of 1999, Public Law 106–170. (Catalog of Federal Domestic Assistance Program No. 93.779, Centers for Medicare and Medicaid Services Research, Demonstration, and Evaluations).

Dated: January 23, 2002.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 02–2017 Filed 1–24–02; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

CMS–2087–PN

RIN 0938–AK91

Medicaid Program; State Allotments for Payment of Medicare Part B Premiums for Qualifying Individuals: Federal Fiscal Year 2001

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

ACTION: Proposed notice.

SUMMARY: The Social Security Act provides for the Medicaid program to pay all or part of the Medicare Part B premiums (for months during the period beginning with January 1998, and ending with December 2002) for two specific eligibility groups of low-income Medicare beneficiaries, referred to as Qualifying Individuals. This notice announces the proposed allotments that would be available for State agencies to pay Medicare Part B premiums for these eligibility groups for Federal fiscal year 2001.

DATES: We will consider comments if we receive them at the appropriate address, as provided below, no later than 5 p.m. on March 26, 2002.

If the proposed allotments are adopted as final, they will be available for expenditures made during the Federal fiscal year 2001 (beginning October 1, 2000).

ADDRESSES: Mail written comments (1 original and 3 copies) to the following address: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–2087–PN, PO Box 8010,Baltimore, MD 21244–8010.

To insure 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, orRoom C5–16–03, 7500 Security Boulevard, Baltimore, MD 21244–8010.

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 CMS–2087–PN. Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at 7500 Security Blvd, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 to 5 p.m. (phone: (410) 786–9994).

FOR FURTHER INFORMATION CONTACT: Miles McDermott, (410) 786–3722.

SUPPLEMENTARY INFORMATION:

I. Background

A. Before the Balanced Budget Act of 1997

Before the enactment of the Balanced Budget Act of 1997 (BBA), section 1902(a)(10)(E) of the Social Security Act (the Act) specified that a Medicaid State plan must provide for Medicare cost-sharing for three eligibility groups of low-income Medicare beneficiaries. These three groups included Qualified Medicare Beneficiaries (QMBs), Specified Low-income Medicare Beneficiaries (SLMBs), and Qualified Disabled and Working Individuals (QDWIs).

A QMB is an individual entitled to Medicare Part A with income at or below the Federal poverty level and resources below $4,000 for an individual and $6,000 for a couple. An SLMB is an individual who meets the QMB criteria, except that his or her income is between a State-established level (at or below the Federal poverty level) and 120 percent of the Federal poverty level. A QDWI is an individual who is entitled to enroll in MedicarePart A, whose income does not exceed 200 percent of the Federal poverty level for a family of the size involved, whose resources do not exceed twice the amount allowed under the Supplementary Security Income (SSI) program, and who is not otherwise eligible for Medicaid. The definition of Medicare cost-sharing at section 1905(p)(3) of the Act includes payment for premiums for Medicare Part B.

B. After the Balanced Budget Act of 1997

Section 4732 of the BBA amended section 1902(a)(10)(E) of the Act to require States to provide for Medicaid payment of all or part of the Medicare Part B premiums, during the period beginning January 1998 and ending December 2002, for selected members of two eligibility groups of low-income Medicare beneficiaries, referred to as Qualifying Individuals (QIs).

Under section 1902(a)(10)(E)(iv)(I) of the Act, State agencies are required to pay the full amount of the Medicare Part B premium for selected QIs who would be QMBs except that their income level is at least 120 percent but less than 135 percent of the Federal poverty level for a family of the size involved. These individuals cannot otherwise be eligible for medical assistance under the approved State Medicaid plan.

The second group of QIs, under section 1902(a)(10)(E)(iv)(II) of the Act, includes Medicare beneficiaries who would be QMBs except that their income is at least 135 percent but less than 175 percent of the Federal poverty level for a family of the size involved. These QIs may not be otherwise eligible for Medicaid under the approved State plan, but are eligible for a portion of Medicare cost-sharing consisting only of a percentage of the increase in the Medicare Part B premium attributable to the shift of Medicare home health coverage from Part A to Part B (as provided in section 4611 of the BBA).

Section 4732(c) of the BBA also added section 1933 of the Act, which specifies the provisions for State coverage of the Medicare cost-sharing for additional low-income Medicare beneficiaries.

Section 1933(a) of the Act specifies that a State agency must provide, through a State plan amendment, for medical assistance to pay for the cost of Medicare cost-sharing on behalf of QIs who are selected to receive assistance.

Section 1933(b) of the Act sets forth the rules that State agencies must follow in selecting QIs and providing payment for Medicare Part B premiums. Specifically, the State agency must permit all QIs to apply for assistance and must select individuals on a first-come, first-served basis in the order in which they apply. Under section 1933(b)(2)(B) of the Act, when selecting persons who will receive assistance in calendar years after 1998, State agencies must give preference to those individuals who received assistance as QIs, QMBs, SLMBs, or QDWIs in the last month of the previous year and who continue to be, or become, QIs. Under section 1933(b)(4), persons selected to receive assistance in a calendar year are entitled to receive assistance for the remainder of the year, but not beyond, as long as they continue to qualify. The fact that an individual is selected to

receive assistance at any time during the year does not entitle the individual to continued assistance for any succeeding year. Because the State's allotment is limited by law, section 1933(b)(3) of the Act provides that the State agency must limit the number of QIs so that the amount of assistance provided during the year is approximately equal to the State's allotment for that year.

Section 1933(c) of the Act limits the total amount of Federal funds available for payment of Part B premiums each fiscal year and specifies the formula to be used to determine an allotment for each State from this total amount. For State agencies that execute a State plan amendment in accordance with section 1933(a) of the Act, a total of $1.5 billion was allocated over 5 years as follows: $200 million in FY 1998; $250 million in FY 1999; $300 million in FY 2000; $350 million in FY 2001; and $400 million in FY 2002.

The Federal matching rate for Medicaid payment of Medicare Part B premiums for QIs is 100 percent for expenditures up to the amount of the State's allotment. No Federal matching funds are available for expenditures in excess of the State's allotment amount. Administrative expenses associated with the payment of Medicare Part B premiums for QIs remain at the 50 percent matching level and may not be taken from the State's allotment.

The amount available for each fiscal year is to be allocated among States according to the formula set forth in section 1933(c)(2) of the Act. The formula provides for an amount to each State agency that is to be based on each State's share of the Secretary's estimate of the ratio of—

(1) An amount equal to the sum of the following: (a) Twice the total number of individuals who meet all but the income requirements for QMBs, whose incomes are at least 120 percent but less than 135 percent of the Federal poverty level, and who are not otherwise eligible for Medicaid; and (b) The total number of individuals in the State who meet all but the income requirements for QMBs, whose incomes are at least 135 percent but less than 175 percent of the Federal poverty level, and who are not otherwise eligible for Medicaid; to

(2) The sum of all of these individuals under item (1) for all eligible States.

II. Provisions of This Proposed Notice

This notice announces the proposed allotments to be made available to individual States for Federal fiscal year 2001 for the Medicaid payment of Medicare Part B premiums for QIs identified under sections 1902(a)(10)(E)(iv)(I) and (II) of the Act. The formula used to calculate these allotments was described in detail in the January 26, 1998 **Federal Register** (63 FR 3752, 3754) and, except for the incorporation of the latest data, has been used here without changes.

FY 2001 STATE ALLOTMENTS FOR PAYMENT OF PART B PREMIUMS

[Under Sec. 4732 of the BBA of 1997]

State	(in thousands)			State share of (c) (percent)	State FY2001 allocation (dollars in thousands)
	(a) M1[1]	(b) M2[2]	(c) [2 × (a)] + (b)		
AK	1	4	6	0.10	340
AL	28	74	130	2.10	7,357
AR	21	46	88	1.42	4,980
AZ	21	66	108	1.75	6,112
CA	108	310	526	8.50	29,766
CO	10	27	47	0.76	2,660
CT	8	57	73	1.18	4,131
DC	2	5	9	0.15	509
DE	6	10	22	0.36	1,245
FL	113	282	508	8.21	28,747
GA	22	67	111	1.79	6,281
HI	4	14	22	0.36	1,245
IA	17	59	93	1.50	5,263
ID	6	19	31	0.50	1,754
IL	38	148	224	3.62	12,676
IN	41	80	162	2.62	9,167
KS	10	40	60	0.97	3,395
KY	20	65	105	1.70	5,942
LA	24	67	115	1.86	6,508
MA	34	79	147	2.38	8,319
MD	26	52	104	1.68	5,885
ME	7	16	30	0.49	1,698
MI	36	138	210	3.40	11,884
MN	23	46	92	1.49	5,206
MO	24	78	126	2.04	7,130
MS	15	44	74	1.20	4,188
MT	4	11	19	0.31	1,075
NC	46	111	203	3.28	11,487
ND	5	13	23	0.37	1,302
NE	10	34	54	0.87	3,056
NH	2	12	16	0.26	905
NJ	35	101	171	2.76	9,677
NM	7	25	39	0.63	2,207
NV	6	23	35	0.57	1,981
NY	94	236	424	6.86	23,994
OH	51	161	263	4.25	14,883
OK	23	61	107	1.73	6,055
OR	8	39	55	0.89	3,112

FY 2001 STATE ALLOTMENTS FOR PAYMENT OF PART B PREMIUMS—Continued

[Under Sec. 4732 of the BBA of 1997]

State	(in thousands)			State share of (c) (percent)	State FY2001 allocation (dollars in thousands)
	(a) M1[1]	(b) M2[2]	(c) [2 × (a)] + (b)		
PA	81	195	357	5.77	20,202
RI	9	18	36	0.58	2,037
SC	28	61	117	1.89	6,621
SD	5	13	23	0.37	1,302
TN	36	58	130	2.10	7,357
TX	81	223	385	6.22	21,787
UT	7	18	32	0.52	1,811
VA	31	87	149	2.41	8,432
VT	3	8	14	0.23	792
WA	22	48	92	1.49	5,206
WI	21	95	137	2.22	7,753
WV	13	42	68	1.10	3,848
WY	3	7	13	0.21	736
Total	1296	3593	6185	100.00	350,000

[1] Three-year average (1998–2000) of number of Medicare beneficiaries in State who are not enrolled in Medicaid but whose incomes are at least 120% but less than 135% of FPL

[2] Three-year average (1998–2000) of number of Medicare beneficiaries in State who are not enrolled in Medicaid but whose incomes are at least 135% but less than 175% of FPL

III. 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 notice, and, if we proceed with a subsequent document, we will respond to the major comments in that document.

IV. Regulatory Impact Statement

We have examined the impact of this proposed notice as required by Executive Order 12866 and the Regulatory Flexibility Act (RFA) (Pub. L. 96–354). Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, when 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 statement (RIA) must be prepared for major rules with economic effects of $100 million or more annually. Under 5 U.S.C. 804, we have determined this to be a major rule.

The RFA requires agencies to analyze options for regulatory relief for small entities. For purposes of the RFA, States and individuals are notconsidered to be small entities.

This proposed notice would allocate, among the States, Federal funds to provide Medicaid payment for Medicare Part B premiums for QIs. The total amount of Federal funds available during a Federal fiscal year and the formula for determining individual State allotments are specified in the law. Because the formula for determination of State allotments is specified in the statute, there were not other options to be considered. Therefore, we have applied the statutory formula for the State allotments except for the use of specified data. Because the data specified in the law were not currently available, we have used comparable data from the U.S. Census Bureau on the number of possible QIs in the States, as described in detail in the January 26, 1998 **Federal Register**. These new allotments for FY 2001 incorporate the latest data from the Census Bureau covering 1998 through 2000, as specified in the footnotes to the preceding table.

We believe the statutory provisions that would be implemented in this proposed notice would have a positive effect on States and individuals. Federal funding at the 100 percent matching rate is available for Medicare cost-sharing for Medicare Part B premium payments for selected QIs, and a greater number of low-income Medicare beneficiaries would be eligible to have their Medicare Part B premiums paid under Medicaid.

Section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any notice that may have a significant impact on the operations of a substantial number of small rural hospitals. Such an 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 a Metropolitan Statistical Area and has fewer than 100 beds.

Section 605(b) of the RFA states that preparing an impact analysis is not necessary if the agency certifies that the rule will not have a significant economic impact on a substantial number of small entities. Because this proposed notice would simply provide notice of funding ceilings, as determined under the statute, and is not proposing any new requirements, it would not have a significant impact on small entities or on the operations of a substantial number of small rural hospitals. Therefore, we are not preparing analyses for either the RFA or section 1102(b) of the Act.

Section 202 of the Unfunded Mandate Reform Act of 1995, Public Law 104–4, also requires that agencies assess anticipated costs and benefits before issuing any proposed rule and a final rule preceded by a proposed rule that may result in an expenditure in any one year by State, local or tribal governments, in the aggregate, or any the private sector, or $110 million or more. This notice would have no consequential effect of the governments mentioned or on the private sector.

In accordance with the provisions of Executive Order 12866, this notice was reviewed by the Office of Management and Budget.

We have reviewed this notice under the threshold criteria of Executive Order

13132, Federalism. Because this proposed notice would simply provide notice of funding ceilings, as determined under the statute, and is not proposing any new requirements, we have determined that this proposed notice would not significantly affect the rights, roles, and responsibilities of States.

Authority: Sections 1902(a)(10)(E) and 1933 of the Social Security Act (42 U.S.C. 1396a(a)(10)(E) and 1396x).

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

Dated: January 14, 2002.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid, Services.

[FR Doc. 02–1304 Filed 1–24–02; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–4025–FN]

RIN 0938–ZA15

Medicare Program; Medicare+Choice Organizations—Approval of the Deeming Authority of the National Committee for Quality Assurance (NCQA) for Medicare+Choice (M+C) Managed Care Organizations That Are Licensed as Health Maintenance Organizations (HMOs)

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

ACTION: Final notice.

SUMMARY: This final notice announces the approval of the National Committee for Quality Assurance (NCQA) for deeming authority of Medicare+Choice (M+C) organizations that are licensed as health maintenance organizations (HMOs). We have found that NCQA's standards for managed care organizations (MCOs) submitted to us in the application process meet or exceed those established by the Medicare program. Therefore, M+C organizations that are licensed as HMOs and are accredited by NCQA may receive, at their request, deemed status for the M+C requirements in the six areas—Quality Assurance, Information on Advance Directives, Antidiscrimination, Access to Services, Provider Participation Rules, and Confidentiality and Accuracy of Enrollee Records—that are specified in Section 1852(e)(4)(C) of the Social Security Act (the Act). Regulations set forth in 42 CFR 422.157(b)(2) specify that the Secretary will publish a **Federal Register** notice that indicates whether an accreditation organization's request for approval has been granted and the effective date and term of the approval, which may not exceed 6 years.

FOR FURTHER INFORMATION CONTACT: Trisha Kurtz, (410) 786–4670.

SUPPLEMENTARY INFORMATION:

Copies: To order copies of the **Federal Register** containing this document, send your request to: New Orders, Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250–7954. Specify the date of the issue requested and enclose a check or money order payable to the Superintendent of Documents, or enclose your Visa or Master Card number and expiration date. Credit card orders can also be placed by calling the order desk at (202) 512–1800 or by faxing to (202) 512–2250. The cost for each copy is $9. As an alternative, you can view and photocopy the **Federal Register** document at most libraries designated as Federal Depository Libraries and at many other public and academic libraries throughout the country that receive the **Federal Register**.

This **Federal Register** document is also available from the **Federal Register** online database through GPO Access, a service of the U.S. Government Printing Office. The Website address is: *http://www.access.gpo.gov/nara/index.html.*

I. Background

Under the Medicare program, eligible beneficiaries may receive covered services through a managed care organization (MCO) that has a Medicare+Choice (M+C) contract with the Centers for Medicare & Medicaid Services (CMS). To enter into an M+C contract, the organization must be licensed by the State as a risk bearing entity and must meet the requirements that are set forth in 42 CFR part 422. These regulations implement Part C of Title XVIII of the Social Security Act (the Act), which specifies the services that an MCO must provide and the requirements that the organization must meet to be an M+C contractor. Other relevant sections of the Act are Parts A and B of Title XVIII and Part A of Title XI pertaining to the provision of services by Medicare certified providers and suppliers.

Following approval of the M+C contract, CMS engages in routine monitoring of the M+C organization to ensure continuing compliance. The monitoring process is comprehensive and uses a written protocol that itemizes the Medicare requirements the M+C organization must meet.

An M+C organization may be exempt from CMS monitoring of the requirements that are in the areas listed in section 1852(e)(4)(C) of the Act as a result of the organization being accredited by a CMS-approved accrediting organization. In essence, the Secretary ''deems'' that the Medicare requirements are met based on a determination that the accrediting organization's standards are at least as stringent as Medicare requirements. Regulations for the M+C deeming program are set forth in §§ 422.156, 422.157, and 422.158. The term for which an accrediting organization may be approved by CMS may not exceed 6 years as stated in § 422.157(b)(2). For continuing approval, the accrediting organization will have to re-apply to CMS.

II. Provisions of the Proposed Notice

On August 1, 2001, we published a proposed notice in the **Federal Register** (66 FR 39775) announcing the receipt of an application from NCQA for approval of deeming authority for M+C organizations that are licensed as health maintenance organizations (HMOs). In the proposed notice, we provided the factors on which we would base our evaluation. In accordance with § 422.157(b)(iii) of the proposed notice, we provided a 30-day public comment period. We did not receive public comments in response to the proposed notice for NCQA.

III. Deeming Approval Review and Evaluation

As set forth in section 1852(e)(4) of the Act and our regulations at § 422.158, the review and evaluation of the NCQA's accreditation program was compared to the requirements set forth in part 422 for the M+C program.

A. Components of the Review Process

The review of NCQA's application for approval of M+C deeming authority included the following components.

1. Site Visit

A site visit to NCQA's headquarters to assess—

- Corporate policies and procedures that relate to the MCO accreditation program;
- The survey, decision-making, and report-writing processes used in NCQA's MCO accreditation program;
- The resources available for accreditation reviews and the ability to financially sustain an M+C deeming program;
- The staff and surveyor training and evaluation programs;