test procedures to update the methods, provide minor corrections and clarifications, and address specific stakeholder concerns. The proposed changes are intended to improve the performance of WET tests, and thus increase confidence in the reliability of the results obtained using the test procedures. By proposing to revise and ratify WET test methods, EPA satisfied obligations in a settlement agreement designed to resolve litigation over the original rulemaking that standardized WET test procedures.

In the September 28, 2001 notice of proposed rulemaking, EPA requested public comment on its proposal to revise and ratify WET test methods. The 60-day public comment period established for this rule was scheduled to end on November 27, 2001. EPA received a request to extend the public comment period beyond the November 27, 2001 due date. In order to ensure that the public has an adequate opportunity to review and comment on the proposed rule, EPA is extending the comment period for an additional 45 days to January 11, 2002.

Dated: November 15, 2001.

G. Tracy Mehan, III,

Assistant Administrator for Water.

[FR Doc. 01–29270 Filed 11–21–01; 8:45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 447

[CMS–2134–P]

RIN 0938–AL05

Medicaid Program; Modification of the Medicaid Upper Payment Limit for Non-State Government-Owned or Operated Hospitals

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

ACTION: Proposed rule.

SUMMARY: This proposed rule would modify the Medicaid upper payment limit provisions to remove the 150 percent UPL for inpatient hospital services and outpatient hospital services furnished by non-State government-owned or operated hospitals. This proposed rule is part of this Administration's efforts to restore fiscal integrity to the Medicaid program and reduce the opportunity for abusive funding practices based on payments unrelated to actual covered Medicaid services.

DATES: We will consider comments if we receive them at the appropriate address, as provided below, no later than 5 p.m. on December 24, 2001.

ADDRESSES: In commenting, please refer to file code CMS–2134–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

Mail written comments (one original and three copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–2134–P, P.O. Box 8016, Baltimore, MD 21244–8016.

Please allow sufficient time for mailed comments to be timely received in the event of delivery delays.

If you prefer, you may deliver (by hand or courier) your written comments (one original and three copies) to one of the following addresses: Room 443–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or Room C5–14–03, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and could be considered late. For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Marge Lee, (410) 786–4361.

SUPPLEMENTARY INFORMATION: *Inspection of Public Comments:* Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, call Ms. Freddie Wilder at (410) 786–7195 or (410) 786–0082.

I. Background

Section 1902(a)(30)(A) of the Social Security Act (the Act) requires that Medicaid State plans have methods and procedures relating to the payment for care and services to assure that payments are consistent with efficiency, economy, and quality of care. This provision is implemented in regulations at 42 CFR part 447 that set upper payment limits (UPLs) for different types of items and services. For certain institutional providers, including hospitals, these upper payment limits apply in the aggregate to all payments to a particular class of providers, and are based on the estimated payment under Medicare payment principles.

In a final rule published on January 12, 2001 in the **Federal Register** (66 FR 3148), we revised the Medicaid upper payment limit (UPL) for inpatient and outpatient hospitals to require separate UPLs for State-owned or operated facilities, non-State government-owned or operated facilities, and privately owned and operated facilities. In that final rule, we also created an exception for payments to non-State government-owned or operated hospitals. That exception provided that the aggregate Medicaid payments to those hospitals may not exceed 150 percent of a reasonable estimate of the amount that would be paid for the services furnished by these hospitals under Medicare payment principles. At that time, we believed that there was a need for a higher UPL to apply to payments to these public hospitals because their important role in serving the Medicaid population.

Based on further analysis, we do not believe that a significant amount of the additional payments permitted under this exception is being used to further the mission of these hospitals or their role in serving Medicaid patients. The Office of the Inspector General has issued several reports demonstrating that a portion of the additional payments are being transferred directly back to the State via intergovernmental transfers and used for other purposes (which may include funding the State share of other Medicaid expenditures). Since the public hospitals are not retaining the funds available as a result of this higher UPL, those funds are neither furthering their special mission nor ensuring continued access to these facilities for the Medicaid population. Instead, the only result of the higher UPL is that the Federal government is effectively paying more than its share of net State Medicaid expenditures.

II. Provisions of the Proposed Rule

As part of this Administration's efforts to restore fiscal integrity to the Medicaid program and reduce the opportunity for abusive funding practices based on payments unrelated to actual covered Medicaid services, we propose to remove the 150 percent UPL for non-State government-owned or operated hospitals.

Under §§ 447.272(b) and 447.321(b), aggregate payments to non-State government-owned or operated facilities would be limited to a reasonable estimate of the amount that would be

paid for the services furnished by this group of facilities under Medicare payment principles. Payments under an approved State plan would be reduced to comply with this limit as of the effective date of the subsequent final rule. In addition, we would not approve any methodologies that allow payments in excess of this limit as of the effective date of the final rule. Moreover, States should note that we have issued a letter to State Medicaid Directors announcing a policy for addressing amendments submitted after the publication date of this proposed rule, which would provide for payments that exceed those permitted under this proposed rule. States cannot reasonably expect to rely on financing from such plan amendments that exceed the proposed limit as we intend to proceed with a final rule in the near future.

In § 447.272(c), we would remove the exception in paragraph (c)(1) regarding payments to non-State government-owned or operated hospitals. We would redesignate the exceptions in paragraph (c)(2) to (c)(1) and (c)(3) to (c)(2) for payments to Indian Health Services and tribal facilities and disproportionate share hospitals (subject to a separate limit on payments to disproportionate share hospitals). In § 447.321, we would revise paragraphs (b) through (d).

State payment methodologies that qualify for a transition period described in §§ 447.272(e) and 447.321(e) would continue to qualify for the same transition period. However, aggregate payments to non-State government-owned or operated hospitals during the transition period would need to be reduced to 100 percent of a reasonable estimate of the amount that would be paid for the services furnished by this group of facilities under Medicare payment principles rather than 150 percent as described in the final rule published on January 12, 2001. In §§ 447.272 and 447.321, we would redesignate paragraph (e)(2)(ii)(C)(8) regarding when a reduction begins as paragraph (e)(2)(iii). We would also redesignate paragraph (e)(2)(iii) as (e)(2)(iv).

State payment methodologies that do not qualify for a transition period must be in compliance with the 100 percent UPL for non-State government-owned or operated hospitals as of the effective date of a subsequent final rule.

We would also remove § 447.272(f)(1)(i) and (f)(1)(ii) and § 447.321(f)(1)(i) and (f)(1)(ii), which describes the reporting requirements for non-State government-owned or operated hospitals, and retain paragraph (f)(1) that describes only the reporting requirements for payments made by States in excess of the amount described in paragraph (b) of this section during the transition periods. The reporting requirements for these States would not change.

III. 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 major comments in the preamble to that document.

IV. Collection of Information Requirements Paperwork Reduction Act

Under the Paperwork Reduction Act of 1995 (PRA), we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the PRA requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are seeking comments on these issues for the provisions discussed below:

Section 447.272 Inpatient Services: Application of Upper Payment Limits

Under paragraph (f), *Reporting requirements for payments during the transition periods,* States that are eligible for a transition period described in section 447.272(e), and that make payments that exceed the limit under section 447.272(b) must report annually the following information to CMS:

(1) The total Medicaid payments made to each facility for services furnished during the entire State fiscal year.

(2) A reasonable estimate of the amount that would be paid for the services furnished by the facility under Medicare payment principles.

We estimate that there would be 57 reports filed the first year and that they would take 8 hours, for a total of 456 hours. The number of reports and corresponding burden would decrease each year.

Section 447.321 Outpatient Hospital and Clinic Services: Application of Upper Payment Limits

Under paragraph (f), *Reporting requirements for payments during the transition periods,* States that are eligible for a transition period described in section 447.321(e), and that make payments that exceed the limit under section 447.321(b), would have to report annually the following information to CMS:

(1) The total Medicaid payments made to each facility for services furnished during the entire State fiscal year.

(2) A reasonable estimate of the amount that would be paid for the services furnished by the facility under Medicare payment principles.

We estimate that there would be 31 reports filed the first year under this section and that it would take 8 hours to complete one, for a total of 248 hours. The number of reports and corresponding burden would decrease over the next 8 years.

The particular information collection requirements contained in these two sections were published in the January 12, 2001 final rule. We are proposing to revise these requirements by eliminating the reporting requirement that States report hospital expenditures up to the 150 percent UPL, consistent with its elimination in this proposed rule.

We have recently submitted an emergency request for approval of the information collection requirements associated with the January 12, 2001 final rule to OMB for review of the requirements in §§ 447.272 and 447.321. These sections have been approved by OMB under OMB number 0938–0855 through May 2002 and are now in effect. In conjunction with the development of this proposed rule, we plan to revise these reporting requirements consistent with the content of the final rule, taking all comments into account.

If you comment on these information collection and recordkeeping requirements, please mail copies directly to the following: Centers for Medicare and Medicaid, Office of Information Services, DHES, SSG, Attn: Julie Brown, CMS–2134–P, Room N2–14–26, 7500 Security Boulevard, Baltimore, MD 21244–1850; and Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office

Building, Washington, DC 20503, Attn: Brenda Aguilar.

V. Regulatory Impact Analysis

A. Introduction

We have examined the impact of this proposed rule as required by Executive Order (EO) 12866, the Unfunded Mandates Act of 1995, and the Regulatory Flexibility Act (RFA) (Pub. L. 96–354). EO 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any one year). We consider this a major rule and provide an analysis below.

B. Overall Impact

The estimates provided below are based on State-reported Federal fiscal year information submitted with State plan amendments and State expenditure information, where available.

We have identified approximately 28 States with State plan amendments that may provide for payments to non-State government-owned or operated hospitals for inpatient or outpatient services in excess of the 100 percent UPL. These plans currently account for approximately $3.1 billion in Federal spending annually. This estimate is based on State-reported Federal fiscal information submitted with State plan amendments and State expenditure information, where available. In addition, we expect that, absent rulemaking, additional States would submit amendments to increase spending above the 100 percent UPL in the future. Estimates of these increased costs, both current and future, are included in the President's FY 2002 Medicaid budget baseline. Based on these budget estimates, we estimate that removing the higher UPL for non-State government-owned or operated hospitals would reduce potential Federal costs by about $9 billion over fiscal years 2002 through 2006.

C. Impact on Small Entities and Rural Hospitals

The Regulatory Flexibility Act requires agencies to analyze options for regulatory relief of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations and government agencies. Most hospitals and other providers and suppliers are small entities, either by nonprofit status or by having revenues of $5 million to $25 million (see 65 FR 69432) or less annually. For purposes of the RFA, all hospitals are considered to be small entities. Individuals and States are not included in the definition of a small entity.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant number of small rural hospitals. This analysis must conform to the provisions of section 603 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 of a Metropolitan Statistical Area and has fewer than 100 beds.

We believe the removal of the higher UPL proposed in this rule may have a significant impact on small entities, including rural hospitals. Although the rules published on January 12, 2001 would allow States to make higher payments to non-State government-owned or operated hospitals, States had made higher payments to these providers under the prior rules. Arguably, these hospitals may have developed a reasonable reliance on the higher payments. Nevertheless, we believe the impact of this rule will be largely mitigated due to several factors. First, payment methodologies in excess of the January 2001 final rule may qualify for one of the transition periods described in §§ 447.272(e) and 447.321(e). State payment methodologies that qualify for one of the transition periods would continue to qualify under this rule; the only difference is that payments to non-State government-owned or operated hospitals must be reduced over the transition period to a 100 percent UPL rather than a 150 percent UPL. In addition, the OIG has issued several reports demonstrating that hospitals transfer the bulk of the higher payments to the States. Since the hospitals are not retaining the funds available as a result of this higher UPL, those funds are neither furthering their special mission nor ensuring continued access to these facilities for the Medicaid population.

We invite public comments on the possible effects that this proposed rule would have on small entities in general and on small rural hospitals in particular.

D. The Unfunded Mandates Act

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies perform an assessment of anticipated costs and benefits before proposing any rule that may result in a mandated expenditure in any one year by State, local, or Tribal governments, in the aggregate, or by private sector, of $100 million. Because this proposed rule does not mandate any new spending requirements or costs, but rather limits aggregate payments to a group of hospitals, we do not believe it has any unfunded mandate implications.

E. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct compliance costs on State and local governments, preempts State law, or otherwise has Federalism implications. We do not believe this proposed rule in any way imposes substantial direct compliance costs on State and local governments or preempts or supersedes State or local law.

F. Executive Order 12866

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

List of Subjects in 42 CFR Part 447

Accounting, Administrative practice and procedure, Drugs, Grant programs-health, health facilities, Health professions, Medicaid, Reporting and recordkeeping requirements, Rural areas.

For reasons set forth in the preamble, the Centers for Medicare and Medicaid Services proposes to amend 42 CFR part 447 as follows:

PART 447—PAYMENTS FOR SERVICES

1. The authority citation for part 447 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

2. Amend § 447.272 as follows:

a. Revise paragraph (b).

b. Remove paragraph (c)(1).

c. Redesignate paragraph (c)(2) as (c)(1).

d. Redesignate paragraph (c)(3) as (c)(2).

e. Revise paragraph (d).

f. Revise paragraph (e)(1)(ii).

g. Redesignate paragraph (e)(2)(iii) as (e)(2)(iv).

h. Redesignate paragraph (e)(2)(ii)(C)(*8*) as paragraph (e)(2)(iii).

i. Revise paragraph (f).

§ 447.272 Inpatient services: Application of upper payment limits.

* * * * *

(b) *General rules.* (1) Upper payment limit refers to a reasonable estimate of

the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles in subchapter B of this chapter.

(2) Except as provided in paragraph (c) of this section, aggregate Medicaid payments to a group of facilities within one of the categories described in paragraph (a) of this section may not exceed the upper payment limit described in paragraph (b)(1) of this section.

* * * * *

(d) *Compliance dates.* Except as permitted under paragraph (e) of this section, a State must comply with the upper payment limit described in paragraph (b)(1) of this section by one of the following dates:

(1) *For non-State government-owned or operated hospitals*—[the effective date of the final rule].

(1) *For all other facilities*—March 13, 2001.

(e) *Transition periods*—* * *

(1) * * *

(ii) *UPL* stands for the upper payment limit described in paragraph (b)(1) of this section for the referenced year.

* * * * *

(f) *Reporting requirements for payments during the transition periods.* States that are eligible for a transition period described in paragraph (e) of this section, and that make payments that exceed the upper payment limit under paragraph (b)(1) of this section, must report annually the following information to CMS:

(1) The total Medicaid payments made to each facility for services furnished during the entire State fiscal year.

(2) A reasonable estimate of the amount that would be paid for the services furnished by the facility under Medicare payment principles.

3.Amend § 447.321 as follows:

a. Revise paragraphs (b) through (d).

b. Revise paragraph (e)(1)(ii).

c. Redesignate paragraph (e)(2)(iii) as (e)(2)(iv).

d. Redesignate paragraph (e)(2)(ii)(C)(*8*) as paragraph (e)(2)(iii).

e. Revise paragraph (f).

§ 447.321 Outpatient hospital and clinic services: Application of upper payment limits.

* * * * *

(b) *General rules.* (1) Upper payment limit refers to a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles in subchapter B of this chapter.

(2) Except as provided in paragraph (c) of this section, aggregate Medicaid payments to a group of facilities within one of the categories described in paragraph (a) of this section may not exceed the upper payment limit described in paragraph (b)(1) of this section.

(c) *Exception—Indian Health Services and tribal facilities.* The limitation in paragraph (b) of this section does not apply to Indian Health Services facilities and tribal facilities that are funded through the Indian Self-Determination and Education Assistance Act (Public Law 93–638).

(d) *Compliance dates.* Except as permitted under paragraph (e) of this section, a State must comply with the upper payment limit described in paragraph (b)(1) of this section by one of the following dates:

(1) *For non-State government-owned or operated hospitals*—[the effective date of the final rule].

(2) *For all other facilities*—March 13, 2001.

(e) *Transition periods*—* * *

(1) * * *

(ii) *UPL* stands for the upper payment limit described in paragraph (b)(1) of this section for the referenced year.

* * * * *

(f) *Reporting requirements for payments during the transition periods.* States that are eligible for a transition period described in paragraph (e) of this section, and that make payments that exceed the limit under paragraph (b)(1) of this section, must report annually the following information to CMS:

(1) The total Medicaid payments made to each facility for services furnished during the entire State fiscal year.

(2) A reasonable estimate of the amount that would be paid for the services furnished by the facility under Medicare payment principles.

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program)

Dated: October 16, 2001.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

Approved: November 6, 2001.

Tommy G. Thompson,

Secretary.

[FR Doc. 01–29327 Filed 11–20–01; 11:00 am]

BILLING CODE 4120–01–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 1

[IB Docket No. 95–91; DA 01–2570]

Authorization of Satellite Digital Audio Radio Service Terrestrial Repeater Networks

AGENCY: Federal Communications Commission.

ACTION: Proposed rule.

SUMMARY: With this document, the Federal Communications Commission seeks to augment the record concerning terrestrial repeaters in the Satellite Digital Audio Radio Service. Comments are sought on the proposals set out in the document to seek resolution of issues identified in the record that have not yet been directly addressed by commenters. The comments filed in response to this document and those currently in the record will be used to develop specific rules for the use of terrestrial repeaters in SDARS.

DATES: Comments are due December 14, 2001. Reply comments are due December 21, 2001.

ADDRESSES: Comments may be filed using the Commission's Electronic Comment Filing System (ECFS). (*See* Electronic Filing of Documents in Rulemaking Proceedings, 63 FR 24121 (1998)). Comments filed through the ECFS can be sent as an electronic file via the Internet to *http://www.fcc.gov/e-file/ecfs.html.* In completing the transmittal screen, parties responding should include their full name, mailing address, and the applicable docket number, IB Docket No. 95–91. Parties filing comments on paper must file an original and four copies of each filing. All filings must be sent to the Commission's Secretary, Magalie Roman Salas, Office of the Secretary, Federal Communications Commission, 445 12th Street, SW., Room TW–A325, Washington, DC 20554. An additional copy of all pleadings should also be sent to Rockie Patterson, International Bureau, FCC Room 6–B524, 445 12th Street, SW., Washington, DC 20554. One copy of all comments should also be sent to the Commission's copy contractor, Qualex International, 445 12th Street, SW., Room CY–B402, Washington, DC 20554. Copies of all filings are available for public inspection and copying during regular business hours at the FCC's Reference Information Center, 445 12th Street, SW., Washington, DC, telephone 202–857–3800; facsimile 202–857–3805.

FOR FURTHER INFORMATION CONTACT: Rockie Patterson, Satellite Engineering