DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 401 and 405

[CMS–4064–RCN]

RIN 0938–AM73

Medicare Program; Changes to the Medicare Claims Appeal Procedures; Continuation of Effectiveness and Extension of Timeline for Publication of Final Rule

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

ACTION: Interim final rule; continuation of effectiveness and extension of timeline for publication of final rule.

SUMMARY: This notice announces the continuation of effectiveness of a Medicare interim final and the extension of the timeline for publication of the final rule. This notice is issued in accordance with section 1871(a)(3)(C) of the Social Security Act (the Act), which allows an interim final rule to remain in effect after the expiration of the timeline specified in section 1871(a)(3)(B) of the Act if prior to the expiration of the timeline, the Secretary publishes in the **Federal Register** a notice of continuation and explains the exceptional circumstances justifying the extension of the timeline for publishing a final rule.

DATES: *Effective Date:* February 29, 2008.

FOR FURTHER INFORMATION CONTACT: David Danek, (617) 565–2682, or Arrah Tabe-Bedward, (410) 786–7129.

SUPPLEMENTARY INFORMATION:

I. Background

Section 1871(a)(3)(A) of the Social Security Act (the Act) requires the Secretary, in consultation with the Director of the Office of Management and Budget (OMB), to establish and publish a regular timeline for the publication of a final rule based on the previous publication of a proposed rule or an interim final rule. In accordance with section 1871(a)(3)(B) of the Act, such regular timeline may vary among different regulations, based on the complexity of the rule, the number and scope of the comments received, and other relevant factors. The timeline for publishing the final regulation; however, cannot exceed 3 years from the date of publication of the proposed or interim final rule, unless there are exceptional circumstances. After consultation with the Director of OMB, we published a notice in the **Federal Register** on December 30, 2004 (69 FR 78442) establishing a general 3-year timeline for finalizing a Medicare proposed and an interim final rule.

Section 1871(a)(3)(C) of the Act states that a Medicare interim final rule shall not continue in effect if the final rule is not published before the expiration of the regular timeline, unless the Secretary publishes at the end of the regular timeline a notice of continuation that includes an explanation of why the regular timeline was not met. Upon publication of such a notice, the timeline for publishing the final rule is extended for 1 year.

II. Notice of Continuation

Section 521 of the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Benefits Improvement and Protection Act of 2000 (BIPA), amended section 1869 of the Act to provide for significant changes to the Medicare claims appeal procedures. On November 15, 2002, we published in the **Federal Register** a proposed rule (67 FR 69312) consistent with Section 521 of BIPA. An interim final rule with comment implementing the BIPA provisions as well as further changes to the claim appeals procedures enacted in Title IX of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) appeared in the **Federal Register** in March 2005 (70 FR 11420). Under the previously established regular timeline for publication of a final rule, we must publish a final rule responding to public comments on the interim final rule with comment period no later than March 1, 2008.

This notice announces an extension of the timeline for publication of the final rule and the continuation of effectiveness of the interim final rule with comment period. We are not able to meet the 3-year timeline for publication of the final rule due to the complexity of the rule and the need to ensure coordination with other government agencies. Specifically, the development of the final rule requires collaboration among other HHS agencies (that is, the Office of Medicare Hearings and Appeals (OMHA), and the Departmental Appeals Board (DAB), as well as extensive involvement from the HHS Office of the General Counsel). Although OMHA was not in existence when the interim final rule with comment period was published, OMHA is now a key component of the Medicare claims appeal process. We note that extensive coordination is needed to ensure that there is a mutual understanding of these provisions among all three affected administrative agencies. In addition, the development of the final rule requires significant coordination with other HHS policy related regulations (that is, the Provider Reimbursement Determinations and Appeals final rule and the Medicare Prescription Drug Appeals Process proposed rule (Part D proposed rule,)) which are currently under development.

We believe that an extension of the publication timeline is necessary and appropriate to ensure that we are able to address all of the issues raised in response to the interim final.

Therefore, this notice extends the timeline for publication of the final rule until March 1, 2009. In accordance with section 1871(a)(3)(C) of the Act, interim final rule shall remain in effect through March 1, 2009 (unless the final rule is published and becomes effective before March 1, 2009).

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

Dated: February 25, 2008.

Ann Agnew,

Executive Secretary to the Department.

[FR Doc. E8–3861 Filed 2–28–08; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 488

[CMS–2278–IFC4]

RIN 0938–AP22

Revisit User Fee Program for Medicare Survey and Certification Activities

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

ACTION: Interim final rule with comment period.

SUMMARY: This interim final rule with comment period implements the continuation of the revisit user fee program for Medicare Survey and Certification activities, in accordance with the statutory authority in the Continuing Appropriations Resolution entitled, ''Making further continuing appropriations for the fiscal year 2008, and for all other purposes,'' Public Law 110–149 (''Continuing Resolution'') signed into law on December 21, 2007. On September 19, 2007, we published a final rule that established a system of revisit user fees applicable to health

care facilities that have been cited for deficiencies during initial certification, recertification or substantiated complaint surveys and require a revisit to confirm that previously-identified deficiencies have been corrected.

DATES: *Effective date:* These regulations are effective February 29, 2008, and applicable beginning December 21, 2007.

Comment date: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on April 29, 2008.

ADDRESSES: In commenting, please refer to file code CMS–2278–IFC4. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (no duplicates, please):

1. *Electronically.* You may submit electronic comments on specific issues in this regulation to *http://www.cms.hhs.gov/eRulemaking.* Click on the link ''Submit electronic comments on CMS regulations with an open comment period.'' (Attachments should be in Microsoft Word, WordPerfect, or Excel; however, we prefer Microsoft Word.)

2. *By regular mail.* You may mail written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–2278–IFC3, P.O. Box 8010, Baltimore, MD 21244–8016.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments (one original and two copies) to the following address only: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–2278–IFC4, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to one of the following addresses. If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786–7195 in advance to schedule your arrival with one of our staff members: Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201; or 7500 Security Boulevard, Baltimore, MD 21244–1850.

(Because access to the interior of the HHH Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Kelley Tinsley, (410) 786–6664.

SUPPLEMENTARY INFORMATION:

Submitting Comments: As the public was provided an opportunity to comment on the substance of the rule during the comment period prior to the publication of the September 19, 2007 final rule, and as the substance of the rule is not changed by this interim final rule with comment period, we are accepting comments only to the extent that they pertain to the applicability of the new authority for the rule. You can assist us by referencing the file code CMS–2278–IFC3.

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: *http://www.cms.hhs.gov/eRulemaking.* Click on the link ''Electronic Comments on CMS Regulations'' on that Web site to view public comments.

Comments received timely will be available for public inspection as they are received, generally beginning approximately three weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

SUPPLEMENTARY INFORMATION:

I. Background

In the June 29, 2007 **Federal Register** (72 FR 35673), we published the proposed rule entitled, ''Establishment of Revisit User Fee Program for Medicare Survey and Certification Activities'' and provided for a 60-day comment period. In the September 19, 2007 **Federal Register** (72 FR 53628) we published the Revisit User Fee Program final rule. That final rule set forth final requirements and a final fee schedule for providers and suppliers who require a revisit survey as a result of deficiencies cited during an initial certification, recertification, or substantiated complaint survey.

The Centers for Medicare & Medicaid Services (CMS) has in place an outcome-oriented survey process that is designed to ensure that existing Medicare-certified providers and suppliers or providers and suppliers seeking initial Medicare certification, meet statutory and regulatory requirements, conditions of participation, or conditions for coverage. These health and safety requirements apply to the environments of care and the delivery of services to residents or patients served by these facilities and agencies. The Secretary of the Department of Health and Human Services (HHS) has designated CMS to enforce the conditions of participation/coverage and other requirements of the Medicare program. The revisit user fee will be assessed for revisits conducted in order to determine whether deficiencies cited as a result of failing to satisfy federal quality of care requirements have been corrected.

Pursuant to the requirements of the Continuing Appropriations Resolution budget bill for fiscal year (FY) 2007, the Secretary directed CMS to implement the revisit user fees for FY 2007 for certain providers and suppliers for which a revisit was required to confirm that previously-identified failures to meet federal quality of care requirements had been remedied. The fees recover the costs associated with the Medicare Survey and Certification program's revisit surveys. The primary purpose for implementing the revisit user fees is to ensure the continuance of CMS Survey and Certification quality assurance activities that improve patient care and safety. The fees became effective upon publication September 19, 2007, when the final rule was published.

II. Provisions of the Interim Final Rule

The current Continuing Resolution Public Law 110–149, amends Public Law 110–92 Division B by striking the date specified in section 106(3) and inserting 'December 31, 2007'. The current Continuing Resolution authorizes HHS to continue to impose

revisit user fees until December 31, 2007, as follows:

* * * * *

Sec. 101. Such amounts as may be necessary, at a rate for operations as provided in the applicable appropriations Acts for fiscal year 2007 and under the authority and conditions provided in such Acts, for continuing projects or activities (including the costs of direct loans and loan guarantees) that are not otherwise specifically provided for in this joint resolution, that were conducted in fiscal year 2007, and for which appropriations, funds, or other authority were made available in the following appropriations Acts:

* * * * *

(3) The Continuing Appropriations Resolution, 2007 (division B of Public Law 109–289, as amended by Public Law 110–5). *(H.J. Res. 20, § 101 (2007)).*

Sec. 106. Unless otherwise provided for in this joint resolution or in the applicable appropriations Act for fiscal year 2008, appropriations and funds made available and authority granted pursuant to this joint resolution shall be available until whichever of the following first occurs:

* * * * *

(3) December 31, 2007.

As directed by the Secretary, in the September 19, 2007 **Federal Register** (72 FR 53628), we established the revisit user fee program for revisit surveys. We put forth in regulation the relevant definitions, criteria for determining the fees, the fee schedule, procedures for the collection of fees, the reconsideration process, enforcement and regulatory language addressing enrollment and billing privileges, and provider agreements. In the September 19, 2007 final rule, cost projections were based on FY 2006 actual data and were expected to amount to $37.3 million for FY 2007. These calculations were included in section IV of the final rule (72 FR 53642).

We stated in the final rule that, ''if authority for the revisit user fee is continued, we will use the current fee schedule in [the final rule] for the assessment of such fees until such time as a new fee schedule notice is proposed and published in final form.'' (72 FR 53628). The current Continuing Resolution continues the authority of the FY 2007 Continuing Resolution from December 21, 2007 through December 31, 2007.

Due to the enactment of the Consolidated Appropriations Act, 2008, on December 26, 2007, the current Continuing Resolution will cease to be effective on December 26, 2007. The authority of the Consolidated Appropriations Act supersedes that of the current Continuing Resolution, therefore ending its effective date the day on which the Appropriations Act was signed. Accordingly, the revisit fees will continue to be assessed for the 5-day time period authorized by the current Continuing Resolution to begin December 21, 2007, and ending on the day the Consolidated Appropriations Act was signed by the President, December 26, 2007.

III. Response to Comments

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

IV. Waiver of Proposed Rulemaking and Delay in Effective Date

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment on the proposed rule in accordance with *5 U.S.C. 553*(b) of the Administrative Procedure Act (APA). The notice of proposed rulemaking includes a reference to the legal authority under which the rule is proposed, and the terms and substance of the proposed rule or a description of the subjects and issues involved. This procedure can be waived, however, if an agency finds good cause that a notice-and-comment procedure is impracticable, unnecessary, or contrary to the public interest and incorporates a statement of the finding and its reasons in the rule issued. We find that the notice-and-comment procedure is unnecessary in this circumstance because providers and suppliers have already been provided notice and an opportunity to comment on the substance of this rule. This interim final rule with comment merely updates the Congressional authority under which the rule operates.

Therefore, we find good cause to waive the notice of proposed rulemaking and to issue this final rule on an interim basis. We are providing a 60-day public comment period.

We ordinarily provide a 30-day delay in the effective date of the provisions of a rule in accordance with the Administrative Procedure Act (APA), 5 U.S.C. 553(d). However, the delay in the effective date may be waived as, in pertinent part, ''provided by the agency for good cause found and published with the rule.'' 5 U.S.C. 553(d)(3). The Secretary finds that good cause exists to waive the 30-day effective date delay.

The good cause exception to the 30-day effective date delay provision of section 553(d) of the APA is read to be broader than the good cause exception to the notice and comment provision of section 553(b) of the APA.

The legislative history of the APA indicates that the purpose for deferring the effectiveness of a rule under section 553(d) was to ''afford persons affected a reasonable time to prepare for the effective date of a rule or rules or to take other action which the issuance may prompt.'' S. Rep. No. 752, 79th Cong., 1st Sess. 15 (1946); H.R. Rep. No. 1980, 79th Cong. 2d Sess. 25 (1946). In this case, affected parties do not need time to adjust their behavior before this rule takes effect. This rule merely updates the authority under which the revisit fee is assessed and does not provide any additional requirements for the affected parties. Moreover, with or without a revisit fee, a provider or supplier must be found to have corrected significant deficiencies in order to avoid termination. Additionally, the application of a fee for the revisit does not place appreciable administrative burdens on the affected providers or suppliers. We do not expect appreciable cost to State survey agencies because we are undertaking the billing and collection of the revisit user fee.

We identified in the September 19, 2007 final rule the immediacy of this revisit user fee program and the specific statutory requirement contained limited in the Continuing Resolution that required us to implement the revisit user fee program in FY 2007. Accordingly, providers and suppliers have been on notice for some time that these fees will be imposed, and do not need additional time to be prepared to comply with the requirements of this regulation. We believe that given the short timeframe that we have to collect fees before the statutory authority of the current Continuing Resolution expires, there is good cause to waive the 30-day effective date.

V. Collection of Information Requirements

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.

VI. Regulatory Impact Analysis

A. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19,

1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

Executive Order 12866 (as amended by Executive Order 13258, which merely reassigns responsibility of duties) 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). This rule is not a major rule. The aggregate costs will total approximately $37.3 million in any 1 year.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Individuals and States are not included in the definition of a small entity. Small businesses are small entities, either by nonprofit status or by having revenues of $6.5 million to $31.9 million or less in any one year for purposes of the RFA. The September 19, 2007 final rule provided an analysis on the impact of small entities (72 FR 53642–3). The analysis published in the final rule remains valid. Since this interim final rule with comment merely updates the Congressional authority under which the rule operates, we have determined that this rule will not have a significant impact on small entities based on the overall effect on revenues.

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 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area (superseded by Core Based Statistical Areas) and has fewer than 100 beds. This rule affects those small rural hospitals that have been cited for a deficiency based on noncompliance with required conditions of participation and for which a revisit is needed to ensure that the deficiency has been corrected. We identified in the September 19, 2007 final rule that for the effective period of that rule that less than 3 percent of all hospitals may be assessed a revisit user fee and that less than 1 percent of those hospitals would be rural hospitals (72 FR 53643). The analysis published in the final rule remains valid. Since this interim final rule with comment merely updates the Congressional authority under which the rule operates, we maintain that this rule will not have a significant impact on small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any one year of $100 million in 1995 dollars, updated annually for inflation. That threshold level is currently approximately $120 million. This interim final rule with comment will have no mandated effect on State, local, or tribal governments and the impact on the private sector is estimated to be less than $120 million and will only affect those Medicare providers or suppliers for which a revisit user fee is assessed based on the need to conduct a revisit survey to ensure deficient practices that were cited have been corrected.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. This interim final rule with comment will not substantially affect State or local governments. This rule establishes user fees for providers and suppliers for which CMS has identified deficient practices and requires a revisit to assure that corrections have been made. Therefore, we have determined that this interim final rule with comment will not have a significant effect on the rights, roles, and responsibilities of State or local governments.

B. Impact on Providers/Suppliers

There is no change on the impact on providers and suppliers with the publication of this interim final rule with comment. The impact remains as discussed in the final rule (72 FR 53643).

Final Fee Schedule for Onsite and Offsite Revisit Surveys

The FY 2007 fee schedule published on September 19, 2007 (72 FR 53647) in the final rule will be retained. As noted in the final rule, the published fee schedule will be used by CMS for the assessment of fees until a new fee schedule is proposed and published in final form. The calculations used to determine the fee as identified in the final rule will be the same (72 FR 53645–6). We will continue to assess a flat fee based on provider or supplier type and type of revisit survey conducted. Table A below identifies the final fee schedule.

TABLE A.—FINAL FEE SCHEDULE

Facility	Fee assessed per offsite revisit survey	Fee assessed per onsite revisit survey
SNF & NF	$168	$2,072
Hospitals	168	2,554
HHA	168	1,613
Hospice	168	1,736
ASC	168	1,669
RHC	168	851
ESRD	168	1,490

Costs for All Revisit User Fees Assessed

We anticipated that the combined costs for all providers and suppliers for all revisit surveys in FY 2007 would total approximately $37.3 million on an annual basis, with onsite revisit surveys amounting to approximately $34.6 million and offsite revisit surveys totaling approximately $2.7 million. (72 FR 53645). However, actual fees assessed in FY 2007 were much less than this amount, since CMS did not charge for revisits that occurred prior to publication of the final regulation. Since we continue to operate under this same estimate for FY 07, we provide below monthly estimates of the impact for the period of the current Continuing Resolution in Tables B and C. For the period of the current Continuing Resolution, we will use the FY 2007 fee schedule established in the final rule for the assessment of fees until a new fee schedule notice is proposed and published as final.

In Table B below, we provide the projected costs for the period of this current Continuing Resolution based on the fee schedule of the final rule. We expect the combined costs for all providers and suppliers for all onsite revisit surveys for the period of this current Continuing Resolution to total approximately $473,503 thousand. We first multiplied the total number of onsite revisit surveys in one year by the expected revisit user fees assessed per revisits as finalized in Table A above, estimated by provider or supplier, to obtain the annual cost of revisit surveys. We then divided this number by 365 to obtain the daily cost per provider or supplier of onsite revisit surveys. To obtain the total costs for onsite revisit surveys for the effective period of the current Continuing Resolution (5 days), we then took the daily cost and multiplied it by 5. Finally, to achieve

the total costs for all onsite revisit surveys for the period of this current Continuing Resolution, we totaled all providers and suppliers.

TABLE B.—ONSITE REVISIT SURVEYS—ESTIMATED 5 DAY COSTS

Facility	Number of onsite revisit surveys (FY 2006)	Fee assessed per onsite revisit surveys (hrs × $112)	Number of onsite revisit surveys est. for 5 days*	5 day costs for onsite revisit surveys**
SNF & NF	14,288	$2,072	198	$ 405,544
Hospitals	575	2,554	8	20,117
HHA	1,068	1,613	15	23,598
Hospice	256	1,736	4	6,087
ASC	95	1,669	1	2,171
RHC	149	851	2	1,737
ESRD	698	1,490	10	14,246
Total	17,129	.....	238	473,500

*Estimated total numbers of onsite revisit surveys for 5 days were rounded up after dividing yearly survey totals from FY 2006 actual data by 365 and multiplying that number by 5.
**5 day costs may differ from the multiple of 5 day revisits and fee per revisit due to rounding.

We expect the combined costs for all providers and suppliers for all offsite revisit surveys to total $37,684 for the period of the current Continuing Resolution. In Table C below, we first estimated by provider or supplier the number of offsite revisit surveys expected for an entire fiscal year, and multiplied this number by the expected revisit user fee of $168 per offsite revisit survey to obtain the annual cost of surveys. We then divided this number by 365 to obtain the daily cost of offsite revisit surveys. To obtain the total costs for offsite revisit surveys for the period of the current Continuing Resolution (5 days), we then took the daily cost and multiplied it by 5. Finally, to achieve the total costs for all offsite revisit surveys for the period of this current Continuing Resolution, we totaled all providers and suppliers.

TABLE C.—OFFSITE REVISIT SURVEYS—ESTIMATED 5 DAY COSTS

Facility	Number of offsite revisit surveys (FY 2006)	Fee assessed per offsite revisit survey ($112 × 1.5 hrs)	Number of offsite revisit surveys est. for 5 days*	5 day costs for offsite revisit surveys**
SNF & NF	15,138	$168	207	$34,838
Hospitals	278	168	4	640
HHA	517	168	1	1,190
Hospice	51	168	1	117
ASC	93	168	1	214
RHC	67	168	1	154
ESRD	231	168	3	531
Total	16,375	.....	224	37,684

*Estimated total numbers of offsite revisit surveys for 5 days were rounded up after dividing yearly survey totals from FY 2006 actual data by 365 and multiplying that number by 5.
**5 day costs may differ from the multiple of 5 day revisits and fee per revisit due to rounding.

As shown in Table D below, we provide the aggregate costs expected as projected for the entire FY 2007, as well as the costs we would expect to offset for the period of the current Continuing Resolution.

TABLE D.—TOTAL COSTS COMBINED FOR ALL REVISITS SURVEYS PER FISCAL YEAR & PERIOD OF CR

	FY 2007	Period of CR*
Onsite Revisit Surveys	$34,565,760	$473,503
Offsite Revisit Surveys	2,751,000	37,684
Total Costs All Revisits	37,316,760	511,187

*CR period's costs are based on CR period revisit surveys rounded up to the nearest whole number as shown in Tables B & C.

E. Alternatives Considered

We considered a number of alternatives to the revisit user fee program. Such alternatives were discussed in the final rule published on September 19, 2007 (72 FR 53647). We affirm the continuing validity of that analysis. The current Continuing Resolution provides CMS with the authority to continue projects or activities as was otherwise provided for in FY 2007, and as such CMS is required to publish an interim final rule with comment. This interim final rule with comment merely updates the

Congressional authority under which the rule operates.

In accordance with Executive Order 12866, this rule was not reviewed by the Office of Management and Budget.

List of Subjects in 42 CFR Part 488

Administrative practice and procedure, Health facilities, Medicare, Reporting and recording requirements.

■ For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR chapter IV, part 488 as set forth below:

PART 488—SURVEY, CERTIFICATION, AND ENFORCEMENT PROCEDURES

■ 1. The authority citation for part 488 is revised to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act, unless otherwise noted (42 U.S.C. 1302 and 1395(hh)); Continuing Resolution Pub. L. 110–149 H.J. Res. 72.

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

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

Dated: January 30, 2008.

Kerry Weems,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: February 14, 2008.

Michael O. Leavitt,

Secretary.

[FR Doc. E8–3830 Filed 2–28–08; 8:45 am]

BILLING CODE 4120–01–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 76

[MM Docket No. 92–264; FCC 07–219]

The Commission's Cable Horizontal and Vertical Ownership Limits

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: This document adopts a rule prohibiting cable operators from owning or having an attributable interest in cable systems serving more than 30 percent of multichannel video programming subscribers nationwide. It also eliminates the overbuilder exception, which allowed cable operators to count against its horizontal limit only those cable subscribers served by its ''incumbent cable franchises'' and excluding new subscribers gained through overbuilding ''non-incumbent cable systems. Elimination of the exception prevents a cable operator near the horizontal limit from using the exception to exceed the 30 percent limit and thereby reduce the open field below the 70 percent necessary to ensure that no single operator can, by simply refusing to carry a video network, cause it to fail. The revised rule balances the need to ensure that cable operators cannot use their dominant position in the multichannel video programming distribution (MVPD) market to impede unfairly the flow of video programming to consumers with consideration of the efficiencies and other benefits that might be gained through increased ownership or control.

DATES: Effective March 31, 2008.

FOR FURTHER INFORMATION CONTACT: Elvis Stumbergs, (202) 418–7878; Mania Baghdadi, (202) 418–2330.

SUPPLEMENTARY INFORMATION: This is a summary of the Federal Communications Commission's *Fourth Report and Order* in MB Docket No. 92–264, FCC 07–219, adopted December 18, 2007, and released February 11, 2008. The full text of this document is available for public inspection and copying during regular business hours in the FCC Reference Center, Federal Communications Commission, 445 12th Street, SW., CY–A257, Washington, DC 20554. These documents will also be available via ECFS (*http://www.fcc.gov/cgb/ecfs*). The complete text may be purchased from the Commission's copy contractor, 445 12th Street, SW., Room CY–B402, Washington, DC 20554. To request this document in accessible formats (computer diskettes, large print, audio recording and Braille), send an e-mail to *fcc504@fcc.gov* or call the FCC's Consumer and Governmental Affairs Bureau at (202) 418–0530 (voice) (202) 418–0432 (TTY).

Summary of the Report and Order

1. This *Order* was adopted pursuant to Section 613(f)(1)(A) of the Telecommunications Act of 1996 (''1996 Act''), which requires the Commission to prescribe rules and regulations establishing reasonable limits on the number of cable subscribers a person is authorized to reach through cable systems owned by such person, or in which such person has an attributable interest, and to respond to the concerns of the United States Court of Appeals for the District of Columbia Circuit in *Time Warner Entertainment Co.* v. *FCC* (''*Time Warner II*'') that the Commission had failed adequately to justify the 30 percent limit.

2. The court in *Time Warner II* held that Section 613(f) authorizes the Commission to set a limit to ensure that no single company could be in a position single-handedly to deal a programmer a death blow but does not authorize the agency to regulate the legitimate, independent editorial choices of multiple MSOs and further found that the Commission lacked evidence that cable operators would collude and that the Commission could not simply assume that cable operators would coordinate their behavior in an anticompetitive manner.

3. The *Report and Order* establishes a 30% cable horizontal ownership limit by relying on a modified ''open field'' approach to ensure that no single cable operator becomes so large that a programming network can survive only if that operator carries it and eliminates the overbuilder exception to the calculation of the limit.

4. The Commission considered comments it had received relative to three possible approaches to use in fashioning a horizontal ownership limit: (1) The open field approach, which examines whether one or more cable operators are large enough to effectively limit the viability of a programming network if they denied it carriage; (2) monopsony theory, which considers whether a cable operator has sufficient market power to restrict the price it pays for programming by purchasing less of it and thereby restrict the flow of programming to subscribers; and (3) bargaining theory, which examines the negotiations between the programming network and the cable operator in order to determine the point at which programmers will curtail their activities and thereby limit the quality and diversity of programming.

5. We determine that the open field approach, suitably modified, represents the best method of determining an appropriate horizontal limit. We determine that monopsony theory does not apply to this market because of the lack of a single market price in the market for programming. Although we find that bargaining theory is useful in establishing the need for a limit, the record is insufficient to derive a specific limit using this theory.

6. The open field approach determines whether a programming network would have access to alternative MVPDs of sufficient size to allow it to successfully enter the market, if it were denied carriage by one or more of the largest cable operators.

7. To calculate a horizontal limit that meets this test, we first determine the minimum number of subscribers a network needs in order to survive in the marketplace and then estimate the percentage of subscribers a network is