice Plans and Risk-Sharing Contractors

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

ACTION: Interim final rule with request for comments.

SUMMARY: This interim final rule with a request for comments establishes the methodology that will be employed to assess fees applicable to Medicare risk-sharing contractors for fiscal year (FY) 1998. Under section 4002 of the Balanced Budget Act of 1997, these contractors must contribute their pro rata share of costs relating to beneficiary enrollment, dissemination of information, and certain counseling and assistance programs. The Medicare+Choice regulation to be published in June of 1998 will implement this requirement for Medicare+Choice plans.

DATES: *Effective Date:* These regulations are effective on January 1, 1998.

Comment Date: Comments will be considered if we receive them at the appropriate address, as provided below, no later than 5 p.m. on February 2, 1998.

ADDRESSES: Mail an original and 3 copies of written comments to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: HCFA-1911-IFC, P.O. Box 7517, Baltimore, MD 21207-5187.

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

Room 309-G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, D.C. 20201, or Room C5-09-26, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

Comments may also be submitted electronically to the following e-mail address: HCFA-1911-IFC@hcfa.gov. E-mail comments must include the full name and address of the sender, and must be submitted to the referenced address in order to be considered. All comments must be incorporated in the e-mail message because we may not be able to access attachments.

Electronically submitted comments will be available for public inspection at the Independence Avenue address, below.

Because of staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code HCFA-1911-IFC. Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, in Room 309-G of the Department's offices at 200 Independence Avenue, SW., Washington, D.C., on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (phone: (202) 690-7890).

FOR FURTHER INFORMATION CONTACT: Randy Ricktor, (410) 786-4632, Marty Abeln, (410) 786-1032.

SUPPLEMENTARY INFORMATION:

I. Background

Section 4001 of the Balanced Budget Act of 1997 (BBA) (Public Law 105-33), added a new section 1857(e)(2) to the Social Security Act (the Act), that establishes a fee requirement that Medicare+Choice plans must contribute their pro rata share, as determined by the Secretary, of costs relating to enrollment and dissemination of information and certain counseling and assistance programs. Section 4002(b) of the BBA makes this requirement applicable to those managed care plans with risk sharing contracts under section 1876 of the Act. Any amounts collected are authorized to be appropriated only for the purpose of carrying out section 1851 of the Act (relating to enrollment and dissemination of information) and section 4360 of the Omnibus Budget Reconciliation Act of 1990 (Public Law 103-66, OBRA 1990), relating to the health insurance counseling and assistance program.

For any Federal fiscal year (FY), the fees authorized under section 1857(e)(2)(B) of the Act are contingent upon enactment in an appropriations act of a provision specifying the aggregate amount of fees the Secretary is directed to collect in that fiscal year. The BBA fees collected during any FY are to be credited as offsetting collections. Under section 1857(e)(2)(D), the fees authorized under section 1857(e)(2)(B) are not to be established at any amount greater than the lesser of the estimated costs to be incurred by the Secretary in the FY in carrying out the activities described in sections 1851 of the Act and 4360 of the OBRA 1990; or \$200 million in Federal fiscal year 1998; \$150 million in fiscal year 1999; and \$100 million in fiscal year 2000 and

each subsequent fiscal year (or such amounts as may be specified in appropriations bills). The appropriations bill for FY 1998, permits the Secretary to collect no more than \$95 million in FY 1998. We estimate that the costs to be incurred in carrying out the activities described in sections 1851 and 4360 will exceed the full limit of \$95 million for FY 1998. Therefore, we will collect the full \$95 million amount provided for in the FY 1998 appropriation bill.

II. Discussion of Possible Approaches to Collecting Medicare+Choice Fees

Risk Contracting Plans

The BBA authorizes the collection of fees from both Medicare+Choice plans and existing managed care plans with risk sharing contracts under section 1876 of the Act. Under section 4002 of the BBA Medicare risk contracting plans may continue to contract with HCFA through December 31, 1998. Effective, January 1, 1999, all risk contracting plans are required to contract with HCFA only as Medicare+Choice plans. We do not expect final regulations for the Medicare+Choice program to be effective before June 1998. Until the Medicare+Choice program regulations are published the only organizations subject to the BBA fees will be Medicare risk contracting plans. Regulations implementing the BBA fees for Medicare+Choice plans will be included as part of the larger Medicare+Choice regulation to be published in June of 1998. In the June regulation we will describe how we will continue to assess the BBA fees from Medicare risk contracting plans during FY 1998 and how Medicare+Choice plans will be included in the FY 1998 assessment of \$95 million. The June 1998 regulation will also describe the BBA assessment methodology for future fiscal years. It should be noted that any new Medicare risk contracts and Medicare+Choice plans (during the FY 1998 assessment period) will be subject to the FY 1998 BBA fee assessment. Since we anticipate that Medicare risk contracting plans will necessarily be responsible for a substantial portion of the FY 1998 BBA fees the following background is provided regarding the size and scope of the Medicare risk contracting program.

As of October 1, 1997, there were 279 active Medicare risk plans with each having an average enrollment of 28,000 Medicare beneficiaries. There is great range in the size of Medicare risk plans, with the smallest risk plans having less than 500 enrolled beneficiaries, up to the largest risk plan having almost 300,000 enrolled beneficiaries.

Enrollment in risk contracting plans is not evenly distributed, in fact, almost 50 percent of beneficiaries enrolled in Medicare risk contracting plans are concentrated in only 10 percent of the risk plans. A Medicare risk contracting plan is paid a capitation payment (that varies depending on the geographic location of the plan) for each enrolled beneficiary in its plan, thus the range of total Medicare payments received by risk plans also varies greatly. The typical risk contracting plan is paid about \$12 million each month. Medicare's monthly payments to all risk contracting plans exceed \$2 billion a month, with payments to some of the largest risk contracting plans averaging over \$100 million a month.

Approaches to Assessing Fees

A number of approaches were considered in selecting a methodology for assessing the BBA fees which would be consistent with the goals of the Medicare+Choice program and also equitable in terms of financial impact on current Medicare risk contracting plans as well as new Medicare+choice plans. In order to ensure that the selected fee assessment methodology meets the Medicare+Choice goals and is equitably applied to all eligible plans, we identified the specific criteria described below.

The following criteria were used in selecting the BBA fee assessment methodology:

- The fee assessment should serve to support the goal of promoting enrollment growth in Medicare+Choice plans. In particular, the fee assessment should not present a barrier to the entry of new or small plans (e.g., low enrollment plans in rural areas) into the Medicare+Choice program.
- The fees should be equitably applied to all eligible plans on a basis which is balanced by their Medicare revenue from the Federal government.
- The methodology for assessing the fees should be as simple as possible, and implemented in a manner that minimizes the financial impact on plans and the administrative costs to HCFA.

We considered four general approaches which might be used in assessing the BBA fees:

- The first and most direct approach considered was to divide the total annual BBA fee cost equally among all the eligible plans. While this approach would be simple to implement and administer it was rejected because it clearly imposes a disproportionate financial burden on small plans, as they would be paying the same amount of BBA fees as the largest plans. In addition, an equal fee assessment could

serve as a prohibitive financial barrier restricting entry of new low enrollment plans into the Medicare+Choice program.

- As a second general approach, we evaluated assessing the BBA fees based on the number of beneficiaries enrolled in a particular plan. Specifically, under this approach a fixed per capita rate would be assessed on a per member month basis. Thus, a fixed dollar amount would be deducted from the capitation payment of each beneficiary enrolled in the plan. For example, at a total enrollment level of 5 million beneficiaries, the assessment of a \$95 million BBA fee (over a nine month collection period) would result in a deduction of approximately \$2.09 from the monthly capitation payment for each beneficiary enrolled in an eligible plan. Collecting fees under this approach would mean that each plan's assessment is directly related to the number of beneficiaries enrolled in the plan. Thus, this method equitably links the BBA fee assessment with the size of the plan as determined by beneficiary enrollment. However, this method does not adjust for the geographic variation in the monthly capitation payment paid to plans, which range from approximately \$367 per member month in the lowest payment areas (typically rural) up to a maximum of \$782 per member month in the highest capitation payment areas (typically urban).

- A third approach considered was to assess the BBA fee as a fixed percentage of the total monthly payment to each plan. This approach is financially equitable since any plan's assessment is based specifically on the total capitation dollars an eligible plan receives from the Federal government. Thus, the more dollars a plan is paid the greater the BBA fee assessment. Generally, this approach would impose a slightly higher cost on eligible plans located in the higher capitation payment areas. Alternatively, this approach would not disproportionately effect those plans in the lowest payment areas which tend to be smaller plans in rural areas.

- A fourth approach considered was establishing a flat base fee assessment (a percentage of the overall fee) that each eligible plan would pay, coupled with a variable assessment that would be determined by the size of the plan. We evaluated such an approach because of concern that assessing fees based solely on size (determined either by beneficiary enrollment or dollars paid to the plan), would mean that smaller and new plans with limited enrollment might not be contributing their fair share toward the annual BBA fee assessment. However, upon evaluating

various fixed dollar amounts as a base fee assessment we recognized that any fixed amount would have to be very small in order to not present an excessive financial burden for small plans or create an entry barrier for new low enrollment plans. For example, at the \$95 million national fee level, if all plans were assessed an annual fee of \$15,000 combined with a variable cost, we estimated that for small plans (500 or fewer members) the \$15,000 annual fee amount (combined with the variable assessment) would result in these plans being assessed from 1 to 5 percent of the total capitation payments small plans receive from the Medicare program. This result is in contrast to the other assessment approaches discussed above under which all plans would be assessed less than 1 percent of the payments they receive from the Medicare Program.

Conclusion

Based on the selection criteria, we have chosen the third methodology (described above) which calls for the BBA fees to be assessed as a fixed percentage of the total monthly calculated Medicare payments eligible plans receive from Medicare. Assessing fees on this basis in FY 1998 will require the deduction of only a very small percentage of any plan's total annual Medicare payments (less than one-half of one percent). Accordingly, we believe this approach best meets the goals of supporting the Medicare+Choice program as well as being equitable to current Medicare risk contracting plans and future Medicare+Choice plans.

III. Provisions of the Interim Final Rule

In summary the provisions of this interim final rule are as follows:

- Section 1857(e)(2) of the Act provides for the collection of fees from each eligible organization with a risk-sharing contract its share of the fees for administering section 1851 of the Act relating to enrollment and dissemination of information and section 4360 of the OBRA 1990 relating to the health insurance counseling and assistance program in accordance with the specified requirements. (§ 417.472(h))
- The aggregate amount of fees for a fiscal year are the lesser of the estimated costs to be incurred by HCFA in that fiscal year to carry out the activities described in section 1851 of the Act and section 4360 of the OBRA 1990, or, if less, the amount set forth in the DHHS appropriation for the fiscal year. (§ 417.472(h)(1)).

- We establish a fee percentage rate and collect the fees over nine consecutive months beginning with January of the fiscal year or until the \$95 million assessment limit has been reached. The aggregate amount of fees we are authorized to collect in FY 1998 is \$95 million. We will begin collecting the BBA fees for fiscal year 1998 from eligible plans starting January 1, 1998. The three months from October thru December will be used by HCFA to make any necessary adjustments regarding the fees collected from plans in the previous assessment period.

The percentage BBA fee assessment for FY 1998 is .428 percent. This percentage rate is based on the total estimated Medicare payment amount to all eligible plans on January 1, 1998. The percentage amount is calculated by multiplying the projected total January payment amount by nine (months in the assessment period) and then dividing this figure into the total FY 1997 BBA fee assessment of \$95 million. We estimate that we will pay all risk contracting plans \$2,464,524,000 in January of 1998. We then multiplied \$2,464,524,000 times nine (the projected assessment period) which equals \$22,180,716,000. A \$95 million total BBA fee represents .428 percent of the \$22,180,716,000 figure. Accordingly, during the nine month assessment period we will deduct .428 percent of each eligible plan's total calculated monthly payment as its portion of the BBA fee. Adjustments for retroactive enrollments and disenrollments to our enrollment system subsequent to November are not considered or factored into the calculation for the fee determination. (§ 417.472(h)(2))

- An eligible organization with a risk contract's pro rata share of the annual fee is determined based upon the organization's monthly calculated Medicare payment amount during the preceding nine consecutive months beginning with January. We will calculate each monthly pro rata share for an eligible plan by multiplying the established BBA fee percentage by the total monthly calculated Medicare payment amount to plans as recorded in our payment system on the first day of the month. We recognize that retroactive changes to enrollment and disenrollment dates are normal business transactions and occur on a routine basis. However, we have determined that the overall dollar impact on plans of these enrollment and disenrollment changes do not represent a material amount to warrant an adjustment to the organization's pro rata share of the BBA fee assessment. (§ 417.472(h)(3))

- We will collect the fees by offset against the organization's monthly Medicare payment. Beginning with the January payment, we will withhold the organization's share of fees and deduct the amount from the total payment made to the organization for that month. (§ 417.472(h)(4))

- We will stop collecting the BBA fee from plans when the \$95 million has been assessed. We will not collect more than the \$95 million FY 1998 assessment from eligible plans.

- Should delays occur in determining the aggregate amount of fees for a fiscal year we may adjust the assessment time period and fee percentage amount if: (1) it becomes evident that the full aggregate amount of fees cannot be collected within the allotted assessment time period; or (2) for any other reason the assessment cannot be started in January. In addition, if the annual fee limit is reached in any month prior to the end of the assessment period, we will cease collecting fees. (§ 417.472(h)(5))

Medicare demonstrations with a section 1876 risk sharing contract will also be subject to the annual fee assessment.

IV. Regulatory Impact Statement

A. Background

We have examined the impact of this interim final rule as required by Executive Order 12866 and the Regulatory Flexibility Act (RFA) (Public Law 96-354). Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects; distributive impacts; and equity). The Regulatory Flexibility Act (RFA) requires agencies to analyze options for regulatory relief for small businesses, unless we certify that the regulation would not have a significant economic impact on a substantial number of small entities. Most Medicare risk contracting plans are not considered to be small entities within the meaning of the RFA.

Section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a final rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside a Metropolitan Statistical Area and has fewer than 50

beds. We are not preparing an analysis for section 1102(b) of the Act because we have determined, and we certify, that this final rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

The Balanced Budget Act of 1997 directs HCFA to collect the BBA fees from Medicare risk contracting plans, and from Medicare+Choice plans, in order to finance an annual informational campaign for Medicare beneficiaries. These collections begin in fiscal year 1998, and are limited, in the aggregate, to amounts stipulated in the BBA and determined by the Congress in appropriations legislation. This interim final rule discusses the regulatory alternatives that HCFA considered in establishing user fee charges to these organizations.

Although we view the anticipated results of this interim final regulation as beneficial to the Medicare program as well as to Medicare beneficiaries, we recognize that some of the provisions could be controversial and may be responded to unfavorably by some affected entities. We also recognize that not all of the potential effects of these provisions can be anticipated, and that it may be impossible to quantify meaningfully some of the potential effects, particularly the economic impact of the informational campaign on individual Medicare+Choice plans. It is clear that all existing Medicare risk contracting plans and future Medicare+Choice plans will be affected by these provisions to varying degrees. In selecting our regulatory options, we have attempted to identify a methodology that is consistent with the legislative intent of the BBA while being equitable to current Medicare risk contracting plans and new Medicare+Choice plans. For the aforementioned reasons, we have prepared the following voluntary analysis. This analysis, in combination with the rest of the preamble, is consistent with the standards of analysis set forth by the RFA.

B. Anticipated Effects

1. Effects on the Medicare Trust Funds

The user fees outlined in this regulation to be collected by HCFA are established as a result of enactment of the BBA. We have determined that the estimated costs to be incurred in carrying out the activities described in section 1851 of the Act and section 4360 of the OBRA 1990 will exceed the limit contained in the FY 1998 appropriations bill. Therefore, the maximum amount to be collected by HCFA will be the

amount authorized in the appropriation bill.

Under any regulatory approach to collect these user fees, we would collect the same aggregate amount of BBA fees. This is because we collect the lesser of the amount of estimated costs or the amount specified in appropriations legislation.

2. Effects on Risk-sharing Plans

Assessing BBA fees based on the payment plans receive from the Medicare program distributes the impact of these fees in direct proportion to the amount of money the plan is receiving from the Federal government. It should also be noted that Medicare risk contracting plans and Medicare+Choice plans will benefit from the Secretary's enrollment and information activities, which will be financed through the BBA fee assessment. Accordingly, we believe that assessing the BBA fees as a fixed percentage of total Medicare payments to plans is the most equitable approach.

3. Effects on Medicare Beneficiaries

Medicare beneficiaries are certain to benefit from the informational campaign financed by these user fee collections. They are not, however, directly affected by the regulatory approach to establishing BBA fee charges to risk contracting plans and are therefore not directly impacted by the provisions of this interim final rule.

C. Alternatives Considered

We considered several alternatives in assessing BBA fees on Medicare risk contracting plans and discussed them elsewhere in this preamble.

The first alternative was to simply equally divide the total annual user fee cost among all the eligible plans. With approximately 280 plans currently subject to the fees, this approach would mean for example, that in FY 1998, with a total assessment of \$95 million, each of the eligible plans would be assessed more than \$339,000. The regulatory impact of this alternative, which we rejected, results in a disproportionate financial burden on smaller plans.

As a second general approach, we evaluated assessing the BBA fees based on the number of beneficiaries enrolled in a particular plan. Specifically, under this approach a fixed per capita rate would be assessed on a per member month basis. Thus, a fixed dollar amount would be deducted from the capitation payment of each beneficiary enrolled in the plan. For example, given a constant enrollment level of 5 million beneficiaries, the assessment of a \$95 million dollar BBA fee would result in

a deduction of approximately \$2.09 from the monthly capitation payment for each beneficiary enrolled in a risk contracting plan over a nine month assessment time frame. Collecting fees under this approach means that each plan's assessment is directly related to the number of beneficiaries enrolled in the plan. Thus, this approach can be considered equitable since it directly links the BBA fee assessment with the size of the plan. However, the method does not adjust for the wide geographic variation in the monthly capitation payment paid to plans, which ranges from approximately \$367 per member month in the lowest payment areas up to a maximum of \$782 per member month in the highest capitation payment area.

A third alternative which we considered and accepted was to assess the BBA fee through a fixed percentage deduction from the plan's aggregate monthly capitation payments.

A fourth alternative reviewed in assessing user fees is a combination of a flat annual fee with a variable component. That is, there would be a base fee assessment that each eligible plan would pay, plus an additional assessment based on a variable element such as plan enrollment or total plan payment. We rejected the regulatory approach of a base assessment with additional variable assessments as we have determined that a flat fee of more than a nominal amount (e.g., \$15,000 in FY 1998) will result in a disproportionate impact on smaller plans.

As noted above we decided to impose fees based on a percentage of the total dollar amount of capitation payments a plan is receiving from the Medicare program. Collecting the BBA fees under this approach means that each plan's assessment will be directly related to the total dollars the plan is receiving from the Federal government. Thus, eligible plans which are receiving the largest payments (based on number of enrollees and monthly payment levels) from the Federal government will pay the largest share of the fees. Conversely, smaller plans will have an assessment directly related to their smaller size. We also found this approach met the criteria we had established for the selection of the BBA Fee assessment methodology. Specifically, we determined that an assessment based on percentage of plan payment is: consistent with the intent of the Medicare+Choice program in that it does not pose barriers to the participation of new plans and those with small enrollment levels; the approach is equitable for current Medicare risk contracting plans (large

and small) and finally; the approach is simple for eligible plans and for HCFA to administer.

D. Conclusion

Since the number of plans over which the BBA fee collections will be spread is likely to continue to rise with increased participation in the Medicare+Choice program in future years, we believe the regulatory impact of any reasonable selected option for imposition of fees on Medicare risk contracting plans and ultimately Medicare+Choice plans will not be significant. In accordance with our stated objective of choosing the assessment methodology which best supports the goals of the Medicare+Choice program and is equitable to current risk contracting plans we have selected the option to impose fees based on total plan payment assessed on a monthly basis. Assessing fees based on the total Medicare dollars paid to plans over a nine month time frame will represent only a small percentage of any plan's total payment from the government. In subsequent fiscal years, BBA fees as a percentage of Medicare payments will likely represent an even smaller percentage of the Medicare payments as the number of eligible plans increase and the existing plans experience enrollment growth. In addition, it should also be noted that the information campaign (financed by the BBA fees) will be designed to reach all Medicare beneficiaries and it is likely that, to the extent that this encourages growth in the Medicare+Choice program, larger more experienced plans will be well positioned to take advantage of an expanding market. The economic impact of this regulatory option measured in terms of the BBA fees as a percentage of overall plan revenues from the Federal government is very small. The consequence of a fee assessment based on a percentage of total payment is a distribution of the BBA fee burden proportional to the size of the plan. We have concluded this is the most equitable approach for all eligible plans in assessing the BBA fees.

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

V. Waiver of Notice of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite prior public comment on proposed rules. The notice of proposed rulemaking can be waived, however, if an agency finds good cause that a notice-and-comment procedure is

impracticable, unnecessary, or contrary to the public interest and it incorporates a statement of the finding and its reasons in the rule issued. We find good cause to waive the notice-and-comment procedure with respect to this rule because it is impracticable to employ such a procedure in this instance, because it is unnecessary, and because the delay in promulgating this rule would be contrary to the public interest. Even if we did not find good cause for a waiver of prior notice and comment, section 1856(b)(1) of the Act expressly authorizes the Secretary to publish final rules without prior notice and comment implementing provisions in the new Part C of Title XVIII including the fees provided for in section 1857(e)(2) of the BBA.

Issuing a proposed rule with a comment period before issuing a final rule would be impracticable because it would allow for less time for HCFA to collect the full \$95 million amount allowed by Congress in the appropriations bill for FY 1998. An abbreviated assessment period would increase the financial impact on those plans subject to the BBA fees in FY 1998.

For these reasons, we find good cause to waive publishing a proposed rule and to issue this final rule with comment period. We invite written comments on this final rule and will consider comments we receive by the date and time specified in the **DATES** section of this preamble. Although we cannot respond to comments individually, if we change this rule as a result of our consideration of timely comments, we will respond to such comments in the preamble of the amended rule.

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, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

List of Subjects in 42 CFR Part 417

Administrative practice and procedure, Grant programs-health, Health care, Health facilities, Health insurance, Health maintenance organizations (HMO), Loan programs-health, Medicare, Reporting and record keeping requirements.

42 CFR Part 417 is amended as set forth below:

PART 417—HEALTH MAINTENANCE ORGANIZATIONS, COMPETITIVE MEDICAL PLANS, AND HEALTH CARE PREPAYMENT PLANS

1. The authority citation for Part 417 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh), secs. 1301, 1306, and 1310 of the Public Health Service Act (42 U.S.C. 300e, 300e-5, and 300e-9); and 31 U.S.C. 9701.

2. In § 417.470, paragraph (a) is revised to read as follows:

§ 417.470 Basis and Scope.

(a) *Basis.* This subpart implements those portions of section 1857(e)(2) of the Act pertaining to cost sharing in enrollment-related costs and section 1876(c), (g), (h), and (i) of the Act that pertain to the contract between HCFA and an HMO or CMP for participation in the Medicare program.

* * * * *

3. Section 417.472 is amended by adding a new paragraph (h) to read as follows:

§ 417.472 Basic contract requirements.

* * * * *

(h) *Collection of fees from risk contracting plans.* HCFA is authorized to charge and directed to collect from each eligible organization with a risk-sharing contract its share of fees for administering section 1851 of the Act relating to enrollment and dissemination of information and section 4360 of the Omnibus Budget Reconciliation Act of 1990 relating to the health insurance counseling and assistance program in accordance with the requirements of paragraphs (h)(1) through (5) of this section.

(1) The aggregate amount of fees for a fiscal year are the lesser of the estimated costs to be incurred by HCFA in that fiscal year to carry out the activities described in section 1851 of the Act and section 4360 of the Omnibus Budget Reconciliation Act of 1990, or, if less, the amount set forth in the DHHS appropriation for the fiscal year.

(2) HCFA establishes a fee percentage rate and collects the fees over nine consecutive months beginning with January of the fiscal year. The percentage rate is determined by multiplying the total of the estimated January 1998 payments to all eligible plans by nine (months in the assessment period) and dividing this figure into the total fee assessment as determined in paragraph (h)(1) of this section. Adjustments for retroactive enrollments and disenrollments to HCFA's enrollment system subsequent to November are not considered or

factored into the calculation for the fee determination.

(3) An eligible organization with a risk contract's pro rata share of the annual fee is determined based upon the organization's monthly calculated Medicare payment amount during the preceding nine consecutive months beginning with January. HCFA calculates each monthly pro rata share for an organization by multiplying the established BBA fee percentage by the total monthly calculated Medicare payment amount to plans as recorded in HCFA's payment system on the first day of the month.

(4) HCFA offsets the fees against the organization's monthly Medicare payment. Beginning with the January payment, HCFA withholds the organization's share of fees and deducts the amount from the total payment made by HCFA to the organization for that month. HCFA will stop collecting the FY 1998 BBA fee from eligible plans when \$95 million has been assessed.

(5) Should delays occur in determining the amount of fees specified in paragraph (h)(1) of this section or the fee percentage rate specified in paragraph (h)(2) HCFA may adjust the assessment time period and fee percentage amount.

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

Dated: November 26, 1997.

Nancy-Ann Min DeParle,

Administrator, Health Care Financing Administration.

Approved: November 26, 1997.

Donna E. Shalala,

Secretary.

[FR Doc. 97-31710 Filed 12-1-97; 8:45 am]

BILLING CODE 4120-01-P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 73

[MM Docket No. 96-195; RM-8867]

Radio Broadcasting Services; Geneseo, IL and DeWitt, IA

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: The Commission, at the request of Connoisseur Communications of Quad Cities, L.P., substitutes Channel 285C3 for Channel 285A at Geneseo, Illinois, reallocates Channel 285C3 from Geneseo to DeWitt, Iowa, and modifies

Station WGEN-FM's license accordingly. See 61 FR 51075, September 30, 1996. Channel 285C3 can be reallocated to DeWitt in compliance with the Commission's minimum distance separation requirements with a site restriction of 14.0 kilometers (8.7 miles) southeast to avoid short-spacings to the licensed sites of Station WXRQ(FM), Channel 285A, Belvidere, Illinois, and Station WXCL(FM), Channel 285A, Pekin, Illinois, at petitioner's requested site. The coordinates for Channel 285C3 at DeWitt are North Latitude 41-42-50 and West Longitude 90-27-20. With this action, the proceeding is terminated.

EFFECTIVE DATE: January 5, 1998.

FOR FURTHER INFORMATION CONTACT: Sharon P. McDonald, Mass Media Bureau, (202) 418-2180.

SUPPLEMENTARY INFORMATION: This is a synopsis of the Commission's Report and Order, MM Docket No. 96-195, adopted November 12, 1997, and released November 21, 1997. The full text of this Commission decision is available for inspection and copying during normal business hours in the FCC Reference Center (Room 239), 1919 M Street, NW., Washington, DC.

The complete text of this decision may also be purchased from the Commission's copy contractors, International Transcription Service, Inc., (202) 857-3800, 1231 20th Street, NW., Washington, DC 20036.

List of Subjects in 47 CFR Part 73

Radio broadcasting.

Part 73 of Title 47 of the Code of Federal Regulations is amended as follows:

PART 73—[AMENDED]

1. The authority citation for Part 73 continues to read as follows:

Authority: 47 U.S.C. 154, 303, 334, 336.

§ 73.202 [Amended]

2. Section 73.202(b), the Table of FM Allotments under Illinois, is amended by removing Channel 285A at Geneseo.

3. Section 73.202(b), the Table of FM Allotments under Iowa, is amended by adding DeWitt, Channel 285C3.

Federal Communications Commission.

John A. Karousos,

Chief, Allocations Branch, Policy and Rules Division, Mass Media Bureau.

[FR Doc. 97-31512 Filed 12-1-97; 8:45 am]

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FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 73

[MM Docket No. 96-243; RM-8925]

Radio Broadcasting Services; Chugwater, WY

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: The Commission, at the request of Mountain Tower Broadcasting, allots Channel 258A at Chugwater, Wyoming, as the community's first local aural transmission service. See 61 FR 65509, December 13, 1996. Channel 258A can be allotted to Chugwater in compliance with the Commission's minimum distance separation requirements at city reference coordinates. The coordinates for Channel 258A at Chugwater are North Latitude 41-45-36 and West Longitude 104-49-30. With this action, this proceeding is terminated.

EFFECTIVE DATE: January 5, 1998. A filing window for Channel 258A at Chugwater, Wyoming, will not be opened at this time. Instead, the issue of opening a filing window for this channel will be addressed by the Commission in a subsequent order.

FOR FURTHER INFORMATION CONTACT: Sharon P. McDonald, Mass Media Bureau, (202) 418-2180.

SUPPLEMENTARY INFORMATION: This is a synopsis of the Commission's Report and Order, MM Docket No. 96-243, adopted November 5, 1997, and released November 21, 1997. The full text of this Commission decision is available for inspection and copying during normal business hours in the FCC Reference Center (Room 239), 1919 M Street, NW., Washington, DC. The complete text of this decision may also be purchased from the Commission's copy contractors, International Transcription Service, Inc., (202) 857-3800, 1231 20th Street, NW., Washington, DC 20036.

List of Subjects in 47 CFR Part 73

Radio broadcasting.

Part 73 of Title 47 of the Code of Federal Regulations is amended as follows:

PART 73—[AMENDED]

1. The authority citation for Part 73 continues to read as follows:

Authority: 47 U.S.C. 154, 303, 334, 336.