power and responsibilities established by Congress in the preemption provisions of FFDCA section 408(n)(4).

For these same reasons, the Agency has determined that this rule does not have any ''tribal implications'' as described in Executive Order 13175, entitled *Consultation and Coordination with Indian Tribal Governments* (65 FR 67249, November 6, 2000). Executive Order 13175, requires EPA to develop an accountable process to ensure ''meaningful and timely input by tribal officials in the development of regulatory policies that have tribal implications.'' ''Policies that have tribal implications'' is defined in the Executive Order to include regulations that have ''substantial direct effects on one or more Indian tribes, on the relationship between the Federal government and the Indian tribes, or on the distribution of power and responsibilities between the Federal government and Indian tribes.'' This rule will not have substantial direct effects on tribal governments, on the relationship between the Federal government and Indian tribes, or on the distribution of power and responsibilities between the Federal government and Indian tribes, as specified in Executive Order 13175. Thus, Executive Order 13175 does not apply to this rule.''

Because this rule has been exempted from review under Executive Order 12866 due to its lack of significance, this rule is not subject to Executive Order 13211, *Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution, or Use* (66 FR 28355, May 22, 2001).

IX. Submission to Congress and the Comptroller General

The Congressional Review Act, 5 U.S.C. 801 *et seq.*, as added by the Small Business Regulatory Enforcement Fairness Act of 1996, generally provides that before a rule may take effect, the agency promulgating the rule must submit a rule report, which includes a copy of the rule, to each House of the Congress and to the Comptroller General of the United States. EPA will submit a report containing this rule and other required information to the U.S. Senate, the U.S. House of Representatives, and the Comptroller General of the United States prior to publication of this final rule in the **Federal Register**. This final rule is not a ''major rule'' as defined by 5 U.S.C. 804(2).

List of Subjects in 40 CFR Part 180

Environmental protection, Administrative practice and procedure, Agricultural commodities, Pesticides and pests, Reporting and recordkeeping requirements.

Dated: August 14, 2001.

Peter Caulkins, Acting

Director, Registration Division, Office of Pesticide Programs.

Therefore, 40 CFR chapter I is amended as follows:

PART 180—[AMENDED]

1. The authority citation for part 180 continues to read as follows:

Authority: 21 U.S.C. 321(q), 346(a) and 371.

2. Section 180.516 is amended by alphabetically adding the following commodity to the table in paragraph (b) to read as follows:

§ 180.516 Fludioxonil; tolerances for residues.

* * * * *

(b) * * *

Commodity	Parts per million	Expiration/revocation date
* * * * *		
Pomegranate	5.0	6/30/03
* * * * *		

* * * * *

[FR Doc. 01–22524 Filed 9–11–01; 8:45 am]

BILLING CODE 6560–50–S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 422

[CMS–1160–F]

RIN 0938–AK41

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

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

ACTION: Final rule.

SUMMARY: This final rule changes the requirement for 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. This change simplifies administrative requirements by retaining consistency with the private accrediting processes. This rule benefits M+COs and providers within the M+COs who must be recredentialed, while continuing to address quality issues of Medicare beneficiaries.

DATES: The effective date of this rule is October 12, 2001.

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 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 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, considers performance indicators such as those collected through quality assurance programs, utilization management systems, handling of grievances and appeals, enrollment satisfaction surveys,

and other plan activities, and includes 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.

On December 27, 2000, we published a proposed rule in the **Federal Register** (65 FR 81813) proposing to change the requirement for the recredentialing of providers who are physicians or other health care professionals for M+COs in § 422.204(b)(2)(ii) from at least a 2-year cycle to at least a 3-year cycle. The proposed change to the regulation still allowed for M+COs to recredential their providers on a 2-year cycle if they wished to do so.

II. Analysis of, and Responses to, Public Comments on the Proposed Rule

We received 8 timely comments in response to the December 27, 2000 proposed rule. The majority of the comments were from health plans and credentials verification organizations. We reviewed each commenter's letter and grouped like or related comments. Some comments were identical, indicating that the commenters had submitted form letters. The comments and our responses are summarized below.

A. Change the Recredentialing Requirement From at Least Every 2 Years to at Least Every 3 Years

Comment: The majority of commenters expressed their support of changing the recredentialing cycle for M+COs from at least every 2 years to at least every 3 years. They stated that the change will decrease administrative costs and result in consistency with private accrediting organizations, while at the same time maintaining the level of quality necessary to adequately protect Medicare beneficiaries.

Response: We appreciate the support of these commenters. This change will make our regulations consistent with the recredentialing standards adopted by nationally recognized private quality assurance accrediting organizations. We agree that it will lessen the administrative burdens on M+COs and their providers without negatively affecting Medicare beneficiaries or the Medicare program.

Comment: One commenter pointed out that the proposed rule modified § 422.204(b)(2)(ii) by omitting several words in the explanation of the purpose of recredentialing. The commenter agreed with the move from at least every 2 years to at least every 3 years, but suggested that the final rule otherwise retain the existing regulatory language.

Response: Our purpose for making minor editorial changes to the language was not to change the intent of the rule, but to make the language clearer. The recredentialing process does the following:

- Updates information obtained during initial credentialing.
- Considers performance indicators such as those collected through quality assurance programs, utilization management systems, handling of grievances and appeals, enrollee satisfaction surveys, and other plan activities.
- Includes an attestation of the correctness and completeness of the new information.

We understand the commenter's concern with the regulations text in the proposed rule and we have changed the text in this final rule to more accurately distinguish between the three components of recredentialing above.

Comment: Several commenters, representing credentials verification organizations (CVOs), expressed concern about moving from a 2-year to a 3-year recredentialing cycle. These commenters cited risk management issues, such as protecting their patients from harm, on the part of the M+COs.

These commenters also stated that timely and thorough recredentialing practices ensure quality health care, while reducing the risk to health plans and reducing the probability of medical errors and substandard care. They stated that there is no definitive research showing that moving to a 3-year cycle is in the best interest of the public (pointing out that of the 32 states that require recredentialing, 12 require recredentialing every 2 years while only eight require it every 3 years), and they believe that most M+COs will choose to implement the 3-year recredentialing cycle, even though we allow them to accept a more stringent standard.

Response: The M+CO must assess any possible risks, including risk management issues, of implementing any standards in their own organizations. Since the regulation still allows for more frequent recredentialing of providers, it is the decision of the M+CO whether to implement the 3-year recredentialing cycle. We believe that, as a national policy, risk management will not be negatively effected by a 3-year recredentialing cycle.

We agree that timely and thorough recredentialing is necessary to ensure quality health care, reduce risk to health plans and members, and reduce the probability of medical errors and substandard care. However, we agree with the nationally recognized private quality assurance accrediting organizations who have determined that these factors are not compromised by moving from a 2-year recredentialing cycle to a 3-year recredentialing cycle. If a State law requires a more stringent recredentialing cycle for M+CO providers, the State law supercedes our 3-year requirement.

B. Miscellaneous Comments

Comment: Several commenters expressed the need for a form of interim monitoring of providers credentials including licensure, querying the National Practitioner Data Bank (NPDB), and sanction activity.

Response: We currently require interim monitoring in several ways. We require that all M+CO's monitor the Medicare and Medicaid sanction list published by the Office of the Inspector General as frequently as that list is published (monthly). We also require resolution and documentation of any member complaint or grievance. The M+CO is also prohibited from contracting with providers who opt out of Medicare. In addition to accessing the NPDB, M+COs are encouraged to query the Healthcare Integrity and Protection Data Bank (HIPDB). M+COs are also permitted to establish their own interim monitoring procedures, in order to ensure that unqualified providers are not providing care to Medicare beneficiaries.

Comment: One commenter suggested that we try to simplify and standardize credentialing requirements. The commenter suggested establishing a centralized credentialing provider databank and ''perpetual'' verifications, outside of the NPDB.

Response: Although this request is outside the scope of this regulation, we, in conjunction with other organizations, are in the process of exploring the possibility of having a centralized data bank for provider credentials.

Comment: One commenter suggested that we align our credentialing standards with those of the National Committee for Quality Assurance (NCQA). This commenter believes that a meaningful reduction in administrative burden is dependent upon comprehensive standardization. This commenter also believed that aligning

standards with the NCQA standards would not compromise the rigorous standards currently required through the Quality Improvement System for Managed Care standards. Another commenter suggested that we accept a form of provisional credentialing to remain consistent with NCQA.

Response: Although this request is not directly related to this regulation, we are currently re-examining all of our standards related to provider credentialing. We are assessing standards that are implemented by private accrediting organizations and evaluating the applicability of those standards to the Medicare program.

III. Provisions of This Final Regulation

This final rule incorporates the 3-year recredentialing cycle of the proposed rule. As discussed in section II of this preamble, we believe the requirement of a 3-year recredentialing cycle for providers who are physicians or other health care professionals for M+COs is consistent with industry standards and continues to ensure high quality care for Medicare beneficiaries.

We have made a minor editorial change to the language describing what recredentialing includes, but have not changed the substance or the intent of this language from the current regulation or the proposed rule.

IV. 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, considers performance indicators such as those collected through quality assurance programs, utilization management systems, handling of grievances and appeals, enrollee satisfaction surveys, and other plan activities, and includes 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:

Centers for Medicare & Medicaid Services, 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, CMS Desk Officer.

V. 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 ($110 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 final rule. Since the rule changes the recredentialing requirement from a 2-year to a 3-year cycle, it 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 to $25 million or less annually (see 66 FR 69432). 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. This 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 does 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.

List of Subjects Affected 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, 42 CFR chapter IV is amended 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, considers performance indicators such as those collected through quality assurance programs, utilization management systems, handling of grievances and appeals, enrollee satisfaction surveys, and other plan activities, and that includes 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: September 7, 2001.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

Dated: September 7, 2001.

Tommy G. Thompson,

Secretary.

[FR Doc. 01–22915 Filed 9–11–01; 8:45 am]

BILLING CODE 4120–01–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 73

[DA 01–2055; MM Docket No. 01–89; RM–10094]

Television Broadcasting Services; Decatur, Plano, TX.

AGENCY: Federal Communications Commission.

ACTION: Final rule, dismissal.

SUMMARY: The Commission dismisses a petition for rule making filed by Word of God Fellowship, Inc. (''petitioner''), requesting the reallotment of Television Channel 29 from Decatur to Plano, Texas as the community's first local transmission service. Petitioner filed no comments in response to the Notice of Proposed Rulemaking.

FOR FURTHER INFORMATION CONTACT: Victoria M. McCauley, Mass Media Bureau, (202) 418–2180.

SUPPLEMENTARY INFORMATION: This is a synopsis of the Commission's Report and Order, MM Docket No. 01–89 adopted August 22, 2001 and released August 31, 2001. The full text of this Commission decision is available for inspection and copying during normal business hours in the FCC Reference Information Center (Room CY–A257), 445 12th Street, SW., Washington, DC. The complete text of this decision may also be purchased from the Commission's copy contractor, International Transcription Service, Inc., (202) 857–3800, 1231 20th Street, NW., Washington, DC 20036.

Federal Communications Commission.

John A. Karousos,

Chief, Allocations Branch, Policy and Rules Division, Mass Media Bureau.

[FR Doc. 01–22834 Filed 9–11–01; 8:45 am]

BILLING CODE 6712–01–U

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 648

[Docket No. 001121328–1041–02; I.D. 111500C]

Fisheries of the Northeastern United States; Summer Flounder, Scup, and Black Sea Bass Fisheries; Adjustments to the 2001 Summer Flounder, Scup, and Black Sea Bass Commercial Quotas

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Commercial quota adjustment; correction.

SUMMARY: NMFS publishes corrected adjustments to the 2001 commercial quotas for summer flounder, scup, and black sea bass. This action is necessary to comply with the regulations that implement the Fishery Management Plan for the Summer Flounder, Scup, and Black Sea Bass Fisheries (FMP), which specify that any summer flounder landings in excess of or less than a given state's individual 2000 commercial quota be deducted from or added to that state's quota for 2001. For scup and black sea bass, the FMP specifies that landings in excess of a quota for a given period or quarter be deducted from the quota for the same period or quarter in the following year. The intent of this