received by the authorized officer. However, if a copy of the State's repealing or amending legislation is received after July 1, payments made directly to eligible units of local government shall not begin until the subsequent Federal fiscal year.

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January 10, 1985

Part IV

Department of the Interior

Bureau of Land Management

43 CFR Part 2880

Rights-of-Way Under the Mineral Leasing Act; Procedures for Collection of Reimbursable Costs; Final Rule

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

43 CFR Part 2880

[Circular No. 2557]

Rights-of-Way Under the Mineral Leasing Act; Procedures for Collection of Reimbursable Costs

AGENCY: Bureau of Land Management, Interior.

ACTION: Final rulemaking.

SUMMARY: This final rulemaking amends 43 CFR Part 2880 by providing cost reimbursement procedures that are currently contained in 43 CFR Part 2800 and updates them to provide more adequately for recovery by the United States of the costs of processing and monitoring rights-of-way and temporary use permits granted under authority provided by section 28 of the Mineral Leasing Act of 1920, as amended and supplemented.

EFFECTIVE DATE: February 11, 1985.

ADDRESS: Any suggestions or inquiries should be sent to: Director (330), Bureau of Land Management, 1800 C Street NW., Washington, D.C. 20240.

FOR FURTHER INFORMATION CONTACT:

Theodore G. Bingham, (202) 343–5441;

or

Robert C. Bruce, (202) 343–8735.

SUPPLEMENTARY INFORMATION: The proposed rulemaking amending for the second time the procedures for cost recovery for right-of-way grants and temporary use permits granted under the Mineral Leasing Act of 1920, as amended and supplemented (30 U.S.C. 181 et seq.) was published in the **Federal Register** on June 25, 1984 (49 FR 25972). During the 60-day comment period, 16 comments were received; 8 from businesses engaged in the oil and gas industry, 5 from Federal agencies, 2 from associations and 1 from an attorney. The comments and the action taken on them are discussed below.

Several of the comments questioned the appropriateness of the costs shown in the fee schedule, with some feeling that they were too high, while others felt that they were not sufficient to cover the costs incurred by the United States. As discussed in the preamble to the proposed rulemaking of June 25, 1984, the costs shown in the fee schedules are based on current average costs incurred in processing right-of-way grant and temporary use permit applications and monitoring those grants by various offices of the Bureau of Land Management. Since these costs are average costs, there are instances where the cost of handling specific applications by the various offices may be higher or lower than those shown in the schedule. The use of current average costs to set a fee schedule is a commonly accepted practice in both the private and public sectors. The Department has further determined that this method results in less administrative expense than accounting for and reporting actual costs for each right-of-way activity. Therefore, no change has been made in the fee schedule in the final rulemaking.

Several of the comments expressed concern that the process in the proposed rulemaking for determining the appropriate category would delay completing the processing of a right-of-way grant or temporary use permit application. The comments stated this delay could be expecially lengthy in those instances where an application is submitted through the mail. The concern was that the procedures provided in the proposed rulemaking would require the authorized officer to review an application and to return it if it was found inadequate because of the failure to submit a sufficient fee. This would add time to the processing of an application. After careful review of the procedures in the proposed rulemaking, the final rulemaking changes those procedures to permit the acceptance of an application for the purpose of determining the category and nonrefundable fee. Once this determination is made, the applicant will be notified of the category determination and the amount of the nonrefundable fee. No action will be taken on processing an application until the nonrefundable fee has been submitted in full. The final rulemaking also provides for refunding any overpayment of the nonrefundable fee submitted with an application.

The Bureau of Land Management continues to urge right-of-way applicants to take advantage of the pre-application activity provided in the existing regulations. Experience has shown that this process saves the applicant/holder and the Bureau time and avoids problems. Applicants who find it impossible to participate in face-to-face pre-application activity may find that they can save time and avoid problems by working out questions over the telephone. These direct communications are invaluable in reducing delays that can result from misunderstanding.

A few of the comments again raised the point that in their view the collection of reimbursable costs and an annual rental is a double charge for the use of the lands covered by an application/grant. The Mineral Leasing Act requires the collection of costs incurred by the United States in processing and monitoring a right-of-way grant or temporary use permit and the collection of an annual rental. The proposed and final rulemakings follow the requirements of the Mineral Leasing Act regarding cost recovery and no change has been made in these provisions by the final rulemaking.

A couple of comments suggested that the value of the lands involved in a specific application should be considered when setting the fee schedule. The fee schedule is based upon the costs incurred by the Bureau of Land Management in processing an application and monitoring a grant. Those costs were based on the average costs of actions by Bureau personnel in carrying out their responsibilities. These costs would be the same for a visit, whether to lands of high or low value. Any difference in the return received by the United States on lands of high or low value is in the annual rental received once a grant or permit has been issued.

A few of the comments again raised the point that there was an inadequate explanation of how the fee schedules were derived. The preamble to the proposed rulemaking contained a discussion of the process the Bureau of Land Management used in arriving at its fee schedules. The schedules are based on the Bureau's experience in handling application/grants over the past few years. The data that are the basis of the fee schedules are available for review. The Bureau will continue to collect data as it processes/monitors right-of-way grants and temporary use permits. Those data will be the basis for any future revisions of the fee schedules if that should prove necessary.

One comment pointed out that the proposed rulemaking did not clearly provide that the category for monitoring would be the same as that for application processing. This comment is well taken and the final rulemaking incorporates language clarifying the point that the category for processing and monitoring will be based on a single determination by the authorized officer.

A couple of comments raised the issue that the descriptions of categories V and VI in the proposed rulemaking made it impossible to distinguish between a category V and category VI application. The final rulemaking changes the description of category VI to remove this ambiguity.

A few of the comments expressed concern that there would be a variance in the determination of the categories because of the differences in judgment of the various authorized officers. Even though individuals can reasonably reach

a different conclusion using the same data, the Bureau of Land Management has provided careful instructions in this area through its Manual an other instructions. Further, and applicant who feels that a category determination is inappropriate may use the appeal procedure provided in the regulations for an administrative review of that decision.

A couple of the comments requested that the final rulemaking give the authorized officer greater authority than was provided in the proposed rulemaking to change the category determination once it has been made. The Bureau of Land Management's experience in processing applications and monitoring grants indicates that there is very small probability for a change in the category determination once it has been made and that small probability does not justify the additional time and expense that would be incurred by all concerned in the effort to obtain a change of categories. Both of the rulemakings provide authority to change the category to Category VI when it is determined that an environmental impact statement is required, because of the high cost of preparing such a document.

One comment suggested that the final rulemaking should provide relief for an activity of marginal value where there would be an adverse economic effect from the collection of reimbursable costs. The Mineral Leasing Act provides only limited authority for waiving the collection of reimbursable costs. In addition, waiving such costs for a project would provide an indirect government subsidy from all the taxpayers to that project, giving it an unfair competitive advantage over those projects that are required to pay such costs. This suggestion was not adopted by the final rulemaking.

A couple of comments raised questions about the category determination for a large project that encompasses rights-of-way for various purposes, i.e., roads, pipelines, communications sites, working sites, etc. If an application is filed for a pipeline right-of-way, that application will be processed under the provisions of 43 CFR Part 2880, Rights-of-Way Under the Mineral Leasing Act.

The other activities are considered "related facilities" and may be consolidated into the application for the pipeline right-of-way, with the category determination being based on the entire package. Any needed ancillary temporary use permits may also be consolidated into this right-of-way application. However, there is nothing in the existing regulations or this final rulemaking that would prevent an applicant from filing several applications for the various parts of a large project and having them treated as separate applications. No change has been made in the final rulemaking as a result of this comment.

The final rulemaking adds a new paragraph (d) which contains the language of paragraph (b) of the temporary final rulemaking that was published in the **Federal Register** on August 3, 1984 (49 FR 31208). This language has been added to continue in effect the provisions of that temporary final rulemaking until such time as a decision is made on the permanent adoption of those provisions. The Department of the Interior is continuing its review of the comments on the temporary final rulemaking and a final decision on its implementation will be issued in the near future.

Editorial and grammatical changes as needed have been made by the final rulemaking.

The principal author of this final rulemaking is Sheldon Weil, Division of Right-of-Way, Bureau of Land Management, assisted by the staff of the Office of Legislation and Regulatory Management, Bureau of Land Management.

The Department of the Interior has determined that this document is not a major rule under Executive Order 12291 and will not have a significant economic effect on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601 et seq.).

The changes made by this final rulemaking will not, when the payments for all right-of-way and temporary use permit applications are considered, substantially increase the payments made by right-of-way applicants/holders for processing and monitoring. The changes made by this final rulemaking make the reimbursement of costs procedures used by the Bureau of Land Management more equitable and will recover for the United States a greater portion of the costs incurred in the processing and monitoring of right-of-way grants and temporary use permits.

The changes made by this final rulemaking will be equally applicable to all entities that make application to the Bureau of Land Management for use of the Federal lands for oil or gas right-of-way grants or temporary use permits for related facilities.

There are no additional information collection requirements in this final rulemaking requiring approval by the Office of Management and Budget under 44 U.S.C. 3507.

List of Subjects in 43 CFR Part 2880

Administrative practice and procedure, Common carriers, Oil and gas industry, Pipelines, Public lands—rights-of-way.

Under the authority of section 28 of the Mineral Leasing Act of 1920, as amended and supplemented (30 U.S.C. 181 et seq.), Part 2880, Group 2800, Subchapter B, Chapter II of Title 43 of the Code of Federal Regulations is amended as set forth below.

Dated: December 17, 1984.

J. Steven Griles,

Acting Assistant Secretary of the Interior.

§ 2882.1 [Amended]

1. Section 2882.1(c) is amended by removing the citation "§ 2803.1–1" and replacing it with the citation "§ 2883.1–1".

2. Subpart 2883 is amended by revising § 2883.1–1 to read:

§ 2883.1–1 Cost reimbursement.

(a) (1) An applicant for a right-of-way grant or a temporary use permit shall reimburse the United States for administrative and other costs incurred by the United States in processing the application, including the preparation of reports and statements pursuant to the National Environmental Policy Act of 1969 (42 U.S.C. 4321–4347), prior to the United States having incurred such costs. All costs shall be paid before the right-of-way grant or temporary use permit shall be issued under the regulations of this title.

(2) The regulations contained in this subpart do not apply to State or local governments or agencies or instrumentalities thereof where the Federal lands are used for governmental purposes and such lands and resources continue to serve the general public, except as to right-of-way grants or temporary use permits issued to State or local governments or agencies or instrumentalities thereof or a municipal utility or cooperative whose principal source of revenue is derived from charges levied on customers for services rendered that are similar to services rendered by a profit making corporation or business enterprise.

(3) The applicant shall submit with each application a nonrefundable application processing fee in the amount required by a schedule of fees for this purpose contained in paragraph (c) of this section which shall be based on a review of the use of the Federal lands for which the application is made, the resources affected and the complexity and costs to the United States for processing required by an application

for a right-of-way grant and shall be established according to the following general categories:

(i) *Category I.* An application for a right-of-way grant or temporary use permit to authorize a use of Federal lands for which the data necessary to comply with the National Environmental Policy Act are available in the office of the authorized officer; and no field examination of the lands affected by the application is required;

(ii) *Category II.* An application for a right-of-way grant or temporary use permit to authorize a use of Federal lands for which the data necessary to comply with the National Environmental Policy Act are available in the office of the authorized officer; and one field examination of the lands affected by the application to verify the existing data is required;

(iii) *Category III.* An application for a right-of-way grant or temporary use permit to authorize a use of Federal lands for which the data necessary to comply with the National Environmental Policy Act are available in the office of the authorized officer; and two field examinations of the lands affected by the application to verify the data are required;

(iv) *Category IV.* An application for a right-of-way grant or temporary use permit to authorize a use of Federal lands for which some original data are required to be gathered to comply with the National Environmental Policy Act; and two or three field examinations of the lands affected by the application are required;

(v) *Category V.* An application for a right-of-way grant or temporary use permit to authorize a use of Federal lands for which original data are required to be gathered to comply with the National Environmental Policy Act and evaluation of these data require formation of an interdisciplinary team; and three or more field examinations of the lands affected by the application are required;

(vi) *Category VI.* An application for a right-of-way grant or temporary use permit to authorize a use of Federal lands for which the cost of processing activities will be in excess of $5,000.

(4)(i) The authorized officer may accept an application for the purpose of determining the appropriate category and the nonrefundable application processing fee; however, the authorized officer shall collect the full amount of the nonrefundable application processing fee prior to processing such application. A record of the authorized officer's category determination shall be made and given to the applicant, and the decision is a final decision for purposes of appeal under § 2884.1 of this title. Notwithstanding the pendency of such appeal, an application shall not be processed without payment of the fee determined by the authorized officer, and where such payment is made, the application may be processed and, if proper, the grant or permit issued. The authorized officer shall make any refund directed by the appeal decision. Where the amount of the nonrefundable application processing fee submitted by an applicant exceeds the amount of such fee as determined by the authorized officer, the authorized officer shall refund any excess unless requested in writing by the applicant to apply all or part of any such refund to the grant monitoring fee required by paragraph (b) of this section or to the rental payment for such grant or permit.

(ii) During the processing of an application, the authorized officer may change a category determination to place an application in Category VI at any time that it is determined that the application requires preparation of an environmental impact statement. A record of change in category determination under this paragraph shall be made, and the decision is appealable in the same manner as an original category determination made under paragraph (a)(4)(i) of this section.

(5) (i) An applicant whose application is determined to be in Category VI shall, in addition to the nonrefundable application processing fee, reimburse the United States for the full actual administrative and other costs of processing the application. The nonrefundable application processing fee required under the fee schedule shall be credited toward the total cost reimbursement obligation of such applicant. When such an application is filed, the authorized officer shall estimate the costs expected to be incurred in processing the application, inform the applicant of the estimated amount to be reimbursed and require the applicant to make periodic payments of such estimated reimbursable costs prior to such costs being incurred by the United States.

(ii) If the payments required by paragraph (a)(5)(i) of this section exceed the actual costs to the United States, the authorized officer may adjust the next billing to reflect the overpayment, or make a refund from applicable funds under the authority of 43 U.S.C. 1734. An applicant may not set off or otherwise deduct any debt due to it or any sum claimed to be owed it by the United States without the prior written approval of the authorized officer.

(iii) Prior to issuance of a right-of-way grant or temporary use permit, an applicant subject to paragraph (a)(5)(i) of this section shall pay such additional amounts as are necessary to reimburse the United States for any costs which exceed the payments required by paragraph (a)(5)(i) of this section.

(iv) An applicant subject to paragraph (a)(5)(i) of this section whose application is denied is responsible for costs incurred by the United States in processing the application, and such amounts as have not been paid in accordance with paragraph (a)(5)(i) of this section are due within 30 days of receipt of a bill from the authorized officer giving the amount due.

(v) An applicant subject to paragraph (a)(5)(i) of this section who withdraws an application before a decision is reached is responsible for costs incurred by the United States in processing the application up to the date the authorized officer receives written notice of the withdrawal, and for costs subsequently incurred in terminating the application review process. Such amounts as have not been paid in accordance with paragraph (a)(5)(i) of this section are due within 30 days of receipt of a bill from the authorized officer giving the amount due.

(6) When 2 or more applications for right-of-way grants are filed which the authorized officer determines to be in competition with each other, each applicant shall reimburse the United States as required by paragraph (a)(3) of this section. If reimbursement of actual costs is required under paragraph (a)(5)(i) of this section, each applicant shall be responsible for the costs identifiable with his/her application. Costs that are not readily identifiable with one of the applications, such as costs for portions of an environmental impact statement that relate to all of the applications generally, shall be paid by each of the applicants in equal shares or such other proration as may be agreed to in writing by the applicants and authorized officer prior to the United States incurring such costs.

(7) When, through partnership joint venture or other business arrangement, more than one person partnership, corporation, association or other entity apply together for a right-of-way grant or temporary use permit, each such applicant shall be jointly are severally liable for costs under this section.

(8) When 2 or more noncompeting applications for right-of-way grants are received for what, in the judgment of the authorized officer, is one right-of-way system, all of the applicants shall be jointly and severally liable for costs under this section for the entire system.

subject, however, to the provisions of paragraph (a)(7) of this section.

(b) (1) After issuance of a right-of-way grant or temporary use permit for which a fee was assessed under paragraph (a) of this section, the holder thereof shall, prior to the United States having incurred such costs, reimburse the United States for costs incurred by the United States in monitoring the construction, operation, maintenance and termination of authorized facilities on the right-of-way or permit area, and for protection and rehabilitation of the lands involved. The monitoring cost category shall be the same as that for the application processing category for that project.

(2) The holder shall submit a monitoring cost fee along with the written acceptance of the terms and conditions of the grant or permit pursuant to § 2882.3(1) of this title. The amount of the required fee shall be determined by the schedule of fees described in paragraph (c) of this section. Acceptance of the terms and conditions of the grant or permit shall not be effective unless the required fee is paid.

(3) A holder whose application was determined to be in Category VI for application processing purposes shall reimburse the United States for the actual administrative costs and other costs of monitoring the grant or permit. When such a grant or permit is issued, the authorized officer shall estimate the costs expected to be incurred in monitoring the grant or permit, inform the holder of the estimated amount to be reimbursed and require the holder to make periodic payment of such estimated reimburseable costs prior to such costs being incurred by the United States.

(4) If the payments required by paragraph (b)(3) of this section exceed the actual costs of the United States, the authorized officer may adjust the next billing to reflect the overpayment, or make a refund from applicable funds under the authority of 43 U.S.C. 1734. A holder may not set off or otherwise deduct any debt due to it or any sum claimed to be owed it by the United States without the prior written approval of the authorized officer.

(5) Following termination of a right-of-way grant or temporary use permit, any grantee or permittee that was determined to be in Category VI shall pay such additional amounts as are necessary to reimburse the United States for any costs which exceed the payments required by paragraph (b)(3) of this section.

(c) The schedules of nonrefundable fees are as follows:

(1) For processing an application for a right-of-way and/or temporary use permit:

Category	Fee
I	$125
II	275
III	350
IV	600
V	1,000
VI	[1] 5,000

[1] A minimum of.

(2) For monitoring a right-of-way grant or temporary use permit:

Category	Fee
I	$25
II	50
III	75
IV	150
V	250
VI	(1)

[1] As required.

(d) Reimbursement of costs for application processing and administration of right-of-way grants and temporary use permits pertaining to the Trans-Alaska Pipeline System shall be made by payment of such sums as the Secretary determines to be required to reimburse the Department of the Interior for the actual costs of these services. In processing applications and administering right-of-way grants and temporary use permits relating to the Trans-Alaska Pipeline System, the Department of the Interior shall avoid unnecessary employment of personnel and needless expenditure of funds as determined by the Secretary. Reimbursement of costs shall be made for each quarter ending on the last day of March, June, September and December. On or before the 16th day after the close of each quarter, the authorized officer shall submit to the permittee a written statement of costs incurred during that quarter which are reimbursable.

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January 10, 1985

Part V

Department of Health and Human Services

Health Care Financing Administration

42 CFR Parts 405 and 417

Medicare Program; Payment to Health Maintenance Organizations and Competitive Medical Plans; Final Rule With Comment Period

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 405 and 417

[BERC-247-F]

Medicare Program; Payment to Health Maintenance Organizations and Competitive Medical Plans

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

ACTION: Final rule with comment period.

SUMMARY: These regulations implement section 114 of the Tax Equity and Fiscal Responsibility Act of 1982 by authorizing Medicare reimbursement for health care services to eligible health maintenance organizations (HMOs) and competitive medical plans (CMPs) on a prospective basis for those entities that have a risk contract or on a reasonable cost basis for those that have a cost contract. The regulations set forth the requirements that an entity must meet in order to be—

- Eligible to enter into a Medicare contract (either risk or reasonable cost) as an eligible organization; and
- Reimbursed by Medicare on a capitation basis (either prospectively or retrospectively) for items and services furnished to Medicare enrollees.

In addition, these regulations implement sections 2322 and 2350 (b) and (c) of Pub. L. 98-369 [Deficit Reduction Act of 1984], which further amended the Social Security Act concerning payments to HMOs and CMPs.

DATES: Effective Date: These regulations are effective February 1, 1985. However, for further information and a detailed discussion of effective dates, we refer the reader to section V. of this preamble.

Comment Date: Although these regulations are final, comments may be submitted as described in section VIII of this preamble. To assure consideration, comments must be received by February 11, 1985.

ADDRESS: Address comments in writing to: Department of Health and Human Services, Health Care Financing Administration, Attention: BERC-247-FC, P.O. Box 26676, Baltimore, Maryland 21207.

In commenting, please refer to file code BERC-247-FC.

If you prefer, you may deliver your comments to Room 309-G, Hubert H. Humphrey Building, 200 Independence Ave., SW., Washington, D.C., or to Room 132, East High Rise Building, 6325 Security Boulevard, Baltimore, Maryland.

Comments will be available for public inspection as they are received, beginning approximately three weeks after today, in Room 309-G of the Department's offices at 200 Independence Ave., SW., Washington, D.C., on Monday through Friday of each week from 8:30 a.m. to 5:00 p.m. (phone: 202-245-7890).

FOR FURTHER INFORMATION CONTACT:

Frank Emerson, 301-597-1807 (Reimbursement)

Rita McGrath, 301-594-8558 (Qualifying Conditions, Enrollment, Contract Procedures, Change of Ownership and Leasing of Facilities, and Hearings and Appeals).

SUPPLEMENTARY INFORMATION:

I. Background

A health maintenance organization (HMO) may be generally defined as an entity that provides health care in a geographic area to a group of persons who are enrolled as members. The HMO agrees to provide or otherwise assure delivery of an agreed upon set of health services and to be reimbursed through a predetermined, fixed periodic payment made by or on behalf of the enrollees, without regard to the amounts of actual services provided. Because the HMO receives a fixed payment from enrollees, regardless of the volume of services provided, there is a financial incentive to the HMO to control costs and to provide the least expensive services appropriate to its enrollees' needs.

Section 226 of the Social Security Amendments of 1972 (Pub. L. 92-603, enacted October 30, 1972) added section 1876 to the Social Security Act (the Act) to authorize Medicare payment to HMOs on a capitation basis. Prior to this legislation, reimbursement to HMOs for Medicare Parts A and B services was made on the basis of the costs to the organization of providing the specific services to the beneficiaries. Because of this, the financial incentives that HMOs might have had in their regular non-Medicare business to provide a continuum of services, to keep costs low, and to control utilization of services were not fully incorporated directly into their relationship with Medicare.

Adding section 1876 to the Act was an attempt by Congress to reimburse HMOs in a manner that would conform more closely to the usual way in which HMOs operate. Under section 1876 of the Act, as enacted by Pub. L. 92-603, HMOs that enter into Medicare contracts can receive interim per capita payments, subject to retrospective adjustments, in return for providing to their Medicare enrollees services covered under Medicare Part A and Part B (or Part B only for certain enrollees). Two types of contracts are available to HMOs: one that permits reimbursement on a reasonable cost basis, and one that allows reimbursement on a risk-sharing basis.

Under the reasonable cost reimbursement method, payment is made to the HMO on an interim basis using a monthly capitation. At the end of the HMO's contract year, payments are adjusted to equal the reasonable costs of the covered services the HMO furnished to its Medicare enrollees, using the Medicare reimbursement principles that are commonly used to calculate reasonable costs (as defined in section 1861(v) of the Act) for providers of services as a model.

An alternative form of reimbursement, reimbursement on a risk-sharing basis, is available to HMOs that have demonstrated a capacity to provide health care of acceptable quality in an organized and effective manner. Under risk reimbursement, HMOs receive monthly payments based on an interim per capita reimbursement rate, similar to reasonable cost HMOs. This rate reflects the estimated costs to the HMO for its enrolled Medicare population. However, the rate cannot exceed 100 percent of the estimated "adjusted average per capita costs" (AAPCC). The AAPCC is an actuarial measure of the cost that would have been incurred by Medicare on behalf of enrollees of the HMO if they had received their covered services from providers and suppliers of services, other than the HMO, in the same geographic area (or a similar area) served by the HMO.

At the end of its contract year, the HMO's reasonable costs of furnishing services to its Medicare enrollees are compared to the retrospectively determined AAPCC incurred for that year. If the HMO's costs are less than the AAPCC, the amount of the difference is called "savings". The HMO receives 50 percent of the savings, up to a maximum of ten percent of the AAPCC, as a bonus. Conversely, if the HMO's costs are higher than the AAPCC, the HMO must absorb that difference ("losses"). However, these losses can be carried forward into subsequent years and offset from savings realized in future years.

Both of these Medicare reimbursement mechanisms present problems for HMOs because, although they are an improvement over the payment methods available before the enactment of Pub. L. 92-603, they are

essentially cost basis methods. Consequently, they are inconsistent with HMOs' usual method of receiving payment on a prepaid capitation basis with no retroactive adjustments. In the non-Medicare portion of an HMO's business, the fixed, prospectively determined payment per enrollee acts as a limit on HMO revenues, creating financial incentives for the organization to control costs and provide appropriate services in the most cost efficient manner.

In addition, HMOs report relatively little financial data to any outside organizations. However, since both Medicare risk and reasonable cost reimbursement entail retrospective determination of costs, HMOs do not know their actual Medicare revenues until sometime after the contract year has ended. This retrospective reimbursement is an awkward arrangement for HMOs since these organizations are designed to operate under a prospective budget without extensive reporting requirements to other third-party payors. Moreover, cost-based reimbursement provides HMOs with a mixed set of incentives. HMOs under Medicare cost contracts are not rewarded for cost-conscious behavior, and, in fact, revenue is reduced as the cost per Medicare enrollee decreases.

Even the risk reimbursement provisions of Pub. L. 92–603 are considered inadequate by HMOs, because in addition to the problems described above, the HMO may receive, at a maximum, only half of the savings it achieves (up to a maximum of ten percent of the AAPCC), while absorbing all the losses. This lack of a strong incentive to contract under risk reimbursement has resulted in only two HMOs entering into this type of contract. A further disincentive for HMOs to contract with Medicare arises under section 1876 of the Act in that it requires all organizations to meet the fairly prescriptive requirements of section 1301 of the Public Health Service (PHS) Act.

In an effort to improve Medicare reimbursement methods for HMOs, Congress enacted section 114 of the Tax Equity and Fiscal Responsibility Act of 1982 (Pub. L. 97–248). Section 114 amends section 1876 of the Act in two major areas.

First, the new legislation expands the definition of organizations that are eligible to contract for Medicare reimbursement under section 1876 of the Act. In addition to HMOs that meet the definition of an HMO contained in the PHS Act, other medical plans, commonly referred to as competitive medical plans (CMPs), are eligible to contract with HCFA for Medicare reimbursement. The requirements for CMPs are set forth in § 417.407. Also, the amended statute permits payment to be made on a prepaid capitation basis without retroactive adjustments of the rate to organizations with a risk contract. The reasonable cost contract option remains in the law while the old risk-sharing contract option is eliminated by this amendment.

As we note below in the discussion of effective dates, section 1876 of the Act as it existed prior to enactment of Pub. L. 97–248 and the implementing regulations in 42 CFR Part 405, Subpart T have continued applicability for HMOs that have existing contracts. On May 25, 1984, we published a notice of proposed rulemaking (NPRM) in the **Federal Register** (49 FR 22198) to implement section 114 of Pub. L. 97–248. This proposal elicited approximately 30,000 pieces of correspondence from the public. The provisions of the NPRM, an analysis of the public comments, our responses to the comments, and a summary of the changes we are making in these final regulations as a result of the comments are presented below.

II. Major Provisions of the Proposed Regulations

A. Organization Eligibility Requirements

1. *Definition of Eligible Organization.* The proposed regulations, in accordance with the section 1876(b) of the Act, defined an "eligible organization" as one that is organized under State law and is either a qualified HMO, as defined in section 1301 of the PHS Act, or an entity that meets the following requirements:

a. It provides its enrolled members at least the following services:

- Physicians' services performed by physicians.
- Inpatient hospital services (unless excepted under the provisions of section 1876(b)(2) of the Act, following (E)).
- Laboratory, X-ray, emergency, and preventive services.
- Out-of-area coverage.

b. It receives compensation, except for deductibles, coinsurance, and copayment, for the health care services it provides enrolled members on a periodic, prepaid capitation basis regardless of the frequency, extent, or kind of services provided.

c. It provides physicians' services primarily through physicians or groups of physicians that are either employees or partners of the organization or through contracts with physicians.

d. It assumes full financial risk on a prospective basis for the provision of the health care services listed above in item a., except the organization may—

- Obtain insurance or make other arrangements for the cost of providing to any enrolled member health care services listed in item a., if the aggregate value of the services exceeds $5,000 in any year;
- Obtain insurance or make other arrangements for the cost of providing health care services listed in item a. to enrolled members other than through the organization because medical necessity required that the services be provided before they could be secured through the organization;
- Obtain insurance or make other arrangements for not more than 90 percent of the amount by which the organization's costs for any of its fiscal years exceed 115 percent of its income for that fiscal year; and
- Make arrangements with physicians or other health professionals, health care institutions, or any combinations of these to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians or other health professionals or through the institutions.

e. It provides against the risk of insolvency to the Secretary's satisfaction.

The Assistant Secretary for Health of the Department has the authority to determine whether an entity is an eligible organization within the meaning of section 1876(b) of the Act. The delegation of this authority was published in the **Federal Register** on April 22, 1983 (48 FR 17395).

2. *Procedures for Contract Approval.* We proposed that an eligible organization that wishes to contract with HCFA under Medicare on either a reasonable cost basis or a risk basis would have to submit an application and supporting information to us in the form and detail required. This information would be needed to ascertain whether an eligible organization meets certain necessary contract requirements (discussed in section III.F. of this preamble). We further proposed that, whenever feasible, we would not require an organization to resubmit information that it has already submitted to the Assistant Secretary for Health in connection with the determination of whether an entity is an eligible organization.

We proposed that, if we determine that the organization meets the contract eligibility requirements, we would notify the organization in writing of the type of contract for which it is eligible, the requirements for submitting a written

contract, and its appeal rights if it is dissatisfied with HCFA's determination.

In like manner, if we determine that an organization does not meet the contract requirements, we will notify the entity in writing of its ineligibility; the reasons why it does not meet the requirements; and its appeal rights if it is dissatisfied with HCFA's determination.

B. Qualifying Conditions

We proposed that, in order to receive Medicare reimbursement as an eligible organization, an entity would have to enter into a contract with HCFA. The NPRM also contained the following provisions:

- If an organization meets the applicable requirements of the statute and regulations and HCFA is satisfied that the organization can bear the risk of potential losses, then the organization may contract on a risk basis. If HCFA is not satisfied that the organization is capable of bearing potential losses, or if the organization cannot meet the requirements in the statute and regulations for contracting on a risk basis, the organization must contract with HCFA on a reasonable cost basis.
- Also, if the entity has voluntarily terminated or failed to renew a risk contract under section 1876 of the Act in the preceding five years, then that entity would not be eligible for a risk contract unless HCFA determines that circumstances warrant special consideration. However, organizations that are qualified to contract on a risk basis would nevertheless be permitted to elect reimbursement on a reasonable cost basis.

We proposed a series of qualifying conditions for eligible organizations that are designed to assure the organization's ability to fulfill the requirements as provided in the statute. Generally, we proposed that each qualifying condition would be interpreted through a series of standards. Thus, to qualify as an eligible organization under Medicare, an organization would have to meet applicable qualifying conditions and standards pertaining to the following:

- The effective and efficient implementation of section 1876 of the Act.
- Sufficient enrollment and operating experience.
- Composition of enrollment.
- Range of services furnished.
- Method of furnishing services.
- Quality assurance program.

We further stated that, in some cases, HCFA would have the authority to waive specific elements of the qualifying conditions.

C. Enrollment

Under the NPRM, a beneficiary would be able to enroll in any organization that services the geographic area in which he or she resides and that has qualified under the law by contracting with HCFA to be reimbursed under section 1876 of the Act for covered Medicare services. An exception to the general rule of open enrollment for Medicare beneficiaries is contained in the amended section 1876(d) of the Act, which prohibits enrollment of individuals medically determined to have end-stage renal disease (ESRD).

Payments to organizations on behalf of Medicare enrollees are made out of the Federal Hospital Insurance trust fund or the Federal Supplementary Medical Insurance trust fund, or both, as appropriate. The payments discharge the liability of Medicare enrollees to pay for the covered services furnished to them by the organization. We proposed that the organization may require payment from Medicare enrollees, in the form of premiums or otherwise, for services not covered under Parts A and B of Medicare, as well as deductibles and coinsurance amounts attributable to services furnished under parts A and B. In addition, organizations would be able to seek payment for services from Medicare enrollees to the extent that enrollees have been reimbursed for the services by a workers' compensation policy or plan, automobile medical, or no-fault insurance, or any liability insurance, and, under certain circumstances, an employer group health plan.

As stated in the NPRM, in the case of organizations with risk contracts, only the organization would be entitled to receive Medicare payments for services furnished to Medicare enrollees of the risk organization. Essentially, this provision would serve to restrict Medicare enrollees to receiving services from the risk organization, except for emergency or urgently needed services.

As proposed, eligible organizations would be required to—

- Conduct an open enrollment period annually of at least 30 days duration; and
- Accept eligible Medicare beneficiaries without restriction, except as authorized in regulations, up to the limits of its capacity in the order in which eligible beneficiaries apply, unless the enrollment would result in the organization violating a qualifying condition (including the limitation on enrollment of Medicare and Medicaid beneficiaries) or would result in an enrollment that is substantially nonrepresentative of the population of the organization's geographic area. Denial of enrollment under the latter condition must be in accordance with written selection policies approved by us. We will carefully monitor all enrollment denials made under these regulations to ensure that this provision does not result in biased selection policies.

In addition, the NPRM set forth the procedures and conditions under which an organization under contract with HCFA would be permitted to advertise and enroll eligible Medicare beneficiaries. In particular, we specified the type of marketing techniques that organizations would be prohibited from using as a means of encouraging Medicare beneficiaries to enroll. Also, we proposed the establishment of a uniform standard of acceptance of applications in chronological order and timely action by the organization on applications. These requirements were included to ensure that Medicare beneficiaries are enrolled in the organization on the required first-come, first-served basis and that applications are acted upon in a reasonable period of time. Generally, under the NPRM, an organization would be able to deny enrollment to an otherwise qualified Medicare beneficiary only for purposes of maintaining the organization's compliance with certain enrollment and qualifying conditions.

We proposed that an individual who already is an enrollee of an organization at the time he or she becomes entitled to Medicare must be converted by the organization to a Medicare enrollee. A Medicare enrollee could not be disenrolled except under the following circumstances:

- The enrollee fails to pay required premiums or other charges.
- The enrollee moves out of the organization's geographic area.
- A nonrisk enrollee refuses to convert to risk after HCFA decides that all of the organization's nonrisk enrollees must convert.
- The enrollee commits fraud or permits abuse of his membership privileges.
- The enrollee loses entitlement to Medicare benefits, dies, or requests disenrollment.

Even though under section 1876(d) of the Act, a beneficiary entitled to Medicare under the ESRD provisions may not enroll in an eligible organization, we included a provision in the NPRM that provides that individuals who are already enrolled in these organizations and who either are ESRD patients at the time the organization enters into a contract with HCFA or

later develop ESRD may not be disenrolled.

D. Entitlement to Services

We stated in the NPRM that Medicare enrollees of organizations would be entitled to receive health care services and supplies directly from the organization, of through arrangements made by it. Medicare enrollees would also be entitled to receive services outside of the organization if the services were emergency or urgently needed services that, because of the circumstances, could not have reasonably been obtained through the organization. The organization is responsible for payment of these services. Under the NPRM, the entitlement would be effective for any month for which a per capita payment is made by HCFA to the organization on behalf of the enrollee. Entitlement would extend to the Medicare services to which the enrollee is entitled (that is, covered Part A and Part B services, or Part B only).

In addition, a Medicare enrollee would be entitled to receive any supplemental services offered by the organization for which the enrollee elects to pay. Supplemental services are those services outside the scope of Medicare coverage (except those furnished as additional benefits by risk organizations as described in the next paragraph) for which the enrollee pays a premium. Supplemental services could include those items or services excluded from Medicare coverage (see section 1862 of the Act), as well as those items or services for which Medicare coverage is limited, such as inpatient hospital days during a spell of illness (see section 1812(a)(1) of the Act) or expenses incurred in treatment of mental disorders (see section 1833(c) of the Act). Furthermore, after receiving HCFA's approval, a risk organization could require that its enrollees receiving benefits under the risk reimbursement portions of its contract accept and pay for supplemental services as a condition of enrollment. HCFA's approval will be based on whether or not these services will discourage enrollment. For example, a mandatory supplemental package that would include a wide range of services not covered by Medicare and that would be costly, would not be approved if the high cost would prevent low-income Medicare beneficiaries from enrolling as members in the organization.

The NPRM stated that Medicare enrollees of organizations with a risk contract could also be eligible for benefits in addition to covered Part A and Part B services, all or part of which would be paid for by the monthly capitation payment made by HCFA, as discussed below in section II. F. These additional benefits could consist of one or both of the following:

- A reduction in the organization's premium rate or in other charges for services furnished to the enrollee.
- Health benefits or services and supplies beyond the required Part A and Part B services.

We also proposed that an organization could make a special supplemental benefits plan available to current nonrisk Medicare enrollees who receive benefits under the reasonable cost reimbursement portion of the organization's contract if the plan meets certain requirements set forth in the NPRM.

Medicare enrollees of an organization that currently has a nonrisk contract and that enters into a risk contract would not automatically be covered under the risk portion of the contract (section 114(c)(1)(A) of Pub. L. 97-248). As proposed in the NPRM, they would not be entitled to the additional benefits the organization offers under the contract until one of the following sets of circumstances exists:

- HCFA determines that, for administrative reasons (for example, an insufficient number of Medicare enrollees to warrant the administrative effort of cost report determination), all current nonrisk Medicare enrollees must be covered under the risk portion of the new contract. We have decided that, as a minimum standard, current nonrisk Medicare enrollees must be converted to risk status if there are fewer than 75 of these enrollees remaining in the organization. If these enrollees do not wish to convert, they must be disenrolled. In this case, the following requirements would have to be met:

—HFCA notifies each affected enrollee 90 days before the effective date of the decision.

—The current nonrisk Medicare enrollee completes and signs a form stating that the enrollee understands the new rules and benefits applicable to him or her.

—The organization notifies the enrollee of the coverage, in writing, at least 30 days before the date on which his or her coverage under the risk portion of the contract takes effect.

- The current nonrisk Medicare enrollee requests that he or she be covered under the risk portions of the contract. In this case, the following requirements would have to be met:

—The organization enrolls two new Medicare enrollees for each of these current nonrisk Medicare enrollee.

—In cases where there are more Medicare enrollees than can be accommodated due to the two-for-one rule (explained below), selection of the current nonrisk Medicare enrollees to be covered under the risk portion of the contract is made in a nonbiased manner.

We also proposed that unless HCFA determines otherwise, a current nonrisk Medicare enrollee may remain under the reasonable cost provision of a contract (that is, receive reasonable cost reimbursment for all covered Part A and Part B services).

As noted above, under the provisions of the NPRM an organization would have to enroll two new Medicare enrollees for each current nonrisk Medicare enrollee it wishes (or is required) to cover under the risk portions of its contract. As defined in the law (section 114(c)(2)(D) of Pub. L. 97-248), a new Medicare enrollee is an individual entitled to Medicare who was not enrolled in the organization in which he or she subsequently enrolls at the time the organization entered into a risk contract, or at any previous time he or she was entitled to Medicare.

The NPRM also included provisions for beneficiary liability.

- An item or service not covered under Part A or Part B is the financial responsibility of the beneficiary entitled to both Parts. In addition, the beneficiary enrolled under Part B only would be liable for services covered under Part A.
- The beneficiary (or someone on his or her behalf) would also be financially responsible for services for which Medicare is not the primary payor (that is, services covered under workers' compensation, automobile medical, or no-fault insurance, or any liability insurance, and, under certain circumstances, an employer group health plan). An organization would be able to offer an optional supplemental benefit plan, which pays for services not covered under Parts A and B for enrollees entitled to both Parts, or Part A services and items and services not covered under Part B for enrollees entitled to Part B only. Payment of premiums or other charges for such a plan would be the responsibility of the Medicare enrollee.

Medicare deductibles and coinsurance would be the responsibility of the Medicare enrollees, or someone on their behalf. If the organization offers a supplemental plan that covers additional services and pays for Medicare deductibles and coinsurance, the amounts attributable to each Medicare enrollee for these additional

services and payments would have to be computed separately and disclosed to enrollees prior to their selection of such plans. Coverage of additional services would have to be optional for the Medicare enrollees of reasonable cost organizations.

E. Contract Requirements

This section of the NPRM contained proposals to implement those provisions of section 1876 of the Act that pertain to the contract between HCFA and an eligible organization under the Medicare program. Those provisions of the law include—

- Content of contract; and
- Procedures for contract termination, renewals, and changes in ownership.

We proposed that, in order to be reimbursed for Medicare services section 1876 of the Act, an eligible organization would have to sign and submit a written contract that meets the requirements of the regulations. A contract between an eligible organization and HCFA would be renewed automatically unless the organization of HCFA gives notice of its intent not to renew the contract, as set forth in the proposed regulations.

We did not include in the proposed rules a specific contractual requirement that an organization must agree to comply with title VI of the Civil Rights Act because, since all entities that furnish Part A services to Medicare beneficiaries are subject to the civil rights statute and regulations (including those at 45 CFR 80.4(a) and 84.5(a)), inclusion of a specific requirement in the contract is not necessary.

F. Reimbursement

Under the NPRM, eligible organizations that contract under the provisions of section 1876 of the Act would be reimbursed on either a risk or a reasonable cost basis. Payment made to an organization under section 1876 of the Act for the provision of covered Medicare services would be in lieu of payment that would otherwise be made to the organization for covered services under sections 1814(b) and 1833(a) of the Act.

As stated in the NPRM, in addition to the payment made by HCFA, an organization would be permitted to charge Medicare enrollees an amount equal to the actuarial value of the deductible and coinsurance for which Medicare enrollees would otherwise be liable had they not enrolled in the organization. Also, there are a number of situations where Medicare is the secondary payor for covered services. For example, if a Medicare enrollee receives covered services from the organization for which the enrollee is entitled to benefits under a workers' compensation law or plan, automobile medical or no-fault insurance, or any liability insurance, or, under certain circumstances, an employer group health plan, the organization would be able to charge the insurance carrier, employer, or other entity that is responsible to pay for the services.

Alternatively, the organization could charge the Medicare enrollee to the extent that the enrollee has been paid by the law, plan, or policy for those services. In addition, in the case of Medicare enrollees in the age group 65–69 who, through employment, have elected their employer's health benefits plan over Medicare, the organization could charge an employer group health plan for services for which Medicare is a secondary payor. The regulations describe these situations, including the coordination of benefits, and emphasize Medicare's secondary liability.

If an organization furnishes supplemental services to its Medicare enrollees, each enrollee, or his or her representative, would be liable for payment of the service. This would not apply to the additional benefits furnished without charge by an organization in accordance with the provisions of its risk contract. Regardless of the form of payment, in no case could the sum of the amounts the organization charges its Medicare enrollees for supplemental services exceed the adjusted community rate (ACR) (as explained below) for these services.

We proposed that we would pay an organization with a risk contract, in advance, its monthly per capita rate of payment for each Medicare enrollee. As provided in the amended section 1876(a) of the Act, this amount would equal 95 percent of the organization's adjusted average per capita cost (AAPCC) for the class of the enrollee (that is, a group of enrollees that is constructed on the basis of actuarial factors). The amount of payment made under this section of the regulations would be retroactively adjusted when necessary to take into account any differences between the organization's actual number of Medicare enrollees in each class and the number of individuals estimated to be enrolled in each class in determining the amount of advance payment. When necessary, HCFA would conduct an annual reconciliation for a contract period to assure that the organization has received the proper payment amount from HCFA for the contract period.

The NPRM allowed a risk organization to elect direct reimbursement by HCFA to hospitals that furnish covered inpatient hospital services to the organization's Medicare enrollees. This election would be binding for the entire contract period, and we would pay the hospital directly for the covered inpatient hospital services provided to the organization's Medicare enrollees. Each month, we would deduct from the organization's per capita payment an amount we estimate we would pay to hospitals on behalf of the organization's Medicare enrollees and administrative costs we would expect to incur in making those payments to hospitals.

We explained in the NPRM that the AAPCC is an actuarial estimate made by HCFA before an eligible organization's contract period begins. The AAPCC is an estimate of the average per capita cost that would have been incurred by Medicare on behalf of each class of Medicare enrollee of the organization if that class of enrollee had received its covered services from providers and suppliers other than an eligible organization in the same or similar geographic area served by the organization. We proposed that an organization would receive notification at least 90 days before the beginning of the organization's contract period of the AAPCC for each class of Medicare enrollee the organization anticipates having enrolled for that contract period.

Although by definition the AAPCC is an estimate, the statute (section 1876(a)(4) of the Act) requires that the method of calculation of the AAPCC ensure "actuarial equivalence" in comparing the health care needs of Medicare beneficiaries enrolled in an eligible organization and those beneficiaries who receive care outside an eligible organization (for example, in a fee-for-service setting). The law (section 114(c)(4) of Pub. L. 97–248) also requires that we notify Congress that we are reasonably certain the methodology we have developed for calculating the AAPCC will assure actuarial equivalence. The NPRM described the method of calculating the AAPCC in general terms based on the method that HCFA has used in the past to calculate a retrospective AAPCC, except that the new calculation would be made prospectively.

The NPRM specified that an organization that contracts on a risk basis would be required to determine, using a prescribed method of computation, its per capita financial requirements (reduced by Medicare deductibles and coinsurance) for furnishing Medicare covered services to its Medicare enrollees. We use the term

"adjusted community rate" (ACR) to describe these financial requirements. The ACR is the equivalent of the premium that the risk organization would have charged to Medicare enrollees independently of Medicare payments using the same rates as charged to non-Medicare enrollees, if the benefit package is limited to covered Medicare services.

We provided in the NPRM that if an organization's proposed ACR is less than the average of the per capita rates of payment to be made to the organizaion, the organization would either thave to provide its Medicare enrollees with additional benefits or accept a reduced monthly payment from HCFA. The additional benefits could be either health benefits beyond the required Parts A and B services; or a reduction in the organization's premium rate or in other charges for services furnished to the enrollee; or a combination of these benefits.

The organization's calculation of its ACR would be subject to review and approval by HCFA. When the organization submits its ACR calculation, it would have to include adequate supporting data, including copies of any annual premium reports submitted to other government agencies (for example, Office of Personnel Management, Office of Health Maintenance Organizations in the Public Health Service, and State Medicaid agencies).

Section 114 of Pub. L. 97-248 made very few changes in the provisions relating to reimbursement of organizations with a reasonable cost contract. Therefore, the proposed regulations for these organizations were similar to the principles of reimbursement of cost-basis HMOs found in the current regulations at 42 CFR Part 405, Subpart T (§§ 405.2040 through 405.2047). However, we did state in the NPRM that we are reviewing several payment issues, including using an organization's AAPCC as an overall limit on reasonable costs and the existing provisions that allow exceptions to Medicare's usual payment methods.

The following two provisions that are currently included in the Subpart T regulations were not included in the proposed regulations:

- The exception to the Medicare rule set forth in § 405.455 on payments at the lower of costs or charges.
- The exception to payment of reasonable charges, as defined in Subpart E of 42 CFR Part 405, in the case of emergency services, urgently needed services, and other services for which the organization assumes financial responsibility.

In addition, reinsurance costs would not be allowable in any situation.

The NPRM also required that an organization reimbursed on a reasonable cost basis would have to submit to HCFA the following reports for each contract period:

- A budget and enrollment forecast submitted at least 90 days before the start of the contract period.
- Quarterly interim cost reports (less frequently for experienced organizations).
- A final cost report submitted to us not later than 180 days after the end of the contract period.

G. Appeals

The NPRM included provisions dealing with the rights of both beneficiaries and eligible organizations to appeal adverse initial determinations, which we defined in the proposed rule.

III. Discussion of Comments

As noted above, we received over 30,000 items of correspondence on the proposed rule. All but 75 of these items were comments from chiropractors and their patients regarding the availability of chiropractic services from eligible organizations. The remaining 75 letters cover a broad range of issues and represent the views of national, State, and local health associations; providers and suppliers of health care services; potential eligible organizations; Federal and State government agencies; actuaries; members of Congress; a State governor; a beneficiary organization; and a HCFA regional office.

The comments received and our responses to those comments are grouped by subject area and are as follows:

A. Definitions (§ 417.401)

Comment: Several commenters objected to the term "geographic area" that is described as the area within which the organization furnishes, or arranges for furnishing, the full range of services that it offers to its Medicare enrollees (§ 417.401). Most of these commenters prefer that these regulations adopt instead the terms "service area" and "enrollment area", as are used in the current Subpart T regulations. The commenters believe that the term geographic area is too broad, inexact, and confusing and implies inclusion of enrollees whose residences may be located outside the organization's service area.

Response: The Subpart T regulations make a distinction between the terms "service area" (defined as the area in which the organization offers its full range of covered Medicare items and services to its Medicare enrollees) and "enrollment area" (defined as the geographic area encompassing the residences of its enrollees, which may include locations outside the organization's service area where it offers less than the full range of covered Medicare items and services). Section 1876(c)(2) of the Act requires the organization to provide to enrollees the full range of covered Medicare services "which are available to individuals residing in the geographic area served by the organization." We have adopted the term "geographic area" because it is used exclusively in the statute and because it eliminates the obsolete distinction between service and enrollment areas. We have specified in the definition in § 417.401, and in the discussion of services in §§ 417.414 and 417.416, that organizations must furnish the full range of services to all Medicare enrollees. These services must be made available and accessible to each of these enrollees. While the terms "service area" and "enrollment area" are obsolete for purposes of contracts under Subpart C of Part 417, they will continue to apply to contracts under Subpart T of Part 405.

Comment: One commenter suggested that the definition of "urgently needed services" as set forth in § 417.401 should be modified to require that these services are necessary because of an unforeseen health problem or one that is not reasonably postponable. The commenter believes that these changes would preclude coverage when individuals who need surgery or other treatment voluntarily leave the organization's geographic area to obtain services from out-of-plan providers.

Response: We have revised the definition of "urgently needed services" to include the commenter's suggested change.

Comment: Several commenters requested clarification of the definition of "urgently needed services" when an enrollee who is "locked-in" to the organization for services is temporarily absent from the organization's geographic area or when the enrollee temporarily changes residence. The commenters were concerned that some organizations would encourage their Medicare enrollees to disenroll so that these organizations would not incur liability for emergency or urgently needed services furnished outside of the plan.

Response: As stated in § 417.414(c), an organization is financially responsible for emergency and urgently needed

services furnished out-of-plan, even if furnished without the organization's approval. Furthermore, the organization must not in any way encourage a Medicare enrollee to disenroll except in very limited circumstances as set forth in § 417.460 (for example, when the enrollee permanently moves out of the organization's geographic area). If the enrollee expresses intent to return within 90 days to his or her permanent residence within the organization's area, the move cannot be considered to be permanent. The organization, in this situation, would be responsible for emergency and urgently needed services provided outside the organization's geographic area.

Of course, an enrollee may choose to disenroll from the organization rather than to limit his or her entitlement of out-of-plan services to those that are emergency or urgently needed. In this case, the disenrollment would be effective no later than the first day of the month following a full calendar month after the notice of disenrollment is signed, and all restrictions on the use of Medicare services would cease on that date.

Comment: Some commenters asked whether the term "current nonrisk Medicare enrollee" includes those Medicare beneficiaries that purchase, on a fee-for-service basis, supplemental services from an organization or those beneficiaries who disenroll from an organization prior to the effective date of these regulations.

Response: The definition of "current nonrisk Medicare enrollee" includes only those Medicare beneficiaries who are enrolled in an organization under an existing cost contract under either section 1876 of the Act as it existed prior to Pub. L. 97–248 or section 1833(a)(1)(A) of the Act. (The latter applies to health care prepayment plans under Medicare Part B.) The definition includes Medicare enrollees who disenroll and later reenroll in the same organization, regardless of the timing of the disenrollment.

B. Eligibility and Contracting Requirements and Conditions (§§ 417.404 Through 417.418)

Comment: Several commenters wanted to know which agency or individual in the Department will have ongoing responsibility for determining a CMP's continuing compliance with the applicable requirements contained in these regulations.

Response: We have revised § 417.406 to clarify that the Assistant Secretary for Health has the ongoing responsibility for monitoring entities that have contracted with HCFA to assure that they continue to meet the definition of an eligible organization.

Comment: Many commenters asked for clarification of the definition of a CMP, including whether a preferred provider organization (PPO) or other types of organizations may be determined to qualify as eligible organizations under the CMP definition.

Response: Any entity that meets the definition in § 417.407 may be found to be an eligible organization. There is nothing in the statute or these regulations that prohibitis a PPO, a medical service corporation, or any similar organization from being a CMP, if it is organized in a manner that enables it to meet the definition in the statute and the regulations. For example, a CMP must assume full financial risk on a fixed prospective prepaid basis in exchange for services that must be provided without regard to frequency, extent, or kind. In addition, physician services must be provided primarily by physicians who are employees or partners of the organization or who are under contract to the organization. CMPs must also be organized under State law and have adequately provided against the risk of insolvency.

Comment: One commenter requested that we specify timeframes for the contract application process described in § 417.408, especially a time limit on HCFA's notice of approval or disapproval.

Response: We expect that the contract application process will encompass much exchange of information and negotiation between the parties. In some cases, this will be a relatively quick procedure; in others, the negotiation process may become prolonged. Therefore, we do not believe that we should set specific timeframes for this applications process. We also note that it is not HCFA's policy to set timeframes for the approval process of contract or provider participation agreements. In any case, we will try to review applications as expeditiously as possible.

Comment: A commenter protested our policy of allowing CMPs to contract on a reasonable cost basis even though they offer less than all covered Medicare services available in their geographic area (§ 417.410(f)(3)). However, an HMO is required to offer all these services even if it is seeking a reasonable cost contract.

The commenter believes that there is no statutory basis for this distinction and that the requirements should be the same for HMOs and CMPs.

Response: We agree with the commenter's arguments and have deleted the exception for CMPs that offer less than the full package of Medicare covered services in the area.

Comment: A large number of commenters objected to our waiver criteria for eligible organizations whose enrolled population consists of over 50 percent Medicare and Medicaid beneficiaries. We specified in the NPRM (49 FR 22201) that we would consider waiving the composition of enrollment standard for an organization that is attempting to enroll non-Medicare and non-Medicaid beneficiaries and whose geographic area is composed of over 50 percent Medicare and Medicaid beneficiaries. However, if a waiver is granted, an organization may not be composed of more than 75 percent Medicare and Medicaid beneficiaries and in no case may the percentage of those beneficiaries in the organization exceed their percentage in the organization's geographic area.

Some of these commenters believe that HCFA does not have the authority to set a limit on the percentage of Medicare and Medicaid enrollees under the waiver. Other commenters stated that such a limit is inconsistent with Medicaid regulations (42 CFR 434.26, 48 FR 54013 (November 30, 1983)), which exempt certain organization from the composition requirement and permit waivers for certain other organizations with no limit on the percentage of Medicare and Medicaid enrollees. Commenters also stated that placing a limit on composition percentages is contrary to the statute's intent because it unnecessarily limits the number of organizations that could qualify to contract. Other commenters indicated that this requirement would force organizations that currently serve Medicare enrollees (for example, organizations participating in HCFA demonstration projects) to withdraw service from Medicare enrollees in order to reduce their Medicare population and, thus, meet the HCFA contract standards.

Response: The statute (section 1876(f)(1) of the Act) specifies that no more than 50 percent of an organization's enrollees may be Medicare and Medicaid enrollees. In recognition of the fact that there may occasionally be extenuating circumstances that make it desirable to waive this requirement, as part of Pub. L. 97–248, Congress added section 1876(f)(2) to the Act, which allows modification or waiver of this requirement if special circumstances warrant and if the organization has taken and is making reasonable effort to enroll individuals other than Medicare and Medicaid beneficiaries.

We agree with the commenters that the provisions of the NPRM were overly restrictive. Therefore, we have revised § 417.413 to remove the 75 percent limit on Medicare and Medicaid beneficiaries. However, we are retaining the requirement that HCFA will not grant a waiver that would permit the percentage of Medicare and Medicaid enrollees in an organization to exceed the percentage of those beneficiaries in the organization's geographic area.

However, we are concerned that otherwise qualified eligible organizations currently participating in HCFA demonstration projects may not be able to qualify for a contract under these regulations on the basis of their failure to meet the requirements for a waiver, and that failure to qualify could disrupt service to Medicare beneficiaries. Therefore, we are including in these final regulations a new paragraph (e)(3) to § 417.413 that permits us, on a case-by-case basis, to grant exceptions to this standard for eligible organization applicants that are participating in operational demonstration projects currently funded by HCFA, even though the organizations do not meet the waiver criteria described above.

Requests for exceptions under this special provision will be evaluated, in part, on the magnitude and substance of the organization's effort to enroll members who are not Medicare or Medicaid beneficiaries. It is expected that an organization will not require an exception for more than three years from the date the organization operating the demonstration project enters into a contract under these final regulations. However, HCFA may extend the exception for more than this three-year period if certain special circumstances continue to exist and it is in the best interest of the Medicare program to do so. For example, HCFA may grant an extension if the organization services a population that is medically underserved or if the termination of the exception would leave a majority of the organization's Medicare enrollees without access to prepaid care.

Comment: Some of the commenters objected to the requirements set forth in the proposed operating experience and enrollment standard for risk organizations (§ 417.413(b)). Specifically, these commenters believe that these requirements would prohibit newly established organizations from qualifying for contracts and that the minimum requirements should be subject to waiver or some sort of phase-in period during which the organization could solicit new enrollments.

Response: As explained in the NPRM (49 FR 22201), the enrollment requirement of 5,000 enrollees for urban risk organizations in § 417.413(b)(1) is specified in the statute (section 1876(g)(1) of the Act). The minimum Medicare enrollment for these organizations (75 members) set forth in that section of the regulations is the least number of Medicare enrollees we believe is necessary to assure an adequate base for calculating an organization's ACR and to justify our administrative costs for entering into a contract with an organization.

With regard to rural organizations with risk contracts, although the statute did not specify nor give any direction concerning the determination of the minimum numer of enrollees necessary, we believe that the enrollment must be sufficient to permit calculation of an ACR and to justify our administrative costs for entering into a contract. Therefore, we specified in the NPRM that these organizations must have 1,500 enrollees, at least 75 of whom must be Medicare enrollees.

Contrary to the commenters' expectation, we believe that these minimum requirements will permit many more organizations to qualify for risk contracts because they are much less stringent than the requirements contained in the current Subpart T regulations. Therefore, we have not changed these minimum enrollment requirements.

Comment: A commenter observed that § 417.413(c)(2) requires that an eligible organization must have at least 75 Medicare enrollees before it could qualify to contract with HCFA on a reasonable cost basis. The commenter believes that the unintended result of this requirement is to prevent any newly established organization from contracting with HCFA.

Response: We have revised that section to permit contracting on a cost basis if the organization either has at least 75 Medicare enrollees or a plan acceptable to us for achieving this minimum enrollment within two years of the beginning of its initial contract period.

Comment: One commenter suggested that the language of § 417.414(c)(2), which states that an organization is financially responsible for services furnished outside its delivery system if upon appeal it is found that the enrollee was entitled to have the services furnished by the eligible organization, is troublesome and needs clarification. The commenter is concerned that this provision could be interpreted to mean that any time an enrollee obtains services outside of the organization he or she would be entitled to reimbursement for those services if they are services that the organization is required to furnish. The commenter would prefer that the regulations specifically state that an enrollee must at least attempt to receive the services from the organization and that the organization must refuse to furnish the services before the enrollee goes out of plan.

Response: We agree with this comment and have made a clarifying change to § 417.414(c)(2).

Comment: As mentioned earlier, we received over 30,000 pieces of correspondence (the overwhelming majority of which were letters from individual patients) concerning eligible organization and the provision of chiropractic services. These commenters suggested that the regulations be revised to ensure that Medicare enrollees of these organizations receive chiropractic services from a chiropractor. We received similar letters from representatives of other types of practitioners including dentists, psychologists, and others urging that the choice of practitioners not be left to the organization.

Response: The proposed regulations (§ 417.414(b)(3)) stated that if more than one type of practitioner is qualified to perform a service, the eligible organization may select the type of practitioner to be used. Under the law (section 1861(r)(5) of the Act), Medicare covered chiropractic services are limited to treatment, by manual manipulation of the spine, of subluxations of the spine that are demonstrated by x-ray to exist. An organization may hire or make arrangements with a chiropractor to treat subluxation of the spine, or may choose any other practitioner who is qualified under State law to perform this service.

We believe that eligible organizations should be free to organize their service delivery in the most efficient manner possible. It is important that they have the option of choosing which practitioner they will use to furnish a given service, as long as all Medicare covered services are available to the enrollee and high quality service is furnished. Therefore, we have made no revision in the regulations to require that organizations hire or contract with specific types of practitioners, including chiropractors, psychologists, dentists, and others.

Comment: One commenter suggested that the definition of physicians who supervise other health care professionals directly involved in

patient care is too broad. The commenter suggested that the word "physician" be replaced with "doctors of medicine and osteopathy."

Response: We do not believe that it is necessary to limit the definition of physician to doctors of medicine and osteopathy for purposes of supervising the health care services furnished by nonphysicians. Section 1861(r) of the Act defines the word "physician" as any number of professionals, including doctors of medicine or osteopathy, doctors of dentistry, podiatrists, chiropractors, and optometrists (with limitations as specified in sections 1861(r) (3), (4), and (5) of the Act, respectively). The qualifications of the physician providing supervision should be governed by the nature of the services being furnished. For example, the provision of covered foot care services could be supervised by a podiatrist (if podiatrists are legally authorized in the State to perform the services). Also, we believe an organization should be free to organize the delivery of services in any manner it sees fit, consistent with law and regulations.

Comment: One commenter is of the opinion that the quality assurance requirements (§417.418) that organizations must meet are too weak and fail to mention quality of care.

Response: We believe that firm quality assurance standards are vital once this innovative program for Medicare beneficiaries is established. Therefore, the quality assurance standards include a requirement that action must be taken to remedy inappropriate or substandard services or services inappropriately denied. In addition, the enrollee has access to grievance and appeal procedures both within and outside the organization, in accordance with §§ 417.600 through 417.638 Also, we have chosen to implement review by utilization and quality control peer review organizations (PROs) under § 417.478 for organizations in these regulations. We believe that the quality assurance provisions in these regulations are adequate if they are fully enforced. We intend to do this and, if experience indicates a need for additional standards, they will be added to the regulations.

Comment: Several commenters suggested that the Assistant Secretary for Health should have responsibility for assuring CMP, as well as HMO, compliance with the quality assurance requirements.

Response: The quality assurance requirements under Medicare and title XIII of the Public Health Service Act are basically the same. The Assistant Secretary for Health is responsible for determining whether an HMO or CMP meets the qualifications necessary to be an eligible organization. However, we believe that HCFA should have responsibility for assuring that quality assurance requirements continue to be met by these organizations. The provision of quality health care to beneficiaries enrolling in eligible organization is of paramount interest to HCFA. The number of beneficiaries enrolling in these organizations is expected to increase significantly under these regulations, and we intend to devote considerable energy to the review and assessment of all eligible organizations' quality assurance programs.

Comment: Several commenters requested that the regulations include a discussion of the provision of hospice care to Medicare enrollees of eligible organizations. The commenters believe that some sort of special arrangements are necessary because the hospice regulations (42 CFR Part 418, Hospice Care, published in the **Federal Register** on December 16, 1983 (48 FR 56008)) specify that Medicare beneficiaries who elect hospice benefits must waive (with certain exceptions) their right to receive medical services that are related to the terminal condition or a related condition from any supplier or provider except the designated hospice. The commenters maintained that the NPRM does not clearly state how this benefit would be managed for an enrollee of an organization.

Response: The statute (section 1812(d)(2) of the Act) requires that an enrollee who elects care from a hospice must waive his or her right to receive services related to the enrollee's terminal condition from the eligible organization in which he or she is enrolled. The individual may continue to receive services that are not subject to the hospice election from the organization; that is, any service, whether related to the terminal condition or not, from his or her attending physician if the physician is an employee or contractor of the organization and is not employed or under contract to the hospice, and any services not related to the terminal condition. See 42 CFR 418.24(e) (48 FR 56008, December 16, 1983). These services will be reimbursed by Medicare on a fee-for-service basis. If the individual revokes the election of hospice benefits as described in § 418.28 or the hospice benefits are exhausted, the individual may again seek all services from the organization. These services will also be reimbursed on a fee-for-service basis until the capitation payment resumes.

However, these regulations provide that Medicare beneficiaries cannot enroll in an eligible organization while they are receiving hospice care. This is because the nonhospice services furnished to a Medicare enrollee who has elected the hospice benefit are so limited that it is not practical for an organization to enroll an individual already receiving hospice care on a capitation basis. Of course, an individual who revokes or exhausts his or her hospice benefit would be eligible to enroll in an organization during the next open enrollment period.

We have revised these regulations by adding new §§ 417.414(b)(3), 417.422(c), and 417.440(c) to include clearly the policy described above. See the comments and responses contained in section III. F. below for a discussion of payment to an eligible organization for a Medicare enrollee who elects hospice benefits.

C. Enrollment, Disenrollment, and Reenrollment

Comment: In the NPRM, we requested comments on the idea of requiring that all the eligible organizations in a single geographic area hold a coordinated open enrollment period. We received numerous comments on this issue. Many of the commenters believe such a requirement would be overly intrusive and would create many operational problems for organizations. Other commenters were in favor of this requirement since it would be beneficial to both Medicare beneficiaries and organizations. In addition, since there were no details of how such a coordinated period would be implemented, several commenters requested that a separate NPRM be published concerning this issue.

Response: Section 2350(a) of Pub. L. 98–369, enacted on July 18, 1984, amended section 1876(c)(3)(A) of the act to require that we establish, for each geographic area served by more than one eligible organization, a single 30-day period each year during which all the organizations must allow open enrollment. The statute permits us to phase in this requirement over a period of three years. The variety of comments we received reflects the complexity of implementing this provision. Therefore, we are not including this new requirement in these final regulations, but rather will publish it in a separate rulemaking document. (See section IV. of this preamble for a further discussion of Pub. L. 98–369.)

Comment: One commenter suggested that, in addition to requiring coordinated open enrollment periods, HCFA should contract with a health "broker" to assist beneficiaries in comparing plans offered in the same geographic area and to help them make the best personal choice among the competing organizations. Alternatively, the commenter suggested that the Federal government could serve as the "broker."

Response: HCFA is currently conducting a demonstration project to test the health broker concept. Depending upon the results of this study, we will consider ways to increase the efficiency of consumer choice among eligible organizations. Concerning the alternative, we believe that it is inappropriate for Federal personnel to intervene in a Medicare beneficiary's choice of plan.

Comment: One commenter objected to the fact that organizations are required to enroll beneficiaries who are entitled only to Medicare Part B.

Response: Section 1876(d) of the Act states that every individual entitled to benefits under Medicare Part A and enrolled under Medicare Part B or enrolled under Medicare Part B only is eligible to enroll with any eligible organization. Therefore, organization may not deny enrollment to Part B-only enrollees and, under section 1876(c)(2)(B) of the Act, must furnish all Part B services that are available in the organization's geographic area to these enrollees.

Comment: Several commenters suggested that enrollees of a risk organization who later become entitled to Medicare should be permitted to choose whether they wish to convert under the risk or cost portions of the contract.

Response: Enrollees who later become entitled to Medicare must be converted under the risk contract, just as new enrollees must be enrolled only under the risk contract. The law (section 114(c)(1)(A) of Pub. L. 97–248) permits only current nonrisk Medicare enrollees as defined in § 417.401 to choose whether to convert under the risk contract (except if HCFA decides that all current nonrisk enrollees should convert as specified in § 417.444).

Comment: Several commenters stated that we should not require organizations to enroll individuals who have used all their inpatient hospital days under Medicare Part A, or, if this is required, special capitation rates should apply to these individuals.

Response: As stated above, section 1876(d) of the Act requires that organizations enroll persons entitled to Medicare Part A and enrolled in Part B, or enrolled in Part B only, regardless of health status. Failure to enroll individuals who have exhausted Part A benefits could be considered an attempt by the organization to screen for health status. However, organizations need not offer benefits in excess of those covered under Part A or Part B, as applicable, unless additional benefits are furnished according to § 417.440(b)(4) or supplemental services are elected by the beneficiary or required by the organization according to §§ 417.440 (b)(2) and (b)(3). There is no authority in the law for us to pay an organization special capitation rates for services not covered by Medicare.

Comment: Several commenters suggested that we clarify that if an individual enrolls in an eligible organization before becoming entitled to Medicare Part B, the organization cannot disenroll that enrollee when he or she becomes entitled to Medicare unless one of the specified criteria for disenrollment in § 417.460 is met.

Response: We agree with this comment and have revised § 417.432 to specify that no enrollee who becomes entitled to Medicare Part A or B, or both, may be disenrolled unless one of the circumstances described in § 417.460 is applicable.

Comment: Some commenters contended that the provisions of § 417.426(c) should be expanded to allow organizations to reserve vacancies for new members of existing group contracts as well as reserving vacancies for anticipated new groups.

Response: We agree with the commenters and have revised § 417.426(c) accordingly.

Comment: A few commenters believe that the requirement that unused vacancies be made available to enrollees who are not Medicare beneficiaries goes beyond the scope of the law.

Response: We disagree with the commenters. It would be beyond HCFA's authority under the statute, as well as unreasonable, to require that vacancies that are not filled within a reasonable period of time be made available only to Medicare beneficiaries.

Comment: We received many comments regarding the requirement that an organization submit marketing materials to HCFA for approval prior to their use. The comments covered many issues including—

- A desire for careful and strict Federal control, including specific guidelines;
- The establishment of broad parameters for advertising and marketing rather than review of an individual organization's marketing plan;
- A reduction of the 60-day time period HCFA has to review and approve marketing material;
- A "sunset" provision that would allow an organization that has completed a reasonable and satisfactory trial period to be exempt from the approval requirement; and
- The belief that marketing constraints of any kind are intrusive and paternalistic.

Response: We agree with the commenters that a blanket preclearance requirement such as that proposed in § 417.428(a)(2) is overly restrictive; therefore, we have deleted this requirement. We believe that the provisions set forth in § 417.428(b) adequately describe what we believe to be deceptive marketing activities and it is not necessary for us to prereview each organization's material to ascertain that it is in compliance with the regulations.

Comment: Commenters requested that the regulations specifically include door-to-door soliciting among the prohibited marketing activities. They noted that this marketing technique is nearly impossible to control or monitor, and, as an example, one commenter cited the problems that arose in California in the early 1970's with prepaid health plans that practiced this technique.

Response: We agree with this comment and have revised § 417.428 accordingly.

Comment: One commenter believes that the regulations are not strict enough and allow organizations to enroll Medicare beneficiaries without giving them adequate notice of their benefits and limitations, charges, and other information. Additionally, we were urged to require that enrollees be informed of changes in an organization's rules.

Response: Section § 417.428(a) states that, as a part of the required marketing materials, organizations must provide adequate written description of rules, procedures, benefits, fees, services, and other information necessary for beneficiaries to make an informed decision about their enrollment in the organization. Upon enrollment, each member must be given a copy of the organization's rules, including how and where to obtain services, as specified in § 417.436. We believe that these requirements are restrictive enough to protect beneficiaries.

We agree that Medicare enrollees should be informed promptly of changes in an organization's rules, and we have amended § 417.436 to include a

requirement that an organization must notify its Medicare enrollees of rule changes 30 days prior to making the changes. We will monitor contractor compliance with these rules.

Comment: One commenter questioned whether rebates could be advertised by an organization as an enrollment inducement to Medicare beneficiaries.

Response: In considering amendments to section 1876 of the Act in 1982, the Senate proposed rebates as one method by which a risk organization could return to the beneficiary the difference between its AAPCC and ACR. However, the Conference agreement specifically deleted the language permitting rebates (H.R. Rep. No. 97–760, 97th Congress, 2d Session 426–427 (1982)). Therefore, we are not allowing risk organizations to provide rebates.

Comment: Some commenters criticized our use of the word "unethical" in describing prohibited marketing practices or activities in § 417.428(b)(1) as vague and troublesome because it was too easily subject to misinterpretation.

Response: We agree with the commenters that the word "unethical" is not necessary, and we have deleted it from these regulations.

Comment: Commenters requested that we clarify the effective date of enrollment for individuals who are enrollees of the organization immediately prior to their entitlement to Medicare. Many of these commenters stated that the time frame for submittal of conversion information to HCFA should be reduced.

Response: An individual who is enrolled in an eligible organization when he or she becomes entitled to Medicare is converted to a Medicare enrollee on the date of that entitlement. If the organization is participating on a risk basis, these enrollees are not subject to the two-for-one rule because, by definition, only "current nonrisk Medicare enrollees" (that is, Medicare enrollees who are enrolled with an organization that has an existing cost contract on the effective date of these regulations) are subject to the two-for-one rule. They may be immediately converted to risk reimbursement membership. However, these individuals are not counted as "new Medicare enrollees" for the purposes of satisfying the two-for-one rule because, by definition, "a new Medicare enrollee" cannot be an individual who enrolled in the organization prior to entitlement to Medicare benefits. The 90-day period required in § 417.432(b) that specified how soon an organization must notify HCFA of an enrollee's conversion to Medicare enrollee was based on the earliest possible time an individual could apply for Medicare entitlement. We agree that this is an unrealistic time frame; however, some lead time is needed to allow HCFA to process the Medicare enrollment. Therefore, we have reduced the 90-day requirement to 30 days.

Comment: One commenter stated that the regulations should include standards for the grievance procedures mentioned in § 417.436(a)(2) to be followed by organizations, and that the regulations do not specifically mention dissatisfaction with the quality of care as a legitimate reason for a grievance.

Response: Standards for grievance procedures will be included in HCFA instructions to eligible organizations. Dissatisfaction with the quality of care is a legitimate reason for grievance and the instructions we issue will deal with this problem.

Comment: One commenter stated that the grievance procedures should require organizations to forward grievances to HCFA.

Response: Procedures for handling grievances will be included in our instructions to eligible organizations. However, the instructions do not include procedures for forwarding grievances to HCFA for resolution. Only initial determinations (see § 417.606) may be reviewed by HCFA under Medicare appeals procedures. Grievances, such as a patient complaint about waiting too long before seeing the physician for a scheduled appointment, allegations that a nurse behaved rudely, or complaints that an organization's telephones are not answered promptly, are handled by internal grievance procedures.

Comment: Many commenters expressed concern about enrollees of risk organizations who move out of the geographic area served by the organization, but who do not voluntarily disenroll. Under the proposed regulations at § 417.448, the "lock-in" would be removed and an organization would be liable for all Medicare services for these enrollees starting with the month after they have permanently left the area. Some of the commenters noted that the enrollee is not required to notify an organization of his or her intention to move, and that the organization would be, under the proposed regulations, responsible for whatever costs for Medicare services the beneficiary incurred elsewhere. Commenters generally wanted the regulations to be fair to both organizations and enrollees.

Response: We recognize the concerns of these commenters and our regulations have been revised. An enrollee is required to advise the organization if he or she is moving out of the area permanently, and an organization's liability would be limited to emergency and urgently needed services until disenrollment occurs. Retroactive disenrollment is not permitted. After the organization sends the required notice to the enrollee, disenrollment may occur no earlier than one month after, but no later than the third month after, we receive a disenrollment notice from the organization.

The lock-in under § 417.448(b)(2) would not end in the case of an enrollee who failed to notify the organization that he or she had moved permanently. We are defining "permanently moved" as at least an uninterrupted absence of more than 90 days from the area. However, if an enrollee "permanently moves" but intends to return to his or her home after the 90-day limit, an organization would have the option of disenrolling the enrollee or retaining him or her as a member without the lock-in restriction. This would make the provision consistent with our liability to make monthly payments for an enrollee and the organization's obligation to pay for all services required by the enrollee in these situations.

Comment: Some commenters proposed that certain Medicare enrollees who regularly leave their home residence to reside in another part of the country for several months of the year should be permitted to disenroll if they are leaving the area for at least three months but be able to reenroll automaticallly when they return to their home residences, without being subject to the first-come, first-served rule on applications.

Response: We believe that adding this type of exception to our enrollment rules would create problems in the administration of enrollment of beneficiaries in a fair and equitable manner. We would be particularly concerned about—

- The acceptance of applicants in the order in which they apply;
- An organization potentially operating beyond its contracted capacity; and
- Ensuring that these "automatic" reenrollment applicants would not be discriminated against if a change in health status occurs.

Of course, this category of beneficiary could disenroll and reenroll in these cases if—

- Its organization has a continuous open enrollment policy; and
- The organization is below its enrollment capacity.

If an organization does not meet these conditions, but wishes to keep these enrollees, it would have the option of

agreeing to pay for all covered Medicare services while the enrollee is out of the geographic area. This option would apply only to those persons who have not permanently left the area.

Comment: Many commenters urged us to revise the regulations to allow an organization to disenroll Medicare enrollees who are especially disruptive. In particular, the commenters sought the addition of regulations to permit the involuntary disenrollment of Medicare enrollees who were uncooperative, abusive, unruly, or disruptive to the extent that they interfered with the organization's ability to carry out its operations.

Response: We agree that organizations should be free to disenroll Medicare enrollees who behave in this manner. In the past, we have been concerned that disenrollment for "cause" offered too great a potential for abuse. A "cause" regulation might provide a means for an organization to rid itself of what it considers an undesirable enrollee. We were afraid that an organization might try to disenroll an enrollee because of his or her health needs or status, which is forbidden by law, by citing cause. For example, an organization might try to circumvent the regulations by claiming that an enrollee with high cost health needs failed to meet some minor rules of the organization and consequently must be disenrolled; or, rather than treat a mentally ill enrollee exhibiting some behavior outside the social norm, the organization might terminate the beneficiary for cause, claiming the individual was disrupting the practice of medicine, or upsetting other patients.

We are adding a new § 417.460(a)(6), to provide for disenrollment for cause. It is designed both to serve the needs of an organization and to protect beneficiaries from acts of personal bias or whim. The organization will need to document the enrollee's behavior, demonstrate its unsuccessful attempts (including internal grievance procedures) to resolve the problems, and submit evidence that the enrollee's problem behavior is not due to the use, including overutilization, of medical services. Documentation shall be submitted to us for review to determine whether the organization has met the requirements for disenrollment for cause. If our review results in the finding that there is insufficient evidence to justify such a disenrollment, the organization will be advised of that finding. We will make its decision within 20 working days after receipt of the documentation. After the organization is notified of our finding, the organization may disenroll the beneficiary.

We expect that the cause provision will be used rarely. However, for the exceptional cases that may occur, the organization will have a means available to resolve the situation.

Comment: A commenter stated that although an organization is required under § 417.460(b) to submit a disenrollment notice within 30 days of the enrollee's request, there is no provision describing what HCFA will do if an organization does not submit the notice timely. The commenter noted that a risk organization could receive payment from HCFA for the individual without being required to pay for services furnished outside the plan that are not emergency or urgently needed services.

Response: We are revising the regulations to indicate that we will be reimbursed by the organization for any capitation payments made after the date payments would have ceased if the organization had notified us on a timely basis as § 417.460(b) requires.

Comment: One commenter suggested that enrollments and disenrollments be processed by Social Security Administration personnel, rather than by the eligible organization, since these personnel are "unbiased." This commenter was afraid that organizations may not process disenrollment requests promptly.

Response: Enrollments and disenrollments are a two-step process. First, the eligible organization must amend its records. Since these organizations are private enterprises, the use of Federal personnel to perform that function would be inappropriate. Second, we must also maintain an accurate and current Federal record of Medicare enrollees in each organization.

We believe that beneficiaries are protected adequately from disenrollment initiated inappropriately by eligible organizations. An organization may not disenroll beneficiaries except for well-defined purposes, and only after specified procedural requirements are met (§ 417.460). Enrollees who believe that their rights regarding enrollment and disenrollment have been violated may complain directly to any HCFA office. Beneficiaries may consult any social security office or any Federal Information Center for the address and telephone number of HCFA's nearest regional office. Enrollees may write also to HCFA's central office at the following address:

Health Care Financing Administration, Group Health Plans Operation Staff, Room 320, Meadows East Building, 6300 Security Blvd., Baltimore, MD 21207

Comment: A commenter asked whether the minimum 30-day period that a beneficiary must wait when he or she reguests disenrollment from one organization in order to join another is necessary.

Response: The regulations reflect the requirement of present law (section 1876(b)(3)(B) of the Act).

Comment: A suggestion was made that HCFA should establish a system by which it could trigger an investigation of an HMO or CMP if beneficiary disenrollment rates exceed a certain rate. The purpose of this investigation would be to determine whether there is a pattern of discrimination against enrollees who use more services than the average enrollee.

Response: Disenrollment is an area of concern to us. Regulations are specific as to reasons and circumstances governing disenrollment. HCFA's regional offices will monitor the eligible organizations to assure that they operate within these regulations. We have decided to enhance the ability of these offices to review disenrollment activity, and we are revising § 417.482 to provide specific authority to inspect and evaluate disenrollment records.

In addition, we have added § 417.460(a)(4)(iv) to provide that when beneficiaries are disenrolled for fraudulent practices, such as permitting other persons to use their membership cards, the organization must report this abuse to the HHS Inspector General so that we may initiate our own investigation of the alleged fraud.

Comment: One commenter suggested that there be a waiting period during which a Medicare enrollee who has applied to an eligible organization for membership may withdraw his or her application, rather than having to follow disenrollment procedures.

Response: While it would be possible to build a holding period into the enrollment procedures, it would, of course, delay the effective date of enrollment. Upon receipt of an application from an eligible organization, we must add certain information to our systems in order to begin a monthly capitation payment and to annotate the enrollee's records so that Medicare services may not be reimbursed in the usual manner. Our experience, to date, has not demonstrated a need for such a delay. Indeed, the procedure might confuse rather than help potential Medicare enrollees.

D. Entitlement to Services

Comment: A number of commenters objected to the two-for-one enrollment conversion rule because the rule penalizes existing cost contract organizations that do not have a pool from which to draw new enrollees and will encourage organizations to delay enrollment of new Medicare beneficiaries until these regulations become effective. Other commenters stated that this rule discriminates against risk enrollees because current nonrisk enrollees of risk organizations are afforded special supplemental benefits under § 417.444. Conversely, current nonrisk enrollees will be discriminated against because they are denied the extra benefits that accrue from risk contracts under § 417.440(b)(4).

Response: The two-for-one enrollment rule is mandatory under the provisions of section 114(c)(2)(A) of Pub. L. 97–248. Through the provisions of these regulations, we have attempted to ensure that the two-for-one conversion criteria will be applied in an unbiased manner, and we intend to monitor closely the implementation of this rule. It is true that section 114(c)(2)(B) of Pub. L. 97–248 permits risk organizations to offer current nonrisk members a special supplemental benefits package; however, in exchange for these benefits, nonrisk enrollee must agree to the "lock-in" provisions of § 417.444(b)(6).

Comment: Several commenters indicated that cost and risk organizations should be allowed to screen applicants on the basis of health status for voluntary supplemental benefit plans that include services not covered by Medicare (for example, outpatient prescription drugs, eyeglasses, or hearing aids).

Response: We disagree. Preliminary results from demonstration projects that were permitted to screen applicants for optional supplemental benefit packages indicate that such screening has an effect on enrollment for the basic benefit plan as well. Data from these demonstrations indicate that when health screening is permitted for any plan, there may be biased selection of relatively healthier applicants. Therefore, in order to assure that Medicare beneficiaries are accepted without restriction by organizations on a first-come, first-served basis as required by section 1876(c)(3)(A) of the Act (except when denial of enrollment is permitted under § 417.424), we are prohibiting health screening for any plan offered to Medicare beneficiaries.

Comment: One commenter stated that organizations that contract on a risk basis should be required to offer a benefit package that includes only covered Medicare services.

Response: Section 1876(c)(2)(B)(ii) of the Act permits risk organizations to require that Medicare enrollees must purchase a mandatory package of supplemental health services, if these services are approved by HCFA. Supplemental services are evaluated on the basis of whether they will substantially discourage Medicare enrollment in the organization (§ 417.440(b)(3)).

Comment: Several commenters stated that organizations should be allowed to charge for special supplemental benefits offered to current nonrisk Medicare enrollees of an organization under a risk contract.

Response: These organizations are prohibited from charging current nonrisk enrollees for these benefits because, as described in §§ 417.442 and 417.444(c)(7), these benefits must be reimbursed from the savings the organization achieves from an ACR that is lower than the average of the per capita rates of payment made by HCFA.

Comment: One commenter suggested that we consider annotating a beneficiary's Medicare card upon his or her enrollment in a risk organization, so that other providers and suppliers of care would be aware that restrictions apply to the reimbursement for Medicare services received outside the organization.

Response: At the present time, it is not practical to modify the Medicare card to notify providers that a beneficiary is an enrollee of an eligible organization. We are aware that some organizations presently provide enrollees with peelable stickers to place on their Medicare cards, and we suggest that this procedure be considered by other organizations experiencing a problem.

Comment: One commenter was concerned with the provisions of § 417.460(a)(1)(iii), which permit a Medicare enrollee of a cost organization to terminate his or her participation in an optional supplemental benefit package merely by nonpayment of the premium while remaining enrolled in the rest of the program. The commenter believes that this policy is unfair to organizations and aggravates the problem of adverse selection. A Medicare enrollee could elect the optional benefits, use it to its maximum, and then drop it by nonpayment. The commenter would prefer that enrollees who elect an optional package be locked into these benefits (and payment of the premium) for a minimum of one year. Allowing them to opt in and out of the program at will creates an untenable rating and adverse selection problem.

Response: While an organization may lose money on an individual enrollee who disenrolls from an optional supplemental benefit package, it is just as likely that a beneficiary will pay premiums for optional supplemental benefits for a year or two, and seldom, if ever, use these services. These regulations are designed to protect from disenrollment by the organization those Medicare enrollees in cost organizations who decide to terminate an optional supplemental plan. We wish to stress that the services at issue are optional, and we are not aware of any optional supplemental health insurance programs where the purchaser loses the right to disenroll. We do not believe that these regulations will cause an adverse selection problem, and they are not being revised.

Comment: One commenter inquired if an enrollee of a risk organization could be disenrolled for failure to pay premiums for supplemental benefits that are part of a separate or integrated premium. This commenter noted that under § 417.460(a)(1)(iii) enrollees of reasonable cost organizations are protected from disenrollment for failure to pay the premium on an optional supplemental plan they wish to terminate.

Response: Enrollee of risk organizations are protected to the same extent as enrollees of cost organizations from disenrollment for failure to pay a premium for an optional supplemental package of benefits. We are revising § 417.460(a)(1)(iii) to make this policy clear.

Comment: A few commenters asked us to clarify when an organization must make refunds for enrollees who have died or cannot be located. Specifically, they questioned why the provisions set forth in the NPRM applied only to risk organizations and whether we intended that organizations refund all incorrectly collected amounts when the beneficiary dies or cannot be located.

Response: Section 417.456, as proposed in the NPRM, incorrectly specified that only risk organizations must refund amounts incorrectly collected when the beneficiary has died or cannot be located. We have corrected this provision to apply to all organizations. It is our intention that organizations must refund all incorrectly collected amounts when the beneficiary has died or cannot be located. If amounts were incorrectly collected from a third party on the beneficiary's behalf, refunds may be made to the third party.

Comment: One commenter stated that the proposed regulations require organizations to refund amounts

collected from beneficiaries when an enrollee was believed not entitled to Medicare benefits, if the enrollee is later determined to have been entitled to Medicare benefits during that time. The commenter stated that, as presently specified in the regulations, these refunds would be due regardless of whether or not HCFA was liable, according to the provisions of § 417.450, for payments during this period.

Response: We have amended § 417.456 to indicate that refunds are due only if HCFA was liable for payments during the period in question.

E. Contract Requirements

Comment: We received several comments that wanted to know which entity has the responsibility for monitoring the performance of contracts between HCFA and eligible organizations.

Response: The HCFA regional offices will have this responsibility. Complaints regarding an organization's compliance with these regulations may be directed to the appropriate HCFA regional office (the address and telephone numbers of which can be obtained from any social security office or any Federal information center), or interested parties may address their written comments to the following address:

Health Care Financing Administration, Group Health Plans Operations Staff, Room 320, Meadows East Building, 6300 Security Boulevard, Baltimore, MD 21207

We wish to state that, if we believe that it would be administratively feasible and cost effective, we may enter into independent contractual arrangements with national organizations that have established arrangements with health care delivery systems in a substantial number of States in order to expedite eligibility determinations and contract administration.

Comment: One commenter believes that organizations that contract with HCFA should be required to prove they furnish high quality service before they are permitted to increase enrollment in their geographic area.

Response: In order to qualify for a contract, eligible organizations are required to demonstrate their ability to furnish high quality services to enrollees. HCFA regional offices will monitor this requirement once the contract is in effect. Enrollees who believe that the services furnished by an organization are substandard should consider notifying us as directed in the immediately preceeding response.

Comment: One commenter suggested that the Assistant Secretary for Health oversee compliance with sections 1301(c)(8) and 1318 (a) and (c) of the PHS Act, which relate to conflict-of-interest and liability arrangements (§§ 417.478 (b) and (c)).

Response: The Assistant Secretary for Health is responsible for overseeing that HMOs comply with these requirements and, as a part of their responsibility in determining CMP eligibility, the Assistant Secretary will review compliance for CMPs.

Comment: One commenter stated that organizations with effective utilization review requirements should be exempt from review by PROs, which is required by § 417.478(a).

Response: The law requires review of hospital inpatient services.

Comment: One commenter stated that § 417.492(b)(4) implies that, if an organization is dissatisfied with HCFA's decision not to renew its contract, that this decision is appealable under the procedures of §§ 417.640 through 417.682. However, § 417.642 states that, unless this decision to not renew is based on one of the reasons stated in § 417.640(c) (that is, the organization failed to carry out the terms of the contract, is carrying it out in a manner inconsistent with the efficient and effective administration of section 1876 of the Act, or the organization no longer meets the qualifying conditions of an eligible organization), then these determinations are administrative actions, which are not appealable. The commenter suggested that all decisions not to renew a contract should be appealable.

Response: While we would not anticipate failure to renew a contract for other than the reasons stated in § 417.640(c), we do not agree that nonrenewals should be appealable in any given situation. Since the nature of contracts are that both parties agree on terms, we prefer to reserve the right to decline to renew the contract as a matter of administrative choice. Also, section 1876(i)(1) of the Act specifically permits either party to terminate the contract at the end of the current term as long as notice has been given as required under § 417.492. We have clarified § 417.492(b)(4) to make this policy clear.

Comment: One commenter said that an organization should have a right to terminate its contract if HCFA fails to substantially carry out the terms of the contracts.

Response: We agree and have made a corresponding change to § 417.494.

Comment: One commenter stated that, if HCFA decides not to renew an organization's contract, that HCFA should notify the organization's Medicare enrollees at least 90 days before the termination date, rather than the 30 days specified in § 417.494. The commenter believes that a Medicare enrollee will need more than 30 days to become enrolled in another organization.

Response: Where practical, HCFA has required risk organizations to provide a 60-day notice to beneficiaries when the organization's contract is not renewed. HCFA will also notify affected Medicare enrollees of the termination at least 30 days before the termination date. When HCFA terminates an organization's contract for cause, we believe that the interests of the beneficiaries are better served by a speedy termination date. Therefore, we are not revising the 30-day notice requirement in § 417.494.

Comment: One commenter requested that § 417.520(b)(3) be revised so that organizations must notify HCFA only 30 days before an anticipated change of ownership instead of the 60 days now required. Some organizations may be unable to meet the 60-day requirement because these transactions may occur rapidly depending on the type of organization and action by stockholders.

Response: We believe 60 days is the minimum time necessary for us to assure that continuation of the contract after the pending change in ownership is in the best interest of the Medicare program.

F. General Reimbursement Rules

Comment: One commenter asked whether it is permissible under § 417.528 for organizations to require an enrollee to sign a lien against benefits from any other health plan to which Medicare is secondary payor.

Response: As stated in the regulations, organizations may charge another plan or the Medicare beneficiary for services when Medicare is not the primary payor. Organizations may require the enrollee to sign a lien against the reimbursement for those benefits. Regulations have not been amended since such liens fall within the definition of the word "charge."

Comment: Several commenters supported the application of the prompt payment provisions of 31 U.S.C. 3901–3906 to the monthly capitation payments made to eligible organizations. These provisions are concerned with the time frames within which the Federal government must make payment for the goods and services it has purchased and interest penalties that accrue when the payment dates are not met.

Response: Although these provisions do not apply to benefit payments made under the Medicare program, we intend

to apply, to the extent possible, the financial management principles set forth in these provisions in our operation of contracts under section 1876 of the Act. However, under section 1876(a)(1)(D) of the Act, we must make our monthly payment to an eligible organization in advance.

Comment: Numerous commenters requested a clear statement of our reimbursement policy for Medicare enrollees who elect hospice care under 42 CFR Part 418, noted above.

Response: For reasonable cost organizations, we have added § 417.531 to provide that for the period a Medicare enrollee has elected hospice care services, reimbursement for those services will be made to the Medicare-participating hospice that furnishes the services. While the enrollee's hospice election is in effect, the organization may receive reimbursement on a reasonable cost basis for only those services that are not waived under § 418.24(e).

For risk organizations, no payment is made to the organization on behalf of an enrollee who has elected hospice care for the period the hospice election is in effect except for the portion of the payment applicable to the additional benefits that are described in § 417.442. During the time the election is in effect, the organization may bill HCFA on a fee-for-service basis, subject to the usual Medicare payment rules, for the services not waived by the enrollee. Full capitated payment resumes in the month following the month in which the hospice benefit terminates or is exhausted. This policy is set forth at § 417.585.

Comment: A commenter wished to know how organizations that are receiving payment for physicians' services will be affected by the physician fee freeze provisions of section 2306 of Pub. L. 98-369.

Response: Section 2306 amended section 1842 of the Act to establish a freeze on Medicare reimbursement for physicians' services, to create a participating physician program and to prohibit certain physicians (those who do not participate) from raising their charges to Medicare beneficiaries after June 30, 1984.

The charge screens used by Medicare carriers to determine the reasonable charges for physician services will be frozen to the limits that were in effect June 30, 1984 (that is, customary and prevailing limits that were established on 1982 charge data). These screens will not be updated until October 1, 1985 using charges made by all physicians for services furnished during the period April 1, 1984 through March 31, 1985.

Those physicians that elect to participate (that is, accept assignment for all Medicare claims) may raise their charges to Medicare beneficiaries and those charges will be recognized in calculating their customary charges effective with the October 1, 1984 update of physician charge screens. Until September 30, 1985, those physicians who do not elect to participate cannot charge a Medicare beneficiary more than the customary pattern that was charged for that service during the period March 1, 1984 through June 30, 1984. Any physician who knowingly and willfully makes a higher charge would be in violation of the law, and subject to civil penalty as well as exclusion from the Medicare program.

An organization may obtain from the Medicare carrier serving its area information necessary to determine the amounts Medicare pays on a fee-for-service basis for covered services. This information is necessary to ensure that those existing reasonable cost organizations that obtain physician services (and other Part B supplier services) on a free-for-service basis under § 417.546(c) do not exceed the reasonable charge for those services as set forth in Subpart E of 42 CFR Part 405 for contract periods beginning before January 1, 1986. The availability of these data will also ensure that the requirements at the prudent and conscientious buyer and comparability of payment for physician services are met.

G. Reasonable Cost Reimbursement

Comment: One commenter complained that, under these regulations, home health agencies (HHAs) will not be able to contract with eligible organizations at "special rates" because of current guidelines governing Medicare payment at the lower of cost or charges to HHAs.

Response: These regulations do not contain the bill payment option that is currently available under Subpart T regulations that allows HCFA to process HHA bills for services furnished to the organization's Medicare enrollees. Both cost and risk-based organizations will be free to negotiate "special rates" with HHAs for services HHAs furnish to the organizations' Medicare enrollees. Under a risk contract, the guidelines on lower of cost or charges (and other reasonable cost rules) will not apply to services furnished to Medicare enrollees by an HHA because, under a risk-capitation system, there are no retroactive adjustments to the capitation rates for these services. Organizations with cost contracts are subject to reasonable cost limits.

Comment: A local medical society believes that allowing organizations to claim as allowable costs those bad debts attributable to deductibles and coinsurance gives these organizations an unfair advantage over physicians who are not allowed to claim bad debts as a cost.

Response: By bad debts we refer only to Medicare deductible and coinsurance amounts that beneficiaries fail to pay. Physicians are paid on a charge basis and their charges may reflect losses that result from the failure of beneficiaries to pay deductibles and coinsurance. In addition, organizations with cost contracts can only claim bad debts for the period reasonably related to the period they need to disenroll a beneficiary who does not pay deductibles and coinsurance (that is, three months). In contrast, a fee-for-service physician may stop furnishing services immediately to beneficiaries who do not pay their deductibles and coinsurance.

Comment: The same commenter is also concerned about the advantages that eligible organizations have over private practitioners in that they can claim reimbursement for enrollment and marketing costs. The commenter believes that this is an unfair competitive edge because private practitioners cannot claim these costs, and the amounts that the organizations can claim and receive are in addition to their regular monthly payment, which is based on 95 percent of the AAPCC.

Response: Organizations with cost contracts are paid a monthly advance payment equivalent to the organization's interim per capita rate for each Medicare enrollee of the organization. However, at the end of a contract period, the organization submits a cost report, and the payments made to the organization are adjusted to equal the reasonable costs of the covered services the organization furnished to its Medicare enrollees. Therefore, the organization does not receive payment for enrollment and marketing costs claimed in addition to its monthly payment. Rather, the monthly payment is adjusted after all these and other costs are considered.

We believe that enrollment and marketing costs are a normal business cost to the organization and we have recognized these as allowable costs for many years. Also, we expect fee-for-service practitioners to take advertising and other overhead expenses into account when they set their charges.

Comment: Many commenters wrote to protest our suggested policy that an organization with a cost contract could

not receive total payment during a contract period that would be in excess of its AAPCC. These commenters believe that this policy—

- Would put the cost contractors on the same basis as the risk contractors without any of the benefits allowed to risk contractors;
- Would discourage organizations from participating in this program; and
- Is not supported by the statute.

We did receive one comment from a potential eligible organization that supported this policy. In addition, one commenter had no objection to using the AAPCC as a limit in the case of reasonable cost payments for current, nonrisk enrollees in a risk organization.

Response: First, it should be noted that we have used a cost HMO's AAPCC as a general guideline of the reasonableness of the organization's costs since we started contracting with HMOs under section 1876 of the Act (see § 405.2041(b)). In addition, section 1861(v)(1)(A) of the Act limits reimbursement on a reasonable cost basis by excluding those costs that are found to be unnecessary in the efficient delivery of health services. With regard to paying HMOs and CMPs on a reasonable cost basis, we believe we are required to consider the principles of reimbursement that are generally applied to established prepayment organizations regardless of whether they are cost or risk organizations. Except within the Medicare program, where we lacked sufficient experience, these organizations have been paid on a risk basis with respect to their enrollees.

Since the purpose of purchasing services from an HMO or CMP is to furnish care more efficiently than is available in the fee-for-service system, it is reasonable to expect that, in the aggregate, an eligible organization operating on a cost basis should be more efficient than the aggregate costs of suppliers and providers of services in its community. Previously, HCFA's lack of experience in this area prevented us from establishing clear standards for comparison. However, some recent studies by HCFA indicate that existing cost HMOs are already operating significantly below the average per capita costs of their community.

Therefore, we believe it is reasonable and consistent with the law that we establish the cost organization's AAPCC as an overall payment limit. The actual limit will be the weighted average of the AAPCCs for each class of the organization's Medicare enrollees. In order to provide existing participating cost organizations time to adjust to this new standard, we will delay the effective date of this change to the regulations until contract periods beginning on or after January 1, 1986. however, the limit will be applied immediately for all new organizations that begin contracting under these provisions.

Comment: Numerous commenters objected to our statement in the NPRM (49 FR 22210) that we were considering eliminating bad debts attributable to uncollected deductibles and coinsurance as an allowable cost. The commenters believe that these costs are part of the usual cost of doing business and that not allowing them as part of the organization's reasonable cost could discriminate against those organizations with a large number of lower income Medicare beneficiaries, who would probably have higher bad debt losses. In addition, they contend that eliminating these costs is inconsistent with usual Medicare policy toward providers.

Response: We agree with the commenters and have decided not to implement this provision. Therefore, we are retaining § 417.536(f).

Comment: In the NPRM (49 FR 22210), we stated that we were reviewing the various exceptions to the usual Medicare principles of reimbursement to see if these exceptions are justified. We specifically requested comments on this issue, and received only limited comments.

One commenter stated that the exception to the reasonable charge screens provided in § 417.546(c)(2) concerning payment to a physician group organized on an individual practice (IPA) basis should be revised because the Assistant Secretary for Health no longer requires a separate IPA entity. Therefore, the exception should state that payment to physicians organized on an individual practice basis is not subject to the reasonable charge screens if the eligible organization pays its physicians (either directly or through a group entity) on a fee-for-service basis and has procedures under which the physicians accept effective incentives.

One potential eligible organization wrote to suggest that we should include in § 417.560(c) and (d) an exception to the reasonable charge limit for emergency and urgently needed services and medical services furnished under an arrangement on a fee-for-service basis if these services are furnished infrequently, the charges for these services represent an insignificant amount of the organization's total reimbursement, and the charges do not exceed the amounts charged by the physician or supplier to other patients. This exception is allowed in the Subpart T regulations and the commenter believes it is justifiable because it is not reasonable to expect organizations to determine reasonable charge rates for services that are infrequently furnished and are an insignificant part of total reimbursement.

Response: Since, as stated above, we are applying the AAPCC as an overall limit on payments to a cost organization, we see no need to apply the reasonable charge limits set forth in 42 CFR 405, Subpart E to physician and supplier compensation. Therefore, we will not apply these limits to any new reasonable cost organizations that begin to contract with us and we will eliminate the limitations for existing cost organizations with contract periods beginning on or after January 1, 1986. Instead, for these organizations, we are applying reasonable cost rules to all physician and supplier costs an organization incurs, regardless of the payment method it uses.

Although we received no specific comments on other exceptions set forth in the proposed regulations, we have decided to make the following changes to what was proposed in the NPRM:

- We are eliminating the exception that allowed a cost organization that does not furnish services on a fee-for-service basis to nonenrollees to be free from the lower of cost or charges rule (§ 417.536(o)). We believe that this exception is no longer necessary because eligible organizations and their providers and suppliers no longer exclusively service their own enrollees.
- For contract periods beginning on or after January 1, 1986, we will be eliminating the weighting factor used in determining the reasonable costs of Part B direct professional services (§ 417.562) because this factor is inconsistent with the usual Medicare reasonable cost principles. Continuing to pay reasonable cost organizations with the added weighting factor results in their receiving more payment for Part B services than rates paid in the Medicare fee-for-service market. For example, no adjustment factor is paid to a hospital outpatient department or to a community health clinic after its reasonable costs are determined, yet, if the services are furnished by an organization's ambulatory clinic under the same payment rules, it receives an additional payment amount based on the weighting factor. As mentioned above, this revision will not be effective until the beginning of contract periods beginning on or after January 1, 1986, to allow organizations time to adjust their payment procedures.

Comment: A few commenters disagreed with the provisions of

§ 417.542, which do not permit reinsurance costs to be considered an allowable cost.

Response: There is no statutory authority to include reinsurance costs as allowable costs and, since cost organizations incur no risk relative to the limits of Medicare coverage because they are paid on a reasonable costs basis, we do not believe these should be included as allowable.

Comment: A potential eligible organization commented on the provisions of § 417.576(b)(2)(i), which state that consolidated cost reports are required if an organization is related to another entity by common ownership or control. The commenter is unclear as to whether this provision applies only to organizations with cost contracts or also to those with risk contracts. In any case, this entity believes that requiring consolidated cost reports of separate entities that have separate contracts with HCFA is unreasonable.

Response: The regulations at §§ 417.530–417.576 only apply to reasonable cost reimbursement. Section 1876(h)(4)(C) of the Act requires that if an eligible organization paid by Medicare on a reasonable cost basis is related to another organization by common ownership or control, a consolidated financial statement must be filed. Therefore, the regulations must contain this requirement.

H. Risk Reimbursement

1. *Adjusted Average Per Capita Cost (AAPCC).*

Comment: One commenter believes that an organization should be notified by HCFA of its AAPCC as early as possible and that information on the manner in which the AAPCC was computed should be made available.

Response: In general, we agree with this comment. It should be noted that the regulations state that HCFA will furnish the organization with its AAPCC at least 90 days before the start of the contract period. For a further discussion of this issue, see the comments and responses in section III. H. 2. of this preamble.

Comment: A beneficiary organization suggested that HCFA should monitor a risk organization's costs closely so that HCFA may lower an organization's monthly per capita rate of payment below 95 percent of its AAPCC if it discovers that organizations are operating well below this level. A hospital trade association suggested that the final regulations should provide for a five-year transition period during which the payment rate cannot be lowered below 95 percent.

Response: The 95 percent of the AAPCC provision is mandated by the statute (section 1876(a)(1)(D) of the Act) and HCFA does not have the option of changing the percentage figure. However, HCFA will be evaluating payment rates and the ACR in terms of appropriate levels of efficiency for risk organizations.

Comment: Several commenters expressed concern about the actual method we will use to develop the AAPCC rate book and inquired whether there would be an opportunity to appeal our methodology and assumptions.

Response: Since no organization will be signing a risk contract prior to publication of the rate book, each organization will have full opportunity to review the rates and decide if they are adequate. If an organization believes that the rates are not adequate, then that organization can simply decide not to participate in a risk contract. There will be no provision for appeal of our methodology and assumptions used in determining the AAPCC. However, in the addendum to this final rule, we describe the methodology, and we welcome comments and suggestions for improvement. In addition, we will be conducting demonstrations that we hope will assist us in further refining the AAPCC methodology.

Comment: One commenter suggested that the AAPCC methodology should be guaranteed for a period of five years.

Response: We believe that this would not be practical since changes in the law, new data, or other changes may result in improvements in our AAPCC methodology.

Comment: One commenter objected to our mentioning in the NPRM (49 FR 22208) that we may, in the future, include in the AAPCC methodology a health status adjustment. The commenter believes that including this adjustment would lead to wide-spread abuse. Another commenter supported the inclusion of this adjustment factor.

Response: An independent actuarial consultant has advised us that a health status adjustment would not result in improvement in the AAPCC methodology at this time. As noted in the NPRM, we will incorporate this adjustment only if future research indicates its feasibility.

Comment: One commenter asked how we have interpreted the requirement for "actuarial equivalence" of the AAPCC and how it could be demonstrated that this requirement has been met.

Response: The law (section 114(c)(4) of Pub. L. 97–248) requires that the Secretary be reasonably certain that the methodology to make appropriate adjustments have been developed and can be implemented to assure actuarial equivalence in the estimation of the AAPCC. This requirement will be met when the Secretary notifies the Committee on Finance of the Senate and the Committees on Ways and Means and on Energy and Commerce of the House of Representatives of her certification of the AAPCC methodolgy.

Comment: One commenter inquired about the definitions of "welfare" and "institutionalized" individuals as used in the AAPCC calculation.

Response: The definitions as used in the AAPCC methodology are as follows:

"Institutionalized" means a Medicare beneficiary who has been a resident for at least 30 days of a nursing home, sanatorium, rest home, convalescent home, long-term care hospital, or domiciliary home. "Welfare" means a Medicare beneficiary who has been determined by the Medicaid agency of the State in which he or she resides to be eligible for Medicaid. However, for purposes of clarification, we have revised the term "welfare" to "medicaid" (see the addendum to this rule).

2. *Adjusted Community Rate (ACR).*

Comment: We received a comment that suggested that prior to the effective date of these final regulations, HCFA should publish, for public comment, the guidelines on the computation of the ACR, and the details of the community rating system.

Response: We believe that the explanation of the ACR that was included in the NPRM satisfies any requirements for publishing for comment our policy concerning computation of the ACR. We do plan to provide organizations with further details in administrative issuances. However, we wish to stress that the methods used to calculate the community rate must be internally consistent with rates used for calculating premiums charged to the organization's non-Medicare enrollees. Thus, documentation of rates for each service category of the community rate must be consistent with the rates used in the premium calculations for the same services.

Comment: Numerous commenters objected to the timeframes set forth in the regulations (§ 417.592(d)) concerning HCFA's furnishing of an organization's payment rates, approval by HCFA of an organization's proposed ACR and weighted averages of the per capita rates of payment. They believe these timeframes do not allow the organization sufficient time to market its package. These commenters suggested that earlier time periods be provided for HCFA notification of per capita

payment rates; the organization's submission of its ACR; and weighted averages of per capita rates and descriptions of additional benefits; and HCFA approval of that submittal. They proposed the following timeframes:

- HCFA furnishes payment rates to organization—180 days prior to the start of the contract period. (The NPRM specified 90 days.)
- Organization submits its weighted average of its per capita rates of payment and the ACR to HCFA for approval—150 days prior to the contract period. (The NPRM specified 45 days.)
- HCFA notifies the organization of its approval or disapproval—120 days prior to the contract period. (The NPRM did not specify any time frame for this approval.)

Response: Although providing payment rates 180 days in advance of the contract period may be possible in the future, we cannot do so at this time. Therefore, we will provide the rates 90 days in advance of the contract period, as stated in the NPRM. Since the other timeframes are linked to the payment rates, they will also remain as stated in the NPRM. However, we are considering all aspects of this provision, and we may, in the future, be able to provide payment rates further in advance of the contract period.

Comment: Some commenters expressed concern about the fact that we did not explicitly state in the NPRM whether or not an organization may include in its ACR computation a reasonable contribution to its contingency reserve fund against the risk of adverse selection or overutilization.

Response: An organization is free to do so if its premium for its non-Medicare enrollee groups includes this element.

Comment: An association wrote to express its concern about what supporting documentation HCFA will require an organization to submit with its ACR.

Response: The burden of identifying and proving the basis of the community rate and the adjustments for the ACR fall to each risk organization and will depend upon a fact-finding process that is based on the individual circumstances, utilization experience, private business, and expenses of each. No standardized formula applies and, thus, proof depends upon reliable, consistent, accurate, and authentic business records that the risk organization provides to us. This means that HCFA must have access to the records of the organization to verify information. Therefore, in response to the comment and in order to provide guidance to risk organizations, we are adding a new § 417.481 to specify what kind of documentation the risk organization must maintain with regard to its ACR calculation. This includes requiring that an organization will have to maintain and make available to HCFA records of reports filed with other Federal programs and State authorities.

Comment: A commenter was confused about the ACR computation methodology. Specifically, the commenter wanted to know if an organization may use the community rate method or the aggregate premium as it chooses, or if it must use both of them.

Response: As specified in § 417.594(b), an organization must choose one method or the other; however, the choice belongs to the organization.

Comment: A few commenters objected to our decision to prohibit the use of a time factor as an adjustment to the organization's community rate except as a temporary measure in the organization's initial contract period (§ 417.594(c)(2)(ii)). They believe that the time factor adjustment is well established and has been used under cost-based contract for many years; therefore, the risk organizations should be allowed to use it.

Response: We proposed in the NPRM (see § 417.594(c)(2)(ii)) that an organization with a risk contract has the option of using a time factor in its first contract period merely to allow the organization time and experience to develop empirical evidence that demonstrates the differences in the complexity of intensity of services furnished to Medicare enrollees. We have revised this section of the regulations to allow this adjustment for the first year of this program's operation. After this date, we believe that an organization should be able to gather supporting evidence to do this.

Comment: A potential eligible organization requested that, in adjusting their initial rate to take into account the characteristics of Medicare enrollees, organizations be allowed to use what it refers to as "standard area specific age/sex experience tables" as an alternative adjustment to the volume or intensity adjustments set forth in §§ 417.594(c) (1) and (2).

Response: Since the commenter described these tables in only general terms, it is difficult for us to categorically respond to their validity in making adjustments to the initial rate calculation. However, nationally recognized tables of this type could be used if—

- The organization uses the tables in developing its initial rate; and
- The organization demonstrates to HCFA's satisfaction that the tables are valid indicators of the utilization of health services.

Comment: One commenter stated that the requirements of §§ 417.594(c)(2) (i) and (ii), as set forth in the NPRM, could be in conflict with the requirements of title XIII of the PHS Act. As written, those sections would allow an organization to adjust its community rate to reflect the difference in the complexity or intensity of services furnished to its Medicare enrollees if the adjustment is made equally to *all enrollees*. The commenter believes that the term "all enrollees" should be revised to read "all Medicare enrollees"; otherwise, organizations would be required to experience rate it non-Medicare enrollees, which is prohibited under the PHS Act.

Response: We agree with the commenter that the language of the noted sections, as proposed, was misleading. We have revised those sections of the regulations to specify that if an organization chooses to use the adjustments in §§ 417.594(c)(2) (i) and (ii), then its calculation of its initial rate must also have included the elements of the adjustment. As long as this is done for all enrollees, the organization is not experience rating.

Comment: An association of prepaid health organizations is concerned about confidentiality of data submitted to HCFA regarding ACR calculations. The commenter stated that the structuring of rates is highly confidential, because ratemaking decisions are critical to the competitive position of each organization in the marketplace. The recommendation is that this information be exempted from disclosure under the Freedom of Information Act (FOIA).

Response: These data are exempted from mandatory disclosure under the FOIA by 5 U.S.C. 552(b)(4), which deals with "trade secrets and commercial or financial information obtained from a person which is privileged or confidential." Organizations should separate their ACR calculations from their other submissions to HCFA and clearly identify them as confidential. Within HCFA, access to this information will be limited to those who have a responsibility for review and evaluation of the data.

Comment: One commenter urged us to allow organizations that have already been subject to a State rate review process to submit those data to HCFA and that HCFA would accord appropriate weight to these determinations. This would, in the commenter's opinion, avoid duplicative

and unnecessarily burdensome reviews for the organizations and avoid HCFA determinations that conflict with State regulatory requirements.

Response: We will explore the possibility of coordinating our review efforts with those of state insurance premium review agencies. However, because of major differences among the various requirements in State and the Medicare program, there may be many administrative difficulties in effective and efficient coordination.

Comment: An actuary contended that HCFA should not allow organizations to compute their own average of their per capita cost of payments, since this can be manipulated to minimize required additional benefits or reduced payments. The organization will not be penalizing itself by calculating a low average for submission to HCFA because the actual payment is based on true enrollment.

Response: We disagree with the commenter. The key element in calculating the average payment rates is the expected enrollment for the contract period. We believe that the organization is best qualified to make this estimate. We will review the organization's assumptions and calculations to ensure their validity when they are reported to us under the provisions of § 417.590.

Comment: A commenter questioned whether an organization whose ACR is less than its average of the per capita rates of payment could make up the difference by a combination of accepting a reduced payment from HCFA and furnishing additional benefits to reconcile the difference.

Response: We agree that an organization may do this, and we have revised the regulations (§ 417.442(b)) to make this policy clear.

Comment: A commenter stated that the ACR computation does not appear to take into account area differences in the distribution of an eligible organization's regular business and its Medicare business. Another commenter wanted HCFA to allow separate ACRs by county with separate premiums.

Response: By definition, a community rating system spreads the risk of health insurance costs over the broad population that an organization serves. The ACR calculations must begin by being consistent with the premium calculations used by organizations in their non-Medicare business. Since these organizations usually do not set premium rates by county, if the ACR was calculated on this basis it would artificially impose a rate setting adjustment that has not been recognized or applied uniformly by the industry.

Comment: A potential eligible organization believes that we should eliminate the requirement that an organization that is utilizing the initial rate calculation described in § 417.594(b)(3) must include a separate component for overhead. The commenter suggests that overhead should be allocated among the direct service components because that is the current common practice. Overhead is driven by and a function of the direct service component.

Response: We believe that distinguishing this element separately is necessary for proper evaluation of an organization's ACR. However, we have changed "overhead" to "general and administrative" to be more consistent with usual accounting practices.

Comment: One commenter believes that, because of the prospective payment system for inpatient hospital services, the cost per unit of furnishing those services to Medicare enrollees may be more or less than the organization's cost from a related provider or charges from an unrelated provider for non-Medicare enrollees. The commenter maintained that this cost differential should be recognized in the regulations as an appropriate measure of intensity for purposes of adjusting the initial rate in the ACR computation.

Response: Just as we no longer recognize a separate adjustment to hospital payment rates to reflect an intensity factor through the nursing differential, we will not be allowing separate adjustments for prospective payment rates compared with the rates paid by organizations to hospitals. This adjustment would artifically elevate an organization's ACR in a manner that is not related to its own purchasing arrangements for hospital services.

Comment: A few commenters believed that the ACR methodology should allow flexibility so that each organization may use adjustments that take into account its usual financial needs and risks.

Response: As long as an organization's calculation method is consistent with either of the two basis methods mandated by law (that is, community rating or aggregate weighted premium method), we will recognize circumstances unique to each organization if—

- There is an equitable financial impact on the general enrollment and the Medicare enrollment; and
- Proper supporting documentation is furnished.

Comment: A potential eligible organization asked if the costs incurred by an organization in entering into contracts with existing medical groups (network model organizations) can be included in the organization's ACR calculation.

Response: An organization may include these costs if it also includes them in the premium for non-Medicare enrollee groups.

Comment: A commenter wanted to know if HCFA will attemp to recover the difference if an organization's actual ACR for a given period falls below the budgeted or projected ACR due to the improved efficiency of the organization. The commenter believes that there should be no attempt to recover that difference and that the only action taken by HCFA should be in reflecting that difference in the ACR for the following contract period. Similarly, another commenter questioned whether an organization could retain the profit it makes if its average per capita expenses are less that its average per capita payment because its Medicare enrollees' utilization was lower than what the organization estimated in calculating its proposed ACR or the organization was able to deliver services at a lower unit cost than it estimated.

Response: We will not attempt to recover the difference between a projected ACR and actual ACR due to improved efficiency or lower utilization because there is no statutory authority for us to do so. However, if this occurs, we will take appropriate action when we review the organization's proposed ACR for the next contract period.

3. *Direct Payment Option.*

Comment: One commenter favored expanding the direct payment option allowed for inpatient hospital services (§ 417.586) to include Medicare Part B services.

Response: The direct payment option for risk organizations is limited in the statute to hospitals and, since the enactment of section 2350(c) of Pub. L. 98-369 (the Deficit Reduction Act) on July 18, 1984, to skilled nursing facilities (SNFs.). (The SNF direct payment option is discussed in detail in section IV.C. of this preamble.) In addition, we believe that eligible organizations should be providing most ambulatory services directly. Not to do so implies that the organization merely arranges for services, which is inconsistent with the definition of a risk organization.

Comment: One commenter suggested that if it is administratively feasible, an organization should be allowed to elect the direct payment to hospital option at the midpoint of its contract period as well as at the beginning of the contract period.

Response: We believe that implementing this suggestion would not be administratively feasible because our system procedures are organized on a contract period basis.

Comment: Since section 1876(g)(4) of the Act states that electing direct payment to the hospital is solely at the option of the eligible organization, one commenter believes that HCFA has no authority to require that it must approve these organizations' request for the option. The commenter suggests that this should be merely a notice, rather than approval, requirement.

Response: We agree with this comment and are removing the approval requirement from the regulations (§ 417.586).

Comment: A commenter states that the NPRM is unclear as to how HCFA will estimate administrative costs applicable to paying hospital bills under the direct payment option.

Response: The initial withholding will be based on an estimate, which includes information furnished by the organization, of the organization's expected hospital utilization. This estimate will be adjusted based on the organization's actual experience.

Comment: A commenter suggested that if an organization elects to have HCFA pay the hospital directly, then HCFA and the organization, instead of only HCFA, should decide on the amount of the withholding HCFA makes from the capitation payment.

Response: Under section 1876(g)(4) of the Act, HCFA is required to decide how much to withhold from the organization's payment rate. However, HCFA would ordinarily use the organization's estimates when calculating the withholding.

Comment: A potential eligible organization believes that there should be a mechanism to protect the organization that elects the direct hospital payment option from an intermediary that makes payment for unauthorized services.

Response: We have had a service lock-in mechanism, such as the one described, in place and operating for almost 10 years. We believe that this procedure will protect the organization.

Comment: A commenter is concerned that if an organization elects to have HCFA make payment to hospitals for Part A services, then HCFA will make that payment under the prospective payment system. The commenter believes that there is no incentive for an organization to reduce length of stay for Medicare enrollees under the prospective payment system. The commenter suggests that HCFA allow other bases for payment if an organization is willing to negotiate a special rate with its affiliated institution. This would allow HCFA to realize savings from an organization's financial incentive strategies.

Response: An organization that does not elect the HCFA payment to hospital option may negotiate any payment method it wants with the hospitals it uses to furnish services to its Medicare enrollees. However, once an organization elects to have HCFA make these payments, then under section 1876(g)(4)(A) of the Act, the payment will be made in accordance with the usual Medicare payment rules (that is, prospective payment or, for hospitals excluded from that system, reasonable cost). Therefore, we have no option to negotiate special rates for HCFA to pay.

Comment: A commenter wanted to know if payment for hospital inpatient services furnished directly by a risk organization to its current nonrisk Medicare enrollees, for whom the organization receives payment on a reasonable cost basis, will be made under the prospective payment system.

Response: Payment for these enrollees will be made under the reasonable cost contract provisions, which include payment under the prospective payment system for hospital inpatient services.

Comment: One commenter suggested that risk organizations be allowed the option of either contracting directly with hospitals or allowing direct HCFA payment to the hospital.

Response: This option is available under § 417.586.

4. *Other Risk Reimbursement Comments.*

Comment: One organization recommended that the regulations should clearly state that an organization with a risk contract may continue to receive reimbursement for its nonrisk Medicare enrollees through health care prepayment plan (HCPP) contracts under section 1833(a)(1)(A) of the Act.

Response: Section 226(b) of Pub. L. 92-603 prohibits an organization that is receiving payment from Medicare for some enrollees under section 1876 of the Act from also receiving reimbursement for other enrollees under other sections of the Act. Therefore, normally, an organization that has a contract with us under section 1876 of the Act for some Medicare enrollees connot, at the same time, be receiving payment from us as an HCPP. However, sections 114(c)(1) and (c)(2) of Pub. L. 97-248 provide exceptions in the case of existing organizations being reimbursed by Medicare on a reasonable cost basis (that is, HCPPs and HMOs) for transition periods during which Medicare may make, under certain conditions, payments on both a reasonable cost and risk basis to the same organization during the time it converts to a risk contract.

Comment: Most of the potential eligible organizations that commented favor our permitting organizations to establish a benefit stabilization fund. This fund would be used by an eligible organization to stabilize both the premium and additional benefits furnished to Medicare enrollees from year to year.

Response: Section 2350(b) of Pub. L. 98-369 specifically permits us to implement such a provision. We are including this change in these final regulations and a detailed discussion of the revisions can be found in section IV.B. of this preamble.

Comment: Another organization expressed confusion about how it will receive payment for its current nonrisk enrollees after it elects a risk contract.

Response: An organization that contracts on a risk basis will continue to be paid on a reasonable cost basis for its current nonrisk Medicare enrollees.

Comment: A physician organization wanted to know how the hospital inpatient service prospective payment system will relate to eligible organization's payment for those services.

Response: If HCFA pays the hospital bills for the eligible organization's Medicare enrollees, the payment will be based on the principles set forth in Subpart D of 42 CFR Part 405, which include payment on a prospective payment basis to hospitals not excluded from that system. If the eligible organization pays the hospital for the services furnished to its Medicare enrollees, the payment method will be negotiated between the organization and the hospital, subject to applicable State law.

Comment: A potential eligible organization is concerned about the requirements related to charging Medicare Part B-only enrollees for Part A services furnished by the organization. Section 417.452(c)(3) states "The sum of the amounts an organization charges its Medicare enrollees for services that are not covered under Part A or Part B may not exceed the ACR for these services." If the provisions of this paragraph are applied to payment for Part A services for Medicare enrollees who are entitled to Medicare Part B only, the organization will be deprived of its full financial requirements for these members. This results from the fact that the AAPCC will usually be greater than an organization's ACR for Part A

services because an organization's major cost savings is in reduced hospitalization. The regulations should clearly address how the Part B-only Medicare enrollees pay for Part A services under a risk contract.

Response: Under the law (for example, section 1876(a) and (g) of the Act), Part B-only Medicare enrollees are entitled to a different set of benefits from those to which Part A and B enrollees are entitled. This includes both Medicare covered services and the additional benefits that a risk organization must provide its enrollees if the organization's ACR for Medicare covered services is less than Medicare's payment to the organization. This means, in the case of Part B-only enrollees, that Medicare's payment to the organization is only for Part B covered services and the organization is required to provide additional benefits without cost to the enrollee only if the organization's ACR applicable to Part B services is less than Medicare's payment (unless, of course, the organization accepts a reduced payment). These additional benefits may be different, therefore, from the additional benefits the same organization must provide its Medicare enrollees who are entitled to both part A and B services.

The policy set forth in § 417.452(c)(3) is mandated by section 1876(e)(2) of the Act and, therefore, can not be revised. If the organization furnishes services which, if the enrollee was entitled to part A services, would be covered under Part A, we do not have the authority to decide the method the organization uses to collect payment for these services. The organization may devise any method it desires so long as the amount does not exceed the ACR for the service. We have added language to § 417.452 that makes this clear.

However, in reviewing the subject comment, we believe that the regulations need to be clarified, not only with respect to Part A services furnished to a Part B-only Medicare enrollee, but also with regard to other noncovered services furnished to these enrollees if the organization wishes to standardized the benefit package of its Part B-only enrollee with that for its Parts A and B enrollees. Therefore, we have also added language to § 417.452 that provides that if Part B-only enrollees are furnished coverage for a benefits package that is identical to that furnished at no cost to Medicare enrollees who are entitled to both Parts A and B (that is, both Medicare covered services and the additional benefits), the premium (or other payment method) charged the Part B-only enrollees for those services may not exceed Medicare's payment to the organization for the enrollees entitled to both Parts A and B. (In the event that applicable deductible or coinsurance liabilities are not fully satisfied through this payment, or the Part B-only enrollees are furnished other supplementary benefits, the organization could make appropriate additional charges.)

Comment: An actuary objected to the requirement that risk organizations must either accept reduced payment for the difference between the AAPCC and the ACR or make up the difference in additional benefits. The commenter suggests instead that risk organizations should make up only a portion of the difference between the ACR and the AAPCC in additional benefits and accepting reduced payment from HCFA, thus saving HCFA money in all cases.

Response: Section 1876(g)(2) of the Act clearly gives a risk organization the right to elect between furnishing additional benefits or accepting reduced payment to reconcile the difference between its AAPCC and ACR. HCFA can share in the savings only when the organization elects to receive reduced payment in whole or in part.

I. Appeals

Comment: One commenter stated that the beneficiary appeals procedures outlined by these regulations (§§ 417.600–417.638) are too complicated for the elderly who have health problems to understand and that a central authority is necessary to coordinate the appeals process.

Response: We have attempted to construct a grievance and appeals process that affords fair treatment to beneficiaries. Enrollees may request assistance from the eligible organization in filing grievances and appeals under § 417.436. For reconsiderations, hearings, and appeals, enrollees may request assistance from any Social Security office.

Comment: One commenter asked that we verify that contract appeal procedures apply to CMPs as well as HMOs.

Response: Contract appeal procedures discussed in §§ 417.640 through 417.694 apply to all eligible organizations and those seeking to qualify as eligible organizations.

J. Other Comments

Comment: We received a number of comments regarding the procedures under which HCFA will convert current demonstrations projects to contracts under these regulations.

Response: Existing demonstration projects will be required to convert to contracts under these regulations at the earliest possible date. Each demonstration project will be contacted by HCFA's Office of Research and Demonstrations regarding the termination and transition of its project to program status.

Comment: One commenter stated that eligible organizations should be required to establish a Medicare Beneficiary Advisory Board.

Response: The statute contains no provision explicitly dealing with such boards. However, organizations qualifying as HMOs under title XIII of the PHS Act must have HMO members comprise at least one-third of its policy making body (see 42 CFR 110.108(f)). Medicare members could be part of this body.

Comment: One commenter stated that these regulations should be flexible to permit coordination with those governing the Federal employees health benefits plan (FEHBP) and certain other non-Federal programs.

Response: We have not discovered any conflict between Federal regulations governing the FEHBP and these regulations. Any organization that experiences difficulty with coordination of its Medicare contract with FEHBP or other plan contract should contact its servicing HCFA regional office for assistance.

Comment: One commenter requested that enrollment of Medicare beneficiaries in eligible organizations be coordinated with State Medicaid offices.

Response: We plan to keep State Medicaid offices informed of contracts and enrollment where beneficiaries are entitled both to Medicare and Medicaid. State Medicaid offices should contact their servicing HCFA regional office for further details.

Comment: One commenter stated that HCFA should study the differences in quality of services provided by for-profit and not-for-profit organizations.

Response: HCFA intends to monitor the quality of service provided by all organizations receiving contracts under these regulations.

IV. New Legislation

After the NPRM was published on May 25, 1984, Congress enacted, on July 18, 1984, Pub. L. 98–369 (Deficit Reduction Act of 1984). Sections 2322 and 2350 of Division B of that law further amended sections 1861 and 1876 of the Act to provide for the following:

- Organizations with risk contracts can permit the services of clinical psychologists (as defined by the

Secretary), and the services and supplies incident to their services, to be furnished without the direct personal supervision of a physician. (Section 1861(s)(2)(H)(ii) of the Act.)

• The Secretary is required to establish, for each geographic area served by more than one eligible organization, a single 30-day period each year during which all the organizations serving the area must provide for open enrollment. The Secretary must determine an organization's rate of payment in such a way that individuals who enroll during this coordinated open enrollment period will not have premium charges increased or any additional benefits decreased for 12 months after the individuals' effective dates of enrollment. (Section 1876(c)(3)(A)(ii) of the Act.)

• With the Secretary's approval and for a period of less than five years, an organization with a risk contract may have a part of the value of the additional benefits it is required to provide be withheld and reserved by the Secretary for subsequent annual contract periods. These funds would be used to stabilize and prevent undue fluctuation in the additional benefits offered in those subsequent periods. (Section 1876(g)(5) of the Act.)

• Organizations with risk contracts are permitted to elect direct reimbursement by HCFA to SNFs that furnish covered services to the organization's Medicare enrollees. (Section 1876(g)(4)(A) of the Act.)

As a part of this final rule, we are implementing all but the second provision mentioned above (that is, sections 2322 and 2350(b) and (c), respectively). We plan to implement section 2350(a) in a separate rulemaking document because of the complexity of the issues involved.

A. Services of Psychologists

As stated above, section 2322 of Pub. L. 98-369 amended section 1861(s)(2)(H) of the Act to allow the services of clinical psychologists, and the services and supplies incident to their services, to be furnished in organizations with risk contracts without the direct personal supervision of a physician. We have included this provision in § 417.416(d)(2). The statute also directs us to provide a definition of clinical psychologist. We have decided to include in these regulations a definition that is similar to the definition (contained in § 405.1038(e)(1)) of the psychologist who is the staff director of the psychology department or service in a psychiatric hospital, but that also contains language adopted from the original Senate amendment that added this provision to the law.

B. Benefit Stabilization Fund

Section 2350(b) of Pub. L. 98-369 amended section 1876(g)(2) of the Act and added section 1876(g)(5) to the Act to permit an organization with a risk contract to set aside in a benefit stabilization fund a part of the value of the additional benefits the organization must provide when its ACR is less than the average of the per capita rates of payment to be made to the organization. The establishment of such a fund must be approved by us and will not be available for use by the organization for more than four years. The fund is to be used by an organization during subsequent contract periods to the extent required to stabilize and prevent excessive fluctuation in the additional benefits offered during those subsequent periods.

The statute specifies that the monies withheld for the purpose of establishing a benefit stabilization fund are to be reserved in the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Trust Fund. Any amounts that remain in a stabilization fund after the four year period expires will revert to the Trust Funds.

In addition to these requirements, section 2350(b)(3) of Pub. L. 98-369 states that we may not approve the establishment of a benefit stabilization fund under section 1876(g)(5) of the Act for any contract period beginning after July 18, 1988. The provisions of section 2350(b) are implemented in §§ 417.596 and 417.597 of this final rule and are explained below.

1. *Limitations on amounts withheld.* Since a benefit stabilization fund is intended only to prevent excessive fluctuations in the provision of additional benefits to Medicare enrollees by risk organizations, we believe that it was the intent of Congress that a limitation should be placed on the amount an organization can request to be withheld. The Conference Committee Report accompanying Pub. L. 98-369 states that although it is the organization's option to request establishment of a fund, "... the amounts withheld would be approved and held by the Secretary. The Secretary would establish limits on the amounts withheld to assure that they do not exceed the minimum levels necessary for reasonable benefit stabilization, taking into account the requirements of individual plans." (H.R. Rep. No. 98-861, 98th Congress, 2d Session 1334 (1984).) A limit on the amounts to be set aside is necessary to protect beneficiaries in situations in which an organization might use a stabilization fund to reduce the value of the additional benefits it offers. The limit will also protect against the possibility that an organization could set aside excess amounts of money so that in a future contract period it could offer an additional benefit package of such high value that it would be unfair competition to other organizations in the area.

Accordingly, we have decided to limit the amount an organization may have withheld during any contract period to 15 percent of the difference between the ACR and the average of the per capita rates of payment made to the organization for that contract period. However, an organization will never be permitted to accumulate in its fund more than 25 percent of the difference between the ACR and the average of the per capita rates of payment for a given contract period. For example, if during an organization's first contract period, the difference between its ACR and the average of the per capita rates of payment is $100,000, then the organization may set aside $15,000. If during its second contract period, the difference is $110,000 and the organization does not withdraw any money from its fund, it will be permitted to add only another $12,500 to its fund, assuming that it has made no withdrawals, so that the total in the fund does not exceed $27,500 (25 percent of $110,000).

If an organization can demonstrate that the value of the additional benefits it provides to Medicare enrollees fluctuates substantially in excess of 15 percent demonstrates the need for an exception to the 15 percent limit for each contract period, we may grant such an exception.

2. *Use of the fund.* Since the purpose of a fund is only to stabilize additional benefits from one contract period to another, the statute does not allow an organization to use the amounts withheld in the fund to finance any losses the organization suffers in its regular business. Thus, the fund may not be used in the contract period in which the monies were withheld in order to cover reserve requirements of the organization or to prevent the organization from losing money. Similarly, an organization will not be permitted to withdraw monies from its fund to refinance prior contract period losses.

3. *Establishment of and withdrawal from the fund.* Section 417.596 specifies that the risk organization must notify us of its desire to establish a benefit stabilization fund or to add money to a

fund that was previously established at the same time it submits its ACR, that is, no later than 45 days before the beginning of the contract period. As mentioned above, the amount of the fund may not exceed 25 percent of the value of the additional benefits the organization must provide during the current contract period. We will review the organization's request and determine if it is appropriate.

The monies that are withheld for the purpose of a benefit stabilization fund will be reserved in the Medicare Trust Funds. Since the amounts withheld in the stabilization fund are reduced payments in the year in which they are withheld from the organization, recommitment of the funds to the organization in the subsequent years represents an additional amount to the payment that the organization would normally receive. Thus, during the period when the monies were held in the stabilization fund but not paid out, they are not to be treated as obligations by the Trust Funds. Therefore, no interest is earned on these monies by the organization during the period they are withheld in a benefit stabilization fund.

The organization's request for a withdrawal of monies from the stabilization fund for a subsequent contract period must be made at the same time as the organization's submittal of its ACR for that contract period. The organization must—

- Indicate how it intends to use the withdrawn amounts;
- Justify the need for the withdrawal in terms of stabilizing the additional benefits it provides to Medicare enrollees;
- Document the organization's experience in fluctuations of revenue requirements relative to the additional benefits provided to Medicare enrollees; and
- Document the organization's experience during its previous contract period to assure us that any losses suffered during that period are not being refinanced through the withdrawal from the stabilization fund.

We will approve an organization's request for a withdrawal of monies from its stabilization fund for an upcoming contract period only if one of the following circumstances occurs:

- The organization's average of its per capita rates of payment for that contract period is less than that of the prior contract period.
- The organization's ACR for that contract period is significantly higher than that of the prior contract period.
- The organization's revenue requirements in that contract period for providing the additional benefits it provided during the prior contract period is significantly higher than the requirements for that previous period and the ACR for the upcoming contract period results in an additional benefits package that is less in total value than that of the prior contract period.

Payment of monies withdrawn from a benefit stabilization fund will be made in equal monthly amounts throughout the contract period. These amounts will be added to the organization's monthly per capita payment.

As specified in section 1876(g)(5) of the Act, any amounts that remain in an organization's benefit stabilization fund after the fourth year after it was established will revert to the Medicare Trust Funds. Also, as noted above, we will not approve the establishment of a benefit stabilization fund for any contract period that begins after July 18, 1988.

C. Direct Payment to SNFs

Section 2350(c) of Pub. L. 98-369 amended section 1876(g)(4)(A) of the Act to permit organizations with risk contracts to elect direct reimbursement by HCFA to SNFs that furnish services to the organizations' Medicare enrollees. We plan to implement this provision in the same way we proposed to implement the direct HCFA payment to hospitals option in the NPRM (49 FR 22208 and § 417.586).

An organization that wishes to elect direct payment to SNFs will submit a written request to us before the organization's contract period begins. The election would be binding for the entire contract period. We will pay SNFs directly for the covered Medicare services furnished to the organization's Medicare enrollees. The payment made will be equal to the amount HCFA would pay the SNF for Medicare beneficiaries not enrolled in the organization.

Each month we will deduct from the organization's per capita payment an amount we estimate we will be paying to SNFs on behalf of the organization's Medicare enrollees and administrative costs we expect to incur in making these payments to SNFs. This amount will be adjusted as necessary to allow us to retain sufficient funds with which to pay the SNF bills.

If the contract between HCFA and the organization is not renewed or is terminated, we will retain the balance of the amounts withheld from the organization's payment for three years after the expiration of the contract.

The organization must agree to accept liability for and to provide to us the additional necessary funds if—

- During the contract period or the subsequent year, we do not have sufficient funds on hand from the withheld amounts to pay the SNF bills of the organization's Medicare enrollees; or
- After we return any balance of amounts withheld to the organization, we receive additional SNF bills that cover services furnished during the organization's contract period.

V. Effective Dates

As specified in section 114(c)(1) of Pub. L. 97-248, the provisions of amended section 1876 of the Act must apply with respect to services furnished on or after the initial effective date of the statute, except in certain circumstances as explained below. Section 114(c)(4) defines the initial effective date as the later of—

—October 1, 1983, or

—The first day of the month after the month in which the Secretary notifies Congress that the Secretary is reasonably certain that the methodology for determining the prospective rate based on 95 percent of the AAPCC is developed and can be implemented.

As we discussed above, the methodology is described in the addendum to this final rule. However, until the Secretary provides to Congress the required certification concerning the methodology, the initial effective date of the amended section 1876 of the Act remains undetermined. Therefore, although the regulations in the new 42 CFR Part 417, Subpart C are being issued as part of this final rule, we are unable to implement them until the first day of the first month after the month in which the certification process is complete. We note this fact in § 417.402 of the new regulations, and we plan to issue an amendment to that section in the **Federal Register** to enter a certain effective date as soon as that information is available to us.

In addition, however, we emphasize that the regulations we revised and transferred from 42 CFR Part 405, Subpart F (§ 405.692) and Subpart T (§§ 405.2093–405.2098) into the new 42 CFR Part 417, Subpart D are operative on the effective date of this final rule as indicated in the beginning of this preamble. Moreover, as explained below, special considerations apply to certain Medicare beneficiaries and organizations involved in changing circumstances because of the provisions in the amended section 1876 of the Act concerning risk contracts and existing demonstration projects.

If a beneficiary is enrolled in an eligible organization receiving reasonable cost reimbursement under either section 1876 of the Act as it existed prior to the enactment of Pub. L. 97-248 or section 1833(a)(1)(A) of the Act and that organization enters into a new risk contract, the services furnished to that beneficiary will not be subject to the amended section 1876 of the Act as implemented in these final regulations unless—

- The individual requests at any time that the amended provisions apply, or
- HCFA determines at any time that the amended section 1876 of the Act must apply to all Medicare enrollees of the organization because it is not cost effective or administrative by feasible not to include these enrollees under the new risk contract and HCFA informs, in advance, each effected member of the organization.

Also, unless the organization requests an earlier application, the amended section 1876 of the Act will not apply for five years after the initial effective date if the organization has an existing risk-basis contract under current 1876 of the Act on the initial effective date. This exception also applies to organizations that were furnishing services under a demonstration project under section 402 of the Social Security Amendments of 1967 (42 U.S.C. 1395b-1) or under section 222(a) of the Social Security Amendments of 1972 (42 U.S.C. 1395b-1 (note)) as of the date of enactment of Pub. L. 97-248 (September 3, 1982), if the project was concluded before the initial effective date and the organization entered into an existing risk-basis contract before the initial effective date.

The provisions of amended section 1876 of the Act would also not apply to services furnished by an organization during the period of an existing demonstration project if the organization was furnishing services under that project on the initial effective date and the project concludes after that date. However, we believe that once these regulations are operative, there will no longer be a need to conduct HMO risk demonstration projects operating under provisions similar to those of section 1876 of the Act as amended by section 114 of Pub. L. 97-248. HCFA conducted several demonstration projects that tested the HMO risk model before section 114 of Pub. L. 97-248 was enacted. Now that section 1876 of the Act has been amended to include some of these tested concepts, we no longer need to continue these types of demonstrations. Therefore, after the publication date of these final regulations, we do not plan to accept any new risk demonstration projects that would operate under provisions similar to those of section 1876 of the Act as amended by section 114 of Pub. L. 97-248, nor extend any of these projects that are currently in effect.

Finally, an eligible organization that is receiving reimbursement on a reasonable cost basis under current section 1876 of the Act or section 1833(a)(1)(A) of the Act on the initial effective date and then enters into a new risk contract may receive payment under that new contract for current, nonrisk Medicare enrollees only to the extent that the organization enrolls two new Medicare enrollees for each nonrisk enrollee.

VI. Summary of Changes

We are adopting the provisions set forth in the NPRM except for the following changes.

A. Changes Resulting From Public Comment

The following are the changes we are making to the proposed regulations based on public comment. These changes are discussed in detail in section III of the preamble.

1. In § 417.401, we revised the definition of urgently needed services to clarify that the need for these services must result from an unforeseen illness or injury.

2. We added a new paragraph (b) to § 417.406 to provide that the Assistant Secretary for Health has the responsibility for overseeing the continued compliance of eligible organizations.

3. We deleted § 417.410(f)(3), which permitted CMPs that offer less than all required services to become eligible organizations.

4. We revised § 417.413(c)(2) to allow an organization to contract with us on a reasonable cost basis even though it does not have at least 75 Medicare enrollees as long as it has a plan for reaching this enrollment level within two years.

5. In § 417.413, we revised paragraph (d)(3) to delete the 75 percent limitation and added a new paragraph (e) to allow current HCFA demonstration projects a special exception to the composition of enrollment standard. Former paragraph (e) was redesignated as paragraph (f).

6. To clarify our policy on coverage of hospice care for Medicare enrollees of eligible organizations, we revised §§417.414, 417.420, 417.422, and 417.440 and added §§ 417.531 and 417.585.

7. We revised § 417.414(c)(2) to clarify when organizations are financially responsible for services furnished by other sources to a Medicare enrollee.

8. We revised § 417.426(c) to allow organizations to set aside a reasonable number of vacancies for anticipated new members of an existing group contract, as well as for an anticipated new group contract.

9. We revised § 417.428 by deleting the preapproval requirement for marketing material (paragraph (a)(2)), removing the word "unethical" from the description of prohibited marketing practices (paragraph (b)(1)), and adding door-to-door solicitation as a prohibited marketing activity.

10. In § 417.432, we added new paragraphs (b), (c), and (d), redesignated proposed paragraphs (b) and (c) as (e) and (f), and revised redesignated (e)(1) to—

- Clarify the effective date of the conversion of enrollees of an organization who became entitled to Medicare;
- State that organizations may not disenroll these converted enrollees unless one of the disenrollment conditions specified in § 417.460 is met;
- Provide that converted enrollees must sign an application form as Medicare enrollees; and
- Revise the time frame within which organizations must inform us of the impending conversion of an enrollee.

11. We revised § 417.436 to provide that an organization must inform its Medicare enrolless of any changes in its membership rules 30 days prior to making the change and that the organization must maintain written rules on enrollee obligations regarding permanent moves by enrollees out of the organization's geographic area.

12. We revised § 417.440(b)(2) to prohibit all organizations from health screening Medicare enrollees for any service offered by the organization.

13. In § 417.442, we revised paragraph (b) to allow risk organizations whose AAPCC exceeds their ACR to elect to receive partially reduced payment and to furnish Medicare enrollees with additional benefits to make up the difference.

14. We revised § 417.448 to clarify the restriction on obtaining services outside the risk organization for Medicare enrollees who move out of the organization's geographic area.

15. We revised § 417.452 to clarify our policy regarding how much an organization may charge its Medicare Part B-only enrollees for services beyond those covered under Part B.

16. We revised the definition of "amounts incorrectly collected" set forth in § 417.456(a) to clarify that it includes amounts collected when the Medicare enrollee was believed not to be entitled

to Medicare benefits and is later determined to have been entitled and Medicare is liable for the payments.

17. In § 417.456, we also revised paragraphs (b), (c), (d), and (e) to clarify that the provisions of that section apply to both reasonable cost and risk organizations. The same revision was made to § 417.458(a).

18. In § 417.460, the following changes were made:

- We revised paragraph (a)(1)(iii) to clarify that both cost and risk organizations may not disenroll a Medicare enrollee for failure to pay a premium for optional supplemental benefits.
- We added a provision to paragraph (a)(2) to allow an organization to retain an enrollee as a member even if he or she plans to permanently move out of the area and to clarify that the lock-in restriction does not apply to those enrollees.
- We added a new paragraph (a)(6) and redesignated the proposed paragraph (a)(6) as paragraph (a)(7) to allow an organization to disenroll a Medicare enrollee for cause if the organization meets certain procedural requirements.
- We added a new paragraph (b)(4) to state that an organization that does not inform HCFA on a timely basis about the disenrollment of a Medicare enrollee must reimburse HCFA for any capitation payments received after the month in which payments would have ceased if the information had been provided timely.

19. We added a new § 417.481 to describe the types of records a risk organization must maintain.

20. A new paragraph (d) was added to § 417.482 to provide that an organization must agree to allow HCFA to evaluate, through inspection or other means, an organization's enrollment and disenrollment records.

21. In § 417.492(b)(4), we revised the language to clarify that, if HCFA decides not to renew an organization's contract, the organization may appeal the decision only if the decision was based on one of the reasons specified in § 417.640(c).

22. We added a new paragraph (c) to § 417.494 to permit an organization to terminate its contract with us if we fail to carry out the terms of the contract.

23. We revised § 417.532 to provide that the total amount payable to reasonable cost organizations will be limited by the organization's AAPCC. The effective date of this change is delayed until contract periods beginning on or after January 1, 1986, for existing cost organizations.

24. We revised § 417.546 to eliminate the application of the reasonable charge limitations set forth in Subpart E of 42 CFR Part 405 to physician compensation. The effective date of this change is delayed until contract periods beginning on or after January 1, 1984 for existing cost organizations.

25. We revised § 417.562 to eliminate the weighting factor used in determining the reasonable costs of Part B direct professional services for contract periods beginning on or after January 1, 1986.

26. We changed § 417.594(b)(3)(ix) to read "general and administrative" rather than "overhead" to be consistent with usual accounting principles.

27. We revised § 417.594 to clarify how a risk organization calculates its ACR.

B. Changes Resulting From Pub. L. 98–369

1. In § 417.416, we are revising paragraph (c) and adding a new paragraph (d) to allow clinical psychologists to furnish services in risk organizations without the direct personal supervision of a physician.

2. We revised § 417.586 to allow risk organizations to elect direct HCFA payment to SNFs as well as to hospitals.

3. We added new §§ 417.596 and 417.597, redesignated the proposed § 417.596 as § 417.598, and revised §§ 417.401, 417.442(b), 417.592(c), and 417.594(b) to permit a risk organization to have a part of the value of the additional benefits it is required to provide withheld and reserved in a benefit stabilization fund to be used in subsequent contract periods to stabilize and prevent undue fluctuation in those additional benefits.

C. Miscellaneous Changes to Part 417

1. We added a definition for adjusted community rate (ACR) to § 417.401. Also in that section, we corrected the definition of a reasonable cost reimbursement contract by deleting the incorrect reference to section 1833(a)(1)(A) of the Act.

2. As mentioned above in section V. of this preamble, we added a new § 417.402 to indicate that Subpart C of Part 417 is not effective until the first day of the first month after the month in which the Secretary certifies the AAPCC methodology.

3. In § 417.416, we revised paragraph (a) and added a new paragraph (e) to implement the provisions of section 1876(c)(4)(A) of the Act, which are concerned with accessibility, availability, and continuity of care furnished by organizations to their Medicare enrollees. We inadvertently omitted this qualifying standard from the conditions proposed in the NPRM.

4. We revised § 417.424(b) by changing the phrase "ten percentage points" to "ten percent" to make it consistent with § 417.413(f)(2).

5. We deleted § 417.444(a)(1)(iii), which stated that current nonrisk Medicare enrollees must be selected to convert to risk enrollees in an unbiased manner. This provision is unnecessary because paragraph (a)(1) deals with the one-time conversion of *all* current nonrisk Medicare enrollees; therefore, there is no need to select the enrollees on any basis.

6. We added a provision to § 417.460(a)(4) that requires an organization to report to the HHS Inspector General any disenrollment of a Medicare beneficiary for fraudulent practices.

7. We revised § 417.472 by adding a new paragraph (e) to ensure an organization's compliance with civil rights laws and by adding a new paragraph (f) to implement the provisions of section 1876(i)(5) of the Act. Section 1876(i)(5) of the Act authorizes the Secretary to administer contracts with eligible organizations without regard to other laws and regulations concerning contracts if any of these laws or regulations are inconsistent with the efficient and effective administration of the Medicare program.

8. We revised § 417.474(c) to specify that the initial term of a contract can be anywhere from 12 to 23 months, but any term subsequent to that must be 12 months. We made this change to clarify exactly what is meant by "a contract period."

9. In § 417.528, we revised paragraphs (a) and (c) and added a new paragraph (d) to specify more clearly the role eligible organizations must play in identifying and collecting payment from payors that are primary to Medicare. This section now specifies that organizations must identify the primary payors, the amounts payable by them, and determine the costs associated with services furnished to Medicare enrollees for whom the primary plan or insurer is liable. Organizations reimbursed on a reasonable cost basis must provide this information to ensure that Medicare reimbursement is not made for these costs. In the case of risk organizations, this information is necessary to ensure that the ACR reflects the organization's revenue requirements.

10. We revised § 417.564 to clarify how administrative and general costs are apportioned and allocated in reasonable cost organizations.

11. In § 417.586, we revised paragraph (d) to provide that we will retain the balance of withheld funds for direct payment to hospitals and SNFs for a period of three years. Although the NPRM (49 FR 22208) proposed that these funds would be retained for only one year, we did state that we were considering retaining them for the same period of time we allow Part A claims to be submitted. We received no comments on this issue, but we have decided to make the change.

12. We have revised § 417.594(e)(2) to specify a risk organization's appeal rights with respect to our determination that the ACR submitted by the organization is not acceptable. If, as a result of a hearing conducted under the provisions of this section, our determination is revised, we will make appropriate adjustments to the ACR and, if the revised ACR is less than the organization's average of its per capita payment rate, the organization will have a new opportunity to determine what additional benefits it wants to provide or whether it wants to accept a reduced payment from us.

13. We added a new paragraph (b) to § 417.606 to describe those actions that are not initial determinations. This section was inadvertently omitted from the NPRM.

D. Redesignations and Corrections

1. In the NPRM (49 FR 22199), we stated that we intended to move the current Part 405, Subpart T regulations (which deal with the requirements for HMOs set forth in section 1876 of the Act before it was amended by Pub. L. 97–248) to Subpart B of Part 417. As part of this final rule, we are redesignating §§ 405.2001 through 405.2092 of Subpart T as a new Subpart B of Part 417. We have also redesignated §§ 405.2093 through 405.2098, which deal with reimbursement for health care prepayment plans (HCPPs), as a new Subpart D in Part 417. In addition, we have redesignated § 405.692 as a new § 417.801. A redesignation table for Subpart T of Part 405 is located at the end of this preamble.

2. We are also correcting an error that was made in FR Doc. 82–35354 (the Health Care Prepayment Plans final rule published December 30, 1982). On page 58258 of that document, in the second column, under item 4.b., we inadvertently omitted paragraph (g)(3) from § 405.2042 (redesignated as § 417.242). We have added that paragraph back in as a part of this document. In addition, we are revising paragraphs (g)(1), (g)(2), and (h) of that section to change incorrect cross-references and to make other minor technical changes.

VII. Impact Analysis

A. Introduction

A preliminary analysis of the impact of these regulations was included in the proposed rule published May 25, 1984.

The purpose of that analysis was to fulfill, in combination with the preamble, the requirements of Executive Order 12291 and the Regulatory Flexibility Act of 1980 (5 U.S.C. Chapter 6).

Executive Order 12291 requires that, for any major rule, a regulatory impact analysis be performed and made available to the public. A "major rule" is defined as one that would:

- Result in an annual effect on the national economy of $100 million or more;
- Result in a major increase in costs or prices for consumers, any industries, any government agencies, or any geographic regions; or
- Have significant adverse effects on competition, employment, investment, productivity, innovation or on the ability of U.S.-based enterprises to compete with foreign-based enterprises in domestic or import markets.

The Regulatory Flexibility Act (RFA) requires us to prepare and publish a regulatory flexibility analysis for regulations for which a notice of proposed rulemaking is utilized unless the Secretary certifies that the regulations will not have a significant economic impact on a substantial number of small entities. For purposes of the Regulatory Flexibility Act, we treat all providers and suppliers participating in Medicare as small entities.

Under both the Executive Order and the Regulatory Flexibility Act, such analyses must, when prepared, examine regulatory alternatives that minimize unnecessary burden or otherwise assure that regulations are cost-effective.

In considering whether the proposed regulations required a regulatory impact analysis or regulatory flexibility analysis, we determined that they would not, in themselves, meet the criteria for a major rule under the Executive Order. However, we determined that the proposed rules would have a significant impact on a substantial number of HMOs, CMPs, and other suppliers of services. Therefore, although a regulatory impact analysis was not required, we did perform an initial regulatory flexibility analysis meeting the requirements of section 603 of the RFA.

Based on comments received on, and further study of, the proposed rules, and especially considering the recent rate of growth of prepaid plans and enrollment in those plans, we have carefully reconsidered these determinations. We believe that in combination with other developments and trends, these regulations may contribute to extensive changes in the health care marketplace that would significantly impact most providers and suppliers participating in the Medicare program. We recognize that it can be argued that the changed incentives of the system could result in economic consequences, particularly in view of economic effects beyond the immediate change in the level of program expenditures, exceeding $100 million annually in subsequent years, meeting the primary Executive Order definition of a "major rule".

For these reasons, we have chosen to prepare the analysis we would be required to prepare if these final regulations were a major rule under Executive Order 12291. In the discussion below, we discuss the expected impacts of these regulations and summarize our expectations of their net effect. This discussion, combined with the rest of this preamble, constitutes a voluntary final regulatory impact analysis and a final regulatory flexibility analysis meeting the requirements of Executive Order 12291 and the RFA.

B. Objectives of These Regulations

The purpose of these regulations is to implement section 114 of Pub. L. 97–248. We expect this to encourage the growth, participation in Medicare, and increased prepaid Medicare beneficiary enrollment of HMOs and CMPs, and believe economies and efficiencies in the delivery of health care services will result. HMOs have shown that they can reduce hospitalization and utilization of high cost medical services will result. Successful competition of HMOs and CMPs with providers and suppliers of services in the fee-for-service sector should produce changes in that sector also. Since prepayment plans have stronger incentives to control costs than the fee-for-service sector, their success and example are expected to restrain the rate of growth of health care costs generally. Our intention is to restrain health costs while continuing to maintain quality of care throughout the health care system.

Medicare has been supporting demonstrations of prepaid HMO plans throughout the country since 1978. Thousands of elderly or disabled beneficiaries have enrolled in these demonstrations. These projects have shown that prepayment plans can work for Medicare and that Medicare beneficiaries will opt for HMO-type

coverage when they understand the advantages for them. Therefore, we expect these regulations to result in a substantial increase in prepaid enrollment for Medicare beneficiaries—perhaps to as many as 800,000 beneficiaries in the next three to four years, and possibly as much as a 50 to 100 percent increase in the number of contracts between prepayment plans and Medicare.

Under these regulations, beneficiaries will be enabled to enroll in an HMO or CMP to participate in plans based on preset rates paid in advance, thus obtaining full coverage at a fixed price. Participating risk-based plans would provide coverage of all Medicare covered services for a preset amount. That means they have the incentive to deliver quality care—including preventive care—at the lowest possible cost. In the past, Medicare has not taken full advantage of those incentives. Instead, through reimbursement of the "reasonable costs" of most participating HMOs, Medicare simply paid more when needed care cost more.

Despite an expected initial increase in Medicare program costs, as discussed below, we believe it is important to implement this new program. There are several reasons. First, Congress intended that Medicare beneficiaries should be afforded a choice of alternative health plans. Section 114 of Pub. L. 97-248 and these regulations are designed to afford this choice to a larger number of beneficiaries than previous law and regulations allowed. Second, we believe that prepayment plans are more efficient than more traditional forms of health care delivery. Finally, the opportunity for a beneficiary to receive enhanced benefits if the HMO in which he or she is enrolled can operate below 95 percent of AAPCC represents a significant benefit.

We also believe that these rules will to some extent, correct perverse incentives currently affecting competition and productivity in the health care sector of the economy. In our view, the anticipated effects of these regulations will have a beneficial impact on competition and productivity by increasing both, and will also have a beneficial effect by encouraging innovative means of delivering health care services.

C. Problems of Quantifying the Impacts

We expect these rules to result in net costs to the Medicare program in the first years of their implementation. We are currently paying, and presumably would continue paying if these regulations were not implemented, significantly less than 95 percent of AAPCC for many enrollees under cost contracts, and will pay more for each of these enrollees converted to a risk basis. We believe that, in the absence of these regulations, the Medicare program initially would have saved more from beneficiaries' enrollment in HMOs under cost contracts. However, for the reasons discussed below, we have determined that quantitative estimates of costs and savings would be arguable and that a general discussion of the various changes in incentives and types of expected impacts from these rules would be more useful.

As described in the NPRM, we estimated, using United States Per Capita Cost (USPCC) figures taken from the 1983 Reports of the Trustees of the Medicare Trust Funds, that net Medicare program costs would increase by $30 million in FY 1985 and $65 million in FY 1986 as a result of the NPRM. We made certain key assumptions, concerning the number of HMOs and CMPs expected to participate, and the rate of growth in the number of Medicare enrollees. We assumed that—

- Under existing contract provisions, Medicare HMO enrollees would increase at a rate of 10 percent annually, half of which would be due to age-ins (that is, due to persons already enrolled in HMOs and CMPs becoming eligible for Medicare).
- Under the NPRM, Medicare HMO enrollees would increase at a rate of 15 percent annually; that is, five percent more per year than under existing contracts.
- HMOs and HCPPs representing half of the present Medicare HMO enrollees would elect risk contracts.
- On the basis of covered services only, risk-basis HMOs and CMPs would operate, on the average, at 80 percent of what Medicare would pay on the basis of reasonable costs and charges for those services if they were furnished to a given individual by providers and suppliers in the fee-for-service sector.
- HMOs and CMPs would enroll, age-in, and convert relatively young people who are seldom institutionalized or on welfare, compared to the total Medicare beneficiary population.
- Selective enrollment, discriminating against higher-risk, higher-cost beneficiaries, would be largely avoided through administrative protections.
- HMOs and CMPs would concentrate in urban areas with costs 15 percent above USPCC for Part A and 30 percent above USPCC for Part B.

We pointed out that we believed the cost estimates could be somewhat lower if HMOs and CMPs were assumed on the average to be operating at 85 percent rather than 80 percent of the AAPCC, if there were antiselection, and if the HMO and CMP population growth rate resulting from these regulations were 20 percent rather than 15 percent, and if half of the new growth were to occur in new HMOs and CMPs and other than existing plans where the conversion option can be exercised. We also explained that actual resulting net Medicare program expenditures could be higher than the estimates if persistent biased selection were to occur.

As is clear from the above, we were careful in the proposed rule to qualify our assumptions and estimates, and to explain that different assumptions would yield different estimates. Since then, developments have shown the vulnerability of any set of assumptions that might be chosen for purposes of making such estimates. For example, recent reports show that during 1983 the rate of growth of prepayment plans and their enrollment, including Medicare enrollment, far exceeded what we had anticipated. The market for HMO and CMP services may be much more volatile, and hence unpredictable, than it has been heretofore. Various publications have also continued the debate about the relative impact of adverse (or favorable) selection on the costs and savings experienced by prepaid plans. For example, a recent RAND Corporation report* gives support to the HMO proponents who argue that efficient HMOs achieve savings as a result of reduced hospital utilization, preventive care, and the cost-neutral and volume-neutral financial incentives for physicians in a prepaid group practice setting. However, it is not at all clear that the study results could be generalized to a growing population of Medicare enrollees, or to all types of prepaid plans.

We are also making changes from the NPRM in these final regulations that could affect the behavior of HMOs in ways not easily taken into account in the estimating process. For example, by revising the rules applicable to cost contracts, we will probably affect how strongly HMOs converting from cost to risk contracts would encourage cost enrollees to convert to a risk basis. Due to the two-for-one rule, this will also affect their marketing targets for new enrollees. For many of the provisions of these regulations, even though the direction of incentives may be known, the real degree of resulting behavior

*Manning, William G., and others, "A Controlled Trial of the Effect of a Prepaid Group Practice on Use of Services." *New England Journal of Medicine*, Vol. 310, No. 23: June 7, 1984: pages 1505 to 1510.

change is not predictable. Finally, the recent enactment of Pub. L. 98-369 has resulted in changes to the Medicare statute that will affect HMO behavior, including the provisions concerning benefit stabilization and coordinated open enrollment, the latter of which will be implemented later.

Since it is not possible to develop a reliable quantitative analysis and comparison of the costs and benefits to all the various affected parties, we have instead made an effort to explain the kinds of interactions, and the decisions that those parties will have to consider. Therefore, we believe that the approach we have taken in the specific impact discussions below is the best feasible.

D. Numbers and Types of Prepaid Plans Participating in Medicare

Many potentially eligible HMOs and CMPs have indicated their interest in participating under the amended section 1876 of the Act and these regulations. The attraction of a prospective rate, an opportunity to share risk, and significantly fewer paperwork requirements are the stated reasons for such interest. Generally increased participation of HMOs and CMPs, and increased Medicare enrollment in participating organizations can be viewed as benefiting both those organizations and the beneficiaries.

There are a number of different ways that prepaid medical services may be organized. The necessary common elements are that the organization act both as insuror and as a health care delivery system. The organization may furnish services directly, arrange to have them furnished, or both. Some eligible organizations own their own facilities, including hospitals. Others provide services primarily through the offices of physicians who may also have a fee-for-service practice. Generally, HMOs and CMPs can be classified in terms of the relationship of the organization to their physicians, as follows:

- *A staff HMO or CMP* delivers services at one or more central locations through its own physicians who are employees of the plan;
- *A group practice HMO or CMP* contracts with a group of physicians to provide care at one or more sites;
- *An individual practice association (IPA)* contracts with doctors in the community, who practice out of their own offices and see HMO or CMP members there; and
- *A network HMO or CMP* contracts with more than one medical group or IPA organization to deliver care to plan members in different geographic locations. Each medical group or IPA provides a full range of comprehensive benefits and is contractually linked to a central point of accountability. Sometimes network plans are classified among IPAs.

Currently, there are about 335 prepayment plans operating in the country, of which around 210 are Federally-qualified HMOs. Most of these prepayment plans do not currently have Medicare HMO (or HCPP) contracts. They receive Medicare payments on the same basis as physicians and other suppliers in the community.

Under existing regulations, a prepayment plan may participate in Medicare as an HMO in three ways. A Federally-qualified HMO may enter into a cost contract; a risk-sharing contract; or a risk-basis demonstration project. In each of these cases, the plan would furnish all services covered under Part A and Part B. In addition, whether or not it is a Federally-qualified HMO, a prepayment plan may participate in Medicare as an HCPP under section 1833(a)(1)(A) of the Act, furnishing Part B services only, and reimbursed on a reasonable cost basis.

As of June 1, 1984, 133 prepayment plans were participating in Medicare, with numbers and enrollment as follows:

Type of contract	Number*	Estimated number of Medicare enrollees (thousands)
Cost contract	62	100
Risk-sharing contract	1	30
Risk demonstration	26	170
HCPP	44	575
Total	133	875

*These numbers exclude four contracts not actively operating.

The risk-basis demonstration HMOs are currently paid at 95 percent of AAPCC. When these regulations are implemented, those demonstrations that operate similarly to what the provisions of section 114 of Pub. L. 97-248 provide for will convert to new risk contracts. We also expect a number of HMOs currently participating under cost contracts and as HCPPs to choose to convert to risk contracts. The one plan currently participating under a risk-sharing contract may continue for up to five years, or the organization may elect either a risk or a cost contract under these regulations.

We estimate that in the next few years, at least half and perhaps as many as two-thirds (150 to 200) of the existing potential eligible organizations will choose to participate in this program under risk contracts subject to these regulations. As a result, we expect the numbers of HMO cost contracts and cost-reimbursed HCPPs may decline. In addition, new potential eligible organizations may be formed. However, we have no basis on which to estimate how many of these there may be.

E. Enrollment

As of June 1984, there were more than 14 million people enrolled in HMOs in this country. This is roughly six percent of the population. It is unlikely that in the short run this proportion of the Medicare population will enroll. There are currently about 30 million Medicare beneficiaries, of which about 1.8 million would have to be enrolled in HMOs or CMPs to achieve a comparable percentage. Nonetheless, we do expect these rules to result in increased Medicare enrollment in HMOs.

As of June 1984, there were about 875,000 Medicare beneficiaries enrolled in HMOs and HCPPs. (Of these, about 200,000 are already paid for on a risk basis under either an existing risk-sharing contract or demonstrations.) This represents an increase of about 145,000 just in the last year. Risk demonstration HMO enrollment alone increased by more than 100,000 in the year from June 1983 to June 1984. We believe this demonstrates an increase in both marketing to the Medicare population and an increased willingness of the elderly to enroll in prepayment plans.

In the proposed rule, we projected that in the next three to four years (the time we expect it to take for this new program to become fully implemented) about 250,000 to 600,000 additional Medicare beneficiaries would enroll in HMOs and CMPs. This was not an actuarial estimate. Estimation of the total rate of growth under both risk and cost contracts is technically difficult, because we were uncertain as to the extent to which the rate of growth of risk enrollees would be at the expense of the growth of cost enrollees. Therefore, we made a projection stated in terms of a wide range.

The recent increase in the rate of growth of HMO enrollment suggests that the NPRM estimate may have been understated. Total national enrollment in HMOs increased by 9.5 percent just in the last 6 months of 1983, and Medicare enrollment in prepayment plans increased by nearly 20 percent in the year ending in June 1984. Just continuing these trends will result in an increase of over 600,000 in the next three years, equaling the upper limit of the range of the previous estimate. As a result, we now believe it is more realistic to expect Medicare enrollment in these plans to

increase by 400,000 to 800,000 over the next three to four years.

Given these estimates, a series of additional calculations can be made. Specifically, 400,000 to 800,000 new enrollees spread throughout 150 participating HMOs means each HMO would attract, on the average, 2,700 to 5,300 new Medicare enrollees. Since average HMO enrollment is approximately 47,000, this would represent roughly a 5 to 10 percent increase in enrollment for the average HMO.

We believe that an HMO's ability to attract new enrollees is dependent to some extent on the stage of development of the HMO, since size and maturity appear strongly correlated to recruitment capabilities. However, many other factors are also important. For example, size may work against an HMO that has achieved great market penetration in a locality, since a high proportion of the potential enrollees would already have been recruited. Another important factor is the marketing behavior of HMOs and CMPs. A plan that views the level of Medicare payment available as highly attractive, and that has an energetic marketing program, will probably be able to achieve significant enrollment increases. New IPA-type HMOs may be able to attract "new" enrollees by recruiting physicians who in turn enroll beneficiaries who had been their regular patients on a fee-for-service basis.

F. Effect on Other Providers and Suppliers

Since participating HMOs and CMPs must furnish or arrange for at least all Part A and Part B covered services for Medicare enrollees otherwise available in the geographic area, their expansion in any particular locality has effects on the physicians, hospitals, home health agencies, and other providers and suppliers of health care services in the area. The nature and extent of these effects are dependent on many factors that will vary from organization to organization and from area to area. Some of these factors are:

- The organizational type of the HMO or CMP;
- The relationship of the HMO or CMP to local hospitals and other providers and suppliers;
- The local market penetration of prepaid organizations, both for the general populace and the Medicare population;
- The existence or absence of competing prepayment plans;
- The marketing strategies adopted by HMOs or CMPs; and
- The type and range of supplemental benfits offered by an HMO or CMP.

Some fee-for-service physicians may lose patients to eligible HMOs. As shown above, we project they will lose, in the aggregate, about 400,000 to 800,000 Medicare patients over the first three to four years. This would represent less than three precent of total Medicare patients, and a much smaller fraction of total patients. Nonetheless, in some localities, the shift from fee-for-service to prepaid plans could be substantial.

Although the impact on affected physicians will be a fractional decrease in caseload, we expect marketplace adjustments to restrain the adverse effects of such decreases in most cases. For example, some physicians or practices will be newly hired by or make arrangements with HMOs or CMPs, and most physicians losing patients will be able to replace these patients with others. Also, these regulations permit reasonable cost contracts that might prove attractive not only to HMOs but also to fee-for-service physician groups organized as IPA-type CMPs. In response to our NPRM discussion of the potential loss of patients by physicians, one commenter pointed out that, due to the growth of such organizations, in many cases a Medicare enrollee may merely continue to see his or her previous primary and referral physician, but as a Medicare HMO or CMP enrollee rather than as a fee-for-service patient. In fact, this is common in the individual practice association-type organization, especially those located in smaller communities and rural areas where there is a limited supply of physicians.

However, we expect that the primary impact that these regulations will have on the fee-for-service sector will be more indirect. Economic behavior is the result of the expectations of the parties making individual choices. Thus, when a prepayment plan begins or expands operation, the behavior of other providers and suppliers in that area is governed initially by the effects they expect could happen, as well as by actual shifts in patients' choice of sources of services. As a result, some of the effects of these rules will include many decisions by physicians and others concerning fee levels, services offered, and so forth. For example, we expect that the number of physicians accepting assignment of their patients' Medicare claims may increase in some localities, irrespective of the incentive for assignment provided by section 2306 of Pub. L. 98–369, discussed above.

HMO and CMP growth in an area will affect the local hospitals in various ways. Those hospitals that have arrangements with the plans may be able to ensure a certain level of occupancy. A plan with high Medicare enrollment could affect the Medicare utilization of the hospitals with which it deals. Of course, there are also secondary effects on the hospitals that do not have arrangements with the HMOs or CMPs, such as reduction of Medicare utilization. In addition, if enrollee selection favored the prepayment plan in an area, then less healthy and more costly beneficiaries would be receiving proportionally more of their services from the fee-for-service sector.

Non-hospital providers and suppliers of Medicare covered services would be affected similarly to hospitals. Those having arrangements with HMOs and CMPs could experience significant benefits. Those without such arrangements may experience some reduction of Medicare utilization, if a significant number of beneficiaries choose to enroll. This possibility was clearly illustrated by the comments we received from chiropractors, psychologists, and others. The supplemental benefits offered by HMOs and CMPs could extend these effects to services not covered by Medicare, such as optical and dental practitioners. This could also affect the demand for Medigap insurance (which covers costs of medical care not paid for by Medicare, such as deductible and coinsurance amounts) in areas in which an eligible plan offered competitive benefits.

G. Impact on Beneficiaries

Participation in a prepaid plan is voluntary on the part of beneficiaries. The incentive to join will come only if the HMO or other plan can offer beneficiaries more coverage, lower personal costs, or both. The regulations do not dictate any one kind of health care for the elderly and the disabled. On the contrary, these regulations are opening a whole new range of options for their benefit and at their choice.

The elderly and the disabled, for the most part, have had long-established physician relationships, and have been less likely to change the ways in which they secure medical treatment than are younger people. Historically, prepayment plans have demonstrated limited ability to enroll Medicare beneficiaries. However, as noted above, Medicare demonstrations have been very successful in recent years in enrolling Medicare beneficiaries. IPA-type plans in particular are often able to offer a beneficiary the benefits of prepaid enrollment while continuing his

or her relationship with a particular physician.

We expect that the primary effects on beneficiaries will be beneficial. In particular, we expect that beneficiaries will, on the average, have reduced out-of-pocket expenses. Some plans may offer financial advantages as part of their supplemental benefits and marketing strategies. Many plans will offer coverage of services not covered by Medicare Part A or Part B, such as physical examinations, prescription drugs, and eyeglasses.

Of course, not all beneficiaries who choose to enroll in an HMO or CMP will be satisfied. Similarly, some beneficiaries who enroll in risk plans will seek services out of plan, and will become liable for the payment for those services. However, we believe that the opportunity for self-disenrollement will afford these beneficiaries the freedom they need to protect themselves.

H. Conclusion

In summary, we expect the following types of changes to result from these regulations in the short-term:

- Some HMOs currently participating on a cost basis will convert to a risk basis.
- Some HCPPs currently participating only for provision of Part B services will convert to HMO or CMP status.
- Some potential eligible organizations will newly enter the program as HMOs or CMPs.
- The rate of HMO enrollment increase will accelerate.
- Increased Medicare enrollment in HMOs and CMPs will result in a decline in HCPP enrollment.
- Risk-basis organizations will significantly increase their Medicare enrollment.
- Some cost-basis organizations subject to the "two-for-one" rule may limit their marketing efforts to Medicare beneficiaries while they assess their potential conversion to risk basis reimbursement.
- Many, but not all, current nonrisk enrolleers will choose to convert to risk basis, as a result of the opportunity for increased benefits.

Over the longer term, perhaps in five to ten years, we expect a number of additional consequences:

- Inpatient hospital utilization for Medicare enrollees will be significantly lower than for beneficiaries receiving services solely from the fee-for-service sector.
- To the extent that selection favorable to the prepayment plans is avoided, the total cost of care for Medicare enrollees will be lower than it would have been had we paid for all services on the basis of fee-for-service costs and charges.
- In the long run, if selection favorable to prepayment plans does not prevent it, the incentives for HMOs and CMPs to furnish care economically could result in program savings.
- The competition of prepayment plans will significantly affect the fee-for-service sector, which will:

—Attempt to demonstrate that it too can be economical and efficient; and
—Restrain its increases of costs and charges;

- Many HMOs and CMPs will develop supplemental benefit packages that will afford improved benefits to Medicare enrollees.
- The availability of Federal risk-based payments will increase the rate of growth of prepayment plans, making their services and benefits increasingly accessible to both the Medicare and non-Medicare population.

Some of these changes will result in costs, others in savings. For example, as discussed above, conversion of enrollees from cost to risk contracts will result in initial increases in program expenditures. In addition, savings will result from new enrollees only to the extent that they represent enrollment that would not have occurred in the absence of these regulations, and they are representative of the fee-for-service beneficiaries in the geographic area served. Ultimately, the increase of prepaid enrollment due to the advantages of risk-based contracts, changes in the fee-for-service sector, and effective avoidance of biased selection should result in progressive savings sufficient to offset the potential costs. Although the magnitude of these effects is inestimable, and we cannot confidently quantify either the costs or benefits expected to result from these regulations, we are confident that the benefits will substantially outweigh the costs. Thus, we believe that this document meets the objectives of Executive Order 12291 and the Regulatory Flexibility Act.

VIII. Other Required Information

A. Waiver of Proposed Rulemaking for Certain Sections

In section IV. of this preamble, we noted that sections 2322 and 2350 of Pub. L. 98-369 made four amendments to sections 1861 and 1876 of the Act. Three of the four amendments, that is, those dealing with services by clinical psychologists in risk organizations, with direct payments to SNFs, and with the establishment of benefit stabilization funds, are being implemented in this final rule in § 417.416, § 417.588, and §§ 417.401, 417.442, 417.592, and 417.594–417.597 respectively.

Generally, we issue a notice of proposed rulemaking and provide a period for public comment before implementing amendments to the law through regulations. However, we may waive this procedure if it would be impractical, unnecessary, or contrary to the public interest.

In § 417.416, we provide that clinical psychologists will be permitted to furnish services in risk organizations without the direct personal supervision of a physician. This establishes an option for risk organizations that did not exist prior to enactment of Pub. L. 98-369. In § 417.586, we specify that risk organizations may elect to have HCFA pay SNFs directly for services provided to Medicare enrollees, under the auspices of the organization, in the same manner that we directly pay hospitals for inpatient services provided to Medicare enrollees. Both of these provisions constitute beneficial options to risk organizations in terms of reduced paperwork and management practices. In view of the fact that Pub. L. 98-369 was enacted on July 18, 1984, we believe it would be advantageous to risk organizations to have regulations in place so that these provisions can be implemented as soon as the regulations in Subpart C of 42 CFR Part 417 are effective.

The remaining revisions made to these regulations concern the provisions of section 2350(b) of Pub. L. 98-369. This amendment authorizes us to allow a risk organization to have placed in a benefit stabilization fund a part of the value of the additional benefits it is required to provide to its Medicare enrollees. This fund would be used to stabilize and prevent undue fluctuation in the additional benefits afforded in subsequent contract periods. We may not approve the establishment of a benefit stabilization fund for any contract period beginning later than July 18, 1988.

This provision constitutes a beneficial option to risk organizations and their Medicare enrollees in terms of protection against having to decrease the additional benefits the organizations provide to those enrolless or increase premium changes from one contract period to the next, if the organization's original estimate of its ACR or enrollment figures for its contract period is incorrect. In addition, a benefit stabilization fund is of most use to an organization during its first contract periods, before it has gained experience in the program. Therefore, for these organizations, it would be beneficial to

have this provision included in this final rule so that the stabilization fund option is available as they begin their first contract period with us under the provisions of these new regulations.

Finally, since no stabilization fund may be established for any contract period beginning later than July 18, 1988, the earliest possible implementation of this provision will allow the longest period of time risk organizations have to take advantage of its benefits. We would also like to note that several of the potential eligible organizations that commented on the NPRM are in favor of including this provision in the final regulations. Therefore, for the above reasons, we conclude that it would be contrary to the public interest to delay implementation of these several provisions until a rulemaking proceeding is completed. However, we are providing a 30-day comment period so that interested parties may comment on the regulations issued under sections 2322 and 2350 (b) and (c) of Pub. L. 98–369.

B. Waiver of 30-Day Delay of Effective Date

As discussed previously, section 114(c) of Pub. L. 97–248 states that the provisions of section 1876 of the Act must apply with respect to services furnished on or after the first day of the month after the month in which the Secretary notifies Congress that she is reasonably certain that the methodology for determining the prospective rate based on 95 percent of the AAPCC is developed and can be implemented. Since the Secretary provided Congress with this certification during the month of January 1985, the statutory effective date of these provisions is February 1, 1985. As a practical matter, we would be unable to implement this final rule by February 1, 1985 if we were to provide the customary 30-day delay in the effective date. Therefore, we find good cause to waive the delay in the effective date.

C. Public Comments

As discussed above, we are inviting comments on certain regulations in this final rule that implement Pub. L. 98–369 and that were not proposed in the NPRM published on May 25, 1984. Because of the large number of comments we receive, we cannot acknowledge or respond to them individually. However, we will consider all comments on §§ 417.401, "Benefit stabilization fund"; 417.416(d)(2); 417.442(b)(2); 417.586; 417.592(c)(2); 417.594(b)(5); 417.596; and 417.597 that are received by the date specified in the "Dates" section of this preamble. If, as a result of these public comments, we conclude that changes in these final regulations are needed, we will respond to the comments and include the changes in a future **Federal Register** publication.

All other provisions included in these final regulations were proposed in the NPRM, and we are responding in this document to comments received on these provisions. Therefore, if another **Federal Register** publication is necessary, we expect to address only comments about the regulations that implement sections 2322 and 2350 (b) and (c) of Pub. L. 98–369, as listed above.

D. Paperwork Burden

The following sections of this rule contain information collection requirements:

417.412(b)
417.413(a)
417.414(b)(3)
417.418(c)(4)
417.424(b)
417.426
417.428(a)
417.430(b)
417.432(e)
417.436
417.444(a)(1)(iii)
417.446 (b) and (c)
417.454(b)
417.460(a)(1)–(a)(4)
417.460(a)(6)(iv)
417.460 (b) and (c)
417.474
417.476
417.480
417.481
417.486(a)
417.488
417.492 (a) and (b)
417.494 (a)(2) and (a)(3)
417.494(c)
417.520 (b)(2) and (b)(3)
417.522 (a) and (b)(4)
417.532 (d) and (e)(3)
417.546
417.548(a)
417.566(b)
417.568 (a), (b), (d), and (e)
417.570 (b) and (c)
417.572 (a) and (c)
417.576(b)
417.586(a)(2)
417.592(d)
417.594
417.596
417.604 (c)
417.608 (a) and (b)
417.610 (a), (b), (c), and (e)
417.620
417.624
417.650
417.662 (a) and (b)
417.801(e)
417.808 (b) and (c)
417.810(b)

We have submitted an information collection request to the Executive Office of Management and Budget for approval of these requirements under section 3507 of the Paperwork Reduction Act of 1980 (44 U.S.C. 3507). A notice will be published in the **Federal Register** when approval is obtained.

List of Subjects

42 CFR Part 405

Administrative practice and procedure, Certification of compliance, Clinics, Contracts (Agreements), End-Stage Renal Disease (ESRD), Health care, Health facilities, Health maintenance organizations (HMO), Health professions, Health suppliers, Home health agencies, Hospitals, Inpatients, Kidney diseases, Laboratories, Medicare, Nursing homes, Onsite surveys, Outpatient providers, Reporting requirements, Rural areas, X-rays.

42 CFR Part 417

Appeals, Competitive medical plan (CMP), Contracts, Eligible organization, Health care prepayment plan (HCPP), Health maintenance organization (HMO), Medicare.

42 CFR Chapter IV, Subchapter B is amended as set forth below:

I. The table of contents for Chapter IV is amended by adding a new Part 417 to Subchapter B to read as follows:

CHAPTER IV—HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

* * * * *

SUBCHAPTER B—MEDICARE PROGRAMS

* * * * *

Part
417 Health Maintenance Organizations, Competitive Medical Plans, and Health Care Prepayment Plans

* * * * *

II. Part 405 is amended as follows:

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

A. The table of contents of Part 405, Subpart F is amended by removing § 405.692.

B. The table of contents of Part 405, Subpart T is redesignated as the tables of contents of the new Subparts B and D in the new Part 417.

C. Part 405, Subpart B is amended as follows:

Subpart B—Supplementary Medical Insurance Benefits; Enrollment, Coverage, Exclusions, and Payment

1. The authority citation for Subpart B is revised to read as follows:

Authority: Secs. 1102, 1831–1843, 1861, 1862, 1866, 1871, 1877, and 1881 of the Social Security Act (42 U.S.C. 1302, 1395j–1395v, 1395x, 1395y, 1395cc, 1395hh, 1395nn, and 1395rr).

2. Section 405.241 is revised to read as follows:

§ 405.241 Payment of supplementary medical insurance benefits to prepayment organizations.

A prepayment organization that has not qualified as a health care prepayment plan (HCPP), health maintenance organization (HMO), or competitive medical plan (CMP) will be paid through its Medicare carrier, for Part B services furnished to its Medicare enrollees, on the basis of reasonable charges in accordance with § 405.240 and § 405.251. These organizations will be paid 80 percent of reasonable charges after subtracting their enrollees' deductible amounts and taking the other limitations under Part B into consideration. (See 42 CFR Part 417 of this chapter for applicable definitions and regulations governing reimbursement of HCPPs, HMOs, and CMPs.)

D. Part 405, Subpart F is amended as follows:

Subpart F—Notice, Election and Agreements

1. The authority citation for Subpart F is revised to read as follows:

Authority: Secs. 1102, 1816, 1842, 1861(u), 1964, 1866, 1871, and 1881 of the Social Security Act (42 U.S.C. 1302, 1395h, 1395u, 1395x(u), 1395aa, 1395cc, 1395hh, and 1395rr), unless otherwise noted.

2. Section 405.692 is revised and redesignated as new § 417.801, as set forth below in the new Part 417, Subpart D.

E. Part 405, Subpart T is amended as follows:

Subpart T—Health Maintenance Organizations

1. The authority citation for Subpart T reads as follows:

Authority: Sec. 1102, 1833(a)(1)(A), 1871, 1874, and 1876 (42 U.S.C. 1302, 13951(a)(1)(A), 1395hh, 1395kk and 1395mm).

2. Subpart T is redesignated as new Subparts B and D of new Part 417, Health Maintenance Organizations, Competitive Medical Plans, and Health Care Prepayment Plans, as follows (Subpart A of new Part 417 is reserved):

(a) Sections 405.2001 through 405.2092 are redesignated as new §§ 417.201 through 417.292 in a new Subpart B of Part 417 and all internal cross-references are corrected.

(b) The uncoded internal heading immediately preceding § 405.2093 is removed; § 405.2093 and §§ 405.2094 through 405.2098 are revised and redesignated as § 417.800 and §§ 417.802 through 417.810 respectively, in the new Part 417, Subpart D as set forth below.

These redesignations are set forth in the table below:

REDESIGNATION TABLE FOR 42 CFR 405.2001 THROUGH 405.2098 (PART 405, SUBPART T)

Old section	New section
405.2001	417.201
405.2002	417.202
405.2003	417.203
405.2004	417.204
405.2005	417.205
405.2007	417.207
405.2020	417.220
405.2021	417.221
405.2022	417.222
405.2023	417.223
405.2024	417.224
405.2025	417.225
405.2028	417.228
405.2029	417.229
405.2030	417.230
405.2031	417.231
405.2032	417.232
405.2033	417.233
405.2034	417.234
405.2035	417.235
405.2036	417.236
405.2037	417.237
405.2038	417.238
405.2039	417.239
405.2040	417.240
405.2041	417.241
405.2042	417.242
405.2043	417.243
405.2044	417.244
405.2045	417.245
405.2046	417.246
405.2047	417.247
405.2049	417.249
405.2050	417.250
405.2051	417.251
405.2052	417.252
405.2053	417.253
405.2054	417.254
405.2056	417.256
405.2058	417.258
405.2059	417.259
405.2060	417.260
405.2061	417.261
405.2062	417.262
405.2063	417.263
405.2065	417.265
405.2066	417.266
405.2067	417.267
405.2068	417.268
405.2069	417.269
405.2070	417.270
405.2072	417.272
405.2073	417.273
405.2074	417.274
405.2075	417.275
405.2076	417.276
405.2077	417.277
405.2078	417.278
405.2079	417.279
405.2080	417.280
405.2081	417.281
405.2082	417.282
405.2083	417.283
405.2084	417.284
405.2085	417.285
405.2086	417.286
405.2087	417.287
405.2088	417.288
405.2089	417.289
405.2090	417.290
405.2091	417.291
405.2092	417.292
405.2093	[1] 417.800
405.2094	417.802
405.2095	417.804
405.2096	417.806
405.2097	417.808
405.2098	417.810

[1] Section 417.801 was redesignated from 42 CFR 405.692.

3. Redesignated § 417.201 is amended by redesignating paragraph (b) as paragraph (c) and adding a new paragraph (b) to read as follows:

§ 417.201 Health maintenance organizations; general.

* * * * *

(b) *Other applicable regulations.* Subpart C of this part contains regulations and effective dates applicable to organizations qualifying for Medicare payments under section 1876 of the Act as amended by section 114 of Pub. L. 97–248 (Tax Equity and Fiscal Responsibility Act of 1982).

* * * * *

4. In redesignated § 417.242, paragraph (g) is amended by revising paragraphs (g)(1) and (g)(2) and corrected by adding paragraph (g)(3), and paragraph (h) is revised to read as follows:

§ 417.242 Allowable costs.

* * * * *

(g) *Physicians' services under arrangements.* (1) The amount paid by an HMO to a physician group (organized on a group-practice or individual-practice basis) for physicians' services, and for other covered Part B services, furnished under arrangements (as described in § 110.104 of this title), is an allowable expense to the extent it is reasonable.

(2) The amount paid by an HMO on a fee-for-service basis to physicians and other suppliers and to a physician group organized on an individual-practice basis for physicians' services and other covered Part B services furnished under arrangements (as described in § 110.104 of this title) is an allowable expense to the extent it is not in excess of the reasonable charges, as defined in Subpart E of Part 405 of this chapter. Therefore, payment is limited to the amount that would otherwise be paid if the services were furnished by the physician group (or by similar physicians, practitioners, or suppliers) to Medicare beneficiaries who are not enrolled in the HMO. The same limitation also applies to the amount

paid by the HMO for such covered services furnished under arrangements with a physician, physician-directed clinic, or a supplier of services.

(3) However, an exception to the reasonable charges limitation described in paragraph (g)(2) of this section is permitted, if the HMO demonstrates to HCFA's satisfaction that the physician group organized on an individual-practice basis has an agreement that includes acceptance by the members of the physician group of effective incentives, such as risk-sharing or other financial incentives, designed to avoid unnecessary or unduly costly utilization of health services. In such cases, the amount of physician compensation paid by an HMO is an allowable expense to the extent it is reasonable.

(h) *Provider services through arrangements.* The cost incurred by an HMO for covered services furnished by a provider through arrangements (see § 110.104 of this title and § 405.2043(b)) are allowable to the extent that such cost would be allowable and reimbursable pursuant to Subpart D of Part 405 of this chapter unless the HMO can demonstrate to the satisfaction of HCFA that payment in excess of the reasonable cost allowed pursuant to such Subpart D of Part 405 of this chapter is justified on the basis of advantages gained by the HMO. For example, if an HMO has an arrangement with a provider of services located outside the HMO's enrollment area that is not related to the HMO by common ownership or control, payment for the provider's charges to the HMO for covered services (rather than the provider's reasonable cost as determined under Subpart D of Part 405 of this chapter) may be justified if: The provider furnishes services to enrollees of the HMO on an infrequent basis; the charges represent an insignificant amount of total reimbursement to the HMO by the program; and the charges do not exceed the customary charges by the provider to its other patients for similar services. The advantages gained under this arrangement include a more timely final settlement with the HMO and the elimination of administrative costs necessary to determine the provider's reasonable cost for these services. An advantage gained represents a real and tangible benefit received by the HMO for the excess cost incurred. Any such excess payment is also subject to other applicable requirements of Part 405 of this chapter, including tests of reasonableness.

* * * * *

5. Subpart C is added to new Part 417 and Subpart D (as redesignated and revised above) is set forth to read:

Subpart C—Health Maintenance Organizations and Competitive Medical Plans

Sec.

Eligibility and Contracting Requirements and Conditions

Enrollment, Entitlement, and Disenrollment

Contract Requirements

Change of Ownership and Leasing of Facilities

General Reimbursement Rules

Reasonable Cost Reimbursement

Authority: Secs. 1102, 1833(a)(1)(A), 1861(s)(2)(H), 1871, 1874, and 1876 of the Social Security Act as amended (42 U.S.C. 1302, 13951(a)(1)(A), 1395x(s)(2)(H), 1395hh, 1395kk, and 1395mm); section 114(c) of Pub. L. 97-248 (42 U.S.C. 1395mm note); and section 1301 of the Public Health Service Act (42 U.S.C. 300e).

Subpart A—[Reserved]

Subpart B—Health Maintenance Organizations

* * * * *

Subpart C—Health Maintenance Organizations and Competitive Medical Plans

§ 417.400 Basis and scope.

(a) *Statutory basis.* The regulations in this subpart implement section 1876 of the Act as amended by section 114 of Pub. L. 97-248. Section 1876 of the Act authorizes Medicare payments to HMOs and competitive medical plans (CMPs) through contracts under which the HMOs and CMPs are reimbursed for furnishing covered services to Medicare beneficiaries.

(b) *Scope.* This subpart sets forth the requirements an entity must meet in order to enter into a contract with HCFA as an HMO or CMP to be reimbursed, through capitation payments, for services furnished to Medicare beneficiaries who are enrolled with the HMO or CMP. It also specifies the principles that apply for each of the two methods for reimbursing HMOs and CMPs: reimbursement on a risk basis and reimbursement on a reasonable cost basis.

§ 417.401 Definitions.

As used in this subpart, unless the context indicates otherwise—

Adjusted average per capita cost (AAPCC) means an actuarial estimate made by HCFA in advance of an organization's contract period that represents what the average per capita cost to the Medicare program would be for each class of the organization's Medicare enrollees if they had received covered services other than through the organization in the same geographic area or in a similar area.

Adjusted community rate (ACR) is the equivalent of the premium that a risk organization would have charged to Medicare enrollees independently of Medicare payments using the same rates as charged to non-Medicare enrollees if the benefit package was limited to covered Medicare services.

Arrangement or arrangements means a written agreement executed between an eligible organization and another entity in which the other entity agrees to furnish specified services to Medicare enrollees of the organization, but the organization retains responsibility for those services. Under an arrangement, Medicare payment to the organization discharges the beneficiary's obligation to pay for the service.

Benefit stabilization fund means a fund established by HCFA at the request of an eligible organization with a new risk contract to withhold a portion of the per capita payments available to the organization for payment in a subsequent contract period for the purpose of stabilizing fluctuations in the availability of the additional benefits provided by the organization to its Medicare enrollees.

Current demonstration project Medicare enrollee means an individual who, on the effective date of these regulations, is—

(a) Enrolled with an HMO or CMP that is furnishing services pursuant to an existing demonstration project; and

(b) Entitled to benefits under part A and B of Medicare or enrolled for Part B only.

Current nonrisk Medicare enrollee means—

(a) An individual who, with respect to an eligible organization that has an existing cost contract, is enrolled with that organization on the effective date of these regulations, and is entitled to benefits under Parts A and B of Medicare or is enrolled in Part B only; and

(b) includes Medicare enrollees who disenroll and later reenroll in the same eligible organization.

Current risk Medicare enrollee means an individual who, on the effective date of these regulations, is—

(a) Enrolled with an HMO having an existing risk-sharing contract; and

(b) Entitled to benefits under Parts A and B of Medicare or enrolled in Part B only.

Eligible organization or *organization* means a public or private entity that is either an HMO or a CMP and meets all the applicable requirements of section 1876(b) of the Act. (See § 417.407.)

Emergency services means covered inpatient or outpatient services that are furnished by an appropriate source other than the organization and—

(a) Are needed immediately because of an injury or sudden illness, and

(b) The time required to reach the organization's providers or suppliers (or alternatives authorized by the organization) would have meant risk of permanent damage to the patient's health.

These services are considered to be emergency services as long as transfer of the enrollee to the organization's source of health care or designated alternative is precluded because of risk to the enrollee's health or because transfer would be unreasonable, given the distance involved in the transfer and the nature of the medical condition.

Enrollee means an individual who is enrolled in an HMO or a CMP to receive health care services on a prepaid capitation basis.

Entity with an existing cost contract means an entity that, on the effective date of these regulations, does not have in effect an existing risk contract or an existing demonstration project and—

(a) Has in effect a contract that is entered into under section 1876 of the act that was in effect prior to the effective date of these regulations (that is, a cost contract under Subpart T of Part 405 of this chapter); or

(b) is reimbursed on a reasonable cost basis under section 1833(a)(1)(A) of the Act.

Entity with an existing risksharing contract means an entity that, on the effective date of these regulations, has in effect a contract entered into under section 1876(i)(2)(A) of the Act as in effect prior to the effective date of these regulations (that is, a risk-sharing contract under Subpart T of Part 405 of this chapter).

Existing demonstration project means a demonstration project under section 402 of the Social Security Amendments of 1967 (42 U.S.C. 1395b–1) or section 222(a) of the Social Security Amendments of 1972 (42 U.S.C. 1395b–1 (note)), relating to the provision of services for which payment is made under Medicare on a prospectively determined basis.

Geographic area means the area found by HCFA to be the area within which the organization furnishes, or arranges for furnishing, the full range of services that it offers to its Medicare enrollees.

Medicare enrollee means an individual who is entitled to Medicare benefits (Part A and Part B or Part B only) and who has been identified on HCFA records as an enrollee of an eligible organization that has a contract under section 1876 of the Act.

New Medicare enrollee means an individual who—

(a) Enrolls with an organization after the date on which the organization first enters into a risk contract under this subpart;

(b) Is entitled to both Part A and Part B benefits under Medicare or Part B benefits only at the time of the enrollment; and

(c) Was not enrolled with the organization at the time the individual became entitled to benefits under Part A, or eligible to enroll in Part B of Medicare.

New risk contract means a contract entered into under section 1876(g) of the Act (that is, a risk contract under this subpart).

Reasonable cost reimbursement contract means a contract entered into under section 1876(h) of the Act (that is, a cost contract under this subpart).

Urgently needed services means covered services required in order to prevent serious deterioration of an enrollee's health that results from an unforeseen illness or injury if—

(a) The enrollee is temporarily absent from the organization's geographic area; and

(b) Receipt of the health care service cannot be delayed until the enrollee's return to the organization's geographic area.

§ 417.402 Effective date.

Under section 114(c) of Pub. L. 97–248, this subpart was effective on the first day of the first month after the month in which the Secretary certified that the AAPCC methodology, as described in § 417.588, could be implemented. Based on this provision, the effective date of this subpart is February 1, 1985.

Eligibility and Contracting Requirements and Conditions

§ 417.404 Introduction.

(a) *General requirements.* In order to participate as an eligible organization under Medicare an entity must—

(1) Establish that it is an eligible organization; and

(2) Satisfy the contract requirements for an eligible organization to enter into a contract with HCFA.

(b) *Applicable regulations.* (1) Sections 417.406 and 417.407 set forth the requirements an entity must meet to be determined to be an eligible organization. These determinations are made by the Assistant Secretary for Health of the Department.

(2) Sections 417.408 through 417.418 set forth the requirements and conditions that an eligible organization must meet in order to enter into a contract with HCFA. Regulations dealing with the contents of the contract are specified in §§ 417.470 through 417.494.

§ 417.406 Eligible organization determinations.

(a) *Responsibility for making determinations.* (1) The Assistant Secretary for Health of the Department has the responsibility for determining if an entity is an eligible organization.

(2) The Assistant Secretary for Health will use the procedures set forth in § 110.605 (a) through (d) of this title in determining whether an entity meets the definition of a competitive medical plan as set forth in § 417.407(b). For purposes of this paragraph, references in those sections to "qualified HMO" are deemed references to "competitive medical plan" and references to requirements for qualification are deemed references to the requirements contained in the definition of "competitive medical plan", except that the third sentence of § 110.605(a) applies only to HMOs and not to CMPs.

(3) The Assistant Secretary for Health will, upon completion of the determination, certify in writing to HCFA whether the entity meets the definition of an eligible organization as set forth in § 417.407.

(4) HCFA will not act on any request made by an entity to contract under section 1876 of the Act until HCFA receives the certification from the Assistant Secretary for Health.

(b) *Oversight of continuing eligibility.* (1) The Assistant Secretary of Health is responsible for overseeing an entity's continuing compliance with the definition of an eligible organization as set forth in § 417.407.

(2) If the Assistant Secretary for Health notifies HCFA that an entity no longer meets the definition of an eligible organization, HCFA will terminate the entity's contract as specified in § 417.494(b)(iii).

§417.407 Definition of an eligible organization.

(a) *State law.* To qualify as an eligible organization, an entity must be organized under the laws of any State and be either an HMO or CMP under

paragraphs (b) or (c) of this section, respectively.

(b) *Health maintenance organization (HMO).* An HMO is a legal entity that is a qualified HMO as defined in section 1301(d) of the Public Health Service (PHS) Act. The PHS regulations for qualified HMOs are set forth in Subpart A of Part 110 of this title.

(c) *Competitive medical plan (CMP).* A CMP is a legal entity that meets the following requirements:

(1) Except as specified in paragraph (d) of this section, the entity provides to its enrolled members at least the following services:

(i) Physicians' services performed by physicians.

(ii) Laboratory, X-ray, emergency, and preventive services.

(iii) Out-of-area coverage.

(iv) Impatient hospital services.

(2) The entity receives compensation (except for deductibles, coinsurance, and copayments) for the health care services it provides to enrolled members on a periodic, prepaid capitation basis regardless of the frequency, extent, or kind of services provided to any member.

(3) The entity provides physicians' services primarily through—

(i) Physicians who are employees or partners of the entity; or

(ii) Physicians or groups of physicians (organized on a group or individual practice basis) under contract with the entity to provide physicians' services.

(4) The entity assumes full financial risk, under the procedures described in §110.108(b) of this title, on a prospective basis for the provision of health care services listed in paragraph (c)(1) of this section, except that the entity may—

(i) Obtain insurance or make other arrangements for the cost of providing to any enrolled member the health care services listed in paragraph (c)(1) of this section, if the aggregate value of the services exceeds $5,000 in any year;

(ii) Obtain insurance or make other arrangements for the cost of providing health care services listed in paragraph (c)(1) of this section to enrolled members other than through the entity for cases in which medical necessity required that the services be provided before they could be secured through the entity;

(iii) Obtain insurance or make other arrangements for not more than 90 percent of the amount by which the entity's costs for any of its fiscal years exceed 115 percent of its income for that fiscal year; and

(iv) Make arrangements with physicians and other health professionals, health care institutions, or any combination of these to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians or other health professionals or through the institutions.

(5) The entity provides adequately against the risk of insolvency by meeting the fiscal and administrative management requirements of § 110.108(a)(1)(i) through (iv) and (a)(3) of this title.

(d) *Exception for Medicaid prepayment risk contracts.* An entity that had a Medicaid prepayment risk contract before 1970 that did not include provision of inpatient hospital services does not have to meet the requirement of paragraph (b)(1)(iv) of this section.

§ 417.408 Contract application process.

(a) *Contents of application.* (1) The application for a contract must include supporting information in the form and detail required by HCFA.

(2) Whenever feasible, HCFA will exempt the organization from resubmittal of information it has already submitted to the Assistant Secretary for Health of the Department in connection with a determination made under the provisions of § 417.406.

(b) *Approval of application.* (1) If HCFA approves the application, it will give written notice to the organization, indicating that it meets the requirements for either a risk or reasonable cost contract or only for a reasonable cost contract.

(2) If the organization is dissatisfied with a determination that it meets the requirements only for a reasonable cost contract, it may request reconsideration in accordance with the procedures specified in §§ 417.640 through 417.658.

(c) *Denial of application.* If HCFA denies the application, it will give written notice to the organization indicating—

(1) That it does not meet the contract requirements under section 1876 of the Act;

(2) The reasons why the organization does not meet the contract requirements; and

(3) The organization's right to request reconsideration in accordance with the procedures specified in §§ 417.640 through 417.658.

§ 417.410 Qualifying conditions: General.

(a) In order to qualify for a contract with HCFA under this subpart, an eligible organization must demonstrate its ability to enroll members and to deliver a specified comprehensive range of high qualify services efficiently, effectively, and economically to its Medicare enrollees.

(b) An eligible organization must meet qualifying conditions that pertain to operating experience, enrollment, range of services, furnishing of services, and a quality assurance program.

(c) Generally, each qualifying condition is interpreted by a series of standards that are used in surveying an eligible organization to determine its qualifications for a Medicare contract.

(d) Application of the standards enables the surveyor to determine—

(1) The organization's activities;

(2) The extent to which the organization complies with each condition;

(3) The nature and extent of any deficiencies; and

(4) The need for improvement if HCFA should enter into a contract with the organization.

(e) An eligible organization may enter into a risk contract with HCFA if it—

(1) Meets all the applicable requirements in the statute and regulations;

(2) Has at least 5,000 enrollees or 1,500 enrollees if it serves a primarily rural area as defined in § 417.413(b)(3);

(3) Has at least 75 Medicare enrollees or has an acceptable plan to achieve this Medicare membership within 2 years;

(4) Satisfies HCFA that it can bear the potential losses of a risk contract; and

(5) Has not previously terminated or failed to renew a risk contract within the preceding 5 years, unless HCFA determines that circumstances warrant special consideration.

(f) An eligible organization may enter into a reasonable cost contract if it meets one of the following:

(1) The organization qualifies for a risk contract, but chooses a reasonable cost contract.

(2) The organization meets the conditions for entering into a risk contract specified in paragraph (e) of this section except that HCFA does not judge the organization capable of bearing the potential losses of a risk contract.

(g) Regulations on reasonable cost and risk reimbursement are set forth in §§ 417.530 through 417.596.

§ 417.412 Qualifying condition: Administration and management.

(a) HCFA will enter into or renew a contract only if it determines that that action would be consistent with the effective and efficient implementation of section 1876 of the Act.

(b) The eligible organization must demonstrate that it—

(1) Has sufficient administrative capability to carry out the requirements of the contract; and

(2) Does not have any agents or management staff or persons with ownership or control interests who have been convicted or criminal offenses related to their involvement in Medicaid, Medicare, or social service programs under title XX of the Act.

§ 417.413 Qualifying condition: Operating experience and enrollment.

(a) *Condition.* The organization must demonstrate that it has operating experience and an enrolled population sufficient to provide a reasonable basis for establishing a prospective per capita reimbursement rate or a reasonable cost reimbursement rate, as appropriate.

(b) *Standard: Enrollment and operating experience for organizations to contract on a risk basis:* (1) To be eligible to contract for Medicare reimbursement on a risk basis, a nonrural organization must currently have—

(i) At least 5,000 enrollees; and

(ii) At least 75 Medicare enrollees or a plan acceptable to HCFA for achieving a Medicare enrollment of 75 within two years of the beginning of its initial contract period.

(2) To be eligible to contract for Medicare reimbursement on a risk basis, a rural organization must currently have—

(i) At least 1,500 enrollees; and

(ii) At least 75 Medicare enrollees or a plan acceptable to HCFA for achieving a Medicare enrollment of 75 within two years of the beginning of its initial contract period.

(3) For purposes of this paragraph, an organization is considered rural if at least 50 percent of its enrollees reside in nonmetropolitan areas. A nonmetropolitan area is an area—

(i) No part of which is within a metropolitan statistical area (MSA) as designated by the Executive Office of Management and Budget; and

(ii) That does not contain a city whose population exceeds 50,000 individuals.

(4) A subdivision or subsidiary of an organization that meets the requirements of paragraph (b)(1) or (b)(2) of this section need not demonstrate that it meets those requirements as an independent unit if the organization assumes responsibility for the financial risk, and adequate management and supervision of health care services furnished by its subdivision or subsidiary.

(c) *Standard: Enrollment and operating experience for organizations to contract on a reasonable cost basis.* To be eligible to contract for Medicare reimbursement on a reasonable cost basis, an organization must currently have an enrolled population sufficient to provide a reasonable basis for entering into a contract.

The organization must have—

(1) At least 1,500 enrollees;

(2) At least 75 Medicare enrollees, or a plan acceptable to HCFA for achieving a Medicare enrollment of 75 within two years of the beginning of its initial contract period; and

(3) At least 250 Medicare enrollees by the beginning of its fourth contract period.

(d) *Standard: Composition of enrollment*—(1) *Requirement.* Except as specified in paragraphs (d)(2) and (e) of this section, not more than 50 percent of an organization's enrollment may be Medicare and Medicaid beneficiaries.

(2) *Waiver of composition of enrollment standard.* Unless limited by the criteria specified in paragraph (d)(3) of this section, HCFA may waive compliance with the requirements of paragraph (d)(1) of this section if—

(i) The organization is making reasonable efforts to enroll individuals who are not Medicare or Medicaid beneficiaries; and

(ii) Medicare and Medicaid beneficiaries constitute more than 50 percent of the population of the organization's geographic area.

(3) *Limitations on waivers.* HCFA will not grant a waiver that would permit the percentage of Medicare and Medicaid enrollees to exceed the percentage of Medicare and Medicaid beneficiaries in the organization's geographic area.

(e) *Exception to composition of enrollment standard.* An organization that is an existing demonstration project on the date it applies for a contract under the provisions of this subpart and that HCFA finds is making reasonable effort to enroll individuals who are not Medicare or Medicaid beneficiaries is not subject to the composition of enrollment standard specified in paragraph (d)(1) of this section. This exception to the standard applies—

(1) For a period not to exceed three years from the start of the organization's first contract period; or

(2) For a longer period, to be determined by HCFA before the expiration of the three year period, if special circumstances indicate that it is in the best interests of the Medicare program to continue this exception.

(f) *Standard: Open enrollment.* (1) Except as specified in paragraph (f)(2) of this section, an organization must enroll Medicare beneficiaries on a first-come, first-served basis to the limit of its capacity and provide annual open enrollment periods of at least 30 days duration for Medicare beneficiaries.

(2) HCFA may waive the requirement of paragraph (f)(1) of this section if compliance would prevent compliance with the limitation on enrollment of Medicare and Medicaid beneficiaries (paragraph (d) of this section) or result in an enrollment substantially nonrepresentative of the population of the organization's geographic area. The enrollment would be "substantially nonrepresentative" if the proportion of a subgroup to the total enrollment exceeded, by 10 percent or more, its proportion of the population in the organization's geographic area, as shown by census data or other data acceptable to HCFA. For purposes of this paragraph, a subgroup means a class of Medicare enrollees as defined in § 417.582.

§ 417.414 Qualifying condition: Range of Services.

(a) *Condition.* The organization must demonstrate that it is capable of delivering to Medicare enrollees the range of services required in accordance with this section.

(b) *Standard: Range of services furnished by eligible organizations*—(1) *Basic requirement.* Except as specified in paragraph (b)(3) of this section, an organization must furnish to its Medicare enrollees (directly or through arrangements with others) all the Medicare services to which those enrollees are entitled that are available to Medicare beneficiaries who reside in the organization's geographic area but are not enrolled in the organization.

(2) *Criteria for availability.* The services are considered available if—

(i) The sources are located within the organization's geographic area; or

(ii) It is common practice to refer patients to sources outside that geographic area.

(3) *Exception for hospice care.* An organization is not required to furnish hospice care as described in Part 418 of this chapter. However, organizations must inform their Medicare enrollees about the availability of hospice care if—

(i) A hospice participating in Medicare is located within the organization's geographic area; or

(ii) It is common practice to refer patients to hospices outside the geographic area.

(4) *Choice of practitioners.* If more than one type of practitioner is qualified to furnish a particular item or service, the organization may select the type of practitioner to be used.

(c) *Standard: Financial responsibility for services furnished outside the organization.* (1) An organization must assume financial responsibility and provide reasonable reimbursement for emergency services and urgently needed services (as defined in § 417.401) that are obtained by its Medicare enrollees from providers and suppliers outside the organization even in the absence of the organization's prior approval.

(2) An organization must assume financial responsibility for services that the Medicare enrollee attempted to obtain from the organization, but that the organization failed to furnish or unreasonably denied, and that are found, upon appeal by the enrollee under §§ 417.600 through 417.638, to be services that the enrollee was entitled to have furnished to him or her by the organization.

§ 417.416 Qualifying condition: Furnishing of services.

(a) *Condition.* The organization must furnish the required services to its Medicare enrollees through providers and suppliers that meet applicable Medicare statutory definitions and implementing regulations. The organization must also ensure that the required services, additional services, and any other supplemental services for which the Medicare enrollee has contracted are available and accessible and are furnished in a manner that ensures continuity.

(b) *Standard: Conformance with conditions of participation, conditions for coverage, and conditions for certification.* (1) Hospitals, SNFs, HHAs, comprehensive outpatient rehabilitation facilities, and providers of outpatient physical therapy or speech pathology services must meet the applicable conditions of participation in Medicare, as set forth elsewhere in this chapter.

(2) Suppliers must meet the conditions for coverage or conditions for certification of their services, as set forth elsewhere in this chapter.

(c) *Standard: Physician supervision.* The organization must provide for supervision by a physician or other health care professionals who are directly involved in the provision of health care as generally authorized under section 1861 of the Act. Except as specified in paragraph (d) of this section, with respect to medical services furnished in an organization's clinic or the office of a physician with whom the organization has a service agreement, the organization must ensure that—

(1) Services furnished by paramedical, ancillary, and other nonphysician personnel are furnished under the direct supervision of a physician;

(2) A physician is present to perform medical (as opposed to administrative) services whenever the clinics or offices are open; and

(3) Each patient is under the care of a physician.

(d) *Exceptions to physician supervision.* The following services may be furnished without the direct personal supervision of a physician:

(1) The organization may permit the services of physician assistants and nurse practitioners (as defined in § 481.2 of this chapter), and the services and supplies incident to their services, to be furnished without the direct personal supervision of a physician. For purposes of this section, the definitions of physician assistants' and nurse practitioners' services and the services and supplies incident to their services for rural health clinics as specified in §§ 405.2414 and 405.2415 of this chapter are applicable.

(2) An organization that proposes to contract on a risk basis may permit the services of clinical psychologists, and the services and supplies incident to their professional services, to be furnished without the direct personal supervision of a physician. For purposes of this section, a clinical psychologist is defined as an individual who—

(i) Holds a doctoral degree in psychology from a program in clinical psychology that is approved by the American Psychological Association or an adjudged equivalent program, or has attained recognition of competency through the American Board of Examiners for Professional Psychology or through endorsement by the individual's State psychological association;

(ii) Is licensed or certified at the independent practice level of psychology in the State in which he or she practices; and

(iii) Possesses two years of supervised clinical experience at least one of which is postdegree.

(e) *Standard: Accessibility and continuity.* (1) The organization must ensure that the required services and any other services for which Medicare enrollees have contracted are accessible, with reasonable promptness, to the enrollees with respect to geographic location, hours of operation, and provision of after hours service. Medically necessary emergency services must be available twenty-four hours a day, seven days a week.

(2) The organization must maintain a health (including medical) recordkeeping system through which pertinent information relating to the health care of its Medicare enrollees is accumulated and is readily available to appropriate professionals.

§ 417.418 Qualifying condition: Quality assurance program.

(a) *Condition.* The organization must make arrangements for a quality assurance program that meets the requirements of this section.

(b) *Standard: Quality assurance program for HMOs.* An HMO must have an ongoing quality assurance program that meets the requirements set forth in § 110.108(h) of this title.

(c) *Standard: Quality assurance program for CMPs.* A CMP must have an ongoing quality assurance program for the health services it furnishes that—

(1) Stresses health outcomes to the extent consistent with the state of the art;

(2) Provides review by physicians and other health professionals of the process followed in the provision of health services;

(3) Uses systematic data collection of performance and patient results, provides interpretation of these data to its practitioners, and institutes needed changes; and

(4) Includes written procedures for taking appropriate remedial action whenever, as determined under the quality assurance program, inappropriate or substandard services have been furnished or services that should have been furnished have not been furnished.

Enrollment, Entitlement, and Disenrollment

§ 417.420 Basic rules on enrollment and entitlement.

(a) *Enrollment.* Individuals who are entitled to benefits under both Part A and Part B of Medicare or only Part B may elect to receive those benefits through an organization that has in effect a contract with HCFA under §§ 417.470 through 417.494.

(b) *Entitlement.* If a Medicare beneficiary enrolls with an organization, Medicare will make payments to the organization on his or her behalf for the services to which he or she is entitled, as described in § 417.440.

(c) *Beneficiary liability.* (1) As authorized in § 417.440, the organization may require payment, in the form of premiums or otherwise, from individuals for services not covered under Medicare, as well as deductible and coinsurance amounts attributable to Medicare covered services.

(2) As described in § 417.448, Medicare enrollees of risk organizations are liable for services that they obtain

from sources other than the organization, unless the services are—

(i) Emergency or urgently needed; or

(ii) Determined, on appeal under §§ 417.600 through 417.638, to be services that should have been furnished by the organization.

§ 417.422 Eligibility to enroll in an organization.

(a) *General criteria.* Except as specified in § 417.424 and paragraphs (b) and (c) of this section, an organization must enroll, either for an indefinite period or for a specified period of at least 12 months, any individual who—

(1) Is entitled to Medicare benefits under Parts A and B or under Part B only;

(2) Lives within the geographic area served by the organization;

(3) Is not enrolled in any other organization that has entered into a contract under this subpart or Subpart T of Part 405 of this chapter;

(4) During an enrollment period of the organization, completes and signs the organization's application form and gives whatever information is required for enrollment;

(5) Agrees to abide by the organization's rules after they are disclosed to him or her in connection with the enrollment process;

(6) Is not denied enrollment by the organization under a selection policy, if any, that has been approved by HCFA under § 417.424(b); and

(7) Is not denied enrollment by the organization on the basis of any of the administrative criteria concerning denial of enrollment in § 417.424(a).

(b) *ESRD patients.* Medicare beneficiaries who have been medically determined to have end-stage renal disease are not eligible to enroll in eligible organizations except as specified in § 417.434 concerning reenrollment.

(c) *Hospice patients.* Medicare beneficiaries who have elected hospice care under § 418.24 of this chapter are not eligible to enroll in eligible organizations as long as the hospice election remains in effect.

§ 417.424 Denial of enrollment.

(a) *Basis for denial.* An organization may deny enrollment to an individual who meets the criteria of § 417.422 if acceptance would—

(1) Cause the number of enrollees who are Medicare or Medicaid beneficiaries to exceed 50 percent of the organization's total enrollment.

(2) Prevent the organization from complying with any of the other contract qualifying conditions set forth in §§ 417.412–417.416 of this part;

(3) Require the organization to exceed its enrollment capacity; or

(4) Cause the enrollment to become substantially nonrepresentative of the general population in the organization's geographic area.

(b) *Selection policies.* Denial under paragraph (a)(4) of this section must be in accordance with written selection policies approved by HCFA. Enrollment of individuals will not be considered to make the enrollment of the organization substantially nonrepresentative of the general population in the organization's geographic area unless, as a result of the enrollment, the proportion of the subgroup (as defined in § 417.413(f)(2)) of enrollees to which the enrollee belongs as compared to the organization's total enrollment exceeds by at least ten percent its proportion to the general population in the geographic area of the organization.

§ 417.426 Open enrollment requirements.

(a) *Basic requirements.* (1) Eligible organizations must provide open enrollment for Medicare beneficiaries for at least 30 consecutive days during each contract year.

(2) During open enrollment, the organization must enroll eligible Medicare beneficiaries in the order in which their applications are received and until its enrollment capacity is reached.

(3) The organization may accept applications from Medicare beneficiaries after it has reached capacity if it places those individuals on a waiting list and enrolls them in chronological order as vacancies occur.

(b) *Capacity to accept new enrollees.* (1) If an organization chooses to limit enrollments because of its capacity, it must notify HCFA at least 90 days before the beginning of its open enrollment period and, at that time, provide HCFA with its reasons for limiting enrollment.

(2) HCFA will evaluate the organization's submittal under paragraph (b)(1) of this section.

(3) The organization must promptly notify HCFA if there is any change in its enrollment capacity.

(c) *Reserved vacancies.* An organization may set aside a reasonable number of vacancies for an anticipated new group contract or for anticipated new members of an existing group contract that will have its enrollment period after the Medicare open enrollment period during the contract year—

(1) Subject to HCFA's approval; and

(2) On condition that any vacancies set aside that are not filled within a reasonable period of time after the beginning of the group contract enrollment period be made available to Medicare beneficiaries and other nongroup applicants under the requirements of this subpart.

§ 417.428 Marketing activities.

(a) *Required marketing activities.* An organization must meet the following requirements:

(1) Offer its plan to Medicare beneficiaries and provide to those interested in enrolling adequate written descriptions of the organization's rules, procedures, benefits, fees and other charges, services, and other information necessary for beneficiaries to make an informed decision about enrollment.

(2) Notify the general public of its enrollment period (whether time limited or continuous) in an appropriate manner through appropriate media, throughout its enrollment area.

(b) *Prohibited marketing activities—general.* In offering its plan to Medicare beneficiaries an organization may not engage in any of the following practices or activities:

(1) Practices that are discriminatory. For example, the organization may not engage in any activity intended to recruit Medicare beneficiaries from higher income areas (usually an indicator of better health) without making a comparable effort to enroll Medicare beneficiaries from lower income areas.

(2) Activities that could mislead or confuse Medicare beneficiaries, or misrepresent the organization, its marketing representatives, or HCFA. For example, the organization may not claim that it is recommended or endorsed by HCFA or that HCFA recommends that the beneficiary enroll in the organization. It may, however, explain that the entity is approved as an organization for purposes of participation in Medicare.

(3) Offers of gifts or payment as an inducement to enroll in the organization. This does not prohibit the explanation of any legitimate benefits the beneficiary might obtain as an enrollee of the organization, such as eligibility to enroll in a supplemental benefit plan that covers deductibles and coinsurance or preventive services.

(4) Door-to-door solicitation of Medicare beneficiaries.

(c) *Marketing activities of risk organizations.* In addition to the generally permitted or prohibited marketing activities described in paragraphs (a) and (b) of this section, a risk organization must provide potential Medicare enrollees with adequate written descriptions of the additional

benefits or services, or reductions in premiums, deductible or copayments that may pertain under risk reimbursement.

§ 417.430 Application procedures.

(a) *Application forms.* (1) The application form must comply with HCFA instructions regarding format and content and must include the beneficiary's signature and authorization for disclosure and exchange of necessary information between HCFA and the organization.

(2) The organization must file and retain application forms for the period specified in HCFA instructions.

(b) *Handling of applications.* An organization must have an effective system for receiving, controlling, and processing applications for Medicare beneficiaries. The system must meet the following conditions and requirements:

(1) Each application is dated as of the day it is received.

(2) Applications are processed in chronological order by date of receipt.

(3) The organization notifies the beneficiary in writing of acceptance or denial of the application promptly.

(4) The notice of acceptance—

(i) Specifies the date on which the organization will request HCFA to make the enrollment effective; or

(ii) If the organization is currently enrolled to capacity, explains the procedures that will be followed when vacancies occur.

(5) The notice of denial explains the reason for denial.

(6) The organization transmits the information necessary for HCFA to add the beneficiary to its records of the organization's Medicare enrollees—

(i) Within 30 days from the date of application or from the date a vacancy occurs for an applicant who was accepted while the organization was enrolled to capacity; or

(ii) Within an additional period of time approved by HCFA on a showing by the organization that it needs more time.

(7) The organization promptly notifies the beneficiary of the effective month of his or her enrollment as a Medicare enrollee, when it receives that information from HCFA.

(8) If the organization accepts applications while it is enrolled to capacity, its procedures ensure that vacancies are filled in chronological order by date of application of beneficiaries who are still eligible to enroll, unless that would result in failure to comply with any of the qualifying conditions set forth in § 417.413.

§ 417.432 Conversion of enrollment.

(a) *Basic rule.* An organization must accept as a Medicare enrollee any individual who is enrolled in the organization for the month immediately before the month in which he or she is entitled to both Medicare Parts A and B or Part B only.

(b) *Effective date of conversion.* Unless the individual chooses to disenroll from the organization, the individual's conversion to a Medicare enrollee is effective the month in which he or she is entitled to both Medicare Parts A and B or Part B only.

(c) *Prohibition against disenrollment.* An organization may not disenroll an individual who is converting under the provisions of paragraph (a) of this section unless one of the conditions specified in § 417.460 is met.

(d) *Application form.* The individual who is converting must sign an application form as described in § 417.430(a).

(e) *Expedite submittal of information to HCFA.* The organization must notify HCFA, within the following time frames, of the enrollee's authorization for disclosure and exchange of information and the information necessary for HCFA to include the enrollee in its records as a Medicare enrollee of the organization:

(1) At least 30, but no earlier than 90, days before the enrollee—

(i) Attains age 65; or

(ii) Reaches his or her 25th month of entitlement to social security disability benefits under title II of the Act or railroad retirement disability benefits under section 7(d) of the Railroad Retirement Act of 1974.

(2) Within 30 days after the enrollee initiates a course of renal dialysis, or on or before the day he or she enters a hospital in anticipation of a kidney transplant.

(f) *Two-for-one rule concerning conversion of current nonrisk Medicare enrollees.* A risk organization that is receiving reimbursement for current nonrisk Medicare enrollees on a reasonable cost basis may, as provided in § 417.444, convert those enrollees to its risk reimbursement membership if it enrolls two new Medicare enrollees for each current nonrisk enrollee it converts under § 417.448. Selection of the current nonrisk Medicare enrollees to be converted must be unbiased as described in § 417.446(c).

§ 417.434 Reenrollment

If an organization requires periodic reenrollment, it must reenroll Medicare enrollees unless there is a basis for disenrollment as set forth in § 417.460.

§ 417.436 Membership rules for enrollees.

(a) *Maintaining rules.* An organization must maintain written membership rules that deal with, but need not be limited to—

(1) Procedures for paying premiums and other charges for which Medicare enrollees may be liable;

(2) Grievance and appeal procedures;

(3) Disenrollment rights;

(4) The obligation of an enrollee who is permanently moving out of the organization's geographic area; that is, expects to be absent from the area for more than 90 days, must notify the organization of the move or absence;

(5) How and where to obtain services from or through the organization; and

(6) Any other matters that HCFA may prescribe.

(b) *Availability of rules.* The organization must furnish a copy of the rules to each Medicare enrollee.

(c) *Changes in rules.* If an organization changes its rules, it must notify its Medicare enrollees of the changes at least 30 days before the effective date of the changes.

§ 417.440 Entitlement to health care services from an organization.

(a) *Basic rules.* (1) Subject to the conditions and limitations set forth in this subpart, a Medicare enrollee of an organization is entitled to receive health care services and supplies directly from, or through arrangements made by, the organization as specified in this section and §§ 417.442–417.446.

(2) A Medicare enrollee is also entitled to receive timely and reasonable payment directly (or have payment made on his or her behalf) for services he or she obtained from a provider or supplier outside the organization if those services are—

(i) Emergency services or urgently needed services as defined § 417.401;

(ii) Services denied by the organization and found (upon appeal under §§ 417.600 through 417.638) to be services the enrollee was entitled to have furnished by the organization.

(b) *Scope of services.* (1) *Part A and Part B services.* Except as specified in paragraph (c) of this section, a Medicare enrollee is entitled to receive all the services and supplies that are covered by Part A and Part B of Medicare (if he or she is entitled to benefits under both programs) or by Medicare Part B (if he or she is entitled only under that program) that are available to individuals residing in the geographical area served by the organization.

(2) *Supplemental services elected by enrollee.* A Medicare enrollee of an organization may elect to pay for

optional services that are offered by the organization in addition to the covered Part A and Part B services, and, for risk organizations, in addition to the additional benefits required under § 417.442. The organization may not set health status standards for those enrollees whom it will accept for these optional supplemental services.

(3) *Supplemental services imposed by risk reimbursement organizations.* Subject to the approval of HCFA, a risk organization may require Medicare enrollees to accept and pay for services in addition to the covered Part A and Part B services. These services must be imposed on all applicable enrollees without regard to health status. HCFA will approve the supplemental services if it determines that the requirement will not discourage enrollment in the organization by other Medicare beneficiaries.

(4) *Additional benefits from risk organizations required by statute.* Subject to the conditions stated in § 417.422, a new Medicare enrollee or a current nonrisk Medicare enrollee who converts to risk reimbursement under § 417.444 is eligible to receive, in addition to the covered Part A and Part B benefits for which he or she is eligible, benefits consisting of one or both of the following:

(i) A reduction in the organization's premium rate or in other charges for services furnished to Medicare enrollees.

(ii) Provisions of health benefits or services and supplies beyond the required Part A and Part B coverage.

(5) *Special supplemental benefits.* Under conditions described in § 417.444(c), current nonrisk Medicare enrollees who are not converted to the risk portion of the contract, may enroll in a special supplemental plan, if offered by the organization, for some or all of the additional benefits described in paragraph (b)(4) of this section.

(c) *Limitation on hospice care.—(1) Extent of the limitation.* If a Medicare enrollee elects to receive hospice care under the provisions of § 418.24 of this chapter, the enrollee waives his or her right to receive from the organization any Medicare services, including services equivalent to hospice care, that are related to the treatment of the terminal condition for which hospice care was elected or to a related condition, except for services furnished by the individual's attending physician, if that physician is an employee or contractor of the organization and is not an employee of the designated hospice or receiving compensation from the hospice for those services.

(2) *Effective date of limitation.* The limitation in paragraph (c)(1) of this section begins on the effective date of the beneficiary's election of hospice care under § 418.24 of this chapter and remains in effect until the earlier of—

(i) The effective date of the enrollee's revocation of the election of hospice care as described in § 418.28 of this chapter; or

(ii) The date the enrollee exhausts his or her hospice benefits.

(3) *Payment to organization.* For the period that the Medicare enrollee's election of hospice care is in effect, payment will be made to reasonable cost organizations only as described in § 417.531 and to risk organizations only as described in § 417.585.

§ 417.442 Risk organizations: Conditions for provision of additional benefits.

(a) *General rule.* Except as provided in paragraph (b) of this section, an organization with a risk contract must provide its Medicare enrollees with the additional benefits described in § 417.440(b)(4) during a contract period if, prior to the contract period, the organization's ACRs (calculated separately for Part A and Part B enrollees and Part B-only enrollees) are less than the average of the per capita rates of payment for those beneficiaries that HCFA will be making to the organization. The computation of the value of the additional benefits, the ACR, and the average of the per capita payment rates are described in §§ 417.592 and 417.594.

(b) *Exceptions.*—(1) *Reduced payment election.* An organization is not obligated to furnish additional services under paragraph (a) of this section if it has requested a reduction in its monthly payment from HCFA under § 417.592(e), and it—

(i) Elects to receive reduced payment so that there is no difference between the average of its per capita rates of payment and its ACR; or

(ii) Elects to receive partially reduced payment and furnish Medicare enrollees with additional benefits described in § 417.440 (b)(4) so that the combined value of benefits and reduced payment is equivalent to the difference between the average of its per capita rates of payment and its ACR.

(2) *Benefit stabilization fund.* An organization may elect to have a part of the value of the additional benefits it must provide under paragraph (a) of this section withheld in a benefit stabilization fund as described in § 417.596.

§ 417.444 Special rules for current nonrisk Medicare enrollees of an organization under a risk contract.

(a) *Condition for additional benefits.* Current nonrisk Medicare enrollees of a risk organization may retain that status indefinitely and, therefore, are not entitled to the additional benefits under § 417.442 unless HCFA determines that the enrollee's status must be changed or a change is requested by the enrollee, as follows:

(1) HCFA determines that, for administrative reasons or because there are fewer than 75 current nonrisk Medicare enrollees remaining in the organization, all current nonrisk Medicare enrollees of an organization must be covered under the risk provisions of the contract; and

(i) HCFA notifies each affected enrollee of the decision at least 90 days prior to the effective date;

(ii) The current nonrisk Medicare enrollees complete and sign forms stating that they understand and accept the new rules and benefits that will be applicable to them; and

(iii) The organization notifies each affected enrollee, in writing, at least 30 days in advance, of the date upon which his or her coverage under the risk portion of the contract takes effect.

(2) A current nonrisk Medicare enrollee requests, using the same or a similar form to that described in paragraph (a)(1)(ii) of this section, that he or she be covered under the risk portion of the contract, and—

(i) The organization has enrolled two new Medicare enrollees for each of these current nonrisk Medicare enrollees; and

(ii) In cases where there are more current nonrisk Medicare enrollees than can be accommodated due to the two-for-one rule, the selection of those to be covered under the risk portion of the contract is made in an unbiased manner, as provided in § 417.446(c).

(b) *Conditions for special supplemental benefits.* A current nonrisk Medicare enrollee of an organization with a risk contract who is precluded from enrollment under the risk portion of the contract because of the two-for-one rule in § 417.446(a) may enroll in a plan for special supplemental benefits, if one is offered by the organization. The plan may cover some or all of the additional benefits described in § 417.440(b)(4). The plan must—

(1) Be offered to all current nonrisk Medicare enrollees of the organization who meet the requirements of this paragraph;

(2) Be offered at no cost to those enrollees;

(3) Offer a uniform package of benefits to all those enrollees;

(4) Be voluntary for those enrollees;

(5) Not affect the selection of the enrollees who will be converted to coverage under the risk portion of the contract;

(6) Restrict the enrollees who accept the plan from receiving payment directly or on their behalf for covered items and services received from sources outside the organization, in the same manner and subject to the conditions described in § 417.420(c);

(7) Provide that reimbursement for the special supplemental services for such enrollees be made from the savings the organization achieves, in the manner described in § 417.442; and

(8) Be offered with full disclosure of all provisions, especially the restriction described in paragraph (c)(6) of this section.

(c) *Notification.* Current nonrisk Medicare enrollees must be informed of the availability of any special supplemental benefits at least 90 days prior to the beginning of the organization's enrollment period, or other opportunity to enroll.

§ 417.446 Two-for-one enrollment criteria.

(a) *Basic rule.* In order to receive reimbursement on a risk basis for a current nonrisk Medicare enrollee, a risk organization must enroll two new Medicare enrollees for each current nonrisk Medicare enrollee who is converting. Selection of those enrollees to be converted must be made in an unbiased manner as prescribed in paragraphs (b) and (c) of this section.

(b) *Procedure for conversion.* (1) The organization must keep an accurate count of new Medicare enrollees and, on request by HCFA, be able to demonstrate that it has done so.

(2) Unused opportunities to convert current nonrisk Medicare enrollees to the risk provisions of the contract may be carried forward indefinitely from one contract period to another regardless of the death or subsequent disenrollment of a new Medicare enrollee.

(3) The organization may convert current nonrisk Medicare enrollees continuously as vacancies occur under the two-for-one criteria or during a special period designated for this purpose at least annually.

(i) The organization need not have a special period if no conversions are possible.

(ii) If special periods are held, current nonrisk Medicare enrollees must be informed about the period 60 days before it begins.

(iii) If waiting lists are used, the organization may convert the current nonrisk Medicare enrollees as vacancies occur, or on a group basis (for example, 10 or 20 at a time) for administrative ease. In either case, the enrollees must be converted in the order in which they appear on the waiting list. Placement on a waiting list must be on an equitable basis such as first-come, first-served.

(iv) The organization may allow continuous application for conversion with applicants being placed on a waiting list and converted as vacancies occur.

(c) *Requirements for unbiased conversion.* The organization, whether it uses a waiting list, a special period or another approach such as selection by lottery, must convert current nonrisk Medicare enrollees to the risk provisions of the contract in an unbiased manner. This means that the organization must—

(1) Inform in a timely, open, and complete manner all current nonrisk Medicare enrollees of their right to convert to the risk portion of the contract and the procedures for doing so;

(2) Not discriminate among the current nonrisk Medicare enrollees on the basis of geographic location, health status, or whether or not they have enrolled in the organization's plan for special supplemental benefits, if one is offered;

(3) Not discriminate among current nonrisk Medicare enrollees who are in similar circumstances, such as length of previous enrollment; and

(4) If it uses a waiting list, place the current nonrisk Medicare enrollees on the list in an equitable manner, such as first-come, first-served during a special period, a lottery, or greatest length of time enrolled in the organization.

§ 417.448 Restrictions on obtaining services for Medicare enrollees of risk organizations.

(a) *Basic rule.* Except for emergency and urgently needed services (defined in § 417.401), certain Medicare enrollees of risk organizations may not have Medicare payments made to them or on their behalf for any services received that are not provided directly or through arrangements made by the organization. This restriction applies to—

(1) New Medicare enrollees;

(2) Current nonrisk Medicare enrollees who convert to risk reimbursement; and

(3) Current nonrisk Medicare enrollees who elect special supplemental coverage plans.

(b) *End of restriction.* The restriction on obtaining services imposed by paragraph (a) of this section does not apply to a—

(1) Disenrolled Medicare enrollee as of the first day of the month in which termination of enrollment is effective as provided under § 417.460(b)(3); or

(2) Medicare enrollee who permanently leaves the geographic area served by the risk organization as of the first day of the first month following the month in which the enrollee notifies the organization (as required in § 417.436(a)(4)) that he or she has permanently moved out of the area, unless the organization and enrollee have made arrangements for the enrollee's membership to continue as provided in § 417.460(a)(2)(v).

§ 417.450 Effective date of coverage.

(a) *Basic rules.* Except as specified in paragraph (b) of this section—

(1) Medicare's liability for payments to an organization on behalf of a Medicare beneficiary begins on the first day of the month in which he or she is—

(i) Entitled to Medicare benefits; and

(ii) Enrolled in an organization; and

(2) The effective month of coverage may not be earlier than the first month after, nor later than the third month after the month in which HCFA receives the information necessary to include the beneficiary as a Medicare enrollee of the organization in HCFA records.

(b) *Exceptions.* (1) HCFA may approve a later month if it is requested by the organization and the beneficiary.

(2) If an individual becomes an organization enrollee before becoming entitled to Medicare Part B benefits, the effective month of coverage is the first month for which he or she becomes entitled to Medicare Part B benefits.

(c) *Notice of effective date of coverage.* HCFA will promptly advise the organization of the month for which HCFA's liability for payment begins for each beneficiary added to its records as an enrollee of the organization.

§ 417.452 Liability of Medicare enrollees.

(a) *Deductibles and coinsurance.* (1) A Medicare enrollee of an organization is responsible for applicable Medicare deductible and coinsurance amounts, unless the organization's charges for these amounts are reduced under § 417.442.

(2) The deductible and coinsurance amounts may be paid by the enrollee or on his or her behalf by another individual, organization, or entity. The payments may be made in the form of a premium, membership fee, charge per unit or similar charge.

(3) The sum of the amounts the organization charges its Medicare enrollees for Medicare deductibles and coinsurance may not exceed, on the

average, the actuarial value of the deductible and coinsurance the Medicare enrollees otherwise would have been liable for had they not enrolled in the organization or in another organization.

(b) *Services not covered under Medicare.* Unless the services are provided under § 417.442 or § 417.444(b), a Medicare enrollee of an organization is liable for payment for—

(1) All services that are not covered under Medicare Part A or Part B; or

(2) If entitled only to Medicare Part B benefits, all services that are not covered under Medicare Part B.

(c) *Services for which Medicare is not primary payor.* A Medicare enrollee of an organization is liable for payments made to the enrollee for all covered services for which Medicare is not the primary payor as provided in § 417.528.

(d) *Optional supplemental benefits plan.* (1) The organization may offer its Medicare enrollees a supplemental benefit plan to cover deductible and coinsurance amounts, or services not covered under Medicare, or both.

(2) If a supplemental benefit plan premium includes charges for both noncovered services and the deductible and coinsurance amounts applicable to covered services, the portion of the premium that is for deductibles and coinsurance must be computed separately and must be disclosed to the beneficiary during the enrollment process and before he or she elects coverage options.

(3) The sum of the amounts an organization charges its Medicare enrollees for services that are not covered under Part A or Part B may not exceed the ACR for these services.

(e) *Coverage of Part A services for Part B-only Medicare enrollees.* If an organization furnishes coverage of Medicare Part A services to a Medicare enrollee entitled to Part B only, the organization's premium (or other payment method) for these services may not exceed the ACR for these services. In addition, if a risk organization furnishes these services and supplemental services, which are the same as the additional benefits furnished Medicare enrollees of the organization who are entitled to benefits under both Parts A and B, the organization's combined premium for both these groups of services that the Part B enrollee must pay may not exceed 95 percent of the weighted average AAPCC for Part A services (or the Medicare payment for Part A services, if it is less) for the Medicare enrollees in the organization.

§ 417.454 Charges to Medicare enrollees.

(a) The organization must agree to charge its Medicare enrollees only for the—

(1) Deductible and coinsurance amounts applicable to furnished covered services;

(2) Charges for noncovered services or services for which the enrollee is liable as described in § 417.452; and

(3) Services for which Medicare is not the primary payor as provided in § 417.528.

(b) A risk organization must report, within 90 days after the end of the contract period, all premiums, enrollment fees, and other charges collected from its Medicare enrollees during that period.

§ 417.456 Refunds to Medicare enrollees.

(a) *Definitions.* As used in this section—

Amounts incorrectly collected means amounts collected that are in excess of those specified in § 417.452. It includes amounts collected when the enrollee was believed not entitled to Medicare benefits if the enrollee is later determined to have been entitled to Medicare benefits and Medicare is liable for payments as specified in § 417.450.

Other amounts due means amounts due a Medicare enrollee for services obtained outside the organization if they were—

(1) Emergency services;

(2) Urgently needed services for which the organization has assumed financial responsibility; or

(3) On appeal under §§ 417.600 through 417.638, found to be services the enrollee was entitled to have furnished by the organization.

(b) *Basic commitment.* An organization must agree to refund all amounts incorrectly collected from its Medicare enrollees, or from others on behalf of the enrollees, and any other amounts due the enrollees or others on their behalf.

(c) *Refund by lump sum payment.* An organization must make refunds to its current and former Medicare enrollees, or to others who have made payments on behalf of enrollees, by lump sum payment for the following:

(1) Incorrectly collected amounts that were not collected as premiums.

(2) Other amounts due.

(3) All amounts due, if the organization is going out of business.

(d) *Refund by premium adjustment or lump sum payment or both.* An organization may make refund by adjustment of future premiums, by lump sum payment, or by a combination of both methods, for amounts that were incorrectly collected in the form of premiums or through a combination of premium payments and other charges.

(e) *Refund when enrollee has died or cannot be located.* If an enrollee has died or cannot be located after reasonable effort by the organization, the organization must make the refund in accordance with State law.

(f) *Reduction by HCFA.* If the organization does not make refund in accordance with paragraphs (b) through (d) of this section by the end of the contract period following the contract period during which an amount was determined to be due an enrollee, HCFA will reduce its payment to the organization by the amounts incorrectly collected or otherwise due, and arrange for those amounts to be paid to the Medicare enrollee.

§ 417.458 Recoupment of uncollected deductible and coinsurance amounts.

An organization agrees to recoup deductible and coinsurance amounts for which Medicare enrollees were liable in a previous contract period only in the following circumstances:

(a) The organization failed to collect the deductible and coinsurance amounts during the contract period in which they were due because of—

(1) Underestimation of the actuarial value of the deductible and coinsurance amounts; or

(2) A billing error.

(b) The organization has identified the amounts and obtained advance HCFA approval of the recoupment and the method and timing of recoupment.

(c) The organization collects these amounts no later than the end of the contract period following the contract period during which they were found to be due.

§ 417.460 Disenrollment of beneficiaries and termination of payments to an organization.

(a) *Disenrollment of health insurance program beneficiaries.* An organization may not, orally or in writing, or by any action or inaction, request or encourage a Medicare enrollee to disenroll, except in the following circumstances:

(1) *Failure to pay premiums*—(i) *Basic rules.* Except as specified in paragraph (a)(1)(iii) of this section, an organization may disenroll a Medicare enrollee who fails to pay premiums or other charges imposed by the organization for deductible and coinsurance amounts for which the enrollee is liable, if the organization—

(A) Can demonstrate to HCFA that it made reasonable efforts to collect the unpaid amount;

(B) Gives the enrollee written notice of disenrollment, including an explanation of the enrollee's right to a hearing under the organization's grievance procedures; and

(C) Sends the notice of disenrollment to the enrollee before it notifies HCFA.

(ii) *When HCFA's liability ends.* (A) HCFA's liability to make monthly capitation payments to the organization on behalf of the enrollee ends as of the first day of the month following the month in which termination of enrollment as a Medicare enrollee is effective, as shown on HCFA records.

(B) Disenrollment will be effective no earlier than the month immediately after, and no later than the third month after, the month in which the disenrollment notice is received in acceptable form by HCFA.

(iii) *Exception.* If a Medicare enrollee of an organization fails to pay the separate premium (or the corresponding portion of a single premium) for optional supplemental benefits (that is, a package of benefits that an enrollee is not required to accept) but pays the premium for the deductible and coinsurance amounts, the organization may discontinue the optional supplemental benefits but may not disenroll the enrollee.

(2) *Enrollee moves out of the organization's geographic area*—(i) *Basic rule.* Except as provided in paragraph (a)(2)(iv) of this section, an organization must disenroll a Medicare enrollee who moves out of its geographic area and does not voluntarily disenroll under paragraph (b) of this section if the organization—

(A) Establishes, on the basis of a written statement from the enrollee or other evidence acceptable to HCFA, that the enrollee has permanently moved out of its geographic area; and

(B) Complies with the notice requirements set forth in paragraph (a)(1)(i) of this section.

(ii) *Failure to disenroll does not expand geographic area.* If the organization does not disenroll an enrollee who has moved out of its geographic area, that area is not automatically expanded to encompass the location of the enrollee's new residence.

(iii) *When HCFA's liability ends.* The provisions of paragraph (a)(1)(ii) of this section apply.

(iv) *Exception.* An organization may, if the enrollee agrees, retain as a member an enrollee who permanently moves out of the organization's geographic area. For purposes of this section, a permanent move means an uninterrupted absence of more than 90 days from the organization's geographic area. The restriction on obtaining services under § 417.448(a) does not apply to these enrollees. Organizations that choose to exercise this exception must do so for all their Medicare enrollees who permanently move out of the organization's geographic area.

(3) *Failure to convert to risk provisions of contract*—(i) *Disenrollment and notice.* A risk organization must disenroll a current, nonrisk Medicare enrollee if the enrollee refuses to convert to the risk provisions of the organization's contract after HCFA has determined under § 417.444(a)(1) that all of the organization's current nonrisk Medicare enrollees must be converted. The organization must notify the enrollee that failure to convert will result in disenrollment. The notice must be sent at least 30 days before the organization notifies HCFA of the disenrollment.

(ii) *When HCFA's liability ends.* The provisions of paragraph (a)(1)(ii) of this section apply.

(4) *Enrollee commits fraud or permits abuse of organization membership card.* (i) A Medicare beneficiary may be disenrolled by the organization if the beneficiary knowingly provides, on the application form, fraudulent information upon which an organization relies and which materially affects his or her eligibility to enroll in the organization, or if the beneficiary intentionally permits others to use his or her membership card to receive services from the organization. (ii) In either case, the organization must give the beneficiary a written notice of termination of enrollment. The notice must be mailed to the enrollee prior to the submission of the disenrollment notice to HCFA. The notice must include an explanation of the enrollee's right to have the disenrollment heard under the grievance procedures established under § 417.436.

(iii) The liability of HCFA to make monthly capitation payments to the organization on behalf of the beneficiary terminates as of the first day of the month in which the termination of the membership in the organization is made effective, as shown on HCFA records. In no event may that month be earlier than the month immediately following, or later than the third month following the month in which the disenrollment notice is received in acceptable form by HCFA.

(iv) The organization must report any disenrollment made under the provisions of this paragraph (a)(4) to the Inspector General of the Department.

(5) *Enrollee's entitlement to benefits under the supplementary medical insurance program ends.* (i) The liability of HCFA to make monthly capitation payments to the organization on behalf of the beneficiary ends with the month immediately following the last month of entitlement to benefits under Part B of Medicare. The beneficiary may be continued as an enrollee other than as a Medicare enrollee by the organization under its regular plan if the organization and the enrollee so choose.

(ii) If an enrollee loses entitlement to benefits under Part A of Medicare but remains entitled to benefits under Part B, the enrollee automatically continues as a Medicare enrollee of the organization and is entitled to receive and have payment made for Part B services beginning with the month immediately following the last month of his or her entitlement of Part A benefits.

(6) *Disenrollment for cause.*—(i) *When cause may be cited.* An organization may disenroll a Medicare enrollee for cause if the enrollee's behavior is disruptive, unruly, abusive, or uncooperative to the extent that his or her continuing membership in the organization seriously impairs the organization's ability to furnish services to either the enrollee or other members.

(ii) *Effort to resolve the problem.* The organization must make a serious effort to resolve the problem presented by the enrollee, including the use (or attempted use) of internal grievance procedures.

(iii) *Consideration of extenuating circumstances.* The organization must ascertain that the enrollee's behavior is not related to the use of medical services or mental illness.

(iv) *Documentation.* The organization must document the problems, efforts, and medical conditions as described in paragraphs (a)(6) (i), (ii), and (iii) of this section.

(v) *HCFA review of an organization's proposed disenrollment.* HCFA will decide, based on a review of the documentation submitted by the organization, whether disenrollment requirements have been met. HCFA will make this decision within 20 working days of receipt of the documentation material, and notify the organization within five working days after its decision is made.

(vi) *Effective date of disenrollment.* If HCFA permits an organization to disenroll an enrollee for cause, the disenrollment takes effect on the first day of the calendar month after the month in which the organization complies with the notice requirements in paragraphs (a)(1)(i) (B) and (C) of this section (other than the right to a hearing as described in paragraph (a)(1)(i)(B) of this section).

(vii) *When HCFA's liability ends.* The provisions of paragraph (a)(1)(ii)(A) of this section apply.

(7) *Death of the enrollee.* The liability of HCFA for payments to the organization on behalf of a Medicare enrollee who dies ends as of the first day of the month following the month of death.

(b) *Disenrollment by the enrollee.* (1) A Medicare enrollee may disenroll at any time by giving the organization a signed, dated request in the form and manner prescribed by the organization. The enrollee may request a certain disenrollment date but it may be no earlier than the first day of the second month following the month in which the organization receives the request.

(2) The organization must submit a disenrollment notice to HCFA within 30 days of receipt of the enrollee's request.

(3) HCFA's responsibility for payments to the organization ends with the close of the month of termination requested by the enrollee and approved by the organization.

(4) If the organization fails to submit the notice required in paragraph (b)(2) of this section on a timely basis, the organization must reimburse HCFA for any capitation payments received after the month in which payments would have ceased if the requirement had been met timely.

(c) *Effect of termination or default of contract*—(1) *Termination of contract.* If the contract between HCFA and the organization is terminated by mutual consent or by unilateral action of either party, HCFA's liability for payments ends as of the first day of the month after the last month for which the contract is in effect.

(2) *Default of contract.* If the organization defaults on the contract before the end of the contract year because of bankruptcy or other reasons, HCFA will—

(i) Determine the month in which its liability for payments ends; and

(ii) Notify the organization and all affected Medicare enrollees as soon as practicable.

Contract Requirements

§ 417.470 Basis and scope.

(a) *Basis.* Sections 417.472 through 417.494 implement those portions of section 1876(c), (g), (h), and (i) of the Act that pertain to the contract between HCFA and an organization for participation in the Medicare program.

(b) *Scope.* Sections 417.472 through 417.494 set forth—

(1) Specific contract requirements; and

(2) Procedures for renewal, nonrenewal, or termination of a contract.

§ 417.472 Basic contract requirements.

(a) *Submittal of contract.* In order for an eligible organization to participate in the Medicare program, an authorized official of the organization must sign and submit a contract that meets the requirements of this subpart and any other provisions required by HCFA.

(b) *Contract provisions for all eligible organizations.* The contract must provide that the organization agrees to comply with all the applicable requirements and conditions set forth in this subpart and general instructions of HCFA.

(c) *Other contract provisions.* In addition to the requirements set forth in §§ 417.474 through 417.488, the contract must contain any other terms and conditions that HCFA requires to implement section 1876 of the Act.

(d) *Exemption from Federal procurement regulations.* The Federal Acquisition Regulations and HHS Acquisition Regulations contained in Title 48 of the Code of Federal Regulations do not apply to Medicare contracts under section 1876 of the Act.

(e) *Compliance with civil rights laws.* The organization must comply with title VI of the Civil Rights Act of 1964 (regulations at 45 CFR Part 80), section 504 of the Rehabilitation Act of 1973 (regulations at 45 CFR Part 84), and the Age Discrimination Act of 1975 (regulations of 45 CFR Part 91).

(f) *Authority to waive conflicting contract requirements.* Under section 1876(l)(5) of the Act, the Secretary is authorized to administer the terms of this subpart without regard to provisions of law or other regulations relating to the making, performance, amendment, or modification of contracts of the United States if he or she determines that those provisions are inconsistent with the efficient and effective administration of the Medicare program.

§ 417.474 Effective date and term of contract.

(a) The contract must specify its effective date.

(b) The effective date may not be earlier than the date it is signed by both HCFA and the organization.

(c) The contract must specify the duration of its term. However, the initial term of the contract must be at least 12 months, but not more than 23 months; and any subsequent term must be for a period of 12 months.

§ 417.476 Waived conditions.

The contract must specify the following information for each of the qualifying conditions required under §§ 417.410 through 417.418 that is waived by HCFA:

(a) The specific terms of the waiver.

(b) The expiration date of the waiver.

(c) Any other information required by HCFA.

§ 417.478 Requirements of other laws and regulations.

The contract must provide that the organization agrees to comply with—

(a) The requirements for PRO review of services furnished to Medicare enrollees as set forth in Subchapter D of this chapter;

(b) Sections 1318(a) and (c) of the PHS Act, which pertain to disclosure of certain financial information;

(c) Section 1301(c)(8) of the PHS Act, which relates to liability arrangements to protect members of the organization; and

(d) The reporting requirements in § 110.108(j)(i) of this title, which pertain to the monitoring of an organization's continued compliance. For purposes of this paragraph, references in that section to "HMO" are also deemed references to "CMP".

§ 417.480 Maintenance of records: Reasonable cost organizations.

A contract with a reasonable cost organization must provide that the organization agrees to maintain books, records, documents, and other evidence of accounting procedures and practices that—

(a) Are sufficient to—

(1) Ensure an audit trial; and

(2) Properly reflect all direct and indirect costs claimed to have been incurred under the contract; and

(b) Include at least records of the following:

(1) Ownership, organization, and operation of the organization's financial, medical, and other recordkeeping systems.

(2) Financial statements for the current contract period and three prior periods.

(3) Federal income tax or information returns for the current contract period and three prior periods.

(4) Assets acquisition, lease, sale, or other action.

(5) Agreements, contracts, and subcontracts.

(6) Franchise, marketing, and management agreements.

(7) Schedules of charges for the organization's fee-for-service patients.

(8) Matters pertaining to costs of operations;

(9) Amounts of income received by source and payment.

(10) Cash flow statements.

(11) Any financial reports filed with other Federal programs or State authorities.

§ 417.481 Maintenance of records: Risk organizations.

A contract with a risk organization must provide that the organization agrees to maintain, and make available to HCFA upon request, books, records, documents, and other evidence of accounting procedures and practices that—

(a) Are sufficient to—

(1) Establish component rates of the ACR for determining additional and supplementary benefits; and

(2) Determine the rates utilized in setting premiums for State insurance agency purposes; and

(b) Include at least any records or financial reports filed with other Federal agencies or State authorities.

§ 417.482 Access to facilities and records.

The contract must provide that the organization agrees to the following:

(a) HHS may evaluate, through inspection or other means, the quality, appropriateness, and timeliness of services furnished under the contract to its Medicare enrollees.

(b) HHS may evaluate, through inspection or other means, the facilities of the organization when there is reasonable evidence of some need for that inspection.

(c) HHS, the Comptroller General, or their designees may audit or inspect any books and records of the organization or its transferee that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the contract.

(d) HHS may evaluate, through inspection or other means, the enrollment and disenrollment records for the current contract period and three prior periods, when there is reasonable evidence of some need for that inspection.

(e) In the case of a reasonable cost organization, to make available for the purposes specified in paragraphs (a), (b), (c), and (d) of this section, its premises, physical facilities, and equipment, its records relating to its Medicare enrollees, the records specified in § 417.480 and any additional relevant information that HCFA may require.

(f) That the right to inspect, evaluate, and audit, will extend through three years from the date of the final settlement for any contract period unless—

(1) HCFA determines there is a special need to retain a particular record or group of records for a longer period and notifies the organization at least 30 days before the normal disposition date;

(2) There has been a termination, dispute, fraud, or similar fault by the organization, in which case the retention may be extended to three years from the date of any resulting final settlement; or

(3) HCFA determines that there is a reasonable possibility of fraud, in which case it may reopen a final settlement at any time.

§ 417.484 Requirement applicable to related entities.

(a) *Definition.* As used in this section, "related entity" means any entity that is related to the organization by common ownership or control and—

(1) Performs some of the organization's management functions under contract or delegation;

(2) Furnishes services to Medicare enrollees under an oral or written agreement; or

(3) Leases real property or sells materials to the organization at a cost of more than $2,500 during a contract period.

(b) *Requirement.* The contract must provide that the organization agrees to require all related entities to agree that—

(1) HHS, the Comptroller General, or their designees have the right to inspect, evaluate, and audit any pertinent books, documents, papers, and records of the subcontractor involving transactions related to the subcontract; and

(2) The right under paragraph (b)(1) of this section to information for any particular contract period will exist for a period equivalent to that specified in § 417.482(f).

§ 417.486 Disclosure of information and confidentiality.

The contract must provide that the organization agrees—

(a) To submit to HCFA—

(1) All financial information required under §§ 417.530 through 417.576 and for final settlement; and

(2) Any other information necessary for the administration or evaluation of the Medicare program.

(b) To comply with the requirements set forth in Part 420, Subpart C, of this chapter pertaining to the disclosure of ownership and control information;

(c) To comply with the requirements of the Privacy Act, as implemented by 45 CFR Part 5b and Subpart B of Part 401 of this chapter, with respect to any system of records developed in performing carrier or intermediary functions under §§ 417.532 and 417.533; and

(d) To meet the confidentially requirements of § 405.1026(a) of this chapter for medical records and for all other information on enrollees, not covered under paragraph (c) of this section, that is contained in its records or obtained from HCFA or others.

§ 417.488 Written notice of termination.

A risk contract must provide that if the contract is terminated, the organization agrees to give to its Medicare enrollees, and to be responsible for the cost of, the following notices.

(a) A written notice of the termination at least 60 days before the termination date.

(b) A written description of alternatives available for obtaining Medicare services after termination.

§ 417.490 Renewal contract.

A contract with an organization is renewed automatically for the next 12-month period unless HCFA or the organization decides not to renew, in accordance with § 417.492.

417.492 Nonrenewal of contract.

(a) *Nonrenewal by the organization.* (1) If an organization does not intend to renew its contract, it must—

(i) Give written notice to HCFA at least 90 days before the end of the current contract period;

(ii) Notify each Medicare enrollee by mail at least 60 days before the end of the contract period; and

(iii) Notify the general public at least 30 days before the end of the contract period, by publishing a notice in one or more newspapers of general circulation in each community or county located in the organization's geographic area.

(2) HCFA may accept a nonrenewal notice submitted less than 90 days before the end of a contract period if—

(i) The organization notifies its Medicare enrollees and the public in accordance with paragraph (a)(1) of this section; and

(ii) Acceptance would not otherwise jeopardize the effective and efficient administation of the Medicare program.

(b) *Nonrenewal by HCFA.* If HCFA decides not to renew a contract, it will notify interested parties of certain information, as follows:

(1) The organization at least 90 days before the end of the contract peiod;

(2) the organization's Medicare enrollees at least 60 days before the end of the contract period;

(3) The general public at least 30 days before the end of the contract period; and

(4) The organization that if the organization is dissatisfied with the decision, and HCFA's decision was based on one of the reasons specified in § 417.640(c), the organization may appeal that decision in accordance with procedures specified in §§ 417.640 through 417.682.

§ 417.494 Modification or termination of contract.

(a) *Modification or termination by mutual consent.* (1) HCFA and an organization may modify or terminate a contract at any time by written mutual consent.

(2) If the contract is modified, the organization must notify its Medicare enrollees of any changes that HCFA determines are appropriate for notification.

(3) If the contract is terminated, the organization must notify its Medicare enrollees, and HCFA will notify the general public, at least 30 days before the termination date.

(b) *Termination by HCFA.* (1) HCFA may terminate a contract for any of the following reasons:

(i) The organization has failed substantially to carry out the terms of the contract.

(ii) The organization is carrying out the contract in a manner that is inconsistent with the effective and efficient implementation of section 1876 of the Act.

(iii) PHS determines that the organization no longer meets the applicable conditions necessary to qualify as an eligible organization under section 1876 of the Act and this subpart.

(2) If HCFA determines that a contract will be terminated, it will send written notice to the organization and indicate the organization's right to appeal that determination in accordance with the procedures specified in §§ 417.640 through 417.682.

(3) An organization with a risk contract must notify its Medicare enrollees of the termination as described in § 417.488.

(4) HCFA will notify the organization's Medicare enrollees and the general public of the termination at least 30 days before the termination date.

(c) *Termination by the organization.* The organization may terminate the contract if HCFA has failed substantially to carry out the terms of the contract.

(1) The organization must notify HCFA at least 90 days before the effective date of the termination and must include in its notice the reasons for the termination.

(2) The organization must notify its Medicare enrollees of the termination at least 60 days before the termination date. Risk organizations must also provide a written description of alternatives available for obtaining Medicare services after termination of the contract. The organization is responsible for the cost of these notices.

(3) The organization must notify the general public of the termination at least 30 days before the termination date.

(4) The contract will be terminated effective 60 days after the notice to Medicare enrollees is mailed, as required in paragraph (c)(2) of this section.

(5) HCFA's liability for payment ends as specified in § 417.460(c).

Change of Ownership and Leasing of Facilities.

§ 417.520 General provisions.

(a) *Definitions.* As used in this subpart—

Lessee means the entity to which an organization leases all or part of its facilities.

Lessor means the organization that leases all or part of its facilities to another entity.

Novation agreement means a document executed and signed by the current owner of the organization, the proposed new owner, and HCFA, under which HCFA recognizes the new owner as the successor in interest to the current owner's Medicare contract.

(b) *Basic rules*—(1) *Change of ownership.* Except as provided in paragraph (b)(3)(ii) of this section, a change of ownership of an organization makes its Medicare contract invalid with respect to the period following the change of ownership, unless there is a novation agreement.

(2) *Effect of change without novation agreement.* If the new owner wishes to participate in the Medicare program, it must notify HCFA of the change of ownership and apply for and enter into a contract in accordance with §§ 417.472 through 417.488.

(3) *Advance notice of HCFA.* (i) An organization with a contract under this subpart that is considering or negotiating a change of ownership must notify HCFA at least 60 days before the anticipated change.

(ii) If the organization fails to provide the required notice to HCFA timely, it will continue to be liable for capitation payments HCFA makes to it on behalf of Medicare enrollees after the date of change of ownership.

§ 417.521 What constitutes change of ownership.

(a) *Partnership.* The removal, addition, or substitution of a partner, unless the partners expressly agree otherwise as permitted by applicable State law, constitutes a change ownership.

(b) *Unincorporated sole proprietorship.* Transfer of title and property to another party constitutes change of ownership.

(c) *Corporation.* (1) The merger of the organization's corporation into another corporation or the consolidation of the organization with one or more other corporations, resulting in a new corporate body, constitutes a change of ownership.

(2) Transfer of corporate stock or the merger of another corporation into the organization's corporation with the organization surviving, does not ordinarily constitute change of ownership.

§ 417.522 Novation agreement requirements.

(a) *Conditions for HCFA approval of a novation agreement.* HFCA will approve a novation agreement if the following conditions are met:

(1) *Advance notification.* The organization notifies HCFA at least 60 days before the date of the proposed change of ownership.

(2) *Advance submittal of agreement.* The organization submits to HCFA, at least 30 days before the proposed change of ownership date, three signed copies of the novation agreement containing the provisions specified in paragraph (b) of this section, and one copy of other relevant documents required by HCFA.

(3) *HCFA's determination.* HCFA determines that—

(i) The proposed new owner is in fact a successor in interest to the contract;

(ii) Recognition of the new owner as a successor in interest to the contract is in the best interest of the Medicare program; and

(iii) The Assistant Secretary of Health has certified that successor organization meets the PHS requirements to qualify as an eligible organization.

(b) *Provisions of a novation agreement*—(1) *Assumption of contract obligations.* The new owner must assume all obligations under the contract.

(2) *Waiver of right to reimbursement.* The previous owner must waive its rights to reimbursement for covered services furnished during the rest of the current contract period.

(3) *Guarantee of performance.*

(i) The previous owner must guarantee performance of the contract by the new owner during the contract period; or

(ii) The new owner must post a performance bond that is satisfactory to HCFA.

(4) *Records Access.* The previous owner must agree to make its books and records and other necessary information available to the new owner and to HCFA to permit an accurate determination of costs for the final settlement of the contract period.

§ 417.523 Effect of leasing of an organization's facilities.

(a) *Effect of lessee status.* If an organization leases all or part of its facilities to another entity, the lessee does not acquire eligible organization status under section 1876 of the Act.

(b) *Effect of lease of all facilities.* (1) If an organization leases all of its facilities to another entity, the contract terminates.

(2) If the lessee wishes to participate in Medicare as an eligible organization, it must apply for and enter into a contract in accordance with this subpart.

(c) *Effect of partial lease of facilities.* If the organization leases part of its facilities to another entity, its contract with HCFA remains in effect while HCFA surveys the organization to determine whether it continues to be in compliance with the requirements and qualifying conditions specified in §§ 417.410 through 417.416.

General Reimbursement Rules

§ 417.524 Payment to eligible organizations: General.

(a) *Basic rule.* The payments made to an eligible organization in accordance with the provisions of this subpart for furnishing covered Medicare services are in lieu of any payment that would otherwise be made to a beneficiary or the organization under sections 1814(b) and 1833(a) of the Act.

(b) *Basis of payment.* Reimbursement to eligible organizations is made on either a reasonable cost basis or a risk basis depending on the type of contract the organization has with HCFA. In certain cases, organizations that have contracted on a risk basis also receive reimbursement on a reasonable cost basis for certain Medicare enrollees. (See § 417.444 for a discussion of this provision.)

§ 417.526 Payment for covered services.

Sections 417.530 through 417.576 set forth the principles that HCFA follows in determining Medicare reimbursement to an eligible organization that has a reasonable cost contract. Sections 417.580 through 417.596 describe the per capita method of Medicare reimbursement to eligible organizations that contract on a risk basis.

§ 417.528 Payment for covered services—Medicare not primary payor.

(a) HCFA may not reimburse an organization for services to the extent that Medicare is not the primary payor under the provisions of section 1862(b) of the Act. The circumstances under which an organization may charge, or authorize a provider to charge, for covered Medicare services where Medicare is not the primary payor are stated in paragraphs (b) and (c) of this section.

(b) If a Medicare enrollee receives otherwise covered services from an eligible organization for which the enrollee is entitled to benefits under a State or Federal worker's compensation law or plan, an automobile medical, or no-fault insurance, or any liability insurance policy or plan, including a self-insured plan, the organization 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 compensated under the law or policy.

(c) An eligible organization may charge an employer group health plan for covered services furnished by the organization to a Medicare enrollee and may charge the Medicare enrollee to the extent that he or she has been reimbursed by the employer group health plan for these covered services if—

(1) The Medicare enrollee is covered by the group health plan; and

(2) HCFA is not permitted to make payment for the covered services furnished under the provisions of sections 1862(b)(2) or 1862(b)(3)(A)(i) of the Act.

(d) An organization must—

(1) Identify payors that are primary to Medicare under section 1862(b) of the Act;

(2) Determine the amounts payable by these payors; and

(3) Coordinate the benefits of its Medicare enrollees with these payors.

Reasonable Cost Reimbursement

§ 417.530 Basis and scope.

Sections 417.530 through 417.576 set forth the principles that HCFA follows in determining the amount it will pay to an organization for services furnished by the organization to its Medicare enrollees for whom HCFA reimburses the organization on a reasonable cost basis (or under section 1886 of the Act, as applicable). 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 in Subpart D of Part 405 of this chapter for reimbursement of provider costs on a reasonable cost basis.

§ 417.531 Hospice care services.

(a) If a Medicare enrollee of an organization with a reasonable cost contract makes an election under § 418.24 of this chapter to receive hospice care services, reimbursement for these services is made to the hospice participating in the Medicare program that furnishes the services in accordance with Part 418 of this chapter.

(b) While the enrollee's hospice election is in effect, the organization may be reimbursed on a reasonable cost basis for only the following covered Medicare services furnished to the Medicare enrollee:

(1) Services of the enrollee's attending physician if the physician is an employee or contractor of the organization and is not employed by or under contract to the enrollee's hospice.

(2) Services not related to the treatment of the terminal condition for which hospice care was elected or a condition related to the terminal condition.

§ 417.532 General considerations.

(a) *Conditions and criteria for reimbursement.* (1) The costs incurred by the organization to furnish services covered by Medicare are reimbursable if they are—

(i) Proper and necessary;

(ii) Reasonable in amount; and

(iii) Except as provided in § 417.550, appropriately apportioned among the organization's Medicare enrollees, other enrollees, and nonenrolled patients.

(2) In determining fair and equitable reimbursement for the organizations, HCFA generally applies the cost reimbursement principles set forth in § 405.402 (a) and (b) of this chapter.

(3) Except as specified in paragraph (a)(4) of this section, in judging whether costs are reasonable, HCFA applies the weighted average to the AAPCCs of each class of the organization's Medicare enrollees (as defined in § 417.582) for the organization's geographic area as an absolute limitation on the total amount payable.

(4) For contract periods beginning before January 1, 1986, an entity with an existing cost contract is not subject to the reimbursement limitation specified in paragraph (a)(3) of this section. In judging whether costs for these organizations are reasonable, HCFA may consider the per capital costs

incurred by the organization for its Medicare enrollees in relation to the AAPCC for the organization's geographic area or a similar area. In those cases, HCFA will use the AAPCC as a general guideline for reimbursement to a reasonable cost organization rather than as a reimbursement limitation.

(b) *Method and amount of reimbursement to the organization.* (1) HCFA makes interim per capita payments each month for each Medicare enrollee, equivalent to the interim per capita cost rate determined in accordance with § 417.570.

(2) HCFA adjusts the interim per capita rate as necessary during the contract period and makes final adjustments at the end of the contract period.

(3) In determining the amount due the organization, HCFA deducts from the reasonable cost actually incurred by the organization for covered services furnished to its Medicare enrollees, an amount equal to the actuarial value of the applicable Medicare Part A and Part B deductible and coinsurance amounts that would have applied to the covered services for which payment is being made if these enrollees had not enrolled in the organization or another eligible organization.

(c) *Election by organization.* An organization must elect, on an individual provider basis, one of the following methods for reimbursement for hospital and SNF services it furnishes to Medicare enrollees:

(1) Direct payment by HCFA.

(2) Direct payment by the organization.

(d) *Notice of election.* The election must be made in writing before the beginning of the contract period and is binding for that period.

(e) *Reimbursement by organization.* If the organization elects to pay providers directly, as provided in paragraph (c) of this section, it must—

(1) Determine the eligibility of its Medicare enrollees to receive covered services through the organization;

(2) Make proper coverage decisions and appropriate payments, in accordance with §§ 421.100 and 421.200 of this chapter, for the services furnished to its Medicare enrollees;

(3) Ensure that providers maintain and furnish appropriate documentation of physician certification and recertification, to the extent required under Subpart P of Part 406 of this chapter; and

(4) Carry out any other procedures required by HCFA.

(f) *Review of organization's bill processing capabilities.* If the organization elects to pay providers directly, HCFA will determine whether the organization has the experience and capability to carry out the responsibilities specified in paragraph (e) of this section in an efficient and effective manner.

(g) *Direct reimbursement by HCFA.* Under the election specified in paragraph (c)(1) of this section, HCFA pays a provider for the covered services it furnishes to the organization's Medicare enrollees on a reasonable cost basis or on the basis of prospectively determined rates, whichever is applicable to that provider as described in Subpart D of Part 405 of this chapter. HCFA will deduct these payments and any other payments made by intermediaries or carriers on behalf of the organization (for example, payments for emergency or urgently needed services made under § 417.558(a)) in computing the payments to the organization under paragraph (b) of this section.

(h) *Reimbursement for services furnished to Medicare beneficiaries not enrolled in the organization.* HCFA reimburses the organization for services it furnishes to Medicare beneficiaries who are not its enrollees through the organization's Medicare intermediary or carrier, as appropriate.

§ 417.533 Part B carrier responsibilities.

In paying for Part B services furnished to its enrollees by suppliers, the organization is responsible for—

(a) Determining the eligibility of individuals to receive those services through the organization;

(b) Making proper coverage decisions and appropriate payment as authorized under § 421.200 of this chapter for the services for which its Medicare enrollees are eligible; and

(c) Carrying out any other procedures that HCFA may require.

§ 417.534 Allowable costs.

(a) *Definition—Allowable costs* means the direct and indirect costs, including normal standby costs incurred by the organization, that are proper and necessary for efficient delivery of needed health care services. They include the costs of furnishing services to the organization's Medicare enrollees, other enrollees, and nonenrolled patients, which are typical "provider" costs, and costs (such as marketing, enrollment, membership, and operation of the organization) that are peculiar to health care prepayment organizations.

(b) *Basic rules.* (1) The allowability of an organization's costs for furnishing services is generally determined in accordance with principles applicable to provider costs, as set forth in § 417.536.

(2) The allowability of other costs is determined in accordance with principles set forth in §§ 417.538 through 417.550.

(3) Costs for covered services for which Medicare is not the primary payor, as described in § 417.528, are not allowable.

§ 417.536 Provider cost reimbursement principles applicable to the organizations.

(a) *Applicability.* Unless otherwise specified in this subpart, the principles or reasonable cost reimbursement set forth in Subpart D of Part 405 of this chapter are applicable to the organization's costs when incurred by an organization or by providers of services and other facilities owned or operated by the organization, or related to the organization by common ownership or control. This most common examples of these costs are set forth in this section.

(b) *Depreciation.* An appropriate allowance for depreciation on buildings and equipment is an allowable cost, in accordance with §§ 405.415, 405.417, and 405.418 or this chapter.

(c) *Interest expense.* Necessary and proper interest on both current and capital indebtedness is an allowable cost, in accordance with § 405.419 of this chapter.

(d) *Cost of educational activities.* An appropriate part of the net cost of approved educational activities of a provider or other health care facility owned or operated by an organization is an allowable cost in accordance with § 405.421 of this chapter.

(e) *Compensation of owners.* An appropriate amount of compensation for services of owners is an allowable cost, if the services are actually performed and are necessary, as specified in § 405.426 of this chapter.

(f) *Bad debts.* (1) In accordance with § 405.420 of this chapter, bad debts are deductions from revenue and may be included as allowable costs only if—

(i) They are attributable to Medicare deductible and coinsurance amounts for which the Medicare enrollee is liable, and

(ii) The organization has made a reasonable, but unsuccessful, effort to collect those amounts.

(2) If all or part of the deductible and coinsurance amounts is payable through a monthly premium or other periodic payment, the amount allowed as a bad debt may not exceed three times the monthly rate for the actuarial value of the deductible and coinsurance amounts, or its equivalent, if the periodic payment is on other than a monthly basis.

(3) Any bad debt related to a service furnished to a Medicare enrollee or the organization, and claimed on a cost report submitted for reimbursement by a provider or other facility reimbursed on a cost basis, may not be claimed as a bad debt by the organization.

(g) *Charity and courtesy allowances.* As specified in § 405.420 of this chapter, charity and courtesy allowances are deductions for revenue and may not be included as allowable costs.

(h) *Research costs.* As specified in § 405.422 of this chapter, costs incurred for research purposes, over and above patient care, are not allowable costs.

(i) *Value of services of nonpaid workers.* The value of services of nonpaid workers of an organization is not an allowable cost, except as provided in § 405.425 of this chapter.

(j) *Purchase discounts and allowances and refund of expenses.* Discounts and allowances that an organization receives on purchases of goods and services and refunds of previous expense payments must be deducted from the costs to which they relate, in accordance with § 405.425 of this chapter.

(k) *Cost to related organizations.* (1) The costs of services, facilities, or supplies furnished to an organization by a related entity are allowable at the cost to the related entity in accordance with § 405.427 of this chapter.

(2) An entity is not considered related to the organization merely because—

(i) It has a risk or incentive agreement under which the organization reimburses or compensates the entity for services it furnishes to the organizations's enrollees; or

(ii) Substantially all the services the entity furnishes are furnished to the organization's enrollees.

(3) However, an entity described in paragraph (k)(2) of this section and an organization are considered related if either of them is in a position to exercise significant management or ownership influence or control over the other.

(l) *Return on equity capital of proprietary providers owned by the organization.* An allowance for a reasonable return on equity capital invested and used in providing services is allowable in addition to the reasonable cost of services furnished by a proprietary provider owned by the organization. The amount of the allowance is determined in accordance with § 405.429 of this chapter.

(m) *Limitations on reimbursement.* Medicare payment for covered services furnished by entities owned by or operated by, or related to, an organization reimbursed on a reasonable cost basis is subject to certain provisions of Subparts D and E of Part 405 of this chapter that pertain to reasonable cost and reasonable charge. Those provisions include, but are not necessarily limited to, the following:

(1) For ESRD treatment, the limitations authorized under §§ 405.439, 405.542, and 405.544 of this chapter.

(2) For services of physical, occupational, and speech therapists and other therapists and nonphysician health specialists, the limitations set forth in § 405.432 of this chapter.

(3) For drugs, the allowable cost as determined under § 405.433 of this chapter.

(4) The overall cost limits established in accordance with § 405.460 of this chapter.

(5) The limitation to the lesser of reasonable cost or customary charges, as set forth in § 405.455 of this chapter.

§ 417.538 Enrollment and marketing costs.

(a) *Principle.* Enrollment and marketing costs incurred by an organization in the course of performing the activities described in §§ 417.426 through 417.436 are allowable as provided in this section.

(b) *Definition.* Allowable enrollment and marketing costs are those necessary and proper costs incurred in offering the organization's plan to potential enrollees in accordance with this part. Those costs include selling, advertising, promotional, and other marketing costs and may not exceed an amount that would be incurred by a prudent and cost-conscious management.

(c) *Application.* Enrollment and marketing costs are allowable, whether incurred directly by organization staff or under contract with marketing specialists or other outside consultants.

(d) *Reimbursement limitation.* The relatively higher costs that an organization is likely to incur in initially offering its plan to Medicare beneficiaries are taken into account in determining whether enrollment and marketing costs are reasonable in amount. However, if such costs exceed amounts that would be paid by prudent management, the excess is not allowable.

§ 417.540 Membership costs.

(a) *Principle.* Membership costs are allowable if incurred in maintaining and servicing subscriber contracts for prepayment enrollees.

(b) *Kind of costs included.* Membership costs include, but are not limited to, reasonable costs incurred in connection with maintaining statistical, financial, and other data on enrollees.

§ 417.542 Reinsurance costs.

Reinsurance costs are not allowable.

§ 417.544 Physicians' services furnished directly by the organization.

(a) *Principles.* Conpensation paid by an organization to physicians is an allowable cost to the extent that it is commensurate with the compensation paid for similar services performed by similar physicians practicing in the same or a similar locality. Physician compensation may take various forms, but the aggregate compensation allowable must be reasonable in relation to the services personally furnished. If aggregate physician compensation costs exceed what is normally incurred, the excess is not a reasonable cost.

(b) *Application.* In determining the allowability of the costs of physicians' services, the cost of personal services (for example, expenses attributable to salaries, wages, incentive payments, fringe benefits) must be distinguished from the cost of nonpersonal services (for example, expenses attributable to facilities, equipment, support personnel, supplies). To be allowable, compensation must be reasonable in relation to the personal services furnished.

§ 417.546 Physicians' services and other Part B supplier services furnished under arrangements.

(a) *General principle.* Except as specified in paragraph (b) of this section, the amount paid by an organization for physicians' services and other Part B supplier services furnished under arrangements is an allowable cost to the extent it is reasonable. Costs are considered reasonable if they—

(1) Do not exceed those that a prudent and cost-conscious buyer would incur to purchase those services; and

(2) Are comparable to costs incurred for similar services furnished by similar physicians or other suppliers in the same or a similar geographic area.

(b) *Special limitation for entities with existing cost contracts.* For entities with existing cost contracts, the provisions of this paragraph apply for contract periods beginning before January 1, 1986.

(1) If the organization pays for physicians' services and other Part B supplier services on other than a fee-for-service basis—

(i) Except as specified in paragraph (b)(1)(ii) of this section, the costs incurred by the organization may be considered reasonable if they—

(A) Do not exceed those that a prudent and cost-conscious buyer would incur to purchase those services; and

(B) Are comparable to costs incurred for similar services furnished by similar physicians or other suppliers in the same or a similar locality.

(ii)(A) If a physician group to whom the organization makes payment compensates its physicians on a fee-for-service basis, the organization's payment to the group may not exceed the reasonable charges for those services, as defined in Subpart E of Part 405 of this chapter.

(B) Payment in excess of the limits specified in paragraph (b)(1)(ii)(A) of this section is allowable if the group has procedures under which members of the group accept effective incentives, such as risk-sharing, designed to avoid unnecessary or unduly costly utilization of health services. In such cases, the amount paid by the organization is considered reasonable if it meets the conditions specified in paragraph (b)(1)(i) of this section.

(2) If the organization pays for physicians' services and other Part B supplier services on a fee-for-service basis—

(i) Except as specified in paragraph (b)(2)(ii) of this section, the costs incurred by the organization are considered reasonable if they do not exceed—

(A) The reasonable charges for those services, as defined in Subpart E of Part 405 of this chapter; and

(B) The amount that HCFA would pay for those services, if they were furnished to beneficiaries who are not enrolled in the organization and who receive the services from sources other than providers of services or other entities that are reimbursed on a reasonable cost basis.

(ii) Payment to a physician group organized on an individual-practice basis is not subject to the limitations specified in paragraph (b)(2)(i) of this section if the group pays its physicians on a fee-for-service basis and has procedures under which the members of the group accept effective incentives, such as risk-sharing, designed to avoid unnecessary or unduly costly utilization of health services. In such cases, the amount paid by the organization is considered reasonable if it meets the conditions specified in paragraph (b)(1)(i) of this section.

§ 417.548 Provider services through arrangements.

(a) *Principle.* The cost incurred by an organization for covered services furnished under arrangement with a provider is allowable to the extent that it would be allowable and reimbursable under Subpart D of Part 405 of this chapter, unless, upon the organization's petition to HCFA, the organization can demonstrate to HFCA's satisfaction that payment in excess of the amount authorized under Subpart D of Part 405 of this chapter is justified on the basis of advantages gained by the organization.

(b) *Application.* An advantage gained must represent a real and tangible benefit received by the organization for the excess cost incurred, and any excess payment is subject to other applicable requirements of Part 405 of this chapter, including tests of reasonableness. For example, in the case of an arrangement an organization has with a provider that is located outside the organization's geographic area and that is not related to the organization by common ownership or control, payment of the provider's charges to the organization (rather than the provider's reasonable cost as determined under Subpart D of Part 405 of this chapter) may be justified in exchange for the advantages of not having to incur the administrative costs of determining the provider's reasonable cost and of making a more timely final settlement with the organization. However, repayment of the provider's charges would be acceptable only if—

(1) The provider furnishes services to the organization's enrollees infrequently;

(2) The charges represent an insignificant portion of total Medicare reimbursement to the organization; and

(3) The charges do not exceed the customary charges by the provider to its other patients for similar services.

§ 417.550 Special Medicare program requirements.

(a) *Principle.* Except as specified in paragraph (d) of this section, Medicare reimburses the total reasonable cost incurred by an organization for activities specified in this section that are solely for Medicare purposes and unique to Medicare contracts under section 1876 of the Act.

(b) *Application.* The following costs are reimbursed in full for cost-reimbursed Medicare enrollees:

(1) The reasonable cost of reporting data concerning increases and decreases in Medicare enrollment.

(2) The reasonable cost incurred, solely for Medicare purposes, for the independent certification of the organization's cost report required under § 417.576.

(3) The total reasonable cost of special data that HCFA requires from organizations solely for program planning and evaluation purposes.

(c) *Prior approval.* Costs that are reimbursed in full under this section must be separately budgeted and approved by HCFA before the contract period begins.

(d) *Exception: Apportioned costs.* (1) Payment in full is limited to the costs specified in paragraph (b) of this section.

(2) The normal administrative costs incurred by the organization in obtaining Medicare reimbursement (such as the cost of maintaining and reporting membership statistical, and actuarial data needed to determine the amount of reimbursement to the organization, and the cost of preparing costs reports) must be apportioned in accordance with § 417.552.

§ 417.552 Cost apportionment: General provisions.

(a) *Basic rule.* Except as provided in § 417.556(c), the organization must apportion its total allowable direct and indirect costs among its Medicare enrollees, its other enrollees, and its nonenrolled patients—

(1) In accordance with §§ 417.530 through 417.576; and

(2) Using methods approved by HCFA.

(b) *Purpose of apportionment.* The purpose of apportionment is to ensure that—

(1) The cost of services furnished to Medicare enrollees is not borne by other enrollees and nonenrolled patients; and

(2) The cost of the services furnished to other enrollees and nonenrolled patients is not borne by Medicare.

§ 417.554 Apportionment: Provider services furnished directly by the organization.

The Medicare share of the cost of covered services furnished to Medicare enrollees by providers that are owned or operated by the organization or are related to the organization by common ownership or control must be determined in accordance with the apportionment methods set forth in §§ 405.452, 405.453, 405.470 through 405.477, and 405.460 of this chapter.

§ 417.556 Apportionment: Provider services furnished by the organization through arrangements with others.

The Medicare share of the cost of covered services furnished to Medicare enrollees through arrangements with providers other than those specified in § 417.554 must be determined as follows:

(a) The Medicare share must be based on the cost the organization pays the provider under their arrangement, to the extent that cost is reasonable and within the limits established by §§ 417.534 through 417.548.

(b) Except as specified in paragraph (c) of this section, apportionment must

be on the same approved basis that is used by the provider for Medicare beneficiaries who are not Medicare enrollees of the organization, subject to the conditions and limitations set forth in § 417.548.

(c) If, because of the special nature or terms of the organization's arrangement with the provider, apportionment on the basis specified in paragraph (b) of this section would result in Medicare's bearing the costs of furnishing services to individuals other than the organization's Medicare enrollees, apportionment must be on another basis that is approved by HCFA and that will ensure that Medicare does not pay any of the cost of furnishing services to individuals who are not Medicare enrollees of the organization.

(d) If the organization elects to have providers reimbursed by the organization's Medicare intermediary, the Medicare share is the amount the intermediary paid the provider.

§ 417.558 Emergency and urgently needed services, and out-of-area services for which the organization assumes financial responsibility: Source of payment.

(a) *Payment by intermediary.* An intermediary may reimburse its providers for the reasonable cost of covered emergency or urgently needed services as defined in § 417.401, and other covered out-of-area services for which the organization assumes financial responsibility.

(b) *Payment by organization*—(1) *Basic rule.* Except as specified in paragraph (b)(2) of this section, a payment by the organization to a provider for emergency or urgently needed services as defined in § 417.401 or other out-of-area services is allowable only to the extent it would be allowable under Subpart D of Part 405 of this chapter.

(2) *Exception.* Payment in excess of the reasonable cost allowed under Subpart D of Part 405 of this chapter is allowable only if the organization demonstrates to HCFA's satisfaction that it is justified on the basis of advantages gained by the organization, as set forth in § 417.548.

§ 417.560 Apportionment: Part B physician and supplier services.

(a) *Medical services furnished directly by the organization.* The total allowable cost of Part B physician and supplier services furnished by employees or partners of the organization or by a related entity of the organization must be apportioned on the basis of the ratio of covered Part B services furnished to Medicare enrollees to total services furnished to all the organization's enrollees and nonenrolled patients. The organization must use a method for reporting costs that is approved by HCFA. HCFA will base its approval on a finding that the method—

(1) Results in an accurate and equitable allocation of allowable costs; and

(2) Is justifiable from an administrative and cost efficiency standpoint.

(b) *Medical services furnished under arrangements made by the organization.* When the organization pays for Part B physician and supplier services on some basis other than fee-for-services, the reasonable cost the organization pays under its financial arrangement with the physician or supplier must be apportioned between Medicare enrollees and others based on the ratio of covered services furnished to Medicare enrollees to the total services furnished to all enrollees and nonenrolled patients. If apportionment on this basis would result in Medicare bearing the cost of furnishing services to individuals who are not Medicare enrollees, the Medicare share must be determined on another basis (approved by HCFA) to ensure that Medicare pays only for services furnished to Medicare enrollees.

(c) *Medical services furnished under an arrangement that provides for the organization to pay on a fee-for-service basis.* The Medicare share of the cost of Part B physician and supplier services furnished to Medicare enrollees under arrangements, and paid for by the organization on a fee-for-service basis, is determined by multiplying the total amount for all such services by the ratio of charges for covered services furnished to Medicare enrollees to the total charges for all such services.

(d) *Emergency services, urgently needed services, and other covered medical services for which the organization assumes financial responsibility.* (1) Except as provided in paragraph (d)(2) of this section, the Medicare share of the cost of Part B emergency or urgently needed services or other Part B services that are not furnished by a provider and for which the organization accepts financial responsibility is determined in accordance with paragraphs (b) and (c) of this section.

(2) For contract periods beginning before January 1, 1986, in the case of entities with existing cost contracts, payment of the physician's or supplier's charges instead of the reasonable charges as defined in Subpart E of Part 405 of this chapter may be justified if the organization demonstrates to HCFA's satisfaction that—

(i) The physician or supplier furnishes services infrequently to enrollees of the organization;

(ii) The charges represent an insignificant portion of total Medicare payments to the organization; and

(iii) The charges do not exceed the amounts the physician or supplier charges other patients for similar services.

§ 417.562 Weighting of direct services furnished by physicians and other practitioners.

(a) *Basic Rule.* For contract periods beginning before January 1, 1986, an organization may adjust ("weight") the statistics it uses to compute the apportionment of the costs of the direct professional covered Part B services of physicians and other health care personnel furnished to different patient groups to reflect variations in complexity and time required to furnish the services. HCFA must approve the weighting in advance as set forth in paragraph (b) of this section.

(b) *Basis for HCFA approval.* HCFA will approve weighting if—

(1) The weighting is based on data acceptable to HCFA;

(2) All services (covered and noncovered) used in the apportionment ratio (that is, those furnished to Medicare enrollees, to other enrollees, and to nonenrolled patients) are weighted on the same basis;

(3) The organization uses only one weighting method at a time;

(4) The wighting is applied only to services furnished to Medicare enrollees—

(i) In which there is a face-to-face contact between the enrollee and the health care personnel; and

(ii) In an ambulatory health care setting that is not a provider (for example, a medical center or clinic);

(5) The payment limitations set forth in § 417.560(c) are applied to the services, if applicable; and

(6) In the case of covered Part B services furnished under arrangements, apportionment is on the basis of services as specified in § 417.560(b).

(c) *Weighting procedure.* Weighting is accomplished by adjusting the statistics in which weighting is permissible. These weighted statistics are used to compute the weighted apportionment ratio that is applied to the salaries, wages, incentive payments, fringe benefits, and other forms of compensation of those health care personnel who furnish services that involve face-to-face contact with patients. The organization may not weight—

(1) Costs related to equipment, medical records, and supplies;

(2) Other costs not related to the compensation for the direct professional services of physicians and other health care personnel; or

(3) Costs already apportioned by relative value units or some other apportionment method in which time or complexity is reflected in the apportionment statistic.

(d) *Limitations on payment for services-furnished under arrangement.* If payment is on a fee-for-service basis, time and complexity are recognized, subject to the payment limitation in § 417.560(c) but only to the extent that they are specific and reasonable elements of the amount that the organization has agreed to pay for the services.

§ 417.564 Apportionment and allocation of administrative and general costs.

(a) Enrollment, marketing, and other administrative and general costs of the organization that benefit the total enrolled population of the organization and are not directly associated with providing medical care must be apportioned on the basis of a ratio of Medicare enrollees to the total enrollment of the organization.

(b) Administrative and general costs that bear a significant relationship to the services furnished are not apportioned to Medicare directly. These costs include facility costs, interest expense, medical record costs, centralized purchasing costs, accounting and data processing costs, and the administrative and general costs that are not included in paragraph (a) of this section. These costs are allocated or distributed to the components of the organization and are then apportioned to Medicare in accordance with the rules described in §§ 417.552 through 417.560. The allocation or distribution process must be made as follows:

(1) If a separate entity or department of an organization performs administrative functions whose benefits 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 organization in reasonable proportion to the benefits received by these components.

(2) If a separate entity or department of an organization performs administrative functions whose benefits 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 organization on the basis of a ratio of total incurred and distributed costs per component to the total incurred and distributed costs for all components.

§ 417.566 Other methods of allocation and apportionment.

(a) *Justification.* A method of apportionment or allocation of costs, other than the methods prescribed in this subpart may be used if it results in a more accurate and equitable apportionment of allowable costs and is justifiable from an administrative and cost standpoint.

(b) *Required approval.* (1) An organization that desires to use an alternative method must submit a written request for HCFA approval at least 90 days before the beginning of the period for which the different method is to be used.

(2) If HCFA approves use of a different method, the organization may not revert to another method without first obtaining HCFA's approval.

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

(a) *Maintenance of records.* (1) An organization must maintain sufficient financial records and statistical data for proper determination of costs payable by Medicare for covered services the organization furnished to its Medicare enrollees, either directly or under arrangements with others. These include accurate and sufficient detail of incurred costs and enrollment data.

(2) Unless otherwise provided for in this subpart, standardized definitions and accounting, statistics, and reporting practices that are widely accepted in the health care industry must be followed.

(b) *Provision of data.* (1) The organization must provide adequate cost and statistical data, based on its financial and statistical records, that can be verified by qualified auditors.

(2) The cost data must be based on an approved method of cost finding and, except as described in this paragraph, on the accrual method of accounting.

(3) For governmental institutions that use a cash basis of accounting, cost data based on this basis will be acceptable. However, only depreciation on capital assets, rather than the expenditure for the capital asset, is allowable.

(c) *Provider services furnished directly by the organization.* If provider services are furnished directly by the organization, the provider is subject to the cost-finding and cost-reporting requirements set forth in Subpart D of Part 405 of this chapter. An approved cost-finding method described in § 405.453 of this chapter must be used to determine the actual cost of covered services furnished directly by the organization during its contract period.

(d) *Supplier services furnished directly by the organization.* If the organization furnishes Part B physician and supplier services directly, the organization must furnish statistics that indicate the frequency and type of service provided, in the form and detail prescribed by HCFA.

(e) *Part B physician and supplier services furnished through arrangement.* If the organization furnishes Part B physician and supplier services under arrangements with others, it must furnish to HCFA statistical, financial, and other information with respect to those services in the form and detail prescribed by HCFA.

§ 417.570 Interim per capita payments.

(a) *Principle of payment.* (1) HCFA makes monthly advance payments equivalent to the organization's interim per capita rate for each beneficiary who is registered in HCFA records as a Medicare enrollee of the organization.

(2) Additional lump-sum payments may be made at other times during the contract period, at HCFA's discretion, to adjust the total amounts paid during the contract period to the level of incurred costs.

(b) *Determination of rate.* The interim per capita rate of payment is equal to the estimated per capita cost of providing covered services to the organization's Medicare enrollees, based upon the types and components of costs that are reimbursable under this part. The interim per capita rate is determined annually by HCFA on the basis of the organization's annual operating and enrollment forecast (as set forth in § 417.572) and may be revised during the contract period as explained in paragraphs (c) and (d) of this section.

(c) *Adjustments of payments.* In order to maintain the interim payments at the level of current reasonable costs, HCFA will adjust the interim per capita rate, to the extent necessary, on the basis of adequate data supplied by the organization in its interim estimated cost and enrollment reports or on other evidence showing that the rate based on actual costs is more or less than the current rate. Adjustments may also be made if there is—

(1) A change in the number of Medicare enrollees that affects the per capita rate;

(2) A material variation from the costs estimated when the annual operating budget was prepared; or

(3) A significant change in the use of covered services by the organization's Medicare enrollees.

(d) *Reduction of interim payments.* If the organization does not submit, on time, the reports and other data required to determine the proper amount of payment, HCFA may reduce interim payments to the extent appropriate, or may take any other action authorized under this part. An interim payment reduction remains in effect until HCFA can make a reasonable estimate of per capita costs.

§ 417.572 Budget and enrollment forecast and interim reports.

(a) *Annual submittal.* The organization must submit an annual operating budget and enrollment forecast, in the form and detail required by HCFA, at least, 90 days before the beginning of each contract period. The forecast must be based on financial and statistical data and records that can be verified if HCFA requires a detailed review of supporting records. The data and records include, but are not limited to, all ledgers, books, records, and original evidence of costs, and statistical data used in the determination of reasonable cost.

(b) *Effect of failure to submit on time.* If the organization does not submit the budget and enrollment forecast on time, HCFA may—

(1) Establish an interim per capita rate of payment on the basis of the best available data and adjust payments on the basis of that rate until the required reports are submitted and a new interim per capita rate can be established; or

(2) If there is not enough data on which to base an interim per capita rate, inform the organization that interim payments will not be made until the required reports are submitted.

(c) *Interim cost reports.* (1) An organization must submit interim cost reports on a quarterly basis in the form and detail prescribed by HCFA. These interim cost reports must be submitted no later then 60 days after the close of each quarter of the contract period.

(2) HCFA may reduce the frequency of the reports required under paragraph (c)(1) of this section if HCFA determines that, on the basis of the organization's reporting experience, there is good cause to do so.

§ 417.574 Interim settlement.

(a) *Determination.* Within 30 days following the receipt of the organization's final interim cost and enrollment reports, HCFA will make an interim determination of the estimated amount payable to the organization for the reasonable cost of covered services furnished to its Medicare enrollees during the contract period. HCFA will base the determination on the interim cost report and enrollment data submitted by the organization, and any other relevant data HCFA finds appropriate. For this purpose, HCFA will accept costs as reported, subject to later review or audit, unless there are obvious errors or inconsistencies.

(b) *Payment.* Any difference between the total amount of interim payments and the amount found payable on the basis of the interim determination under paragraph (a) of this section, must be paid by the organization or will be paid by HCFA, whichever is appropriate, no later than 30 days after HCFA's determination.

§ 417.576 Final settlement.

(a) *General rule.* Final settlement and payment of amounts due the organization or the appropriate Medicare trust funds are made following the organization's submission and HCFA's review of an independently certified cost report and supporting documents as described in paragraph (b) of this section.

(b) *Certified cost report as basis for final settlement*—(1) *Timing of cost report.* The organization must submit to HCFA an independently certified cost report and supporting documents, in the form and detail required by HCFA, no later than 180 days after the end of each contract period, unless HCFA extends the period for good cause shown by the organization.

(2) *Content of cost report.* The cost report and supporting documents must include—

(i) The per capita costs incurred by the organization, including those of entities related to the organization by common ownership or control, in furnishing covered services to its Medicare enrollees, determined in accordance with §§ 417.532 through 417.568.

(ii) The organization's methods of apportioning cost among Medicare enrollees, other enrollees, and nonenrolled patients, in accordance with the reimbursement procedures specified in this subpart (and, as applicable, in Subpart D of Part 405 of this chapter); and

(iii) Any other information required by HCFA.

(3) *Failure to report required financial information.* If the organization fails to submit the required cost report and supporting documents within 180 days after the end of the contract period, without having requested and received an extension of time for good cause shown, HCFA may—

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

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

(c) *Final determination and adjustment.* (1) After receipt of acceptable reports as specified in paragraph (b) of this section, HCFA determines the total reimbursement due the organization for providing covered services to its Medicare enrollees (which is subject to the audit provisions of this subpart) and makes a retroactive adjustment to bring interim payments into agreement with the reimbursable amount due the organization.

(2) A final settlement may be made with the organization even though a provider that is not owned or operated by the organization or related to the organization by common ownership or control and that provides services to the organization's Medicare enrollees has not had a final settlement with HCFA under Subpart D of Part 405 of this chapter for services furnished by the provider to Medicare beneficiaries who are not enrolled in the organization. In this situation—

(i) HCFA must be satisfied that the costs of covered services furnished to the organization's Medicare enrollees, as shown in the reports specified in paragraph (b) of this section, are reasonable and that the interest of the Medicare program would best be served by not delaying final settlement with the organization until there is a final settlement with the provider for services furnished to Medicare beneficiaries not enrolled in the organization; and

(ii) Prompt settlement with the organization would be in the best interest of the Medicare program if, for instance, the provider's costs represent an insignificant amount of total reimbursement due to the organization; or if HCFA is satisfied that the provider's costs, as shown in the reports specified in paragraph (b) of this section, will not be modified, to any significant extent, by the final settlement with the provider under Subpart D of Part 405 of this chapter.

(d) *Notice of amount of reimbursement.* The notice of amount of Medicare reimbursement—

(1) Explains HCFA's determination regarding total Medicare reimbursement due the organization for the contract period covered by the financial information specified in paragraph (b) of this section;

(2) Relates this determination to the organization's claimed total reimbursable cost for that period;

(3) Explains the amounts and reasons, by appropriate reference to law, regulations, and Medicare program policy and procedures, if the determined amounts differ from the organization's claim; and

(4) Informs the organization of its right to a hearing in accordance with Subpart R of part 405 of this chapter.

(e) *Basis for retroactive adjustment.* (1) HCFA's determination (as contained in the notice of amount of Medicare reimbursement) constitutes the basis for making retroactive adjustments to any Medicare payment made to the organization during the period to which the determination applies.

(2) Further payments to the organization may be withheld or offset in order to recover, or to aid in the recovery of, any overpayment identified in the determination as having been made to the organization, even if the organization requests a hearing under Subpart R of Part 405 of this chapter.

(3) Any withholding will continue until—

(i) The overpayment is liquidated;

(ii) The organization enters into an agreement with HCFA to refund the overpaid amount; or

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

Risk Reimbursement

§ 417.580 Basis and scope.

(a) *Basis.* Sections 417.582 through 417.596 implement those portions of section 1876 (a), (e), and (g) of the Act that pertain to the amount HCFA reimburses an organization for its Medicare enrollees who are enrolled on a risk basis.

(b) *Scope.* Sections 417.582 through 417.596 set forth—

(1) Method of payment;

(2) Procedures for determining the organization's payment rate; and

(3) Procedures for determining the additional benefits (and their value) the organization must provide to its Medicare enrollees.

§ 417.582 Definitions applicable to risk reimbursement.

As used in §§ 417.584 through 417.596—

Actuarial factors means factors such as the age, sex, and disability level distribution of the population and any other relevant factors that HCFA determines have a significant effect on the level of utilization and cost of health services.

Class of Medicare enrollees means a group of Medicare enrollees of an organization that HCFA constructs on the basis of actuarial factors.

Similar area means an area similar to the organization's geographic area but free from special characteristics that would distort the determination of the AAPCC.

U.S. per capita incurred cost means the average per capita cost, including intermediary or carrier administrative costs, incurred by Medicare, as determined on an accrual basis, for covered services furnished to Medicare beneficiaries nationwide during the most recent period for which HCFA has complete data.

§ 417.584 Payment to organization with risk contracts.

Except as provided in §§ 417.585 and 417.586, HCFA makes payments for covered services furnished to the organization's Medicare enrollees only to the organization.

(a) *Principle of payment.* HCFA makes monthly advance payments equivalent to the organization's per capita rate of payment for each beneficiary who is registered in HCFA records as a Medicare enrollee of the organization.

(b) *Determination of rate.* (1) The annual per capita rate of payment for each class of Medicare enrollees is equal to 95 percent of the AAPCC (as determined under the provisions of § 417.588) for that class of Medicare enrollees.

(2) HCFA furnishes each organization with its per capita rate of payment for each class of Medicare enrollees not later than 90 days before the beginning of the organization's contract period.

(c) *Adjustments to payments.* If the organization's actual number of Medicare enrollees in each class differs from the number of individuals estimated to be enrolled for purposes of determining the amount of advance payment, HCFA will adjust the amount of payment made in subsequent months to take these enrollment changes into amount.

(d) *Reduction of payments.* If an organization requests a reduction in its monthly payment in accordance with § 417.592(e), HCFA will reduce the amount of payment by the appropriate amount. Reductions in the monthly payment to an organization will also be made if the organization elects the hospital or SNF payment option described in § 417.586.

§ 417.585 Exception for hospice care services.

(a) No payment is made to an organization on behalf of a Medicare enrollee who has elected hospice care under § 418.24 of this chapter except for the portion of the payment applicable to the additional benefits described in § 417.592. No payment is made effective the first day of the month following the month of election to receie hospice care, until the first day of the month following the month in which the enrollee resumes normal Medicare coverage.

(b) During the time the election is in effect, the organization may bill HCFA on a fee-for-service basis (subject to the usual Medicare rules of payment for only the following covered Medicare services:

(1) Services of the enrollee's attending physician if the physician is an employee or contractor of the organization and is not employed by or under contract to the enrollee's hospice.

(2) Services not related to the treatment of the terminal condition for which hospice care was elected or a condition related to the terminal condition.

(3) Services furnished after the revocation or expiration of the enrollee's hospice election until the full monthly capitation payments begin again.

(c) Payment for hospice care services furnished to Medicare enrolees of an organization are made to the hospice participating in Medicare elected by the enrollee.

§ 417.586 Organization option: Payment to hospitals and SNFs.

(a) *Election by organization.* (1) An organization may elect to have hospitals or SNFs that furnish inpatient services to its Medicare enrollees, or both of those types of providers, obtain payment directly from the provider's Medicare intermediary.

(2) If an organization wishes to elect either or both of these options, it must submit a written request to HCFA before the organization's contract period begins.

(3) The election of these payment options by the organization is binding for the entire contract period.

(b) *Payment by intermediary to the hospital or SNF.* (1) After an organization submits its request, HCFA pays the hospital or SNF through the provider's Medicare intermediary for the covered inpatient services furnished to the organization's Medicare enrollees.

(2) The payment made under paragraph (b)(1) of this section is equal to the payment made in accordance with the principles of reimbursement specified in Subpart D of Part 405 of this chapter.

(c) *Reduction in organization's per capita payment.* (1) Each month HCFA will deduct from the organization's per

capita payment described in § 417.584 an amount HCFA estimates it will be paying to hospitals or SNFs on behalf of the organization's Medicare enrollees and administrative costs HCFA incurs in making the payments to the hospitals or SNFs.

(2) The amount of deduction will be adjusted as necessary to allow HCFA to retain sufficient funds with which to pay the bills.

(d) *Retention of withheld funds.* If the contract between the organization and HCFA is terminated or not renewed, HCFA will retain the balance of the amounts withheld from the organization's per capita payment for three years after the expiration or termination of the contract.

(e) *Organization's liability.* In making an election under this section, the organization must agree to accept liability and to provide the additional necessary funds to HCFA if—

(1) During the contract period or in subsequent years, HCFA did not withhold sufficient funds to pay the bills of the organization's Medicare enrollees;

(2) After HCFA returns any balance of amounts withheld to the organization, HCFA receives additional bills that cover services furnished to Medicare enrollees of the organization during its contract period.

§ 417.588 Computation of adjusted average per capita cost (AAPCC).

(a) *Basic data.* In computing the (AAPCC), HCFA uses the U.S. per capita incurred cost and adjusts it by the factors specified in paragraph (c) of this section resulting in an AAPCC for each class of Medicare enrollees.

(b) *Advance notice to the organization.* Before the beginning of a contract period, HCFA informs the organization of the specific adjustment factors it will use in computing the AAPCC.

(c) *Adjustment factors*—(1) *Geographic.* HCFA makes an adjustment to reflect the relative level of Medicare expenditures for beneficiaries who reside in the organization's geographic area (or a similar area). This adjustment is based on reimbursement for Medicare covered services and uses the most accurate and timely data that pertain to the organization's geographic area and that is available to HCFA when it makes the determination.

(2) *Enrollment.* A further adjustment is made by HCFA to remove the cost effect of all area Medicare beneficiaries who are enrolled in the organization or another eligible organization.

(3) *Age, sex, and disability status.* HCFA makes adjustments to reflect the age and sex distribution and the disability status of the organization's enrollees based on Medicare program experience and available data that indicate cost differences that result from those factors.

(4) *Other relevant factors.* If accurate data are available and appropriate, HCFA makes adjustments to reflect welfare and institutional status and other relevant factors.

§ 417.590 Computation of the average of the per capita rates of payment.

(a) *Computation by the organization.* As indicated in § 417.584(b), prior to the start of an organization's contract period, HCFA determines an organization's per capita rate of payment for each class of Medicare enrollees. For purposes of determining an organization's required additional benefits (see § 417.592), an organization must compute a weighted average of these per capita rates of payment based on the organization's anticipated enrollment distribution. This computation must be done separately for Part A and Part B enrollees and Part B-only enrollees and is subject to HCFA's review and approval.

(b) *Computation by HCFA.* If the organization claims to have insufficient enrollment experience to make the computation required by paragraph (a) of this section, and HCFA agrees with this claim, then HCFA will compute the average of the per capita rates of payment based on the best information available to HCFA, including the enrollment experience of other organizations that have contracted with HCFA to receive reimbursement on a risk basis.

§ 417.592 Determination of required additional benefits.

(a) *General consideration.* Except as provided in paragraph (e) of this section, if the organization's average of its per capita rates of payment as determined under § 417.590 is more than the organization's adjusted community rate (ACR) as determined under § 417.594, then the organization must provide its Medicare enrollees with additional benefits as described in paragraphs (b) and (c) of this section. This determination must be done separately for Part A and Part B enrollees and Part B-only enrollees.

(b) *Form of additional benefits.* The additional benefits are selected by the organization and may be—

(1) A reduction in the organization's premium or other charges made by the organization in the form of deductibles and coinsurance; or

(2) Health benefits beyond the required Part A and B services; or

(3) A combination of the benefits specified in paragraphs (b)(1) and (b)(2).

(c) *Value of additional benefits.* The additional benefits must be at least equal in value to the difference between the ACR and the average of the per capita rates of payment, unless—

(1) The organization requests a reduction in its monthly payment as provided in paragraph (e) of this section; or

(2) The organization requests that HCFA withhold in a benefit stabilization fund as provided in § 417.596, a part of the value of the additional benefits it is required to provide.

(d) *Notification to HCFA.* (1) The organization must notify HCFA not later than 45 days before the beginning of the contract period of its ACR and its weighted average of its per capita rates of payment (as computed under § 417.590) for the contract period.

(2) If the proposed ACR is less than the average of the per capita rates of payment to be made at the beginning of the contract period, the organization must provide HCFA with—

(i) A description of the additional benefits (as described in paragraph (b) of this section) the organization has elected to provide its Medicare enrollees; and

(ii) Supporting evidence to demonstrate that the selected additional benefits are at least equal in value to the difference between the organization's proposed ACR and the average of the per capita rates of payment.

(e) *Exception.* (1) If the organization's ACR is less than the average of the per capita rates of payment, the organization may request a reduction in its monthly payment from HCFA instead of offering its Medicare enrollees additional benefits.

(2) The reduction in the monthly payment must, over the course of the contract period, be equal in value to the difference between the proposed ACR and the average of the per capita rates of payment, or meet the requirements of § 417.442(b)(1)(ii).

§ 417.594 Computation of ACR.

(a) *General.* (1) Each organization must compute its own ACR. In computing the ACR, the organization calculates an initial rate (using the methods described in paragraph (b) of this section) that represents the organization's premium if it provided the Medicare covered services package to its general membership (that is, its non-Medicare enrollees). The organization then either adjusts that rate by the factors specified in paragraph (c) of this section or requests that HCFA adjust the

rate in accordance with the procedures specified in paragraph (d) of this section.

(2) The organization or HCFA further reduces this rate by the actuarial value of applicable Medicare coinsurance and deductibles.

(3) Separate ACRs must be calculated for Part A and Part B enrollees and Part B-only enrollees.

(4) In calculating its initial rate, the organization must identify and take into account anticipated revenue from health insurance payors for those services for which Medicare is not the primary payor as described in § 417.528.

(b) *Initial rate calculation.* (1) The organization's initial rate is calculated, at the organization's election, using either—

(i) A community rating system as defined in § 110.105(b) of this title; or

(ii) A system, approved by HCFA, under which the organization develops an aggregate premium for all its enrollees that is weighted by the size of the various enrolled groups that compose the organization's enrollment.

(For purposes of this section, enrolled groups are defined as employee groups or other bodies of subscribers that purchase membership in the organization on a premium basis.)

(2) Regardless of which method the organization uses to calculate its initial rate, the initial rate must be equal to the premium the organization would charge its non-Medicare enrollees for the Medicare covered services.

(3) Except as provided in paragraph (b)(4) of this section, the organization must identify in its initial rate calculation, the following components whose rates must be consistent with rates used by the organization in calculating premiums for non-Medicare enrollees:

(i) Hospital services (services covered under Medicare Part A and Part B shown separately).

(ii) Physicians services.

(iii) Other medical services (for example, X-ray and laboratory services).

(iv) Home health services.

(v) Out-of-plan claims for emergency services.

(vi) Skilled nursing care services.

(vii) Ambulance services.

(viii) Other Medicare covered services.

(ix) General and administrative.

(x) Noncovered Medicare services for example, eyeglasses).

(xi) Services for which Medicare is the secondary payor

(xii) Enrollee liabilities (for example, deductibles, coinsurance, or copayments) for covered services.

(4) An organization that does not usually separate its premium components as described in paragraph (b)(3) of this section may calculate its initial rate with the methods it uses for its other enrolled groups if the organization provides HCFA with the documentation necessary to support any adjustments the organization makes to the initial rate in accordance with paragraph (e) of this section.

(5) The initial rate calculation must not carry forward any losses experienced by the organization during prior contract periods. The organization must submit supporting documentation to assure HCFA that rates do not include past losses but only premiums for the price of additional benefits and services of the upcoming contract period.

(c) *Adjustment factors.* These factors are designed to adjust on a component basis the initial rate calculated under paragraph (b) of this section to reflect the utilization characteristics of the organization's Medicare enrollees. The organization may adjust the same service using more than one factor if the factors do not duplicate each other. The factors are as follows:

(1) *Unit of service.* If the organization purchases or identifies services on a unit of service basis and the unit of service is defined the same for all enrollees, the organization 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.

(2) *Complexity or intensity of services.* (i) The organization 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.

(ii) If an organization cannot support an adjustment such as that described in paragraph (c)(2)(i) of this section, it may, for contract periods beginning before January 1, 1986, make an adjustment to the direct professional services of physicians and other health care personnel. This adjustment will reflect the difference in time of service furnished to the organization's Medicare enrollee if the calculation of the organization's initial rate includes the elements of this adjustment.

(3) *Supporting documentation.* All adjustments made by the organization must be accompanied by adequate supporting data. If an organization 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.

(d) *Adjustment by HCFA.* If the organization 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 organization's request, adjust the initial rate. HCFA will adjust the rate on the basis of differences in the utilization characteristics of—

(1) Medicare and non-Medicare enrollees in other eligible organizations; or

(2) Medicare beneficiaries in the organization's area, State, or the United States who are eligible to enroll in an eligible organization and other individuals in that same area, State, or the United States.

(e) *HCFA review.* (1) The organization's methodology and computation of its ACR are subject to review and approval by HCFA. When the organization submits the ACR computation, it must include adequate supporting data.

(2) If the organization is dissatisfied with a HCFA determination that the organization's ACR computation is not acceptable, the organization may, within 30 days after the date of receipt of notification of this determination, file a request for a hearing with HCFA. The request must state why the determination is incorrect and must be accompanied by any supporting evidence the organization wishes to submit. The hearing will be conducted by a hearing officer designated by HCFA under the hearing procedures described in §§ 405.1819 through 405.1833 of this chapter.

§ 417.596 Establishment of a benefit stabilization fund.

(a) *General.* For contract periods beginning before July 19, 1988, if an organization is required to provide its Medicare enrollees with additional benefits as described in § 417.592, the organization may request that HCFA withhold a part of its monthly per capita payment in a benefit stabilization fund. The fund will be used to prevent excessive fluctuation in the provision of those additional benefits in subsequent contract periods.

(b) *Notification to HCFA.* An organization's request to have monies withheld in a benefit stabilization fund must be made when the organization notifies HCFA under § 417.592(d) of its ACR and the average of its per capita rates of payment in preparation for its next contract period.

(c) *Limitations on the amounts withheld.*—(1) *Limit per contract period.* Except as provided in paragraph (b)(3) of this section, HCFA will not withhold in a benefit stabilization fund more than 15 percent of the difference between an organization's ACR and the average of its per capita rates or payment for a given contract period.

(2) *Cumulative limit.* If HCFA has established a benefit stabilization fund for an organization, it will not approve a request for withholding made by that organization for a subsequent contract period that would cause the total value of the benefit stabilization fund to exceed 25 percent of the difference between the organization's ACR and the average of its per capita rates of payment for that subsequent contract period.

(3) *Exception.* HCFA may grant an exception to the limit described in paragraph (b)(1) of this section if an organization can demonstrate to HCFA's satisfaction that the value of the additional benefits it provides to its Medicare enrollees fluctuates substantially in excess of 15 percent from one contract period to another.

(d) *Financial management of benefit stabilization funds.* (1) The amounts withheld by HCFA for the purpose of establishing or maintaining a benefit stabilization fund are in the custody of the Federal Health Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund.

(2) The amounts withheld in a benefit stabilization fund are accounted for by HCFA in accounts in which interest does not accrue to the organization.

§ 417.597 Withdrawal from a benefit stabilization fund.

(a) *Notification to HCFA.* An organization's request to make a withdrawal from its benefit stabilization fund for use during a contract period must be made when the organization notifies HCFA of its ACR and the average of its per capita rates of payment for that contract period. In making its request, the organization must—

(1) Indicate how it intends to use the withdrawn amounts;

(2) Justify the need for the withdrawal in terms of stabilizing the additional benefits it provides to Medicare enrollees;

(3) Document the organization's experience with fluctuations of revenue requirements relative to the additional benefits it provides to Medicare enrollees; and

(4) Document the organization's experience during the contract period previous to the one for which the withdrawal is requested to ensure that the organization will not be using the withdrawn amounts to refinance losses suffered during that previous contract period.

(b) *Criteria for HCFA approval.* HCFA will approve an organization's request for a withdrawal from its benefit stabilization fund for use during the next contract period only if—

(1) The organization's average of its per capita rates of payment for the next contract period is less than that of the previous contract period;

(2) The organization's ACR for the next contract period is significantly higher than that of the previous contract period; or

(3) The organization's revenue requirements for the next contract period for providing the additional benefits it provided during the previous contract period is significantly higher than the requirements for that previous period and the ACR for the next contract period results in an additional benefits package that is less in total value than that of the previous contract period.

(c) *Basis for denial.* HCFA will not approve an organization's request for a withdrawal from its benefit stabilization fund if the withdrawal allows the organization to—

(1) Offer without charge the supplemental services it provides to its Medicare enrollees under the provisions of § 417.440 (b)(2) or (b)(3); or

(2) Refinance prior contract period losses or to avoid losses in the upcoming contract period.

(d) *Form of payment.* Payment of monies withdrawn from a benefit stabilization fund is made, in equal parts, as an additional amount to the monthly advance payment made to the organization under § 417.584 during the period of the contract.

(e) *Availability of a benefit stabilization fund.* (1) Amounts withheld in a benefit stabilization fund are available for use by an organization only for four years following the establishment of the fund.

(2) Any amounts remaining in a benefit stabilization fund after the period of availability described in paragraph (c)(1) of this section will revert to the Medicare Trust Funds in the proportions HCFA determines to be appropriate.

§ 417.598 Annual enrollment reconciliation.

HCFA's payment to an organization may be subject to an enrollment reconciliation at least annually. HCFA will conduct this reconciliation as necessary to assure that the payments made do not exceed or fall short of the appropriate per capita rate of payment for each Medicare enrollee of the organization during the contract period. The organization must submit any information or reports required by HCFA to conduct the reconciliation.

Beneficiary Appeals

§ 417.600 Scope.

Sections 417.600 through 417.638 establish procedures for the presentation and resolution of initial determinations, reconsiderations, hearings, Appeals Council reviews, court reviews, and finality of decisions, that are applicable in matters arising under section 1876 of the Act and this subpart. The grievance procedures established by organizations under § 417.436(a)(2) apply to all complaints that do not involve initial determinations. Those grievance procedures must provide to Medicare enrollees a thorough explanation of—

(a) The steps to follow in completing the procedure; and

(b) The time limits imposed on each step of the procedure.

§ 417.602 Definitions applicable to beneficiary appeals.

As used in §§ 417.604 through 417.638, unless the context indicates otherwise—

ALJ stands for administrative law judge.

Enrollee means a Medicare enrollee.

RRB stands for Railroad Retirement Board.

§ 417.604 General provisions.

(a) *Applicability.* (1) The appeals procedure described in §§ 417.604 through 417.638 pertain to disputes involving an initial determination, as defined in § 417.606, with which the enrollee is dissatisfied.

(2) Any determinations regarding items or services that were furnished by the organization, 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 (see § 417.440(b)(2)) are subject only to a grievance procedure under § 417.436(a)(2).

(4) Except as provided in § 417.610(b), physicians and other individuals who furnish items or services under arrangements with an organization have no right of appeal under this subpart.

(5) The provisions of Subpart R of 20 CFR Part 404 dealing with representation of parties under Title II of the Act are, unless otherwise provided in this subpart, also applicable

to matters arising under section 1876 of the Act.

(b) *Responsibility for establishing appeals procedures.* (1) Except as provided in paragraph (b)(2) of this section, the provisions of §§ 417.604 through 417.638 apply equally to all enrollees regardless of the method of claims processing adopted by the organization. The organization is responsible for establishing and maintaining the appeals procedures that are specified in these sections.

(2) If a carrier or intermediary processes the claims for an organization's enrollees, the carrier or intermediary—

(i) Is acting in the place of the organization, except with regard to initial determinations as specified in § 417.606(a)(3), and

(ii) Acts for the organization with respect to the appeals procedures specified in §§ 417.604 through 417.638, except that § 417.620(b)(2) does not apply to a carrier or intermediary.

(c) *Written description of appeals procedure.* Each organization is responsible for ensuring that all enrollees are informed in writing of the appeals procedures that are available to them.

§ 417.606 Initial determinations.

(a) *Actions that are initial determinations.* An initial determination is a determination made by an organization, or carrier or intermediary acting for the organization, concerning the rights of an enrollee with regard to services payable by Medicare that are furnished by the organization. In addition, an initial determination is also any determination made with respect to—

(1) Reimbursement for emergency or urgently needed services;

(2) Any other health services furnished by a provider or supplier other than the organization that the enrollee believes—

(i) Are covered under Medicare; and

(ii) Should have been furnished, arranged for, or reimbursed by the organization.

(3) The organization's refusal to provide services that the enrollee believes should be furnished or arranged for by the organization and the enrollee has not received the services outside the organization.

(b) *Actions that are not initial determinations.* The following are not initial determinations for purposes of this subpart:

(1) A determination regarding items or services that were furnished by the organization, either directly or under arrangement, for which the enrollee has no further obligation for payment.

(2) A determination regarding items or services included in an optional supplemental plan (see § 417.440(b)(2)).

(c) *Relation to grievances.* A determination that is not an initial determination is subject only to a grievance procedure under § 417.436(a)(2).

§ 417.608 Notice of adverse initial determination.

(a) If an organization, carrier, or intermediary makes an initial determination that is partially or fully adverse to the enrollee, it must notify the enrollee of the determination within 60 days of receiving the enrollee's request for payment of services.

(b) The notice must—

(1) State the specific reasons for the determination; and

(2) Inform the enrollee of his or her right to reconsideration.

(c) The failure to provide the enrollee with timely notification of an adverse initial determination constitutes an adverse initial determination and may be appealed.

§ 417.610 Parties to the initial determination.

The parties to the initial determination are—

(a) The enrollee;

(b) An assignee of the enrollee (that is, a physician or other supplier who accepts assignment for services furnished to an enrollee that are not covered by the organization's plan);

(c) The legal representative of a deceased enrollee's estate; or

(d) Any other entity determined to have an appealable interest in the proceeding.

§ 417.612 Effect of initial determinations.

The initial determination is final and binding on all parties unless it is reconsidered in accordance with § 417.614 through 417.626, or revised in accordance with § 417.638.

§ 417.614 Right to reconsideration.

Any party to an initial determination who is dissatisfied with that determination may request a reconsideration of the determination after reopening in accordance with the procedures of § 417.616.

§ 417.616 Request for reconsideration.

(a) *Method and place for filing a request.* A request for reconsideration must be made in writing and filed with—

(1) The organization, carrier, or intermediary that made the initial determination;

(2) An SSA office; or

(3) In the case of a qualified railroad retirement beneficiary, an RRB office.

(b) *Time for filing a request.* Except as provided in paragraph (c) of this section, the request for reconsideration must be filed within 60 days from the date of the notice of the initial determination.

(c) *Extension of time to file a request.* (1) *Rule.* If good cause is shown, the organization, carrier, or intermediary that made the initial determination may extend the time for filing the request for reconsideration.

(2) *Method of requesting an extension.* If the time limit in paragraph (a) of this section has expired, a party to the initial determination may file a request to extend the time to file a request for reconsideration with the organization, carrier, intermediary, HCFA, SSA, or, in the case of a qualified railroad retirement beneficiary, an RRB office. The request to extend the time limit must—

(i) Be in writing; and

(ii) State why the request for reconsideration was not filed timely.

(d) *Parties to the reconsideration.* The parties to the reconsideration are the parties to the initial determination as described in § 417.610, and any other person or entity whose rights with respect to the initial determination may be affected by the reconsideration, as determined by the entity that conducts the reconsideration.

(e) *Withdrawal of request.* A request for reconsideration may be withdrawn by the party who filed the request. The request for withdrawal must be filed at one of the places specified in paragraph (c)(2) of this section.

§ 417.618 Opportunity to submit evidence.

The organization, carrier, or intermediary must provide the parties to the reconsideration reasonable opportunity to present evidence and allegations of fact or law, related to the issue in dispute, in person as well as in writing.

§ 417.620 Responsibility for reconsideration.

(a) *Basic rule.* Except as specified in paragraph (b) of this section, the entity that made the initial determination is the entity that reconsiders it.

(b) *Exception.* If the organization made the initial determination or the issue is the organization's refusal to furnish or arrange for requested services, the organization or HCFA makes the reconsidered determination, as follows:

(1) *Favorable determination by the organization.* If the organization can

make a reconsidered determination completely favorable to the enrollee, it issues a reconsidered determination.

(2) *Unfavorable recommendation by the organization.* If the organization recommends partial or complete affirmance of the initial adverse determination, the organization must prepare a written explanation and forward the entire case file to HCFA, which makes a reconsidered determination.

§ 417.622 Reconsidered determination.

A reconsidered determination is a new determination that—

(a) Is based on a review of the initial determination, the evidence and findings upon which it was based, and any other evidence submitted by the parties, or obtained by HCFA, the organization, or the carrier or intermediary; and

(b) Is made by a person or persons who were not involved in making the initial determination.

§ 417.624 Notice of reconsidered determination.

(a) *Responsibility for notice.* The entity that makes the reconsidered determination is responsible for mailing notice to the parties and, if that entity is not HCFA, for sending a copy to HCFA.

(b) *Content of notice.* The notice must—

(1) State the specific reasons for the reconsidered determination;

(2) Inform the party of his or her right to a hearing if the amount in controversy is $100 or more; and

(3) Describe the procedures that the party must follow to obtain a hearing.

§ 417.626 Effect of reconsidered determination.

A reconsidered determination is final and binding on all parties unless a request for a hearing is filed in accordance with the provisions of § 417.632, or unless it is revised in accordance with § 417.638.

§ 417.628 Hearings: General.

Unless otherwise provided in this subpart, regulations at 20 CFR 404.929 through 404.961 dealing with the conduct of hearings are also applicable to hearings arising under this subpart.

§ 417.630 Right to hearing.

Any party to the reconsideration who is dissatisfied with the reconsidered determination has a right to a hearing if the amount in controversy is $100 or more. The amount in controversy is computed in accordance with § 405.740 of this chapter for Part A services and § 405.820(b) of this chapter for Part B services. When the basis for the appeal is the refusal of services, the projected value of those services must be used in computing the amount in controversy.

§ 417.632 Request for hearing.

(a) *Method and place for filing a request.* A request for a hearing must be made in writing and filed at one of the places specified in § 417.616(c)(2).

(b) *Time for filing a request.* Except when the time is extended by a presiding officer as provided in 20 CFR 404.933(c), a request for a hearing must be filed within 60 days of the date of the notice of reconsidered determination.

(c) *Parties to a hearing.* The parties to a hearing must be the parties to the reconsideration as described in § 417.616(d), and any other person or entity whose rights with respect to the reconsidered determination may be affected by the hearing, as determined by the ALJ. The organization must be made a party to the hearing; however, the organization does not have a right to request a hearing. Fees for any services provided by a representative appointed on behalf of the organization are not subject to section 206 of the Act, which governs appointment of representatives and payment of fees to representatives.

(d) *Dismissal of request for hearing when amount in controversy is less than $100.* The ALJ makes the determination as to whether the amount incontroversy is $100 or more. The ALJ will dismiss the request for a hearing if the request plainly shows that less than $100 is in controversy. If a hearing is held and the ALJ finds that the amount in controversy is less than $100, he or she will dismiss the request for hearing and will not rule on the substantive issues involved in the appeal.

§ 417.634 Appeals Council review.

Any party to the hearing, including the organization, who is dissatisfied with the hearing decision, may request the Appeals Council to review the ALJ's decision or dismissal. Provisions regarding Appeal Council review are contained in 20 CFR 404.967 through 404.981.

§ 417.636 Court review.

(a) *Review of ALJ's decision.* A party or the organization may request judicial review of an ALJ's decision if—

(1) The Appeals Council denied the party's or the organization's request for review; and

(2) The amount in controversy is $1,000 or more.

(b) *Review of Appeals Council decision.* A party or the organization may request judicial review of the Appeals Council decision if—

(1) It is the final decision of the Secretary; and

(2) The amount in controversy is $1,000 or more.

(c) *Request for review.* The civil action must be filed in a district court of the United States in accordance with section 205(g) of the Act (see 20 CFR 422.210 for a description of the procedures to follow in requesting judicial review).

§ 417.638 Reopening determinations and decisions.

An initial, reconsidered, or revised determination made by an organization, carrier, intermediary, or HCFA, or a decision or revised decision of an ALJ or the Appeals Council, may be reopened in accordance with the provisions of § 405.750 of this chapter.

Contract Appeals

§ 417.640 Determinations subject to appeal.

Sections 417.640 through 417.694 establish the procedures for making and reviewing the following initial determinations:

(a) A determination that an eligible organization is not qualified to enter into a contract with HCFA under section 1876 of the Act.

(b) A determination that an eligible organization is qualified only for a reasonable cost contract.

(c) A determination to terminate, or to refuse to renew, a contract with an organization because—

(1) The organization has failed substantially to carry out the terms of the contract;

(2) The organization is carrying out the contract in a manner that is inconsistent with the efficient and effective administration of section 1876 of the Act; or

(3) The organization no longer meets the applicable conditions necessary to qualify as an eligible organization under section 1876 of the Act and this subpart.

§ 417.642 Administrative actions that are not initial determinations.

Administrative actions that are not initial determinations under §§ 417.640 through 417.694 include, but are not limited to, HCFA's refusal to renew a contract with an organization when the refusal is not based on the causes specifed in § 417.640(c).

§ 417.644 Notice of initial determination.

(a) When HCFA makes an initial determination, it will notify the organization in writing.

(b) The notice specifies—

(1) The reasons for the determination; and

(2) The organization's right to request reconsideration.

(c) Notice of an initial determination specified in § 417.640 is mailed to the organization at least 90 days before the end of the contract period, or in the case of termination, at least 90 days before the effective date of the termination.

§ 417.646 Effect of initial determination.

The initial determination is final and binding on all parties unless—

(a) It is reconsidered in accordance with §§ 417.648 through 417.658;

(b) In the case of an initial determination described in § 417.640(c), a request for a hearing is filed; or

(c) It is revised as a result of a reopening under § 417.692.

§ 417.648 Right to request reconsideration.

An entity that is dissatisfied with an initial determination as described in § 417.640 (a) or (b) may request a reconsideration of the determination in accordance with the procedures specified in § 417.650.

§ 417.650 Request for reconsideration.

(a) *Method and place for filing a request.* A request for reconsideration must be made in writing and filed with any HCFA office.

(b) *Time for filing a request.* Except as provided in paragraph (c) of this section, the request for reconsideration must be filed within 60 days from the date of the notice of the initial determination.

(c) *Extension of time to file a request.* HCFA may, in response to a party's written petition showing good cause, accept a request for reconsideration after the expiration of the 60 day period.

(d) *Proper party to file a request.* Only an authorized official of the entity that was a party to an initial determination may file the request for reconsideration.

(e) *Withdrawal of a request.* A request for reconsideration may be withdrawn by the party who filed the request at any time before the notice of the reconsidered determination is mailed. The request for withdrawal must be in writing and filed with HCFA. If HCFA approves, the request for reconsideration is withdrawn.

§ 417.652 Opportunity to submit evidence.

HCFA will provide the parties to the reconsideration reasonable opportunity to present as evidence any documents or written statements that are relevant and material to the matters at issue.

§ 417.654 Reconsidered determination.

A reconsidered determination is a new determination that—

(a) Is based on a review of the initial determination, the evidence and findings upon which that was based, and any other written evidence submitted before notice of the reconsidered determination is mailed, including facts relating to the status of the entity subsequent to the initial determination; and

(b) Affirms, reverses, or modifies the initial determination.

§ 417.656 Notice of reconsidered determination.

Written notice of the reconsidered determination is mailed by HCFA to the party concerned and—

(a) Contains findings with respect to the eligible organization's qualifications to enter into a contract with HCFA under section 1876 of the Act;

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

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

§ 417.658 Effect of reconsidered determination.

A reconsidered determination is final and binding on all parties unless a request for a hearing is filed in accordance with § 417.662 or it is revised in accordance with § 417.692.

§ 417.660 Right to a hearing.

The following parties are entitled to a hearing:

(a) An entity that has been determined in a reconsidered determination to be unqualified to enter into a contract with HCFA under section 1876 of the Act.

(b) An eligible organization that has been determined in a reconsidered determination to be qualified only for a reasonable cost contract.

(c) An organization whose contract with HCFA has been terminated or has not been renewed as a result of an initial determination as provided in § 417.640(c).

§ 417.662 Request for hearing.

(a) *Method and place for filing a request.* A request for a hearing must be made in writing and filed by an authorized official of the entity or organization that was the party to the determination under appeal. The request for a hearing must be filed with any HCFA office.

(b) *Time for filing a request.* Except as provided in paragraph (c) of this section, a request for a hearing must be filed within 60 days after the date of receipt of the notice of initial or reconsidered determination.

(c) *Extension of time to file a request.* If good cause is shown, the 60-day period to request a hearing may be extended by HCFA.

(d) *Parties to a hearing.* The parties to a hearing must be—

(1) The parties described in § 417.660;

(2) At the discretion of the hearing officer, any interested parties who make a showing that their rights may be prejudiced by the decision to be rendered at the hearing; and

(3) HCFA.

§ 417.664 Postponement of effective date of initial determination.

When a request for a hearing with respect to an initial determination is filed timely—

(a) The effective date of the initial determination to terminate a contract with an organization will be postponed until a hearing decision is reached; and

(b) The current contract will be extended at the end of the contract period (in the case of a determination not to renew) only—

(1) If HCFA finds that an extension of the contract will be consistent with the purpose of section 1876 of the Act; and

(2) For such period as HCFA and the organization agree.

§ 417.666 Designation of hearing officer.

HCFA will designate a hearing officer to conduct the hearing. The hearing officer need not be an ALJ.

§ 417.668 Disqualification of hearing officer.

(a) A hearing officer may not conduct a hearing in a case in which he or she is prejudiced or partial to any party or has any interest in the matter pending for decision.

(b) A party to the hearing who objects to the designated hearing officer must notify that officer in writing at the earliest opportunity.

(c) The hearing officer must consider the objection, and may, at his or her discretion, either proceed with the hearing or withdraw.

(1) If the hearing officer withdraws, HCFA will designate another hearing officer to conduct the hearing.

(2) If the hearing officer does not withdraw, the objecting party may, after the hearing, present objections and request that the officer's decision be revised or a new hearing be held before another hearing officer. The objections must be submitted to HCFA.

§ 417.670 Time and place of hearing.

(a) The hearing officer will fix a time and place for the hearing and send written notice to the parties. The notice must also inform the parties of the general and specific issues to be

resolved and information about the hearing procedure.

(b) The hearing officer may, on his or her own motion, or at the request of a party, change the time and place for the hearing. The hearing officer may adjourn or postpone the hearing.

(c) The hearing officer will give the parties reasonable notice of any change in time or place of adjournment.

§ 417.672 Appointment of representatives.

A party may appoint as its representative at the hearing anyone not disqualified or suspended from acting as a representative before the Secretary or otherwise prohibited by law.

§ 471.674 Authority of representatives.

(a) A representative appointed and qualified in accordance with § 417.672 may, on behalf of the represented party—

(1) Give or accept any notice or request pertinent to the proceedings set forth in this subpart;

(2) Present evidence and allegations as to facts and law in any proceedings affecting that party; and

(3) Obtain information to the same extent as the party.

(b) A notice or request sent to the representative has the same force and effect as if it had been sent to the party.

§ 417.676 Conduct of hearing.

(a) The hearing will be open to the parties and to the public.

(b) The hearing officer will inquire fully into all the matters at issue and must receive in evidence the testimony of witnesses and any documents that are relevant and material.

(c) The parties will be provided an opportunity to enter any objection to the inclusion of any document.

(d) The hearing officer will decide the order in which the evidence and the arguments of the parties are presented and the conduct of the hearing.

§ 417.678 Evidence.

The hearing officer will rule on the admissibility of evidence and may admit evidence that would be inadmissible under rules applicable to court procedures.

§ 417.680 Witnesses.

(a) The hearing officer may examine the witnesses.

(b) The parties or their representatives will be permitted to examine their witnesses and cross-examine witnesses of other parties.

§ 417.682 Discovery.

(a) Prehearing discovery will be permitted upon timely request of a party.

(b) A request is timely if it is made before the beginning of the hearing.

(c) A reasonable time for inspection and reproduction of documents will be provided by order of the hearing officer.

(d) The hearing officer's order on all discovery matters is final.

§ 417.684 Prehearing.

The hearing officer may schedule a prehearing conference if he or she believes that a conference would more clearly define the issues.

§ 417.686 Record of hearing.

(a) A complete record of the proceedings at the hearing will be made and transcribed and made available to all parties upon request.

(b) The record may not be closed until a hearing decision has been issued.

§ 417.688 Authority of hearing officer.

In exercising his or her authority, the hearing officer must comply with the provisions of title XVIII and related provisions of the Act, the regulations issued by the Secretary, and general instructions issued by HCFA in implementing that Act.

§ 417.690 Notice and effect of hearing decision.

(a) As soon as practical after the close of the hearing, the hearing officer will issue a written decision that—

(1) Is based upon the evidence of record; and

(2) Contains separately numbered findings of fact and conclusions of law.

(b) The hearing officer will provide a copy of the hearing decision to each party.

(c) The hearing decision is final and binding unless it is reopened and revised in accordance with § 417.692.

§ 417.692 Reopening of initial or reconsidered determination and decision of a hearing officer.

(a) *Initial or reconsidered determination.* An initial or reconsidered determination may be reopened and revised by HCFA upon its own motion within one year of the date of the notice of determination.

(b) *Decision of hearing officer.* A decision of a hearing officer that is unfavorable to any party and is otherwise final may be reopened and revised by the hearing officer upon the officer's own motion within one year of the notice of the hearing decision. It may be reopened and revised by another hearing officer designated by HCFA if the hearing officer who issued the decision is unavailable.

(c) *Notices.* (1) The notice of reopening and of any revisions following the reopening will be mailed to the parties.

(2) The notice of revision will specify the reasons for revisions.

§ 417.694 Effect of revised determination.

The revision of an initial or reconsidered determination is final and binding unless a party files a written request for hearing of the revised determination in accordance with § 417.662.

Subpart D—Health Care Prepayment Plans

§ 417.800 Reimbursement of health care prepayment plans; definitions and basic rule.

(a) *Definitions.* As used in this subpart, unless the context indicates otherwise—

"Covered Part B services" means physicians' services, diagnostic X-ray tests, laboratory, other diagnostic tests, and any additional medical and other health services, that the HCPP furnishes to its Medicare enrollees.

"Health care prepayment plan" (HCPP) means an organization that—

(1) Is responsible for the organization, financing and delivery of covered Part B services to a defined population on a prepayment basis;

(2) Meets the conditions specified in paragraph (b) of this section; and

(3) Elects to be reimbursed on a reasonable cost basis.

"Medicare enrollee" means a beneficiary under Part B of Medicare who has been identified of HCFA records as an enrollee of the HCPP.

"Reporting period" means the period specified by HCFA for which an HCPP must report its costs and utilization.

(b) *Qualifying conditions.* (1) Except as provided in paragraph (b)(2) of this section, an organization wishing to participate as an HCPP must—

(i) Enter into a written agreement with HCFA as specified in § 417.801;

(ii) Furnish physicians' services through its employees or under a formal arrangement with a medical group, independent practice association or individual physicians; and

(iii) Furnish covered Part B services to its Medicare enrollees through institutions, entities, and persons that have qualified under the applicable requirements of Title XVIII of the Social Security Act.

(2) An organization that, as of January 31, 1983, was being reimbursed on a reasonable cost basis under section 1833(a)(1)(A) of the Act, and that would not otherwise meet the conditions specified in paragraph (b)(1), may receive reimbursement on a reasonable

cost basis as an HCPP, provided it files an agreement with HCFA as required by § 417.801.

(c) *Payment of reasonable cost.* (1) Except as otherwise provided in this subpart, HCFA pays an HCPP on the basis of the reasonable cost it incurs, as specified in §§ 417.530 through 417.576, for the covered Part B services furnished to its Medicare enrollees.

(2) In determining the amount due an HCPP for covered Part B services furnished its Medicare enrollees, HCFA deducts from the reasonable cost actually incurred by the HCPP an amount equal to the actuarial value of the deductible and coinsurance amount that would otherwise be applicable to those services if the Medicare enrollees who received the services had not been enrolled in the HCPP.

(d) *Covered services not reimbursed to an HCPP.* (1) Services reimbursed under Part A are not reimbursable to an HCPP. HCFA makes payment for these services directly to the hospital, or other provider of services, on a reasonable cost basis through the provider's Medicare fiscal intermediary (for more details, see Subpart D of Part 405 of this chapter).

(2) Covered Part B services furnished by a provider of services to an HCPP's Medicare enrollees are not payable to the HCPP. HCFA makes payment for these services to the provider on behalf of the Medicare enrollee through the provider's Medicare fiscal intermediary. This requirement does not affect Medicare payment to the HCPP for physicians' services furnished to its Medicare enrollees for which the physicians are compensated by the HCPP.

(e) *Payment for services to nonenrollees.* HCFA makes payment to an HCPP for covered Part B services furnished by the HCPP to a Medicare beneficiary who is not enrolled in the HCPP if the beneficiary assigns his rights to payment in accordance with § 405.1675 of this chapter. Payment is made on a reasonable charge basis through the HCPP's Medicare carrier.

§ 417.801 Agreements between HCFA and health care prepayment plans.

(a) *General requirement.* (1) In order to participate and receive payment under the Medicare program as an HCPP as defined in § 417.800, an organization must enter into a written agreement with HCFA.

(2) An existing group practice prepayment plan (GPPP) that continues as an HCPP under this Subpart D must have entered into a written agreement with HCFA within 60 days of January 31, 1983.

(b) *Terms.* The agreement must provide that the HCPP agrees to—

(1) Maintain compliance with the requirements for participation and reimbursement on a reasonable cost basis of HCPPs as specified in § 417.800;

(2) Not charge the Medicare enrollee, as defined in § 417.800, a beneficiary, or any other person for items or services for which that individual is entitled to have payment made under the provisions of this part, except for any deductible or coinsurance amounts for which the individual is liable;

(3) Refund, as promptly as possible, any money incorrectly collected as charges or premiums, or in any other way from Medicare enrollees in the HCPP in accordance with the requirements specified in § 417.456;

(4) Not impose any limitations on the acceptance of Medicare enrollees or beneficiaries for care and treatment that it does not impose on all other individuals; and

(5) Consider any additional requirements that HCFA finds necessary or desirable for efficient and effective program administration.

(c) *Duration of agreement.* Except for the term of the initial agreement, the agreement is for a term of one year and may be renewed annually by mutual consent. The term of the intitial agreement is set by HCFA.

(d) *Termination or nonrenewal of agreement by HCFA.* (1) HCFA may terminate or not renew an agreement if it determines that—

(i) The HCPP no longer meets the requirements for participation and reimbursement as an HCPP as specified in § 417.800;

(ii) The HCPP is not in substantial compliance with the provisions of the agreement, applicable HCFA regulations, or applicable provisions of the Medicare law; or

(iii) The HCPP undergoes a change in ownership as specified in §§ 417.520 through 417.523.

(2) HCFA will give notice of termination or nonrenewal to the HCPP at least 90 days before the effective date stated in the notice.

(e) *Termination or nonrenewal of agreement by HCPP.* (1) If an HCPP does not wish to renew its agreement at the end of the term, it must give written notice to HCFA at least 90 days before the end of the term of the agreement. If an HCPP wishes to terminate its agreement before the end of the term, it must file a written notice with HCFA stating the intended effective date of termination.

(2) HCFA may approve the termination date proposed by the HCPP, or set a different date no later than 6 months after that date. HCFA makes this decision based on a finding that termination on a specific date would not—

(i) Unduly disrupt the furnishing of services to the community serviced by the HCPP; or

(ii) Otherwise interfere with the efficient administration of the Medicare program.

§ 417.802 Allowable costs.

(a) *General rule.* The costs that are considered allowable for HCPP reimbursement are the same as those for reasonable cost HMOs and CMPs specified in §§ 417.530 through 417.550, except those in §§ 417.531, 417.532 (a)(3) and (c) through (g), 417.536 (l) and (m), 417.546, 417.548, and 417.550(b)(2).

(b) *Physicians' services and other Part B supplier services furnished under arrangements.*—(1) *Principle.* The amount paid by an HCPP for physicians' services and other Part B supplier services furnished under arrangements is an allowable cost to the extent it is reasonable.

(2) *Application: Payment on other than a fee-for-service basis.* If the HCPP pays for physicians' services and other Part B supplier services on other than a fee-for-service basis—

(i) Except as specified in paragraph (b)(2)(ii) of this section, the costs incurred by the HCPP may be considered reasonable if they—

(A) Do not exceed those that a prudent and cost-conscious buyer would incur to purchase those services; and

(B) Are comparable to costs incurred for similar services furnished by similar physicians of other suppliers in the same or a similar locality.

(ii)(A) If a physician group to whom the HCPP makes payment compensates its physicians on a fee-for-service basis, the HCPP's payment to the group may not exceed the reasonable charges for those services, as defined in Subpart E of Part 405 of this chapter.

(B) Payment in excess of the limits specified in paragraph (b)(2)(ii)(A) of this section is allowable if the group has procedures under which members of the group accept effective incentives, such as risk-sharing, designed to avoid unnecessary or unduly costly utilization of health services. In such cases, the amount paid by the HCPP is considered reasonable if it meets the conditions specified in paragraph (b)(2)(i) of this section.

(3) *Application: Payment on a fee-for-service basis.* If the HCPP pays for physicians' services and other Part B supplier services on a fee-for-service basis—

(i) Except as specified in paragraph (b)(3)(ii) of this section, the costs incurred by the HCPP are considered reasonable if they do not exceed—

(A) The reasonable charges for those services, as defined in Subpart E of Part 405 of this chapter; and

(B) The amount that HCFA would pay for those services if they were furnished to beneficiaries who are not enrolled in the HCPP and who receive the services from sources other than providers of services or other entities that are reimbursed on a reasonable cost basis.

(ii) Payment to a physician group organized on an individual-practice basis is not subject to the paragraph (b)(3)(i) of this section if the group pays its physicians on a fee-for-service basis and has procedures under which the members of the group accept effective incentives, such as risk-sharing, designed to avoid unnecessary or unduly costly utilization of health services. In these cases, the amount paid by an HCPP is considered reasonable if it meets the conditions specified in paragraph (b)(2)(i) of this section.

§ 417.804 Cost apportionment.

(a) The HCPP follows the cost apportionment principles specified in §§ 417.552 through 417.566, except for provisions on provider costs and provisions on departmental apportionment.

(b) The HCPP may use a method for reporting costs that is approved by HCFA. HCFA bases its approval on a finding that the method—

(1) Results in an accurate and equitable allocation of allowable costs; and

(2) Is justifiable from an administrative and cost efficiency standpoint.

§ 417.806 Financial records, statistical data, and cost finding.

(a) The principles specified in § 417.568 will apply to HCPPs, except those in paragraph (c) of that section.

(b) The HCPP may use a method for reporting costs that is approved by HCFA. HCFA bases its approval on a finding that the method—

(1) Results in an accurate and equitable allocation of allowable costs; and

(2) Is justifiable from an administrative and cost efficiency standpoint.

(c) An HCPP must permit the Department and the Comptroller General to audit or inspect any books and records of the HCPP and of any related organization that pertain to the determination of amounts payable for covered Part B services furnished its Medicare enrollees. For purposes of this requirement, the principles specified in § 417.486 apply to HCPPs.

§ 417.808 Interim per capita payments.

The HCPP follows the principles specified in §§ 417.570 and 417.572 on interim per capita payments, except for the following:

(a) When applying these principles in to HCPPs, the term "reporting period" should be used instead of the term "contract period" contained in that section.

(b) An HCPP must submit to HCFA an annual operating budget and enrollment forecast, in the form and detail specified by HCFA, at least 60 days before the beginning of each reporting period. A reporting period must be 12 consecutive months, except that the HCPP's initial reporting period for participating in Medicare may be as short as 6 months or as long as 18 months.

(c) An HCPP must submit to HCFA an interim cost report and enrollment data applicable to the first 6-month period of the HCPP's reporting period in the form and detail specified by HCFA. The interim cost report must be submitted not later than 45 days after the close of the first 6-month period of the HCPP's reporting period.

(d) In lieu of an interim payment based on the actual monthly enrollment in an HCPP, HCFA and the HCPP may agree to a uniform monthly interim reimbursement rate for a reporting period. This interim rate is based on the HCPP's budget and enrollment forecast, if HCFA is satisified that the rate is consistent with efficiency and economy, and will not result in excessive adjustment at the end of the reporting period.

§ 417.810 Final settlement.

(a) *General requirement.* HCFA and an HCPP must make a final settlement, and payment of amounts due either to the HCPP or to HCFA, following the submission and review of the HCPP's annual cost report and the supporting documents specified in paragraph (b) of this section.

(b) *Annual cost report as basis for final settlement*—(1) *Form and due date.* An HCPP must submit to HCFA a cost report and supporting documents in the form and detail specified by HCFA, no later than 120 days following the close of a reporting period.

(2) *Contents.* The report must include—

(i) The HCPP's per capita incurred costs of providing covered Part B services to its Medicare enrollees during the reporting period, including any costs incurred by another organization related to the HCPP by common ownership or control;

(ii) The HCPP's methods of apportioning costs among its Medicare enrollees, enrollees who are not Medicare beneficiaries, and other nonenrollees, including Medicare beneficiaries receiving health care services on a fee-for-service or other basis; and

(iii) Information on enrollment and other data as specified by HCFA.

(3) *Extension of time to submit cost report.* HCFA may grant an HCPP an extension of time to submit a cost report for good cause shown.

(4) *Failure to report required financial information.* If an HCPP does not submit the required cost report and supporting documents within the time specified in paragraph (b)(1) of this section, and has not requested and received an extension of time for good cause shown, HCFA may—

(i) Regard the failure to report this information as evidence of likely overpayment and reduce or suspend interim payments to the HCPP; and

(ii) Determine that amounts previously paid are overpayments, and make appropriate recovery.

(c) *Determination of final settlement.* Following the HCPP's submission of the reports specified in paragraph (b) of this section in acceptable form, HCFA makes a determination of the total reimbursement due the HCPP for the reporting period and the difference, if any, between this amount and the total interim payments made to the HCPP. HCFA sends to the HCPP a notice of the amount of reimbursement by the Medicare program. This notice—

(1) Explains HCFA's determination of total reimbursement due the HCPP for the reporting period; and

(2) Informs the HCPP of its right to have the determination reviewed at a hearing as provided in Part 405, Subpart R of this subchapter.

(d) *Payment of amounts due.* (1) Within 30 days of HCFA's determination, HCFA or the HCPP, as appropriate, will make payment of any difference between the total amount due and the total interim payments made to the HCPP by HCFA.

(2) If the HCPP does not pay HCFA within 30 days of HCFA's determination of any amounts the HCPP owes HCFA, HCFA may offset further payments to the HCPP to recover, or to aid in the recovery of, any overpayment identified in its determination.

(3) Any offset of payments HCFA makes under paragraph (d)(2) of this section will remain in effect even if the HCPP has requested a hearing on the

determination under the provisions of Part 405, Subpart R of this chapter.

(e) *Tentative settlement.* (1) If a final settlement cannot be made within 90 days after the HCPP submits the report specified in paragraph (b) of this section, HCFA will make an interim settlement by estimating the amount payable to the HCPP.

(2) HCFA or the HCPP will make payment within 30 days of HCFA's determination under the tentative settlement of any estimated amounts due.

(3) The tentative settlement is subject to adjustment at the time of a final settlement.

(Catalog of Federal Domestic Assistance Programs No. 13.773, Medicare-Hospital Insurance Program, and No. 13.774, Medicare-Supplementary Medical Insurance Program)

Dated: October 5, 1984.

Carolyne K. Davis,

Administrator, Health Care Financing Administration.

Approved: December 7, 1984.

Margaret M. Heckler,

Secretary.

[Editorial Note.—The following addendum will not appear in the Code of Federal Regulations.]

Addendum—Adjusted Average Per Capita Cost Methodology for the Implementation of Prospective Risk Contracts

The Tax Equity and Fiscal Responsibility Act (Pub. L. 97-248) authorized prospective Medicare payment under risk contracts with eligible organizations. Eligible organizations are health maintenance organizations (HMOs) and other prepaid plans, known as competitive medical plans (CMPs), that provide health care services to their enrollees in return for fixed predetermined premium payments.

The Medicare program will pay monthly per capita payments in advance to an eligible organization with a risk contract for each Medicare eligible individual enrolled with the organization under the risk contract. In order to determine the appropriate payments, each enrollee will be assigned to a demographic class based on age, sex, Medicare entitlement status, institutionalization, and Medicaid status. The annual rate of the payment for each enrollee will then be set at 95 percent of the adjusted average per capita cost (AAPCC) for the demographic class to which that enrollee is assigned.

The AAPCC applicable to a demographic class is a prospective estimate of the average per capita amount that would be payable by Medicare in the contract year for a group of similarly classified Medicare eligibles in a geographic area if services were to be furnished by other than an eligible organization in the same or a similar geographic area. Thus, the AAPCC is a prospective estimate of Medicare cost levels by demographic category, in the fee-for-service (that is, noneligible organization) sector of the geographic area.

A set of AAPCC values is calculated at the county level for all Medicare insureds except those having end-stage renal disease (ESRD), in which case the calculation is performed at the State level because of the relatively small size of this segment of the population. The calculation of AAPCC values that are applicable to a future calendar year is developed in four conceptually basic steps:

1. Medicare national average calendar year per capita costs are projected for the future year under consideration.

2. Geographic adjustment factors that reflect the historical relationships between the county's and the nation's per capita costs are used to convert the national average per capita costs to the county level.

3. Expected Medicare per capita costs for the county are adjusted (by removing both reimbursement and enrollment attributable to Medicare beneficiaries in eligible organizations under contract with HCFA) to a fee-for-service basis.

4. The fee-for-service Medicare cost per capita is disaggregated into its demographically defined component parts to produce a set of county AAPCC values.

These steps are discussed in greater detail below.

Step 1.—The national average per capita costs to the Medicare program are projected for the future calendar year under consideration. These numbers are known as the United States per capita costs (USPCCs) and are estimated average incurred benefit costs per Medicare enrollee, loaded for carrier and intermediary expenses.

For each of Part A (hospital insurance) and Part B (supplementary medical insurance) of Medicare, the USPCCs are developed separately for the aged, the disabled, and those beneficiaries having end-stage renal disease (ESRD). The estimates that are used as the basis for the USPCCs are the most recent Medicare cost estimates prepared by the actuaries in the Office of Financial and Actuarial Analysis within HCFA.

Carrier and intermediary expense loadings are calculated separately for Part A and Part B as the ratio of cash administrative expenses to cash benefits. The administrative expense amounts are obtained from reports of HCFA's Division of Contractor Financial Management. The cash benefits amount are obtained from reports of the U.S. Treasury's Division of Financial Management. Monthly USPCCs are calculated for the future calendar year as:

$$\text{USPCC} = \frac{\text{(annual incurred benefit outlays)}}{\text{(projected enrollment)}} \times (1.0 + \text{loading factor})$$

where

$$\text{loading factor} = \frac{\text{(cash administrative expenses)}}{\text{(cash benefit outlays)}}$$

Step 2.—After the USPCCs have been determined, national costs to the Medicare program are adjusted to a county level. For each of Parts A and B, the historical relationship between the county per capita cost and the national per capita cost is established separately for the aged, the disabled, and the ESRD beneficiaries, and is used to make the adjustment. These per capita costs are developed from the entire Medicare enrollment and the aggregate amount of claims paid. No sample population is involved.

Calculations of county and national per capita costs are based on reimbursement *and* enrollment data tabulated in Medicare's statistical system along with reimbursement data provided by HCFA's Group Health Plans Operations Staff (GHPOS). The reimbursement data provided by GHPOS represents payments excluded from Medicare's statistical system that were made to health care prepayment plans (HCPPs) and HMOs dealing directly with HCFA.

The statistical system data is tabulated by county of the beneficiary's

residence as well as by coverage (Part A or Part B) and Medicare eligibility status (aged, disabled, or ESRD). The GHPOS reimbursement data is listed only by coverage and by the prepaid plan to which it was paid. Consequently, one of two approximation methods is used to allocate the GHPOS reimbursement amounts by county of residence and by Medicare eligibility status.

Since service areas and enrollment mixes are not uniform among the prepaid plans, the allocations are performed separately for each plan. The allocation is made on the basis of the distribution of the plan's Medicare membership by county of residence. If the membership by county is not available, the overall Medicare enrollment by county is used as the basis for allocation. Once a GHPOS reimbursement allocation is made to the county, the amount is added to the statistical system's reimbursement amount for that county, giving the total reimbursement for the county.

County per capita costs for each of the five most recent available years are then calculated as follows:

$$\frac{\text{(statistical system reimbursement + GHPOS reimbursement)}}{\text{(statistical system enrollment)}}$$

National per capita costs for each of the five years involved are similarly calculated using reimbursement and enrollment data applicable to the entire nation.

If CPCC, and NPCC, respectively represent the county and national per capita costs in year i, then the geographic index for year i is:

$GI_i = CPCC_i / NPCC_i$.

The adjustment factor to be applied to the USPCC is the unweighted average of the geographic indices for the five years. This factor is known as the "geographic adjustment" (GA):

$GA = (GI_1 + GI_2 + \ldots + GI_5)/5$.

Application of this factor to the contract year USPCC is used to adjust the projected national per capita cost to the county level:

Projected County Per Capita Cost = GA × USPCC.

For that portion of the population having end-stage renal disease, the relationship between the State per capita cost and the national per capita cost is used to make the geographic adjustment. State data rather than county data are used because of the relatively small size of this segment of the population.

Step 3.—At this point, six per capita cost figures have been calculated for the county. For each of Parts A and B, there is a separate cost for each of the aged, disabled, and renal disease populations. These costs are averages for the entire county (or State for the renal disease beneficiaries) and therefore include the reimbursement and enrollment totals of prepaid health plans. The third step is to remove, from the county (or state) per capita cost, the incurred cost and enrollment of any eligible organization that serves the county and is under contract with HCFA. This is accomplished by subtracting the combined total of the organization's incurred costs and enrollments from the entire county's (or State's) Medicare cost and enrollment. The per capita cost is then recalculated.

Step 4.—In the final step, the recalculated county per capita cost is converted into rates that vary according to certain demographic variables: age, sex, Medicaid status, and institutional status. (For purposes of this methodology, an institutionalized individual is a Medicare beneficiary who has been a resident for at least 30 days of a nursing home, sanatorium, rest home, convalescent home, long-term care hospital, or domiciliary home, and a Medicaid individual is a Medicare beneficiary who has been determined by the Medicaid agency of the State in which he or she resides to be eligible for Medicaid.) For each of the aged and disabled, there are thirty cells for each of Parts A and B, corresponding to different combinations of these variables (see Table 1). The factor shown in each cell is the ratio of the cost for a Medicare beneficiary having that particular demographic-cell characteristic to the average per capita cost. These relative cost factors are referred to as demographic factors, and were developed from the last three years (1974–76) of the Current Medicare Survey, incorporating roughly 20,000 Medicare beneficiary-years of observations. Through the use of these demographic factors, the county per capita cost is converted into rates. (A detailed methodology for this step is shown in the Appendix.) However, no demographic adjustment is made to the state per capita cost for those beneficiaries having end-stage renal disease.

For the county, there will be thirty rates for each of Parts A and B, for the aged and disabled populations separately. For each Medicare eligible enrolled under the risk contract, Medicare will pay the organization 95 percent of the rate corresponding to the demographic class to which the beneficiary is assigned.

Appendix to Addendum—Conversion of County Per Capita Costs Into Rates

The AAPCC methodology adjusts for age, sex, Medicaid status, and institutional status of the Medicare beneficiaries in a given county.[1] Table 1 shows the demographic cells used in this adjustment. The adjustment process hinges on the demographic factors (DF_i for each demographic cell i) developed from the Current Medicare Survey. Each factor relates the Medicare cost for a person in that demographic cell to the cost for the average Medicare beneficiary (factor = 1.00). Because of rounding and shifts in the demographic distribution of the Medicare population, it is possible that the average demographic factor for the entire Medicare population would not be exactly 1.00, although it should be close to that value. Demographic distributions for a given county could lead to an average demographic factor other than 1.00. The extent of institutionalization can be extremely volatile, especially for a small county. Medicaid entitlement can vary dramatically by State. Even age-sex differences can have an impact. This problem of county demographic variations is addressed by adjusting the county fee-for-service per capita costs ($PCC_{f,s}$) to the theoretical level, K, that would result if the county demographic distribution were such as to give an average demographic factor of 1.00. This is accomplished simply by dividing $PCC_{f,s}$ by the average demographic factor for the county calculated by using the actual fee-for-service county population ($_{f,s}P_i$ for each demographic cell i):

$$K = PCC_{f,s} \times \frac{(_{f,s}P_1 + \ldots + {}_{f,s}P_{30})}{(_{f,s}P_1 * DF_1 + \ldots + {}_{f,s}P_{30} * DF_{30})}$$

[1] This adjustment does not apply to those beneficiaries suffering from end-stage renal disease.

This calculation (and in fact, the entire AAPCC calculation) must be done separately for each of aged Part A, aged Part B, disabled Part A, and disabled Part B beneficiaries.

Demographic adjustments are not made for Medicare beneficiaries with end-stage renal disease because we cannot determine the significance of demographics in determining the cost for people having this rare and extremely costly condition. After the county fee-for-service per capita cost has been standardized for demographic variables, yielding a value for K as defined above, it is possible to estimate the amount that those in a given demographic cell would have cost Medicare had they not been enrolled in a prepaid health plan, simply by multiplying K by DF_i for each cell i. This procedure allows 95 percent of the AAPCC to be presented as a set of rates, $R_i = .95 * K * DF_i$, varying according to the demographic cells shown in Table 1.

Table 2 sets forth the standardized per capita rates of payment by county. These standardized per capita rates of payment represent 95 percent of the standardized county per capita cost. As mentioned above, these rates must be multiplied by the demographic cost factors shown in Table 1 to give the actual per capita rates of payment for each county. The following is an example of how the actual per capita rates of payment will be calculated for a particular county.

Sample Calculation of the Per Capita Rates of Payment for Autauga County, Alabama

For each county, there will be thirty rates of payment for each of aged Part A, disabled Part A, aged Part B, and disabled Part B. These rates vary according to the demographic cells shown in Table 1.

The rates for Autauga County, Alabama are presented below in table form. The thirty rates for each part are calculated by multiplying the county standardized per capita rates obtained from Table 2 by the corresponding demographic factors in Table 1. For example, Table 2 shows that the aged Part A standardized per capita rate is $111.81. Table 1 shows that the aged Part A demographic factors for male noninstitutionalized Medicaid enrollees range from 1.35 (ages 65–69) to 2.30 (ages 85 and over).

Age group	Demographic cost factor	Standardized per capita rate	95 pct of AAPCC rates
85 and over	2.30		$257.16
80 to 84	2.25		251.57
75 to 79	2.00	$111.81	223.62
70 to 74	1.65		184.49
65 to 69	1.35		150.94

Multiplying each of these factors by the standardized per capita rate gives the corresponding per capita rates of payment shown in the sample table set forth below.

As further example, the disabled Part B noninstitutionalized non-Medicaid rate ($55.18) for a female age 57 can be calculated by multiplying the demographic factor for her age group (1.10) by the appropriate standardized per capita rate ($50.16).

SAMPLE CALCULATION OF PER CAPITA RATES OF PAYMENT FOR CALENDAR YEAR 1985 FOR AUTAUGA COUNTY

STATE: ALABAMA COUNTY NAME	AGED PART A	AGED PART B	DISABLED PART A	DISABLED PART B
AUTAUGA (From Table 2)	$111.81	$43.60	$125.12	$50.16

AGE GROUP	MALE INSTITUTIONALIZED	MALE NONINSTITUTIONALIZED MEDICAID	MALE NONINSTITUTIONALIZED NON-MEDICAID	FEMALE INSTITUTIONALIZED	FEMALE NONINSTITUTIONALIZED MEDICAID	FEMALE NONINSTITUTIONALIZED NON-MEDICAID
AGED			PART A			
85 & OVER	251.57	257.16	134.17	223.62	206.85	122.99
80-84	251.57	251.57	128.58	223.62	190.08	117.40
75-79	251.57	223.62	117.40	223.62	162.12	95.04
70-74	251.57	184.89	95.04	212.44	128.58	78.27
65-69	223.62	150.94	78.27	190.08	100.63	67.09
DISABLED						
60-64	68.82	212.70	112.61	81.33	187.68	156.40
55-59	100.10	175.17	93.84	125.12	181.42	125.12
45-54	137.63	162.66	81.33	181.42	181.42	118.86
35-44	150.14	131.38	68.82	187.68	162.66	81.33
UNDER 35	181.42	112.61	62.56	206.45	143.89	62.56
AGED			PART B			
85 & OVER	78.48	69.76	47.96	69.76	52.32	41.42
80-84	78.48	69.76	47.96	69.76	52.32	41.42
75-79	78.48	67.58	47.96	69.76	52.32	41.42
70-74	78.48	63.22	43.60	69.76	50.14	37.06
65-69	76.30	54.50	37.06	67.58	47.96	30.52
DISABLED						
60-64	45.14	72.73	45.14	57.68	75.24	60.19
55-59	55.18	65.21	37.62	70.22	70.22	55.18
45-54	65.21	62.70	32.60	87.78	65.21	50.16
35-44	67.72	50.16	25.08	87.78	55.18	40.13
UNDER 35	67.72	45.14	17.56	87.78	45.14	32.60

Table 3 sets forth the actual per capita rates of payment by State for Medicare enrollees who have been medically determined to have ESRD. These rates are *not* multiplied by the demographic cost factors in Table 1.

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TABLE 1

Demographic Cost Factors For 1985

AGE GROUP	MALE			FEMALE		
	INSTITUTIONALIZED	NONINSTITUTIONALIZED		INSTITUTIONALIZED	NONINSTITUTIONALIZED	
		MEDICAID	NON-MEDICAID		MEDICAID	NON-MEDICAID
PART A - HOSPITAL INSURANCE						
AGED						
85 & OVER	2.25	2.30	1.20	2.00	1.85	1.10
80-84	2.25	2.25	1.15	2.00	1.70	1.05
75-79	2.25	2.00	1.05	2.00	1.45	.85
70-74	2.25	1.65	.85	1.90	1.15	.70
65-69	2.00	1.35	.70	1.70	.90	.60
DISABLED						
60-64	.55	1.70	.90	.65	1.50	1.25
55-59	.80	1.40	.75	1.00	1.45	1.00
45-54	1.10	1.30	.65	1.45	1.45	.95
35-44	1.20	1.05	.55	1.50	1.30	.65
UNDER 35	1.45	.90	.50	1.65	1.15	.50
PART B - SUPPLEMENTAL MEDICAL INSURANCE						
AGED						
85 & OVER	1.80	1.60	1.10	1.60	1.20	.95
80-84	1.80	1.60	1.10	1.60	1.20	.95
75-79	1.80	1.55	1.10	1.60	1.20	.95
70-74	1.80	1.45	1.00	1.60	1.15	.85
65-69	1.75	1.25	.85	1.55	1.10	.70
DISABLED						
60-64	.90	1.45	.90	1.15	1.50	1.20
55-59	1.10	1.30	.75	1.40	1.40	1.10
45-54	1.30	1.25	.65	1.75	1.30	1.00
35-44	1.35	1.00	.50	1.75	1.10	.80
UNDER 35	1.35	.90	.35	1.75	.90	.65

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: ALABAMA COUNTY NAME	****** AGED ****** PART A	 PART B	*** DISABLED *** PART A	 PART B
AUTAUGA	$111.81	$43.60	$125.12	$50.16
BARBOUR	$91.33	$36.30	$100.60	$43.61
BLOUNT	$120.47	$50.62	$135.80	$62.74
BUTLER	$90.89	$34.82	$101.94	$42.61
CHAMBERS	$88.39	$40.82	$110.94	$60.10
CHILTON	$98.09	$42.71	$120.31	$57.29
CLARKE	$95.20	$41.16	$98.11	$43.80
CLEBURNE	$104.27	$40.57	$141.42	$61.18
COLBERT	$117.00	$39.97	$145.94	$54.31
COOSA	$86.71	$42.51	$100.36	$53.40
CRENSHAW	$93.41	$37.65	$86.96	$36.15
DALE	$90.13	$39.89	$113.57	$50.37
DE KALB	$75.91	$33.46	$100.81	$43.90
ESCAMBIA	$110.51	$48.04	$132.54	$59.85
FAYETTE	$80.24	$35.87	$111.61	$54.96
GENEVA	$91.12	$40.95	$82.07	$39.83
HALE	$72.32	$31.56	$108.39	$44.42
HOUSTON	$103.63	$45.82	$127.47	$56.03
JEFFERSON	$140.73	$60.29	$173.24	$71.23
LAUDERDALE	$97.80	$38.17	$122.22	$54.39
LEE	$78.92	$38.38	$98.55	$46.46
LOWNDES	$80.01	$42.86	$64.57	$36.95
MADISON	$102.46	$48.56	$114.51	$56.69
MARION	$106.26	$41.96	$123.83	$52.08
MOBILE	$133.05	$51.79	$146.42	$57.97
MONTGOMERY	$118.55	$46.73	$112.95	$47.24
PERRY	$72.73	$32.35	$82.72	$38.55
PIKE	$84.17	$35.24	$105.14	$43.62
RUSSELL	$123.32	$42.63	$169.16	$57.97
SHELBY	$133.86	$62.40	$164.20	$77.67
TALLADEGA	$104.97	$52.39	$112.11	$61.16
TUSCALOOSA	$99.29	$42.10	$107.11	$46.62
WASHINGTON	$113.76	$47.68	$116.91	$47.41
WINSTON	$100.31	$38.76	$143.73	$56.65
STATE: ALASKA				
ALEUTIAN	$79.32	$31.36	$99.26	$36.86
ANGOON	$97.39	$19.49	$112.99	$58.10
BETHEL	$45.20	$14.77	$54.73	$6.20
BRISTOL BAY	$54.43	$24.42	$47.90	$19.00
FAIRBANKS	$198.42	$93.18	$181.88	$100.16
JUNEAU	$158.27	$57.42	$155.15	$72.86
KETCHIKAN	$116.50	$64.29	$116.11	$65.60
KODIAK	$146.53	$67.81	$151.98	$82.04
MATANUSKA	$155.83	$60.84	$83.72	$43.61
OUTER KETCHIKAN	$89.35	$26.42	$179.31	$90.68
SEWARD	$168.11	$68.43	$254.61	$70.34
SKAGWAY-YAKUTAT	$186.77	$51.74	$130.80	$64.16
UPPER YUKON	$131.49	$39.56	$164.10	$78.75

STATE: ALABAMA COUNTY NAME	****** AGED ****** PART A	 PART B	*** DISABLED *** PART A	 PART B
BALDWIN	$101.23	$45.98	$111.20	$57.21
BIBB	$90.21	$47.06	$113.00	$52.55
BULLOCK	$64.76	$26.69	$84.59	$30.74
CALHOUN	$105.54	$46.53	$116.78	$54.80
CHEROKEE	$93.16	$42.11	$139.94	$66.25
CHOCTAW	$93.10	$45.01	$120.72	$56.22
CLAY	$66.55	$30.95	$83.78	$39.75
COFFEE	$94.58	$40.02	$117.33	$48.61
CONECUH	$99.64	$43.94	$120.17	$54.94
COVINGTON	$113.55	$46.05	$147.19	$61.65
CULLMAN	$112.85	$43.47	$141.50	$57.89
DALLAS	$89.01	$39.92	$104.34	$46.42
ELMORE	$115.59	$42.94	$137.55	$53.33
ETOWAH	$108.39	$40.31	$127.90	$49.57
FRANKLIN	$104.70	$39.69	$142.02	$56.27
GREENE	$61.11	$27.08	$57.64	$25.92
HENRY	$93.29	$38.98	$117.67	$48.57
JACKSON	$76.28	$36.02	$88.15	$44.80
LAMAR	$87.28	$30.64	$115.01	$44.69
LAWRENCE	$104.35	$45.30	$141.51	$61.41
LIMESTONE	$79.17	$34.24	$90.07	$40.71
MACON	$68.78	$31.53	$58.01	$29.96
MARENGO	$99.15	$37.19	$112.87	$41.45
MARSHALL	$74.89	$34.85	$102.67	$49.21
MONROE	$100.81	$37.78	$99.84	$47.91
MORGAN	$118.96	$43.39	$133.22	$53.58
PICKENS	$85.44	$36.98	$104.92	$41.03
RANDOLPH	$96.26	$35.73	$109.62	$46.59
ST CLAIR	$117.88	$48.49	$137.87	$62.40
SUMTER	$94.36	$44.00	$130.56	$50.92
TALLAPOOSA	$86.92	$38.18	$114.91	$54.99
WALKER	$143.19	$58.15	$155.20	$65.35
WILCOX	$64.12	$29.33	$70.92	$28.93
STATE: ALASKA				
ANCHORAGE	$186.66	$90.20	$160.65	$79.88
BARROW-NORTH SLOPE	$70.41	$31.39	$178.12	$47.48
BRISTOL BAY BOROUGH	$154.95	$78.89	$239.61	$109.12
CORDOVA-MC CARTHY	$152.09	$61.34	$216.44	$101.47
HAINES	$100.15	$33.58	$173.05	$82.70
KENAI-COOK INLET	$127.55	$55.76	$131.81	$52.92
KOBUK	$44.83	$20.20	$136.75	$70.48
KUSKOKWIN	$60.38	$30.79	$174.91	$76.30
NOME	$93.25	$27.78	$65.61	$21.44
PRINCE OF WALES	$95.11	$28.34	$188.94	$92.80
SITKA	$141.88	$56.36	$200.33	$88.85
SOUTHEAST FAIRBANKS	$112.31	$54.06	$156.63	$64.21
VALDZ-CHITNA-WHITIER	$95.52	$40.30	$234.29	$81.49

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: ALASKA COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
WADE HAMPTON	$30.46	$7.78	$100.72	$17.10
YUKON-KOYUKUK	$143.51	$47.84	$324.56	$111.37
STATE: ARIZONA				
APACHE	$55.11	$19.58	$43.61	$18.40
COCONINO	$83.46	$44.75	$102.30	$54.45
GRAHAM	$109.29	$58.71	$104.29	$55.80
MARICOPA	$131.30	$76.91	$164.09	$101.16
NAVAJO	$81.85	$37.75	$79.17	$43.41
PINAL	$110.58	$58.86	$118.20	$73.45
YAVAPAI	$91.03	$53.53	$93.52	$62.29
STATE: ARKANSAS				
ARKANSAS	$107.47	$58.25	$89.10	$52.83
BAXTER	$90.68	$43.99	$110.18	$55.97
BOONE	$73.52	$39.05	$63.43	$43.68
CALHOUN	$84.12	$47.43	$118.68	$69.98
CHICOT	$95.66	$42.71	$78.68	$44.20
CLAY	$99.92	$44.81	$86.38	$46.73
CLEVELAND	$74.72	$46.10	$54.14	$35.64
CONWAY	$97.03	$55.41	$88.04	$58.77
CRAWFORD	$101.43	$50.26	$93.41	$56.97
CROSS	$92.04	$39.55	$97.31	$47.30
DESHA	$83.39	$42.71	$86.53	$49.66
FAULKNER	$91.76	$49.84	$81.91	$52.16
FULTON	$81.00	$39.05	$68.85	$46.02
GRANT	$78.16	$48.71	$60.88	$42.04
HEMPSTEAD	$84.07	$40.84	$83.83	$49.04
HOWARD	$84.14	$44.17	$71.57	$40.45
IZARD	$70.08	$38.04	$73.65	$43.55
JEFFERSON	$59.51	$42.13	$64.83	$48.23
LAFAYETTE	$68.83	$33.94	$74.93	$52.46
LEE	$79.97	$37.24	$93.99	$55.07
LITTLE RIVER	$85.27	$42.89	$91.62	$54.66
LONOKE	$97.26	$56.98	$86.37	$56.48
MARION	$97.69	$44.25	$100.29	$56.41
MISSISSIPPI	$115.53	$51.16	$107.69	$51.12
MONTGOMERY	$73.44	$49.28	$61.37	$49.59
NEWTON	$52.60	$31.55	$60.46	$37.05
PERRY	$102.65	$57.13	$63.00	$53.88
PIKE	$78.35	$43.89	$71.03	$49.78
POLK	$76.34	$40.85	$65.00	$46.23
PRAIRIE	$113.44	$62.45	$98.25	$65.46
RANDOLPH	$89.46	$43.80	$70.90	$41.96
SALINE	$107.79	$60.04	$96.97	$63.56
SEARCY	$55.92	$34.86	$56.91	$37.58
SEVIER	$86.66	$41.24	$99.44	$58.15
STONE	$105.15	$44.39	$76.45	$45.43
VAN BUREN	$73.78	$44.78	$62.09	$43.88

STATE: ALASKA COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
WRANGELL-PETERSBURG	$126.25	$64.73	$69.38	$39.86
STATEWIDE	$148.31	$69.38	$150.70	$72.42
STATE: ARIZONA				
COCHISE	$111.55	$56.28	$105.83	$66.34
GILA	$122.38	$61.56	$123.24	$69.56
GREENLEE	$98.36	$48.37	$112.50	$56.22
MOHAVE	$124.32	$61.87	$132.33	$83.54
PIMA	$132.76	$70.02	$141.67	$87.16
SANTA CRUZ	$99.69	$46.59	$102.58	$49.75
YUMA	$108.10	$59.81	$119.58	$74.51
STATE: ARKANSAS				
ASHLEY	$85.15	$39.10	$102.99	$47.71
BENTON	$100.77	$46.91	$107.36	$54.85
BRADLEY	$75.02	$35.33	$57.35	$37.93
CARROLL	$77.50	$36.42	$78.19	$48.76
CLARK	$91.67	$48.84	$72.23	$50.19
CLEBURNE	$71.87	$42.88	$80.24	$56.38
COLUMBIA	$79.41	$32.93	$79.51	$36.12
CRAIGHEAD	$87.96	$53.56	$99.30	$63.39
CRITTENDEN	$95.36	$44.51	$112.04	$53.77
DALLAS	$82.09	$47.02	$73.62	$47.23
DREW	$75.29	$38.83	$86.44	$45.71
FRANKLIN	$81.26	$40.19	$66.83	$50.90
GARLAND	$101.97	$60.96	$99.14	$67.55
GREENE	$79.65	$42.08	$82.60	$64.02
HOT SPRING	$100.50	$54.49	$79.42	$57.15
INDEPENDENCE	$93.91	$43.78	$77.01	$51.41
JACKSON	$143.19	$78.75	$134.89	$81.15
JOHNSON	$102.96	$55.37	$70.55	$51.26
LAWRENCE	$84.04	$48.40	$85.22	$50.83
LINCOLN	$60.66	$44.49	$66.21	$47.11
LOGAN	$83.76	$46.51	$82.57	$49.39
MADISON	$82.55	$34.12	$77.59	$49.08
MILLER	$89.48	$47.60	$107.78	$63.72
MONROE	$83.28	$45.77	$79.82	$44.40
NEVADA	$78.14	$44.52	$73.47	$42.96
OUACHITA	$78.16	$48.52	$75.38	$50.81
PHILLIPS	$88.93	$40.67	$104.81	$51.60
POINSETT	$94.14	$50.23	$113.64	$71.12
POPE	$99.51	$47.91	$89.25	$54.44
PULASKI	$116.01	$65.76	$107.50	$68.87
ST FRANCIS	$85.47	$39.72	$104.25	$47.99
SCOTT	$84.30	$47.01	$79.38	$60.64
SEBASTIAN	$110.19	$57.52	$115.41	$68.00
SHARP	$73.99	$42.08	$58.92	$40.62
UNION	$98.98	$44.81	$96.16	$49.29
WASHINGTON	$105.59	$45.28	$84.23	$50.01

TABLE 2

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: ARKANSAS COUNTY NAME	****** AGED ****** PART A	 PART B	*** DISABLED *** PART A	 PART B
WHITE	$90.85	$54.03	$90.15	$60.35
YELL	$86.06	$47.14	$79.02	$52.42
STATE: CALIFORNIA				
ALAMEDA	$154.50	$84.90	$156.79	$106.59
AMADOR	$113.01	$70.33	$97.71	$87.48
CALAVERAS	$111.37	$68.71	$112.69	$94.08
CONTRA COSTA	$144.68	$95.84	$147.73	$107.40
ELDORADO	$95.78	$69.76	$108.44	$78.88
GLENN	$111.10	$66.67	$93.50	$75.94
IMPERIAL	$121.69	$88.00	$108.39	$86.65
KERN	$130.02	$80.33	$122.16	$95.19
LAKE	$135.96	$81.90	$121.05	$94.26
LOS ANGELES	$192.42	$108.99	$195.70	$126.25
MARIN	$134.86	$87.10	$178.63	$113.38
MENDOCINO	$117.05	$65.66	$115.02	$82.17
MODOC	$130.11	$66.66	$129.35	$74.75
MONTEREY	$94.73	$67.46	$113.52	$84.88
NEVADA	$100.17	$62.03	$101.77	$75.10
PLACER	$111.69	$72.48	$98.18	$80.04
RIVERSIDE	$139.36	$85.29	$141.49	$99.05
SAN BENITO	$98.05	$63.48	$103.90	$78.99
SAN DIEGO	$127.04	$91.28	$156.91	$120.62
SAN JOAQUIN	$104.09	$73.69	$103.61	$91.97
SAN MATEO	$157.51	$84.78	$179.43	$107.18
SANTA CLARA	$122.15	$79.00	$143.55	$94.91
SHASTA	$114.47	$74.65	$97.45	$83.41
SISKIYOU	$109.60	$63.40	$99.49	$72.97
SONOMA	$118.72	$74.62	$113.44	$86.57
SUTTER	$107.66	$76.27	$116.86	$97.30
TRINITY	$107.92	$65.26	$108.26	$85.30
TUOLUMNE	$126.25	$70.01	$119.50	$84.48
YOLO	$101.41	$73.37	$115.91	$94.54
STATE: COLORADO				
ADAMS	$141.56	$66.17	$158.40	$84.56
ARAPAHOE	$137.37	$66.38	$171.04	$90.90
BACA	$123.10	$44.55	$135.85	$43.98
BOULDER	$102.62	$50.67	$124.29	$70.44
CHEYENNE	$144.52	$45.55	$209.24	$87.22
CONEJOS	$105.00	$47.10	$78.23	$44.99
CROWLEY	$76.45	$40.32	$75.67	$43.87
DELTA	$72.64	$41.18	$75.07	$48.64
DOLORES	$122.18	$50.88	$119.27	$67.81
EAGLE	$127.72	$51.34	$173.79	$86.58
EL PASO	$127.01	$59.62	$130.27	$75.18
GARFIELD	$117.75	$56.47	$177.27	$75.74
GRAND	$148.79	$62.70	$120.25	$65.34
HINSDALE	$123.99	$58.93	$142.51	$75.12

STATE: ARKANSAS COUNTY NAME	****** AGED ****** PART A	 PART B	*** DISABLED *** PART A	 PART B
WOODRUFF	$103.36	$57.83	$84.69	$55.16
STATE: CALIFORNIA				
ALPINE	$128.48	$66.69	$100.78	$68.46
BUTTE	$111.53	$70.99	$103.39	$86.31
COLUSA	$153.58	$78.59	$137.07	$95.51
DEL NORTE	$128.87	$62.10	$115.22	$67.61
FRESNO	$81.06	$63.17	$79.40	$67.56
HUMBOLDT	$113.05	$73.61	$110.94	$88.23
INYO	$158.59	$72.68	$170.20	$94.11
KINGS	$81.50	$60.16	$80.82	$77.00
LASSEN	$120.37	$67.81	$128.37	$85.54
MADERA	$87.90	$65.46	$74.15	$67.82
MARIPOSA	$96.65	$65.36	$103.72	$87.41
MERCED	$108.95	$77.75	$100.80	$84.43
MONO	$142.87	$65.35	$96.65	$81.23
NAPA	$135.50	$84.01	$147.90	$112.93
ORANGE	$181.38	$107.58	$206.71	$136.45
PLUMAS	$126.30	$71.67	$136.41	$91.46
SACRAMENTO	$116.37	$79.14	$121.48	$91.84
SAN BERNARDINO	$139.83	$80.28	$141.98	$95.95
SAN FRANCISCO	$181.55	$89.32	$177.45	$99.84
SAN LUIS OBISPO	$119.97	$81.10	$131.34	$105.42
SANTA BARBARA	$129.09	$82.61	$119.39	$94.08
SANTA CRUZ	$94.59	$67.32	$114.47	$93.23
SIERRA	$122.03	$75.03	$71.03	$66.77
SOLANO	$122.04	$86.26	$121.77	$94.80
STANISLAUS	$110.24	$73.73	$109.42	$90.04
TEHAMA	$101.52	$64.38	$89.97	$73.56
TULARE	$85.37	$63.09	$79.44	$70.58
VENTURA	$134.87	$88.74	$144.45	$116.42
YUBA	$112.90	$79.39	$101.46	$87.53
STATE: COLORADO				
ALAMOSA	$92.28	$43.64	$70.10	$48.85
ARCHULETA	$94.05	$43.04	$170.80	$59.12
BENT	$80.32	$43.30	$44.75	$29.00
CHAFFEE	$108.53	$43.85	$122.99	$52.38
CLEAR CREEK	$149.33	$65.63	$102.54	$69.18
COSTILLA	$77.14	$39.46	$85.84	$35.77
CUSTER	$83.61	$54.88	$185.64	$104.47
DENVER	$156.15	$67.15	$167.94	$83.97
DOUGLAS	$116.70	$58.63	$161.65	$86.10
ELBERT	$109.00	$47.43	$133.09	$56.76
FREMONT	$84.65	$50.79	$108.21	$68.41
GILPIN	$160.15	$66.99	$178.59	$96.97
GUNNISON	$85.54	$46.18	$84.28	$47.91
HUERFANO	$100.05	$54.12	$88.95	$43.60

TABLE 2

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: COLORADO COUNTY NAME	****** AGED PART A	****** PART B	*** DISABLED *** PART A	PART B
JACKSON	$89.98	$43.40	$111.99	$29.84
KIOWA	$141.37	$49.09	$90.28	$26.02
LAKE	$195.57	$58.75	$217.06	$69.34
LARIMER	$84.09	$50.53	$105.48	$68.15
LINCOLN	$111.65	$45.04	$99.40	$52.39
MESA	$93.53	$49.83	$98.10	$65.97
MOFFAT	$98.79	$46.84	$140.27	$74.88
MONTROSE	$85.89	$44.57	$97.96	$58.74
OTERO	$87.48	$42.57	$78.04	$45.51
PARK	$91.59	$44.85	$125.52	$76.49
PITKIN	$169.62	$65.31	$210.16	$79.67
PUEBLO	$108.92	$55.63	$133.67	$75.97
RIO GRANDE	$99.29	$42.38	$111.63	$57.12
SAGUACHE	$100.74	$45.71	$42.20	$31.63
SAN MIGUEL	$88.23	$45.73	$124.39	$61.91
SUMMIT	$106.91	$53.41	$167.77	$115.47
WASHINGTON	$111.33	$44.20	$190.76	$86.35
YUMA	$97.13	$34.04	$112.78	$45.00
STATE: CONNECTICUT				
FAIRFIELD	$147.75	$67.83	$182.97	$92.34
LITCHFIELD	$125.05	$53.80	$168.15	$92.61
NEW HAVEN	$135.17	$61.49	$154.08	$86.05
TOLLAND	$135.64	$56.32	$182.34	$96.13
STATE: DELAWARE				
KENT	$107.11	$53.05	$120.26	$70.96
SUSSEX	$124.78	$52.38	$133.41	$66.59
STATE: DIST. OF COL.				
DISTRICT OF COLUMBIA	$192.25	$86.58	$208.81	$85.66
STATE: FLORIDA				
ALACHUA	$121.18	$61.08	$105.82	$58.99
BAY	$117.71	$66.49	$122.87	$78.80
BREVARD	$113.70	$70.46	$129.45	$90.50
CALHOUN	$84.75	$45.93	$98.10	$46.04
CITRUS	$103.10	$53.14	$98.91	$62.16
COLLIER	$92.37	$66.75	$125.37	$85.95
DADE	$203.32	$125.79	$227.63	$145.01
DIXIE	$122.63	$59.09	$58.24	$43.90
ESCAMBIA	$145.83	$69.41	$157.41	$83.16
FRANKLIN	$109.33	$53.16	$112.37	$55.13
GILCHRIST	$124.49	$63.07	$99.48	$66.43
GULF	$107.95	$64.75	$108.30	$62.91
HARDEE	$123.36	$61.54	$87.65	$46.33
HERNANDO	$95.28	$55.11	$97.02	$71.18
HILLSBOROUGH	$118.79	$69.04	$127.22	$82.33
INDIAN RIVER	$118.44	$72.43	$145.92	$94.28

STATE: COLORADO COUNTY NAME	****** AGED PART A	****** PART B	*** DISABLED *** PART A	PART B
JEFFERSON	$129.51	$64.06	$156.05	$83.61
KIT CARSON	$135.15	$46.63	$147.51	$53.80
LA PLATA	$125.24	$47.97	$157.06	$72.53
LAS ANIMAS	$108.29	$53.45	$99.64	$51.70
LOGAN	$105.29	$47.59	$133.78	$56.34
MINERAL	$123.99	$56.93	$180.01	$88.04
MONTEZUMA	$114.73	$48.80	$123.61	$61.40
MORGAN	$88.28	$40.80	$117.50	$50.11
OURAY	$110.75	$46.55	$67.48	$73.41
PHILLIPS	$107.23	$49.21	$104.78	$64.06
PROWERS	$112.36	$43.29	$100.79	$39.77
RIO BLANCO	$111.93	$47.59	$116.76	$59.85
ROUTT	$104.87	$52.00	$162.30	$59.05
SAN JUAN	$147.27	$46.90	$149.43	$77.90
SEDGWICK	$100.67	$45.01	$125.00	$74.15
TELLER	$121.93	$61.84	$181.16	$85.00
WELD	$105.22	$53.70	$125.40	$70.37
STATE: CONNECTICUT				
HARTFORD	$134.82	$62.05	$158.60	$93.72
MIDDLESEX	$119.21	$58.47	$139.56	$87.00
NEW LONDON	$116.47	$50.71	$146.41	$83.90
WINDHAM	$130.91	$54.10	$156.53	$75.58
STATE: DELAWARE				
NEW CASTLE	$142.13	$61.40	$151.83	$77.94
STATE: DIST. OF COL.				
STATE: FLORIDA				
BAKER	$124.45	$65.23	$160.31	$77.64
BRADFORD	$132.84	$57.15	$154.58	$67.01
BROWARD	$160.98	$103.18	$202.80	$135.00
CHARLOTTE	$156.57	$79.45	$167.05	$100.63
CLAY	$128.89	$77.83	$134.44	$88.98
COLUMBIA	$141.74	$63.29	$135.81	$73.56
DE SOTO	$115.02	$60.54	$124.27	$65.89
DUVAL	$147.96	$77.74	$173.56	$99.24
FLAGLER	$167.84	$66.73	$159.10	$72.62
GADSDEN	$74.71	$41.64	$92.40	$52.64
GLADES	$149.20	$67.95	$174.57	$81.02
HAMILTON	$126.51	$52.16	$118.41	$56.45
HENDRY	$127.95	$59.22	$136.84	$75.12
HIGHLANDS	$101.87	$53.99	$115.70	$63.55
HOLMES	$114.25	$49.46	$123.93	$65.02
JACKSON	$91.07	$42.54	$98.04	$51.56

TABLE 2

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: FLORIDA COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
JEFFERSON	$61.11	$31.70	$78.84	$39.93
LAKE	$98.05	$60.25	$108.75	$69.56
LEON	$95.06	$54.57	$124.47	$70.15
LIBERTY	$100.33	$53.28	$79.78	$48.54
MANATEE	$115.70	$59.08	$130.37	$74.82
MARTIN	$99.97	$61.55	$106.53	$75.95
NASSAU	$154.71	$68.31	$162.50	$81.19
OKEECHOBEE	$165.73	$70.17	$147.85	$81.73
OSCEOLA	$150.90	$69.88	$164.97	$83.19
PASCO	$104.35	$60.82	$103.89	$71.30
POLK	$92.07	$52.76	$108.82	$63.98
ST JOHNS	$141.57	$72.65	$167.66	$83.30
SANTA ROSA	$170.99	$81.10	$181.01	$97.96
SEMINOLE	$119.15	$62.54	$135.93	$78.78
SUWANNEE	$111.47	$56.47	$96.22	$52.63
UNION	$182.54	$73.69	$160.58	$65.77
WAKULLA	$85.24	$51.27	$107.44	$60.65
WASHINGTON	$118.34	$54.99	$117.30	$67.65
STATE: GEORGIA				
APPLING	$93.49	$53.72	$107.97	$63.17
BACON	$83.46	$47.44	$101.52	$55.02
BALDWIN	$85.79	$38.90	$91.89	$40.44
BARROW	$93.87	$43.57	$117.93	$58.81
BEN HILL	$79.80	$40.17	$96.41	$46.87
BIBB	$82.42	$46.50	$93.36	$59.22
BRANTLEY	$98.16	$54.42	$94.31	$56.47
BRYAN	$112.88	$55.70	$91.85	$57.27
BURKE	$93.04	$42.61	$88.99	$45.09
CALHOUN	$65.98	$33.33	$81.67	$34.84
CANDLER	$82.08	$46.07	$84.23	$49.75
CATOOSA	$128.41	$47.22	$127.81	$59.21
CHATHAM	$110.39	$58.72	$150.48	$82.30
CHATTOOGA	$69.79	$35.36	$105.06	$54.27
CLARKE	$87.86	$41.94	$102.65	$54.34
CLAYTON	$133.18	$71.04	$176.40	$105.14
COBB	$126.45	$63.69	$163.27	$90.95
COLQUITT	$86.99	$43.75	$92.79	$52.03
COOK	$71.03	$42.74	$62.71	$51.65
CRAWFORD	$70.77	$36.85	$72.31	$54.87
DADE	$103.41	$40.89	$124.18	$50.78
DECATUR	$70.21	$37.03	$86.85	$51.17
DODGE	$100.87	$48.93	$101.38	$54.35
DOUGHERTY	$74.92	$37.42	$93.75	$52.34
EARLY	$83.28	$45.77	$99.41	$57.64
EFFINGHAM	$98.52	$51.07	$138.40	$76.08
EMANUEL	$83.28	$43.37	$91.27	$55.42
FANNIN	$99.46	$39.10	$128.14	$55.76
FLOYD	$78.58	$40.66	$95.90	$54.36

STATE: FLORIDA COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
LAFAYETTE	$106.14	$54.81	$90.38	$66.38
LEE	$119.87	$66.82	$125.00	$76.80
LEVY	$110.44	$55.96	$87.86	$58.01
MADISON	$82.54	$40.91	$90.31	$48.64
MARION	$95.01	$51.53	$95.87	$59.82
MONROE	$159.23	$74.99	$162.76	$87.38
OKALOOSA	$150.84	$69.11	$153.82	$79.84
ORANGE	$134.25	$68.47	$148.99	$86.82
PALM BEACH	$114.84	$80.99	$136.99	$99.01
PINELLAS	$129.83	$64.82	$152.03	$83.17
PUTNAM	$112.37	$56.68	$113.99	$69.36
ST LUCIE	$109.02	$64.76	$120.99	$76.05
SARASOTA	$109.88	$68.10	$135.63	$84.56
SUMTER	$109.63	$57.20	$94.50	$62.53
TAYLOR	$108.03	$60.14	$103.42	$70.40
VOLUSIA	$120.31	$59.46	$142.60	$77.79
WALTON	$139.43	$59.21	$134.82	$84.81
STATE: GEORGIA				
ATKINSON	$110.18	$52.64	$96.15	$45.93
BAKER	$95.69	$46.34	$104.25	$56.35
BANKS	$95.00	$41.53	$147.31	$62.04
BARTOW	$82.02	$36.80	$104.04	$54.54
BERRIEN	$121.55	$56.25	$136.50	$64.94
BLECKLEY	$102.30	$38.74	$97.82	$42.93
BROOKS	$73.45	$39.42	$76.95	$47.19
BULLOCH	$83.93	$50.90	$90.96	$61.40
BUTTS	$99.09	$42.80	$135.18	$65.46
CAMDEN	$126.18	$62.75	$137.16	$86.39
CARROLL	$122.54	$47.82	$147.89	$66.04
CHARLTON	$108.21	$52.04	$95.95	$55.83
CHATTAHOOCHEE	$113.70	$51.46	$62.25	$47.84
CHEROKEE	$122.36	$51.88	$119.79	$64.64
CLAY	$68.07	$32.96	$79.23	$57.47
CLINCH	$111.59	$54.26	$111.90	$59.39
COFFEE	$95.83	$45.74	$96.35	$47.35
COLUMBIA	$123.22	$59.63	$103.39	$69.50
COWETA	$110.56	$47.91	$146.86	$72.67
CRISP	$79.58	$38.57	$95.07	$48.81
DAWSON	$104.47	$46.81	$103.18	$55.97
DE KALB	$111.28	$57.85	$133.61	$72.76
DOOLY	$90.25	$43.44	$118.95	$60.76
DOUGLAS	$153.11	$71.96	$214.48	$107.48
ECHOLS	$140.21	$63.24	$68.01	$39.31
ELBERT	$82.80	$33.24	$99.69	$41.16
EVANS	$110.96	$47.65	$135.13	$67.34
FAYETTE	$99.85	$53.12	$159.27	$87.41
FORSYTH	$97.14	$48.57	$135.53	$66.21

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: GEORGIA COUNTY NAME	****** AGED ****** PART A	 PART B	*** DISABLED *** PART A	 PART B
FRANKLIN	$81.15	$39.67	$97.37	$49.54
GILMER	$112.40	$43.66	$126.84	$50.01
GLYNN	$103.83	$55.78	$124.69	$76.61
GRADY	$83.35	$39.18	$93.13	$46.85
GWINNETT	$128.93	$53.11	$165.79	$81.87
HALL	$92.23	$42.55	$128.99	$62.23
HARALSON	$124.30	$49.14	$131.57	$61.40
HART	$73.93	$36.40	$90.99	$47.21
HENRY	$116.49	$56.87	$131.36	$73.32
IRWIN	$60.08	$39.31	$65.95	$43.45
JASPER	$87.97	$42.82	$102.43	$48.19
JEFFERSON	$83.17	$39.08	$83.49	$44.94
JOHNSON	$71.62	$36.14	$68.73	$42.68
LAMAR	$76.43	$33.39	$76.16	$38.59
LAURENS	$67.04	$37.69	$72.87	$44.62
LIBERTY	$88.69	$48.29	$89.42	$55.47
LONG	$107.70	$52.98	$82.37	$47.66
LUMPKIN	$87.40	$39.61	$113.89	$59.59
MC INTOSH	$101.07	$59.63	$98.76	$66.71
MADISON	$81.81	$38.80	$95.85	$54.01
MERIWETHER	$71.40	$39.14	$83.74	$60.43
MITCHELL	$70.05	$38.20	$65.25	$42.76
MONTGOMERY	$109.19	$53.92	$122.49	$69.55
MURRAY	$98.40	$41.25	$132.30	$61.99
NEWTON	$104.09	$44.11	$99.01	$52.01
OGLETHORPE	$81.22	$38.83	$76.08	$43.11
PEACH	$91.95	$41.09	$99.02	$45.88
PIERCE	$87.73	$48.33	$84.37	$52.45
POLK	$91.41	$42.41	$103.59	$56.26
PUTNAM	$120.92	$44.21	$125.80	$67.31
RABUN	$112.42	$48.42	$129.52	$61.42
RICHMOND	$112.09	$58.78	$93.28	$60.28
SCHLEY	$87.46	$36.06	$107.83	$46.24
SEMINOLE	$84.44	$41.95	$123.31	$59.99
STEPHENS	$77.95	$36.87	$86.55	$44.83
SUMTER	$72.41	$30.53	$89.70	$43.91
TALIAFERRO	$73.97	$37.35	$112.09	$52.36
TAYLOR	$70.71	$35.83	$85.53	$43.67
TERRELL	$70.71	$31.98	$84.33	$39.36
TIFT	$62.38	$42.71	$78.65	$55.59
TOWNS	$75.61	$29.78	$65.92	$35.81
TROUP	$97.99	$46.43	$106.00	$56.85
TWIGGS	$76.75	$37.04	$54.47	$28.14
UPSON	$69.48	$31.83	$81.67	$42.23
WALTON	$114.01	$43.80	$119.27	$55.54
WARREN	$73.28	$40.88	$90.76	$52.50
WAYNE	$112.56	$53.21	$114.93	$61.72
WHEELER	$92.27	$47.35	$119.14	$57.80
WHITFIELD	$97.28	$42.58	$120.03	$60.90

STATE: GEORGIA COUNTY NAME	****** AGED ****** PART A	 PART B	*** DISABLED *** PART A	 PART B
FULTON	$115.69	$58.82	$130.66	$71.41
GLASCOCK	$77.57	$42.02	$77.75	$46.43
GORDON	$91.67	$40.85	$100.30	$56.29
GREENE	$67.29	$32.76	$68.13	$34.07
HABERSHAM	$79.30	$41.46	$102.46	$53.76
HANCOCK	$73.78	$34.51	$83.51	$36.72
HARRIS	$78.49	$37.45	$100.27	$49.39
HEARD	$109.99	$45.17	$116.46	$51.53
HOUSTON	$99.39	$48.27	$100.79	$53.62
JACKSON	$101.23	$43.85	$127.56	$57.48
JEFF DAVIS	$107.74	$50.49	$116.19	$54.34
JENKINS	$87.25	$38.51	$88.56	$45.29
JONES	$63.09	$35.14	$93.00	$54.38
LANIER	$111.51	$52.29	$125.17	$80.14
LEE	$70.60	$36.85	$102.47	$47.24
LINCOLN	$86.06	$41.38	$89.66	$58.63
LOWNDES	$86.44	$50.32	$86.62	$51.21
MC DUFFIE	$99.00	$46.61	$104.30	$59.53
MACON	$83.78	$36.72	$96.30	$46.66
MARION	$85.66	$42.36	$99.64	$53.32
MILLER	$64.17	$35.30	$60.53	$34.83
MONROE	$74.04	$34.78	$86.45	$51.75
MORGAN	$80.31	$37.07	$88.33	$42.87
MUSCOGEE	$100.69	$52.15	$107.86	$65.90
OCONEE	$79.76	$42.17	$80.00	$48.20
PAULDING	$134.22	$61.69	$173.97	$86.40
PICKENS	$108.86	$47.21	$100.78	$49.82
PIKE	$74.40	$34.15	$94.79	$47.57
PULASKI	$83.91	$36.83	$97.27	$47.95
QUITMAN	$83.91	$35.80	$132.50	$54.26
RANDOLPH	$58.28	$29.82	$65.21	$32.36
ROCKDALE	$112.37	$52.47	$141.57	$71.55
SCREVEN	$87.92	$44.65	$101.80	$49.08
SPALDING	$79.40	$39.05	$94.69	$51.91
STEWART	$87.48	$37.24	$113.00	$51.46
TALBOT	$69.74	$31.24	$53.41	$41.78
TATTNALL	$102.88	$49.73	$111.20	$60.29
TELFAIR	$84.50	$40.29	$81.15	$43.26
THOMAS	$72.49	$40.38	$72.86	$48.10
TOOMBS	$96.98	$50.07	$106.80	$62.65
TREUTLEN	$75.49	$42.76	$89.75	$51.40
TURNER	$69.58	$39.07	$80.07	$41.81
UNION	$86.27	$40.60	$99.32	$58.49
WALKER	$111.90	$42.74	$131.19	$57.70
WARE	$77.59	$48.88	$95.16	$60.98
WASHINGTON	$73.06	$32.83	$78.77	$35.65
WEBSTER	$97.17	$37.17	$95.58	$42.42
WHITE	$74.23	$36.98	$120.48	$58.21
WILCOX	$76.64	$35.57	$90.41	$41.95

TABLE 2

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: GEORGIA COUNTY NAME	****** AGED ****** PART A	 PART B	*** DISABLED *** PART A	 PART B
WILKES	$71.47	$35.64	$82.35	$42.77
WORTH	$72.85	$37.91	$66.07	$38.19
STATE: HAWAII				
HAWAII	$77.58	$52.33	$86.30	$67.71
KALAWAO	$80.39	$65.70	$84.68	$72.30
MAUI	$90.41	$76.60	$93.29	$68.57
STATE: IDAHO				
ADA	$100.57	$47.83	$114.30	$64.02
BANNOCK	$114.80	$49.46	$133.30	$69.25
BENEWAH	$94.95	$40.35	$104.11	$46.63
BLAINE	$127.71	$49.54	$192.67	$72.68
BONNER	$108.43	$45.91	$106.48	$56.01
BOUNDARY	$109.69	$41.73	$140.54	$61.37
CAMAS	$98.60	$39.87	$103.79	$61.17
CARIBOU	$96.07	$44.95	$78.11	$44.97
CLARK	$108.63	$43.89	$119.15	$63.72
CUSTER	$112.57	$41.81	$86.45	$34.84
FRANKLIN	$77.42	$42.43	$112.64	$64.13
GEM	$85.20	$36.54	$89.74	$52.30
IDAHO	$87.55	$40.69	$70.14	$33.87
JEROME	$97.70	$44.43	$94.63	$59.83
LATAH	$74.84	$39.47	$81.28	$55.78
LEWIS	$94.10	$45.26	$52.33	$45.26
MADISON	$100.66	$42.26	$100.32	$48.33
NEZ PERCE	$108.11	$53.08	$126.75	$67.03
OWYHEE	$115.76	$46.70	$137.06	$48.33
POWER	$114.80	$45.33	$65.67	$45.60
TETON	$96.99	$41.85	$170.27	$56.55
VALLEY	$113.16	$45.33	$123.63	$57.29
STATE: ILLINOIS				
ADAMS	$126.25	$42.26	$134.56	$51.99
BOND	$113.62	$33.85	$162.40	$53.78
BROWN	$108.62	$30.81	$156.80	$53.12
CALHOUN	$159.01	$42.00	$149.57	$43.06
CASS	$139.01	$43.28	$186.76	$61.75
CHRISTIAN	$167.61	$57.12	$209.03	$78.93
CLAY	$89.22	$30.26	$77.77	$33.76
COLES	$93.84	$38.60	$112.04	$49.18
CRAWFORD	$110.78	$38.55	$139.98	$59.71
DE KALB	$121.72	$42.85	$150.63	$59.06
DOUGLAS	$124.61	$43.21	$126.65	$46.21
EDGAR	$83.58	$33.44	$96.81	$53.35
EFFINGHAM	$103.17	$34.72	$114.16	$42.79
FORD	$121.23	$44.18	$144.65	$61.95
FULTON	$151.65	$48.16	$191.37	$74.94
GREENE	$114.89	$36.38	$115.29	$41.97

STATE: GEORGIA COUNTY NAME	****** AGED ****** PART A	 PART B	*** DISABLED *** PART A	 PART B
WILKINSON	$86.28	$39.94	$105.02	$54.31
STATE: HAWAII				
HONOLULU	$123.89	$75.89	$132.06	$87.83
KAUAI	$111.10	$48.82	$135.40	$67.78
STATE: IDAHO				
ADAMS	$107.27	$39.44	$116.48	$57.48
BEAR LAKE	$94.54	$40.75	$200.26	$103.93
BINGHAM	$97.12	$38.70	$116.79	$55.41
BOISE	$92.50	$37.64	$51.77	$48.82
BONNEVILLE	$103.59	$46.57	$93.07	$54.08
BUTTE	$89.87	$34.60	$76.78	$42.96
CANYON	$115.93	$45.40	$112.53	$55.36
CASSIA	$91.47	$39.21	$115.05	$55.18
CLEARWATER	$98.60	$45.68	$101.42	$48.48
ELMORE	$114.77	$53.03	$71.21	$45.38
FREMONT	$101.27	$42.74	$156.11	$72.08
GOODING	$94.80	$43.97	$71.38	$40.47
JEFFERSON	$109.65	$44.00	$123.42	$54.05
KOOTENAI	$90.77	$49.87	$97.81	$61.13
LEMHI	$101.48	$40.22	$105.51	$57.98
LINCOLN	$112.55	$44.83	$106.38	$59.55
MINIDOKA	$103.71	$44.40	$115.04	$62.23
ONEIDA	$112.75	$41.93	$103.76	$60.74
PAYETTE	$85.52	$37.57	$88.53	$47.50
SHOSHONE	$109.27	$42.85	$140.84	$61.51
TWIN FALLS	$101.82	$46.49	$99.84	$53.74
WASHINGTON	$83.99	$34.33	$77.59	$38.81
STATE: ILLINOIS				
ALEXANDER	$119.37	$40.09	$106.71	$44.35
BOONE	$106.81	$44.50	$161.05	$69.02
BUREAU	$129.92	$40.45	$143.74	$50.78
CARROLL	$96.31	$36.61	$118.22	$52.43
CHAMPAIGN	$142.15	$51.48	$159.20	$67.83
CLARK	$74.92	$35.25	$92.93	$51.42
CLINTON	$134.12	$43.59	$126.16	$49.82
COOK	$216.20	$67.27	$240.44	$81.20
CUMBERLAND	$91.66	$30.97	$105.81	$53.63
DE WITT	$136.05	$44.74	$166.40	$63.84
DU PAGE	$165.17	$61.52	$224.66	$89.75
EDWARDS	$94.68	$31.51	$115.70	$39.30
FAYETTE	$96.69	$35.55	$94.14	$42.27
FRANKLIN	$117.78	$44.41	$96.04	$45.07
GALLATIN	$136.64	$43.26	$118.41	$51.39
GRUNDY	$135.29	$52.23	$178.02	$70.51

TABLE 2

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: ILLINOIS COUNTY NAME	****** AGED PART A	****** PART B	*** DISABLED *** PART A	PART B
HAMILTON	$135.99	$37.20	$121.29	$44.24
HARDIN	$145.93	$44.55	$130.59	$47.58
HENRY	$109.55	$37.73	$145.67	$54.09
JACKSON	$107.16	$39.50	$98.60	$49.00
JEFFERSON	$139.20	$43.64	$128.56	$53.54
JO DAVIESS	$126.20	$41.89	$102.89	$43.48
KANE	$144.55	$53.98	$202.86	$82.49
KENDALL	$125.46	$46.30	$166.30	$73.94
LAKE	$160.75	$56.15	$166.28	$72.19
LAWRENCE	$108.88	$32.53	$125.61	$47.64
LIVINGSTON	$133.88	$44.35	$163.01	$59.77
MC DONOUGH	$123.15	$37.15	$122.43	$48.67
MC LEAN	$124.55	$45.30	$150.75	$61.25
MACOUPIN	$147.58	$42.46	$175.73	$58.58
MARION	$129.28	$43.47	$136.51	$55.33
MASON	$160.26	$48.12	$161.22	$61.62
MENARD	$157.30	$47.17	$138.67	$51.70
MONROE	$112.42	$36.39	$131.24	$53.57
MORGAN	$121.62	$39.21	$109.72	$39.72
OGLE	$99.12	$38.24	$126.16	$59.66
PERRY	$126.42	$41.25	$134.50	$47.78
PIKE	$125.89	$41.64	$109.92	$50.26
PULASKI	$100.67	$36.54	$77.96	$34.39
RANDOLPH	$114.44	$36.49	$139.97	$54.49
ROCK ISLAND	$140.73	$44.29	$181.07	$70.62
SALINE	$119.02	$39.64	$107.56	$44.09
SCHUYLER	$127.43	$30.37	$123.43	$40.85
SHELBY	$117.86	$35.84	$90.43	$37.97
STEPHENSON	$103.60	$39.84	$135.47	$58.52
UNION	$99.40	$36.60	$76.28	$34.58
WABASH	$114.29	$32.75	$121.31	$36.19
WASHINGTON	$112.46	$38.83	$142.59	$62.88
WHITE	$100.02	$38.87	$122.94	$47.63
WILL	$148.91	$56.86	$188.54	$82.45
WINNEBAGO	$106.87	$46.87	$142.83	$67.81
STATE: INDIANA				
ADAMS	$110.40	$36.78	$142.08	$55.24
BARTHOLOMEW	$125.04	$42.10	$140.49	$58.91
BLACKFORD	$122.71	$36.38	$148.90	$47.49
BROWN	$107.32	$37.49	$163.83	$61.39
CASS	$117.43	$41.44	$137.03	$48.41
CLAY	$94.12	$36.29	$98.82	$47.46
CRAWFORD	$96.76	$27.54	$63.72	$25.25
DEARBORN	$141.65	$39.26	$126.58	$42.13
DE KALB	$99.50	$37.13	$125.10	$50.35
DUBOIS	$128.55	$37.94	$148.80	$53.11
FAYETTE	$129.45	$42.41	$151.86	$49.69
FOUNTAIN	$110.25	$35.82	$133.28	$51.04

STATE: ILLINOIS COUNTY NAME	****** AGED PART A	****** PART B	*** DISABLED *** PART A	PART B
HANCOCK	$125.71	$39.41	$142.46	$46.61
HENDERSON	$132.27	$40.59	$183.86	$61.32
IROQUOIS	$133.31	$50.05	$166.51	$70.03
JASPER	$107.25	$34.13	$118.99	$36.91
JERSEY	$142.48	$43.45	$190.25	$62.21
JOHNSON	$113.53	$36.95	$100.46	$45.22
KANKAKEE	$166.67	$55.93	$187.24	$73.34
KNOX	$144.39	$46.18	$151.26	$57.47
LA SALLE	$142.57	$44.45	$159.69	$63.44
LEE	$122.31	$40.15	$109.54	$40.61
LOGAN	$121.89	$41.91	$127.39	$43.36
MC HENRY	$142.17	$48.83	$196.10	$76.11
MACON	$118.21	$41.86	$140.58	$60.86
MADISON	$172.84	$50.63	$234.04	$76.08
MARSHALL	$140.34	$46.78	$144.01	$48.88
MASSAC	$120.36	$38.03	$116.24	$44.28
MERCER	$134.34	$42.90	$151.45	$48.85
MONTGOMERY	$127.55	$38.16	$148.95	$53.85
MOULTRIE	$96.79	$32.14	$93.04	$45.70
PEORIA	$144.65	$50.82	$180.38	$76.32
PIATT	$117.71	$41.01	$90.60	$36.88
POPE	$127.05	$37.81	$99.41	$35.17
PUTNAM	$159.50	$51.14	$141.47	$70.57
RICHLAND	$105.28	$33.62	$114.66	$43.13
ST CLAIR	$132.86	$45.62	$166.33	$62.94
SANGAMON	$174.79	$53.57	$208.16	$73.91
SCOTT	$113.22	$40.15	$173.98	$56.30
STARK	$105.75	$40.65	$117.40	$48.23
TAZEWELL	$131.07	$48.79	$169.89	$70.35
VERMILION	$120.36	$42.41	$121.27	$49.28
WARREN	$119.32	$40.04	$129.69	$52.89
WAYNE	$98.73	$34.51	$108.51	$43.70
WHITESIDE	$94.43	$34.77	$115.42	$53.90
WILLIAMSON	$125.39	$50.09	$117.10	$48.22
WOODFORD	$117.77	$43.09	$149.60	$57.83
STATE: INDIANA				
ALLEN	$112.84	$45.96	$132.63	$58.20
BENTON	$143.71	$43.85	$215.19	$68.02
BOONE	$134.21	$42.56	$185.44	$78.60
CARROLL	$125.46	$43.16	$121.24	$50.63
CLARK	$137.18	$47.92	$155.94	$60.55
CLINTON	$99.37	$33.85	$120.64	$47.71
DAVIESS	$118.60	$35.69	$114.13	$42.78
DECATUR	$149.27	$40.76	$172.12	$61.93
DELAWARE	$132.66	$44.56	$146.97	$55.19
ELKHART	$91.64	$38.98	$127.52	$58.03
FLOYD	$119.91	$38.13	$141.00	$54.78
FRANKLIN	$110.02	$34.69	$109.29	$41.83

TABLE 2

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: INDIANA COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
FULTON	$111.38	$42.66	$114.76	$50.94
GRANT	$102.79	$42.80	$110.84	$57.75
HAMILTON	$153.42	$45.92	$174.43	$64.67
HARRISON	$104.22	$27.17	$120.61	$38.95
HENRY	$132.58	$45.80	$119.07	$49.02
HUNTINGTON	$103.27	$33.24	$114.51	$42.36
JASPER	$145.79	$44.76	$167.04	$62.75
JEFFERSON	$107.55	$37.17	$96.69	$48.23
JOHNSON	$132.39	$41.74	$178.18	$64.18
KOSCIUSKO	$101.85	$38.87	$145.34	$64.71
LAKE	$174.97	$51.71	$218.18	$72.10
LAWRENCE	$156.86	$44.53	$167.14	$60.60
MARION	$159.91	$52.50	$187.17	$71.36
MARTIN	$126.18	$36.94	$105.67	$40.56
MONROE	$108.95	$42.31	$137.63	$61.48
MORGAN	$141.18	$47.47	$154.44	$62.79
NOBLE	$105.06	$34.73	$116.10	$46.59
ORANGE	$124.04	$37.07	$116.89	$44.84
PARKE	$95.40	$38.57	$115.74	$53.12
PIKE	$141.26	$44.55	$139.07	$59.13
POSEY	$129.26	$41.74	$126.20	$47.27
PUTNAM	$128.00	$38.20	$115.19	$42.37
RIPLEY	$110.13	$33.72	$115.00	$44.35
ST JOSEPH	$105.75	$40.81	$142.69	$60.48
SHELBY	$134.98	$44.72	$161.06	$65.23
STARKE	$117.27	$42.00	$127.49	$47.21
SULLIVAN	$145.45	$40.27	$101.85	$42.45
TIPPECANOE	$129.26	$45.08	$150.25	$63.67
UNION	$101.04	$39.43	$110.91	$41.76
VERMILLION	$102.82	$42.23	$129.36	$66.94
WABASH	$92.42	$40.62	$121.01	$56.94
WARRICK	$134.37	$49.02	$167.99	$71.09
WAYNE	$94.74	$36.34	$104.35	$46.12
WHITE	$132.14	$42.60	$169.92	$66.30
STATE: IOWA				
ADAIR	$112.73	$35.60	$141.11	$54.28
ALLAMAKEE	$92.08	$38.15	$98.15	$47.46
AUDUBON	$92.74	$29.68	$123.20	$56.49
BLACK HAWK	$115.39	$43.12	$137.30	$60.90
BREMER	$92.32	$33.88	$115.17	$51.60
BUENA VISTA	$85.05	$35.48	$103.05	$41.69
CALHOUN	$103.68	$38.32	$106.38	$42.22
CASS	$124.19	$35.46	$154.31	$41.93
CERRO GORDO	$108.75	$40.02	$124.67	$59.49
CHICKASAW	$116.00	$48.16	$138.33	$75.53
CLAY	$85.46	$37.98	$115.93	$50.12
CLINTON	$135.56	$39.61	$172.56	$63.77
DALLAS	$137.37	$44.93	$138.22	$50.60

STATE: INDIANA COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
GIBSON	$129.84	$45.67	$157.42	$51.53
GREENE	$110.05	$38.43	$120.02	$46.66
HANCOCK	$117.44	$44.14	$137.79	$58.14
HENDRICKS	$137.83	$43.59	$173.91	$69.01
HOWARD	$142.92	$50.23	$163.97	$68.01
JACKSON	$120.43	$33.13	$124.60	$48.06
JAY	$127.50	$37.98	$128.20	$45.95
JENNINGS	$121.03	$36.83	$94.42	$26.50
KNOX	$133.90	$40.98	$151.59	$54.29
LAGRANGE	$112.66	$46.40	$103.86	$50.11
LA PORTE	$117.92	$47.85	$151.29	$67.38
MADISON	$151.92	$46.19	$170.75	$60.92
MARSHALL	$92.25	$39.88	$95.55	$47.80
MIAMI	$126.38	$52.10	$121.12	$60.65
MONTGOMERY	$98.03	$40.13	$125.00	$59.23
NEWTON	$138.77	$42.75	$157.29	$56.68
OHIO	$115.71	$35.38	$98.81	$41.30
OWEN	$98.49	$32.74	$124.94	$53.34
PERRY	$110.86	$31.30	$102.99	$38.95
PORTER	$146.91	$59.42	$204.33	$86.56
PULASKI	$115.27	$37.52	$126.54	$48.00
RANDOLPH	$121.32	$38.14	$138.21	$49.49
RUSH	$126.97	$35.25	$151.09	$52.47
SCOTT	$132.78	$40.87	$118.69	$50.06
SPENCER	$119.86	$38.75	$136.90	$52.68
STEUBEN	$94.97	$38.57	$124.33	$55.28
SWITZERLAND	$117.26	$35.97	$111.14	$42.55
TIPTON	$186.91	$40.74	$187.93	$56.01
VANDERBURGH	$133.23	$47.74	$166.03	$68.02
VIGO	$100.02	$45.41	$135.13	$68.69
WARREN	$129.26	$37.02	$128.38	$44.33
WASHINGTON	$114.39	$30.02	$132.56	$48.72
WELLS	$120.23	$38.93	$116.62	$47.44
WHITLEY	$105.26	$35.88	$178.89	$61.73
STATE: IOWA				
ADAMS	$109.01	$39.73	$84.29	$45.69
APPANOOSE	$128.22	$32.99	$159.63	$46.31
BENTON	$99.68	$36.46	$118.22	$39.33
BOONE	$126.32	$42.56	$133.88	$48.04
BUCHANAN	$105.96	$36.94	$127.56	$59.46
BUTLER	$101.48	$37.60	$141.56	$53.45
CARROLL	$112.35	$35.71	$113.61	$44.15
CEDAR	$96.67	$33.55	$140.10	$44.93
CHEROKEE	$108.58	$35.46	$114.90	$58.05
CLARKE	$134.13	$36.22	$86.87	$33.94
CLAYTON	$101.49	$34.13	$105.20	$49.74
CRAWFORD	$116.77	$36.07	$128.45	$51.43
DAVIS	$127.24	$35.11	$130.40	$43.58

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: IOWA COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
DECATUR	$109.72	$34.92	$94.37	$42.45
DES MOINES	$104.67	$35.07	$117.71	$43.28
DUBUQUE	$135.88	$43.09	$171.64	$64.31
FAYETTE	$110.57	$39.28	$125.81	$54.83
FRANKLIN	$103.63	$37.18	$118.16	$49.31
GREENE	$107.81	$35.65	$117.91	$52.20
GUTHRIE	$114.53	$35.91	$104.98	$41.88
HANCOCK	$89.93	$34.16	$106.86	$62.63
HARRISON	$143.45	$41.93	$154.41	$48.00
HOWARD	$87.21	$38.22	$86.34	$63.39
IDA	$102.20	$32.79	$124.96	$40.38
JACKSON	$142.41	$40.32	$156.77	$56.67
JEFFERSON	$99.12	$31.88	$92.82	$39.04
JONES	$105.97	$34.32	$132.47	$45.66
KOSSUTH	$99.48	$39.94	$94.77	$39.68
LINN	$116.66	$42.41	$173.46	$67.54
LUCAS	$160.42	$44.31	$184.01	$61.57
MADISON	$129.77	$40.65	$102.11	$40.45
MARION	$117.34	$38.09	$119.99	$44.20
MILLS	$140.87	$48.01	$90.58	$35.11
MONONA	$120.81	$37.97	$116.62	$53.33
MONTGOMERY	$131.11	$54.44	$155.71	$70.06
O BRIEN	$87.21	$32.82	$105.06	$41.31
PAGE	$106.82	$39.63	$153.40	$61.13
PLYMOUTH	$97.95	$34.26	$93.49	$43.35
POLK	$161.40	$54.72	$203.07	$75.87
POWESHIEK	$110.13	$39.12	$149.82	$55.64
SAC	$98.01	$35.90	$88.40	$36.71
SHELBY	$134.01	$37.97	$209.74	$71.56
STORY	$105.27	$41.93	$152.61	$64.85
TAYLOR	$106.69	$34.98	$117.59	$39.35
VAN BUREN	$108.55	$29.26	$91.05	$31.42
WARREN	$122.38	$42.60	$133.90	$55.22
WAYNE	$130.02	$34.21	$100.18	$36.55
WINNEBAGO	$90.38	$37.07	$106.70	$47.43
WOODBURY	$146.89	$42.18	$199.27	$57.23
WRIGHT	$91.29	$35.25	$134.87	$65.96
STATE: KANSAS				
ALLEN	$128.50	$43.96	$141.92	$57.89
ATCHISON	$123.58	$45.68	$125.54	$54.57
BARTON	$132.19	$51.74	$146.34	$62.17
BROWN	$139.31	$45.89	$157.70	$57.75
CHASE	$117.75	$38.73	$82.73	$48.51
CHEROKEE	$132.12	$43.77	$157.44	$63.50
CLARK	$137.83	$57.12	$178.28	$86.23
CLOUD	$106.09	$42.60	$142.04	$65.02
COMANCHE	$120.47	$42.88	$127.44	$38.85
CRAWFORD	$110.39	$46.01	$112.19	$56.28

STATE: IOWA COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
DELAWARE	$107.31	$35.69	$125.35	$43.31
DICKINSON	$95.80	$41.96	$94.85	$51.69
EMMET	$94.06	$43.40	$96.07	$49.79
FLOYD	$86.91	$39.45	$120.02	$56.60
FREMONT	$143.73	$39.78	$163.20	$47.85
GRUNDY	$103.56	$39.44	$94.14	$47.34
HAMILTON	$116.04	$44.08	$131.69	$51.63
HARDIN	$108.29	$35.66	$104.91	$44.46
HENRY	$87.67	$31.84	$96.31	$37.16
HUMBOLDT	$110.03	$36.65	$135.43	$55.33
IOWA	$94.36	$31.23	$123.07	$38.50
JASPER	$123.86	$40.43	$155.44	$54.32
JOHNSON	$92.42	$32.91	$177.90	$59.41
KEOKUK	$103.05	$34.93	$124.22	$46.78
LEE	$125.25	$36.62	$163.50	$53.13
LOUISA	$93.57	$33.14	$89.46	$35.81
LYON	$98.72	$32.95	$78.35	$39.73
MAHASKA	$95.84	$30.96	$66.20	$31.53
MARSHALL	$91.42	$40.57	$118.67	$54.21
MITCHELL	$73.46	$35.84	$109.93	$63.24
MONROE	$131.61	$38.91	$163.95	$55.52
MUSCATINE	$100.80	$33.56	$124.66	$52.54
OSCEOLA	$77.68	$28.61	$72.62	$25.45
PALO ALTO	$116.96	$41.50	$100.05	$44.81
POCAHONTAS	$94.75	$37.16	$123.68	$50.63
POTTAWATTAMIE	$168.13	$53.12	$190.55	$74.37
RINGGOLD	$116.40	$33.97	$83.35	$25.94
SCOTT	$128.79	$43.27	$155.70	$58.34
SIOUX	$95.18	$33.63	$96.49	$43.44
TAMA	$105.80	$40.93	$126.16	$58.39
UNION	$114.32	$38.25	$129.33	$56.45
WAPELLO	$125.20	$40.74	$129.66	$54.42
WASHINGTON	$87.50	$28.04	$104.62	$37.99
WEBSTER	$103.41	$38.66	$134.74	$51.95
WINNESHIEK	$100.26	$38.80	$122.41	$44.09
WORTH	$98.65	$37.51	$106.66	$46.62
STATE: KANSAS				
ANDERSON	$111.83	$41.75	$131.29	$53.04
BARBER	$173.22	$56.34	$198.63	$69.51
BOURBON	$110.77	$45.56	$144.81	$66.98
BUTLER	$159.16	$61.09	$226.89	$97.46
CHAUTAUQUA	$159.42	$50.10	$198.80	$64.17
CHEYENNE	$109.15	$39.37	$69.90	$31.67
CLAY	$98.38	$36.13	$124.29	$45.24
COFFEY	$142.46	$41.66	$122.76	$47.16
COWLEY	$118.93	$56.66	$107.67	$56.68
DECATUR	$113.42	$50.58	$140.00	$62.60

TABLE 2

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: KANSAS COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
DICKINSON	$118.40	$45.70	$102.68	$46.43
DOUGLAS	$110.59	$49.18	$165.26	$72.04
ELK	$112.88	$46.23	$222.02	$60.86
ELLSWORTH	$116.32	$41.21	$110.06	$46.35
FORD	$124.25	$52.30	$122.66	$55.52
GEARY	$123.58	$48.58	$92.54	$46.94
GRAHAM	$157.39	$62.65	$146.92	$61.52
GRAY	$113.99	$51.53	$188.08	$80.70
GREENWOOD	$151.05	$55.67	$178.58	$66.21
HARPER	$184.35	$69.11	$290.78	$126.01
HASKELL	$175.78	$65.63	$141.67	$70.59
JACKSON	$120.73	$46.09	$151.14	$67.32
JEWELL	$84.38	$33.76	$84.99	$55.00
KEARNY	$204.47	$62.40	$179.67	$98.89
KIOWA	$160.70	$50.64	$186.98	$65.15
LANE	$165.43	$56.63	$203.34	$51.70
LINCOLN	$94.53	$37.98	$129.68	$76.31
LOGAN	$148.37	$54.48	$257.15	$91.39
MC PHERSON	$105.59	$43.02	$128.22	$75.24
MARSHALL	$114.49	$40.67	$83.10	$40.70
MIAMI	$123.94	$51.81	$179.48	$87.25
MONTGOMERY	$117.93	$48.18	$142.96	$62.79
MORTON	$177.40	$55.93	$296.02	$79.40
NEOSHO	$125.55	$45.98	$161.16	$63.41
NORTON	$125.25	$46.68	$98.66	$41.68
OSBORNE	$121.60	$52.09	$131.31	$62.84
PAWNEE	$144.66	$50.56	$204.22	$66.13
POTTAWATOMIE	$126.97	$49.48	$131.50	$55.76
RAWLINS	$155.24	$53.29	$144.29	$67.29
REPUBLIC	$74.96	$32.29	$72.07	$40.60
RILEY	$127.34	$50.17	$168.30	$69.51
RUSH	$143.95	$60.27	$151.63	$72.76
SALINE	$94.18	$42.89	$128.84	$62.72
SEDGWICK	$164.10	$62.18	$201.86	$82.99
SHAWNEE	$143.40	$59.43	$130.92	$64.59
SHERMAN	$169.23	$56.44	$205.12	$74.75
STAFFORD	$166.58	$60.18	$273.67	$108.77
STEVENS	$111.09	$42.40	$157.83	$109.59
THOMAS	$163.66	$56.79	$175.69	$69.18
WABAUNSEE	$108.33	$43.02	$124.86	$51.82
WASHINGTON	$127.40	$42.05	$131.71	$49.61
WILSON	$134.64	$45.65	$128.41	$64.56
WYANDOTTE	$175.60	$60.57	$211.65	$84.64
STATE: KENTUCKY				
ADAIR	$101.85	$33.81	$104.75	$37.64
ANDERSON	$96.68	$29.42	$104.97	$44.79
BARREN	$80.49	$26.56	$96.18	$39.60
BELL	$106.38	$45.29	$83.72	$37.01

STATE: KANSAS COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
DONIPHAN	$122.47	$39.11	$126.62	$56.13
EDWARDS	$163.96	$55.23	$124.54	$55.61
ELLIS	$139.87	$58.16	$147.14	$82.09
FINNEY	$154.07	$53.62	$210.31	$68.52
FRANKLIN	$113.22	$43.36	$124.61	$56.83
GOVE	$117.79	$54.86	$92.91	$60.83
GRANT	$194.91	$60.45	$279.86	$141.70
GREELEY	$161.92	$61.55	$190.09	$68.24
HAMILTON	$159.14	$54.23	$221.39	$65.77
HARVEY	$97.01	$49.53	$141.34	$79.35
HODGEMAN	$134.80	$45.78	$181.36	$81.02
JEFFERSON	$110.90	$48.35	$102.66	$56.28
JOHNSON	$166.33	$68.67	$213.46	$98.71
KINGMAN	$134.11	$50.15	$126.03	$48.71
LABETTE	$149.85	$51.43	$140.49	$62.11
LEAVENWORTH	$134.49	$54.15	$124.80	$63.63
LINN	$110.29	$46.78	$147.84	$61.16
LYON	$160.97	$45.95	$147.01	$55.11
MARION	$100.31	$44.31	$118.08	$55.28
MEADE	$133.80	$49.39	$123.67	$53.66
MITCHELL	$132.50	$52.37	$162.73	$60.89
MORRIS	$125.50	$46.22	$128.22	$70.43
NEMAHA	$114.70	$45.89	$98.44	$46.81
NESS	$155.41	$54.87	$143.75	$62.55
OSAGE	$102.56	$40.12	$72.70	$43.18
OTTAWA	$104.16	$40.34	$123.94	$59.57
PHILLIPS	$132.96	$56.75	$169.96	$79.96
PRATT	$180.19	$57.86	$165.35	$66.90
RENO	$109.85	$50.29	$121.87	$61.94
RICE	$105.36	$43.86	$107.31	$54.27
ROOKS	$114.62	$50.70	$175.29	$92.09
RUSSELL	$154.17	$59.44	$171.96	$70.93
SCOTT	$125.33	$47.00	$93.28	$38.26
SEWARD	$140.58	$52.58	$141.45	$62.29
SHERIDAN	$117.26	$76.69	$147.62	$143.14
SMITH	$88.59	$33.75	$110.58	$67.07
STANTON	$190.83	$66.70	$199.67	$133.34
SUMNER	$148.90	$50.28	$182.43	$69.68
TREGO	$125.62	$61.52	$149.39	$74.96
WALLACE	$145.84	$57.42	$163.60	$71.20
WICHITA	$174.59	$64.67	$213.82	$80.29
WOODSON	$111.69	$39.96	$133.98	$61.15
STATE: KENTUCKY				
ALLEN	$98.52	$27.95	$108.10	$37.34
BALLARD	$112.55	$37.16	$120.35	$48.47
BATH	$72.99	$27.54	$68.14	$36.02
BOONE	$140.50	$42.98	$133.70	$50.53

TABLE 2

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: KENTUCKY COUNTY NAME	****** AGED PART A	****** PART B	*** DISABLED *** PART A	PART B
BOURBON	$102.48	$33.98	$121.34	$51.14
BOYLE	$87.74	$33.27	$97.46	$40.03
BREATHITT	$70.01	$31.68	$49.80	$22.94
BULLITT	$117.59	$38.18	$140.76	$60.74
CALDWELL	$106.07	$35.49	$79.77	$38.69
CAMPBELL	$108.26	$36.79	$127.44	$43.98
CARROLL	$114.18	$32.41	$89.83	$36.85
CASEY	$83.64	$30.05	$64.82	$32.32
CLARK	$85.66	$31.67	$93.45	$40.38
CLINTON	$100.88	$35.63	$108.58	$46.44
CUMBERLAND	$89.70	$36.06	$104.33	$45.27
EDMONSON	$98.32	$36.26	$95.71	$41.75
ESTILL	$68.61	$28.01	$45.16	$21.89
FLEMING	$104.75	$33.92	$107.37	$39.07
FRANKLIN	$101.67	$31.66	$77.11	$34.71
GALLATIN	$128.20	$34.46	$79.72	$30.82
GRANT	$120.97	$37.37	$114.88	$44.71
GRAYSON	$101.91	$29.97	$99.57	$37.57
GREENUP	$116.61	$35.74	$106.11	$48.48
HARDIN	$91.40	$35.50	$68.71	$38.19
HARRISON	$97.52	$26.92	$128.18	$38.91
HENDERSON	$109.01	$40.45	$108.98	$48.74
HICKMAN	$108.58	$31.39	$108.33	$33.62
JACKSON	$85.64	$36.10	$55.98	$26.86
JESSAMINE	$74.97	$36.15	$73.72	$39.83
KENTON	$132.06	$41.75	$161.59	$54.85
KNOX	$93.13	$34.13	$82.73	$32.89
LAUREL	$79.11	$30.66	$75.34	$32.33
LEE	$74.99	$31.78	$56.72	$30.06
LETCHER	$102.79	$33.18	$74.89	$44.41
LINCOLN	$92.16	$31.04	$64.64	$34.78
LOGAN	$105.85	$37.51	$94.01	$43.42
MC CRACKEN	$123.14	$40.33	$137.32	$54.46
MC LEAN	$98.36	$37.57	$92.28	$42.90
MAGOFFIN	$92.69	$35.74	$55.57	$29.34
MARSHALL	$90.93	$33.32	$118.91	$49.74
MASON	$115.23	$30.29	$124.17	$44.96
MENIFEE	$68.05	$30.19	$35.13	$17.92
METCALFE	$88.37	$34.00	$81.89	$34.11
MONTGOMERY	$94.39	$30.66	$83.70	$36.45
MUHLENBERG	$104.57	$32.56	$88.47	$39.54
NICHOLAS	$83.74	$29.69	$123.27	$47.35
OLDHAM	$88.66	$31.83	$96.12	$43.17
OWSLEY	$60.03	$24.67	$57.08	$25.30
PERRY	$117.90	$49.91	$76.02	$34.29
POWELL	$86.51	$33.45	$64.65	$30.91
ROBERTSON	$92.25	$27.26	$140.34	$26.47
ROWAN	$69.60	$33.10	$64.44	$41.60
SCOTT	$86.14	$29.66	$68.09	$30.50

STATE: KENTUCKY COUNTY NAME	****** AGED PART A	****** PART B	*** DISABLED *** PART A	PART B
BOYD	$98.13	$33.96	$94.26	$41.40
BRACKEN	$105.00	$28.94	$105.00	$38.48
BRECKINRIDGE	$87.26	$26.05	$102.17	$36.61
BUTLER	$101.58	$39.72	$98.31	$42.94
CALLOWAY	$115.04	$39.59	$133.34	$56.57
CARLISLE	$122.83	$41.42	$115.98	$47.16
CARTER	$72.39	$30.54	$55.00	$24.81
CHRISTIAN	$97.35	$36.84	$88.39	$61.32
CLAY	$95.68	$32.22	$50.96	$24.31
CRITTENDEN	$127.29	$31.55	$130.24	$33.77
DAVIESS	$114.07	$42.26	$126.43	$55.21
ELLIOTT	$71.20	$31.13	$58.10	$25.42
FAYETTE	$82.45	$39.52	$90.09	$48.61
FLOYD	$119.47	$52.07	$77.04	$50.44
FULTON	$87.57	$29.95	$100.55	$36.10
GARRARD	$93.93	$31.80	$56.08	$27.40
GRAVES	$113.62	$38.95	$113.99	$50.63
GREEN	$83.07	$25.44	$94.17	$41.19
HANCOCK	$106.93	$34.33	$92.67	$39.63
HARLAN	$92.12	$48.24	$77.34	$42.14
HART	$89.47	$28.48	$86.86	$33.66
HENRY	$91.98	$30.37	$117.89	$38.02
HOPKINS	$124.60	$51.49	$135.43	$62.89
JEFFERSON	$125.03	$45.51	$144.30	$61.74
JOHNSON	$92.10	$39.40	$61.64	$38.22
KNOTT	$80.36	$42.92	$60.49	$40.84
LARUE	$88.78	$32.71	$84.59	$43.99
LAWRENCE	$111.72	$36.07	$76.51	$34.42
LESLIE	$86.25	$36.19	$63.48	$28.28
LEWIS	$92.75	$30.31	$79.53	$34.05
LIVINGSTON	$109.48	$29.99	$132.04	$49.13
LYON	$108.92	$37.24	$95.84	$39.40
MC CREARY	$85.21	$40.74	$77.20	$39.41
MADISON	$92.21	$32.26	$66.80	$30.23
MARION	$89.82	$29.64	$96.40	$34.10
MARTIN	$101.19	$41.47	$57.26	$38.74
MEADE	$110.90	$37.22	$135.50	$46.11
MERCER	$100.19	$33.21	$93.00	$43.63
MONROE	$88.86	$28.54	$111.72	$39.62
MORGAN	$78.64	$26.89	$65.29	$31.68
NELSON	$84.35	$32.76	$81.87	$35.43
OHIO	$110.67	$34.02	$122.84	$46.87
OWEN	$101.86	$27.86	$111.85	$45.81
PENDLETON	$98.45	$28.49	$80.76	$33.30
PIKE	$98.88	$46.47	$66.04	$38.18
PULASKI	$78.22	$30.62	$70.66	$33.59
ROCKCASTLE	$106.75	$32.34	$61.29	$26.23
RUSSELL	$87.25	$29.68	$80.82	$35.47
SHELBY	$89.53	$30.57	$79.65	$38.11

TABLE 2

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: KENTUCKY COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
SIMPSON	$105.25	$35.99	$94.56	$37.35
TAYLOR	$95.70	$29.58	$103.63	$40.66
TRIGG	$96.74	$34.96	$107.94	$46.16
UNION	$113.90	$37.85	$139.00	$52.60
WASHINGTON	$85.68	$27.82	$84.13	$29.56
WEBSTER	$123.09	$44.57	$113.84	$62.85
WOLFE	$70.33	$26.69	$63.54	$22.95
STATE: LOUISIANA				
ACADIA	$87.74	$35.28	$64.92	$28.87
ASCENSION	$111.99	$45.75	$99.13	$46.33
AVOYELLES	$74.19	$31.50	$62.62	$28.48
BIENVILLE	$71.91	$29.31	$72.37	$33.82
CADDO	$90.11	$37.92	$86.69	$37.72
CALDWELL	$133.75	$38.54	$127.66	$43.02
CATAHOULA	$89.75	$30.98	$75.34	$29.31
CONCORDIA	$75.89	$28.01	$89.44	$35.80
EAST BATON ROUGE	$112.04	$48.85	$98.42	$44.78
EAST FELICIANA	$90.87	$31.72	$81.35	$29.15
FRANKLIN	$62.79	$28.74	$87.43	$35.64
IBERIA	$90.01	$34.70	$74.58	$32.30
JACKSON	$88.25	$34.12	$78.02	$39.30
JEFFERSON DAVIS	$84.98	$35.62	$70.26	$31.39
LAFOURCHE	$103.01	$37.69	$89.55	$36.13
LINCOLN	$78.14	$32.91	$83.70	$39.97
MADISON	$49.36	$26.78	$54.28	$27.96
NATCHITOCHES	$68.73	$31.78	$74.95	$38.48
OUACHITA	$85.50	$37.23	$87.16	$42.66
POINTE COUPEE	$86.42	$37.38	$72.37	$35.98
RED RIVER	$60.02	$33.56	$84.59	$41.37
SABINE	$88.85	$34.76	$74.16	$32.48
ST CHARLES	$131.91	$44.81	$127.14	$59.09
ST JAMES	$83.80	$31.45	$78.91	$30.77
ST LANDRY	$85.12	$35.05	$79.85	$33.46
ST MARY	$116.16	$38.19	$113.73	$46.02
TANGIPAHOA	$97.95	$39.56	$88.35	$38.12
TERREBONNE	$80.38	$35.36	$86.95	$43.65
VERMILION	$114.56	$38.90	$90.45	$38.42
WASHINGTON	$126.63	$41.86	$117.18	$43.92
WEST BATON ROUGE	$96.64	$41.58	$77.66	$32.56
WEST FELICIANA	$84.05	$33.02	$88.28	$35.03
STATE: MAINE				
ANDROSCOGGIN	$111.05	$48.97	$118.78	$68.51
CUMBERLAND	$134.74	$51.46	$137.38	$66.55
HANCOCK	$129.88	$44.93	$140.99	$61.19
KNOX	$103.08	$42.31	$93.26	$45.22
OXFORD	$122.22	$47.61	$120.14	$56.44
PISCATAQUIS	$117.25	$38.91	$104.88	$45.45
SPENCER	$86.06	$38.80	$94.45	$39.95
TODD	$73.43	$30.66	$83.96	$38.34
TRIMBLE	$92.41	$28.90	$76.29	$30.99
WARREN	$115.95	$39.54	$121.47	$57.34
WAYNE	$82.26	$35.29	$77.51	$41.20
WHITLEY	$88.73	$35.25	$76.17	$34.95
WOODFORD	$105.20	$30.86	$104.82	$41.15
STATE: LOUISIANA				
ALLEN	$102.08	$37.57	$81.87	$36.22
ASSUMPTION	$84.24	$36.21	$69.74	$33.55
BEAUREGARD	$102.13	$38.66	$90.88	$41.06
BOSSIER	$93.75	$33.82	$110.33	$42.27
CALCASIEU	$110.45	$46.80	$105.37	$52.70
CAMERON	$133.06	$52.13	$122.86	$56.06
CLAIBORNE	$61.83	$24.41	$81.13	$31.07
DE SOTO	$69.94	$30.48	$65.38	$30.91
EAST CARROLL	$42.78	$21.70	$49.80	$23.72
EVANGELINE	$108.50	$34.04	$107.19	$37.17
GRANT	$84.63	$34.21	$62.49	$28.89
IBERVILLE	$103.60	$40.65	$73.19	$33.94
JEFFERSON	$153.90	$55.42	$143.31	$63.37
LAFAYETTE	$98.92	$36.89	$90.54	$39.96
LA SALLE	$130.23	$44.03	$142.10	$58.96
LIVINGSTON	$122.77	$49.34	$108.22	$51.47
MOREHOUSE	$63.44	$25.86	$71.45	$31.14
ORLEANS	$138.75	$45.67	$118.21	$43.49
PLAQUEMINES	$154.87	$53.96	$127.00	$50.20
RAPIDES	$91.21	$35.81	$72.98	$39.07
RICHLAND	$55.23	$23.52	$66.97	$28.74
ST BERNARD	$192.10	$56.78	$164.64	$68.00
ST HELENA	$88.60	$33.54	$76.66	$31.26
ST JOHN BAPTIST	$95.41	$34.09	$98.31	$40.43
ST MARTIN	$77.63	$31.25	$63.52	$29.03
ST TAMMANY	$145.99	$54.33	$130.56	$55.32
TENSAS	$54.07	$24.55	$73.84	$31.43
UNION	$78.19	$28.82	$48.20	$22.77
VERNON	$128.34	$38.23	$113.62	$36.03
WEBSTER	$94.03	$31.25	$92.46	$35.07
WEST CARROLL	$67.54	$26.19	$64.76	$35.69
WINN	$124.38	$37.94	$115.46	$42.11
STATE: MAINE				
AROOSTOOK	$128.10	$43.90	$120.35	$54.08
FRANKLIN	$106.02	$42.73	$110.91	$54.74
KENNEBEC	$117.99	$44.53	$114.63	$53.99
LINCOLN	$103.87	$39.56	$132.63	$59.07
PENOBSCOT	$125.40	$44.90	$130.13	$66.89
SAGADAHOC	$110.41	$46.27	$98.84	$53.49

TABLE 2

Page 14 of 36

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: MAINE COUNTY NAME	****** AGED ****** PART A	 PART B	*** DISABLED *** PART A	 PART B
SOMERSET	$127.92	$43.97	$137.24	$56.18
WASHINGTON	$117.13	$37.48	$127.80	$55.65
STATE: MARYLAND				
ALLEGANY	$153.66	$49.84	$162.98	$58.86
BALTIMORE	$170.32	$63.37	$210.90	$89.39
CALVERT	$170.10	$70.94	$168.47	$92.62
CARROLL	$114.31	$49.57	$138.37	$68.82
CHARLES	$189.45	$81.40	$203.18	$108.87
FREDERICK	$97.31	$41.77	$138.10	$62.35
HARFORD	$189.06	$69.27	$180.36	$78.28
KENT	$138.76	$51.51	$170.44	$69.71
PRINCE GEORGES	$208.78	$99.20	$252.31	$130.53
ST MARYS	$138.56	$57.62	$141.36	$67.47
TALBOT	$111.58	$43.89	$124.51	$55.00
WICOMICO	$111.64	$48.35	$139.58	$68.54
STATE: MASSACHUSETTS				
BARNSTABLE	$123.46	$53.97	$148.52	$73.84
BRISTOL	$116.99	$51.78	$121.30	$64.63
ESSEX	$158.34	$66.95	$169.40	$84.34
HAMPDEN	$129.68	$58.72	$133.33	$73.24
MIDDLESEX	$179.95	$72.06	$176.46	$87.49
NORFOLK	$177.96	$73.21	$175.60	$84.76
SUFFOLK	$204.30	$81.46	$180.34	$93.43
STATE: MICHIGAN				
ALCONA	$116.82	$49.82	$151.23	$69.73
ALLEGAN	$120.29	$46.63	$137.94	$67.30
ANTRIM	$121.18	$50.87	$151.96	$72.12
BARAGA	$112.05	$38.66	$117.38	$52.76
BAY	$152.76	$59.36	$178.48	$86.24
BERRIEN	$110.62	$46.52	$127.43	$63.67
CALHOUN	$155.55	$57.46	$154.25	$75.14
CHARLEVOIX	$129.10	$52.05	$137.41	$69.63
CHIPPEWA	$126.41	$46.22	$102.32	$42.89
CLINTON	$138.25	$52.37	$156.39	$76.46
DELTA	$104.57	$44.03	$97.75	$48.87
EATON	$146.85	$52.93	$182.13	$87.17
GENESEE	$191.55	$86.24	$198.66	$105.24
GOGEBIC	$100.67	$34.12	$98.32	$43.99
GRATIOT	$108.39	$46.51	$118.38	$64.53
HOUGHTON	$107.78	$39.09	$90.22	$47.69
INGHAM	$144.23	$56.87	$163.42	$81.12
IOSCO	$135.64	$57.09	$137.38	$74.82
ISABELLA	$136.35	$58.00	$119.97	$64.75
KALAMAZOO	$142.54	$57.21	$173.23	$88.88
KENT	$108.12	$46.40	$128.58	$66.40
LAKE	$107.19	$49.41	$112.74	$63.51

STATE: MAINE COUNTY NAME	****** AGED ****** PART A	 PART B	*** DISABLED *** PART A	 PART B
WALDO	$122.24	$41.65	$128.23	$52.05
YORK	$119.89	$49.28	$130.08	$62.91
STATE: MARYLAND				
ANNE ARUNDEL	$157.21	$68.60	$194.19	$92.42
BALTIMORE CITY	$193.10	$66.12	$203.22	$80.95
CAROLINE	$104.36	$41.01	$118.65	$51.01
CECIL	$145.48	$51.96	$173.33	$69.63
DORCHESTER	$129.49	$53.75	$159.31	$67.83
GARRETT	$112.29	$36.45	$113.46	$41.99
HOWARD	$169.38	$67.09	$175.65	$80.45
MONTGOMERY	$135.99	$87.31	$171.94	$109.32
QUEEN ANNES	$121.80	$46.11	$132.80	$58.25
SOMERSET	$115.32	$42.84	$122.92	$51.05
WASHINGTON	$93.32	$39.52	$117.37	$56.17
WORCESTER	$107.90	$45.28	$128.72	$60.12
STATE: MASSACHUSETTS				
BERKSHIRE	$147.56	$54.80	$152.50	$68.91
DUKES	$212.12	$73.68	$275.58	$83.71
FRANKLIN	$125.76	$48.75	$134.94	$59.85
HAMPSHIRE	$123.28	$51.17	$121.98	$58.91
NANTUCKET	$163.35	$54.99	$101.53	$41.95
PLYMOUTH	$144.86	$60.65	$143.62	$71.96
WORCESTER	$166.48	$65.72	$168.50	$81.70
STATE: MICHIGAN				
ALGER	$112.66	$38.58	$94.93	$41.55
ALPENA	$128.06	$46.43	$157.00	$62.77
ARENAC	$153.82	$62.57	$146.09	$67.13
BARRY	$127.36	$51.75	$138.61	$68.59
BENZIE	$134.47	$50.11	$152.55	$71.55
BRANCH	$113.09	$42.64	$108.06	$55.31
CASS	$127.82	$49.20	$150.53	$65.41
CHEBOYGAN	$143.93	$56.02	$158.47	$75.15
CLARE	$137.35	$60.22	$130.95	$70.69
CRAWFORD	$147.54	$52.35	$147.02	$76.66
DICKINSON	$101.25	$38.27	$89.21	$41.27
EMMET	$132.98	$52.44	$153.42	$66.23
GLADWIN	$166.17	$74.73	$170.24	$96.68
GRAND TRAVERSE	$123.55	$51.85	$143.16	$85.62
HILLSDALE	$125.50	$46.84	$112.79	$50.87
HURON	$139.13	$52.01	$134.73	$66.42
IONIA	$141.83	$52.33	$154.49	$66.63
IRON	$121.25	$47.06	$113.06	$51.28
JACKSON	$126.72	$54.75	$158.30	$74.50
KALKASKA	$147.08	$52.11	$140.95	$73.35
KEWEENAW	$103.17	$40.56	$70.22	$46.72
LAPEER	$171.97	$68.15	$120.06	$74.71

TABLE 2

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: MICHIGAN COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
LEELANAU	$127.49	$46.98	$181.26	$73.26
LIVINGSTON	$154.21	$68.76	$160.94	$77.42
MACKINAC	$123.78	$50.40	$99.66	$48.15
MANISTEE	$143.73	$45.09	$148.09	$64.30
MASON	$104.95	$43.98	$108.56	$59.05
MENOMINEE	$97.09	$31.06	$92.52	$39.50
MISSAUKEE	$139.13	$45.49	$148.10	$67.54
MONTCALM	$130.57	$51.29	$149.67	$70.27
MUSKEGON	$145.15	$62.47	$147.50	$78.97
OAKLAND	$186.41	$99.27	$206.66	$124.47
OGEMAW	$132.44	$58.63	$149.34	$85.58
OSCEOLA	$125.13	$44.22	$107.10	$52.94
OTSEGO	$119.09	$56.29	$103.84	$62.79
PRESQUE ISLE	$146.89	$49.61	$145.66	$59.96
SAGINAW	$151.13	$56.75	$176.82	$76.90
ST JOSEPH	$124.94	$44.69	$151.42	$71.87
SCHOOLCRAFT	$109.86	$48.18	$85.65	$50.94
TUSCOLA	$138.48	$52.30	$166.56	$74.73
WASHTENAW	$179.12	$68.80	$206.48	$106.72
WEXFORD	$137.68	$44.32	$153.61	$61.63
STATE: MINNESOTA				
AITKIN	$102.51	$36.54	$88.77	$39.28
BECKER	$105.44	$38.20	$134.29	$55.71
BENTON	$94.47	$35.31	$104.00	$50.86
BLUE EARTH	$78.50	$40.62	$79.27	$56.77
CARLTON	$104.70	$35.19	$108.39	$43.01
CASS	$95.30	$35.63	$110.47	$45.32
CHISAGO	$114.06	$37.47	$151.34	$65.18
CLEARWATER	$86.95	$31.24	$104.14	$42.12
COTTONWOOD	$106.72	$38.91	$136.67	$49.65
DAKOTA	$141.87	$52.41	$162.40	$67.33
DOUGLAS	$91.75	$34.86	$117.00	$44.71
FILLMORE	$74.45	$50.18	$111.59	$95.81
GOODHUE	$82.92	$51.26	$102.78	$69.10
HENNEPIN	$152.01	$59.21	$209.66	$84.84
HUBBARD	$111.03	$40.23	$101.67	$48.46
ITASCA	$103.70	$36.31	$132.90	$51.62
KANABEC	$119.48	$39.66	$121.74	$54.13
KITTSON	$116.75	$41.70	$116.77	$47.14
LAC QUI PARLE	$96.24	$33.97	$144.13	$55.33
LAKE OF WOODS	$91.25	$27.93	$184.72	$35.35
LINCOLN	$98.55	$33.91	$104.56	$37.44
MC LEOD	$110.92	$36.76	$96.94	$47.13
MARSHALL	$125.01	$44.08	$138.45	$51.15
MEEKER	$105.25	$34.36	$126.73	$40.19
MORRISON	$97.35	$35.98	$117.74	$48.77
MURRAY	$97.16	$32.37	$85.11	$42.44
NOBLES	$88.80	$36.55	$101.81	$54.27

STATE: MICHIGAN COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
LENAWEE	$138.35	$48.07	$170.22	$68.16
LUCE	$115.12	$43.45	$119.15	$50.58
MACOMB	$189.30	$99.01	$200.47	$121.18
MARQUETTE	$136.57	$56.10	$129.57	$71.61
MECOSTA	$125.90	$55.35	$122.65	$70.71
MIDLAND	$132.20	$54.37	$180.88	$83.84
MONROE	$165.30	$68.62	$190.51	$90.13
MONTMORENCY	$128.04	$60.44	$143.77	$76.51
NEWAYGO	$118.61	$50.81	$131.64	$70.12
OCEANA	$125.47	$51.42	$116.12	$63.53
ONTONAGON	$149.10	$47.58	$161.42	$56.27
OSCODA	$122.09	$50.25	$137.82	$91.57
OTTAWA	$102.20	$45.16	$138.01	$71.68
ROSCOMMON	$141.38	$57.79	$146.18	$74.80
ST CLAIR	$133.54	$60.29	$159.50	$78.96
SANILAC	$159.14	$55.24	$158.38	$66.98
SHIAWASSEE	$140.15	$56.22	$162.41	$72.32
VAN BUREN	$133.96	$52.56	$152.08	$68.96
WAYNE	$203.74	$91.92	$227.69	$113.10
STATE: MINNESOTA				
ANOKA	$139.34	$62.15	$185.57	$78.36
BELTRAMI	$86.69	$33.39	$108.44	$47.41
BIG STONE	$115.30	$35.04	$126.04	$49.20
BROWN	$88.43	$32.44	$107.10	$57.78
CARVER	$120.54	$44.39	$143.11	$59.94
CHIPPEWA	$78.94	$30.28	$53.86	$24.85
CLAY	$121.62	$42.61	$180.89	$64.84
COOK	$143.61	$52.09	$104.19	$52.76
CROW WING	$114.68	$41.58	$94.31	$55.22
DODGE	$73.34	$69.09	$90.97	$69.25
FARIBAULT	$83.54	$44.33	$82.94	$43.04
FREEBORN	$71.53	$40.10	$94.67	$62.22
GRANT	$119.10	$40.98	$95.90	$47.70
HOUSTON	$77.80	$40.86	$108.91	$55.13
ISANTI	$124.80	$39.00	$119.36	$46.97
JACKSON	$117.33	$43.46	$88.19	$42.73
KANDIYOHI	$76.58	$33.85	$92.11	$43.37
KOOCHICHING	$136.23	$45.88	$146.64	$54.00
LAKE	$90.47	$44.64	$147.41	$70.26
LE SUEUR	$96.18	$41.57	$105.60	$54.27
LYON	$99.49	$36.16	$129.37	$47.46
MAHNOMEN	$97.83	$32.67	$110.75	$34.77
MARTIN	$83.12	$43.15	$86.57	$43.69
MILLE LACS	$125.94	$40.90	$168.43	$63.75
MOWER	$89.56	$53.69	$106.57	$78.45
NICOLLET	$84.48	$37.58	$107.48	$51.35
NORMAN	$89.74	$34.19	$87.57	$39.29

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: MINNESOTA COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
OLMSTED	$78.58	$91.43	$112.30	$124.76
PENNINGTON	$101.28	$48.82	$148.84	$48.65
PIPESTONE	$87.43	$34.03	$71.23	$36.55
POPE	$90.96	$34.14	$84.37	$39.98
RED LAKE	$141.16	$48.07	$140.45	$60.97
RENVILLE	$93.90	$31.45	$118.59	$41.82
ROCK	$87.77	$33.83	$65.82	$40.11
ST LOUIS	$117.59	$42.83	$135.65	$53.22
SHERBURNE	$106.62	$40.79	$138.18	$66.61
STEARNS	$111.95	$41.08	$103.80	$46.43
STEVENS	$116.09	$43.05	$112.65	$41.35
TODD	$103.14	$35.94	$99.42	$37.60
WABASHA	$89.07	$61.39	$95.07	$77.53
WASECA	$78.58	$43.95	$78.08	$58.44
WATONWAN	$84.96	$36.63	$110.31	$52.05
WINONA	$91.92	$52.34	$95.14	$61.02
YELLOW MEDICINE	$103.05	$32.15	$129.50	$46.71
STATE: MISSISSIPPI				
ADAMS	$96.45	$38.41	$90.57	$36.58
AMITE	$88.74	$33.08	$91.98	$38.45
BENTON	$85.46	$37.03	$84.46	$43.01
CALHOUN	$100.83	$38.24	$93.82	$37.56
CHICKASAW	$90.41	$37.11	$109.51	$45.93
CLAIBORNE	$75.53	$37.12	$49.94	$29.28
CLAY	$64.57	$26.62	$82.48	$32.75
COPIAH	$84.40	$35.94	$71.71	$37.10
DESOTO	$119.96	$45.11	$131.94	$59.43
FRANKLIN	$82.48	$35.19	$86.60	$42.95
GREENE	$120.25	$51.71	$105.43	$50.17
HANCOCK	$133.43	$51.10	$131.99	$57.78
HINDS	$93.59	$43.24	$93.89	$51.10
HUMPHREYS	$94.97	$41.07	$70.65	$34.14
ITAWAMBA	$81.04	$35.52	$89.89	$46.43
JASPER	$82.25	$44.12	$66.32	$38.87
JEFFERSON DAVIS	$95.80	$40.83	$78.33	$43.08
KEMPER	$80.01	$30.90	$65.36	$28.44
LAMAR	$115.19	$48.84	$104.38	$50.23
LAWRENCE	$138.72	$54.10	$115.77	$50.20
LEE	$94.41	$42.55	$92.85	$48.61
LINCOLN	$87.91	$39.10	$85.20	$41.66
MADISON	$75.23	$34.50	$74.06	$39.50
MARSHALL	$89.81	$37.19	$103.25	$44.80
MONTGOMERY	$90.88	$39.26	$80.24	$38.33
NEWTON	$96.75	$40.67	$107.37	$50.67
OKTIBBEHA	$64.39	$31.94	$60.59	$36.26
PEARL RIVER	$139.66	$51.15	$119.11	$50.55
PIKE	$86.97	$39.24	$87.86	$39.75
PRENTISS	$108.71	$36.55	$116.48	$39.58

STATE: MINNESOTA COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
OTTER TAIL	$106.13	$39.50	$95.96	$43.43
PINE	$107.95	$34.20	$139.29	$51.67
POLK	$111.16	$41.57	$122.28	$49.93
RAMSEY	$157.42	$58.53	$218.06	$87.62
REDWOOD	$89.73	$32.35	$80.03	$37.96
RICE	$101.87	$44.83	$100.88	$54.67
ROSEAU	$110.40	$39.13	$113.50	$45.14
SCOTT	$114.89	$42.45	$125.30	$53.96
SIBLEY	$99.71	$33.54	$108.65	$43.29
STEELE	$78.97	$47.81	$103.56	$68.08
SWIFT	$92.95	$32.05	$94.12	$33.18
TRAVERSE	$110.49	$40.42	$93.17	$41.62
WADENA	$103.73	$33.91	$125.04	$55.62
WASHINGTON	$127.03	$46.06	$196.95	$78.03
WILKIN	$114.45	$35.99	$102.58	$38.93
WRIGHT	$112.35	$39.68	$128.26	$60.36
STATE: MISSISSIPPI				
ALCORN	$111.30	$41.76	$110.45	$49.36
ATTALA	$76.55	$29.08	$69.02	$32.80
BOLIVAR	$78.39	$33.65	$91.30	$39.02
CARROLL	$85.97	$39.27	$78.11	$38.45
CHOCTAW	$74.80	$34.69	$63.66	$35.72
CLARKE	$113.02	$43.66	$124.91	$56.17
COAHOMA	$84.77	$35.72	$81.27	$37.58
COVINGTON	$136.97	$45.85	$99.28	$41.57
FORREST	$118.55	$50.65	$114.13	$53.48
GEORGE	$145.24	$50.27	$124.61	$50.88
GRENADA	$112.05	$39.90	$135.25	$51.09
HARRISON	$139.36	$51.24	$130.46	$56.44
HOLMES	$81.67	$32.40	$69.03	$33.65
ISSAQUENA	$67.13	$33.08	$97.29	$42.03
JACKSON	$151.63	$52.99	$140.93	$58.92
JEFFERSON	$102.74	$42.30	$76.73	$37.60
JONES	$93.39	$41.51	$84.99	$43.97
LAFAYETTE	$83.22	$33.26	$89.73	$37.28
LAUDERDALE	$110.67	$45.17	$119.62	$57.01
LEAKE	$77.76	$32.66	$79.72	$41.54
LEFLORE	$87.71	$42.14	$90.97	$40.98
LOWNDES	$82.64	$33.30	$88.52	$37.29
MARION	$119.30	$44.83	$108.75	$47.09
MONROE	$74.87	$35.01	$70.20	$38.44
NESHOBA	$83.91	$41.22	$100.49	$52.51
NOXUBEE	$87.65	$34.25	$82.33	$33.38
PANOLA	$100.12	$36.98	$102.95	$39.89
PERRY	$128.99	$49.91	$81.55	$41.56
PONTOTOC	$92.77	$36.77	$83.37	$42.76
QUITMAN	$91.76	$33.96	$89.05	$35.61

TABLE 2

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: MISSISSIPPI COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
RANKIN	$73.08	$38.47	$83.85	$50.11
SHARKEY	$77.61	$38.41	$58.36	$28.19
SMITH	$93.22	$46.09	$90.35	$45.11
SUNFLOWER	$90.08	$39.20	$79.36	$37.43
TATE	$115.49	$41.59	$127.94	$54.25
TISHOMINGO	$100.38	$38.73	$112.40	$50.60
UNION	$79.23	$32.61	$81.82	$43.46
WARREN	$76.95	$39.52	$84.59	$44.45
WAYNE	$112.54	$43.82	$86.04	$44.24
WILKINSON	$76.21	$31.66	$63.38	$27.15
YALOBUSHA	$84.03	$33.40	$83.68	$39.58
STATE: MISSOURI				
ADAIR	$163.36	$48.40	$178.28	$57.18
ATCHISON	$133.06	$39.08	$118.31	$32.17
BARRY	$99.53	$35.34	$95.88	$46.73
BATES	$136.59	$50.33	$118.55	$51.69
BOLLINGER	$103.70	$35.27	$110.29	$43.55
BUCHANAN	$127.14	$44.05	$136.44	$58.65
CALDWELL	$102.08	$33.36	$138.38	$54.63
CAMDEN	$136.29	$43.93	$106.15	$52.96
CARROLL	$132.00	$43.66	$129.14	$54.40
CASS	$139.95	$51.89	$157.44	$70.19
CHARITON	$122.99	$40.00	$65.90	$32.07
CLARK	$153.06	$44.19	$99.64	$37.63
CLINTON	$129.60	$42.26	$146.17	$52.98
COOPER	$140.88	$42.58	$120.87	$50.60
DADE	$95.42	$34.46	$129.23	$50.70
DAVIESS	$102.41	$32.61	$100.55	$43.29
DENT	$125.73	$36.68	$107.18	$41.80
DUNKLIN	$108.72	$39.52	$106.50	$46.67
GASCONADE	$121.18	$34.01	$122.46	$40.85
GREENE	$105.62	$43.42	$128.42	$61.08
HARRISON	$126.97	$38.77	$102.92	$44.68
HICKORY	$112.26	$42.35	$88.56	$42.67
HOWARD	$126.88	$40.39	$134.30	$45.68
IRON	$123.00	$34.76	$110.35	$37.52
JASPER	$117.96	$40.35	$117.84	$54.33
JOHNSON	$129.56	$44.56	$134.64	$63.40
LACLEDE	$84.11	$31.88	$84.28	$40.26
LAWRENCE	$105.03	$35.69	$131.37	$58.80
LINCOLN	$139.84	$39.07	$186.35	$51.84
LIVINGSTON	$101.87	$30.94	$109.79	$41.80
MACON	$124.81	$40.12	$153.82	$63.02
MARIES	$136.17	$37.32	$138.37	$44.12
MERCER	$106.26	$31.63	$109.32	$43.45
MISSISSIPPI	$91.00	$36.25	$79.13	$36.12
MONROE	$111.21	$36.46	$153.28	$47.73
MORGAN	$91.04	$34.10	$110.58	$46.74

STATE: MISSISSIPPI COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
SCOTT	$72.39	$34.44	$85.46	$46.11
SIMPSON	$111.46	$40.29	$95.55	$38.90
STONE	$128.93	$43.96	$75.25	$40.10
TALLAHATCHIE	$74.49	$36.76	$65.90	$38.83
TIPPAH	$104.25	$39.51	$94.48	$46.94
TUNICA	$75.71	$35.13	$78.88	$34.85
WALTHALL	$92.07	$39.00	$92.18	$38.69
WASHINGTON	$87.28	$34.85	$84.68	$39.77
WEBSTER	$88.77	$37.42	$105.41	$49.50
WINSTON	$59.47	$29.21	$62.55	$33.03
YAZOO	$81.01	$35.44	$84.28	$40.16
STATE: MISSOURI				
ANDREW	$114.30	$35.35	$123.84	$46.70
AUDRAIN	$132.48	$43.78	$185.98	$65.25
BARTON	$113.45	$34.30	$85.17	$30.85
BENTON	$107.77	$40.29	$114.61	$52.11
BOONE	$138.69	$50.35	$170.59	$69.40
BUTLER	$141.51	$50.62	$122.17	$53.98
CALLAWAY	$111.25	$37.86	$118.33	$51.45
CAPE GIRARDEAU	$117.67	$40.06	$112.91	$47.08
CARTER	$111.29	$44.22	$109.73	$58.03
CEDAR	$83.81	$32.80	$82.55	$40.67
CHRISTIAN	$98.10	$40.89	$117.41	$53.18
CLAY	$165.82	$64.08	$186.59	$82.97
COLE	$133.66	$43.84	$158.61	$56.58
CRAWFORD	$119.16	$37.37	$108.10	$42.62
DALLAS	$89.57	$38.60	$90.39	$41.81
DE KALB	$131.06	$39.50	$124.42	$49.23
DOUGLAS	$90.95	$36.11	$74.53	$32.89
FRANKLIN	$153.32	$43.99	$154.17	$55.32
GENTRY	$126.02	$37.91	$69.09	$32.73
GRUNDY	$123.64	$34.81	$108.02	$44.93
HENRY	$114.19	$39.31	$98.71	$50.58
HOLT	$127.13	$38.95	$147.89	$46.86
HOWELL	$86.85	$32.12	$72.23	$35.74
JACKSON	$179.15	$67.64	$196.39	$85.78
JEFFERSON	$173.61	$51.83	$204.78	$70.27
KNOX	$140.05	$39.83	$102.23	$33.53
LAFAYETTE	$117.72	$45.25	$141.66	$62.96
LEWIS	$125.52	$37.20	$199.51	$61.51
LINN	$123.20	$37.68	$117.53	$44.73
MC DONALD	$96.75	$33.59	$100.04	$37.17
MADISON	$153.06	$44.44	$136.36	$49.30
MARION	$129.97	$35.02	$108.86	$36.17
MILLER	$132.73	$37.22	$102.23	$37.50
MONITEAU	$122.44	$37.07	$116.10	$41.97
MONTGOMERY	$126.89	$38.16	$116.02	$51.04
NEW MADRID	$87.63	$36.65	$78.73	$31.97

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: MISSOURI COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
NEWTON	$94.20	$34.73	$82.63	$40.61
OREGON	$76.62	$32.02	$69.06	$34.68
OZARK	$95.61	$37.65	$82.29	$38.86
PERRY	$127.49	$42.58	$122.33	$46.83
PHELPS	$109.82	$35.45	$104.72	$40.69
PLATTE	$155.15	$57.12	$171.06	$71.32
PULASKI	$114.88	$35.03	$106.84	$42.36
RALLS	$122.45	$38.63	$144.67	$53.19
RAY	$129.53	$46.73	$163.10	$76.67
RIPLEY	$101.78	$35.32	$102.69	$44.24
ST CLAIR	$125.06	$42.51	$123.26	$49.00
ST LOUIS	$164.31	$54.10	$210.83	$74.30
STE GENEVIEVE	$151.34	$40.85	$156.88	$52.92
SCHUYLER	$153.27	$42.88	$102.22	$44.48
SCOTT	$113.24	$40.52	$100.41	$43.53
SHELBY	$96.39	$32.08	$97.05	$34.82
STONE	$98.77	$41.34	$119.36	$61.21
TANEY	$113.33	$42.33	$101.11	$48.83
VERNON	$103.98	$39.76	$128.53	$48.59
WASHINGTON	$137.58	$39.68	$119.74	$42.39
WEBSTER	$88.72	$36.81	$94.29	$55.05
WRIGHT	$94.92	$36.04	$80.94	$40.39
STATE: MONTANA				
BEAVERHEAD	$109.39	$48.02	$94.83	$48.66
BLAINE	$127.57	$46.01	$114.30	$40.06
CARBON	$91.64	$46.38	$95.84	$48.64
CASCADE	$134.95	$54.97	$140.49	$69.35
CUSTER	$115.56	$41.48	$120.43	$52.93
DAWSON	$123.36	$46.60	$66.04	$48.92
FALLON	$107.24	$42.83	$194.02	$50.51
FLATHEAD	$89.25	$44.81	$103.52	$64.28
GARFIELD	$109.53	$38.65	$71.78	$39.01
GOLDEN VALLEY	$95.70	$49.87	$21.24	$13.17
HILL	$148.74	$50.59	$114.10	$54.44
JUDITH BASIN	$145.64	$55.43	$174.66	$74.24
LEWIS AND CLARK	$121.68	$63.34	$107.24	$65.82
LINCOLN	$88.98	$40.44	$92.52	$48.54
MADISON	$89.28	$42.10	$121.14	$49.83
MINERAL	$123.43	$58.98	$89.73	$63.19
MUSSELSHELL	$101.30	$53.20	$105.87	$60.46
PETROLEUM	$108.09	$42.90	$125.94	$68.62
PONDERA	$136.06	$43.37	$126.96	$55.63
POWELL	$135.82	$50.02	$92.90	$55.23
RAVALLI	$78.80	$41.50	$96.14	$60.62
ROOSEVELT	$125.56	$40.39	$170.91	$59.52
SANDERS	$118.48	$42.97	$109.64	$54.94
SILVER BOW	$152.83	$65.04	$160.73	$86.10
SWEET GRASS	$77.17	$34.58	$123.23	$37.88

STATE: MISSOURI COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
NODAWAY	$145.21	$37.80	$133.49	$42.34
OSAGE	$124.63	$37.95	$164.69	$46.31
PEMISCOT	$98.57	$36.78	$91.86	$41.18
PETTIS	$96.37	$35.46	$110.55	$47.19
PIKE	$145.27	$38.54	$115.42	$37.42
POLK	$92.29	$39.18	$88.64	$42.67
PUTNAM	$129.50	$34.78	$127.09	$37.55
RANDOLPH	$139.42	$44.09	$105.31	$43.02
REYNOLDS	$131.09	$36.53	$118.00	$43.10
ST CHARLES	$156.57	$49.40	$187.48	$64.51
ST FRANCOIS	$141.51	$37.20	$132.56	$46.45
ST LOUIS CITY	$164.73	$47.90	$178.77	$58.13
SALINE	$119.80	$37.51	$115.70	$37.90
SCOTLAND	$154.91	$38.65	$75.86	$29.19
SHANNON	$92.86	$32.60	$90.29	$53.38
STODDARD	$95.50	$37.01	$94.54	$44.09
SULLIVAN	$143.51	$40.35	$119.57	$41.89
TEXAS	$93.53	$30.55	$81.26	$41.23
WARREN	$134.29	$39.29	$177.63	$62.51
WAYNE	$112.06	$44.07	$103.24	$45.45
WORTH	$98.02	$25.73	$109.80	$47.34
STATE: MONTANA				
BIG HORN	$89.94	$39.98	$132.80	$48.13
BROADWATER	$122.80	$49.29	$88.82	$34.37
CARTER	$78.92	$36.07	$126.88	$53.85
CHOUTEAU	$140.69	$55.01	$145.92	$54.71
DANIELS	$79.49	$31.86	$106.24	$34.51
DEER LODGE	$126.73	$55.78	$108.80	$61.32
FERGUS	$93.81	$43.94	$85.63	$48.06
GALLATIN	$62.64	$53.20	$79.42	$73.76
GLACIER	$125.77	$47.95	$120.07	$47.81
GRANITE	$125.65	$57.69	$101.17	$53.57
JEFFERSON	$92.19	$50.81	$117.37	$70.75
LAKE	$104.98	$44.64	$90.57	$54.42
LIBERTY	$93.49	$37.64	$52.35	$34.44
MC CONE	$132.82	$42.57	$106.60	$41.67
MEAGHER	$123.99	$56.00	$33.00	$41.26
MISSOULA	$98.00	$51.67	$112.52	$68.40
PARK	$89.19	$43.12	$100.88	$54.36
PHILLIPS	$111.79	$39.07	$148.03	$38.80
POWDER RIVER	$79.36	$37.45	$111.39	$64.13
PRAIRIE	$114.87	$36.06	$92.79	$26.97
RICHLAND	$150.88	$51.37	$151.83	$58.18
ROSEBUD	$101.31	$34.23	$75.52	$35.38
SHERIDAN	$83.20	$30.33	$102.65	$34.62
STILLWATER	$91.87	$39.13	$100.25	$48.76
TETON	$112.19	$46.71	$141.19	$59.08

TABLE 2

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: MONTANA COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
TOOLE	$130.82	$41.18	$138.71	$45.08
VALLEY	$149.02	$46.15	$183.22	$55.82
WIBAUX	$130.97	$50.56	$134.13	$77.47
STATE: NEBRASKA				
ADAMS	$90.20	$35.07	$116.24	$56.21
ARTHUR	$133.27	$32.00	$205.61	$90.75
BLAINE	$130.30	$37.08	$178.19	$78.65
BOX BUTTE	$97.77	$34.22	$172.51	$65.65
BROWN	$92.60	$33.84	$109.89	$43.63
BURT	$106.58	$34.31	$169.24	$59.98
CASS	$140.45	$41.34	$168.79	$60.24
CHASE	$107.34	$36.89	$66.28	$32.55
CHEYENNE	$110.01	$41.79	$99.44	$47.67
COLFAX	$105.33	$31.98	$140.68	$56.17
CUSTER	$94.37	$32.51	$89.91	$35.18
DAWES	$115.19	$40.53	$122.63	$54.06
DEUEL	$109.90	$41.52	$57.43	$26.32
DODGE	$110.90	$42.98	$151.28	$73.35
DUNDY	$114.66	$38.53	$104.02	$39.23
FRANKLIN	$77.59	$32.82	$64.48	$29.84
FURNAS	$90.71	$35.20	$74.52	$38.11
GARDEN	$71.26	$28.61	$83.77	$45.35
GOSPER	$81.86	$38.79	$72.88	$30.10
GREELEY	$87.77	$36.04	$133.67	$62.77
HAMILTON	$87.23	$38.99	$93.13	$53.74
HAYES	$138.35	$49.16	$149.53	$73.16
HOLT	$113.51	$34.85	$112.36	$43.27
HOWARD	$83.00	$36.62	$73.31	$44.67
JOHNSON	$78.87	$31.51	$71.08	$25.39
KEITH	$113.87	$36.29	$121.81	$52.69
KIMBALL	$113.21	$41.01	$113.77	$69.26
LANCASTER	$107.65	$45.00	$120.72	$57.39
LOGAN	$86.72	$29.58	$175.27	$71.50
MC PHERSON	$82.90	$36.03	$145.27	$70.43
MERRICK	$95.58	$36.18	$134.66	$57.12
NANCE	$113.48	$38.94	$111.42	$64.96
NUCKOLLS	$81.79	$29.45	$68.19	$28.48
PAWNEE	$101.23	$35.29	$89.96	$48.80
PHELPS	$96.98	$45.71	$103.71	$47.89
PLATTE	$103.58	$33.22	$93.53	$62.09
REDWILLOW	$104.30	$38.72	$99.13	$43.66
ROCK	$107.71	$35.65	$129.06	$49.00
SARPY	$189.75	$58.71	$220.79	$89.60
SCOTTS BLUFF	$96.76	$36.66	$115.69	$52.16
SHERIDAN	$80.99	$29.68	$93.15	$38.82
SIOUX	$125.30	$41.03	$153.62	$69.39
THAYER	$71.37	$30.11	$87.93	$54.87
THURSTON	$115.49	$33.81	$146.02	$52.88

STATE: MONTANA COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
TREASURE	$116.39	$56.72	$127.08	$73.31
WHEATLAND	$103.24	$50.19	$142.30	$81.18
YELLOWSTONE	$98.07	$49.32	$109.42	$65.22
STATE: NEBRASKA				
ANTELOPE	$119.29	$41.74	$143.33	$57.21
BANNER	$93.12	$33.12	$133.65	$62.09
BOONE	$99.23	$33.69	$109.58	$54.00
BOYD	$112.43	$32.27	$79.11	$34.07
BUFFALO	$97.40	$36.71	$107.59	$53.05
BUTLER	$97.63	$30.15	$92.32	$44.82
CEDAR	$89.91	$32.46	$129.70	$51.30
CHERRY	$91.48	$32.88	$105.29	$38.55
CLAY	$92.42	$33.30	$105.31	$52.65
CUMING	$86.36	$31.42	$105.07	$48.73
DAKOTA	$147.98	$38.60	$167.73	$57.36
DAWSON	$86.68	$34.89	$82.11	$40.19
DIXON	$92.53	$28.83	$170.31	$66.32
DOUGLAS	$177.51	$55.77	$218.01	$89.40
FILLMORE	$75.23	$35.26	$69.13	$34.67
FRONTIER	$89.77	$38.82	$159.32	$78.72
GAGE	$89.53	$32.18	$67.04	$33.18
GARFIELD	$83.72	$32.10	$92.09	$33.47
GRANT	$112.11	$36.32	$152.74	$62.09
HALL	$98.11	$39.17	$78.75	$43.64
HARLAN	$87.53	$38.46	$50.92	$30.32
HITCHCOCK	$103.22	$36.05	$92.86	$54.45
HOOKER	$82.42	$35.99	$158.93	$69.77
JEFFERSON	$90.25	$36.43	$89.07	$50.30
KEARNEY	$73.58	$32.99	$49.93	$35.70
KEYA PAHA	$106.39	$34.59	$157.23	$71.93
KNOX	$101.31	$36.12	$106.75	$44.62
LINCOLN	$95.45	$34.82	$86.22	$45.90
LOUP	$150.54	$43.34	$141.92	$68.06
MADISON	$85.80	$33.05	$142.49	$48.66
MORRILL	$94.67	$33.30	$105.57	$55.06
NEMAHA	$124.07	$41.78	$116.68	$51.70
OTOE	$103.46	$32.77	$126.53	$44.14
PERKINS	$87.38	$35.74	$155.48	$68.77
PIERCE	$84.79	$33.15	$114.88	$46.09
POLK	$124.59	$40.64	$147.86	$60.61
RICHARDSON	$98.48	$36.05	$107.70	$50.26
SALINE	$85.23	$35.00	$115.97	$51.66
SAUNDERS	$104.16	$37.90	$125.49	$52.69
SEWARD	$84.85	$32.35	$128.59	$52.51
SHERMAN	$108.45	$37.89	$68.66	$47.46
STANTON	$82.44	$29.66	$180.64	$44.41
THOMAS	$98.35	$43.00	$207.61	$93.44
VALLEY	$68.86	$28.20	$51.06	$29.53

TABLE 2

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: NEBRASKA COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
WASHINGTON	$105.36	$32.25	$137.83	$60.15
WEBSTER	$69.82	$28.39	$78.45	$29.52
YORK	$84.87	$33.89	$150.93	$63.84
STATE: NEVADA				
CHURCHILL	$151.89	$71.87	$149.87	$84.91
DOUGLAS	$114.18	$64.06	$133.79	$94.22
ESMERALDA	$187.51	$74.01	$240.05	$138.80
HUMBOLDT	$149.46	$60.73	$104.75	$46.94
LINCOLN	$166.13	$67.41	$184.82	$82.54
MINERAL	$158.20	$70.14	$106.30	$66.64
CARSON CITY	$131.30	$70.58	$134.39	$89.97
STOREY	$151.33	$77.64	$209.79	$129.54
WHITE PINE	$119.81	$46.56	$123.21	$55.47
STATE: NEW HAMPSHIRE				
BELKNAP	$96.11	$42.41	$77.71	$41.41
CHESHIRE	$133.64	$50.64	$156.75	$65.78
GRAFTON	$128.26	$47.62	$124.76	$58.31
MERRIMACK	$107.87	$45.98	$125.47	$61.11
STRAFFORD	$98.84	$48.84	$101.15	$61.02
STATE: NEW JERSEY				
ATLANTIC	$119.53	$67.53	$135.46	$80.45
BURLINGTON	$129.48	$65.61	$144.80	$83.69
CAPE MAY	$116.92	$54.78	$114.11	$62.45
ESSEX	$162.68	$75.93	$180.11	$93.85
HUDSON	$156.05	$69.98	$159.67	$84.78
MERCER	$153.82	$67.70	$152.68	$82.33
MONMOUTH	$124.91	$60.78	$155.57	$89.98
OCEAN	$102.34	$56.57	$121.87	$72.98
SALEM	$118.67	$57.42	$126.54	$76.27
SUSSEX	$121.59	$65.05	$165.45	$112.88
WARREN	$122.76	$62.81	$136.98	$85.90
STATE: NEW MEXICO				
BERNALILLO	$122.80	$70.11	$119.15	$87.14
CHAVES	$86.55	$50.71	$81.26	$55.91
CURRY	$101.17	$45.19	$86.79	$45.63
DONA ANA	$120.56	$67.58	$114.97	$72.44
GRANT	$93.26	$40.42	$88.54	$45.50
HARDING	$104.68	$49.05	$123.36	$79.94
LEA	$112.77	$55.83	$118.64	$66.36
LOS ALAMOS	$141.03	$79.48	$218.78	$90.32
MC KINLEY	$77.92	$30.80	$61.68	$30.76
OTERO	$118.66	$58.62	$89.94	$52.67
RIO ARRIBA	$119.79	$60.09	$88.86	$62.97
SANDOVAL	$95.76	$56.79	$129.06	$69.82
SAN MIGUEL	$93.35	$46.85	$64.40	$41.30

STATE: NEBRASKA COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
WAYNE	$93.16	$29.92	$92.59	$38.06
WHEELER	$86.59	$31.31	$188.68	$87.85
STATE: NEVADA				
CLARK	$187.46	$92.33	$221.27	$123.90
ELKO	$101.48	$46.20	$157.95	$63.91
EUREKA	$107.66	$48.88	$198.14	$120.93
LANDER	$121.56	$52.74	$99.02	$52.54
LYON	$133.60	$63.36	$131.76	$87.59
NYE	$164.55	$71.63	$177.48	$104.24
PERSHING	$125.59	$66.78	$132.09	$70.90
WASHOE	$165.52	$79.68	$191.43	$105.09
STATE: NEW HAMPSHIRE				
CARROLL	$110.96	$43.75	$132.00	$65.58
COOS	$133.37	$43.25	$136.59	$54.12
HILLSBORO	$127.88	$47.28	$152.05	$74.96
ROCKINGHAM	$116.30	$50.73	$145.44	$71.57
SULLIVAN	$127.84	$50.47	$112.49	$59.20
STATE: NEW JERSEY				
BERGEN	$123.36	$69.88	$166.98	$99.25
CAMDEN	$154.09	$71.92	$172.44	$90.50
CUMBERLAND	$125.64	$62.81	$127.48	$69.93
GLOUCESTER	$135.87	$65.69	$150.79	$83.83
HUNTERDON	$130.00	$56.42	$120.20	$77.15
MIDDLESEX	$152.88	$64.95	$167.20	$97.95
MORRIS	$134.02	$70.30	$177.15	$108.76
PASSAIC	$128.35	$67.52	$157.91	$104.67
SOMERSET	$126.31	$58.40	$133.74	$76.96
UNION	$148.43	$68.67	$158.53	$85.75
STATE: NEW MEXICO				
CATRON	$92.59	$38.59	$42.72	$23.65
COLFAX	$112.29	$49.85	$79.62	$49.97
DE BACA	$71.14	$34.32	$82.94	$46.97
EDDY	$118.40	$54.24	$129.55	$65.64
GUADALUPE	$103.43	$42.36	$71.66	$34.28
HIDALGO	$116.73	$55.79	$74.07	$44.44
LINCOLN	$112.40	$50.92	$71.94	$43.30
LUNA	$87.25	$41.74	$98.26	$52.31
MORA	$70.40	$38.60	$118.01	$59.80
QUAY	$101.50	$45.90	$90.79	$48.02
ROOSEVELT	$91.66	$45.34	$103.52	$50.67
SAN JUAN	$86.24	$43.26	$79.95	$46.15
SANTA FE	$120.00	$62.25	$116.13	$63.24

TABLE 2

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: NEW MEXICO COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
SIERRA	$91.31	$47.31	$82.65	$45.79
TAOS	$114.61	$48.51	$81.13	$43.10
UNION	$91.52	$41.11	$48.25	$29.95
STATE: NEW YORK				
ALBANY	$133.38	$62.15	$126.13	$71.44
BRONX	$183.57	$91.08	$184.86	$90.30
CATTARAUGUS	$96.79	$45.14	$81.13	$48.47
CHAUTAUQUA	$96.11	$45.80	$165.05	$57.94
CHENANGO	$95.19	$37.42	$96.13	$53.27
COLUMBIA	$95.32	$44.38	$95.86	$50.66
DELAWARE	$123.89	$42.88	$103.35	$48.22
ERIE	$103.92	$46.99	$109.74	$54.08
FRANKLIN	$93.20	$48.11	$79.60	$55.76
GENESEE	$102.66	$42.42	$81.77	$44.39
HAMILTON	$114.79	$51.61	$109.52	$48.60
JEFFERSON	$116.04	$45.53	$125.19	$64.06
LEWIS	$125.85	$45.06	$120.35	$54.50
MADISON	$88.24	$40.42	$84.45	$48.90
MONTGOMERY	$108.87	$40.92	$107.78	$56.98
NEW YORK	$179.55	$100.94	$193.74	$98.28
ONEIDA	$105.88	$45.91	$100.96	$55.54
ONTARIO	$107.36	$45.38	$94.58	$54.71
ORLEANS	$99.68	$46.37	$110.10	$53.11
OTSEGO	$133.38	$34.44	$151.35	$50.45
QUEENS	$148.88	$77.72	$157.51	$90.17
RICHMOND	$171.98	$79.10	$166.52	$88.63
ST LAWRENCE	$95.49	$49.45	$94.76	$57.65
SCHENECTADY	$148.16	$58.01	$142.96	$81.15
SCHUYLER	$127.32	$54.13	$111.57	$65.14
STEUBEN	$118.12	$50.56	$93.02	$58.70
SULLIVAN	$186.49	$65.22	$165.57	$68.73
TOMPKINS	$97.19	$46.77	$131.85	$57.51
WARREN	$119.37	$59.76	$131.99	$74.96
WAYNE	$112.12	$44.66	$85.10	$47.74
WYOMING	$91.11	$41.86	$80.19	$44.22
STATE: N. CAROLINA				
ALAMANCE	$101.51	$40.77	$137.78	$58.50
ALLEGHANY	$90.02	$32.47	$68.29	$34.21
ASHE	$102.21	$33.81	$101.93	$44.36
BEAUFORT	$107.66	$35.54	$119.78	$44.04
BLADEN	$109.90	$39.69	$102.20	$46.76
BUNCOMBE	$83.54	$43.48	$93.90	$56.19
CABARRUS	$109.65	$43.15	$124.98	$56.37
CAMDEN	$100.78	$45.61	$94.19	$42.06
CASWELL	$85.18	$35.80	$115.50	$52.23
CHATHAM	$126.16	$44.07	$145.39	$55.61
CHOWAN	$94.55	$43.25	$95.61	$45.79

STATE: NEW MEXICO COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
SOCORRO	$107.51	$54.08	$99.69	$47.69
TORRANCE	$99.94	$49.04	$77.43	$50.31
VALENCIA	$110.98	$58.15	$96.56	$67.75
STATE: NEW YORK				
ALLEGANY	$113.21	$49.53	$119.05	$64.02
BROOME	$126.46	$57.16	$129.43	$72.82
CAYUGA	$95.09	$45.66	$96.77	$58.51
CHEMUNG	$132.83	$64.72	$129.75	$84.48
CLINTON	$109.47	$63.65	$117.21	$76.34
CORTLAND	$105.99	$42.48	$102.84	$53.23
DUTCHESS	$104.72	$55.38	$86.21	$58.26
ESSEX	$117.69	$59.11	$106.40	$61.83
FULTON	$106.15	$50.92	$99.55	$57.78
GREENE	$106.14	$43.67	$116.24	$51.93
HERKIMER	$103.41	$36.94	$89.90	$39.51
KINGS	$163.20	$82.60	$160.04	$84.70
LIVINGSTON	$110.65	$42.67	$78.34	$41.50
MONROE	$129.47	$51.03	$134.88	$68.43
NASSAU	$149.82	$81.82	$166.61	$97.11
NIAGARA	$111.45	$50.75	$122.58	$66.76
ONONDAGA	$107.91	$52.12	$111.45	$71.19
ORANGE	$129.05	$58.77	$125.22	$73.65
OSWEGO	$92.86	$40.41	$97.77	$52.26
PUTNAM	$144.37	$69.20	$160.71	$87.32
RENSSELAER	$143.34	$62.29	$140.89	$77.25
ROCKLAND	$138.38	$83.66	$119.24	$94.60
SARATOGA	$122.80	$56.16	$121.33	$78.25
SCHOHARIE	$96.86	$36.46	$97.15	$47.22
SENECA	$100.96	$44.42	$98.85	$51.88
SUFFOLK	$118.17	$64.74	$114.29	$76.32
TIOGA	$117.28	$50.26	$136.68	$67.47
ULSTER	$108.45	$51.08	$112.01	$64.08
WASHINGTON	$134.20	$53.37	$127.34	$69.70
WESTCHESTER	$153.46	$80.57	$186.02	$96.87
YATES	$105.08	$42.13	$77.06	$47.92
STATE: N. CAROLINA				
ALEXANDER	$129.18	$42.08	$142.45	$54.79
ANSON	$97.33	$42.03	$117.05	$58.09
AVERY	$143.35	$43.90	$138.78	$53.15
BERTIE	$131.72	$40.96	$133.71	$52.26
BRUNSWICK	$132.20	$41.15	$148.35	$51.43
BURKE	$100.09	$38.40	$110.98	$41.45
CALDWELL	$128.26	$47.94	$135.38	$58.74
CARTERET	$114.10	$42.39	$123.44	$54.21
CATAWBA	$108.97	$39.63	$140.26	$57.71
CHEROKEE	$110.37	$39.66	$140.25	$57.94
CLAY	$91.36	$38.40	$88.13	$47.88

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: N. CAROLINA COUNTY NAME	****** AGED PART A	****** PART B	*** DISABLED *** PART A	PART B
CLEVELAND	$92.44	$33.56	$113.08	$46.90
CRAVEN	$120.27	$54.93	$129.03	$64.12
CURRITUCK	$116.41	$49.22	$107.72	$52.44
DAVIDSON	$93.43	$38.92	$124.28	$58.76
DUPLIN	$109.52	$40.59	$100.91	$42.66
EDGECOMBE	$106.20	$39.96	$120.94	$50.96
FRANKLIN	$117.09	$38.43	$124.76	$49.25
GATES	$115.60	$46.53	$111.97	$51.79
GRANVILLE	$120.34	$38.58	$94.93	$35.76
GUILFORD	$105.92	$48.21	$139.70	$65.79
HARNETT	$120.84	$42.69	$132.19	$53.69
HENDERSON	$89.78	$40.36	$110.69	$60.08
HOKE	$83.11	$38.53	$104.69	$47.14
IREDELL	$107.62	$39.74	$135.19	$56.25
JOHNSTON	$111.76	$44.93	$134.59	$60.88
LEE	$104.52	$42.48	$162.45	$62.82
LINCOLN	$121.60	$39.21	$139.77	$57.61
MACON	$106.07	$35.35	$118.26	$48.29
MARTIN	$128.64	$41.30	$117.12	$41.94
MITCHELL	$124.20	$41.49	$124.98	$51.56
MOORE	$89.61	$42.03	$131.32	$51.72
NEW HANOVER	$98.91	$38.89	$129.47	$53.08
ONSLOW	$123.03	$53.99	$139.34	$62.28
PAMLICO	$98.90	$44.11	$107.70	$51.77
PENDER	$94.90	$31.81	$102.67	$40.64
PERSON	$97.28	$36.91	$101.63	$48.75
POLK	$89.86	$38.22	$118.01	$53.95
RICHMOND	$116.30	$40.02	$118.47	$48.71
ROCKINGHAM	$106.67	$42.59	$146.31	$59.78
RUTHERFORD	$92.84	$35.27	$102.97	$47.73
SCOTLAND	$89.75	$39.00	$103.72	$46.13
STOKES	$127.84	$45.49	$151.39	$65.20
SWAIN	$100.89	$38.68	$110.55	$45.38
TYRRELL	$111.89	$45.90	$91.72	$45.22
VANCE	$78.22	$34.26	$99.46	$50.02
WARREN	$96.06	$38.46	$96.01	$38.93
WATAUGA	$118.00	$39.97	$116.99	$48.03
WILKES	$82.51	$34.98	$98.57	$44.94
YADKIN	$100.60	$38.50	$115.40	$52.25
STATE: N. DAKOTA				
ADAMS	$113.55	$46.67	$123.16	$49.06
BENSON	$144.92	$46.63	$114.31	$45.00
BOTTINEAU	$146.81	$48.50	$181.59	$55.48
BURKE	$132.43	$50.43	$141.13	$53.42
CASS	$132.73	$47.25	$163.83	$65.62
DICKEY	$121.30	$43.16	$186.10	$62.36
DUNN	$129.76	$46.59	$118.68	$44.35
EMMONS	$132.49	$51.38	$159.28	$79.31

STATE: N. CAROLINA COUNTY NAME	****** AGED PART A	****** PART B	*** DISABLED *** PART A	PART B
COLUMBUS	$130.98	$45.21	$143.64	$54.35
CUMBERLAND	$88.81	$42.47	$94.42	$51.00
DARE	$95.54	$44.51	$115.88	$55.86
DAVIE	$113.47	$42.26	$113.82	$54.68
DURHAM	$131.53	$48.99	$153.16	$66.21
FORSYTH	$93.01	$44.17	$121.45	$65.10
GASTON	$92.90	$37.13	$113.15	$51.93
GRAHAM	$91.83	$33.97	$88.07	$32.59
GREENE	$103.57	$46.38	$136.85	$65.49
HALIFAX	$96.58	$36.20	$120.79	$46.34
HAYWOOD	$96.42	$39.00	$96.52	$49.54
HERTFORD	$122.06	$43.75	$142.95	$54.47
HYDE	$88.06	$30.49	$69.69	$28.54
JACKSON	$91.19	$36.76	$105.17	$46.13
JONES	$124.85	$58.15	$133.49	$66.86
LENOIR	$112.34	$40.78	$113.61	$42.22
MC DOWELL	$77.26	$36.35	$90.83	$48.64
MADISON	$72.08	$36.36	$95.25	$54.55
MECKLENBURG	$109.20	$47.56	$138.34	$62.59
MONTGOMERY	$98.55	$36.90	$103.68	$43.13
NASH	$120.26	$45.50	$136.48	$57.95
NORTHAMPTON	$96.33	$35.81	$105.82	$44.70
ORANGE	$134.45	$51.45	$159.35	$65.01
PASQUOTANK	$90.00	$41.15	$101.69	$46.05
PERQUIMANS	$90.80	$39.88	$90.63	$48.66
PITT	$96.82	$42.23	$112.41	$54.38
RANDOLPH	$83.25	$38.34	$117.18	$57.80
ROBESON	$78.82	$37.94	$89.68	$44.76
ROWAN	$84.52	$37.28	$103.81	$53.08
SAMPSON	$114.93	$47.96	$127.99	$55.58
STANLY	$92.41	$38.20	$102.60	$49.49
SURRY	$94.73	$41.48	$102.90	$53.62
TRANSYLVANIA	$82.36	$40.18	$71.67	$42.54
UNION	$98.00	$37.98	$111.00	$51.76
WAKE	$131.91	$50.69	$162.23	$71.07
WASHINGTON	$120.99	$40.08	$98.60	$37.54
WAYNE	$92.03	$34.89	$103.38	$37.18
WILSON	$100.58	$52.41	$135.56	$67.94
YANCEY	$95.76	$36.83	$83.62	$45.49
STATE: N. DAKOTA				
BARNES	$123.92	$38.16	$138.84	$47.37
BILLINGS	$109.26	$38.38	$122.20	$51.81
BOWMAN	$121.25	$40.85	$123.21	$51.69
BURLEIGH	$126.16	$57.48	$156.64	$74.65
CAVALIER	$126.24	$43.23	$156.34	$63.07
DIVIDE	$141.91	$50.95	$147.77	$59.66
EDDY	$123.40	$43.67	$126.53	$63.72
FOSTER	$104.61	$44.29	$170.35	$68.00

TABLE 2

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: N. DAKOTA COUNTY NAME	****** AGED ****** PART A	 PART B	*** DISABLED *** PART A	 PART B
GOLDEN VALLEY	$171.62	$59.70	$144.17	$41.84
GRANT	$155.86	$77.48	$90.04	$56.18
HETTINGER	$125.79	$54.85	$149.73	$73.33
LA MOURE	$117.31	$41.15	$159.49	$69.37
MC HENRY	$155.46	$53.06	$131.25	$48.07
MC KENZIE	$127.86	$53.84	$131.04	$62.91
MERCER	$151.20	$54.09	$208.52	$85.68
MOUNTRAIL	$125.33	$42.08	$222.86	$79.98
OLIVER	$131.44	$47.66	$166.98	$71.24
PIERCE	$141.06	$47.76	$106.27	$50.13
RANSOM	$106.41	$36.00	$108.53	$58.67
RICHLAND	$119.40	$36.47	$147.11	$47.20
SARGENT	$126.34	$43.45	$168.97	$63.27
SIOUX	$139.89	$58.50	$312.23	$89.49
STARK	$122.06	$47.51	$157.69	$63.49
STUTSMAN	$101.66	$43.77	$116.59	$47.89
TRAILL	$119.86	$37.62	$165.64	$48.48
WARD	$150.81	$55.30	$162.55	$71.51
WILLIAMS	$145.36	$52.73	$164.70	$71.31

STATE: N. DAKOTA COUNTY NAME	****** AGED ****** PART A	 PART B	*** DISABLED *** PART A	 PART B
GRAND FORKS	$117.73	$46.26	$143.28	$59.99
GRIGGS	$106.96	$37.72	$142.96	$35.52
KIDDER	$110.82	$46.75	$237.78	$132.34
LOGAN	$143.97	$49.67	$108.54	$55.08
MC INTOSH	$115.20	$43.28	$168.57	$72.96
MC LEAN	$143.00	$55.25	$138.32	$90.23
MORTON	$143.26	$58.05	$166.06	$76.89
NELSON	$129.07	$40.33	$175.37	$48.56
PEMBINA	$127.37	$47.59	$151.32	$64.61
RAMSEY	$126.83	$48.15	$163.28	$57.34
RENVILLE	$136.09	$49.40	$177.93	$73.41
ROLETTE	$175.27	$52.36	$124.27	$43.27
SHERIDAN	$127.08	$44.71	$194.83	$92.68
SLOPE	$112.33	$38.21	$166.53	$72.75
STEELE	$124.55	$44.12	$196.39	$87.68
TOWNER	$135.80	$49.05	$211.00	$81.62
WALSH	$123.97	$45.85	$88.57	$35.99
WELLS	$133.32	$49.31	$125.57	$67.41

STATE: OHIO				
ADAMS	$108.70	$36.18	$97.10	$41.46
ASHLAND	$102.33	$39.91	$130.86	$58.64
ATHENS	$114.82	$43.87	$102.58	$58.88
BELMONT	$152.85	$48.43	$150.30	$58.08
BUTLER	$129.36	$45.56	$159.54	$66.06
CHAMPAIGN	$112.47	$44.51	$122.54	$61.48
CLERMONT	$143.12	$48.79	$143.33	$61.11
COLUMBIANA	$127.83	$45.59	$146.80	$63.71
CRAWFORD	$123.04	$40.23	$156.99	$53.59
DARKE	$87.97	$34.26	$102.66	$49.93
DELAWARE	$111.12	$42.57	$133.31	$59.45
FAIRFIELD	$103.16	$39.56	$98.88	$50.70
FRANKLIN	$126.22	$54.14	$143.98	$71.40
GALLIA	$120.81	$45.16	$76.07	$45.41
GREENE	$109.39	$47.61	$149.70	$67.95
HAMILTON	$148.86	$52.35	$174.35	$70.20
HARDIN	$111.39	$36.89	$114.35	$48.66
HENRY	$117.58	$39.28	$158.52	$69.33
HOCKING	$101.89	$42.97	$111.59	$56.44
HURON	$134.26	$44.80	$160.72	$61.82
JEFFERSON	$187.68	$50.32	$218.71	$67.69
LAKE	$137.86	$58.73	$177.10	$78.71
LICKING	$90.14	$40.63	$114.25	$58.71
LORAIN	$152.01	$57.11	$181.36	$77.27
MADISON	$135.80	$53.57	$155.84	$72.76
MARION	$127.18	$50.60	$151.94	$70.55
MEIGS	$119.30	$40.42	$109.16	$47.80
MIAMI	$109.96	$41.88	$138.28	$61.00

STATE: OHIO				
ALLEN	$112.99	$35.57	$142.33	$52.21
ASHTABULA	$120.54	$48.58	$132.74	$63.75
AUGLAIZE	$123.42	$36.94	$157.26	$61.45
BROWN	$101.55	$33.21	$124.64	$47.69
CARROLL	$106.49	$44.91	$127.05	$64.46
CLARK	$124.41	$45.73	$148.64	$65.65
CLINTON	$112.16	$38.72	$125.85	$56.92
COSHOCTON	$103.09	$33.47	$114.37	$49.61
CUYAHOGA	$177.67	$63.93	$197.05	$78.77
DEFIANCE	$116.68	$45.11	$169.22	$62.22
ERIE	$167.08	$56.76	$220.53	$83.38
FAYETTE	$78.83	$32.54	$92.52	$40.27
FULTON	$141.85	$42.01	$169.25	$55.84
GEAUGA	$149.57	$56.90	$186.97	$83.03
GUERNSEY	$125.73	$41.58	$107.63	$60.43
HANCOCK	$100.81	$33.81	$126.00	$48.62
HARRISON	$127.36	$44.21	$110.99	$50.93
HIGHLAND	$111.12	$37.99	$100.75	$44.01
HOLMES	$58.16	$25.04	$70.57	$35.97
JACKSON	$97.46	$34.73	$82.67	$38.39
KNOX	$100.04	$36.36	$81.96	$46.96
LAWRENCE	$101.88	$37.68	$94.58	$46.79
LOGAN	$125.71	$46.35	$122.13	$59.39
LUCAS	$201.28	$64.61	$239.90	$91.97
MAHONING	$163.64	$61.25	$160.76	$82.01
MEDINA	$121.48	$48.91	$150.79	$67.30
MERCER	$129.71	$37.98	$147.93	$55.82
MONROE	$108.78	$36.07	$128.62	$43.23

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: OHIO COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
MONTGOMERY	$150.27	$54.30	$167.65	$74.18
MORROW	$112.83	$35.69	$116.18	$54.47
NOBLE	$108.26	$33.78	$108.38	$40.00
PAULDING	$140.58	$41.54	$136.22	$53.61
PICKAWAY	$95.80	$42.69	$64.46	$45.94
PORTAGE	$145.39	$47.67	$184.68	$66.24
PUTNAM	$119.29	$43.27	$132.38	$64.09
ROSS	$100.19	$36.00	$84.51	$38.21
SCIOTO	$120.44	$43.34	$130.66	$59.11
SHELBY	$101.08	$37.67	$137.27	$59.62
SUMMIT	$149.13	$57.35	$172.86	$79.08
TUSCARAWAS	$90.25	$35.66	$104.18	$51.86
VAN WERT	$118.04	$40.34	$124.64	$60.30
WARREN	$118.71	$46.47	$146.08	$66.01
WAYNE	$91.59	$36.27	$91.47	$49.88
WOOD	$146.49	$50.41	$196.37	$67.20
STATE: OKLAHOMA				
ADAIR	$97.40	$39.65	$93.10	$45.08
ATOKA	$93.61	$38.94	$104.20	$47.40
BECKHAM	$98.04	$35.45	$93.15	$40.64
BRYAN	$95.65	$43.28	$109.72	$56.60
CANADIAN	$120.24	$45.98	$150.86	$68.90
CHEROKEE	$107.38	$47.23	$110.17	$55.32
CIMARRON	$101.70	$38.78	$124.41	$51.83
COAL	$97.63	$36.30	$83.15	$35.02
COTTON	$85.20	$33.48	$94.03	$42.89
CREEK	$131.36	$48.28	$162.75	$59.83
DELAWARE	$100.19	$38.55	$98.41	$42.30
ELLIS	$128.49	$43.15	$160.97	$46.38
GARVIN	$95.69	$36.06	$107.96	$44.47
GRANT	$127.88	$42.39	$149.00	$58.07
HARMON	$99.85	$38.23	$71.05	$37.21
HASKELL	$88.25	$44.42	$93.83	$51.04
JACKSON	$115.69	$40.83	$111.74	$42.88
JOHNSTON	$87.31	$37.98	$94.96	$49.91
KINGFISHER	$131.75	$42.42	$138.15	$48.80
LATIMER	$91.66	$39.20	$65.10	$35.42
LINCOLN	$99.33	$37.91	$118.03	$48.34
LOVE	$120.29	$49.56	$117.41	$46.76
MC CURTAIN	$90.94	$41.90	$85.11	$42.24
MAJOR	$92.48	$31.46	$98.52	$38.27
MAYES	$124.37	$43.11	$112.39	$47.46
MUSKOGEE	$107.40	$40.57	$101.95	$44.12
NOWATA	$96.90	$37.62	$88.70	$38.38
OKLAHOMA	$132.17	$56.18	$146.70	$67.73
OSAGE	$130.44	$41.08	$130.88	$48.58
PAWNEE	$151.43	$51.48	$150.11	$62.30
PITTSBURG	$98.04	$42.78	$110.50	$50.61

STATE: OHIO COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
MORGAN	$95.54	$36.09	$106.60	$42.11
MUSKINGUM	$106.55	$34.66	$121.58	$52.44
OTTAWA	$159.94	$52.56	$157.87	$66.80
PERRY	$104.35	$36.15	$102.40	$45.11
PIKE	$85.85	$38.54	$79.92	$41.58
PREBLE	$106.94	$39.19	$139.09	$55.40
RICHLAND	$104.59	$40.44	$124.21	$54.69
SANDUSKY	$156.41	$48.81	$170.10	$70.23
SENECA	$126.69	$44.68	$122.25	$57.31
STARK	$120.88	$50.30	$135.49	$68.89
TRUMBULL	$155.38	$58.72	$177.40	$77.69
UNION	$125.22	$44.73	$170.61	$70.71
VINTON	$97.49	$33.99	$79.40	$37.89
WASHINGTON	$128.03	$40.24	$139.01	$56.31
WILLIAMS	$115.90	$41.56	$139.77	$54.72
WYANDOT	$107.08	$41.67	$136.59	$62.98
STATE: OKLAHOMA				
ALFALFA	$133.24	$38.06	$156.50	$48.44
BEAVER	$95.36	$42.68	$100.47	$45.99
BLAINE	$110.76	$37.35	$133.57	$46.03
CADDO	$108.24	$42.65	$99.81	$40.15
CARTER	$92.31	$41.75	$88.22	$41.04
CHOCTAW	$95.75	$48.75	$106.69	$45.78
CLEVELAND	$116.54	$49.32	$132.11	$59.77
COMANCHE	$114.20	$42.27	$107.98	$47.91
CRAIG	$99.13	$35.54	$109.39	$43.13
CUSTER	$123.18	$45.72	$142.99	$60.64
DEWEY	$123.80	$37.79	$123.16	$36.82
GARFIELD	$124.65	$38.68	$134.65	$45.75
GRADY	$102.30	$44.91	$108.96	$52.83
GREER	$125.00	$44.71	$104.07	$46.75
HARPER	$96.27	$35.60	$74.79	$32.08
HUGHES	$120.33	$41.60	$117.69	$45.91
JEFFERSON	$93.79	$40.54	$76.45	$39.46
KAY	$104.76	$40.56	$103.10	$43.30
KIOWA	$101.96	$39.39	$122.63	$53.08
LE FLORE	$85.91	$44.51	$79.27	$48.41
LOGAN	$122.52	$44.32	$121.03	$51.15
MC CLAIN	$100.25	$40.89	$115.85	$53.49
MC INTOSH	$100.00	$45.38	$96.56	$50.63
MARSHALL	$103.93	$46.14	$90.74	$41.88
MURRAY	$96.70	$38.67	$100.42	$41.85
NOBLE	$95.39	$31.83	$102.45	$36.06
OKFUSKEE	$109.22	$40.42	$123.36	$52.36
OKMULGEE	$119.81	$49.67	$110.29	$52.31
OTTAWA	$131.11	$47.57	$126.97	$48.86
PAYNE	$106.10	$37.54	$111.62	$40.48
PONTOTOC	$96.17	$42.09	$94.01	$45.30

TABLE 2

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: OKLAHOMA COUNTY NAME	****** AGED ****** PART A	 PART B	*** DISABLED *** PART A	 PART B
POTTAWATOMIE	$78.09	$37.11	$84.56	$44.71
ROGER MILLS	$107.93	$39.66	$128.78	$46.86
SEMINOLE	$98.39	$39.29	$89.61	$40.44
STEPHENS	$114.78	$42.18	$121.52	$45.89
TILLMAN	$116.72	$40.90	$117.23	$45.34
WAGONER	$131.58	$43.77	$138.38	$61.38
WASHITA	$113.53	$40.12	$136.53	$52.35
WOODWARD	$116.89	$39.57	$129.14	$48.46
STATE: OREGON				
BAKER	$128.70	$47.35	$129.60	$56.65
CLACKAMAS	$116.28	$57.62	$160.43	$88.93
COLUMBIA	$139.46	$52.35	$133.41	$70.24
CROOK	$109.86	$44.12	$110.25	$50.26
DESCHUTES	$110.46	$52.64	$118.40	$67.40
GILLIAM	$117.36	$45.94	$36.46	$25.49
HARNEY	$152.25	$47.81	$153.29	$51.15
JACKSON	$111.52	$51.17	$114.20	$63.41
JOSEPHINE	$92.13	$42.01	$93.94	$54.39
LAKE	$131.02	$49.58	$119.42	$49.57
LINCOLN	$136.68	$49.06	$130.45	$61.99
MALHEUR	$98.27	$39.55	$77.68	$46.24
MORROW	$141.39	$48.86	$138.44	$55.58
POLK	$108.12	$51.77	$103.09	$63.08
TILLAMOOK	$160.72	$54.49	$172.03	$72.76
UNION	$120.24	$47.04	$132.52	$69.15
WASCO	$136.72	$47.78	$141.19	$66.95
WHEELER	$135.01	$45.89	$218.85	$46.25
STATE: PENNSYLVANIA				
ADAMS	$81.00	$39.43	$98.99	$52.89
ARMSTRONG	$110.04	$46.05	$116.43	$52.18
BEDFORD	$98.13	$37.58	$98.36	$46.48
BLAIR	$120.09	$42.62	$122.40	$54.81
BUCKS	$145.73	$73.76	$206.98	$107.62
CAMBRIA	$167.37	$57.99	$158.40	$63.37
CARBON	$124.22	$56.19	$130.22	$80.45
CHESTER	$141.16	$61.09	$155.06	$73.35
CLEARFIELD	$122.91	$47.54	$117.53	$54.65
COLUMBIA	$110.90	$46.29	$116.90	$62.54
CUMBERLAND	$95.30	$50.21	$117.13	$71.89
DELAWARE	$159.89	$72.91	$201.57	$94.48
ERIE	$134.58	$49.32	$143.85	$65.17
FOREST	$154.23	$51.60	$130.35	$55.15
FULTON	$103.76	$41.49	$68.48	$37.35
HUNTINGDON	$108.34	$45.88	$113.07	$54.90
JEFFERSON	$100.84	$42.93	$114.08	$58.33
LACKAWANNA	$145.41	$59.85	$136.70	$74.99
LAWRENCE	$122.60	$47.67	$115.58	$58.21

STATE: OKLAHOMA COUNTY NAME	****** AGED ****** PART A	 PART B	*** DISABLED *** PART A	 PART B
PUSHMATAHA	$81.22	$37.04	$77.52	$45.40
ROGERS	$116.80	$47.67	$112.95	$55.03
SEQUOYAH	$92.87	$42.95	$85.40	$48.86
TEXAS	$114.90	$47.02	$115.29	$49.10
TULSA	$146.76	$59.71	$176.06	$75.63
WASHINGTON	$95.08	$38.74	$133.38	$54.11
WOODS	$121.90	$37.20	$141.29	$49.50
STATE: OREGON				
BENTON	$102.90	$51.17	$121.44	$78.89
CLATSOP	$161.37	$51.62	$157.11	$62.68
COOS	$116.11	$61.83	$114.13	$73.01
CURRY	$123.59	$56.03	$120.79	$59.31
DOUGLAS	$129.87	$52.39	$120.28	$64.64
GRANT	$109.34	$41.62	$137.58	$64.38
HOOD RIVER	$120.24	$42.32	$97.52	$53.49
JEFFERSON	$109.62	$48.26	$118.41	$55.67
KLAMATH	$96.12	$50.82	$113.89	$71.18
LANE	$91.63	$55.75	$108.95	$75.75
LINN	$103.05	$50.45	$101.35	$59.92
MARION	$93.67	$49.35	$88.55	$56.18
MULTNOMAH	$167.60	$64.97	$200.50	$88.41
SHERMAN	$144.35	$46.18	$109.08	$45.05
UMATILLA	$123.51	$47.83	$137.30	$77.64
WALLOWA	$158.55	$53.13	$159.31	$66.87
WASHINGTON	$143.24	$61.84	$190.09	$91.50
YAMHILL	$111.07	$50.49	$106.48	$57.97
STATE: PENNSYLVANIA				
ALLEGHENY	$179.21	$60.48	$190.32	$74.71
BEAVER	$139.24	$50.89	$146.69	$67.29
BERKS	$109.13	$50.30	$121.27	$66.08
BRADFORD	$131.03	$47.29	$125.74	$63.43
BUTLER	$129.16	$51.01	$136.72	$57.51
CAMERON	$119.81	$46.83	$131.10	$56.89
CENTRE	$117.00	$43.50	$113.31	$56.58
CLARION	$126.43	$47.23	$123.61	$57.73
CLINTON	$132.20	$54.32	$156.44	$73.98
CRAWFORD	$121.95	$46.17	$141.58	$63.41
DAUPHIN	$118.39	$56.36	$130.54	$80.29
ELK	$130.03	$52.15	$132.30	$75.77
FAYETTE	$121.61	$50.88	$117.98	$52.27
FRANKLIN	$81.64	$37.79	$86.35	$47.52
GREENE	$132.59	$52.32	$105.78	$47.91
INDIANA	$127.34	$51.31	$111.47	$47.97
JUNIATA	$93.10	$45.10	$111.44	$60.46
LANCASTER	$90.34	$39.43	$131.09	$60.90
LEBANON	$96.38	$41.41	$103.61	$52.78

TABLE 2

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: PENNSYLVANIA COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
LEHIGH	$121.70	$63.61	$154.81	$90.18
LYCOMING	$131.74	$56.01	$142.30	$69.61
MERCER	$123.46	$54.52	$134.82	$62.46
MONROE	$105.65	$56.80	$116.04	$67.16
MONTOUR	$90.22	$62.26	$90.86	$103.68
NORTHUMBERLAND	$97.85	$45.33	$94.36	$57.32
PHILADELPHIA	$196.96	$90.25	$205.16	$97.00
POTTER	$116.51	$48.69	$118.99	$51.16
SNYDER	$86.48	$41.78	$71.06	$43.06
SULLIVAN	$122.87	$47.77	$112.69	$55.62
TIOGA	$118.82	$48.20	$115.17	$56.39
VENANGO	$147.17	$50.64	$134.11	$47.27
WASHINGTON	$155.24	$52.27	$148.26	$56.60
WESTMORELAND	$143.80	$55.37	$152.42	$69.76
YORK	$94.57	$44.31	$105.70	$58.42
STATE: PUERTO RICO				
ADJUNTAS	$29.21	$26.69	$13.81	$19.47
AGUADILLA	$18.21	$17.13	$12.85	$16.95
AIBONITO	$22.07	$27.33	$11.57	$17.93
ARECIBO	$13.75	$21.75	$13.23	$19.64
BARCELONETA	$14.50	$19.25	$12.44	$17.64
BAYAMON	$34.16	$34.37	$20.24	$28.41
CAGUAS	$23.31	$30.15	$15.83	$26.47
CANOVANAS	$27.92	$31.28	$12.49	$18.11
CATANO	$31.38	$30.08	$17.04	$25.45
CEIBA	$21.83	$20.28	$19.71	$20.52
CIDRA	$17.17	$23.85	$10.23	$15.78
COMERIO	$19.52	$27.98	$13.00	$23.44
CULEBRA	$24.99	$29.56	$40.94	$9.05
FAJARDO	$26.31	$26.36	$18.07	$22.34
GUANICA	$32.07	$28.15	$20.59	$21.21
GUAYANILLA	$29.60	$27.06	$14.69	$14.36
GURABO	$25.42	$31.37	$18.84	$28.31
HORMIGUEROS	$25.75	$22.91	$17.43	$46.85
ISABELA	$14.68	$19.45	$11.31	$13.02
JUANA DIAZ	$25.95	$22.75	$15.62	$17.96
LAJAS	$28.52	$20.71	$19.90	$34.62
LAS MARIAS	$18.93	$14.57	$9.51	$10.74
LOIZA	$18.54	$21.83	$16.27	$18.55
MANATI	$19.10	$27.00	$14.10	$20.89
MAUNABO	$21.35	$23.15	$8.88	$12.41
MOCA	$15.38	$20.52	$8.64	$15.05
NAGUABO	$23.51	$24.81	$17.85	$20.39
OROCOVIS	$21.78	$35.70	$10.14	$20.92
PENUELAS	$32.29	$28.82	$14.23	$20.16
QUEBRADILLAS	$17.25	$21.17	$11.59	$17.40
RIO GRANDE	$26.59	$28.19	$24.07	$25.63
SALINAS	$35.53	$25.95	$21.40	$22.16

STATE: PENNSYLVANIA COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
LUZERNE	$130.46	$62.14	$111.97	$67.13
MC KEAN	$113.75	$43.12	$115.28	$55.34
MIFFLIN	$106.46	$49.57	$103.68	$53.23
MONTGOMERY	$140.56	$70.17	$187.51	$94.15
NORTHAMPTON	$126.20	$59.72	$149.16	$78.47
PERRY	$113.24	$51.32	$108.92	$66.65
PIKE	$114.44	$49.77	$107.81	$54.18
SCHUYLKILL	$124.71	$50.98	$114.56	$63.07
SOMERSET	$114.01	$47.48	$126.82	$56.84
SUSQUEHANNA	$106.12	$47.65	$108.23	$58.54
UNION	$78.22	$38.53	$81.15	$45.64
WARREN	$108.36	$47.99	$133.02	$82.31
WAYNE	$118.18	$53.43	$112.32	$59.60
WYOMING	$140.64	$52.58	$152.87	$78.13
STATE: PUERTO RICO				
AGUADA	$14.74	$19.84	$14.22	$14.32
AGUAS BUENAS	$17.05	$25.58	$8.29	$25.17
ANASCO	$22.01	$23.04	$18.08	$29.51
ARROYO	$30.33	$26.80	$21.85	$24.45
BARRANQUITAS	$21.18	$29.20	$9.21	$24.12
CABO ROJO	$21.31	$20.36	$13.59	$20.53
CAMUY	$15.40	$19.40	$10.57	$14.98
CAROLINA	$35.53	$31.52	$23.80	$26.88
CAYEY	$25.34	$27.71	$10.61	$17.21
CIALES	$22.71	$32.80	$10.83	$17.39
COAMO	$23.42	$29.58	$19.68	$25.76
COROZAL	$25.10	$37.13	$13.27	$21.93
DORADO	$26.85	$26.10	$13.81	$24.61
FLORIDA	$17.80	$23.66	$5.92	$6.97
GUAYAMA	$35.78	$28.14	$25.34	$40.99
GUAYNABO	$31.56	$35.94	$21.43	$32.57
HATILLO	$13.62	$20.50	$12.22	$13.04
HUMACAO	$35.51	$31.43	$25.32	$23.64
JAYUYA	$20.46	$19.18	$9.23	$15.59
JUNCOS	$22.88	$29.07	$13.97	$22.45
LARES	$18.43	$20.40	$13.41	$12.93
LAS PIEDRAS	$29.83	$28.58	$20.48	$26.04
LUQUILLO	$24.86	$25.48	$19.88	$25.31
MARICAO	$20.84	$19.06	$6.88	$14.59
MAYAGUEZ	$24.22	$23.81	$16.88	$24.97
MOROVIS	$18.25	$31.41	$8.71	$15.86
NARANJITO	$18.06	$33.81	$6.41	$13.78
PATILLAS	$28.99	$24.74	$19.25	$17.44
PONCE	$32.88	$25.84	$24.34	$28.67
RINCON	$20.28	$18.55	$17.20	$36.89
SABANA GRANDE	$28.97	$22.79	$21.60	$20.71
SAN GERMAN	$31.41	$23.81	$19.82	$21.57

TABLE 2

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: PUERTO RICO COUNTY NAME	****** AGED ****** PART A	 PART B	*** DISABLED *** PART A	 PART B
SAN JUAN	$37.13	$38.12	$27.12	$30.36
SAN SEBASTIAN	$18.56	$19.89	$12.74	$12.41
TOA ALTA	$25.75	$31.03	$14.44	$21.20
TRUJILLO ALTO	$32.22	$32.59	$20.16	$26.09
VEGA ALTA	$27.02	$30.63	$14.98	$21.45
VIEQUES	$25.54	$24.54	$19.64	$19.42
YABUCOA	$23.61	$24.23	$19.84	$19.84
STATE: RHODE ISLAND				
BRISTOL	$125.18	$53.12	$123.99	$61.42
NEWPORT	$145.60	$65.66	$118.77	$60.69
WASHINGTON	$123.40	$61.32	$124.47	$69.06
STATE: S. CAROLINA				
ABBEVILLE	$72.09	$26.52	$87.03	$40.08
ALLENDALE	$84.52	$33.15	$90.41	$32.15
BAMBERG	$93.57	$43.53	$90.01	$44.60
BEAUFORT	$123.57	$46.81	$125.99	$57.93
CALHOUN	$61.26	$35.39	$72.09	$34.73
CHEROKEE	$77.09	$33.63	$88.73	$40.57
CHESTERFIELD	$95.83	$36.05	$90.38	$39.60
COLLETON	$130.11	$45.53	$131.31	$50.55
DILLON	$122.12	$44.08	$124.98	$46.96
EDGEFIELD	$85.51	$35.38	$93.97	$42.85
FLORENCE	$93.19	$38.99	$106.98	$47.54
GREENVILLE	$92.33	$36.65	$100.59	$49.79
HAMPTON	$102.08	$37.79	$107.71	$44.65
JASPER	$133.77	$47.91	$142.29	$57.31
LANCASTER	$81.75	$34.25	$89.03	$42.91
LEE	$88.42	$30.24	$73.04	$30.73
MC CORMICK	$70.36	$30.04	$68.94	$35.31
MARLBORO	$93.47	$34.22	$106.80	$38.23
OCONEE	$86.53	$35.72	$93.40	$44.26
PICKENS	$91.27	$34.61	$105.35	$44.92
SALUDA	$70.61	$29.92	$83.49	$36.87
SUMTER	$78.92	$32.38	$82.60	$36.94
WILLIAMSBURG	$91.38	$34.40	$100.60	$37.67
STATE: S. DAKOTA				
AURORA	$135.74	$32.62	$91.58	$23.56
BENNETT	$113.13	$41.03	$158.91	$67.42
BROOKINGS	$87.68	$33.01	$79.29	$38.06
BRULE	$142.31	$39.47	$141.84	$40.30
BUTTE	$86.95	$33.16	$64.92	$31.07
CHARLES MIX	$92.84	$29.29	$73.75	$23.32
CLAY	$121.29	$42.40	$84.43	$38.47
CORSON	$111.55	$38.50	$135.25	$47.46
DAVISON	$145.80	$33.78	$127.03	$38.29
DEUEL	$110.71	$30.72	$93.19	$36.14

STATE: PUERTO RICO COUNTY NAME	****** AGED ****** PART A	 PART B	*** DISABLED *** PART A	 PART B
SAN LORENZO	$18.96	$25.20	$17.08	$24.87
SANTA ISABEL	$30.03	$25.91	$15.63	$17.87
TOA BAJA	$26.60	$27.26	$16.14	$24.68
UTUADO	$20.34	$19.64	$15.23	$16.78
VEGA BAJA	$23.13	$29.68	$15.26	$25.16
VILLALBA	$20.75	$23.63	$14.94	$20.20
YAUCO	$27.24	$30.74	$19.99	$20.88
STATE: RHODE ISLAND				
KENT	$125.05	$67.90	$131.66	$74.83
PROVIDENCE	$134.50	$66.36	$134.32	$73.40
STATE: S. CAROLINA				
AIKEN	$110.12	$49.81	$104.42	$61.24
ANDERSON	$74.77	$39.88	$89.72	$50.31
BARNWELL	$89.72	$41.50	$88.68	$50.87
BERKELEY	$105.65	$41.97	$101.32	$46.87
CHARLESTON	$114.16	$47.63	$104.55	$47.22
CHESTER	$97.75	$33.69	$104.83	$40.28
CLARENDON	$85.87	$31.41	$90.96	$38.18
DARLINGTON	$97.83	$37.72	$114.51	$47.06
DORCHESTER	$98.14	$39.67	$90.79	$48.42
FAIRFIELD	$93.79	$36.46	$87.50	$36.15
GEORGETOWN	$100.55	$34.97	$110.81	$40.58
GREENWOOD	$85.49	$32.10	$104.39	$46.14
HORRY	$106.56	$40.27	$106.37	$43.72
KERSHAW	$96.34	$41.05	$96.65	$46.27
LAURENS	$79.30	$28.47	$81.94	$27.74
LEXINGTON	$120.93	$47.68	$125.96	$58.33
MARION	$114.72	$42.38	$121.01	$45.65
NEWBERRY	$91.99	$31.03	$86.48	$36.55
ORANGEBURG	$67.62	$37.16	$70.75	$40.68
RICHLAND	$101.34	$44.70	$101.89	$53.41
SPARTANBURG	$95.49	$40.67	$102.55	$53.20
UNION	$92.08	$31.37	$101.47	$44.56
YORK	$80.07	$33.11	$94.61	$45.74
STATE: S. DAKOTA				
BEADLE	$109.93	$39.78	$104.26	$45.22
BON HOMME	$104.48	$33.24	$87.80	$42.94
BROWN	$137.75	$42.27	$144.20	$55.90
BUFFALO	$199.16	$51.64	$196.91	$64.43
CAMPBELL	$105.99	$39.19	$135.65	$47.82
CLARK	$100.13	$37.14	$70.40	$37.34
CODINGTON	$99.12	$33.88	$91.12	$38.64
CUSTER	$94.27	$36.44	$79.23	$36.67
DAY	$137.76	$43.76	$142.01	$54.52
DEWEY	$112.49	$37.43	$104.57	$48.47

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: S. DAKOTA COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
DOUGLAS	$89.95	$28.22	$147.09	$59.04
FALL RIVER	$78.92	$28.13	$51.86	$24.96
GRANT	$103.51	$34.10	$165.35	$85.07
HAAKON	$102.37	$42.33	$113.28	$41.81
HAND	$113.25	$35.31	$88.32	$50.01
HARDING	$106.79	$36.23	$104.38	$44.85
HUTCHINSON	$77.59	$26.65	$104.09	$49.50
JACKSON	$77.99	$34.92	$140.32	$51.98
JONES	$113.60	$35.75	$110.48	$47.20
LAKE	$104.69	$34.17	$104.17	$47.69
LINCOLN	$99.90	$31.55	$129.20	$53.48
MC COOK	$97.31	$30.02	$91.89	$38.87
MARSHALL	$144.60	$39.00	$122.43	$45.90
MELLETTE	$83.76	$37.80	$113.60	$49.13
MINNEHAHA	$107.92	$36.77	$118.94	$49.31
PENNINGTON	$93.91	$44.43	$78.17	$46.20
POTTER	$170.72	$51.90	$226.30	$69.65
SANBORN	$128.16	$35.22	$106.38	$50.29
SPINK	$139.51	$42.76	$105.36	$35.60
SULLY	$126.19	$38.73	$121.21	$44.45
TRIPP	$135.93	$38.83	$106.81	$44.47
UNION	$111.45	$35.51	$131.29	$48.17
WASHABAUGH	$84.71	$33.87	$123.71	$54.19
ZIEBACH	$97.22	$30.07	$104.23	$44.48
STATE: TENNESSEE				
ANDERSON	$95.98	$38.01	$96.48	$50.62
BENTON	$110.42	$36.52	$110.24	$49.07
BLOUNT	$96.33	$38.53	$108.10	$50.99
CAMPBELL	$104.85	$46.82	$85.65	$45.52
CARROLL	$103.03	$33.83	$114.41	$46.97
CHEATHAM	$114.25	$44.98	$113.62	$49.58
CLAIBORNE	$75.83	$33.17	$77.12	$41.60
COCKE	$79.89	$29.46	$83.36	$40.03
CROCKETT	$75.73	$36.19	$77.67	$40.40
DAVIDSON	$135.14	$50.48	$145.92	$61.72
DE KALB	$119.30	$38.01	$131.46	$49.87
DYER	$89.31	$42.56	$97.92	$49.21
FENTRESS	$111.47	$43.48	$109.93	$48.87
GIBSON	$111.63	$36.62	$124.07	$50.00
GRAINGER	$82.72	$34.43	$72.05	$36.87
GRUNDY	$98.11	$42.06	$92.42	$41.89
HAMILTON	$122.39	$47.47	$132.63	$61.51
HARDEMAN	$87.28	$30.88	$122.38	$44.73
HAWKINS	$103.93	$35.85	$107.60	$44.94
HENDERSON	$65.62	$27.50	$77.43	$40.04
HICKMAN	$123.88	$46.34	$101.38	$49.19
HUMPHREYS	$136.82	$45.90	$125.20	$51.96
JEFFERSON	$87.38	$33.15	$103.80	$47.01

STATE: S. DAKOTA COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
EDMUNDS	$138.79	$42.76	$133.38	$57.94
FAULK	$160.34	$44.53	$134.86	$66.20
GREGORY	$110.23	$28.93	$93.85	$27.96
HAMLIN	$90.97	$31.93	$156.65	$50.64
HANSON	$111.87	$28.23	$168.50	$52.23
HUGHES	$118.32	$39.74	$138.26	$46.70
HYDE	$101.48	$33.77	$143.13	$71.51
JERAULD	$115.33	$34.95	$171.09	$50.93
KINGSBURY	$96.62	$34.07	$78.27	$37.41
LAWRENCE	$92.41	$37.85	$90.08	$31.49
LYMAN	$140.22	$38.32	$149.74	$48.68
MC PHERSON	$120.70	$40.33	$142.61	$58.33
MEADE	$82.82	$39.05	$75.48	$40.55
MINER	$112.61	$33.99	$121.68	$50.41
MOODY	$88.77	$31.63	$91.73	$40.73
PERKINS	$105.20	$42.84	$135.32	$51.19
ROBERTS	$112.94	$35.20	$103.17	$44.43
SHANNON	$87.56	$25.34	$42.13	$18.06
STANLEY	$155.26	$50.07	$92.97	$41.94
TODD	$80.52	$30.57	$84.43	$15.92
TURNER	$73.74	$25.79	$88.95	$42.17
WALWORTH	$98.84	$33.44	$133.04	$41.56
YANKTON	$92.41	$34.04	$117.46	$46.17
STATE: TENNESSEE				
BEDFORD	$83.18	$31.68	$79.85	$38.81
BLEDSOE	$99.20	$39.33	$93.14	$48.11
BRADLEY	$101.35	$38.35	$107.29	$46.70
CANNON	$139.11	$42.18	$159.55	$55.30
CARTER	$82.14	$30.96	$73.23	$39.05
CHESTER	$63.26	$27.02	$70.09	$35.81
CLAY	$111.88	$40.13	$106.29	$45.16
COFFEE	$110.30	$43.01	$112.44	$52.28
CUMBERLAND	$99.33	$41.93	$106.55	$49.00
DECATUR	$95.55	$33.91	$87.42	$37.70
DICKSON	$112.77	$45.31	$101.76	$50.22
FAYETTE	$89.72	$34.34	$89.43	$43.73
FRANKLIN	$96.71	$40.64	$96.22	$47.69
GILES	$121.14	$46.72	$145.96	$66.38
GREENE	$84.00	$30.54	$100.41	$44.56
HAMBLEN	$114.38	$41.66	$121.15	$53.79
HANCOCK	$92.96	$31.67	$114.55	$44.50
HARDIN	$88.79	$35.87	$81.82	$42.11
HAYWOOD	$82.68	$32.48	$96.31	$46.46
HENRY	$89.19	$37.94	$92.93	$45.60
HOUSTON	$93.40	$32.56	$82.58	$37.86
JACKSON	$100.51	$37.47	$97.57	$45.26
JOHNSON	$106.42	$37.04	$91.02	$40.87

TABLE 2

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: TENNESSEE COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
KNOX	$103.36	$43.72	$118.20	$58.40
LAUDERDALE	$96.34	$37.40	$102.19	$45.94
LEWIS	$146.74	$39.46	$143.61	$44.87
LOUDON	$95.18	$35.81	$118.75	$54.90
MC MINNY	$83.49	$31.22	$92.75	$36.86
MADISON	$87.97	$36.21	$96.76	$49.92
MARSHALL	$129.88	$45.51	$139.96	$69.20
MEIGS	$106.61	$36.35	$102.71	$46.29
MONTGOMERY	$79.21	$36.69	$83.91	$47.49
MORGAN	$92.57	$42.80	$64.28	$40.90
OVERTON	$105.36	$39.67	$117.37	$48.16
PICKETT	$136.47	$41.21	$118.74	$47.25
PUTNAM	$94.82	$40.01	$99.47	$50.28
ROANE	$108.77	$41.45	$109.81	$54.08
RUTHERFORD	$91.48	$37.07	$105.58	$57.61
SEQUATCHIE	$106.92	$40.48	$108.04	$57.44
SHELBY	$134.20	$50.39	$135.58	$56.81
STEWART	$75.58	$33.27	$76.81	$36.23
SUMNER	$118.01	$42.74	$144.27	$64.39
TROUSDALE	$109.86	$36.25	$159.74	$44.13
UNION	$90.07	$37.37	$91.43	$46.67
WARREN	$128.87	$44.02	$124.82	$55.21
WAYNE	$106.31	$37.20	$138.33	$55.26
WHITE	$91.92	$37.90	$91.06	$43.72
WILSON	$154.15	$46.84	$180.13	$67.99
STATE: TEXAS				
ANDERSON	$87.66	$39.80	$93.24	$43.57
ANGELINA	$96.19	$46.56	$88.85	$44.29
ARCHER	$95.98	$50.98	$81.31	$60.50
ATASCOSA	$111.90	$64.14	$111.16	$74.05
BAILEY	$125.94	$49.38	$167.09	$72.50
BASTROP	$92.53	$45.39	$87.46	$48.13
BEE	$100.20	$50.54	$91.23	$58.76
BEXAR	$121.47	$73.00	$126.36	$88.92
BORDEN	$117.58	$56.49	$138.40	$79.74
BOWIE	$100.44	$50.61	$127.79	$69.21
BRAZOS	$97.22	$42.52	$99.55	$48.20
BRISCOE	$108.31	$48.45	$100.40	$43.88
BROWN	$103.14	$43.01	$99.41	$54.51
BURNET	$88.68	$47.43	$89.94	$49.61
CALHOUN	$118.25	$50.26	$152.79	$68.29
CAMERON	$83.98	$50.44	$76.25	$52.47
CARSON	$111.24	$45.23	$116.65	$56.20
CASTRO	$116.91	$51.26	$162.41	$80.17
CHEROKEE	$120.79	$58.95	$120.77	$67.91
CLAY	$103.58	$39.01	$107.89	$42.31
COKE	$97.58	$50.37	$84.39	$40.23
COLLIN	$119.67	$51.21	$158.56	$72.60

STATE: TENNESSEE COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
LAKE	$83.19	$38.77	$67.64	$36.27
LAWRENCE	$114.43	$36.82	$119.65	$48.49
LINCOLN	$100.90	$40.98	$91.28	$47.24
MC MINN	$92.69	$32.77	$99.00	$46.30
MACON	$109.52	$34.68	$125.81	$53.71
MARION	$122.12	$45.31	$126.04	$49.64
MAURY	$103.92	$39.42	$102.81	$48.44
MONROE	$79.31	$28.43	$80.74	$41.81
MOORE	$99.47	$32.86	$81.36	$43.12
OBION	$86.52	$33.53	$77.87	$35.49
PERRY	$133.90	$35.69	$157.40	$49.15
POLK	$97.17	$37.06	$104.62	$46.54
RHEA	$102.40	$37.86	$95.69	$48.84
ROBERTSON	$112.30	$42.66	$110.92	$52.39
SCOTT	$99.36	$40.81	$70.03	$44.73
SEVIER	$99.53	$38.65	$98.27	$47.41
SMITH	$121.43	$36.06	$105.93	$39.36
SULLIVAN	$110.34	$41.24	$103.56	$51.95
TIPTON	$102.09	$38.07	$106.92	$49.57
UNICOI	$95.60	$31.21	$79.24	$39.10
VAN BUREN	$128.70	$47.16	$69.80	$34.24
WASHINGTON	$98.56	$35.20	$91.68	$43.59
WEAKLEY	$85.01	$29.45	$76.66	$34.22
WILLIAMSON	$117.42	$53.04	$119.27	$62.32
STATE: TEXAS				
ANDREWS	$126.10	$48.45	$213.48	$94.54
ARANSAS	$121.37	$59.64	$119.60	$62.36
ARMSTRONG	$68.32	$37.91	$60.02	$30.25
AUSTIN	$87.91	$39.53	$132.90	$57.55
BANDERA	$76.86	$44.78	$65.80	$47.49
BAYLOR	$139.66	$46.22	$131.56	$53.72
BELL	$80.79	$47.68	$66.39	$60.20
BLANCO	$95.89	$51.40	$108.96	$65.91
BOSQUE	$83.66	$34.44	$107.54	$51.91
BRAZORIA	$141.79	$62.26	$170.27	$78.47
BREWSTER	$86.19	$40.47	$85.81	$42.66
BROOKS	$78.71	$45.56	$86.99	$45.70
BURLESON	$97.57	$42.65	$83.00	$43.64
CALDWELL	$84.89	$46.26	$89.20	$49.15
CALLAHAN	$108.30	$44.96	$141.40	$57.72
CAMP	$102.30	$44.75	$97.18	$52.98
CASS	$88.58	$46.48	$96.39	$52.52
CHAMBERS	$193.90	$75.41	$186.07	$79.75
CHILDRESS	$121.40	$43.21	$153.55	$54.42
COCHRAN	$131.39	$60.16	$222.47	$129.93
COLEMAN	$102.87	$44.69	$125.67	$58.19
COLLINGSWORTH	$98.72	$42.35	$103.90	$43.10

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: TEXAS COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
COLORADO	$109.83	$42.25	$112.35	$51.34
COMANCHE	$107.68	$46.08	$113.63	$58.91
COOKE	$116.36	$46.27	$130.53	$61.99
COTTLE	$127.98	$48.99	$165.31	$50.50
CROCKETT	$134.06	$51.56	$127.42	$77.17
CULBERSON	$143.13	$59.09	$114.61	$61.18
DALLAS	$144.05	$70.71	$158.90	$86.72
DEAF SMITH	$90.15	$42.90	$96.47	$41.73
DENTON	$128.56	$56.02	$127.84	$66.99
DICKENS	$159.90	$59.10	$92.19	$66.71
DONLEY	$77.03	$42.47	$46.42	$33.06
EASTLAND	$103.39	$41.90	$87.72	$49.82
EDWARDS	$112.11	$53.19	$63.11	$38.94
EL PASO	$135.88	$62.91	$129.47	$70.90
FALLS	$108.48	$41.35	$112.65	$46.10
FAYETTE	$90.19	$39.72	$76.03	$37.80
FLOYD	$121.41	$47.17	$143.24	$80.37
FORT BEND	$127.65	$59.54	$107.66	$55.05
FREESTONE	$113.68	$42.88	$106.30	$46.43
GAINES	$126.22	$53.22	$211.43	$89.37
GARZA	$129.97	$57.13	$135.52	$65.39
GLASSCOCK	$111.76	$52.43	$100.83	$56.62
GONZALES	$86.62	$42.73	$111.36	$58.32
GRAYSON	$116.44	$53.14	$132.97	$71.30
GRIMES	$121.11	$54.81	$135.51	$63.04
HALE	$115.95	$50.12	$106.76	$55.33
HAMILTON	$81.56	$36.35	$79.61	$42.93
HARDEMAN	$134.43	$53.30	$96.98	$41.92
HARRIS	$169.39	$73.40	$210.61	$94.39
HARTLEY	$66.86	$40.58	$131.46	$66.45
HAYS	$93.75	$56.11	$83.42	$62.88
HENDERSON	$87.67	$42.83	$100.88	$55.64
HILL	$103.61	$43.36	$101.22	$51.01
HOOD	$113.21	$50.20	$148.50	$89.19
HOUSTON	$145.71	$42.98	$117.88	$53.99
HUDSPETH	$135.15	$55.85	$131.56	$43.43
HUTCHINSON	$103.56	$43.50	$109.13	$55.03
JACK	$96.56	$41.98	$138.04	$65.71
JASPER	$140.33	$56.02	$147.26	$70.14
JEFFERSON	$154.76	$60.95	$182.34	$76.1.
JIM WELLS	$131.74	$70.37	$133.60	$73.59
JONES	$103.32	$43.57	$98.92	$46.00
KAUFMAN	$126.03	$51.47	$142.63	$71.54
KENEDY	$105.38	$53.60	$111.14	$65.12
KERR	$76.00	$42.46	$82.78	$47.38
KING	$117.58	$56.49	$244.51	$100.19
KLEBERG	$123.24	$61.35	$138.56	$67.61
LAMAR	$102.99	$48.85	$104.69	$52.26
LAMPASAS	$71.33	$37.62	$68.15	$55.10

STATE: TEXAS COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
COMAL	$78.43	$53.66	$86.20	$65.84
CONCHO	$120.94	$66.60	$128.35	$63.73
CORYELL	$97.87	$39.59	$67.05	$42.54
CRANE	$76.39	$43.98	$82.64	$58.07
CROSBY	$149.16	$58.01	$154.98	$67.49
DALLAM	$89.15	$43.22	$86.86	$63.29
DAWSON	$108.72	$46.46	$111.99	$49.96
DELTA	$102.39	$51.16	$84.29	$51.64
DE WITT	$102.40	$43.01	$110.60	$57.96
DIMMIT	$86.47	$52.41	$117.99	$73.75
DUVAL	$109.01	$66.86	$93.27	$58.72
ECTOR	$110.49	$59.82	$122.61	$59.42
ELLIS	$94.89	$46.67	$113.82	$57.65
ERATH	$93.70	$41.79	$106.35	$57.87
FANNIN	$105.86	$42.50	$114.91	$52.03
FISHER	$90.19	$39.36	$129.46	$65.06
FOARD	$87.83	$37.59	$97.68	$60.24
FRANKLIN	$112.38	$41.88	$167.94	$65.71
FRIO	$124.79	$67.08	$135.12	$69.60
GALVESTON	$160.63	$79.03	$194.13	$104.38
GILLESPIE	$80.96	$39.91	$83.94	$51.14
GOLIAD	$96.70	$47.63	$160.94	$64.75
GRAY	$110.33	$40.33	$137.33	$55.39
GREGG	$92.65	$46.64	$101.40	$56.29
GUADALOUPE	$73.86	$47.29	$72.90	$57.97
HALL	$76.79	$38.03	$114.53	$52.48
HANSFORD	$124.87	$48.20	$228.96	$83.67
HARDIN	$154.12	$59.16	$158.67	$69.75
HARRISON	$83.26	$39.53	$95.89	$48.41
HASKELL	$77.01	$38.49	$98.30	$51.29
HEMPHILL	$112.05	$35.80	$166.61	$58.37
HIDALGO	$62.64	$44.64	$58.07	$43.44
HOCKLEY	$152.24	$56.58	$151.98	$64.72
HOPKINS	$100.46	$42.48	$109.61	$55.82
HOWARD	$120.10	$45.51	$120.03	$52.85
HUNT	$89.72	$42.06	$113.24	$54.30
IRION	$101.38	$50.13	$151.47	$63.14
JACKSON	$110.56	$49.13	$118.11	$55.72
JEFF DAVIS	$89.79	$36.92	$104.49	$67.22
JIM HOGG	$82.52	$55.49	$90.75	$66.81
JOHNSON	$103.15	$52.14	$129.14	$65.93
KARNES	$104.70	$50.98	$95.48	$46.82
KENDALL	$92.32	$54.37	$116.76	$81.94
KENT	$97.68	$43.76	$95.18	$20.34
KIMBLE	$99.50	$48.21	$51.14	$33.12
KINNEY	$84.99	$49.77	$108.49	$60.21
KNOX	$110.63	$42.43	$109.74	$46.59
LAMB	$127.18	$51.35	$151.10	$61.24
LA SALLE	$105.29	$56.02	$110.36	$50.99

TABLE 2

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: TEXAS COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
LAVACA	$82.49	$38.85	$105.58	$47.20
LEON	$119.99	$43.33	$116.94	$49.97
LIMESTONE	$103.12	$40.14	$47.34	$22.47
LIVE OAK	$101.49	$58.37	$85.25	$62.19
LOVING	$117.58	$56.49	$222.28	$130.25
LYNN	$138.20	$54.95	$150.06	$64.57
MC LENNAN	$72.49	$39.28	$69.66	$46.98
MADISON	$127.45	$45.30	$95.18	$50.16
MARTIN	$100.42	$45.34	$108.86	$59.38
MATAGORDA	$128.11	$48.21	$168.48	$69.92
MEDINA	$107.71	$60.50	$112.51	$69.77
MIDLAND	$101.57	$53.88	$115.30	$70.54
MILLS	$97.65	$40.54	$42.93	$26.64
MONTAGUE	$81.09	$38.47	$78.32	$43.08
MOORE	$90.69	$46.70	$119.75	$75.75
MOTLEY	$117.48	$48.44	$175.72	$81.02
NAVARRO	$78.31	$47.27	$76.09	$50.23
NOLAN	$114.04	$46.38	$130.54	$52.45
OCHILTREE	$115.93	$49.19	$178.23	$75.01
ORANGE	$162.03	$63.70	$192.69	$91.22
PANOLA	$102.57	$43.14	$111.57	$54.27
PARMER	$78.89	$34.12	$82.48	$39.66
POLK	$109.08	$48.48	$134.57	$65.15
PRESIDIO	$86.10	$43.96	$71.72	$29.28
RANDALL	$89.85	$48.70	$129.24	$72.76
REAL	$88.36	$47.92	$57.50	$49.61
REEVES	$107.51	$45.76	$106.86	$52.69
ROBERTS	$106.18	$37.78	$152.82	$88.30
ROCKWALL	$130.99	$64.52	$163.96	$93.46
RUSK	$93.34	$42.02	$86.67	$50.05
SAN AUGUSTINE	$98.80	$40.87	$89.11	$41.74
SAN PATRICIO	$106.95	$59.27	$110.70	$64.38
SCHLEICHER	$107.07	$56.81	$79.84	$48.62
SHACKELFORD	$101.20	$45.89	$76.83	$43.22
SHERMAN	$86.09	$47.40	$125.68	$67.90
SOMERVELL	$115.80	$38.40	$95.38	$35.18
STEPHENS	$98.72	$43.47	$123.69	$58.28
STONEWALL	$117.97	$50.39	$83.18	$56.91
SWISHER	$96.39	$48.27	$145.80	$65.92
TAYLOR	$97.83	$46.08	$82.18	$43.07
TERRY	$136.27	$57.80	$169.60	$68.11
TITUS	$119.62	$48.47	$150.38	$56.17
TRAVIS	$103.28	$59.90	$90.03	$56.53
TYLER	$119.47	$48.80	$118.38	$55.63
UPTON	$90.26	$43.93	$114.29	$66.75
VAL VERDE	$93.42	$46.87	$83.20	$49.92
VICTORIA	$112.34	$58.83	$161.04	$81.96
WALLER	$139.83	$55.75	$149.04	$60.60
WASHINGTON	$93.03	$44.15	$71.48	$35.05

STATE: TEXAS COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
LEE	$94.42	$41.04	$103.93	$53.80
LIBERTY	$153.39	$62.78	$171.16	$78.34
LIPSCOMB	$114.42	$47.53	$107.66	$35.64
LLANO	$88.23	$45.97	$78.23	$52.67
LUBBOCK	$133.31	$58.28	$138.65	$64.55
MC CULLOCH	$87.03	$41.62	$86.34	$39.72
MC MULLEN	$120.48	$71.32	$94.04	$54.27
MARION	$92.67	$41.83	$83.84	$41.85
MASON	$84.78	$45.07	$52.44	$40.89
MAVERICK	$95.23	$50.00	$76.00	$46.95
MENARD	$100.60	$46.79	$174.31	$90.65
MILAM	$92.73	$41.85	$74.79	$39.62
MITCHELL	$99.39	$40.49	$109.35	$48.49
MONTGOMERY	$150.37	$67.74	$169.10	$84.37
MORRIS	$113.17	$49.00	$135.46	$54.12
NACOGDOCHES	$130.92	$53.49	$135.77	$62.55
NEWTON	$128.29	$50.87	$122.57	$55.78
NUECES	$134.74	$70.49	$148.26	$84.50
OLDHAM	$107.54	$48.40	$109.81	$43.28
PALO PINTO	$107.17	$41.54	$118.31	$55.80
PARKER	$96.28	$43.97	$111.53	$63.26
PECOS	$104.67	$38.16	$142.90	$74.32
POTTER	$100.61	$51.20	$108.57	$67.27
RAINS	$117.38	$49.74	$123.10	$58.11
REAGAN	$126.02	$62.66	$151.03	$83.66
RED RIVER	$108.68	$38.74	$127.54	$48.74
REFUGIO	$105.27	$50.22	$112.10	$49.47
ROBERTSON	$88.47	$42.76	$89.48	$44.84
RUNNELS	$87.86	$48.80	$102.58	$50.56
SABINE	$113.02	$43.73	$112.26	$52.15
SAN JACINTO	$151.81	$67.00	$168.06	$80.11
SAN SABA	$95.58	$44.87	$98.39	$56.17
SCURRY	$149.99	$49.58	$163.70	$65.13
SHELBY	$118.47	$46.84	$109.56	$49.86
SMITH	$87.88	$48.49	$112.79	$59.26
STARR	$55.91	$37.25	$58.55	$31.78
STERLING	$76.41	$40.71	$124.75	$65.78
SUTTON	$120.50	$62.41	$171.10	$98.94
TARRANT	$111.39	$55.24	$137.41	$76.49
TERRELL	$104.09	$45.41	$134.87	$46.66
THROCKMORTON	$184.22	$66.83	$295.72	$126.25
TOM GREEN	$95.49	$53.24	$88.70	$53.10
TRINITY	$98.36	$47.32	$139.68	$69.43
UPSHUR	$89.61	$42.26	$111.36	$55.99
UVALDE	$98.00	$51.38	$128.00	$74.00
VAN ZANDT	$100.98	$48.27	$115.83	$58.90
WALKER	$148.09	$67.39	$158.56	$74.39
WARD	$134.45	$55.15	$130.97	$52.30
WEBB	$86.89	$53.11	$72.45	$51.86

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: TEXAS COUNTY NAME	****** AGED ****** PART A	 PART B	*** DISABLED *** PART A	 PART B
WHARTON	$103.94	$43.01	$117.62	$56.53
WICHITA	$91.06	$52.02	$106.05	$64.25
WILLACY	$80.50	$47.47	$69.97	$46.11
WILSON	$97.77	$54.45	$108.89	$69.87
WISE	$99.87	$35.22	$101.16	$46.28
YOAKUM	$136.30	$55.63	$105.78	$60.23
ZAPATA	$85.11	$48.92	$57.27	$41.84
STATE: UTAH				
BEAVER	$122.92	$55.53	$110.36	$47.97
CACHE	$65.50	$38.30	$83.95	$50.16
DAGGETT	$102.55	$47.02	$139.33	$79.58
DUCHESNE	$92.59	$40.07	$111.80	$60.11
GARFIELD	$113.78	$48.58	$73.96	$50.19
IRON	$103.46	$49.26	$104.89	$55.63
KANE	$94.86	$41.58	$153.15	$81.79
MORGAN	$90.59	$43.96	$133.53	$77.40
RICH	$76.93	$44.22	$217.16	$150.20
SAN JUAN	$80.58	$34.59	$55.39	$29.76
SEVIER	$84.84	$38.84	$95.21	$51.03
TOOELE	$101.62	$44.71	$104.22	$52.93
UTAH	$106.79	$49.47	$111.32	$64.43
WASHINGTON	$89.93	$46.29	$96.10	$54.15
WEBER	$97.32	$50.54	$119.77	$68.35
STATE: VERMONT				
ADDISON	$105.33	$42.98	$93.79	$42.82
CALEDONIA	$113.13	$45.12	$91.84	$51.38
ESSEX	$126.87	$39.99	$112.72	$46.10
GRAND ISLE	$130.02	$46.61	$126.49	$62.72
ORANGE	$117.27	$46.33	$116.31	$52.43
RUTLAND	$113.53	$44.07	$106.28	$52.01
WINDHAM	$118.51	$48.33	$164.67	$71.96
STATE: VIRGIN ISLANDS				
ST CROIX	$54.72	$23.11	$69.93	$23.56
STATE: VIRGINIA				
ACCOMACK	$85.22	$34.92	$106.90	$48.25
ALEXANDRIA CITY	$177.24	$85.88	$225.57	$117.14
AMELIA	$108.09	$34.95	$120.09	$46.43
APPOMATTOX	$74.82	$29.98	$79.47	$42.41
AUGUSTA	$85.38	$32.86	$129.80	$52.68
BEDFORD CITY	$71.32	$28.48	$79.70	$44.17
BLAND	$129.29	$43.04	$117.33	$51.84
BRISTOL CITY	$84.31	$36.14	$65.40	$40.02
BUCHANAN	$140.69	$60.91	$93.55	$56.40
BUENA VISTA CITY	$83.70	$36.00	$87.23	$53.11
CAROLINE	$123.26	$44.96	$108.59	$48.65

STATE: TEXAS COUNTY NAME	****** AGED ****** PART A	 PART B	*** DISABLED *** PART A	 PART B
WHEELER	$120.89	$47.29	$156.28	$58.22
WILBARGER	$109.76	$46.73	$136.72	$57.55
WILLIAMSON	$76.26	$41.29	$87.09	$53.11
WINKLER	$128.78	$46.36	$143.01	$64.36
WOOD	$103.65	$45.96	$104.14	$54.52
YOUNG	$107.24	$45.19	$131.80	$60.35
ZAVALA	$100.98	$65.70	$97.28	$60.75
STATE: UTAH				
BOX ELDER	$87.58	$44.13	$92.55	$50.86
CARBON	$125.82	$67.59	$120.28	$62.26
DAVIS	$112.93	$55.92	$140.26	$77.29
EMERY	$106.21	$55.60	$110.26	$52.82
GRAND	$107.34	$39.18	$134.98	$57.35
JUAB	$125.98	$46.66	$81.85	$42.54
MILLARD	$89.31	$38.70	$63.49	$42.82
PIUTE	$102.33	$42.08	$132.09	$50.23
SALT LAKE	$103.09	$53.56	$127.56	$70.95
SANPETE	$99.05	$44.38	$126.04	$59.64
SUMMIT	$113.29	$45.36	$180.15	$73.88
UINTAH	$101.27	$51.49	$130.07	$49.34
WASATCH	$103.98	$46.33	$119.69	$80.02
WAYNE	$94.89	$46.26	$221.01	$63.96
STATE: VERMONT				
BENNINGTON	$123.41	$52.63	$121.24	$63.25
CHITTENDEN	$124.63	$47.46	$136.58	$68.83
FRANKLIN	$120.84	$42.91	$133.26	$59.86
LAMOILLE	$123.42	$53.14	$106.24	$51.56
ORLEANS	$117.21	$36.07	$107.61	$45.29
WASHINGTON	$94.34	$39.49	$97.64	$57.76
WINDSOR	$119.76	$50.23	$109.96	$57.63
STATE: VIRGIN ISLANDS				
ST THOMAS-JOHN	$51.33	$19.74	$53.31	$20.65
STATE: VIRGINIA				
ALBEMARLE	$93.15	$47.21	$137.24	$84.45
ALLEGHANY	$124.95	$47.58	$187.24	$68.74
AMHERST	$71.48	$29.48	$89.83	$38.81
ARLINGTON	$150.72	$78.42	$206.12	$110.44
BATH	$171.02	$45.79	$159.12	$60.20
BEDFORD	$86.41	$33.22	$99.08	$55.09
BOTETOURT	$110.28	$39.26	$86.26	$42.37
BRUNSWICK	$102.21	$39.07	$112.21	$49.73
BUCKINGHAM	$100.53	$45.57	$102.43	$63.58
CAMPBELL	$78.59	$29.90	$78.86	$38.94
CARROLL	$96.49	$33.27	$100.55	$45.53

TABLE 2

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: VIRGINIA COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
CHARLES CITY	$123.28	$39.83	$68.69	$44.98
CHARLOTTESVILLE CITY	$94.61	$50.22	$145.11	$97.13
CHESTERFIELD	$130.07	$52.81	$140.45	$69.79
CLIFTON FORGE CITY	$121.41	$46.37	$137.71	$62.39
COVINGTON CITY	$133.59	$45.33	$104.18	$46.31
CULPEPER	$89.77	$44.90	$82.42	$48.35
DANVILLE CITY	$78.43	$36.48	$95.66	$51.85
DINWIDDIE	$101.77	$36.97	$94.24	$34.29
ESSEX	$121.06	$48.45	$133.58	$57.02
FAIRFAX	$132.60	$76.11	$173.95	$105.26
FAUQUIER	$122.85	$49.45	$124.41	$59.71
FLUVANNA	$96.18	$45.16	$99.12	$60.66
FRANKLIN	$112.23	$32.92	$94.28	$39.74
FREDERICKSBURG CITY	$106.86	$47.33	$127.48	$63.62
GILES	$109.46	$42.09	$89.41	$46.94
GOOCHLAND	$109.61	$43.60	$118.74	$56.61
GREENE	$87.56	$41.93	$148.83	$75.83
HALIFAX	$81.27	$32.56	$102.75	$47.38
HANOVER	$129.51	$48.51	$166.46	$76.37
HENRICO	$129.24	$54.63	$190.04	$79.93
HIGHLAND	$94.51	$32.82	$85.01	$41.05
ISLE OF WIGHT	$111.45	$50.61	$102.30	$57.79
KING AND QUEEN	$142.35	$48.85	$115.97	$61.92
KING WILLIAM	$132.51	$48.42	$158.23	$61.79
LEE	$104.86	$46.12	$88.24	$46.25
LOUDOUN	$119.39	$56.31	$166.16	$86.11
LUNENBURG	$94.36	$36.39	$83.52	$39.25
MADISON	$87.76	$41.79	$78.62	$48.50
MANASSAS CITY	$164.40	$72.62	$200.89	$98.94
MECKLENBURG	$90.04	$37.93	$100.67	$44.74
MONTGOMERY	$104.12	$40.14	$116.39	$53.08
NEW KENT	$136.17	$45.60	$147.54	$72.19
NORFOLK CITY	$153.43	$63.28	$179.46	$81.21
NORTHUMBERLAND	$115.94	$44.82	$132.86	$63.88
NOTTOWAY	$96.86	$41.82	$97.78	$47.43
PAGE	$111.24	$37.02	$99.89	$49.43
PETERSBURG CITY	$119.49	$42.31	$123.09	$51.13
PORTSMOUTH CITY	$127.96	$59.69	$145.27	$82.76
POWHATAN	$115.07	$43.72	$100.26	$45.44
PRINCE GEORGE	$110.85	$44.77	$138.44	$57.12
PULASKI	$144.43	$47.10	$164.26	$73.77
RAPPAHANNOCK	$101.84	$42.51	$83.07	$45.81
RICHMOND CITY	$138.70	$55.66	$159.19	$68.78
ROANOKE CITY	$116.94	$43.13	$129.90	$54.45
ROCKINGHAM	$71.09	$30.73	$82.78	$44.55
SALEM	$94.05	$44.05	$129.14	$56.77
SHENANDOAH	$79.88	$32.37	$84.80	$45.82
SOUTH BOSTON CITY	$84.30	$33.84	$118.56	$52.73
SPOTSYLVANIA	$92.18	$40.84	$109.56	$56.67

STATE: VIRGINIA COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
CHARLOTTE	$73.37	$27.39	$71.13	$30.48
CHESAPEAKE	$159.19	$63.52	$165.44	$82.23
CLARKE	$87.67	$34.95	$115.69	$46.16
COLONIAL HGTS CITY	$120.95	$49.93	$124.01	$59.48
CRAIG	$103.29	$37.35	$145.04	$60.76
CUMBERLAND	$101.98	$39.46	$56.83	$34.16
DICKENSON	$121.23	$52.95	$80.73	$51.19
EMPORIA	$125.20	$54.13	$158.68	$69.47
FAIRFAX CITY	$142.66	$74.90	$165.77	$91.84
FALLS CHURCH CITY	$144.39	$82.72	$204.77	$116.96
FLOYD	$85.36	$32.36	$109.32	$47.40
FRANKLIN CITY	$123.70	$63.64	$144.01	$76.89
FREDERICK	$80.99	$32.76	$86.95	$51.39
GALAX CITY	$100.94	$36.66	$92.94	$41.74
GLOUCESTER	$105.01	$44.53	$122.89	$60.64
GRAYSON	$84.86	$29.32	$81.99	$33.79
GREENSVILLE	$129.48	$60.17	$122.04	$58.32
HAMPTON CITY	$101.11	$51.58	$119.94	$69.33
HARRISONBURG CITY	$66.78	$31.54	$89.59	$47.88
HENRY	$103.37	$38.53	$108.00	$51.42
HOPEWELL CITY	$134.17	$55.91	$158.74	$80.22
JAMES CITY	$86.26	$50.91	$111.95	$48.05
KING GEORGE	$125.17	$49.80	$129.71	$65.46
LANCASTER	$93.63	$39.67	$131.49	$64.25
LEXINGTON	$70.43	$31.89	$52.02	$39.40
LOUISA	$107.39	$46.64	$127.01	$62.67
LYNCHBURG CITY	$83.47	$34.07	$91.92	$45.28
MARTINSVILLE CITY	$91.92	$38.87	$105.87	$57.89
MATHEWS	$100.88	$4 .88	$117.26	$54.15
MIDDLESEX	$105.42	$40.48	$124.56	$53.15
NELSON	$94.24	$38.23	$89.97	$55.08
NEWPORT NEWS CITY	$96.59	$50.37	$109.10	$64.33
NORTHAMPTON	$83.89	$33.77	$95.36	$42.22
NORTON CITY	$161.15	$58.37	$132.17	$57.07
ORANGE	$104.37	$46.49	$93.16	$59.10
PATRICK	$106.97	$34.76	$132.05	$51.87
PITTSYLVANIA	$68.67	$30.13	$77.56	$39.21
POQUOSON CITY	$102.67	$51.64	$127.89	$80.36
PRINCE EDWARD	$90.33	$32.37	$104.24	$40.26
PRINCE WILLIAM	$153.37	$77.44	$209.00	$116.29
RADFORD CITY	$136.43	$46.26	$162.90	$60.97
RICHMOND	$142.11	$50.77	$115.65	$69.57
ROANOKE	$86.02	$36.91	$122.99	$59.78
ROCKBRIDGE	$73.78	$32.11	$98.74	$47.61
RUSSELL	$115.90	$44.50	$97.71	$50.91
SCOTT	$122.19	$41.19	$98.90	$48.46
SMYTH	$80.38	$30.29	$84.72	$38.76
SOUTHAMPTON	$111.06	$52.73	$129.57	$64.98
STAFFORD	$109.66	$48.39	$150.21	$75.71

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: VIRGINIA COUNTY NAME	****** AGED ****** PART A	 PART B	*** DISABLED *** PART A	 PART B
STAUNTON CITY.....	$95.07	$35.83	$107.79	$49.55
SURRY.....	$104.94	$43.86	$98.67	$40.94
TAZEWELL.....	$126.74	$55.61	$117.21	$64.76
WARREN.....	$117.46	$45.62	$157.65	$76.56
WAYNESBORO CITY.....	$121.31	$44.67	$141.07	$66.90
WILLIAMSBURG CITY...	$112.33	$56.41	$149.50	$71.41
WISE.....	$137.01	$53.64	$109.50	$52.47
YORK.....	$104.65	$52.44	$102.46	$59.31
STATE: WASHINGTON				
ADAMS.....	$126.44	$57.94	$120.48	$62.97
BENTON.....	$95.55	$50.94	$107.13	$64.88
CLALLAM.....	$95.59	$51.77	$109.11	$64.75
COLUMBIA.....	$114.62	$47.20	$92.69	$48.13
DOUGLAS.....	$98.17	$57.99	$88.03	$60.71
FRANKLIN.....	$111.77	$51.58	$124.47	$60.31
GRANT.....	$105.98	$53.65	$103.10	$58.17
ISLAND.....	$98.51	$49.86	$88.42	$53.12
KING.....	$129.05	$60.57	$152.80	$77.84
KITTITAS.....	$99.65	$48.44	$103.33	$55.98
LEWIS.....	$104.45	$52.05	$89.95	$57.25
MASON.....	$112.02	$54.89	$89.68	$53.21
PACIFIC.....	$137.85	$51.79	$135.16	$61.90
PIERCE.....	$101.22	$58.29	$97.93	$69.54
SKAGIT.....	$124.91	$57.83	$128.32	$69.25
SNOHOMISH.....	$120.67	$54.79	$132.13	$70.94
STEVENS.....	$110.05	$47.98	$108.88	$60.78
WAHKIAKUM.....	$99.16	$43.01	$119.29	$62.81
WHATCOM.....	$86.30	$49.66	$85.42	$58.33
YAKIMA.....	$107.14	$48.47	$115.52	$61.63
STATE: W. VIRGINIA				
BARBOUR.....	$128.04	$32.96	$91.10	$40.14
BOONE.....	$120.91	$43.67	$83.46	$40.23
BROOKE.....	$163.72	$45.29	$196.60	$59.94
CALHOUN.....	$117.83	$38.48	$83.50	$28.12
DODDRIDGE.....	$95.12	$34.82	$60.50	$27.27
GILMER.....	$96.88	$33.67	$88.50	$36.71
GREENBRIER.....	$102.24	$47.73	$88.21	$46.62
HANCOCK.....	$194.97	$52.60	$214.84	$70.49
HARRISON.....	$110.73	$42.85	$86.29	$43.14
JEFFERSON.....	$104.49	$36.29	$102.68	$43.59
LEWIS.....	$94.42	$33.80	$80.39	$35.36
LOGAN.....	$132.42	$57.82	$96.37	$56.67
MARION.....	$94.93	$32.10	$98.03	$41.85
MASON.....	$122.69	$39.50	$116.51	$46.62
MINERAL.....	$135.92	$39.38	$113.33	$40.74
MONONGALIA.....	$121.94	$48.67	$120.36	$54.65
MORGAN.....	$90.58	$35.22	$97.61	$49.03

STATE: VIRGINIA COUNTY NAME	****** AGED ****** PART A	 PART B	*** DISABLED *** PART A	 PART B
SUFFOLK CITY.....	$115.16	$50.26	$136.51	$66.55
SUSSEX.....	$126.22	$46.11	$113.93	$55.26
VIRGINIA BEACH CITY.	$143.91	$69.18	$182.04	$95.48
WASHINGTON.....	$71.64	$31.35	$78.72	$40.55
WESTMORELAND.....	$130.34	$51.75	$150.38	$65.71
WINCHESTER CITY.....	$86.68	$36.70	$101.34	$45.51
WYTHE.....	$141.21	$41.53	$127.73	$49.52
STATE: WASHINGTON				
ASOTIN.....	$104.38	$50.00	$94.94	$53.70
CHELAN.....	$95.86	$56.51	$107.72	$69.64
CLARK.....	$100.92	$53.55	$100.06	$56.24
COWLITZ.....	$116.10	$49.93	$117.92	$64.69
FERRY.....	$137.51	$53.02	$100.87	$49.10
GARFIELD.....	$119.59	$48.46	$94.79	$72.80
GRAYS HARBOR.....	$112.10	$53.40	$106.78	$60.39
JEFFERSON.....	$101.41	$52.38	$86.84	$55.82
KITSAP.....	$88.51	$57.24	$96.17	$69.74
KLICKITAT.....	$124.67	$46.00	$122.12	$56.89
LINCOLN.....	$102.58	$54.13	$125.54	$87.12
OKANOGAN.....	$110.20	$50.98	$131.69	$70.60
PEND OREILLE.....	$110.79	$48.31	$93.56	$55.78
SAN JUAN.....	$88.78	$48.01	$133.02	$77.58
SKAMANIA.....	$126.04	$49.29	$143.35	$73.03
SPOKANE.....	$111.36	$56.73	$111.14	$71.47
THURSTON.....	$88.19	$54.16	$84.74	$58.55
WALLA WALLA.....	$117.50	$54.77	$128.06	$66.48
WHITMAN.....	$108.76	$49.58	$102.83	$53.79
STATE: W. VIRGINIA				
BERKELEY.....	$107.26	$40.53	$106.99	$48.85
BRAXTON.....	$81.98	$32.67	$57.56	$24.01
CABELL.....	$85.52	$39.19	$76.83	$43.55
CLAY.....	$96.82	$36.14	$66.52	$35.62
FAYETTE.....	$118.44	$40.27	$94.05	$51.63
GRANT.....	$98.17	$36.62	$81.07	$35.99
HAMPSHIRE.....	$96.80	$38.56	$84.49	$40.09
HARDY.....	$77.29	$32.49	$72.82	$29.73
JACKSON.....	$79.65	$30.42	$84.86	$39.76
KANAWHA.....	$137.54	$47.72	$137.52	$54.51
LINCOLN.....	$84.06	$38.30	$62.19	$35.09
MC DOWELL.....	$121.35	$59.63	$79.08	$48.06
MARSHALL.....	$185.79	$45.93	$190.54	$58.56
MERCER.....	$124.91	$57.89	$114.92	$61.57
MINGO.....	$119.95	$52.18	$81.59	$48.98
MONROE.....	$98.02	$47.99	$71.59	$53.13
NICHOLAS.....	$94.01	$45.25	$80.55	$42.90

TABLE 2

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: W. VIRGINIA COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
OHIO	$146.59	$41.93	$207.44	$59.78
PLEASANTS	$124.62	$37.74	$74.96	$34.15
PRESTON	$91.83	$34.92	$73.64	$37.31
RALEIGH	$91.32	$43.74	$69.00	$37.69
RITCHIE	$94.46	$32.14	$87.47	$40.45
SUMMERS	$109.17	$47.90	$109.72	$52.53
TUCKER	$110.25	$42.41	$74.75	$42.69
UPSHUR	$67.79	$31.31	$59.31	$30.43
WEBSTER	$84.78	$38.24	$61.31	$37.69
WIRT	$100.52	$35.22	$103.31	$34.03
WYOMING	$129.44	$40.71	$76.03	$43.16
STATE: WISCONSIN				
ADAMS	$138.95	$46.00	$145.69	$55.08
BARRON	$104.71	$38.06	$102.18	$45.57
BROWN	$108.84	$38.34	$127.74	$60.86
BURNETT	$127.53	$37.88	$137.97	$46.70
CHIPPEWA	$117.49	$44.30	$116.16	$60.25
COLUMBIA	$118.73	$42.49	$133.70	$58.16
DANE	$105.72	$47.16	$133.98	$69.67
DOOR	$117.77	$43.40	$116.46	$55.32
DUNN	$89.75	$38.95	$90.64	$50.18
FLORENCE	$105.32	$36.63	$111.04	$51.86
FOREST	$97.84	$38.14	$88.61	$51.55
GREEN	$90.58	$33.46	$114.20	$56.39
IOWA	$87.79	$33.38	$98.32	$47.34
JACKSON	$124.86	$40.04	$99.06	$43.89
JUNEAU	$106.68	$40.08	$98.51	$47.85
KEWAUNEE	$117.35	$36.83	$128.27	$47.09
LAFAYETTE	$115.33	$38.24	$132.92	$55.40
LINCOLN	$126.67	$42.92	$154.46	$63.92
MARATHON	$102.45	$42.22	$99.70	$50.48
MARQUETTE	$106.19	$41.77	$112.25	$57.07
MILWAUKEE	$181.44	$63.45	$201.15	$88.41
OCONTO	$102.99	$35.48	$101.84	$42.20
OUTAGAMIE	$118.24	$41.53	$135.19	$60.83
PEPIN	$89.32	$40.85	$107.66	$61.33
POLK	$130.27	$40.93	$128.64	$53.92
PRICE	$107.91	$39.44	$117.91	$48.77
RICHLAND	$85.87	$34.63	$85.24	$45.51
ROCK	$106.86	$44.46	$119.03	$55.48
SAUK	$111.34	$44.43	$119.22	$54.32
SHAWANO	$84.77	$36.04	$101.50	$49.47
TAYLOR	$109.39	$39.90	$98.36	$48.21
VERNON	$80.50	$34.07	$88.23	$44.18
WALWORTH	$126.03	$42.20	$170.69	$57.42
WASHINGTON	$124.17	$47.59	$124.00	$61.88
WAUPACA	$91.36	$33.42	$94.26	$44.83
WINNEBAGO	$129.99	$43.74	$147.77	$72.42

STATE: W. VIRGINIA COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
PENDLETON	$69.34	$30.37	$82.74	$28.28
POCAHONTAS	$91.47	$34.00	$90.43	$40.42
PUTNAM	$113.96	$40.85	$105.62	$44.56
RANDOLPH	$95.13	$40.08	$85.80	$42.24
ROANE	$98.64	$30.43	$70.48	$27.37
TAYLOR	$100.29	$37.27	$112.37	$46.06
TYLER	$96.41	$30.17	$75.72	$34.76
WAYNE	$82.52	$35.60	$65.44	$35.95
WETZEL	$110.93	$34.72	$108.89	$37.97
WOOD	$122.84	$41.55	$121.32	$51.06
STATE: WISCONSIN				
ASHLAND	$102.65	$36.34	$131.53	$52.45
BAYFIELD	$114.76	$39.10	$114.87	$45.66
BUFFALO	$89.60	$41.74	$81.53	$48.87
CALUMET	$109.67	$35.79	$105.02	$58.37
CLARK	$95.96	$36.27	$76.66	$41.74
CRAWFORD	$100.53	$38.67	$127.40	$54.05
DODGE	$105.82	$41.19	$103.09	$51.57
DOUGLAS	$146.50	$44.97	$141.98	$49.18
EAU CLAIRE	$120.88	$48.76	$139.60	$62.07
FOND DU LAC	$109.03	$42.59	$123.10	$56.28
GRANT	$109.43	$37.44	$116.41	$49.26
GREEN LAKE	$119.63	$41.77	$129.81	$61.48
IRON	$120.38	$38.16	$85.93	$36.98
JEFFERSON	$109.66	$41.53	$107.31	$48.76
KENOSHA	$164.08	$54.87	$187.94	$76.74
LA CROSSE	$99.46	$49.06	$127.20	$73.49
LANGLADE	$105.89	$42.97	$87.14	$56.23
MANITOWOC	$117.87	$41.33	$147.21	$62.96
MARINETTE	$93.12	$30.89	$80.84	$37.47
MENOMINEE	$101.10	$47.98	$111.00	$57.69
MONROE	$91.95	$37.52	$86.62	$45.09
ONEIDA	$119.65	$44.49	$120.39	$54.78
OZAUKEE	$147.18	$50.58	$188.82	$73.50
PIERCE	$102.17	$39.47	$108.00	$56.21
PORTAGE	$116.39	$39.41	$116.99	$49.96
RACINE	$124.15	$49.83	$150.31	$78.80
ROCK	$117.71	$46.78	$128.50	$63.79
ST CROIX	$117.69	$39.35	$111.68	$48.08
SAWYER	$122.91	$41.65	$125.92	$53.64
SHEBOYGAN	$113.39	$35.83	$148.42	$60.32
TREMPEALEAU	$87.38	$38.80	$91.46	$45.80
VILAS	$131.38	$45.45	$158.62	$61.66
WASHBURN	$152.03	$43.00	$126.50	$42.18
WAUKESHA	$144.76	$52.46	$178.65	$76.94
WAUSHARA	$126.49	$41.01	$110.26	$49.81
WOOD	$106.73	$44.09	$106.45	$55.11

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: WYOMING COUNTY NAME	****** AGED ****** PART A	 PART B	*** DISABLED *** PART A	 PART B
ALBANY	$121.19	$50.73	$171.95	$69.23
CAMPBELL	$135.35	$52.16	$151.54	$57.17
CONVERSE	$99.39	$40.07	$111.00	$91.86
FREMONT	$144.35	$50.69	$108.21	$50.82
HOT SPRINGS	$129.70	$46.97	$113.48	$49.01
LARAMIE	$112.05	$49.16	$105.23	$62.29
NATRONA	$115.12	$46.93	$141.29	$72.71
PARK	$86.65	$46.66	$103.99	$79.28
SHERIDAN	$81.38	$36.46	$75.36	$41.24
SWEETWATER	$117.77	$49.08	$151.47	$62.01
UINTA	$112.67	$49.92	$103.70	$64.80
WESTON	$105.32	$41.66	$126.91	$62.02
STATE: GUAM				
AGANA	$53.81	$14.95	$105.30	$49.96
AGAT	$53.81	$14.95	$104.52	$52.18
BARRIGADA	$53.81	$14.95	$112.17	$58.05
DEDEDO	$53.81	$14.95	$99.37	$45.19
MAITE	$53.81	$14.95	$116.31	$54.03
MERIZO	$53.81	$14.95	$126.00	$54.03
ORDOT	$53.81	$14.95	$60.48	$29.27
SANTA RITA	$53.81	$14.95	$100.80	$46.83
TALOFOFO	$53.81	$14.95	$98.61	$49.01
TOTO	$53.81	$14.95	$117.82	$47.46
YIGO	$53.81	$14.95	$108.00	$51.86

STATE: WYOMING COUNTY NAME	****** AGED ****** PART A	 PART B	*** DISABLED *** PART A	 PART B
BIG HORN	$118.32	$47.41	$109.40	$56.48
CARBON	$142.17	$44.36	$173.37	$76.01
CROOK	$143.92	$41.70	$92.04	$32.15
GOSHEN	$116.38	$39.41	$119.14	$48.63
JOHNSON	$104.91	$41.42	$135.78	$47.70
LINCOLN	$104.93	$42.87	$145.37	$54.71
NIOBRARA	$96.44	$36.80	$144.95	$49.04
PLATTE	$112.67	$42.99	$133.22	$66.33
SUBLETTE	$124.64	$46.26	$120.50	$46.89
TETON	$128.79	$59.35	$181.88	$119.80
WASHAKIE	$109.67	$46.24	$106.99	$54.12
STATE: GUAM				
AGANA HEIGHTS	$53.81	$14.95	$108.78	$52.25
ASAN	$53.81	$14.95	$75.60	$49.19
CHALAN PAGO	$53.81	$14.95	$119.37	$63.86
INARAJAN	$53.81	$14.95	$91.64	$39.57
MANGILAO	$53.81	$14.95	$100.80	$45.32
MONGMONG	$53.81	$14.95	$94.50	$47.89
PITI	$53.81	$14.95	$137.46	$70.24
SINAJANA	$53.81	$14.95	$99.69	$43.90
TAMUNING	$53.81	$14.95	$103.77	$47.89
UMATAC	$53.81	$14.95	$98.61	$45.81
YONA	$53.81	$14.95	$100.19	$51.51

TABLE 3

PER CAPITA RATES OF PAYMENT FOR MEDICARE ENROLLEES

WITH

END-STAGE RENAL DISEASE

STATE	PART A	PART B
ALABAMA	$496.19	$1,084.21
ALASKA	$1,004.21	$1,686.60
ARIZONA	$699.71	$1,740.21
ARKANSAS	$445.29	$1,202.31
CALIFORNIA	$843.36	$1,725.98
COLORADO	$596.32	$1,543.55
CONNECTICUT	$756.81	$1,582.24
DELAWARE	$898.63	$1,563.54
DIST. OF COL.	$1,207.57	$1,732.26
FLORIDA	$656.96	$1,598.61
GEORGIA	$584.89	$1,495.69
HAWAII	$957.16	$1,917.67
IDAHO	$696.87	$1,144.78
ILLINOIS	$784.63	$1,673.74
INDIANA	$839.14	$1,532.16
IOWA	$643.34	$1,073.69
KANSAS	$896.87	$1,500.25
KENTUCKY	$879.29	$1,237.96
LOUISIANA	$588.14	$1,556.44
MAINE	$982.93	$1,317.65
MARYLAND	$1,190.24	$1,698.65
MASSACHUSETTS	$775.67	$1,252.04
MICHIGAN	$1,055.65	$1,485.79
MINNESOTA	$1,515.73	$1,383.51
MISSISSIPPI	$380.06	$1,633.12
MISSOURI	$706.44	$1,314.64
MONTANA	$790.73	$1,214.12
NEBRASKA	$662.32	$1,145.43
NEVADA	$799.68	$1,870.87
NEW HAMPSHIRE	$1,007.77	$1,529.95
NEW JERSEY	$671.35	$1,685.83
NEW MEXICO	$714.94	$1,280.65
NEW YORK	$651.68	$1,530.15
N. CAROLINA	$603.12	$1,406.36
N. DAKOTA	$1,294.64	$1,348.39
OHIO	$768.00	$1,426.83
OKLAHOMA	$618.80	$1,153.85
OREGON	$1,331.94	$1,536.13
PENNSYLVANIA	$793.28	$1,707.26
PUERTO RICO	$245.77	$1,437.06
RHODE ISLAND	$969.39	$1,748.52
S. CAROLINA	$613.34	$1,590.69
S. DAKOTA	$1,469.46	$1,350.27
TENNESSEE	$545.63	$1,388.73
TEXAS	$649.94	$1,523.82
UTAH	$571.47	$1,359.38
VERMONT	$987.80	$1,359.04
VIRGIN ISLANDS	$285.66	$1,639.76
VIRGINIA	$624.85	$1,542.18
WASHINGTON	$784.05	$1,188.74
W. VIRGINIA	$645.28	$1,453.97
WISCONSIN	$1,176.03	$1,327.92
WYOMING	$484.31	$1,158.19
GUAM	$740.23	$1,856.95

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