CAS No.	Substance	Special exemptions	Effective date	Sunset date
* * * * * * *				
	Dicylcopentadiene	77-73-6	§ 716.20(b)(3) and (b)(4) apply	8/4/95	8/4/05
	Dimethyl acetamide	127-19-5	§ 716.20(b)(3) and (b)(4) apply	8/4/95	8/4/05
* * * * * * *				
	Dimethylaniline	121-69-7	§ 716.20(b)(3) and (b)(4) apply	8/4/95	8/4/05
	Methyl isoamyl ketone	110-12-3	§ 716.20(b)(3) and (b)(4) apply	8/4/95	8/4/05
	m-Nitrotoluene	99-08-1	§ 716.20(b)(3) and (b)(4) apply	8/4/95	8/4/05
	p-Nitrotoluene	99-99-0	§ 716.20(b)(3) and (b)(4) apply	8/4/95	8/4/05
	Vinylidene chloride	75-35-4	§ 716.20(b)(3) and (b)(4) apply	8/4/95	8/4/05
* * * * * * *				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Part 417

[OMC–022–F]

Full Reporting by Health Maintenance Organizations (HMOs) and Competitive Medical Plans (CMPs) Paid on a Cost Basis

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

ACTION: Final rule.

SUMMARY: This rule affects HMOs and CMPs that contract with HCFA to furnish services to Medicare beneficiaries and be paid on a cost basis. It requires a cost HMO or CMP to include in its cost report the costs of hospital and skilled nursing facility (SNF) services even if it has elected (under § 417.532(c) of the HCFA regulations) to have HCFA's intermediary process those claims and pay the hospital or SNF directly.

This change is necessary so that HCFA can determine and compare the cost of all services furnished by HMOs and CMPs with the cost of equivalent services paid for under the fee-for-service system.

This rule also adds a definition and makes technical changes to clarify and update certain related provisions of subparts O and U of part 417 of the HCFA rules.

DATES: Effective Date: This rule is effective August 4, 1995.

FOR FURTHER INFORMATION CONTACT: Alfred D'Alberto, (410) 966–7610.

SUPPLEMENTARY INFORMATION:

I. Notice of Proposed Rulemaking

On February 22, 1994, we published a proposed rule (at 59 FR 8435) that would establish—

- Presumptive limits on Medicare payments to cost HMOs and CMPs and to health care prepayment plans (HCPPs) that furnish inpatient hospital services;
- An exception process under which an affected HMO, CMP or HCPP could demonstrate that payment above the presumptive limit is justified as ''reasonable'' because of the special needs of its Medicare enrollees, or because of extraordinary circumstances beyond its control; and
- Criteria for the ''reasonableness'' of the costs of HCPPs that do not furnish inpatient hospital services.

The rule also proposed to require cost HMOs and CMPs to include in their cost reports the costs of hospital and SNF services that the HMO or CMP elects to have paid by the Medicare intermediary, and to make a number of technical changes.

Under this election, although HCFA intermediaries process and pay claims, the HMO or CMP authorizes the services and retains responsibility for coordinating those services with other services it furnishes to Medicare enrollees.

Although section 1876(b)(4)(A) of the Act requires that the HMO or CMP report its ''per capita incurred cost'', HMOs and CMPs currently report only the deductibles and coinsurance they incur for the hospital and SNF services and not the full costs paid directly by the Medicare intermediary.

II. Public Comments

We received 60 letters of comment on the February 22 proposals. Seven of those letters commented on the full reporting and one on the technical changes. Careful consideration of the bulk of the comments and of the very complex exception process will delay publication of a final rule on payment limits. We have, therefore, separated those portions of the proposal that pertain to full reporting and technical changes, which need not be subjected to that delay. Those comments are discussed under part III of this preamble.

III. Discussion of Comments

A. Full Reporting

This new requirement applies only to HMOs and CMPs, because HCFA contracts with HCPPs cover only Part B services, not provider services.

Comment: All seven commenters recommended that full reporting not be required or that implementation be delayed. They expressed concern about—

- Obtaining from HCFA and its intermediaries complete and adequate information on a timely basis;
- The additional time, staff, and systems enhancement that would be required;
- The need to reimburse the HMO or CMP for these additional administrative costs.

They noted specifically the need to—

- Relate HCFA data to plan data so as to match beneficiary number, date of service, place of service and deductible and coinsurance;
- Summarize deductible and coinsurance amounts;
- Identify beneficiary status in terms of institutionalized, Medicaid-eligible, or ESRD;
- Estimate the value of incurred but not reported claims.

One commenter specifically objected to having intermediary-paid part A costs included because administrative and general (A & G) costs attributed to those services are not reimbursable to cost HMOs and CMPs.

One commenter asked whether we would expect them to include items that are not considered in the DRG computations, and if so, where they would get the data.

Response: We are providing lead time before the full reporting requirement goes into effect. During that time, we will be working to achieve the most efficient, least burdensome procedures for handling the data. Comments and recommendations from HMOs and CMPs can be useful for improving HCFA reports and minimizing systems problems. The additional administrative costs incurred because of full reporting are allowable.

We recognize that, under full reporting, there may be some reduction in payments to HMOs and CMPs. This reduction would involve service-related A & G costs only, and only a small percentage of these costs. Service-related A & G costs are generally allocated on the basis of direct identification, functional allocation, or pooling. To the extent service-related A & G costs cannot be allocated to a specific service, they are allocated to services based upon a given service's percentage of the total service costs included on the HMO's or CMP's cost report. It is this small portion of A & G costs that could be affected by full cost reporting. The inclusion of hospital and SNF services in the cost report would result in a larger portion of this category of pool A & G costs being allocated to those services. This, in turn, would result in lower payment, because the amount already paid directly to a hospital or SNF for the services they provide would constitute payment in full for those services, and any pool A & G costs allocated to those services would be disallowed. Because the portion of service-related A & G costs that could be affected in this manner is small, however, we do not anticipate that there would be a significant reduction in payments to the HMO or CMP.

With respect to the last question noted above, we would expect the report to reflect the full cost incurred by the hospital or SNF, including such things as day and cost outliers, pass throughs, graduate medical education, etc. Part of our effort during the lead time will be to ensure that we can provide accurate information on these as well as other pertinent costs.

The fact is that, without full reporting, there is no way to determine the full actual cost of services furnished by cost HMOs and CMPs and how that cost compares with the cost of the same services furnished under the fee-for-service system.

Comment: Two commenters contended that full reporting is in conflict with generally accepted accounting principles (GAAP) and with certain statements of the Financial Accounting Standards Board (the Board).

Noted as an Example: When the intermediary pays a provider, for the HMO or CMP there is no inflow or outflow of assets.

Accordingly, the transaction does not meet the Board's definition of revenue and expense.

Response: The basic rule is that HCFA pays the HMO or CMP all the allowable costs it incurs to furnish covered services to its Medicare enrollees. By law and under the contract, the HMO or CMP is required to provide or arrange for all Medicare-covered services that are generally available in the area it serves. The fact that the HMO or the CMP elects to have HCFA process and pay provider claims does not—

- Relieve it of the responsibility for furnishing provider services when necessary and appropriate; or
- Change the fact that the sums paid by the intermediary are part of the cost of providing Medicare services through an HMO or CMP.

Comment: One commenter argued that full reporting was not supported by current laws and regulations, and others contended that the amounts referred to in section 1876(b)(2) (A) and (B) of the Act and the implementing regulations (§ 417.532(g) of the HCFA rules) are in fact an actuarial projection of the average cost of Medicare covered services, and an actuarial value of the intermediary's payments.

Response: We find support for the requirement in the following provisions of the statute and regulations:

a. Section 1876(h)(4) of the Act provides that under a cost contract, the Secretary must require the HMO or CMP to report ''* * * its per capita incurred cost * * * for providing services described in subsection (a)(1) * * *'' (The services referred to in (a)(1) are all the covered services available to Medicare beneficiaries in the area served by the HMO or CMP.)

b. Section 1876(h)(2)(A) allows the HMO or CMP to elect to have HCFA pay for provider services. Section 1876(h)(2)(B) provides that the amounts paid under the election shall be deducted from the payment that would otherwise be made to the HMO or CMP * * * for the allowable costs of all Medicare-covered services.

These statutory provisions are reflected in § 417.532 of the regulations. The distinction between actuarial values and actual payment amounts is clear from a comparison between § 417.532(c)(3) and § 417.532(g). The first provides for deducting, from the reasonable cost actually incurred by the HMO or CMP, ''an *amount* equal to the

actuarial value * * * of *deductible* and *coinsurance* amounts that would have applied * * * if these enrollees had not enrolled in this or another HMO or CMP.''

Section 417.532(g) states, in part, that ''HCFA will deduct these *payments* * * * in computing the payments to the HMO or CMP''.

Over the years there have been discussions about how to handle these payments within the Medicare program budgeting. There has never been any doubt that these are actual payment amounts and not actuarial representations.

Comment: Two commenters considered that the current cost report form is not adequate for full reporting.

Response: As noted above, we want to ensure the most efficient and least burdensome procedures for full reporting. This will probably require changes in the form, to be worked out during the lead time.

Comment: One commenter thought that including intermediary payments in the cost report might require the auditor that certifies the report to extend its testing procedures to include the intermediaries.

Response: This will not be necessary. The auditor will certify that the amounts reported as paid by the intermediary are part of the HMO's or CMP's incurred costs.

B. Technical Amendments

1. *Comment:* Three commenters inferred, from our proposed revision of § 417.800(c), that we intended to change our current policy of paying 100 percent of reasonable costs for services for which beneficiaries are not liable for coinsurance.

Response: That was not our intent. We have revised paragraph (c)(2)(ii) to clearly state that coinsurance is deducted only for services that are subject to coinsurance.

2. *Other changes.* We have incorporated the proposed definition of ''furnished'', and removed obsolete provisions that applied only to contract periods that began before January 1986.

C. Changes in the Regulations

1. *Definitions.* In § 417.1, we added a definition of ''furnished'' to make clear that, in part 417, the term means made a available by the HMO, CMP, or HCPP either directly or under arrangements it makes with other entities.

2. *Full reporting.* We have amended § 417.576 to make clear that the incurred per capita costs in the cost report must include the costs paid by the Medicare intermediary.

3. *Deductions from HCPP reasonable costs.* In § 417.800, we have revised paragraph (c)(2) to make clear that the 20 percent deduction from the reasonable costs incurred by the HCPP applies only to services that are subject to coinsurance.

4. *Obsolete provisions.* We have removed the following paragraphs and sections that applied to contract periods that began before January 1986:

- Paragraph (b) of § 417.546 (Physician services and other Part B services furnished under arrangements), and the Editorial note at the end of the section.
- Paragraph (d)(2) of § 417.560 (Apportionment: Part B physician and supplier services).
- All of § 417.562 (Weighting of direct services furnished by physicians and other practitioners).

D. Other Required Information

1. Information Collection Requirements

Section 417.576 requires ''full reporting'' as discussed under part D of this preamble. This requirement is subject to review by the Office of Management and Budget under the Paperwork Reduction Act of 1980, and has been submitted for their review. The time required for compiling and processing the information and completing the report with the additional costs is estimated to be 180 hours per year.

2. Regulatory Impact Statement

Consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612), we prepare a regulatory flexibility analysis unless the Secretary certifies that a rule will not have a significant economic impact on a substantial number of small entities. We consider all HMOs and CMPs that contract with us to furnish services to Medicare beneficiaries on a cost basis to be small entities.

In addition, under section 1102(b) of the Act, the Secretary is required to prepare a regulatory impact analysis if a rule may have a significant impact on the operation 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 small rural hospital as a hospital that has fewer than 50 beds and is not located in a Metropolitan Statistical Area.

This final rule requires HMOs and CMPs paid on a cost basis to include in their cost reports the costs of hospital and SNF services even if a Medicare intermediary processes those claims and makes payments directly to the hospital or SNF. There are approximately 25 HMOs and CMPs that have elected to have the Medicare intermediaries pay for these services. As noted earlier in this preamble, we believe that payments to these HMOs and CMPs will not be reduced significantly because of the statutory limits on the A & G costs related to inpatient hospital and SNF care paid by Medicare intermediaries.

The lead time before implementation of the full reporting requirement will enable HCFA and the affected HMOs and CMPs to work out the most efficient, least burdensome, procedures for handling these additional data. The additional costs incurred by the HMOs and CMPs for full reporting are allowable costs.

We have not prepared a regulatory flexibility analysis because we have determined, and the Secretary certifies that this final rule will not have a significant economic impact on a substantial number of small entities or a significant impact on the operations of a substantial number of small rural hospitals.

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

List of Subjects in 42 CFR Part 417

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

42 CFR part 417 is amended as set forth below.

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

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

2. In § 417.1, the following definition is added, in alphabetical order:

* * * * *

Furnished, when used in connection with prepaid health care services, means services that are made available to an enrollee either directly by, or under arrangements made by, the HMO, CMP, or HCPP.

* * * * *

§ 417.546 [Amended]

3. In § 417.546, the following changes are made:

a. Paragraph (b) and the Editorial note are removed.

b. In paragraph (a), the ''(a)'' designation is removed, and the ''(1)''

and (''2'') designations are changed to ''(a)'' and ''(b)'', respectively.

§ 417.560 [Amended]

4. In § 417.560, the following changes are made:

a. Paragraph (d)(2) is removed.

b. In paragraph (d)(1), the designation ''(1)'', and the clause ''Except as provided in paragraph (d)(2) of this section,'' are removed, and the word ''the'', preceding ''Medicare share'' is revised to read ''The''.

§ 417.562 [Removed]

5. § 417.562 is removed.

6. In § 417.576, paragraph (b)(2)(i) is revised to read as follows:

§ 417.576 Final settlement.

* * * * *

(b) * * *

(2) *Content of cost report.* The cost report and supporting documents must include the following:

(i) The per capita costs incurred in furnishing covered services to its Medicare enrollees, determined in accordance with subpart O of this part and including—

(A) The costs incurred by entities related to the HMO or CMP by common ownership or control; and

(B) For reports for cost-reporting periods that begin on or after January 1, 1996, the costs of hospital and SNF services paid by Medicare's intermediaries under the option provided by § 417.532(d).

* * * * *

7. § 417.800 is amended to revise the heading and paragraph (c)(2) to read as follows:

§ 417.800 Payment to HCPPs: Definitions and basic rules.

* * * * *

(c) *Payment of reasonable cost.* * * *

(2) *Payment for Part B services: Basic rules*—(i) *Cost basis payment.* Except as provided in paragraph (d) of this section, HCFA pays an HCPP on the basis of the reasonable costs it incurs, as specified in subpart O of this part, for the covered Part B services furnished to its Medicare enrollees.

(ii) *Deductions.* In determining the amount due an HCPP for covered Part B services furnished to its Medicare enrollees, HCFA deducts, from the reasonable cost actually incurred by the HCPP, the following:

(A) The actuarial value of the Part B deductible.

(B) An amount equal to 20 percent of the cost incurred for any service that is subject to the Medicare coinsurance.

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

Dated: April 20, 1995.

Bruce C. Vladeck,

Administrator, Health Care Financing Administration.

Dated: June 19, 1995.

Donna E. Shalala,

Secretary.

[FR Doc. 95–16411 Filed 7–3–95; 8:45 am]

BILLING CODE 4120–01–P

FEDERAL EMERGENCY MANAGEMENT AGENCY

44 CFR Part 65

Changes in Flood Elevation Determinations

AGENCY: Federal Emergency Management Agency, FEMA.

ACTION: Final rule.

SUMMARY: Modified base flood elevations are finalized for the communities listed below. These modified elevations will be used to calculate flood insurance premium rates for new buildings and their contents.

EFFECTIVE DATES: The effective dates for these modified base flood elevations are indicated on the following table and revise the Flood Insurance Rate Map(s) (FIRMs) in effect for each listed community prior to this date.

ADDRESSES: The modified base flood elevations for each community are available for inspection at the office of the Chief Executive Officer of each community. The respective addresses are listed in the following table.

FOR FURTHER INFORMATION CONTACT: Michael K. Buckley, P.E., Chief, Hazard Identification Branch, Mitigation Directorate, 500 C Street, SW., Washington, DC 20472, (202) 646–2756.

SUPPLEMENTARY INFORMATION: The Federal Emergency Management Agency makes the final determinations listed below of modified base flood elevations for each community listed. These modified elevations have been published in newspapers of local circulation and ninety (90) days have elapsed since that publication. The Associate Director has resolved any appeals resulting from this notification.

The modified base (100-year) flood elevations are not listed for each community in this notice. However, this rule includes the address of the Chief Executive Officer of the community where the modified base flood elevation determinations are available for inspection.

The modifications are made pursuant to section 206 of the Flood Disaster Protection Act of 1973, 42 U.S.C. 4105, and are in accordance with the National Flood Insurance Act of 1968, 42 U.S.C. 4001 et seq., and with 44 CFR part 65.

For rating purposes, the currently effective community number is shown and must be used for all new policies and renewals.

The modified base (100-year) flood elevations are the basis for the floodplain management measures that the community is required to either adopt or to show evidence of being already in effect in order to qualify or to remain qualified for participation in the National Flood Insurance Program.

These modified elevations, together with the floodplain management criteria required by 44 CFR 60.3, are the minimum that are required. They should not be construed to mean that the community must change any existing ordinances that are more stringent in their floodplain management requirements. The community may at any time enact stricter requirements of its own, or pursuant to policies established by other Federal, state or regional entities.

These modified elevations are used to meet the floodplain management requirements of the NFIP and are also used to calculate the appropriate flood insurance premium rates for new buildings built after these elevations are made final, and for the contents in these buildings.

The changes in base flood elevations are in accordance with 44 CFR 65.4.

National Environmental Policy Act. This rule is categorically excluded from the requirements of 44 CFR Part 10, Environmental Consideration. No environmental impact assessment has been prepared.

Regulatory Flexibility Act. The Associate Director, Mitigation Directorate, certifies that this rule is exempt from the requirements of the Regulatory Flexibility Act because modified base flood elevations are required by the Flood Disaster Protection Act of 1973, 42 U.S.C. 4105, and are required to maintain community eligibility in the National Flood Insurance Program. No regulatory flexibility analysis has been prepared.

Regulatory Classification. This final rule is not a significant regulatory action under the criteria of section 3(f) of Executive Order 12866 of September 30, 1993, Regulatory Planning and Review, 58 FR 51735.

Executive Order 12612, Federalism. This rule involves no policies that have federalism implications under Executive