NON-AEROSOL CLEANING SOLVENTS—Continued

End-use	Substitute	Information available
Aerosols		
Aerosol solvents	HCFC–225ca/cb	Report on benchmark dose analysis of acceptable exposure limit for HCFC–225ca/cb, HCFC–225ca, and HCFC–225cb. See Docket A–91–42, item IX–B–73.

[FR Doc. 02–6848 Filed 3–21–02; 8:45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 410, 411, 413, 424, and 489

[CMS–1163–CN]

RIN 0938–AK47

Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Correction

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

ACTION: Final rule; correction.

SUMMARY: This document corrects technical errors that appeared in the final rule published in the **Federal Register** on July 31, 2001 entitled ''Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities—Update''.

EFFECTIVE DATE: This correction is effective October 1, 2001, except for certain wage index corrections that are effective December 1, 2001.

FOR FURTHER INFORMATION CONTACT: Bill Ullman, (410) 786–5667.

SUPPLEMENTARY INFORMATION: In the July 31, 2001 final rule entitled ''Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities—Update'' (66 FR 39562), there were several technical errors in the preamble involving the SNF PPS wage index values. Accordingly, we are correcting several SNF PPS wage index values as published in Table 7.

Specifically, effective October 1, 2001, the wage index value for the Albuquerque, NM Metropolitan Statistical Area (MSA) (area 0200) is corrected from 0.9750 to 0.9759, and the wage index value for the Killeen-Temple, TX MSA (area 3810) is corrected from 0.7292 to 0.7940.

In addition, effective December 1, 2001, the wage index value for the Boston, MA MSA (area 1123) is corrected from 1.1289 to 1.1378, the wage index value for the Savannah, GA MSA (area 7520) is corrected from 0.9243 to 1.0018, and the wage index value for the Killeen-Temple, TX MSA (area 3810) is corrected again from 0.7940 (as corrected in the previous paragraph) to 0.8471.

In accordance with our longstanding policies, these technical and tabulation errors are being corrected prospectively, effective on the dates noted above. This correction notice conforms the published SNF PPS wage index values to the prospectively revised values and does not represent any changes to the policies set forth in the final rule.

The corrections appear in this document under the heading ''Correction of Errors''. The provisions in this correction notice are effective as if they had been included in the document published in the **Federal Register** on July 31, 2001, except for those wage index corrections that we specifically noted to be effective December 1, 2001.

Waiver of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** to provide a period for public comment before provisions of a notice such as this take effect. We can waive this procedure, however, if we find good cause that a notice and comment procedure is impracticable, unnecessary, or contrary to the public interest and incorporate a statement of the finding and its reasons in the notice issued.

We find it unnecessary to undertake notice and comment rulemaking because this notice merely provides technical corrections to the regulations and does not make any substantive changes to the regulations. Therefore, for good cause, we waive notice and comment procedures.

Correction of Errors

In FR Doc. 01–18869 of July 31, 2001 (66 FR 39562), we are making the following corrections:

Corrections to Preamble

1. On page 39572, in column 3 of Table 7, ''Wage Index for Urban Areas'', the entry of ''0.9750'' for the Albuquerque, NM MSA (area 0200) is revised to read ''0.9759''.

2. On page 39573, in column 2 of Table 7, ''Wage Index for Urban Areas'', the entry of ''1.1289'' for Boston, MA MSA (area 1123) is revised by adding ''1.1378 (effective December 1, 2001)''.

3. On page 39575, in column 3 of Table 7, ''Wage Index for Urban Areas'', the entry of ''0.7292'' for the Killeen-Temple, TX MSA (area 3810) is revised to read ''0.7940'' and by adding ''0.8471 (effective December 1, 2001)''.

4. On page 39578, in column 1 of Table 7, ''Wage Index for Urban Areas'', the entry of ''0.9243'' for the Savannah, GA MSA (area 7520) is revised by adding ''1.0018 (effective December 1, 2001)''.

(Authority: Section 1888 of the Social Security Act (42 U.S.C. 1395yy))

(Catalog of Federal Domestic Assistance Program No. 93–773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: March 14, 2002.

Dennis Williams,

Acting, Deputy Assistant Secretary for Information Resources Management.

[FR Doc. 02–6757 Filed 3–21–02; 8:45 am]

BILLING CODE 4120–01–P

THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 417 and 422

[CMS–1181–F]

RIN 0938–AK90

Medicare Program; Modifications to Managed Care Rules Based on Payment Provisions of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, and Technical Corrections

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

ACTION: Final rule.

SUMMARY: This final rule revises the regulations to reflect changes in the Social Security Act (the Act), enacted in certain sections of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), relating to the Medicare+Choice (M+C) program. This final rule only makes conforming changes to the regulations that implement the sections of the BIPA, and do not have any substantive effect.

This final rule also makes technical corrections to the M+C regulation published on June 29, 2000 (65 FR 40170). The remainder of the sections of the BIPA relating to the M+C program will be addressed in a subsequent proposed rule.

DATES: This final rule is effective May 21, 2002.

FOR FURTHER INFORMATION CONTACT: Al D'Alberto, (410) 786–1100.

SUPPLEMENTARY INFORMATION:

I. Background

A. Balanced Budget Act of 1997

Section 4001 of the Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33), added sections 1851 through 1859 to the Social Security Act (the Act) to establish a new Part C of the Medicare program, known as the Medicare+Choice (M+C) program. Under section 1851(a)(1) of the Act, every individual entitled to Medicare Part A and enrolled under Part B, except for individuals with end-stage renal disease, could elect to receive benefits either through the original Medicare fee-for-service program or an M+C plan, if one was offered where he or she lived.

The primary goal of the M+C program was to provide Medicare beneficiaries with a wider range of health plan choices through which to obtain their Medicare benefits. The BBA authorized a variety of private health plan options for beneficiaries, including both the traditional managed care plans (such as those offered by health maintenance organizations (HMOs)) that had been offered under section 1876 of the Act, and new options that were not previously authorized. Three types of M+C plans were authorized under the new Part C:

- M+C coordinated care plans, including HMO plans (with or without point-of-service options), provider-sponsored organization (PSO) plans, and preferred provider organization (PPO) plans.
- M+C medical savings account (MSA) plans (that is, combinations of a high-deductible M+C health insurance plan and a contribution to an M+C MSA).
- M+C private fee-for-service plans.

The BBA also enacted new beneficiary protections and quality assurance requirements, a new methodology for paying risk contractors, and new enrollment rules.

B. Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999

The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA) (Pub.L. 106–113) amended the M+C provisions of the Act. These amendments were implemented in a final rule with comment period published in the **Federal Register** on June 29, 2000 (65 FR 40170). We received 5 comments in response to that final rule, which will be part of the future rulemaking implementing discretionary provisions of the BIPA.

Section 501 of the BBRA amended section 1851(e)(4) of the Act to permit enrollees to receive certain rights ordinarily effective when an M+C plan terminates, at the time the beneficiary receives notice of the termination, as well as when the termination takes effect. These rights include an open enrollment period during which other M+C plans must be open, and the right to choose certain Medigap plans. It also amended section 1851(e)(2) to provide for continuous open enrollment for institutionalized individuals.

Section 502 amended section 1851(f)(2) of the Act to provide that if an election or change in election to an M+C plan were made after the 10th day of a calendar month, the election would be effective the first day of the second calendar month following the date the election or change in election was made, not the first calendar month. In section 503, which amended section 1876(h)(5)(B) of the Act, the BBRA also permitted the extension or renewal of Medicare cost contracts for an additional 2 years, through December 31, 2004. Section 511(a) amended section 1853(a) of the Act by revising the original risk adjustment transition schedule for calendar years (CY) 2000, 2001, and 2002.

Section 512 of the BBRA amended section 1853 of the Act by adding a new paragraph (i) to provide for new entry bonus payments to encourage M+C organizations to offer plans where there were no M+C plans serving the area. Section 513 amended section 1857(c)(4) of the Act to reduce from 5 years to 2 years the period during which an M+C organization that has terminated its M+C contract is barred from entering into a new M+C contract, and provided for a new exception to this rule in cases in which M+C payments are increased by statute or regulation subsequent to the decision to terminate.

M+C organizations were permitted to elect to apply the premium and benefit provisions of section 1854 of the Act uniformly to separate segments of a service area by the amendment in section 515 of the BBRA. The annual deadline for submission of adjusted community rate proposals was changed from May 1 to July 1 pursuant to section 516 of the BBRA, which amended section 1854(a)(1) of the Act.

The annual adjustment in the national per capita M+C growth percentage for 2002, found in section 1853(c)(6) of the Act, was revised by section 517 of the BBRA from a 0.5 percentage point reduction to a reduction of 0.3 percentage points. Section 518 of the BBRA amended section 1852(e)(4) of the Act to make changes in the procedures through which an M+C organization can be deemed by a private accreditation organization to meet certain M+C requirements, and added new categories of requirements that can be deemed to be met.

Section 1852(e)(2) of the Act was amended by section 520 of the BBRA to provide that PPO plans are required to meet only the quality assurance requirements that apply to private fee-for-service plans. Section 522 amended section 1857(e) of the Act by basing the M+C portion of the user fee on the percentage of all Medicare beneficiaries who have enrolled in M+C plans.

Finally, section 523 of the BBRA amended section 1859(e)(2) of the Act to provide that a religious fraternal benefit society could offer any type of M+C plan, and section 524 amended section 1877(b)(3) of the Act to specify that certain Medicare rules that established prohibitions on physician referrals did not apply for purposes of M+C organizations offering M+C coordinated care plans, although they would apply for purposes of M+C MSA plans and private fee-for-service plans.

C. Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000

The Medicare, Medicaid, and SCHIP Benefits Improvement Act of 2000 (BIPA) (Pub. L. 106–554), enacted December 21, 2000, amended the M+C provisions of the Act in sections 601 through 634. In this final rule, we are only making conforming changes to the regulations to reflect amendments made in sections 601, 602, 603, 607, 608, 613, 619, and 634 of the BIPA. In those sections the Congress mandated that the Secretary take certain actions by certain

deadlines, leaving no discretion in implementing these mandates. In a subsequent rulemaking, we will address the remaining sections of the BIPA that amend M+C provisions of the Act.

1. Increase in Minimum Payment Amount

Section 601 amended section 1853(c)(1)(B) of the Act by establishing new minimum payment amount rates (floor rates) in CY 2001 for months after February. The new monthly minimum rates for March through December of 2001 are as follows:

- $525 for any payment area in a Metropolitan Statistical Area (MSA) within the 50 States and the District of Columbia with a population of more than 250,000;
- $475 for any other area within the 50 States; or
- not more than 120 percent of the minimum amount rate for CY 2000 for any area outside the 50 States and the District of Columbia.

For January and February of 2001, the minimum amount rate is the minimum amount rate for the previous year increased by the national per capita M+C growth percentage, as described in § 422.254(b), for the year. Minimum amount rates for January and February 2001 are based on the M+C rate book published in the March 1, 2000 *Announcement of Calendar Year (CY) 2001 Medicare+Choice Payment Rates.* These rates are published on the Centers for Medicare & Medicaid Services (CMS) web site at *http://www.hcfa.gov/stats/hmorates/aapccpg.htm.* Minimum amount rates established by the BIPA for March through December 2001 are published in the January 4, 2001 *Revised Medicare+Choice (M+C) Payment Rates for Calendar Year (CY) 2001.* These rates are published on the CMS web site at *http://www.hcfa.gov/stats/hmorates/aapccpg/htm.*

The BIPA mandated that floor payment amounts are no longer established on a payment area basis. A single floor rate is now assigned to all payment areas (generally, a county) within MSAs of a certain size, and another floor rate is assigned to all other payment areas. If a payment area is located in an MSA with a population greater than 250,000, the BIPA changed the floor rate for that payment area, effective March 1, 2001. As a result, pre-BIPA revisions to prior years' growth estimates for that payment area cannot be linked to post-BIPA revisions for that payment area. Thus, revisions to prior years' growth estimates for area-specific rates will differ from revisions to prior years' growth estimates for floor rates. We are revising § 422.252(b) to reflect these changes.

2. Increase in Minimum Percentage Increase

Section 602 amended section 1853(c)(1)(C) of the Act by specifying that for March through December 2001, the minimum percentage increase rate is changed to 103 percent of the annual M+C capitation rate for a payment area for 2000. For January and February of 2001, for 2002, and for each succeeding year, the minimum percentage increase rate will be 102 percent of the prior year's annual M+C capitation rate. We have reflected this provision in § 422.252(c).

3. Phase-In of Risk Adjustment

Section 603 amended section 1853(a)(3)(C) of the Act by specifying that for CY 2002 and CY 2003, the risk adjustment method will be used to adjust only 10 percent of the M+C payment rate. (The BBRA provided that for 2002 the risk adjustment method would be used to adjust not more than 20 percent of the rate.) Under the BIPA, therefore, we will continue to apply the transition percentages applied in CYs 2000 and 2001, which are 90 percent demographic method and 10 percent risk adjusted method based on inpatient data, through CY 2003. This change for CY 2002 was announced in the January 12, 2001 *Advance Notice of Methodological Changes for Calendar Year (CY) 2002 Medicare+Choice (M+C) Payment Rates, which was published on our web site at http://www.hcfa.gov/stats/hmorates/45d2001.*

Under section 603 of the BIPA, for CY 2004, risk adjustment is to be based on both inpatient hospital and ambulatory data, and the percentage of the M+C payment rate that is risk adjusted is to increase to 30 percent of the capitation rate. The risk adjustment percentage is to increase to 50 percent in 2005, 75 percent in 2006, and 100 percent in 2007 and succeeding years. We are revising § 422.256 to reflect these changes.

Although the risk adjustment methodology will not be based on both inpatient hospital and ambulatory data until 2004, we have been collecting physician and hospital outpatient data since 2001. In a letter to the American Association of Health Plans, the Health Insurance Association of America, the Blue Cross and Blue Shield Association, and all M+C organizations, dated May 25, 2001, the Secretary suspended the required filing of physician and hospital outpatient department encounter data through July 1, 2002, in contemplation of a re-assessment of our approach to implementing comprehensive risk adjustment.

4. Full Implementation of Risk Adjustment for Congestive Heart Failure Enrollees for 2001

Section 607 amended section 1853(a)(3)(C) of the Act to provide for full implementation of risk adjustment for congestive heart failure enrollees for 2001. Under the BBRA, the phase-in amount for risk adjustment was 10 percent in 2001. This section of the BIPA provides for 100 percent implementation of risk adjustment in 2001 for each enrollee who, as determined under the risk adjustment methodology, has a qualifying congestive heart failure inpatient hospital discharge diagnosis that occurred July 1, 1999 through June 30, 2000. This provision only applies, however, to enrollees who are enrolled in a coordinated care plan that was the only coordinated care plan, as of January 1, 2001, offered in the area where the enrollee lives. Full implementation of risk adjustment for congestive heart failure began January 1, 2001, and is not included in the computation of the M+C capitation rates. Payments began in the spring of 2001, retroactive to January 1, 2001, and will end on December 31, 2001. We will revise § 422.256 to reflect these changes.

5. Expansion of Application of Medicare+Choice New Entry Bonus

Section 608 of the BIPA amended section 1853(i)(1) of the Act to expand the application of the new entry bonus to M+C organizations that enter payment areas (generally counties) that have been unserved since January 1 2001. The BBRA established bonus payments to encourage M+C organizations to offer plans in areas that otherwise would not have an M+C plan available. The application of the new entry bonus is governed by three factors: the definition of unserved payment area, the date a plan is first offered, and the period of application of the bonus plan.

First, the BBRA, in section 512, defined a previously unserved payment area as:

- A payment area in which an M+C plan has not been offered since 1997; or
- A payment area in which an M+C plan (or plans) had been offered since 1997, but in which every M+C organization offering an M+C plan in that payment area since then has notified CMS (no later than October 13, 1999) that it would no longer offer M+C plans in that payment area as of January 1, 2000.

Second, under our interpretation of section 608, the date on which a plan is

considered to be first offered is the date on which our contract with the M+C organization becomes effective and M+C beneficiaries may enroll in the plan. Two or more M+C organizations may be eligible for the bonus in the same previously unserved payment area if their M+C plans are first offered on the same date.

Third, the BBRA specified that the new entry bonus payments would only apply to M+C plans that are first offered during the period beginning January 1, 2000 and ending on December 31, 2001 (the period of application). This period of application is a 2-year window during which an M+C organization that enters a previously unserved payment area and offers the first M+C plan in that area will be eligible to begin receiving bonus payments.

Finally, the BBRA specified that the bonus payments to an eligible M+C organization would be 5 percent of the total monthly payment for that payment area for the first 12 months in the previously unserved payment area, and 3 percent for the second 12 months.

Section 608 of the BIPA extended by 1 year (to January 1, 2001) the time period during which an area could become an unserved payment area. The BIPA mandated that a payment area now will be considered a previously unserved payment area if:

- An M+C plan (or plans) had been offered since 1997; and
- Every M+C organization offering an M+C plan in that payment area since then has notified CMS (no later than October 3, 2000) that it would no longer offer M+C plans in that payment area as of January 1, 2001.

The effect of this section of the BIPA was to include additional payment areas in the definition of previously unserved payment area. The BBRA definition of a previously unserved payment area as a payment area in which an M+C plan has not been offered since 1997 remains unchanged.

Table 1 shows a comparison of the two different time periods in effect for the new entry bonus. Although the BIPA changed the time period defining a previously unserved payment area, it did not change the time period during which an M+C plan must first be offered (the period of application). The two time periods are the same: from January 1, 2000 through December 31, 2001.

TABLE 1.—COMPARISON OF BBRA AND BIPA PROVISIONS ON NEW ENTRY BONUS

Provision	BBRA	BIPA
Date a payment area becomes previously unserved	By January 1, 2000	By January 1, 2000 or by January 1, 2001.
Period of application (the window for M+C organizations to first offer an M+C plan in an unserved area).	January 1, 2000 through December 31, 2001.	January 1, 2000 through December 31, 2001.

We discussed the BIPA amendment to the new entry bonus in the January 12, 2001 *Advance Notice of Methodological Changes for Calendar Year 2002 Medicare+Choice Payment Rates,* published on our website at *http://www.hcfa.gov/stats/hmorates/cover01,* and in the March 1, 2001 *Announcement of Calendar Year 2002 Medicare+Choice Payment Rates.* In the March 1 announcement, we indicated that the 1-year extension in the time period defining an unserved area mandated by the BIPA also applied to the 2-year period of application. In effect, this would extend the end of the period of application window from December 31, 2001 to December 31, 2002. As a result, we stated that an M+C organization first offering a plan in a previously unserved payment area on January 1, 2002 would be eligible for the bonus payments.

After further analysis, we have determined that while the BIPA did expand the time period used to define a previously unserved payment area, it did not extend the period of application window during which an M+C organization must first offer a plan in a previously unserved area. The period of application remains January 1, 2000 through December 31, 2001. For example, an M+C organization that first offers a plan in a previously unserved payment area on January 1, 2002 would not be eligible for the new entry bonus payments. However, if the M+C organization first offers a plan in a previously unserved payment area prior to January 1, 2002, then the M+C organization would have first offered an M+C plan within the period of application and the organization would be eligible for new entry bonus payments.

We have reflected the changes in section 608 by the addition of § 422.250(g)(2)(iii).

6. Timely Approval of Marketing Material That Follows Model Marketing Language

Section 613 of the BIPA amended section 1851(h) of the Act by altering the review period for marketing materials that utilize, without modification, proposed model language as specified by us. The review period for these marketing materials was reduced from 45 days to 10 days. All other marketing materials will remain subject to the 45-day review period. We have revised § 422.80(a)(1) to reflect this change.

7. Restoring Effective Date of Elections and Changes of Elections of Medicare+Choice Plans

Section 619 of the BIPA amended section 1851(f) of the Act to reestablish the original BBA effective date of elections or changes in elections to M+C plans during an open enrollment period. The effective date for these elections in the BBA provisions establishing the M+C program was the first day of the calendar month following the election or change in election during an open enrollment period. The BBRA changed this effective date in the case of an election or change in election made after the 10th of the month. Under the BBRA, an election or change in election made after the 10th of the month during an open enrolment period was effective the first day of the second calendar month after the election or change in election. Section 619 of the BIPA reestablishes the original provision making an election or change of election made during an open enrollment period effective the first day of the calendar month following the election, regardless of the day of the month on which the election or change of election is made. We are revising § 422.68(c) to reflect this change, which was effective on June 1, 2001.

8. Service Area Expansion for Medicare Cost Contracts During Transition Period

Section 634 of the BIPA amended section 1876(h)(5) of the Act by revising the limitation on expansion of service areas for cost contracts. We must now accept and approve applications to expand the service area of cost contracts if they are submitted on or before September 1, 2003 and we determine that the organization continues to meet

the requirements applicable to the organization and to cost contracts under section 1876 of the Act. We are revising § 417.402(b) to reflect this change.

D. Technical Corrections

We are making a number of technical corrections to part 422. These corrections are technical and editorial in nature and do not alter the substance of the regulations. In some sections, they represent material that was inadvertently changed or omitted in the final rule published on June 29, 2000 (65 FR 40170). In § 422.100(d), in order to make clear that no change was intended in the final rule, we are restoring the words ''level of'' before ''cost-sharing'', as they appeared before ''cost-sharing'' in the June 26, 1998 interim final rule. This also makes the language consistent with the reference to the ''level of cost-sharing'' in § 422.304(b)(1).

In § 422.100(g)(2), we are restoring language that was inadvertently deleted in the final rule, by inserting, at the end of the sentence, before the word '';and'', the words '', promote discrimination, discourage enrollment, steer subsets of Medicare beneficiaries to particular M+C plans, or inhibit access to services.'' While these concepts arguably are captured in the reference to designing benefits to ''discriminate'' against particular beneficiaries, we want to clarify that the deletion of this language (which was not discussed in the preamble to the final rule) was not intended to make any change in our standards of review in this area.

In § 422.506(a)(4), we are correcting the number of years an M+C organization must wait to enter into a new contract with us after not renewing a contract, which is 2 years, not 5 years, as stated in the current rule. We are also making the same correction to § 422.512(e), by changing the ''5'' to a ''2'', to indicate the number of years an M+C organization must wait to enter into a new contract with us after they have terminated a contract.

II. Provisions of This Final Rule

The provisions of this final rule are as follows:

• In § 417.402, we are revising paragraph (b) to indicate that we must accept and approve service area expansion applications, provided they are submitted on or before September 1, 2003, and we determine that the organization continues to meet the requirements in section 1876 of the Act pertaining to cost contractors and the requirements in its cost contract.

• In § 422.68(c), we are indicating that for an election, or change in election, made during an open enrollment period, coverage is effective as of the first day of the first month following the month in which the election, or change in election, is made.

• In § 422.80, we are revising paragraph (a)(1) to indicate that the review period for marketing materials that utilize, without modification, proposed model language as specified by us, will be 10 days, not the 45 days required for all other marketing materials.

• In § 422.250, we are revising paragraph (g)(2) to extend the category of previously unserved payment areas to include a payment area in which every M+C organization that offered an M+C plan in that payment area notified us by October 3, 2000 that it will no longer offer an M+C plan in that payment area effective January 1, 2001. New entry bonus payments may be made to M+C organizations that first enter these payment areas from January 1, 2000 through December 31, 2001.

• In § 422.252, we are revising paragraph (b) to indicate that the minimum amount rate (floor rate) for a payment area for 1999, 2000, and January and February of 2001 is the minimum amount rate for the preceding year, increased by the national per capita growth percentage, as described in § 422.254(b), for the year. The floor rates for January and February 2001 are published in the March 1, 2000 *Announcement of Calendar Year 2001 Medicare+Choice Payment Rates (http://www.hcfa.gov/stats/hmorates/cover01*). For March through December, 2001, the minimum amount rate for any area in an MSA within the 50 States and the District of Columbia with a population of more than 250,00 is $525; and for any other area within the 50 States, it is $475. For any area outside of the 50 States and the District of Columbia, the minimum amount rate cannot exceed 120 percent of the minimum amounts for those areas for CY 2000. We will also indicate in that section that for 2002, and each succeeding year, the minimum amount rate is the minimum amount for the preceding year, increased by the national per capita growth percentage, as described in § 422.254(b), for the year.

We are also revising paragraph (c) to indicate that the minimum percentage increase for 1999, 2000, and January and February of 2001 is 102 percent of the annual M+C capitation rate for the preceding year. For March through December of 2001, the minimum percentage increase rate is 103 percent of the annual M+C capitation rate for 2000. For 2002, and for each succeeding year, the minimum percentage increase is 102 percent of the annual M+C capitation rate for the preceding year.

• In § 422.256, we are revising paragraph (d) to indicate changes to the phase-in schedule for risk adjustment. For payments beginning January 1, 2000 and ending December 31, 2003, the risk factor will be based on the inpatient hospital data and will comprise 10 percent of the monthly payment. For January 1, 2001 through December 31, 2001 only, this factor comprises 100 percent of the monthly payment for enrollees with a qualifying inpatient diagnosis of congestive heart failure who are enrolled in a coordinated care plan that is the only coordinated care plan offered on January 1, 2001 in the enrollee's county. For payments beginning January 1, 2004, and for all succeeding years, the risk factor will include both inpatient and ambulatory data. The health status risk factor will be phased in according to the following schedule: 30 percent in 2004; 50 percent in 2005; 75 percent in 2006; and 100 percent in 2007 and succeeding years.

The technical corrections in this final rule are as follows:

• In § 422.100(d)(2), we are correcting an omission by inserting the words ''level of'' before ''cost-sharing'', so that the sentence reads ''At a uniform premium, with uniform benefits and level of cost-sharing throughout the plan's service area, or segment of service area as provided in § 422.304(b)(2).''

• In § 422.100(g)(2), we are correcting an omission by inserting a phrase at the end of the section, so that it reads ''M+C organizations are not designing benefits to discriminate against beneficiaries, promote discrimination, discourage enrollment, steer subsets of Medicare beneficiaries to particular M+C plans, or inhibit access to services; and''.

• In § 422.250(g)(2)(ii), we are making a correction by deleting the word ''any'' and replacing it with the word ''all''.

• In § 422.506(a)(4), we are correcting the number of years an M+C organization must wait to enter into a new contract with us after deciding not to renew a contract by deleting the ''5'' and replacing it with a ''2''.

• In § 422.512(e), we are making the same correction by changing the ''5'' to a ''2'', to indicate the number of years an M+C organization must wait to enter into a new contract with us after terminating a contract.

III. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), we are required to provide 60 days notice in the **Federal Register** and solicit public comment when 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:

- Whether the information collection is necessary and useful to carry out the proper functions of the agency;
- The accuracy of our estimate of the information collection burden;
- The quality, utility, and clarity of the information to be collected; and
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995.

IV. Regulatory Impact

A. Overall Impact

We have examined this final rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Unfunded Mandate Reform Act (UMRA, Pub. L. 104–4), the Regulatory Flexibility Act (RFA, Pub.L. 96–354, September 19, 1980), and the Federalism Executive Order 13132.

Executive Order 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).

As a result of changes to the M+C regulations that reflect provisions of the BIPA specified in sections 601, 602, 603, 607, 608, 613, 619, and 634, we have determined that this final rule is a major rule with economically significant effects, as defined in Title 5, United States Code, section 804(2), and under Executive Order 12866. The BIPA provisions addressed in this final rule will result in expenditures by the Federal government of more than $100 million annually. We estimate its impact will be to increase the aggregate payments to M+C organizations by approximately $1 billion in 2001, and approximately $11 billion during the 5-year period from FY 2001 through FY 2005.

Table 2 shows the estimated expenditures under these provisions of the BIPA for this 5-year period. The estimates are rounded to the nearest $5 million, with estimates of less than $5 million represented as $0 in the table. All assumptions applied in calculating the estimates were consistent with the assumptions underlying the President's FY 2002 budget baseline. The total direct impact of approximately $7 billion does not include the additional impact of approximately $4 billion attributable to the indirect effect of increases in fee-for-service expenditures over the same 5-year period. Thus, all provisions of the BIPA addressed in this final rule are expected to increase aggregate payments to M+C organizations by approximately $11 billion over the next 5 years, beginning with $1 billion for 2001. The new payment rates are effective March 1, 2001.

TABLE 2.—ESTIMATED EXPENDITURES FOR BIPA PROVISIONS IN THIS FINAL RULE

BIPA section and provision	Additional cash expenditures, 2001–2005 (in millions)
Sec. 601:	
Increase minimum payment amounts:	
Hospital Insurance (Part A)	$610.
Supplementary Medical Insurance (Part B)	$540.
Sec. 602:	
Increase minimum % pay increase for 2001	Included in figures for Section 601.
Sections 601 and 602 Total	$1,150.
Sec. 603:	
Phase-in of risk adjustment:	
Hospital Insurance (Part A)	$3,310.
Supplementary Medical Insurance (Part B)	$2,430.
Section 603 Total	$5,740.
Sec. 607:	
Full risk adjustment in 2001 for Congestive Heart Failure enrollees:	
Hospital Insurance (Part A)	$50.
Supplementary Medical Insurance (Part B)	$40.
Section 607 Total	$90.
Sec. 608:	
Expand M+C new entry bonus	Not estimable, due to unknown number of eligible M+C organizations. Likely to be $0. (Provision is in effect less than 5 years.)
Sec. 613:	
Timely approval of marketing materials	Not applicable.
Sec. 619:	
Restore effective date of elections	Not applicable.
Sec. 634:	
Service area expansion for Medicare cost contracts	Not applicable.
Total, direct impact of the provisions in this rule	$6,980.
Total, indirect impact of increases in fee-for-service expenditures	Approximately $4,000.
Total, direct and indirect impacts	Approximately $11,000.

The distribution of expenditures for the BIPA provisions included in this final rule varies by whether or not the payment areas served by the M+C organization are floor payment areas, and which type of floor applies. Under the M+C payment methodology prescribed in the BBA, the payment rate for each payment area for a year is the highest of three amounts:

- The minimum payment rate amount, or floor rate;
- The minimum percent increase rate, which is the payment amount received during the last year plus the minimum percent increase for the current year; or
- A blended rate, which is an amount derived from blending the payment area specific rate with a national rate based on historic spending under the original Medicare fee-for-service program.

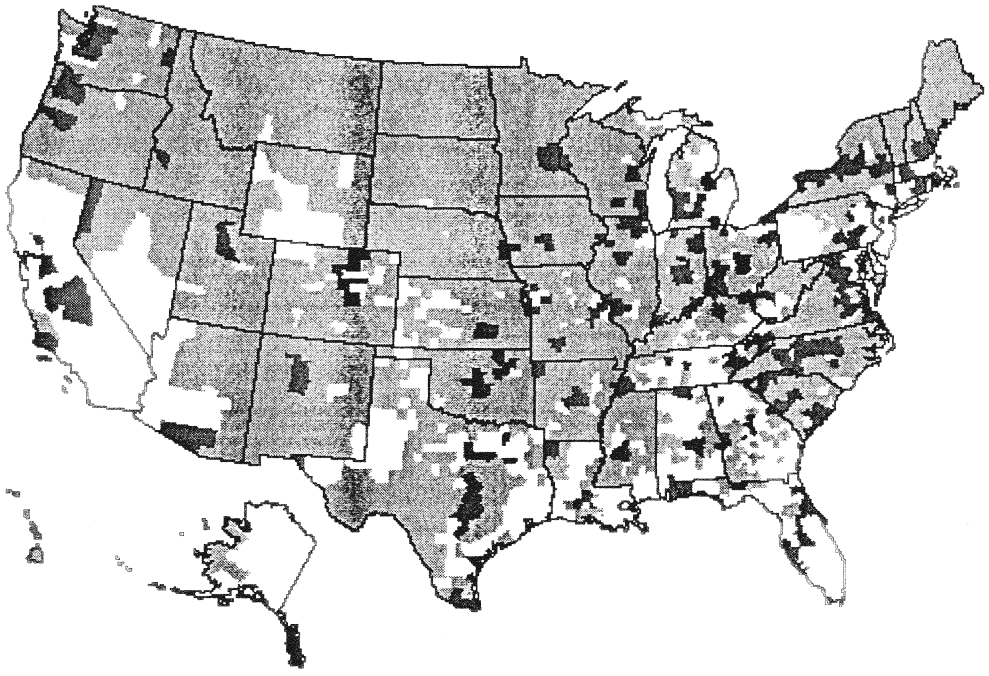
Generally, a payment area is the same as a county. Floor payment areas are payment areas that receive the minimum, or floor payment rate amounts. Under the provisions of the BIPA, there are now two categories of floor payment areas, those in MSAs with populations of 250,000 or more that receive the $525 minimum payment rate, and all other payment areas that receive the $475 minimum payment rate. The BIPA also specifies that from March through December 2001, all payment areas for which the minimum percentage rate is the highest rate (the non-floor payment areas) will receive 103 percent of the prior year's payment rate amount.

Figure 1 shows the distribution of the three types of payment rates assigned to payment areas in 2001. A high proportion of payment areas receive the $475 floor rate. This floor rate predominates in the mountain states of the Western region and the west-central sections of the Midwest. (In CY 2001, all non-floor rates are the minimum percentage increase, since no payment areas receive a blended rate.)

For most rural areas in the United States, the M+C payment rate is the floor rate. In the June 2001 Report to the Congress, MedPAC examined the differences between urban and rural areas. The report stated that in 2000, 94 percent of Medicare beneficiaries living in a Metropolitan Statistical Area (MSA) with at least 1 million people had at least one M+C HMO offered where they lived. In contrast, only 16 percent of beneficiaries living adjacent to an MSA, but in an area without a town of at least 10,000 people had the option to enroll in an M+C HMO. Only 5 percent of the beneficiaries who lived in completely rural areas (not adjacent to any large or small MSA) had an M+C HMO option available where they lived.

BILLING CODE 4120–01–P

Figure 1
2001 Medicare+Choice Payment Rates, by Payment Area**



**Source: Medpac, Report to the Congress, June 2001

BILLING CODE 4120–01–C

Table 3 shows how the distribution of enrollees, payment areas, and payment increases varies according to the three payment categories mandated by the BIPA. Enrollment figures include all enrollees as of January 2001 and payment area figures are based on only those areas that have M+C enrollees.

Payment increases refer to the difference between pre-BIPA rates and the BIPA mandated 2001 rates that are effective March through December 2001.

Non-floor payment areas receive the smallest average payment increase of 1 percent above the pre-BIPA rates for CY 2001, and 75 percent of all M+C enrollees reside in these areas. The 53 percent of payment areas that receive the $475 floor rate for CY 2001 have payment increases, on average, of 8 percent. Two percent of all M+C enrollees live in these payment areas. The largest average increase in payment rates are in payment areas that receive the new $525 floor, where approximately one-quarter of all M+C enrollees live. The 18 percent of payment areas assigned the $525 floor receive an average payment increase of 9.7 percent.

TABLE 3.—DISTRIBUTION OF ENROLLEES AND PAYMENT INCREASES FOR 2001, BY THE BIPA PAYMENT CATEGORY

[In percent]

Payment category	Percent of M+C enrollees in payment category	Percent of payment areas in payment category	Average payment increase
$475 floor payment areas	2	55	8.3
$525 floor payment areas	23	15	9.7
Non-floor payment areas	75	30	1.0

Table 4 shows M+C enrollment by payment categories and geographical region. The table is based on January 2001 enrollment, and includes M+C enrollees in coordinated care and private fee-for-service M+C plans, but not enrollees in cost or other non-risk plans. Within each of the four Census regions, the States are ordered by size of M+C enrollment as of January 2001.

Although the map in Figure 1 may show that all three types of payment categories are present in a State, Table 4 may show that there are no M+C enrollees in 1 or 2 of the payment categories. For example, the map shows that South Dakota has at least 1 payment area that is assigned the non-floor rate, but Table 4 shows that there are no M+C enrollees in the non-floor areas.

TABLE 4.—PERCENT OF M+C ENROLLEES IN EACH STATE, BY BIPA PAYMENT CATEGORY

Enrollee residence	In percent			
	Percent enrollees in low-floor payment areas	Percent enrollees in high-floor payment areas	Percent enrollees in non-floor payment areas	Total M+C enrollees, January 2001
Nation	2	23	75	
Northeast:				
Connecticut	None	<1	100	67,051
New Jersey	None	2	98	154,100
Pennsylvania	2	4	94	507,626
Massachusetts	None	14	86	220,246
New York	2	26	72	393,403
Rhode Island	None	72	28	57,368
New Hampshire	10	90	None	1647
Maine	80	20	None	271
Vermont	100	None	None	96
Midwest:				
Michigan	<1	6	94	78,057
Illinois	4	24	72	149,886
Indiana	2	50	48	11,428
Ohio	2	52	46	237,371
Missouri	2	54	44	124,584
Kansas	<1	70	28	26,133
Iowa	8	92	None	2,446
Minnesota	2	98	None	38,804
Nebraska	2	98	None	8,305
N. Dakota	100	None	None	54
S. Dakota	100	None	None	585
Wisconsin	12	88	None	33,068
South:				
Alabama	<1	<1	100	54,285
Dist. of Columbia	None	None	100	3,715
Georgia	<1	<1	100	38,685
Louisiana	<1	<1	100	92,055
Maryland	<1	<1	100	15,220
Delaware	4	None	96	799
Florida	<1	8	92	667,825
Texas	2	8	92	203,968
W. Virginia	18	2	82	5,334
Mississippi	14	8	78	1,252

TABLE 4.—PERCENT OF M+C ENROLLEES IN EACH STATE, BY BIPA PAYMENT CATEGORY—Continued

Enrollee residence	In percent			
	Percent enrollees in low-floor payment areas	Percent enrollees in high-floor payment areas	Percent enrollees in non-floor payment areas	Total M+C enrollees, January 2001
Tennessee	2	44	52	31,930
Arkansas	34	40	26	17,722
S. Carolina	36	54	10	475
Kentucky	<1	94	6	18,642
Virginia	2	92	6	11,196
N. Carolina	16	82	2	45,192
Oklahoma	4	92	2	46,830
West:				
Alaska	2	None	98	116
California	<1	8	92	1,469,716
Arizona	2	22	76	235,366
Nevada	2	22	74	45,030
Colorado	8	54	38	130,181
Wyoming	78	None	22	97
Washington	6	88	6	149,854
Utah	38	60	2	351
Idaho	6	94	<1	5,344
New Mexico	6	94	<1	27,946
Oregon	10	90	<1	136,707
Hawaii	26	74	None	21,563
Montana	100	None	None	165

Under the BIPA, M+C organizations could qualify for higher payment rates, and the statute mandated that the increase in payments be used by the M+C organizations in the following ways:

- To reduce beneficiary premiums.
- To reduce beneficiary cost-sharing.
- To enhance benefits.
- To make contributions to a benefit stabilization fund to reserve funds for future use to offset premium increases or benefit reductions.
- To stabilize or enhance the network of health care providers.
- A combination of the above.

Table 5 describes how M+C organizations choose to use the higher payments for 2001 by showing the percentage of M+C enrollment by each type of fund use and within payment categories ($475 floor, $525 floor, and non-floor payment areas). Almost two-thirds of M+C enrollees are in M+C organizations that used the increased funds for 2001 to enhance provider networks only, and 17 percent of enrollees are in M+C organizations that selected multiple options. The largest payment rate increases went to both floor payment areas (see Table 3) and M+C organizations serving these payment areas were less likely to use the increase in funds exclusively for enhanced provider networks.

TABLE 5.—USE OF INCREASED PAYMENTS UNDER BIPA, BY PERCENT OF ENROLLMENT WITHIN PAYMENT CATEGORIES

[In percent]

M+C organizations uses of increased payment	Percent of total M+C enrollment	Percent of M+C enrollment in *$475 floor* payment areas	Percent of M+C enrollment in *$525 floor* payment areas	Percent of M+C enrollment in *non-floor* payment areas
Reduced premium or cost-sharing only	6	8.4	8.7	5.3
Added or enhanced benefits only	1	0.9	0	0.94
Used stabilization fund only	11	0	2.8	14.2
Enhanced provider network only	65	48.6	43.5	72.3
Used multiple options	17	42.1	45	7.3

The increases in payment rates also had an impact on the premiums that M+C organizations offered their enrollees for 2001. After the increase in payment rates, the national average 2001 premium for the plan with the lowest premium that had the most generous benefit package offered by an M+C organization in a payment area decreased by about $2 per month. Currently, we have enrollment data at the level of M+C organization contracts, not at the level of individual plans offered by M+C organizations. Thus, we assigned contract level enrollment data to the plan with the lowest premium that had the most generous benefit package offered by an M+C organization in a payment area in each contract. There may be several plans offered by an M+C organization in a payment area, some of which may have additional benefits available for an additional premium.

Premiums have tended to be highest in payment areas where Medicare payment rates have been the lowest. Table 6 shows the impact of the increase in payment rates on 2001 premiums.

TABLE 6.—PREMIUM LEVELS BY PAYMENT CATEGORY, PRE- AND POST-BIPA

Payment category	Pre-BIPA average 2001 premium for ''representative'' plans	Post-BIPA average 2001 premiums for ''representative'' plans	Percent change
All payment areas	$25.44	$23.44	−7.9
$475 floor areas	51.70	48.39	−6.4
$525 floor areas	37.75	31.51	−16.5
Non-floor areas	21.08	20.41	−3.2

Prior to the increase in payment rates, 20.5 percent of enrollees were paying over $50 for 2001 premiums. The increase in payment rates decreased this share by 5 percentage points, so that only 15.6 percent of enrollees pay premiums over $50 in 2001. The increase in payment rates had no effect on the percentage of enrollees in the plan with the lowest premium that had the most generous benefit package offered by an M+C organization in a payment area with a zero dollar premium for 2001. That share would remain approximately 45 percent.

Drug coverage is most common in payment areas with the highest payment rates. Few M+C organizations have used the increase in payment rates to add a drug benefit. Prior to implementation of the BIPA payment provisions, approximately 69 percent of M+C enrollees would have had drug coverage in the plan with the lowest premium that had the most generous benefit package offered by their M+C organization in the payment area in 2001. As a result of the BIPA payment increases, 70 percent of enrollees (an additional 61,000 enrollees) would have drug coverage in the plan with the lowest premium that had the most generous benefit package offered by their M+C organization in the payment area in 2001. Payment areas with the $475 floor recorded the largest change in the percent of enrollees with drug coverage in the plan with the lowest premium that had the most generous benefit package offered by an M+C organization in a payment area as a result of the changes in the BIPA, increasing from 31 percent to 38 percent.

We have not considered alternatives to lessen the impact or regulatory burden of this final rule because the provisions are mandated by the BIPA and no additional burden is imposed by us.

The RFA also requires agencies to analyze options for regulatory relief of small businesses, nonprofit organizations, and governmental agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of between $7.5 million and $25 million annually. Individuals and States are not included in the definition of small entities.

We estimate that fewer than 5 out of 177 M+C contractors have annual revenues of $7.5 million or less. Approximately 35 percent of M+C contractors have tax-exempt status, and thus, for purposes of the RFA are considered to be small entities. We have examined the economic impact of this final rule on M+C organizations, including those that are tax-exempt, and thus small entities, and we find that overall the economic impact is significant but positive, generating an increase in payments. We have not considered alternatives to lessen the impact or regulatory burden of this final rule because the provisions are mandated by the BIPA and no burden is imposed.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a 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 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital located outside of an MSA with fewer than 100 beds. Almost 2 percent of M+C enrollees reside in payment areas outside MSAs, with floor payment rates of $475 for March through December of 2001. M+C organizations in these payment areas will receive, on average, an 8.3 percent increase in payments for 2001. Assuming BIPA-related payment increases in both original Medicare and the M+C program, small rural hospitals in these payment areas could be in a better position to renegotiate their contracts with M+C organizations. This could generate a positive increase in payments to some small rural hospitals. However, information on the payment terms of contracts between M+C organizations and providers is not available, therefore, we are unable to provide data on the level of this impact.

B. The Unfunded Mandates Act

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) requires that agencies assess anticipated costs and benefits before issuing any rule that may result in an annual expenditure by State, local, or tribal governments, in the aggregate, or by the private sector, of $100 million. This final rule would have no consequential effect on the annual expenditures of any State, local, or tribal government, or the private sector. Therefore, we have determined, and we certify, that this final regulation would not result in an annual expenditure by State, local, or tribal governments, in the aggregate, or by the private sector, of $100 million.

C. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed or final rule that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. This final rule will impose no direct requirement costs on State and local governments, would not preempt State law, or have any Federalism implications.

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

V. Waiver of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment on the proposed rule. The notice of proposed rulemaking includes a reference to the legal authority under which the rule is proposed, and the terms and substances of the proposed rule or a description of the subjects and issues involved. The notice of proposed rulemaking can be waived, however, if an agency finds good cause that notice and comment procedures are impracticable, unnecessary, or contrary to the public interest, and it incorporates a statement of the finding and its reasons in the rule issued.

Publishing a proposed rule is unnecessary because this final rule only makes conforming changes to the regulations to implement those sections of the BIPA in which the Congress allowed no discretion as to the actions to be taken and the times in which they must be completed. These changes were enacted by the Congress, and would be in effect on the date mandated by the legislation without regard to whether they are reflected in conforming changes to the regulation text, since a statute controls over a regulation. In this final rule we merely have revised the regulation text to reflect these new statutory provisions. The BIPA provisions have been incorporated virtually verbatim, with no interpretation necessary. In accordance with 5 U.S.C. 808(2), we do not believe that publishing a notice of proposed rulemaking is necessary, nor would it be practicable given that a number of the provisions have already taken effect consistent with the effective dates established under the BIPA.

Also, this final rule contains only technical corrections to a prior final rule with comment period published in the **Federal Register** on June 29, 2000 (65 FR 40170). These technical corrections are editorial in nature and do not alter the substance of the regulations.

Therefore, we find good cause to waive the notice of proposed rulemaking and to issue this final rule.

List of Subjects

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 recordkeeping requirements.

42 CFR Part 422

Administrative practice and procedure, Health facilities, Health maintenance organizations (HMO), Medicare+Choice, Penalties, Privacy, Provider-sponsored organizations (PSO), Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR chapter IV 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 (2 U.S.C. 300e, 300e–5, 300e–9), and 31 U.S.C. 9701.

Subpart J—Qualifying Conditions for Medicare Contracts

2. In § 417.402, paragraph (b) is revised to read as follows:

§ 417.402 Effective date of initial regulations.

* * * * *

(b) The changes made to section 1876 of the Act by section 4002 of the Balanced Budget Act of 1997 (BBA) are incorporated in part 422 of this chapter, except for changes affecting section 1876 cost contracts, which are incorporated in subpart L of this part. Upon enactment of the BBA (August 5, 1998), no new cost contracts are accepted by CMS, except for current Health Care Prepayment Plans that may convert to section 1876 cost contracts. Section 1876 cost contracts may not be extended or renewed beyond December 31, 2004. CMS must accept and approve applications to modify the cost contracts in order to expand the service area, provided they are submitted on or before September 1, 2003 and CMS determines that the organization continues to meet the regulatory requirements and the requirements in its cost contract.

PART 422—MEDICARE+CHOICE PROGRAM

1. The authority citation for part 422 continues to read as follows:

Authority: Secs. 1851 and 1855 of the Social Security Act (42 U.S.C. 1395w–21, and 1395w–25).

Subpart B—Eligibility, Election, and Enrollment

2. In § 422.68, paragraph (c) is revised to read as follows:

§ 422.68 Effective dates of coverage and change of coverage.

* * * * *

(c) *Open enrollment periods.* For an election, or change in election, made during an open enrollment period, as described in § 422.62(a)(3) through (a)(6), coverage is effective as of the first day of the first calendar month following the month in which the election is made.

* * * * *

3. In § 422.80, paragraph (a)(1) is revised to read as follows:

§ 422.80 Approval of marketing materials and election forms.

(a) * * *

(1) At least 45 days (or 10 days if using marketing materials that use, without modification, proposed model language as specified by CMS) before the date of distribution the M+C organization has submitted the material or form to CMS for review under the guidelines in paragraph (c); and

* * * * *

Subpart C—Benefits and Beneficiary Protections

4. In § 422.100, paragraphs (d)(2) and (g)(2) are revised to read as follows:

§ 422.100 General requirements.

* * * * *

(d) * * *

(2) At a uniform premium, with uniform benefits and level of cost-sharing throughout the plan's service area, or segment of service area as provided in § 422.304(b)(2).

* * * * *

(g) * * *

(2) M+C organizations are not designing benefits to discriminate against beneficiaries, promote discrimination, discourage enrollment, steer subsets of Medicare beneficiaries to particular M+C plans, or inhibit access to services; and

* * * * *

Subpart F—Payments to Medicare+Choice Organizations

5. In § 422.250, the following changes are made to read as set forth below:

A. Paragraphs (g)(2)(i) and (g)(2)(ii) are revised.

B. Paragraph (g)(2) (iii) is added.

§ 422.250 General provisions.

* * * * *

(g) * * *

(1) * * *

(2) * * *

(i) A county in which no M+C plan has been offered;

(ii) A county in which an M+C plan or plans have been offered, but where all M+C organizations offering an M+C plan notified CMS by October 13, 1999, that they will no longer offer plans in the county as of January 1, 2000; or

(iii) A county in which an M+C plan or plans have been offered, but where all M+C organizations offering an M+C plan notified CMS by October 3, 2000, that they will no longer offer plans in the county as of January 1, 2001.

* * * * *

6. In § 422.252, the following changes are made to read as set forth below:

A. Paragraph (b)(2) is revised.

B. Paragraphs (b)(3) and (b)(4) are added.

C. Paragraph (c)(2) is revised.

D. Paragraphs (c)(3) and (c)(4) are added.

§ 422.252 Annual capitation rates.

* * * * *

(b) * * *

(2) For 1999, 2000, and January and February of 2001, the minimum amount rate is the minimum amount rate for the preceding year, increased by the national per capita growth percentage (specified in § 422.254(b)) for the year.

(3) For March through December, 2001—

(i) The minimum amount rate for any area in a metropolitan statistical area within the 50 States and the District of Columbia with a population of more than 250,000 is $525;

(ii) For any other area within the 50 States, it is $475; or

(iii) For any area outside the 50 States and the District of Columbia, it is not more than 120 percent of the minimum amount rates for CY 2000.

(4) For 2002 and each succeeding year, the minimum amount rate is the minimum amount for the preceding year, increased by the national per capita percentage (specified in § 422.252(b)) for the year.

(c) * * *

(2) For 1999, 2000, and January and February of 2001, the minimum percentage increase is 102 percent of the annual Medicare+Choice capitation rate for the preceding year.

(3) For March through December of 2001, the minimum percentage increase is 103 percent of the annual Medicare+Choice capitation rate for 2000.

(4) For 2002, and for each succeeding year, the minimum percentage increase is 102 percent of the annual Medicare+Choice capitation rate for the preceding year.

7. In § 422.256, paragraph (d)(2) is revised to read as follows:

§ 422.256 Adjustments to capitation rates and aggregate payments.

* * * * *

(d) * * *

(2) *Implementation.* CMS applies the risk adjustment factor as follows:

(i) For payments beginning January 1, 2001 and ending December 31, 2003, CMS applies a risk factor that incorporates inpatient hospital encounter data. The risk factor will comprise 10 percent of the monthly payment.

(ii) For payments beginning January 1, 2000 and ending December 31, 2001 only, the risk factor comprises 100 percent of the monthly payment for individuals with a qualifying inpatient diagnosis of congestive heart failure who are enrolled in a coordinated care plan that is the only coordinated care plan offered on January 1, 2001 in the area where the individual lives.

(iii) For payments beginning January 1, 2004, and for all succeeding years, CMS applies a risk factor that incorporates inpatient hospital and ambulatory encounter data. This factor is phased in as follows:

(A) 30 percent in 2004;

(B) 50 percent in 2005;

(C) 75 percent 2006; and

(D) 100 percent in 2007 and succeeding years.

* * * * *

Subpart K—Contracts With Medicare+Choice Organizations

§ 422.505 [Corrected]

8. In § 422.506, in paragraph (a)(4), the phrase ''5 years'' is removed and the phrase ''2 years'' is added in its place.

§ 422.512 [Corrected]

9. In § 422.512, in paragraph (e), the phrase ''5 years'' is removed and the phrase ''2 years'' is added in its place.

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

Dated: August 2, 2001.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

Dated: October 16, 2001.

Tommy G. Thompson,

Secretary.

[FR Doc. 02–6956 Filed 3–21–02; 8:45 am]

BILLING CODE 4120–01–P

FEDERAL EMERGENCY MANAGEMENT AGENCY

44 CFR Part 64

[Docket No. FEMA–7779]

Suspension of Community Eligibility

AGENCY: Federal Emergency Management Agency, FEMA.

ACTION: Final rule.

SUMMARY: This rule identifies communities, where the sale of flood insurance has been authorized under the National Flood Insurance Program (NFIP), that are suspended on the effective dates listed within this rule because of noncompliance with the floodplain management requirements of the program. If the Federal Emergency Management Agency (FEMA) receives documentation that the community has adopted the required floodplain management measures prior to the effective suspension date given in this rule, the suspension will be withdrawn by publication in the **Federal Register**.

EFFECTIVE DATES: The effective date of each community's suspension is the third date (''Susp.'') listed in the third column of the following tables.

ADDRESSES: If you wish to determine whether a particular community was suspended on the suspension date, contact the appropriate FEMA Regional Office or the NFIP servicing contractor.

FOR FURTHER INFORMATION CONTACT: Edward Pasterick, Division Director, Program Marketing and Partnership Division, Federal Insurance Administration and Mitigation Directorate, 500 C Street, SW., Room 411, Washington, DC 20472, (202) 646–3098.

SUPPLEMENTARY INFORMATION: The NFIP enables property owners to purchase flood insurance which is generally not otherwise available. In return, communities agree to adopt and administer local floodplain management aimed at protecting lives and new construction from future flooding. Section 1315 of the National Flood Insurance Act of 1968, as amended, 42 U.S.C. 4022, prohibits flood insurance coverage as authorized under the National Flood Insurance Program, 42 U.S.C. 4001 *et seq.*; unless an appropriate public body adopts adequate floodplain management measures with effective enforcement measures. The communities listed in this document no longer meet that statutory requirement for compliance with program regulations, 44 CFR part 59 *et seq.* Accordingly, the communities will be suspended on the effective date in the third column. As of that date, flood insurance will no longer be available in the community. However, some of these communities may adopt and submit the required documentation of legally enforceable floodplain management measures after this rule is published but prior to the actual suspension date. These communities will not be suspended and will continue their eligibility for the sale of insurance. A notice withdrawing the suspension of the communities will be published in the **Federal Register**.

In addition, the Federal Emergency Management Agency has identified the special flood hazard areas in these communities by publishing a Flood Insurance Rate Map (FIRM). The date of