

(16) On November 12, 1993 and March 7, 1995, the designee of the Governor of South Dakota submitted revisions to the plan, which included revised regulations for definitions, minor source construction and federally enforceable state operating permit (FESOP) rules, source category emission limitations, sulfur dioxide rule corrections, new source performance standards (NSPS), new source review (NSR) requirements for new and modified major sources impacting nonattainment areas, and enhanced monitoring and compliance certification requirements. The State also requested that the existing State regulations approved in the South Dakota SIP be replaced with the following chapters of the recently recodified Administrative Rules of South Dakota (ARSD): 74:36:01–74:36:04, 74:36:06; 74:36:07, 74:36:10–74:36:13, and 74:36:15, as in effect on January 5, 1995.

(i) Incorporation by reference.

(A) Revisions to the Administrative Rules of South Dakota, Air Pollution Control Program, Chapters 74:36:01 (except 74:36:01:01(2) and (3)); 74:36:02–74:36:04, 74:36:06; 74:36:07, 74:36:10–74:36:13, and 74:36:15, effective April 22, 1993 and January 5, 1995.

3. A new section 52.2184 is added to read as follows:

**§ 52.2184 Operating permits for minor sources.**

Emission limitations and related provisions established in South Dakota minor source operating permits, which are issued in accordance with ARSD 74:36:04 and which are submitted to EPA in a timely manner in both proposed and final form, shall be enforceable by EPA. EPA reserves the right to deem permit conditions not federally enforceable. Such a determination will be made according to appropriate procedures and will be based upon the permit, permit approval procedures, or permit requirements which do not conform with the operating permit program requirements of EPA's underlying regulations.

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**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**Health Care Financing Administration**

**42 CFR Part 417**

[OMC–014–FC]

**Medicare Program; Payments to HMOs and CMPs and Appeals: Technical Amendments**

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

**ACTION:** Final rule with comment period.

**SUMMARY:** This rule clarifies and updates portions of the HCFA regulations that pertain to payment for services furnished to Medicare enrollees by health maintenance organizations (HMOs) and competitive medical plans (CMPs); appeals by Medicare enrollees concerning payment for those services; and appeals by HMOs and CMPs with regard to their Medicare contracts.

This rule completes the special project aimed at the total technical revision of part 417. Part 417 contains the regulations applicable to all prepaid health care organizations, that is, HMOs, CMPs, and health care prepayment plans (HCPPs).

These are technical and editorial changes that do not affect the substance of the regulations. They are intended to make it easier to find particular provisions, to eliminate needless repetition and remove obsolete content, and to better ensure uniform understanding of the rules.

**DATES:** *Effective dates:* These rules are effective as of October 1, 1995.

*Comment date:* We will consider comments received by October 6, 1995.

**ADDRESSES:** Mail written comments (1 original and 3 copies) to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: OMC–014–FC, PO Box 26688, Baltimore, MD 21207.

If you prefer, you may deliver your written comments (1 original and 3 copies) to one of the following addresses:

Room 309–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or Room C5–09–26, 7500 Security Boulevard, Baltimore, MD 21244–1850

Due to staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code OMC–014–FC.

Written comments received timely will be available for public inspection as

they are received—generally beginning approximately 3 weeks after publication of the document, in Room 309–G of the Department's offices at 200 Independence Avenue, SW., Washington, DC, Monday through Friday, from 8:30 a.m. to 5 p.m. (phone: (202) 690–7890).

Although we cannot respond to individual comments, if we revise this rule as a result of comments, we will discuss all timely comments in the preamble to the revised rule.

**FOR FURTHER INFORMATION CONTACT:** Tracy Jensen, (410) 786–1033.

**SUPPLEMENTARY INFORMATION:**

**A. Background**

The previous 4 technical regulations of the special project have—

- Removed obsolete content;
  - Designated the remaining text under 17 subparts that identify the different program aspects so that it is easier to refer to those aspects and to find particular rules;
  - Through nomenclature and definition changes, established certain terms to be used throughout part 417, so as to preclude confusion, make clear that responsibility for the prepaid health care programs has been delegated to HCFA, and ensure use of the most precise terms available;
  - Redesignated certain portions of part 417 to free section numbers needed so that new rules can be incorporated in logical order; and
  - Established a separate subpart C to set forth the many requirements for the organization and operation of HMOs. Under previous rules, these were compressed into a single section (§ 417.107).
- As a result of the redesignations, §§ 417.107 through 417.119 were made available for new rules that are required because of statutory amendments that affect the furnishing of services by Federally qualified HMOs, or may be needed because of future changes in the statute. Similarly, §§ 417.128 through 417.139 are available for additional rules on the organization and operation of those HMOs.

**B. Changes made by this rule**

This technical rule affects the following subparts:

- Subpart N—Medicare Payment to HMOs and CMPs—General Rules
- Subpart O—Medicare Payment: Cost Basis;
- Subpart P—Medicare Payment: Risk Basis;
- Subpart Q—Beneficiary Appeals; and
- Subpart R—Contract Appeals.

Changes to the first three subparts reflect a general change of approach—

use of the term "payment" rather than "reimbursement". Changes in all five subparts, such as use of the active voice, are intended to improve clarity. They also provide more headings, revise confusing word order, and remove obsolete provisions (rules that applied to contract periods that began before 1986).

In subpart Q, the revisions add a paragraph explaining the statutory basis for the beneficiary appeals rules and expand the "Scope" paragraph to reference a recently added provision that gives the beneficiary the right to request immediate PRO review of a determination that he or she no longer needs inpatient hospital care.

#### Other Required Information

##### *Waiver of Proposed Rulemaking and Delayed Effective Date*

The changes made by this rule are technical and editorial in nature. Their aim is to simplify, clarify, and update subparts N through R of part 417 without substantive change.

Accordingly, we find that notice and opportunity for public comment are unnecessary and that there is good cause to waive proposed rulemaking procedures.

In addition, it is important, for the convenience of the public, that these changes be effective as of October 1, 1995, so that they can be included in the 1995 edition of the Code of Federal Regulations on which the public relies. Therefore, we find good cause to also waive the usual 30-day delay in the effective date.

As previously indicated, however, we will consider timely comments from anyone who believes that, in making the technical and editorial changes, we have unintentionally altered the substance.

##### *Paperwork Reduction Act*

Sections 417.558, 417.576, and 417.600 of the regulations amended by this technical rule contain requirements that are subject to review by the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1980 (44 U.S.C. 3501 et seq.). The requirement for a certified cost report (§ 417.576(b)) has OMB approval under number 0938-0165, with an expiration date of 9-30-95. The burden for this report is estimated at 200 hours for record keeping and 260 hours for completing the report. The requirements for justification of exception to cost limits (§ 417.558(c)) and for grievance and appeals procedures (§ 417.600(b)) are being submitted for OMB approval. If you comment on these requirements, please send a copy directly to: Office of

Information and Regulatory Affairs, Office of Management and Budget, Room 10235, Executive Office Building, Washington, DC 30503.

##### *Regulatory Impact Statement*

Consistent with the Regulatory Flexibility Act (RFA) and section 1102(b) of the Social Security Act, we prepare a regulatory flexibility analysis for each rule, unless the Secretary certifies that the particular rule will not have a significant economic impact on a substantial number of small entities, or a significant impact on the operation of a substantial number of small rural hospitals.

The RFA defines "small entity" as a small business, a nonprofit enterprise, or a governmental jurisdiction (such as a county, city, or township) with a population of less than 50,000. We also consider all providers and suppliers of services to be small entities. 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.

We have not prepared a regulatory flexibility analysis because we have determined and we certify that these rules (which make only technical and editorial changes with no substantive effect) will not have a significant economic impact on a substantial number of small entities or a significant impact on the operation of a substantial number of small rural hospitals.

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

##### **List of Subjects in 42 CFR Part 417**

Administrative practice and procedure, Health maintenance organizations (HMO), Medicare.

42 CFR part 417 is amended as set forth below.

#### **PART 417—HEALTH MAINTENANCE ORGANIZATIONS, COMPETITIVE MEDICAL PLANS, AND HEALTH CARE PREPAYMENT PLANS**

A. 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.

B. Subpart N is amended as set forth below.

#### **Subpart N—Medicare Payment to HMOs and CMPs: General Rules**

1. Section 417.524 is revised to read as follows:

##### **§ 417.524 Payment to HMOs or CMPs: General.**

(a) *Basic rule.* The payments that HCFA makes to an HMO or CMP under this subpart and subparts O and P of this part for furnishing covered Medicare services are in place of any payment that HCFA would otherwise make to a beneficiary or the HMO or CMP under sections 1814(b) and 1833(a) of the Act.

(b) *Basis of payment.* (1) HCFA pays the HMOs or CMPs on either a reasonable cost basis or a risk basis depending on the type of contract the HMO or CMP has with HCFA.

(2) In certain cases a risk HMO or CMP also receives payments on a reasonable cost basis for certain Medicare enrollees who retain nonrisk status, as provided in § 417.444, after the HMO or CMP enters into a risk contract.

##### **§ 417.526 [Amended]**

2. In § 417.526, "reimbursement" is revised to read "payment" each time it appears.

3. Section 417.528 is amended to revise the section heading to revise, paragraphs (a) through (c) and to add a heading to paragraph (d) to read as follows:

##### **§ 417.528 Payment when Medicare is not primary payer.**

(a) *Limits on payments and charges.* (1) HCFA may not pay for services to the extent that Medicare is not the primary payer under section 1862(b) of the Act and part 411 of this chapter.

(2) The circumstances under which an HMO or CMP may charge, or authorize a provider to charge, for covered Medicare services for which Medicare is not the primary payer are stated in paragraphs (b) and (c) of this section.

(b) *Charge to other insurers or the enrollee.* If a Medicare enrollee receives from an HMO or CMP covered services that are also covered under State or Federal worker's compensation, automobile medical, or any no-fault insurance, or any liability insurance policy or plan, including a self-insured plan, the HMO or CMP may charge, or authorize a provider that furnished the service to charge—

(1) The insurance carrier, employer, or other entity that is liable to pay for these services; or

(2) The Medicare enrollee, to the extent that he or she has been paid by the carrier, employer, or other entity.

(c) *Charge to group health plans (GHPs) or large group health plans (LGHPs).* An HMO or CMP may charge a GHP or LGHP for covered services it furnished to a Medicare enrollee and may charge the Medicare enrollee to the extent that he or she has been paid by the GHP or LGHP for these covered services if—

(1) The Medicare enrollee is covered under the plan; and

(2) Under section 1862(b) of the Act, HCFA is precluded from paying for the covered services.

(d) *Responsibilities of HMO or CMP.*  
\* \* \*

C. Subpart O is amended as set forth below.

**Subpart O—Medicare Payment: Cost Basis**

1. Section 417.530 is revised to read as follows:

**§ 417.530 Basis and scope.**

This subpart sets forth the principles that HCFA follows to determine the amount it pays for services furnished by a cost HMO or CMP to its Medicare enrollees. These principles are based on sections 1861(v) and 1876 of the Act and are, for the most part, the same as those set forth—

(a) In part 412 of this chapter, for paying the costs of inpatient hospital services which, for cost HMOs and CMPs, are considered “reasonable” only if they do not exceed the amounts allowed under the prospective payment system; and

(b) In part 413 of this chapter, for the costs of all other covered services.

**§ 417.531 [Amended]**

2. In § 417.531, the following changes are made:

a. In paragraph (a), “reimbursement” is revised to read “payment”, and “participating in the Medicare program” is removed.

b. In paragraph (b), introductory text, “the HMO or CMP may be reimbursed” is revised to read “HCFA pays the HMO or CMP”.

**§ 417.532 [Amended]**

3. In § 417.532, the following changes are made:

a. Throughout § 417.532, “reimbursement” is revised to read “payment” and “reimburses” is revised to read “pays”.

b. In paragraph (a)(3), “Except as specified in paragraph (a)(4) of this section,” is removed and “in judging” is revised to read “in judging”.

c. Paragraph (a)(4) is removed.

d. In paragraph (f), “will determine” is revised to read “determines”.

e. Paragraph (g) is revised to read as follows:

**§ 417.532 General considerations.**

\* \* \* \* \*

(g) *Direct payment by HCFA.* (1) If the HMO or CMP elects to have HCFA pay for provider services, HCFA pays each provider on a reasonable cost basis or under the PPS system, whichever is appropriate for the particular provider under part 412 or part 413 of this chapter.

(2) In computing the Medicare payment to the HMO or CMP, HCFA deducts these payments and any other payments made by the Medicare intermediary or carrier on behalf of the HMO or CMP (such as payment for emergency or urgently needed services under § 417.558).

**§ 417.533 [Amended]**

4. In § 417.533, the following changes are made:

a. In the introductory text, the phrase “is responsible for” is revised to read “must”.

b. In paragraphs (a), (b), and (c), “Determining”, “Making”, and “Carrying” are revised to read “Determine”, “Make”, and “Carry”, respectively.

**§ 417.536 [Amended]**

5. In § 417.536, the following changes are made:

a. The section heading is revised to read “*Cost payment principles.*”

b. In paragraph (a), first sentence, the phrase “or reasonable cost reimbursement” is removed.

c. In paragraphs (a), (f)(3), and (m), “reimbursement” is revised to read “payment”.

d. In paragraph (m), the heading is revised to read “*Limitations on payment.*”; in the introductory text, “reimbursed” is revised to read “paid”; and “subpart E of part 405, and” is removed.

**§ 417.538 [Amended]**

6. In § 417.538, the following changes are made:

a. Paragraph (a) is revised to read as set forth below.

b. The heading of paragraph (b) is revised to read “*Included costs.*”

c. The heading of paragraph (d) is revised to read “*Limitation on payment.*” and in the last sentence, “such costs” is revised to read “those costs”.

**§ 417.538 Enrollment and marketing costs.**

(a) *Principle.* Costs incurred by an HMO or CMP in performing the enrollment and marketing activities

described in subpart k of this part are allowable.

\* \* \* \* \*

**§ 417.544 [Amended]**

7. In § 417.544, in paragraph (a), the paragraph designations (1), (2), and (3) are added, preceding the first, second, and third sentences and in paragraph (b), the paragraph designations (1) and (2) are added preceding the first and second sentences.

**§ 417.548 [Amended]**

9. In § 417.548, the following changes are made:

a. In paragraph (a), “reimbursable” is revised to read “payable”.

b. In paragraph (b), in the second sentence, “For example, in” is removed and “(c) *Example.* In” is inserted in its place, and the parenthetical phrase is revised to read “(rather than the payment amounts determined under part 412 or part 413 of this chapter)”.

10. Section 417.550 is revised to read as follows:

**§ 417.550 Special Medicare program requirements.**

(a) *Principle.* HCFA pays the full reasonable cost incurred by an HMO or CMP for activities that are solely for Medicare purposes and unique to Medicare contracts under section 1876 of the Act.

(b) *Application.* HCFA pays the full reasonable cost of the following activities:

(1) Reporting increases and decreases in the number of Medicare enrollees.

(2) Obtaining independent certification of the HMO’s or CMP’s cost report to the extent that it is for Medicare purposes.

(3) Reporting special data that HCFA requires solely for program planning and evaluation.

(c) *Prior approval requirement.* The costs specified in paragraph (b) of this section must be separately budgeted and approved by HCFA before the contract period begins.

(d) *Limit on full payment.* Full payment is limited to the costs specified in paragraph (b) of this section. All other administrative costs must be apportioned in accordance with § 417.552.

**§ 417.552 [Amended]**

11. In § 417.552, the following changes are made:

a. In the introductory text of paragraph (a), “Except as provided in § 417.556(c)” is removed and “the” is revised to read “The”.

b. In paragraph (a)(1), “§§ 417.530 through 417.576; and” is revised to read “this subpart; and”.

**§ 417.554 [Amended]**

12. In § 417.554, the regulation citations at the end are revised to read “§ 405.480, part 412, and §§ 413.5 and 413.24 of this chapter.”

13. Section 417.558 is revised to read as follows:

**§ 417.558 Emergency, urgently needed, and out-of-area services for which the HMO or CMP accepts responsibility.**

(a) *Source of payment.* Either HCFA or the HMO or CMP may pay a provider for emergency or urgently needed services or other covered out-of-area services for which the HMO or CMP accepts responsibility.

(b) *Limits on payment.* If the HMO or CMP pays, the payment amount may not exceed the amount that is allowable under part 412 or part 413 of this chapter.

(c) *Exception to limit on payment.* Payment in excess of the limit imposed by paragraph (b) of this section is allowable only if the HMO or CMP demonstrates to HCFA's satisfaction that it is justified on the basis of advantages gained by the HMO or CMP, as set forth in § 417.548.

**§ 417.560 [Amended]**

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

a. In paragraph (a) introductory text, “will base” is revised to read “bases”.

b. In paragraph (d)(1), “(1) Except as provided in paragraph (d)(2) of this section,” is removed, and “the Medicare share” is revised to read “The Medicare share”.

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

15.–16. Section 417.564 is revised to read as follows:

**§ 417.564 Apportionment and allocation of administrative and general costs.**

(a) *Costs not directly associated with providing medical care.* Enrollment, marketing, and other administrative and general costs that benefit the total enrollment of the HMO or CMP and are not directly associated with furnishing medical care must be apportioned on the basis of a ratio of Medicare enrollees to the total HMO or CMP enrollment.

(b) *Costs significantly related to providing medical services.* (1) The following administrative and general costs, which bear a significant relationship to the services furnished, are not apportioned to Medicare directly; they must be allocated or distributed to the HMO or CMP components and then apportioned to Medicare in accordance with §§ 417.552 through 417.560:

- (i) Facility costs.
- (ii) Interest expense.

- (iii) Medical record costs.
- (iv) Centralized purchasing costs.
- (v) Accounting and data processing costs.

(vi) Other administrative and general costs that are not included in paragraph (a) of this section.

(2) The allocation or distribution process must be as follows:

(i) If a separate entity or department of an HMO or CMP performs administrative functions the benefit of which can be quantitatively measured (such as centralized purchasing and data processing), the total allowable costs of this entity or department must be allocated or distributed to the components of the HMO or CMP in reasonable proportion to the benefits received by these components.

(ii) If a separate entity or department of an HMO or CMP performs administrative functions the benefit of which cannot be quantitatively measured (such as facility costs), the total allowable costs of this entity or department must be allocated or distributed to the components of the HMO or CMP on the basis of a ratio of total incurred and distributed costs per component to the total incurred and distributed costs for all components.

**§ 417.568 [Amended]**

17. In § 417.568, the following changes are made:

a. In paragraph (a)(1), “payable by Medicare” is revised to read “payable by HCFA”, and the comma after “enrollees” is removed.

b. In paragraph (a)(2), the phrase “the HMO or CMP must follow” is added immediately before “standardized definitions \* \* \*”, and the last three words “must be followed.” are removed.

c. In paragraph (b)(2), “as described in this paragraph” is revised to read “as provided in paragraph (b)(3) of this section”.

d. In paragraph (b)(3), “based on this basis” is revised to read “developed on this basis” and “will be acceptable” is revised to read “is acceptable”.

e. Paragraph (c) is revised to read as set forth below.

f. In paragraph (d), “the HMO or CMP”, the last time it appears, is revised to read “it”.

**§ 417.568 Adequate financial records, statistical data, and cost finding.**

(c) *Provider services furnished directly by the HMO or CMP.* If the HMO or CMP furnishes provider services directly, the provider is subject to the cost-finding and cost-reporting requirements set forth in parts 412 and 413 of this chapter. The provider must use an

approved cost-finding method described in § 413.24 of this chapter to determine the actual cost of these covered services.

\* \* \* \* \*

**§ 417.576 [Amended]**

18. In § 417.576, the following changes are made:

a. In the following paragraphs, “reimbursement” is revised to read “payment”: paragraphs (b)(2)(ii), (c)(1), (c)(2)(ii), (d) heading, introductory text, and (d)(1), and (e)(1).

b. In the following paragraphs, “reimbursable” is revised to read “payable”: paragraphs (c)(1) and (d)(2).

c. In paragraph (b)(2), “§§ 417.532 through 417.566” is revised to read “this subpart”.

d. In paragraph (c)(1), “providing” is revised to read “furnishing”.

e. In paragraph (c)(2)(ii), “an insignificant amount” is revised to read “an insignificant portion”.

f. Paragraphs (b)(3) and (e)(3) are revised to read as set forth below:

**§ 417.576 Final settlement.**

\* \* \* \* \*

(b) *Certified cost report as basis for final settlement.* \* \* \*

(3) *Failure to report required financial information.* If the HMO or CMP fails to submit the required cost report and supporting documents within 180 days (or an extended period approved by HCFA under paragraph (b)(1) of this section), HCFA may—

(i) Consider the failure to report as evidence of likely overpayment; and

(ii) Initiate recovery of amounts previously paid, or reduce interim payments, or both.

\* \* \* \* \*

(e) *Basis for retroactive adjustment.* \* \* \*

(3) Any withholding continues until the earliest of the following occurs:

(i) The overpayment is liquidated.

(ii) The HMO or CMP enters into an agreement with HCFA to refund the overpaid amount.

(iii) HCFA, on the basis of subsequently acquired information, determines that there was no overpayment.

(iv) The decision of a hearing specified in paragraph (d)(4) of this section is that there was no overpayment.

D. Subpart P is amended as set forth below.

**Subpart P—Medicare Payment: Risk Basis**

**§ 417.580 [Amended]**

1. In § 417.580, paragraph (a), “reimbursed” is revised to read “pays”.

§ 417.582 [Amended]

2. In § 417.582 the heading is revised and three definitions are added in alphabetical order, to read as follows:

§ 417.582 Definitions.

AAPCC stands for adjusted average per capita cost.

ACR stands for adjusted community rate.

\* \* \* \* \*

APCRP stands for average of per capita rates of payment.

\* \* \* \* \*

§ 417.584 [Amended]

3. In § 417.584, the following changes are made.

a. The introductory text of the section and paragraph (c) are revised to read as set forth below.

b. In paragraph (d), “§ 417.592(e)” is revised to read “§ 417.592(b)(2)”; “will reduce” is revised to read “reduces”; and the last sentence is removed.

§ 417.584 Payment to HMOs and CMPs with risk contracts.

Except in the circumstances specified in § 417.440(d) for inpatient hospital care, and as provided in § 417.585 for hospice care, HCFA makes payment for covered services only to the HMO or CMP.

\* \* \* \* \*

(c) Adjustments to payments. If the actual number of Medicare enrollees differs from the estimated number on which the amount of advance monthly payment was based, HCFA adjusts subsequent monthly payments to take account of the difference.

\* \* \* \* \*

§ 417.585 [Amended]

4. In § 417.585, the following changes are made:

a. The section heading is revised to read: “Special rules: Hospice care.”

b. In paragraph (a), “No payment is made effective the first day” is revised to read: “This no-payment rule is effective from the first day”.

c. In paragraph (b), Introductory text, “for only” is revised to read “but only for”.

d. In paragraph (b)(2), “hospice care was elected” is revised to read “the enrollee elected hospice care”.

e. In paragraph (c), the clause “are made to the hospice participating in Medicare elected by the enrollee” is revised to read “is made to the Medicare-participating hospice elected by the enrollee”.

§ 417.586 [Removed]

5. Section 417.586 is removed.

§ 417.588 [Amended]

6. In § 417.588, the following changes are made.

a. In paragraph (a), “resulting in an AAPCC” is revised to read “to establish an AAPCC”.

b. In paragraph (c)(2), “A further adjustment is made by HCFA” is revised to read “HCFA makes a further adjustment”.

7. Section 417.592 is revised to read as follows:

§ 417.592 Additional benefits requirement.

(a) General rules. (1) An HMO or CMP that has an APCRP (as determined under § 417.590) greater than its ACR (as determined under § 417.594) must elect one of the options specified in paragraph (b) of this section.

(2) The dollar value of the elected option must, over the course of a contract period, be at least equal to the difference between the APCRP and the proposed ACR.

(b) Options—(1) Additional benefits. Provide its Medicare enrollees with additional benefits in accordance with paragraph (c) of this section.

(2) Payment reduction. Request HCFA to reduce its monthly payments.

(3) Combination of additional benefits and payment reduction. Provide fewer than the additional benefits required under paragraph (b)(1) of this section and request HCFA to reduce the monthly payments by the remaining difference between the APCRP and the ACR.

(4) Combination of additional benefits and withholding in a stabilization fund. Provide fewer than the additional benefits required under paragraph (b)(1) of this section, and request HCFA to withhold in a stabilization fund (as provided in § 417.596) the remaining difference between the APCRP and the ACR.

(c) Special rules: Additional benefits option. (1) The HMO or CMP must determine additional benefits separately for enrollees entitled to both Part A and Part B benefits and those entitled only to Part B.

(2) The HMO or CMP may elect to provide additional benefits in any of the following forms—

(i) A reduction in the HMO’s or CMP’s premium or in other charges it imposes in the form of deductibles or coinsurance.

(ii) Health benefits in addition to the required Part A and Part B covered services.

(iii) A combination of reduced charges and additional benefits.

(d) Notification to HCFA. (1) The HMO or CMP must give HCFA notice of its ACR and its weighted APCRP at least

45 days before its contract period begins.

(2) An HMO or CMP that elects the option of providing additional benefits must include in its submittal—

(i) A description of the additional benefits it will provide to its Medicare enrollees; and

(ii) Supporting evidence to show that the selected benefits meet the requirements of paragraph (a)(2) of this section with respect to dollar value equivalence.

8. Section 417.594 is amended to revise paragraphs (a), (b)(1) and (b)(2), (c), (d), and (e) to read as follows:

§ 417.594 Computation of adjusted community rate (ACR).

(a) Basic rule. Each HMO or CMP must compute its basic rate as follows:

(1) Compute an initial rate in accordance with paragraph (b) of this section.

(2) Adjust and reduce the initial rate in accordance with paragraphs (c) and (d) of this section.

(b) Computation of initial rates. (1) The HMO or CMP must compute its initial rate using either of the following systems:

(i) A community rating system as defined in § 417.104(b); or

(ii) A system, approved by HCFA, under which the HMO or CMP develops an aggregate premium for all its enrollees and weights the aggregate by the size of the various enrolled groups that compose its enrollment.

(For purposes of this section, enrolled groups are defined as employee groups or other bodies of subscribers that enroll in the HMO or CMP through payment of premiums.)

(2) Regardless of which method the HMO or CMP uses—

(i) The initial rate must be equal to the premium it would charge its non-Medicare enrollees for the Medicare-covered services;

(ii) The HMO or CMP must compute the rates separately for enrollees entitled to Medicare Part A and Part B and for those entitled only to Part B; and

(iii) The HMO or CMP must identify and take into account anticipated revenue from health insurance payers for those services for which Medicare is not the primary payer as provided in § 417.528.

\* \* \* \* \*

(c) Adjustment of initial rates—(1) Purpose of adjustment. The purpose of adjustment is to reflect the utilization characteristics of Medicare enrollees.

(2) Adjustment by the HMO or CMP. The HMO or CMP may adjust the rate for a particular service using more than one of the following factors if they do not duplicate each other:

(i) *Unit of service.* If the HMO or CMP purchases or identifies services on a unit of service basis and the unit of service is defined the same for all enrollees, the HMO or CMP may make an adjustment in its initial rate to reflect the number of units of services furnished to its Medicare enrollees in comparison to those furnished to other enrollees.

(ii) *Complexity or intensity of services.* The HMO or CMP may make an adjustment to reflect the differences in the complexity or intensity of services furnished to its Medicare enrollees if the calculation of its initial rate includes the elements of this adjustment.

(3) *Support documentation.* All adjustments made by the HMO or CMP must be accompanied by adequate supporting data. If an HMO or CMP does not have sufficient enrollment experience to develop this data, it may, during its initial contract period, use documented statistics from a nationally recognized statistical source.

(4) *Adjustment by HCFA.* If the HMO or CMP does not have adequate data to adjust the initial rate calculated under paragraph (b) of this section to reflect the utilization characteristics of its Medicare enrollees, HCFA will, at the HMO's or CMP's request, adjust the initial rate. HCFA adjusts the rate on the basis of differences in the utilization characteristics of—

(i) Medicare and non-Medicare enrollees in other HMOs or CMPs; or  
(ii) Medicare beneficiaries (in the HMO's or CMP's area, or State, or the United States) who are eligible to enroll in an HMO or CMP and other individuals in that same area, or State, or the United States.

(d) *Reduction of adjusted rates.* The HMO or CMP or HCFA further reduces the adjusted rates by the actuarial value of applicable Medicare deductibles and coinsurance.

(e) *HCFA review*—(1) *Submission of data.* The HMO or CMP must submit its ACR and the methodology used to compute it for HCFA review and approval, and must include adequate supporting data.

(2) *Appeals procedures.* (i) If HCFA determines that an HMO's or CMP's ACR computation is not acceptable, the HMO or CMP may, within 30 days after receipt of notice of the determination, file with HCFA a request for a hearing.

(ii) The request must state why the HMO or CMP believes the determination is incorrect, and include any supporting evidence the HMO or CMP considers pertinent.

(iii) A hearing officer designated by HCFA conducts the hearing in accordance with the hearing procedures

set forth in §§ 405.1819 through 405.1833 of this chapter.

#### § 417.596 [Amended]

9. In § 417.596, the following changes are made:

a. In paragraphs (a), (b), and (c)(1), “the average of its per capita rates of payment” is revised to read “its APCRP”.

b. In paragraphs (c)(1) and (c)(2), “will not” is revised to read “does not”.

c. In paragraph (d), “for the purpose of establishing and maintaining” is revised to read “to establish and maintain”.

#### § 417.597 [Amended]

10. In paragraph (a) of § 417.597, in the introductory text, “the average of its per capita rates of payment” is revised to read “its APCRP”.

#### § 417.598 [Amended]

11. In § 417.598, “will conduct” is revised to read “conducts”.

E. Subpart Q is amended as set forth below.

### Subpart Q—Beneficiary Appeals

1. Section 417.600 is revised to read as follows:

#### § 417.600 Basis and scope.

(a) *Statutory basis.* (1) Section 1869 of the Act provides the right to a hearing and to judicial review for any individual dissatisfied with a determination regarding his or her Medicare benefits.

(2) Section 1876 of the Act provides for Medicare payments to HMOs and CMPs that contract with HCFA to enroll Medicare beneficiaries and furnish Medicare-covered health care services to them. Section 1876(c)(5) provides that—

(i) An HMO or CMP must establish grievance and appeals procedures; and

(ii) Medicare enrollees dissatisfied because they do not receive health care services to which they believe they are entitled, at no greater cost than they believe they are required to pay, have the following appeal rights:

(A) The right to an ALJ hearing if the amount in controversy is \$100 or more.

(B) The right to judicial review of the hearing decision if the amount in controversy is \$1000 or more.

(iii) The Medicare enrollee and the HMO or CMP are parties to the hearing and to the judicial review.

(b) *Scope.* This subpart sets forth—

(1) The appeals procedures, as required by section 1876(c)(5)(B) of the Act for Medicare enrollees who are dissatisfied with an “organization determination” as defined in § 417.606;

(2) The applicability of grievance procedures established by the HMO or

CMP under section 1876(c)(5)(A) of the Act and § 417.604(a) for complaints that do not involve an organization determination;

(3) The responsibility of the HMO or CMP—

(i) To develop and maintain procedures; and

(ii) To ensure that all Medicare enrollees have a complete written explanation of their grievance and appeal rights, of the steps to follow, and of the time limits for each step of the procedures; and

(4) The special rules that apply when a beneficiary requests immediate PRO review of a determination that he or she no longer needs inpatient hospital care.

#### § 417.602 [Amended]

2. In § 417.602, the heading is revised to read “§ 417.602 Definitions.” and the definition of “enrollee” is removed.

3. Section 417.604 is revised to read as follows:

#### § 417.604 General provisions.

(a) *Responsibilities of the HMO or CMP.* (1) The HMO or CMP must establish and maintain—

(i) Appeals procedures that meet the requirements of this subpart for issues that involve organization determinations; and

(ii) Grievance procedures for dealing with issues that do not involve organization determinations.

(2) The HMO or CMP must ensure that all enrollees receive written information about the grievance and appeals procedures that are available to them.

(b) *Limits on applicability of this subpart.* (1) If an enrollee requests immediate PRO review (as provided in § 417.605) of a determination of noncoverage of inpatient hospital care—

(i) The enrollee is not entitled to subsequent review of that issue under this subpart; and

(ii) The PRO review decision is subject to the appeals procedures set forth in part 473 of this chapter.

(2) Any determination regarding services that were furnished by the HMO or CMP, either directly or under arrangement, for which the enrollee has no further liability for payment are not subject to appeal.

(3) Services included in an optional supplemental plan under (§ 417.440(b)(2)) are subject only to a grievance procedure.

(4) Physicians and other individuals who furnish services under arrangement with an HMO or CMP have no right of appeal under this subpart.

(c) *Applicability of other regulations.* Unless otherwise provided in this

subpart, regulations at 20 CFR, part 404, subparts J and R, (pertaining respectively to conduct of hearings and representation of parties under title II of the Act) are applicable under this subpart.

**§ 417.628 [Removed]**

4. Section 417.628 is removed.  
5. In § 417.632, paragraphs (c) and (d) are revised to read as follows:

**§ 417.632 Request for hearing.**

\* \* \* \* \*  
(c) *Parties to a hearing.* (1) The parties to a hearing must be the parties to the reconsideration and any other person or entity whose rights with respect to the reconsideration may be affected by the hearing, as determined by the ALJ.

(2) The HMO or CMP must be made a party to the hearing but does not have a right to request a hearing.

(d) *ALJ action when the amount in controversy is less than \$100.* (1) If the request plainly shows that the amount in controversy is less than \$100, the ALJ dismisses the request.

(2) If, after a hearing is initiated, the ALJ finds that the amount in controversy is less than \$100, he or she discontinues the hearing and does not rule on the substantive issues raised in the appeal.

F. Subpart R is amended as set forth below.

**Subpart R—Medicare Contract Appeals**

**§ 417.644 [Amended]**

1. In § 417.644, the following changes are made:

a. In paragraph (a), “will notify the HMO or CMP in writing” is revised to read “gives the HMO or CMP written notice”.

b. In paragraph (c), “Notice of an initial determination specified in § 417.640 is mailed to the HMO or CMP” is revised to read “HCFA mails the notice to the HMO or CMP”.

2. Section 417.648 is revised to read as follows:

**§ 417.648 Reconsideration: Applicability.**

(a) Reconsideration is the first step for appealing an organization determination specified in § 417.640 (a) or (b).

(b) HCFA reconsiders either of the specified determinations if the HMO or CMP files a written request in accordance with § 417.650.

**§ 417.652 [Amended]**

3. In § 417.652, “will provide” is revised to read “provides”.

4. Section 417.656 is revised to read as follows:

**§ 417.656 Notice of reconsidered determination.**

(a) HCFA gives the parties written notice of the reconsidered determination.

(b) The notice—

(1) Contains findings with respect to the HMO’s or CMP’s qualifications to enter into a contract with HCFA under section 1876 of the Act;

(2) States the specific reasons for the reconsidered determination; and

(3) Informs the party of its right to a hearing if it is dissatisfied with the determination.

**§ 417.666 [Amended]**

5. In § 417.666, “will designate” is revised to read “designates”.

**§ 417.668 [Amended]**

6. In § 417.668, “will designate” is revised to read “designates”.

**§ 417.670 [Amended]**

7. In § 417.670, the following changes are made:

a. In paragraph (a), “will fix”, “send”, and “must also inform” are revised to read “fixes”, “sends”, and “also informs”, respectively.

b. In paragraph (c), “any change in time or place or of adjournment” is revised to read “any change in time or place of hearing, or of adjournment or postponement”.

**§ 417.676 [Amended]**

8. In § 417.676, the following changes are made:

a. In paragraph (a), “will be open” is revised to read “is open”.

b. In paragraph (b), “will inquire” is revised to read “inquires”, and “must receive” is revised to read “receives”.

c. In paragraph (c), “The parties will be provided” is revised to read “The hearing officer provides the parties”.

d. In paragraph (d), “will decide” is revised to read “decides”.

**§ 417.678 [Amended]**

9. In § 417.678, “will rule” is revised to read “rules”.

**§ 417.680 [Amended]**

10. In § 417.680, paragraph (b), “will be” is revised to read “are”.

**§ 417.682 [Amended]**

11. In § 417.682, in paragraphs (a) and (c), “will be” is revised to read “is”.

**§ 417.686 [Amended]**

12. In § 417.686, in paragraph (a), “will be” is revised to read “is”.

**§ 417.690 [Amended]**

13. In § 417.690, the following changes are made:

a. In paragraph (a), “will issue” is revised to read “issues”.

b. In paragraph (b), “will provide” is revised to read “provides”.

**§ 417.692 [Amended]**

14. In § 417.692, the following changes are made:

a. In paragraph (c)(1), “will be” is revised to read “is”.

b. In paragraph (c)(2), “will specify” is revised to read “specifies”.

**§ 417.694 [Amended]**

15. In § 417.694, “final and binding” is revised to read “binding”.

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

Dated: July 31, 1995.

**Bruce C. Vladeck,**  
*Administrator, Health Care Financing Administration.*

[FR Doc. 95–21695 Filed 9–5–95; 8:45 am]

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**NATIONAL SCIENCE FOUNDATION**

**45 CFR Part 670**

**Conservation of Antarctic Animals and Plants**

**AGENCY:** National Science Foundation.

**ACTION:** Final rule with request for comments.

**SUMMARY:** The National Science Foundation is amending its regulations to designate additional Antarctic Specially Protected Areas, to redesignate one site as a Specially Protected Area which was formerly designated as a Site of Special Scientific Interest, and to revise the designations of Specially Protected Areas consistent with Antarctic Treaty Consultative meeting recommendations. These regulations, issued pursuant to section 6(b)(3) of the Antarctic Conservation Act of 1978 (16 U.S.C. 2405(b)(3)), are being revised to reflect recommendations adopted by the Antarctic Treaty parties at the 16th Antarctic Consultative Meeting.

**EFFECTIVE DATE:** September 6, 1995.

**ADDRESSES:** Comments should be sent to Joyce A. Jatko, Office of Polar Programs, Room 755, National Science Foundation, 4201 Wilson Boulevard, Arlington, VA 22230.

**FOR FURTHER INFORMATION CONTACT:** Joyce A. Jatko at the address above or by telephone at (703) 306–1030.

**SUPPLEMENTARY INFORMATION:** Since these regulations were originally issued