

- (b) * * *
- (4) * * *
- (iii) * * *

[Comment: Additional technical information on BMPs and the elements of a BMP program is contained in publication entitled "Guidance Manual for Developing Best Management Practices (BMP)." Copies may be obtained by written request to the Office of Water Resource Center (mail code: 4100), Environmental Protection Agency, Washington, D.C. 20460].

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 [FR Doc. 95-25845 Filed 10-17-95; 8:45 am]
 BILLING CODE 6560-50-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Part 411

[BPD-482-CN]

RIN 0938-AD73

Medicare Program; Medicare Secondary Payer for Individuals Entitled to Medicare and Also Covered Under Group Health Plans; Correction

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

ACTION: Final rule with comment period; Correcting amendments.

SUMMARY: This document makes corrections to the final rule with comment period entitled "medicare program; medicare secondary payer for individuals entitled to medicare and also covered under group health plans" that was published in the Federal Register on Thursday, August 31, 1995 (60 FR 45344).

EFFECTIVE DATE: September 29, 1995.

FOR FURTHER INFORMATION CONTACT: Roya D. Lotfi, (410) 786-1898

SUPPLEMENTARY INFORMATION:

Background

In the August 31, 1995 issue, we amended the rules to implement certain provisions of section 1862(b) of the Social Security Act, as amended by the Omnibus Budget Reconciliation Acts of 1986, 1989, 1990, and 1993 and the Social Security Act Amendments of 1994 that affected the Medicare secondary payer rules for individuals who are entitled to Medicare on the basis of age or who are eligible or entitled on the basis of end stage renal disease, and who are also covered under group health plans. We also established limits on Medicare payment for services furnished to individuals who are entitled to Medicare on the basis of

disability and who are covered under large group health plans by virtue of their own or a family member's current employment status with an employer; and prohibit large group health plans from taking into account that those individuals are entitled to Medicare on the basis of disability.

The final rule with comment period that is the subject of these corrections was necessary because of the statutory changes referenced above. Those changes required a new subpart for the provisions that now apply generally to all group health plans and Medicare secondary payer situations. We also needed to make room for incorporating in logical order any additional regulations that may be required by future amendments to the Act.

Correction of Publication

As published, the final rule with comment period contains errors. Accordingly, the publication on August 31, 1995 of the final rule with comment that was the subject of FR Doc. 95-21265, is corrected as follows (see also correction published September 20, 1995 at 60 FR 48749):

In the preamble, we correct typographical errors on page 45358, first column, last paragraph. As corrected the first sentence reads:

"In contrast, a plan that is paying primary benefits takes into account ESRD-based eligibility if it attempts to shift that primary payment responsibility to Medicare when an individual becomes eligible for Medicare based on ESRD, or when an individual is already eligible for Medicare based on ESRD but has not completed the 18-month coordination period."

Also in the preamble, on page 45360, third column, first paragraph, several words were inadvertently omitted from the third sentence. As corrected the sentence reads:

"However, section 13561(c)(2) and (3) of OBRA '93 provides that there will be an 18-month coordination period during which employer sponsored primary insurance plans must continue to pay primary benefits even if an individual who is eligible for or entitled to Medicare based on ESRD is also entitled to Medicare on another basis."

In the regulations text of § 411.108(a)(8) on page 46364, we correct drafting errors by removing the words "no more than the Medicare payment rate" and adding the word "less"; by removing the words "but making payments at a higher rate" and adding the word "than"; and by adding the word "furnished" after the word "services" the second place it appears.

As written, a group health plan could pay one dollar more than the Medicare rate, but less than the rate it pays for non-Medicare enrollees, and not be in violation of this paragraph. Paragraph (8) presents an example as the rule, when it should simply state that where the group health plan pays less for the same services for a Medicare beneficiary than for others, the group health plan has taken Medicare entitlement into account. (See § 411.161(b)(2)(iv).)

Also in the text, we are making a conforming change in the second sentence of §§ 411.163 (b)(2) and (b)(3) on page 45369 by removing the word "If" and adding the words "Except as provided in paragraph (b)(4) of this section, if" so that paragraphs (2) and (3) cannot be misconstrued to conflict with paragraph (4).

Finally in the text, we are making a change in the first sentence of § 411.172(b) to conform this section to § 411.170(a)(2) and the statutory provisions of section 1862(b) by adding "and of subparagraph (iii) of § 411.170(a)(2)" after the word "section".

List of Subjects in 42 CFR Part 411

Exclusions from Medicare, Limitations on Medicare payments, Medicare, Recovery against third parties, Reporting and recordkeeping requirements.

PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT

42 CFR Part 411 is corrected by making the following correcting amendments:

1. The authority citation for Part 411 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

§ 411.108 [Corrected]

2. In § 411.108, paragraph (a)(8) is revised to read as follows:

(a) *Examples of actions that constitute "taking into account".* * * *

(8) Paying providers and suppliers less for services furnished to a Medicare beneficiary than for the same services furnished to an enrollee who is not entitled to Medicare.

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§ 411.163 [Corrected]

3. In § 411.163, paragraphs (b)(2) and (b)(3) are revised to read as follows:

* * * * *

(b) * * *

(2) *First month of ESRD-based eligibility or entitlement and first month*

of dual eligibility/entitlement after February 1992 and before August 10, 1993. Except as provided in paragraph (b)(4) of this section, if the first month of ESRD-based eligibility or entitlement and first month of dual eligibility/entitlement were after February 1992 and before August 10, 1993, Medicare—

(i) Is primary payer from the first month of dual eligibility/entitlement through August 9, 1993;

(ii) Is secondary payer from August 10, 1993, through the 18th month of ESRD-based eligibility or entitlement; and

(iii) Again becomes primary payer after the 18th month of ESRD-based eligibility or entitlement.

(3) *First month of ESRD-based eligibility or entitlement after February 1992 and first month of dual eligibility/entitlement after August 9, 1993.* Except as provided in paragraph (b)(4) of this section, if the first month of ESRD-based eligibility or entitlement is after February 1992, and the first month of dual eligibility/entitlement is after August 9, 1993, the rules of § 411.162(b) and (c) apply; that is, Medicare—

(i) Is secondary payer during the first 18 months of ESRD-based eligibility or entitlement; and

(ii) Becomes primary after the 18th month of ESRD-based eligibility or entitlement.

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§ 411.172 [Corrected]

4. In § 411.172, paragraph (b) is revised to read as follows:

* * * * *

(b) *Special rule for multi-employer plans.* The requirements and limitations of paragraph (a) of this section and of (a)(2)(iii) of § 411.170 do not apply with respect to individuals enrolled in a multi-employer plan if—

(1) The individuals are covered by virtue of current employment status with an employer that has fewer than 20 employees; and

(2) The plan requests an exception and identifies the individuals for whom it requests the exception as meeting the conditions specified in paragraph (b)(1) of this section.

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

Dated: October 13, 1995.

Neil J. Stillman,

Deputy Assistant Secretary for Information Resources Management.

[FR Doc. 95-25840 Filed 10-17-95; 8:45 am]

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42 CFR Part 414

[BPD-830-F]

Medicare Program: Authority Citations; Technical Amendments

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

ACTION: Technical Amendment.

SUMMARY: A final rule with comment period published on September 29 at 60 FR 50439 revised the authority citations of most of the Medicare rules and also made a nomenclature change in 42 CFR Part 414. In developing the document, we overlooked two of the sections that require the nomenclature change. This technical amendment corrects that oversight.

DATES: Effective date: This rule is effective as of September 29, 1995.

FOR FURTHER INFORMATION CONTACT: Luisa V. Iglesias (202) 690-6383.

SUPPLEMENTARY INFORMATION:

List of Subjects in 42 CFR Part 414

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Medicare, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 414 is amended as set forth below.

1. The authority citation for part 414 continues to read as follows:

PART 414—[AMENDED]

Authority: Secs. 1102, 1871, and 1881(b)(1) of the Social Security Act (42 U.S.C. 1302, 1395hh, and 1395rr(b)(1)).

§§ 414.28, 414.60 [Amended]

2. In §§ 414.28 and 414.60(a), “physicians’ services” is revised to read “physician services”.

(Catalog of Federal Domestic Assistance Program No. 93773, Medicare Hospital Insurance; Program No. 93.774, Medicare Supplementary Medical Insurance)

Dated: October 11, 1995.

Neil J. Stillman,

Deputy Assistant Secretary for Information Resources Management.

[FR Doc. 95-25839 Filed 10-17-95; 8:45 am]

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suppliers of specialized services, published on September 29, 1995 at 60 FR 50446, redesignated 42 CFR part 485, subpart D as 42 CFR part 486, subpart G, and corrected internal cross-references as required by the redesignation. This document corrects one cross-reference that we failed to identify in the final rule with comment period.

DATES: Effective date: This rule is effective as of September 29, 1995.

SUPPLEMENTARY INFORMATION:

List of Subjects in 42 CFR Part 486

Health professionals, Medicare, Organ procurement, X-rays.

42 CFR Part 486 is amended as set forth below.

PART 486—[AMENDED]

1. The authority citation for part 486 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C 1302 and 1395hh).

§ 486.304 [Amended]

2. In § 486.304(c)(1), “subpart D of part 485” is revised to read “this subpart”.

(Catalog of Federal Domestic Assistance No. 93-773, Medicare—Hospital Insurance, and No. 93-774, Medicare—Supplementary Medical Insurance)

Dated: October 11, 1995.

Neil J. Stillman,

Deputy Assistant Secretary for Information Resources Management.

[FR Doc. 95-25838 Filed 10-17-95; 8:45 am]

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FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 73

[MM Docket No. 90-316; RM-7059]

Radio Broadcasting Services; Rocky Mount, NC

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: The Commission denied an application for review filed by New East Communications, Inc. and Roanoke Chowan Broadcasting Corporation which argued that Station WSAY-FM’s license should not have been modified from Channel 253A to Channel 253C3 at Rocky Mount. Instead, they argued that Stations WSAY-FM, WBCG(FM), Murfreesboro, NC and WCZI-FM, Washington, NC, should have been allowed to improve their facilities from 3 kW to 6 kW. The Commission affirmed the *Memorandum Opinion and*