DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 412 and 413

[HCFA–1069–N]

RIN 0938–AJ55

Medicare Program; Prospective Payment System for Inpatient Rehabilitation Facilities; Extension of Comment Period

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

ACTION: Notice of extension of comment period for proposed rule.

SUMMARY: This notice extends the comment period on a proposed rule published in the **Federal Register** on November 3, 2000 (65 FR 66304). That rule would implement section 1886(j) of the Social Security Act (the Act), as added by section 4421 of the Balanced Budget Act of 1997 (Public Law 105–33) and as amended by section 125 of the Balanced Budget Refinement Act of 1999 (Public Law 106–113). Section 1886(j) of the Act authorizes the implementation of a prospective payment system for inpatient rehabilitation hospitals and inpatient rehabilitation units.

DATES: The comment period is extended to 5 p.m. on February 1, 2001.

ADDRESSES: Mail written comments (one original and three copies) to the following address ONLY: Health Care Financing Administration, Department of Health and Human Services, Attention: HCFA–1069–P, P.O. Box 8010, Baltimore, MD 21244–8010.

If you prefer, you may deliver your written comments (one original and three copies) to one of the following addresses: Room 443–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or Room C5–14–03, Central Building, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Because of staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code HCFA–1069–P. Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, in Room 443–G of the Department's offices at 200 Independence Avenue, SW., Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (Phone: (202) 690–7890).

For comments that relate to information collection requirements, mail a copy of comments to: Health Care Financing Administration, Office of Information Services, Standards and Security Group, Division of HCFA Enterprise Standards, Room N2–14–26, 7500 Security Boulevard, Baltimore, MD 21244–1850, Attn.: Julie Brown HCFA 1069–P; and Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn.: Allison Eydt, HCFA Desk Officer.

FOR FURTHER INFORMATION CONTACT: Robert Kuhl, (410) 786–4597.

SUPPLEMENTARY INFORMATION: On November 3, 2000, we issued a proposed rule in the **Federal Register** (65 FR 66304) that provided information for understanding the development and implementation of the inpatient rehabilitation facility (IRF) prospective payment system (PPS). That information included the following:

- An overview of the current payment system for IRFs.
- A discussion of research on IRF patient classification systems and prospective payment systems, including prior and current research performed by the RAND Corporation.
- A discussion of statutory requirements for developing and implementing an IRF PPS.
- A discussion of the proposed requirement that IRFs complete the Minimum Data Set for Post Acute Care (MDS–PAC) (a patient assessment instrument) as a part of the data collection deemed necessary by the Secretary to implement and administer the IRF PPS.
- A discussion of the IRF patient classification system using case-mix groups (CMGs).
- A detailed discussion of the proposed PPS including the relative weights and payment rates for each CMG, adjustments to the payment system, additional payments, and budget neutrality requirements mandated by section 1886(j) of the Social Security Act.
- An analysis of the impact of the IRF PPS on the Federal budget and inpatient rehabilitation facilities, including small rural facilities.
- Proposed conforming changes to existing regulations as well as new regulations that are necessary to implement the proposed IRF PPS.

The comment period for the proposed rule is scheduled to close at 5 p.m. on January 2, 2001. However, due to the scope and complexity of this proposed rule, we are concerned that the public may not have adequate time to comment on the rule. Accordingly, we are now extending the comment period by 30 days. We will now accept comments on the proposed rule until 5 p.m. on February 1, 2001. We believe the revised date will allow sufficient time for the public to provide comments.

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

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

Dated: December 8, 2000.

Michael M. Hash,

Acting Administrator, Health Care Financing Administration.

Dated: December 20, 2000.

Donna E. Shalala,

Secretary.

[FR Doc. 00–32993 Filed 12–26–00; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Part 422

[HCFA–1160–P]

RIN 0938–AK41

Medicare Program; Requirements for the Recredentialing of Medicare+Choice Organization Providers

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

ACTION: Proposed rule.

SUMMARY: This proposed rule would change the requirement of recredentialing providers, who are physicians or other health care professionals, for Medicare+Choice Organizations (M+COs) from at least every 2 years to at least every 3 years. This change is consistent with managed care industry recognized standards of practice and quality, and with standards already adopted by nationally recognized private quality assurance accrediting organizations. The intent of this change is to simplify administrative requirements by retaining consistency with the private accrediting processes. This rule would benefit M+COs and providers within the M+COs who must be recredentialed, while continuing to address quality issues of Medicare beneficiaries.

DATES: We will consider comments if we receive them at the appropriate

address, as provided below, no later than 5 p.m. on January 26, 2001.

ADDRESSES: Mail written comments (1 original and 3 copies) to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: HCFA–1160–P, P. O. Box 8018, Baltimore, MD 21244–8018.

To ensure that mailed comments are received in time for us to consider them, please allow for possible delays in delivering them.

If you prefer, you may deliver your written comments (1 original and 3 copies) to one of the following addresses: Room 443–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or Room C5–16–03, 7500 Security Boulevard, Baltimore, MD 21244.

Comments mailed to the above addresses may be delayed and received too late for us to consider them.

Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code HCFA–1160–P. Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, in Room 443–G of the Department's office at 200 Independence Avenue, SW., Washington, DC, on Monday through Friday of each week from 8:30 to 5 p.m. (phone: (202) 690–7890).

FOR FURTHER INFORMATION CONTACT: Siera Gollan, (410) 786–6664.

SUPPLEMENTARY INFORMATION:

I. Background

Sections 1851 through 1859 of the Social Security Act (the Act) established a new Part C of the Medicare program, known as the ''Medicare+Choice (M+C) Program.'' On June 26, 1998, we published a comprehensive interim final rule (63 FR 34968) in the **Federal Register** to implement the M+C Program. That interim final rule set forth the new M+C regulations in 42 CFR Part 422—Medicare+Choice Program. We published a subsequent final rule with comment period in the **Federal Register** on June 29, 2000 (65 FR 40170).

When these rules were promulgated, we established a 2-year recredentialing cycle consistent with standards adopted by nationally recognized private quality assurance accrediting organizations. Under § 422.204(b)(2)(ii), Medicare+Choice Organizations (M+COs) are required to recredential providers, who are physicians or other health care professionals (including members of physicians groups) at least every 2 years. The recredentialing updates information obtained during initial credentialing and considers performance indicators such as those collected through quality assurance programs, utilization management systems, handling of grievances and appeals, enrollment satisfaction surveys, other plan activities, and an attestation of the correctness and completeness of the new information.

Since the promulgation of these M+C rules, however, the nationally recognized private quality assurance accrediting organizations' standards for recredentialing have changed to a 3-year cycle. Therefore, our regulations are no longer consistent with standards adopted by these organizations. We believe that the change in the standards for recredentialing from a 2-year cycle to a 3-year cycle is appropriate because it lessens the administrative burdens on M+COs and their providers without negatively affecting Medicare beneficiaries or the Medicare program.

II. Provisions of this Proposed Regulation

We propose to change the recredentialing cycle requirement in § 422.204(b)(2)(ii) from at least a 2-year cycle to at least a 3-year cycle. This change would maintain consistency with managed care industry recognized standards of practice and quality, and is consistent with standards already adopted by nationally recognized private quality assurance accrediting organizations. Under this proposed change to the regulation, M+COs that wish to recredential on a 2-year cycle may continue to do so.

I. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for the following sections of this document that contain information collection requirements:

Section 422.204 (Provider selection and credentialing) requires recredentialing at least every 3 years that updates information obtained during initial credentialing and considers performance indicators such as those collected through quality assurance programs, utilization management systems, handling of grievances and appeals, enrollee satisfaction surveys, other plan activities, and an attestation of the correctness and completeness of the new information. While the criteria and timing of the recredentialing process is currently approved under OMB control number 0938–0753, the general recredentialing criteria of every 2 years is being revised to every 3 years.

If you comment on the information collection and recordkeeping requirements, please mail copies directly to the following:

Health Care Financing Administration, Office of Information Services, Information Technology Investment Management Group, Attn.: John Burke, Room N2–14–26, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Allison Herron Eydt, HCFA Desk Officer.

IV. Regulatory Impact Statement

A. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review) and the Regulatory Flexibility Act (RFA) (September 19, 1980 Public Law 96–354). Executive Order 12866 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 1 year). This rule is not a major rule, as there are no additional costs to implement the one change that results from this proposed rule. Since the proposed rule changes the

recredentialing requirement from a 2-year to a 3-year cycle to remain consistent with the private accreditation processes, the regulation change decreases administrative costs for the health plan and the providers within the health plan.

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 government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $5 million or less annually. For purposes of the RFA, some M+COs are considered to be small entities. Individuals and States are not included in the definition of a small entity.

In addition, section 1102(b) of the Social Security 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 603 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 and has fewer than 50 beds.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in an expenditure in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of $100 million. The proposed rule will not have an effect on State, local, or tribal governments, nor will the rule meet the $100 million threshold.

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 rule does not impose any direct requirement costs on State or local governments.

B. Anticipated Effects

1. Effects on M+COs

The effect on M+COs will be to lessen the mandated recredentialing requirements to at least once every 3 years rather than the current requirement of at least once every 2 years. If the rule is not promulgated, Medicare M+COs would be required to recredential on a schedule that is different and more demanding for Medicare contractors than private contractors, adding an administrative complexity and cost without benefit. M+COs can maintain recredentialing more often at their option; this change simply addresses consistency with standards of private accreditation agencies.

2. Effects on Other Providers

Effects on other providers are limited, except that providers in M+COs will not be required to provide credentialing material at a greater frequency than they are required to provide it by the private accreditation agencies and the M+COs' individual corporate requirements.

3. Effects on the Medicare and Medicaid Programs

This rule makes no change to the Medicaid program. The rule simplifies the recredentialing mandated cycle for consistency with the private accreditation processes for Medicare M+COs. If the rule is not promulgated, a cycle inconsistent with the private accreditation organizations will require private accreditation organizations to change their cycle in order to be deemed for Medicare and require M+COs and their providers to undergo an additional administrative cost and process without identified benefit to Medicare beneficiaries or the Medicare program.

C. Alternatives Considered

The only other alternative would be to leave the regulation unchanged. To meet our goal to be consistent, when appropriate, with the standards of the private accreditation organizations, we decided that the change is necessary.

D. Conclusion

For these reasons, we are not preparing analyses for either the RFA or section 1102(b) of the Act because we have determined, and we certify, that this rule would 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 reviewed by the Office of Management and Budget.

V. Response to Comments

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

List of Subjects in 42 CFR Part 422

Administrative practice and procedure, Health facilities, Health maintenance organizations (HMO), Medicare+Choice, Penalties, Privacy, Provider-sponsored organizations (PSO), Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Health Care Financing Administration would amend 42 CFR chapter IV as follows:

PART 422—MEDICARE+CHOICE PROGRAM

1. The authority citation for part 422 is revised to read as follows:

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

2. Revise § 422.204(b)(2)(ii) to read as follows:

§ 422.204 Provider selection and credentialing.

* * * * *

(b) * * *

(2) * * *

(ii) Recredentialing at least every 3 years that updates information obtained during initial credentialing and considers performance indicators such as those collected through quality assurance programs, utilization management systems, handling of grievances and appeals, enrollee satisfaction surveys, other plan activities, and an attestation of the correctness and completeness of the new information; and

* * * * *

Authority: Secs. 1102, 1851 through 1857, 1859, and 1871 of the Social Security Act (42 U.S.C. 1302, 1395w-21 through 1395w-27, and 1395hh).

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

Dated: November 9, 2000.

Michael M. Hash,

Acting Administrator, Health Care, Financing Administration

Dated: November 28, 2000.

Donna E. Shalala,

Secretary.

[FR Doc. 00–32995 Filed 12–26–00; 8:45 am]

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