of the PTO's final rule until October 10, 1998, unless it is superseded by law.

DATES: The effective date of the final rule published at 63 FR 46891, July 24, 1998, and corrected at 63 FR 46981, September 3, 1998, is delayed until October 10, 1998, unless it is superseded by law. If this date is superseded by law, PTO will publish further notice in the **Federal Register**.

FOR FURTHER INFORMATION CONTACT: Matthew Lee by telephone at (703) 305–8051, fax at (703) 305–8007, or by mail marked to his attention and addressed to the Commissioner of Patents and Trademarks, Office of Finance, Crystal Park 1, Suite 802, Washington, D.C. 20231.

SUPPLEMENTARY INFORMATION: The Patent and Trademark Office (PTO) published a final rule in the **Federal Register** of July 24, 1998, that revised certain patent fee amounts for fiscal year 1999 (63 FR 39731). See also 63 FR 46891 (September 3, 1998) (correcting one of the fee amounts specified in the July 24, 1998 final rule). Since then, a continuing resolution appropriations bill was passed by the Congress and signed by the President on September 25, 1998. See H.J. Res. 128, P.L. 105–240 (1998). It maintains patent fees at their September 1998 (fiscal year 1998) rates through the period of the continuing resolution enacted on September 25, 1998, which expires October 9, 1998. The continuing resolution supersedes the July 24, 1998, final rule on revision of patent fees for fiscal year 1999. Accordingly, this notice delays the effective date of the final rule until October 10, 1998. Additional continuing resolutions could further extend the fiscal year 1998 fee rates into fiscal year 1999.

Legislation is still pending in the Congress to set new patent fees for fiscal year 1999. If an appropriations or authorization bill authorizing new patent fees is enacted prior to the expiration of a continuing resolution, it will supersede the continuing resolution. Patent customers should refer to the official PTO website (www.uspto.gov), or call the PTO General Information Services Division at (703) 308–4357 or (800) PTO–9199, for the most current fee amounts and information.

Dated: September 28, 1998.

Bruce A. Lehman,

Assistant Secretary of Commerce and Commissioner of Patents and Trademarks.

[FR Doc. 98–26428 Filed 9–30–98; 8:45 am]

BILLING CODE 3510–16–P

DEPARTMENT OF HEALTH AND HUMAN SERVICE

Health Care Financing Administration

42 CFR Parts 400, 403, 410, 411, 417, and 422

[HCFA–1030–CN]

RIN 0938–A129

Medicare Program; Establishment of the Medicare+Choice Program

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

ACTION: Correction of interim final rule with comment period.

SUMMARY: On June 26, 1998, we published in the **Federal Register**, at 63 FR 34968. an interim final rule with comment period that explains and implements those provisions of the Balanced Budget Act of 1997 that established the Medicare+Choice program. This notice corrects errors made in the June 26 document.

EFFECTIVE DATE: July 27, 1998.

FOR FURTHER INFORMATION CONTACT: Anthony Culotta (410) 786–4661.

SUPPLEMENTARY INFORMATION:

Background

In drafting **Federal Register** Document 98–16731, we attempted to avoid setting forth identical provisions in two CFR parts. Our plan was to replace certain existing provisions in part 417 with a cross-reference to identical (in effect, if not wording) provisions being established in part 422. In doing this, however, we inadvertently and incorrectly applied the marketing activity provisions of § 422.80 and the beneficiary appeals and grievance procedures of subpart M of part 422 to health maintenance organizations and competitive medical plans with contracts under section 1876 of the Social Security Act (the Act). This notice corrects this error by removing amendatory items 5, 10, and 11. Thus organizations with contracts under section 1876 of the Act remain subject to subpart K, which includes marketing, and subpart Q, which includes beneficiary appeals, of part 417.

In some cases, an M+C organization that has both a Medicare contract and a contract with an employer group health plan arranges for the employer to process election forms for Medicare-entitled group members who wish to enroll under the Medicare contract. However, there can be a delay between the time the beneficiary enrolls through the employer and he or she becomes entitled to receive services from the M+C organization, and when the election form is actually received by the M+C organization. The statute at section 1853(a)(2)(B) of the Act allows for adjustments in payment to account for these situations. We inadvertently failed to address this situation in the June 26, 1998, interim final rule. This notice corrects that by adding §§ 422.60(f) and 422.66(f), and revising § 422.250(b) to allow for adjustments in effective dates to conform with the payment adjustments.

We inadvertently omitted the statutory limitation at section 1854(a)(5)(A) of the Act on cost sharing for supplemental benefits offered by M+C private fee-for-service plans. Therefore, we are correcting § 422.308(b) by adding that, for supplemental benefits, the actuarial value of its cost-sharing may not exceed the amounts approved in the ACR for those benefits, as determined under § 422.310 on an annual basis. Also, to clarify that additional adjustments are not limited to a reduction in the adjusted community rate ''in addition'' was added to the beginning of the second sentence of § 422.310(c)(4).

In addition, we are also making a number of clarifying changes and technical corrections to paragraph designations and cross-references.

Correction of Errors

Preamble

1. On page 34984, in column 3, in the first full paragraph, in the ninth line, ''1854(h)(4)'' is corrected to read ''1851(h)(4)''.

2. On page 35011, in column 2, in the heading of section I.1, ''§ 422.500'' is corrected to read ''§ 422.400''.

3. On page 35012, in column 1, in the heading of section I.2, ''§ 422.502'' is corrected to read ''§ 422.402''.

4. On page 35034, in column 2, in the third full paragraph, in the 14th line, ''§ 422.58(d)(2)'' is corrected to read ''§ 422.62(b)''.

5. On page 35034, in column 3, 22 lines from the top of the column, ''§ 422.110(b)(2)(ii)'' is corrected to read ''§ 422.111(b)(2)(ii)''.

6. On page 35034, in column 3, in the heading of section D.1, ''§ 422.102'' is corrected to read ''§ 422.103''.

7. On page 35034, in column 3, in the first full paragraph, in the first line, ''§ 422.102'' is corrected to read ''§ 422.103''.

8. On page 35034, in column 3, in the first full paragraph, in the fifth line, ''§ 422.102(a)'' is corrected to read ''§ 422.103(a)''.

9. On page 35034, in column 3, in the second full paragraph, in the first line,

''§ 422.102(b)'' is corrected to read ''§ 422.103(b)''.

10. On page 35035, in column 1, in the first full paragraph, ''§ 422.102(c)'' is corrected to read ''§ 422.103(c)'' each time it appears (twice).

11. On page 35035, in column 3, in the heading of section D.2., ''422.103'' is corrected to read ''422.104''.

12. On page 35035, in column 3, in the first full paragraph, in the ninth line, ''§ 422.103(a)'' is corrected to read ''§ 422.104(a)''.

13. On page 35035, in column 3, in the first full paragraph, the reference to ''§ 422.103(a)(2)'' is corrected to read ''§ 422.104(b)'' each time it appears (twice).

14. On page 35036, in column 2, in the first full paragraph ''§ 422.154(b)(1)'' is corrected to read ''§ 422.154(c)''.

15. On page 35038, in column 2, in the first full paragraph, in the first line, ''§ 422.500(b)(2)'' is corrected to read ''§ 422.502(b)''.

16. On page 35062, in column 1, in the fourth full paragraph, ''but no later than 30 calendar days'' is corrected to read ''but no later than 14 calendar days''.

17. On page 35062, in column 1, the fourth full paragraph is corrected by adding the following sentence at the end: ''The M+C organization may extend the 14-day deadline by up to 14 calendar days if the enrollee requests the extension or if the organization justifies a need for additional information and how the delay is in the interest of the enrollee (for example, the receipt of additional medical evidence may change an M+C organization's decision to deny).''

18. On page 35062, in column 2, in the first full paragraph, ''using the 30-calendar-day timeframe'' is corrected to read ''using the 14 calendar-day timeframe''.

19. On page 35062, in column 2, in the fifth full paragraph, beginning in the fourth line, ''if the organization finds that it needs additional information and the delay'' is corrected to read ''if the organization justifies a need for additional information and how the delay''.

20. On page 35063, in column 1, in the third full paragraph, beginning in the second line, ''or a health care professional'' is corrected to read ''or a physician''.

21. On page 35063, in column 1, in the fourth full paragraph, the phrase ''the 45-day timeframe'' is corrected to read ''the 30-day timeframe'' each time it appears (twice).

22. On page 35063, in column 1, in the seventh full paragraph, ''If the M+C organization makes'' is corrected to read ''For service requests, if the M+C organization makes''.

23. On page 35063, in column 1, in the seventh full paragraph, ''but no later than 45 calendar days'' is corrected to read ''but no later than 30 calendar days''.

24. On page 35063, in column 1, the seventh full paragraph is corrected by adding a sentence after the end of the first sentence to read: ''The M+C organization may extend the 30-day deadline by up to 14 calendar days if the enrollee requests the extension or if the organization justifies a need for additional information and how the delay is in the interest of the enrollee.''

25. On page 35063, in column 1 and continuing into column 2, the eighth full paragraph that begins with ''If the M+C organization affirms, * * *'' and ends with ''to the independent entity'' is corrected to read: ''If the M+C organization affirms, in whole or in part, its adverse organization determination, it must prepare a written explanation and send the case file to the independent entity contracted by us no later than 30 calendar days from the date it receives the request for a standard reconsideration (or no later than the expiration of an extension described in § 422.590(a)(1)). The organization must make reasonable and diligent efforts to assist in gathering and forwarding information to the independent entity.''

26. On page 35063, in column 2, in the first full paragraph, beginning in the fifth line, ''or to obtain a good cause extension described in paragraph (e) of this section,'' is removed.

27. On page 35063, in column 2, in the second full paragraph, beginning in the fourth line, ''if the organization finds that it needs additional information and the delay'' is corrected to read ''if the organization justifies a need for additional information and how the delay''.

Regulations Text

1. On page 35065, in the third column, amendatory instruction ''2.'' is corrected to read as follows: ''In § 400.200, the definition for ''PRO'' is revised, the definition for ''Utilization and Quality Control Peer Review Organization'' is removed, and the following definitions are added in alphabetical order.''

2. On page 35066, in column 3 and continuing on page 35067, column 1, amendatory instruction 5 is removed.

3. On page 35067, in column 1, amendatory instructions 6, 7, 8, and 9 are renumbered as amendatory instructions 5, 6, 7, and 8, respectively.

4. On page 35067, renumbered amendatory instruction 6 is corrected to read as follows:

''Sections 417.520, 417.522, and 417.523 of subpart M are redesignated as §§ 422.550, 422.522, and 422.553, respectively, in a new subpart L in part 422, and the heading for the new subpart L to part 422 is added to read 'Effect of Change of Ownership or Leasing of Facilities During Term of Contract'.''

5. On page 35067, in column 1, amendatory instruction 10 is removed.

6. On page 35067, in column 2, amendatory instruction 11 is removed, and amendatory instruction 12 is renumbered as amendatory instruction 9.

§ 417.800 [Corrected]

7. On page 35067, in column 2, the definition of ''Health care prepayment plan'' is corrected to read as follows:

§ 417.800 Payment to HCPPS: Definitions and basic rules.

* * * * *

Health care prepayment plan (HCPP) means an organization that meets the following conditions:

(1) Effective January 1, 1999, (or on the effective date of the HCPP agreement in the case of a 1998 applicant) either—

(A) Is union or employer sponsored; or

(B) Does not provide, or arrange for the provision of, any inpatient hospital services.

(2) Is responsible for the organization, financing, and delivery of covered Part B services to a defined population on a prepayment basis.

(3) Meets the conditions specified in paragraph (b) of this section.

(4) Elects to be reimbursed on a reasonable cost basis.

* * * * *

8. On page 35071, in column 1, in the subpart heading, ''Subpart B'' is corrected to read ''Subpart B''.

§ 422.50 [Corrected]

9. In § 422.50 the following changes are made:

a. On page 35071, in the first column, in paragraph (a) introductory text, the first ''an'' is corrected to read ''An''.

b. On page 35071, in the first column, in paragraph (a)(1), the second appearance of ''may continue to be enrolled in the M+C organization'' is removed.

§ 422.54 [Corrected]

10. On page 35071, in the second column, in § 422.54, in paragraph (d)(2)(i), ''meet requirements'' is corrected to read ''meet the requirement''.

§ 422.56 [Corrected]

11. On page 35071, in the third column, in § 422.56, in paragraph (d), ''§ 422.103'' is corrected to read ''§ 422.104''.

§ 422.60 [Corrected]

12. In § 422.60, the following changes are made:

a. On page 35072, in the first column, in paragraph (a)(1), ''plan that M+C organization'' is corrected to read ''plan that the M+C organizaton''.

b. On the same page, in the same column, in paragraph (b)(1), ''§ 422.306(a)(2)'' is corrected to read ''§ 422.306(a)(1)''.

c. On the same page, in the same column, in paragraph (c)(1), in the second sentence, the word ''beneficiary'' is removed.

d. On the same page, in the second column, in paragraph (3)(4)(i), ''Promptly informs'' is corrected to read ''Informs''.

e. On the same page, in the second column, § 422.60 is further corrected by adding a new paragraph (f) to read as follows:

§ 422.60 Election process.

* * * * *

(f) *Exception for employer group health plans.* (1) In cases in which an M+C organization has both a Medicare contract and a contract with an employer group health plan, and in which the M+C organization arranges for the employer to process election forms for Medicare-entitled group members who wish to enroll under the Medicare contract, the effective date of the election may be up to, but may not exceed, 90 days before the date the M+C organization received the election from the employer. Any adjustment in effective date must conform with adjustments in payment, as described under § 422.250(b).

(2) In order to obtain the effective date described in paragraph (f)(1) of this section, the beneficiary must certify that, at the time of enrollment in the M+C organization, he or she received the disclosure statement specified in § 422.111.

(3) The M+C organization must submit the enrollment within 30 days from receipt of the election form from the employer.

§ 422.62 [Corrected]

13. In § 422.62, the following changes are made:

a. On page 35073, in the first column, in paragraph (b), introductory text, beginning in the second line, ''for M+C plans, and as of January 1, 2002, for all MSA other types of M+C MSA plans,'' is corrected to read ''for M+C MSA plans, and as of January 1, 2002, for all other types of M+C plans,''.

b. On the same page, in the same column, in paragraph (c), in the fifth line, ''coverage election'' is corrected to read ''enrollment''.

c. On the same page, in the second column, in paragraph (d), in the heading, ''M+C plans'' is corrected to read ''M+C MSA plans''.

d. On the same page, in the same column, in paragraph (d)(1), ''M+C plan'' is corrected to read ''M+C MSA plan''.

e. On the same page, in the same column, in paragraph (d)(2) introductory text, ''M+C plan'' is corrected to read ''M+C MSA plan''.

§ 422.66 [Corrected]

14. On page 35074, in the third column, § 422.66 is corrected by adding a new paragraph (f) to read as follows:

§ 422.66 Coordination of enrollment and disenrollment through M+C organizations.

(f) *Exception for employer group health plans.* (1) In cases when an M+C organization has both a Medicare contract and a contract with an employer group health plan, and when the M+C organization arranges for the employer to process election forms for Medicare-entitled group members who wish to disenroll from the Medicare contract, the effective date of the election may be up to, but may not exceed, 90 days before the date the M+C organization received the election from the employer. Any adjustment in effective date must conform with adjustments in payment, as described under § 422.250(b).

(2) The M+C organization must submit a disenrollment notice to NCFA within 15 days of receipt of the notice from the employer.

§ 422.74 [Corrected]

15. On page 35075, in the first column, in § 422.74, in paragraph (b)(3), ''reduces service'' is corrected to read ''reduces the service''.

§ 422.80 [Corrected]

16. In § 422.80, the following changes are made:

a. On page 35076, in the third column, in paragraph (c)(3) ''the organization'' is corrected to read ''the M+C organization''.

b. On the same page, in the same column, in paragraph (d) the word ''material'' is corrected to read ''materials''.

c. On the same page, in the same column, in paragraph (e)(1)(iv), in teh fourth line, ''organization, the'' is corrected to read ''organization. The''.

d. On page 35077, in the first column, in paragraph (e)(3)(i), ''Demonstrate the HCFA's'' is corrected to read ''Demonstrate to HCFA's''.

e. On the same page, in the same column, in paragraph (f), ''potions'' is corrected to read ''portions''.

§ 422.110 [Corrected]

17. On page 35079, in the third column, in § 422.110, in paragraph (c), ''(see § 422.501(h))'' is corrected to read ''(see § 422.502(h))''.

§ 422.112 [Corrected]

18. Beginning on page 35080, in the second column, in order to make numerous paragraph redesignations and other corrections, § 422.112 is corrected to read as follows:

§ 422.112 Access to services.

(a) *Rules for coordinated care plans and network M+C MSA plans.* An M+C organization that offers an M+C coordinated care plan or network M+C MSA plan may specify the networks of providers from whom enrollees may obtain services if the M+C organization ensures that all covered services, including additional or supplemental services contracted for by (or on behalf of) the Medicare enrollee, are available and accessible under the plan. To accomplish this, the M+C organization must meet the following requirements:

(1) *Provider network.* Maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to covered services to meet the needs of the population served. These providers are typically utilized in the network as primary care providers (PCPs), specialists, hospitals, skilled nursing facilities, home health agencies, ambulatory clinics, and other providers.

(2) *PCP panel.* Establish the panel of PCPs from which the enrollee selects a PCP.

(3) *Specialty care.* Provide or arrange for necessary specialty care, and in particular give women enrollees the option of direct access to a women's health specialist within the network for women's routine and preventive health care services provided as basic benefits (as defined in § 422.2) notwithstanding that the plan maintains a PCP or some other means for continuity of care.

(4) *Serious medical conditions.* Ensure that each plan has in effect HCFA-approved procedures that enable the plan to—

(i) Identify individuals with complex or serious medical conditions;

(ii) Assess those conditions, and use medical procedures to diagnose and monitor them on an ongoing basis; and

(iii) Establish and implement a treatment plan that—

(A) Is appropriate to those conditions;

(B) Includes an adequate number of direct access visits to specialists consistent with the treatment plan; and

(C) Is time-specific and updated periodically by the PCP.

(5) *Involuntary termination.* If the M+C organization terminates an M+C plan or any specialists for a reason other than for cause, the M+C organization must do the following:

(i) Inform beneficiaries, at the time of termination, of their right to maintain access to specialists.

(ii) Provide the names of other M+C plans in the area that contract with specialists of the beneficiary's choice.

(iii) Explain the process the beneficiary would need to follow should he or she decide to return to original Medicare.

(6) *Service area expansion.* If seeking a service area expansion for an M+C plan, demonstrate that the number and type of providers available to plan enrollees are sufficient to meet projected needs of the population to be served.

(7) *Credentialed providers.* Demonstrate to HCFA that its providers in an M+C plan are credentialed through the process set forth at § 422.204(a).

(8) *Written standards.* Establish written standards for the following:

(i) Timeliness of access to care and member services that meet or exceed standards established by HCFA. Timely access to care and member services within a plan's provider network must be continuously monitored to ensure compliance with these standards, and the M+C organization must take corrective action as necessary.

(ii) Policies and procedures (coverage rules, practice guidelines, payment policies, and utilization management) that allow for individual medical necessity determinations.

(iii) Provider consideration of beneficiary input into the provider's proposed treatment plan.

(9) *Hours of operation.* Ensure, for each M+C plan, that—

(i) The hours of operation of its M+C plan providers are convenient to the population served by the plan and do not discriminate against Medicare enrollees; and

(ii) The plan makes plan services available 24 hours a day, 7 days a week, when medically necessary.

(10) *Cultural considerations.* (i) Ensure that services are provided in a culturally competent manner to all enrollees, including those with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and physical or mental disabilities.

(ii) Provide coverage for emergency and urgent care services in accordance with paragraph (c) of this section.

(b) *Rules for all M+C organizations to ensure continuity of care.* The M+C organization must ensure continuity of care and integration of services through arrangements that include, but are not limited to the following—

(1) Use of a practitioner who is specifically designated as having primary responsibility for coordinating the enrollee's overall health care.

(2) Policies that specify whether services are coordinated by the enrollee's primary care practitioner or through some other means.

(3) An ongoing source of primary care, regardless of the mechanism adopted for coordination of services.

(4) Programs for coordination of plan services with community and social services generally available through contracting or noncontracting providers in the area served by the M+C plan, including nursing home and community-based services.

(5) Procedures to ensure that the M+C organization and its provider network have the information required for effective and continuous patient care and quality review, including procedures to ensure that—

(i) An initial assessment of each enrollee's health care needs is completed within 90 days of the effective date of enrollment;

(ii) Each provider, supplier, and practitioner furnishing services to enrollees maintains an enrollee health record in accordance with standards established by the M+C organization, taking into account professional standards; and

(iii) That there is appropriate and confidential exchange of information among provider network components.

(6) Procedures to ensure that enrollees are informed of specific health care needs that require follow-up and receive, as appropriate, training in self-care and other measures they may take to promote their own health; and

(7) Systems to address barriers to enrollee compliance with prescribed treatments or regimens.

(c) *Special rules for all M+C organizations for emergency and urgently needed services*—(1) *Coverage.* The M+C organization covers emergency and urgently needed services—

(i) Regardless of whether the services are obtained within or outside the organization; and

(ii) Without required prior authorization.

(2) *Financial Responsibility.* The M+C organization may not deny payment for a condition—

(i) That is an emergency medical condition as defined in § 422.2; or

(ii) For which a plan provider or other M+C organization representative instructs an enrollee to seek emergency services within or outside the plan.

(3) *Stabilized condition.* The physician treating the enrollee must decide when the enrollee may be considered stabilized for transfer or discharge, and that decision is binding on the M+C organization.

(4) *Limits on charges to enrollees.* For emergency services obtained outside the M+C plan's provider network, the organization may not charge the enrollee more than $50 or what it would charge the enrollee if he or she obtained the services through the organization, whichever is less.

19. On page 35090, in the third column, in § 422.250, paragraph (b) is corrected to read as follows:

§ 422.250 general provisions.

* * * * *

(b) *Adjustment of payments to reflect number of Medicare enrollees—(1) General rule.* HCFA adjusts payments retroactively to take into account any difference between the actual number of Medicare enrollees and the number on which it based an advance monthly payment.

(2) *Special rules for certain enrollees.* (i) Subject to paragraph (b)(2)(ii) of this section, HCFA may make adjustments, for a period (not to exceed 90 days) that begins when a beneficiary elects a group health plan (as defined in § 411.101 of this chapter) offered by an M+C organization, and ends when the beneficiary is enrolled in an M+C plan offered by the M+C organization.

(ii) HCFA does not make an adjustment unless the beneficiary certifies that, at the time of enrollment under the M+C plan, he or she received from the organization the disclosure statement specified in § 422.111.

* * * * *

§ 422.268 [Corrected]

20. On page 35093, in the third column, in § 422.268, in paragraph (b), in the third line, ''§§ 422.105'' is corrected to read ''§§ 422.109''.

§ 422.308 [Corrected]

21. In § 422.308 the following corrections are made:

a. On the same page, in the same column, the text of paragraph (b) is redesignated as paragraph (b)(1) and a new paragraph (b)(2) is added to read as follows:

§ 422.308 Limits on premiums and cost sharing amounts.

* * * * *

(b) * * *

(2) For supplemental benefits, the actuarial value of its cost-sharing may not exceed the amounts approved in the ACR for those benefits, as determined under § 422.310 on an annual basis.

* * * * *

§ 422.310 [Corrected]

22. On page 35096, in the second column, in § 422.310 (that section begins on page 35095), in paragraph (c)(4), ''component. Adjustments will be'' is corrected to read ''component. In addition, adjustments will be''.

§ 422.502 [Corrected]

23. In § 422.502, the following corrections are made:

a. On page 35100, in the third column, in paragraph (a)(2), ''§ 422.108'' is corrected to read ''§ 422.110''.

b. On the same page, in the same column, in paragraph (a)(3)(i), ''§ 422.100'' is corrected to read ''§ 422.101'', and ''§ 422.101'' is corrected to read ''§ 422.102''.

c. On page 35101, in the first column, in paragraph (a)(4), ''§ 422.110'' is corrected to read ''§ 422.111''.

d. On page 35103, in the second column, paragraph (m) is redesignated as paragraph (1)(4) and is corrected to read as follows:

§ 422.502 Contract provisions.

* * * * *

(l) * * *

(4) The CEO or CFO must certify that the information in its ACR submission is accurate and fully conforms to the requirements in § 422.310.

§ 422.550 [Corrected]

24. On page 35106, in the second column, amendatory instruction ''19. a.'' is corrected to read as follows:

a. In paragraph (b)(1), the following sentence is added at the end: ''The M+C organization must also provide updated financial information and a discussion of the financial and solvency impact of the change of ownership on the surviving organization.''

§ 422.608 [Corrected]

25. On page 35111, in the third column, in § 422.608, in the heading, the acronym ''(DAB)'' is corrected to read ''(the Board)'' and in the text ''DAB'' is corrected to read ''Board'' each time it appears (twice).

§ 422.612 [Corrected]

26. In § 422.612, the following corrections are made:

a. On page 35111, in the third column, in paragraph (a)(1) ''DAB'' is corrected to read ''Board''.

b. On the same page, in the same column, in the heading of paragraph (b), ''DAB'' is corrected to read ''Board''.

c. On the same page, in the same column, in the text of paragraph (b) introductory text, ''DAB'' is corrected to read ''Board''.

§ 422.616 [Corrected]

27. On page 35111, in the third column that continues on page 35112, in § 422.616(a), ''DAB'' is corrected to read ''Board''.

§ 422.620 [Corrected]

28. On page 35112, in the second column, in § 422.620, in paragraph (a), ''§ 422.112(b)'' is corrected to read ''§ 422.112(c)''.

§ 422.622 [Corrected]

29. On page 35112, in the third column, in § 422.622, in paragraph (c)(1)(i) ''§ 422.112(b)'' is corrected to read ''§ 422.112(c)'' each time it appears (twice).

§ 422.752 [Corrected]

30. On page 35115, in the second column, in § 422.752, in paragraph (a)(6), ''§ 422.204'' is corrected to read ''§ 422.206''.

(Catalog of Federal Domestic Assistance Program No. 93,773, Medicare—Hospital Insurance; and Program No. 93.766, Medicare—Supplementary Medical Insurance Program)

Dated: September 25, 1998.

Neil J. Stillman,

Deputy Assistant Secretary for Information Resources Management.

[FR Doc. 98–26242 Filed 9–30–98; 8:45 am]

BILLING CODE 4120–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 405, 412, and 413

[HCFA–1003–CN]

RIN 0938–AI22

Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 1999 Rates; Corrections

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

ACTION: Final rule; correction notice.

SUMMARY: In the July 31, 1998 issue of the **Federal Register** (63 FR 40594), we published a final rule revising the Medicare hospital inpatient prospective payment systems for operating costs and capital-related costs to implement applicable statutory requirements, including the Balanced Budget Act of 1997 (BBA), as well as changes arising from our continuing experience with the system. In addition, in the addendum to that final rule, we announced the amounts and factors for determining prospective payment rates for Medicare hospital inpatient services for operating costs and capital-related costs applicable to discharges occurring on or after October 1, 1998, and set forth rate-of-increases limits for hospitals and hospital units excluded from the prospective payment systems. This document corrects errors made in that document.

FOR FURTHER INFORMATION CONTACT: Shawn Braxton (410) 786–7292.

SUPPLEMENTARY INFORMATION: The July 31, 1998 final rule contained technical and typographical errors. Therefore, we are making the following corrections:

1. On page 40983, at the top of the page, the second column of the table is replaced with the following:

209
$8,400.32
$1,714.35
$5,914.51
$6,771.69
$7,628.87
$8,400.32

2. On page 40983, at the top of the page, the second footnote, the first line, the second parenthetical figure ''($2,048.86)'' is corrected to read ''($1,714.35)''.

3. On page 41019, in Table 1A—National Adjusted Operating Standardized Amounts, Labor/Nonlabor, the figure for Nonlabor-related share of the Large Urban Areas standardized amount ''1,313.41'' is corrected to read ''1,131.38''.

4. On page 41053, in Table 4A—Wage Index and Capital Geographic Adjustment Factor (GAF) for Urban Areas, the first set of columns, first column, tenth line from the bottom, the footnote number ''[2]'' (for Cincinnati, OH–KY–IN) is corrected to read ''[1]''.

5. On pages 41123, 41124, 41128, 41129, 41130, and 41131, in Appendix D—DRG Charts, the last graph titled—Costs and Payments by Length of Stay (Using Current Transfer Methodology), in the legend, the label ''Costs'' is corrected to read ''Payments'' and the label ''Payments'' is corrected to read ''Costs''.

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program; No. 93.773 Medicare—Hospital Insurance; and No. 93.774, Medicare—Supplementary Medical Insurance)