Dated: June 22, 1993.

William P. Leahy,

Rear Admiral, U.S. Coast Guard, Commander, Seventh Coast Guard District.

[FR Doc. 93–16710 Filed 7–14–93; 8:45 am]

BILLING CODE 4910–14–M

33 CFR Part 117

[CGD01–93–036]

Drawbridge Operation Regulations; Apponagansett River, MA

AGENCY: Coast Guard, DOT.

ACTION: Notice of temporary deviation from regulations.

SUMMARY: The Coast Guard is providing notice that the town of Dartmouth, Massachusetts, has been granted permission to temporarily deviate for sixty (60) days from the regulations governing the Padanaram Bridge over the Apponagansett River at mile 1.0 in Dartmouth, Massachusetts. The deviation permits scheduled openings on the hour from July 1, 1993, through August 29, 1993, rather than on the hour and the half hour. This temporary deviation is being implemented to evaluate the effects of changes requested by the town of Dartmouth, Massachusetts, on vehicular traffic and marine traffic.

DATES: The deviation is effective for 60 days from July 1, 1993 through August 29, 1993. Comments on the deviation must be received on or before October 29, 1993.

ADDRESSES: Comments may be mailed to Commander (obr), First Coast Guard District, room 628 at the John Foster Williams Building, 408 Atlantic Avenue, Boston, Massachusetts. The comments and other materials referenced in this notice will be available for inspection and copying at the above address. Normal office hours are between 7 a.m. and 3:30 p.m., Monday through Friday, except federal holidays. Comments may also be hand-delivered to the above address.

FOR FURTHER INFORMATION CONTACT: William C. Heming, Bridge Administrator, First Coast Guard District, (212) 668–7170.

SUPPLEMENTARY INFORMATION:

Request for Comments

The Coast Guard encourages interested persons to participate in this evaluation of possible changes to the regulations governing the Padanaram Bridge over the Apponagansett River by submitting written data, or arguments for or against this deviation. Persons submitting comments should include their name, address, identify this rulemaking (CGD–01–93–036) and give the reason for each comment. Persons wanting acknowledgement of receipt of comments should enclose a stamped self-addressed post card or envelope.

The Coast Guard will consider all comments received during the comment period and determine whether to revise or eliminate the 60 day deviation. If it appears appropriate to the propose a permanent change to the regulations, the Coast Guard plans to publish a notice of proposed rulemaking which will again request comments during an additional comment period announced by a later notice in the **Federal Register**. Persons may submit comments by writing to the Commander (obr), First Coast Guard District listed under "ADDRESSES".

Background and Purpose

The Padanaram Bridge over the Apponagansett River between Dartmouth and South Dartmouth has a vertical clearance of 9′ above mean high water (MHW) and 12′ above low water (MLW).

The Town of Dartmouth has requested a change from the present operating regulations in 33 CFR 117.587 which allow the Padanaram Bridge to open on the hour and half hour. The town selectmen feel that the vehicular traffic resulting from the bridge opening every 30 minutes, is causing village commence to suffer. The selectmen also consider the 30 minute opening schedule a serious risk to public safety because emergency vehicles can not travel to and from South Dartmouth during the traffic delays created when the bridge opens every half hour. The town of Dartmouth requested that the bridge be required to open only on the hour for a test period of 60 days to evaluate the effects on vehicular and marine traffic. The temporary deviation will retain the provisions of paragraph (a)(1) for the bridge to open on signal as soon as possible for vessels of the United States, state and local vessels used for public safety and vessels in distress.

Notice

Notice is hearby given that:

(1) The Coast Guard has granted the Town of Dartmouth, Massachusetts, a temporary deviation from the operating requirements listed at 33 CFR 117.587 paragraph (b)(1) governing the Padanaram Bridge over the Apponagansett River.

(2) This deviation from normal operating regulations is authorized in accordance with the provisions of 33 CFR 117.43 for the purpose of evaluating possible changes to the permanent regulations. Under this temporary deviation, the Padanaram Bridge operated by the Town of Dartmouth shall open on signal from July 1, 1993 through August 29, 1993 from 5 a.m. to 9 p.m. daily, only on the hour.

(3) The period of deviation is effective July 1, 1993 to August 29, 1993.

Dated: June 22, 1993.

Kent H. Williams,

Rear Admiral, U.S. Coast Guard, Commander, First Coast Guard District.

[FR Doc. 93–16703 Filed 7–14–93; 8:45 am]

BILLING CODE 4910–14–M

33 CFR Part 165

[CGD7 92–41]

RIN 2115–AE42

Regulated Navigation Area: Kings Bay, GA

AGENCY: Coast Guard, DOT.

ACTION: Final rule.

SUMMARY: The Coast Guard is establishing a restricted navigation area to minimize the effect of passing vessels, wakes on U.S. Navy ships moored at the King's Bay Naval Submarine Base Magnetic Silencing Facility, Floating Dry Dock and Tender Refit Moors. At the U.S. Navy's request, the Coast Guard established a regulated navigation area in 1984 to minimize the effects of wakes on the drydock ARDM 1 OAKRIDGE. Since then, the construction of the Magnetic Silencing Facility and the related activities associated with it have increased the size of the regulated navigation area which is necessary to protect workers. The rule extends by approximately 700 yards the southern boundary of the bare steerageway regulated navigation area in the vicinity of the entrance to King's Bay, Georgia.

EFFECTIVE DATE: August 16, 1993.

FOR FURTHER INFORMATION CONTACT: Lieutenant E. Gray, Seventh Coast Guard District, Aids to Navigation Branch, (305) 536–5621.

SUPPLEMENTARY INFORMATION: On July 16, 1992, the Coast Guard published a notice of proposed rule making in the **Federal Register** for this regulation (57 FR 31472). Interested persons were requested to submit comments, and no comments were received.

Drafting Information

The drafters of this regulation are Lieutenant E. Gray, project Officer, Seventh Coast Guard District, Aids to Navigation Branch, and Lieutenant

J. Losego, project attorney, Seventh Coast Guard District Legal Office.

Discussion of Comments

No comments were received regarding this regulation.

Economic Assessment and Certification

This regulation is considered to be non-major under Executive order 12291 on Federal Regulation and nonsignificant under Department of Transportation regulatory policies and procedures (44 FR 11034; February 26, 1979). The economic impact has been found to be so minimal that a full regulatory evaluation is unnecessary. The extension of the existing bare-steerageway zone by an additional 700 yards, as proposed by this regulation, will have little economic impact other than lengthening vessel transit time through the area by a short period.

Since the impact of this final rule is minimal, the Coast Guard certifies that it will not have a significant economic impact on a substantial number of small entities.

Collection of Information

This final rule contains no collection of information requirements under the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*).

Federalism

This action has been analyzed in accordance with the principles and criteria contained in Executive Order 12612, and it has been determined that the final rule does not have sufficient federalism implications to warrant the preparation of a Federalism Assessment.

Environmental Assessment

The Coast Guard considered the environmental impact of this rulemaking and concluded that under section 2.b.2.1. of Commandant Instruction M16475.1B, this rulemaking is categorically excluded from further environmental documentation as an administrative action under the Coast Guard's statutory authority to establish and regulate Restricted Navigational Areas. This action clearly has no environmental impact. A Categorical Exclusion Determination is available in the docket.

List of Subjects in 33 CFR Part 165

Harbors, Marine safety, Navigation (water), Security measures, Vessels, Waterways.

Final Regulations

In consideration of the foregoing, part 165 of title 33, Code of Federal Regulations, is revised as follows:

1. The authority citation for part 165 continues to read as follows:

Authority: 33 U.S.C. 1225 and 1231; 50 U.S.C. 191; 49 CFR 1.46 and 33 CFR 1.05–1(g), 6.04–1, 6.04–6, and 160.5.

2. Section 165.730 is revised to read as follows:

§ 165.730 King's Bay, Georgia—Regulated navigation area.

Vessels transiting in the water bounded by the line connecting the following points must travel no faster than needed for steerageway:

Latitude	*Longitude*
30°48'00.0" N	081°29'24.0" W
30°46'19.5" N	081°29'17.0" W
30°47'35.0" N	081°30'16.5" W

and thence to the point of beginning

Dated: July 9, 1993.

William P. Leahy,

Rear Admiral, U.S. Coast Guard, Commander, Seventh Coast Guard District.

[FR Doc. 93–16712 Filed 7–14–93; 8:45 am]

BILLING CODE 4910–14–M

DEPARTMENT OF DEFENSE

DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 21

RIN 2900–AF52

Veterans Education; Disenrollment From the Post-Vietnam Era Veterans' Educational Assistance Program Following Election To Receive Other Benefits

AGENCY: Department of Defense and Department of Veterans Affairs.

ACTION: Final regulations.

SUMMARY: The Department of Veterans Affairs Nurse Pay Act of 1990 requires VA (Department of Veterans Affairs) to make payments to certain military officers and former officers who were commissioned in 1977 and 1978. The law provides that if any of these officers or former officers participated in VEAP (Post-Vietnam Era Veterans' Educational Assistance Program), they must disenroll from that program before receiving those benefits. The National Defense Authorization Act for Fiscal Year 1991 provides additional ways in which an individual may become eligible for the Montgomery GI Bill—Active Duty. One of these permits certain involuntarily separated veterans who ordinarily would be eligible for benefits under the Post-Vietnam Era Veterans' Educational Assistance Program (VEAP) to elect to receive benefits under the Montgomery GI Bill—Active Duty instead. These regulations will acquaint the public with the way in which VA will administer these provisions of law.

EFFECTIVE DATE: The amendment to § 21.5058, like the provision of law it implements, is retroactively effective on November 5, 1990. The amendment to § 21.5064, like the provision of law it implements, is retroactively effective on August 15, 1990.

FOR FURTHER INFORMATION CONTACT: June C. Schaeffer (225), Assistant Director for Policy and Program Administration, Education Service, Veterans Benefits Administration, Department of Veterans Affairs, 810 Vermont Avenue, NW., Washington, DC 20420, (202) 233–2092.

SUPPLEMENTARY INFORMATION: On pages 41451 and 41452 of the **Federal Register** of September 10, 1992, there was published a Notice of Intent to amend 38 CFR part 21 in order to implement provisions of Public Law 101–366, and Public Law 101–510 which deal with people with potential eligibility for VEAP who elect to receive either the officer adjustment benefit or the Montgomery GI Bill—Active Duty. Interested people were given 33 days to submit comments, suggestions or objections. VA and the Department of Defense received no comments, suggestions or objections. Accordingly, the departments are making the proposed amended regulations final.

Section 207 of the Department of Veterans Affairs Nurse Pay Act of 1990 (Pub. L. 101–366) provides that VA make a benefit payment to certain officers and former officers who elect by January 1, 1992, to receive payments. This officer adjustment benefit is to be the equivalent of what they would have received under the Vietnam Era GI Bill had they been eligible for benefits under that program minus what they received under VEAP. The law provides that VEAP participants must disenroll from VEAP in order to get this benefit.

Section 561 of the National Defense Authorization Act for Fiscal Year 1991 (Pub. L. 101–510) contains provisions that will enable additional individuals to become eligible for the Montgomery GI Bill—Active Duty. Under these provisions some involuntarily discharged veterans may elect to receive benefits under the Montgomery GI Bill—Active Duty rather than VEAP. Such an election is irrevocable. Even if a veteran should subsequently return to active duty, he or she could not reenroll in VEAP. The amendments to these regulations are designed to implement these sections of these acts.

Although these amended regulations generally follow the statutes which they are designed to implement, the statutes do give the implementing departments some freedom in some places. The factors considered in determining the policies contained in the amended regulations were discussed in the Federal Register of September 10, 1992.

The Department of Veterans Affairs and the Department of Defense have determined that these amended regulations do not contain a major rule as that term is defined by E.O. 12291, entitled Federal Regulation. The regulations will not have $100 million annual effect on the economy, and will not cause a major increase in costs or prices for anyone. They will have no significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

The Secretary of Veterans Affairs and the Secretary of Defense have certified that these amended regulations will not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act (RFA), 5 U.S.C. 601–612. Pursuant to 5 U.S.C. 605(b), the amended regulations, therefore, are exempt from the initial and final regulatory flexibility analyses requirements of sections 603 and 604.

This certification can be made because the amended regulations directly affect only individuals. They will have no significant economic impact on small entities, i.e., small businesses, small private and nonprofit organizations and small governmental jurisdictions.

VA and Department of Defense find that good cause exists for making the amendment to § 21.5058 dealing with those who are involuntarily separated, like the provision of law it implements, retroactively effective on November 5, 1990. VA and Department of Defense find that good cause exists for making the amendment to § 21.5058 as well as all other regulations dealing with the officer adjustment benefit, like the provision of law it implements, retroactively effective on August 15, 1990. These regulations are intended to achieve a benefit for individuals. The maximum benefits intended in the legislation will be achieved through prompt implementation. Hence, a delayed effective date would be contrary to statutory design, would complicate administration of the provision of law, and might result in the denial of a benefit to someone who is entitled to it.

The Catalog of Federal Domestic Assistance number of the program affected by this proposal is 64.120.

List of Subjects in 38 CFR Part 21

Civil rights, Claims, Education, Grant programs-education, Loan programs-education, Reporting and recordkeeping requirements, Schools, Veterans, Vocational education, Vocational rehabilitation.

Approved: May 5, 1993.

Jesse Brown,

Secretary of Veterans Affairs.

Approved: June 16, 1993.

Nicolai Timenes, Jr.,

Principal Director (Military Manpower & Personnel Policy), Department of Defense.

For the reasons set out in the preamble, 38 CFR part 21, subpart G is amended as set forth below.

PART 21—VOCATIONAL REHABILITATION AND EDUCATION

Subpart G—Post-Vietnam Era Veterans' Educational Assistance Under 38 U.S.C. Chapter 32

1. The authority citation for part 21, subpart G continues to read as follows:

Authority: 38 U.S.C. 501(a).

2. In § 21.5058, paragraph (b) and its authority citation are revised to read as follows:

§ 21.5058 Resumption of participation.

* * * * *

(b) A person who has disenrolled in order to receive educational assistance allowance under 38 U.S.C., chapter 34 may not disenrolled if he or she has negotiated a check under that chapter for pursuit of a program of education. A person who has disenrolled in order to receive an officer adjustment benefit payable under § 21.4703 of this part may not reenroll if he or she has negotiated a check representing benefits payable under that section. A person who has disemrolled in order to receive educational assistance under the Montgomery GI Bill—Active Duty, as provided in § 21.7045(b), may not reenroll. Any other person who has disenrolled may reenroll, but will have to qualify again for minimum participation as described in § 21.5052(a).

(Authority: 38 U.S.C. 3008A, 3202(1), 3222, Pub. L. 101–366, sec. 207; Pub. L. 98–223, Pub. L. 101–510) (Aug. 5, 1990) (Nov. 5, 1990)

3. In § 21.5064, paragraphs (b)(1) and (b)(2)(i) and the authority citation for paragraph (b)(2) are revised and an authority citation is added for paragraph (b)(1) to read as follows:

§ 21.5064 Refund upon disenrollment.

* * * * *

(b) * * *

(1) If a individual voluntarily disenrolls from the program before discharge or release from active duty, the time limit for providing the serviceperson with a refund will be determined as follows.

(i) If a serviceperson decides to disenroll in order to receive an officer adjustment benefit payable under § 21.4703, VA will refund the unused contributions not later than 60 days after receiving the serviceperson's valid election for the benefit.

(ii) In other cases VA will refund the money on—

(A) The date of the participant's discharge or release from active duty; or

(B) Within 60 days of the receipt of notice by VA of the individual's discharge or disenrollment; or

(C) Any earlier date in an instance of hardship or for other good reasons.

(Authority: 38 U.S.C. 3223, 3232, Pub. L. 101–366, sec. 207) (Aug. 15, 1990)

(2) * * *

(i) If a veteran disenrolls by electing to receive an officer adjustment benefit payable under § 21.4703 rather than receiving educational assistance under 38 U.S.C., chapter 32, VA shall refund his or her contributions not later than 60 days after receiving a valid election for the officer adjustment benefit.

* * * * *

(Authority: 38 U.S.C. 3202, 3223, 3232, Pub. L. 101–366, sec. 207)

* * * * *

[FR Doc. 93–16728 Filed 7–14–93; 8:45 am]

BILLING CODE 8320–01–U

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[LA–6–1–5632; FRL–4675–1]

Approval and Promulgation of Air Quality Implementation Plans; Louisiana; Revision to the State Implementation Plan; Correcting Sulfur Dioxide Enforceability Deficiencies

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final rulemaking.

SUMMARY: This action approves a revision to the Louisiana State Implementation Plan (SIP) to include revisions to Louisiana Administrative Code (LAC), Title 33, Part III, Chapter 15, entitled Emission Standards for Sulfur Dioxide. These revisions correct

enforceability deficiencies and strengthen the provisions of Chapter 15.

EFFECTIVE DATE: This action will become effective on September 13, 1993 unless notice is received by August 16, 1993 that someone wishes to submit adverse or critical comments. If the effective date is delayed, timely notice will be published in the **Federal Register.**

ADDRESSES: Written comments on this action should be addressed to Mr. Thomas H. Diggs, Chief, Planning Section, at the EPA Regional Office listed below. Copies of the documents relevant to this action are available for public inspection during normal business hours at the following locations. The interested persons wanting to examine these documents should make an appointment with the appropriate office at least twenty-four hours before the visiting day.

U.S. Environmental Protection Agency, Region 6, Air Programs Branch (6T–AP), 1445 Ross Avenue, suite 700, Dallas, Texas 75202–2733.

Mr. Jerry Kurtzweg (ANR–443), U.S. Environmental Protection Agency, 401 M Street, SW., Washington, DC 20460.

Louisiana Department of Environmental Quality, Air Quality Division, 7290 Bluebonnet, Baton Rouge, Louisiana 70884.

FOR FURTHER INFORMATION CONTACT: Mr. Mark Sather, Planning Section (6T–AP), Air Programs Branch, U.S. EPA Region 6, 1445 Ross Avenue, Dallas, Texas 75202–2733, Telephone (214) 655–7258.

SUPPLEMENTARY INFORMATION: A nationwide effort is being undertaken to have sulfur dioxide (SO_2) enforceability deficiencies identified and corrected in SIPs before operating permit programs become effective. Because the operating permit programs will initially codify underlying SIP requirements, it is important that the underlying SIP is enforceable so that permits themselves will be enforceable. EPA, Region 6, provided a list of deficiencies in Chapter 15 to the State of Louisiana by cover letter dated March 13, 1991. The Region used the "SO_2 SIP Enforceability Checklist" when reviewing Chapter 15 for enforceability deficiencies. This checklist, developed by the EPA, was included as an attachment to the November 28, 1990, memorandum from Robert Bauman and Rich Biondi to the Air Branch Chiefs. This memorandum, as well as the EPA, Region 6, March 13, 1991, letter are included as attachments to the Technical Support Document. The checklist focused on the following topics: (1) Clarity; (2) averaging times consistent with protection of the SO_2 National Ambient Air Quality Standards (NAAQS); (3) clear compliance determinations; (4) continuous emissions monitoring; (5) adequate reporting and recordkeeping requirements; (6) Director's discretion issues; and (7) Stack Height issues.

The State of Louisiana filed revisions to Chapter 15 in the Louisiana Register on April 20, 1992, in order to correct enforceability deficiencies. The revisions, discussed in detail in the Technical Support Document, are briefly outlined below.

Analysis of State Submission

1. Procedural Background

The Clean Air Act (Act) requires States to observe certain procedural requirements in developing implementation plans for submission to the EPA. Section 110(a)(2) of the Act provides that each implementation plan submitted by a State must be adopted after reasonable notice and public hearing. Section 110(l) of the Act similarly provides that each revision to an implementation plan submitted by a State under the Act must be adopted by such State after reasonable notice and public hearing. The EPA also must determine whether a submittal is complete and therefore warrants further EPA review and action (see section 110(k)(1) and 57 FR 13565). The EPA's completeness criteria for SIP submittals are set out at 40 CFR part 51, appendix V (1991), as amended by 56 FR 42216 (August 26, 1991). The EPA attempts to make completeness determinations within 60 days of receiving a submission. However, a submittal is deemed complete by operation of law if a completeness determination is not made by the EPA six months after receipt of the submission.

The State of Louisiana held a public hearing on February 27, 1992, to entertain public comment on proposed revisions to Chapter 15 addressing enforceability corrections. Public comments were received and adequately addressed by the State. Following the public hearing and consideration of public comments, the SIP revision was adopted by the State and filed in the Louisiana Register on April 20, 1992. The SIP revision was submitted by the Governor to the EPA by cover letter dated August 5, 1992.

The SIP revision was reviewed by the EPA to determine completeness shortly after its submittal, in accordance with the completeness criteria set out at 40 CFR part 51, appendix V (1991). A letter dated September 29, 1992, was forwarded to the Governor indicating the completeness of the submittal and the next steps to be taken in the review process. As noted in this action, the EPA is approving this Louisiana SIP submittal to correct SO_2 enforceability deficiencies.

2. Review of Revisions to Chapter 15

The State of Louisiana revised Chapter 15 in order to correct SO_2 enforceability deficiencies. These revisions supersede the latest version of Chapter 15 which was adopted by the Louisiana Department of Environmental Quality on December 20, 1987. Please reference 54 FR 9783 (March 8, 1989). For a detailed explanation of each change to Chapter 15 being approved today, please refer to the Technical Support Document. A brief summary of the revisions is presented in the following paragraph.

The revisions to Chapter 15 strengthen the provisions. Language has been added to Chapter 15 to protect the three-hour SO_2 NAAQS, and to clearly distinguish between certain new and existing sources. Compliance determination methods were clarified, including the involvement of the EPA in the approval of equivalent test methods. Language was also added to Chapter 15 to include the EPA in the review and approval of any variances or exceptions to certain Chapter 15 provisions. Continuous emissions monitoring provisions (including performance specifications, quality assurance procedures and 40 CFR part 51, appendix P requirements), and recordkeeping and reporting requirements were also added to the regulation.

Final Action

The EPA is approving a revision to the Louisiana SIP to include revisions to LAC, Title 33, Part III, Chapter 15, entitled Emission Standards for Sulfur Dioxide. These revisions correct enforceability deficiencies and strengthen the provisions of Chapter 15. The revisions were filed in the Louisiana Register on April 20, 1992, and were submitted by the Governor to the EPA by cover letter dated August 5, 1992.

The EPA has reviewed these revisions to the Louisiana SIP and is approving them as submitted. The EPA is publishing this action without prior proposal because the Agency views this as a noncontroversial amendment and anticipates no adverse comments. This action will be effective September 13, 1993 unless, within 30 days of its publication, notice is received that adverse or critical comments will be submitted.

If such notice is received, this action will be withdrawn before the effective date by publishing two subsequent

notices. One notice will withdraw the final action and another will begin a new rulemaking by announcing a proposal of the action and establishing a comment period. If no such comments are received, the public is advised that this action will be effective September 13, 1993.

The EPA has reviewed this request for revision of the Federally-approved SIP for conformance with the provisions of the 1990 Clean Air Act Amendments enacted on November 15, 1990. The EPA has determined that this action conforms with those requirements.

Nothing in this action should be construed as permitting or allowing or establishing a precedent for any future request for revision to any SIP. Each request for revision to the SIP shall be considered separately in light of specific technical, economical, and environmental factors, and in relation to relevant statutory and regulatory requirements.

Regulatory Process

Under the Regulatory Flexibility Act, 5 U.S.C. 600 *et seq.*, the EPA must prepare a regulatory flexibility analysis assessing the impact of any proposed or final rule on small entities. 5 U.S.C. 603 and 604. Alternatively, the EPA may certify that the rule will not have a significant impact on a substantial number of small entities. Small entities include small businesses, small not-for-profit enterprises, and government entities with jurisdiction over populations of less than 50,000.

SIP approvals under section 110 and subchapter I, part D, of the Act do not create any new requirements, but simply approve requirements that the State is already imposing. Therefore, because the Federal SIP-approval does not impose any new requirements, I certify that it does not have a significant impact on any small entities affected. Moreover, due to the nature of the Federal-State relationship under the Act, preparation of a regulatory flexibility analysis would constitute Federal inquiry into the economic reasonableness of State action. The Act forbids the EPA to base its actions concerning SIPs on such grounds. *Union Electric Co.* v. *U.S. E.P.A.*, 427 U.S. 246, 256–66 (S. Ct. 1976); 42 U.S.C. 7410(a)(2).

Under section 307(b)(1) of the Act, petitions for judicial review of this action must be filed in the United States Court of Appeals for the appropriate circuit by September 13, 1993. Filing a petition for reconsideration by the Administrator of this final rule does not affect the finality of this rule for the purposes of judicial review nor does it extend the time within which a petition for judicial review may be filed, and shall not postpone the effectiveness of such rule or action. This action may not be challenged later in proceedings to enforce its requirements. (See section 307(b)(2).)

Executive Order 12291

This action has been classified as a table 2 action by the Regional Administrator under the procedures published in the **Federal Register** on January 19, 1989 (54 FR 2214–2225). On January 6, 1989, the Office of Management and Budget (OMB) waived tables 2 and 3 SIP revisions (54 FR 2222) from the requirements of section 3 of Executive Order 12291 for a period of two years. The EPA has submitted a request for a permanent waiver for table 2 and 3 SIP revisions. OMB has agreed to continue the temporary waiver until such time as it rules on the EPA's request.

List of Subjects in 40 CFR Part 52

Air pollution control, Incorporation by reference, Reporting and recordkeeping requirements, Sulfur dioxide.

Note: Incorporation by reference of the SIP for the State of Louisiana was approved by the Director of the Federal Register on July 1, 1982.

Dated: June 25, 1993.

Joe D. Winkle,

Acting Regional Administrator (6A).

40 CFR part 52 is amended as follows:

PART 52—[AMENDED]

1. The Authority citation for part 52 continues to read as follows:

Authority: 42 U.S.C. 7401–7671q.

Subpart T—Louisiana

2. Section 52.970 is amended by adding paragraph (c)(59) to read as follows:

§ 52.970 Identification of plan.

* * * * *

(c) * * *

(59) A revision to the Louisiana State Implementation Plan (SIP) to include revisions to LAC, Title 33, "Environmental Quality," Part III. Air, Chapter 15. Emission Standards for Sulfur Dioxide, effective April 20, 1992, and submitted by the Governor by cover letter dated August 5, 1992.

(i) Incorporation by reference.

(A) Revisions to LAC, Title 33, "Environmental Quality," Part III. Air, Chapter 15. Emission Standards for Sulfur Dioxide, Section 1501, "Degradation of Existing Emission Quality Restricted;" Section 1503, "Emission Limitations;" Table 4, "Emissions—Methods of Contaminant Measurement;" Section 1505, "Variances;" Section 1507, "Exceptions;" Section 1509, "Reduced Sulfur Compounds (New and Existing Sources);" Section 1511, "Continuous Emissions Monitoring;" and Section 1513, "Recordkeeping and Reporting," effective April 20, 1992.

[FR Doc. 93–16364 Filed 7–14–93; 8:45 am]

BILLING CODE 6560–50–P

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40 CFR Part 52

[OK–10–1–5798; FRL–4676–8]

Approval and Promulgation of Air Quality Implementation Plans; Oklahoma; Revision to the State Implementation Plan; Correcting Sulfur Dioxide Enforceability Deficiencies

AGENCY: U.S. Environmental Protection Agency (EPA).

ACTION: Final rule.

SUMMARY: This action approves a revision to the Oklahoma State Implementation Plan (SIP) to include revisions to Oklahoma Title 310, Chapter 200, Subchapter 31, entitled Control of Emissions of Sulfur Compounds. These revisions correct enforceability deficiencies and strengthen the provisions of Subchapter 31.

EFFECTIVE DATE: This action will become effective on September 13, 1993 unless notice is received by August 16, 1993 that someone wishes to submit adverse or critical comments. If the effective date is delayed, timely notice will be published in the **Federal Register.**

ADDRESSES: Written comments on this action should be addressed to Mr. Thomas H. Diggs, Chief, Planning Section, at the EPA Regional Office listed below. Copies of the documents relevant to this action are available for public inspection during normal business hours at the following locations. The interested persons wanting to examine these documents should make an appointment with the appropriate office at least 24 hours before the visiting day.

U.S. Environmental Protection Agency, Region 6, Air Programs Branch (6T–AP), 1445 Ross Avenue, suite 700, Dallas, Texas 75202–2733.

Mr. Jerry Kurtzweg (ANR–443), U.S. Environmental Protection Agency, 401 M Street, SW., Washington, DC 20460.

Oklahoma Air Quality Service, 1000 NE., 10th, Oklahoma City, Oklahoma 73117.

FOR FURTHER INFORMATION CONTACT: Mr. Mark Sather, Planning Section (6T–AP), Air Programs Branch, U.S. Environmental Protection Agency (EPA) Region 6, 1445 Ross Avenue, Dallas, Texas 75202–2733, Telephone (214) 655–7258.

SUPPLEMENTARY INFORMATION: A nationwide effort is being undertaken to have sulfur dioxide (SO_2) enforceability deficiencies identified and corrected in SIPs before operating permit programs become effective. Because the operating permit programs will initially codify underlying SIP requirements, it is important that the underlying SIP is enforceable so that permits themselves will be enforceable. The EPA Region 6 provided a list of deficiencies in Subchapter 31 (formerly Regulation 3.4) to the State of Oklahoma by cover letter dated March 13, 1991. The Region used the "SO_2 SIP Enforceability Checklist" when reviewing Subchapter 31 for enforceability deficiencies. This checklist, developed by the EPA, was included as an attachment to the November 28, 1990, memorandum from Robert Bauman and Rich Biondi to the Air Branch Chiefs. This memorandum, as well as the EPA Region 6 March 13, 1991, letter is included as attachments to the Technical Support Document. The checklist focused on the following topics: (1) Clarity; (2) averaging times consistent with protection of the SO_2 National Ambient Air Quality Standards; (3) clear compliance determinations; (4) continuous emissions monitoring; (5) adequate reporting and recordkeeping requirements; (6) Director's discretion issues; and (7) Stack Height issues.

The State of Oklahoma filed revisions to Subchapter 31 in the Oklahoma Register on April 9, 1993, in order to correct enforceability deficiencies. The revisions, discussed in detail in the Technical Support Document, are briefly outlined below.

Analysis of State Submission

1. Procedural Background

The Clean Air Act (CAA) requires States to observe certain procedural requirements in developing implementation plans for submission to the EPA. Section 110(a)(2) of the CAA provides that each implementation plan submitted by a State must be adopted after reasonable notice and public hearing. See also section 110(l) of the CAA. Also, the EPA must determine whether a submittal is complete, and therefore warrants further EPA review and action (see section 110(k)(1) and 57 FR 13565). The EPA's completeness criteria for SIP submittals are set out at 40 CFR part 51, appendix V (1991), as amended at 56 FR 42216 (August 26, 1991). The EPA attempts to make completeness determinations within 60 days of receiving a submission. However, a submittal is deemed complete by operation of law if a completeness determination is not made by the EPA six months after receipt of the submission.

After providing adequate notice, the State of Oklahoma held a public hearing on March 10, 1992, to entertain public comment on proposed revisions to Subchapter 31 addressing enforceability corrections. Public comments were received and adequately addressed by the State. Following the public hearing and consideration of public comments, the SIP revision was adopted by the State and filed in the Oklahoma Register on June 29, 1992, as an emergency rule. The emergency rule became a permanent rule effective June 1, 1993. The SIP revision was submitted by the Governor to the EPA by cover letter dated December 10, 1992.

The SIP revision was reviewed by the EPA to determine completeness shortly after its submittal, in accordance with the completeness criteria referenced above. A letter dated February 12, 1993, was forwarded to the Governor indicating the completeness of the submittal and the next steps to be taken in the review process. As noted in this action, the EPA is approving this Oklahoma SIP submittal to correct SO_2 enforceability deficiencies. The EPA is also approving this Oklahoma SIP submittal as a recodification of former Regulation 3.4.

2. Review of Revisions to Subchapter 31

The State of Oklahoma revised Subchapter 31 in order to correct SO_2 enforceability deficiencies. For a detailed explanation of each change to Subchapter 31 being approved in this action, please refer to the Technical Support Document. A brief summary of the revisions is presented in the following paragraph.

The revisions to Subchapter 31 strengthen the provisions. Continuous emissions monitoring provisions (including 40 CFR part 51, appendix P requirements, and 40 CFR part 60, appendix B requirements), and recordkeeping and reporting requirements were added to the regulation for certain sulfuric acid plants, fuel-burning equipment, nonferrous smelters and paper pulp mills. In addition, ambient air standards, compliance test provisions (the EPA approved test procedures and the EPA approved dispersion models) and compliance dates were clarified, and clear definitions were added regarding total reduced sulfur operations.

Final Action

The EPA is approving a revision to the Oklahoma SIP to include revisions to Oklahoma Title 310, Chapter 200, Subchapter 31, entitled Control of Emission of Sulfur Compounds. These revisions correct enforceability deficiencies and strengthen the provisions of Subchapter 31. The revisions were submitted by the Governor to the EPA by cover letter dated December 10, 1992.

The EPA has reviewed these revisions to the Oklahoma SIP and is approving them as submitted. The EPA is publishing this action without prior proposal because the Agency views this as a noncontroversial amendment and anticipates no adverse comments. This action will be effective September 13, 1993 unless, within 30 days of its publication, notice is received that adverse or critical comments will be submitted.

If such notice is received, this action will be withdrawn before the effective date by publishing two subsequent notices. One notice will withdraw the final action, and another will begin a new rulemaking by announcing a proposal of the action and establishing a comment period. If no such comments are received, the public is advised that this action will be effective September 13, 1993.

The EPA has reviewed this request for revision of the Federally-approved SIP for conformance with the provisions of the 1990 Clean Air Act Amendments enacted on November 15, 1990. The EPA has determined that this action conforms with those requirements.

Nothing in this action should be construed as permitting or allowing or establishing a precedent for any future request for revision to any SIP. Each request for revision to the SIP shall be considered separately in light of specific technical, economical, and environmental factors, and in relation to relevant statutory and regulatory requirements.

Regulatory Process

Under the Regulatory Flexibility Act, 5 U.S.C. 600 *et seq.*, the EPA must prepare a regulatory flexibility analysis assessing the impact of any proposed or final rule on small entities. 5 U.S.C. 603 and 604. Alternatively, the EPA may certify that the rule will not have a significant impact on a substantial number of small entities. Small entities include small businesses, small not-for-profit enterprises, and government

entities with jurisdiction over populations of less than 50,000

The SIP approvals under section 110 and subchapter I, part D, of the CAA do not create any new requirements, but simply approve requirements that the State is already imposing. Therefore, because the Federal SIP-approval does not impose any new requirements, I certify that it does not have a significant impact on any small entities affected Moreover, due to the nature of the Federal-State relationship under the CAA, preparation of a regulatory flexibility analysis would constitute Federal inquiry into the economic reasonableness of State action The CAA forbids the EPA to base its actions concerning SIPs on such grounds. *Union Electric Co* v. *U.S EPA*, 427 U.S. 246 256–66 (S Ct 1976), 42 U S C. 7410(a)(2)

Under section 307(b)(1) of the CAA, petitions for judicial review of this action must be filed in the United States Court of Appeals for the appropriate circuit by September 13 1993 Filing a petition for reconsideration by the Administrator of this final rule does not affect the finality of this rule for the purposes of judicial review nor does it extend the time within which a petition for judicial review may be filed, and shall not postpone the effectiveness of such a rule or action This action may not be challenged later in proceedings to enforce its requirements. (See section 307(b)(2).)

Executive Order 12291

This action has been classified as a Table 2 action by the Regional Administrator under the procedures published in the **Federal Register** on January 19 1989 (54 FR 2214–2225) On January 6 1989 the Office of Management and Budget (OMB) waived Tables 2 and 3 SIP revisions (54 FR 2222) from the requirements of section 3 of Executive Order 12291 for a period of two years The EPA has submitted a request for a permanent waiver for table 2 and 3 SIP revisions The OMB has agreed to continue the temporary waiver until such time as it rules on the EPA s request

List of Subjects in 40 CFR Part 52

Air pollution control, Incorporation by reference Reporting and recordkeeping requirements, Sulfur dioxide

Note: Incorporation by reference of the SIP for the State of Oklahoma was approved by the Director of the Federal Register on July 1 1982

Dated: June 30, 1993.

Joe D. Winkle,

Acting Regional Administrator (6A).

40 CFR part 52 is amended as follows

PART 52—[AMENDED]

1 The authority citation for part 52 continues to read as follows.

Authority: 42 U S.C. 7401–7671q.

Subpart LL—Oklahoma

2 Section 52.1920 is amended by adding paragraph (c)(43) to read as follows:

§ 52.1920 Identification of Plan.

* * * * *

(c) * * *

(43) A revision to the Oklahoma SIP to include revisions to Oklahoma Title 310 Chapter 200 Subchapter 31, entitled Control of Emissions of Sulfur Compounds.

(i) Incorporation by reference.

(A) Revisions to Oklahoma Title 310 Chapter 200, Subchapter 31 entitled Control of Emissions of Sulfur Compounds, Part 1 "General Provisions," Section 310:200–31–2, "Definitions," Section 310:200–31–3 "Performance testing," Part 3 "Existing Equipment Standards," Section 310:200–31–12, "Sulfur oxides," Section 310:200–31–13 "Sulfuric acid mist;" Section 310:200–31–14, "Hydrogen sulfide," Section 310:200–31–15 "Total reduced sulfur;" Part 5 "New Equipment Standards," Section 310.200–31–25 "Sulfur oxides," and Section 310.200–31–26 "Hydrogen sulfide," as adopted by the Oklahoma State Board of Health on March 24, 1993 and effective June 1, 1993

[FR Doc. 93–16365 Filed 7 14–93 8.45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Part 417

[OCC–015–FC]

Medicare Program, Health Maintenance Organizations: Technical Amendments

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

ACTION: Final rule with comment period

SUMMARY: This rule amends the HCFA regulations that pertain to prepaid health care to provide for uniform use of certain terms throughout part 417, simplify, clarify, and update content that pertains to the furnishing of health care services by, and the organization and operation of, Federally qualified health maintenance organizations (HMOs); and redesignate certain sections, correct internal crossreferences, and make minor conforming changes to ensure internal consistency.

These are technical and editorial changes intended not to change the substance of the rules but rather to make it easier to find particular content and to better ensure uniform understanding of the regulations.

The purpose of redesignations is to free section numbers in areas where it is necessary to insert new provisions (in logical order) to reflect changes in the Public Health Service Act.

DATES: Effective Date: These regulations are effective on July 15 1993

Comment Date Comments will be considered if we receive them at the appropriate address, as provided below, no later than 5 p m on September 13 1993

ADDRESSES: Mail written comments (four copies) to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention OCC–015–FC, P O Box 26676 Baltimore, MD 21207

If you prefer, you may deliver your comments to one of the following addresses.

Room 309–G Hubert H Humphrey Building, 200 Independence Avenue, SW , Washington, DC, or

Room 132 East High Rise Building, 6325 Security Boulevard, Baltimore Maryland

Due to staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission In commenting, please refer to file code OCC–015–FC. Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, in room 309–G of the Department s offices at 200 Independence Avenue SW , Washington DC, on Monday through Friday of each week from 8:30 a.m to 5 p.m (phone: (202) 690–7890)

FOR FURTHER INFORMATION CONTACT: Maureen Miller, (202) 619–0129

SUPPLEMENTARY INFORMATION:

A. Background

The regulations in part 417, which pertain to health maintenance organizations (HMOs), competitive medical plans (CMPs) and health care prepayment plans (HCPPs) are based

partly on the Social Security Act (the Act) and partly on the Public Health Service Act (the PHS Act). They have not been revised to reflect certain changes made in those statutes since the rules were published.

The technical and editorial changes made by this rule are part of a project to simplify, clarify, and update the whole of part 417. The first step in that project was a final rule identified as OCC–022–F, and published in the **Federal Register** on October 17, 1991, at 56 FR 51984.

OCC–022–F—

- Removed outdated content;
- Redesignated certain portions of part 417 to free section numbers needed so that new rules can be incorporated in logical order; and
- Designated the remaining text under new subpart headings to make it easier to refer to particular program aspects. Subpart and section references in this rule are based on the changes made by OCC–022–F.

B. Scope of This Rule

This rule—

- Through nomenclature and definition changes, establishes certain terms to be used uniformly throughout part 417 with the aim of precluding confusion, making clear that responsibility for the prepaid health care programs has been delegated to HCFA, and ensuring use of the most precise terms available.
- Amends § 417.106 to transfer from other sections content that is pertinent to the furnishing of services rather than to the administrative aspects of HMO functions, and to provide descriptive headings for paragraphs and paragraph subdivisions, to serve as signposts for the reader.
- Redesignates the content of § 417.107 as §§ 417.120, 417.122, 417.124, and 417.126 under a new Subpart C—Qualified Health Maintenance Organizations: Organization and Operation.
- Redesignates §§ 417.108 and 417.109 as §§ 417.168 and 417.169, under subpart F, which pertains to the continued regulation of federally qualified HMOs. As a result of these redesignations and others made by OCC–022–F, §§ 417.107 through 417.119 are freed for new rules required by changes in the statutes that govern prepaid health care services or may be required by future changes in those statutes.

This rule also corrects internal cross-references as required by the redesignation of §§ 417.110–417.137 as §§ 417.910–417.937, accomplished by OCC–022–F, of October 17, 1991.

C. Clarification and Updating

On the basis of past experience, we have determined that it is easier to find particular rules or provisions and to understand the regulations if we—

1. Use more sections so that each section deals with a particular subject or program aspect than can be adequately identified by a heading listed in the table of contents.
2. Break down long columns of text to—

a. List and designate (with numbers or letters) the several conditions or requirements; and

b. Use more paragraphs and subdivisions of paragraphs with headings.

3. Follow logical organization.
4. Are precise in our use of language, for example, define frequently used terms and never use different words to mean the same thing or the same word to mean different things.
5. Use the active voice and always specify who does what.
6. Limit the number of designation levels within each section. Two levels—(a)(1)—is ideal; four levels—(a)(1)(i)(A)—is the acceptable maximum. The greater the number of designation levels, the harder it is (in the unindented format of the **Federal Register** text) to determine which portions are subordinate to which other portions of the rules. The italicized (1) and (i) (which represent levels (5) and (6)) are almost impossible to distinguish from the nonitalicized (1) and (i) that identify levels 2 and 3.

The changes needed to update the rules include—

1. The removal of outdated content and terms.
2. Correction of references to—

a. Sections of the law that have been repealed and sections of the rules that have been moved or redesignated;

b. Organizations that have changed their names; and

c. Sources of information or benefits that have changed their addresses.

3. Using the terms that are currently used in HCFA regulations, such as "must" rather than "shall"; "HCFA" rather than "the Secretary" for authorities and responsibilities that have been delegated; and "that" rather than "which" when the term is used to limit or define.

D. Provisions of the Regulation

1. Redesignation of § 417.107

This rule redesignates the content of § 417.107 under four sections as shown in the following table:

§ 417.120 Fiscally sound operation and assumption of financial risk.
§ 417.122 Protection of enrollees.
§ 417.124 Administration and management.
§ 417.126 Recordkeeping and reporting requirements.

In redesignated § 417.124, we have made three changes that require explanation.

a. We have revised paragraph (e) to make clear that all HMOs (including those that do not ordinarily offer individual enrollment) must offer individual enrollment to any enrollee who—

- Leaves an enrolled group; or
- Ceases being eligible for enrollment as a dependent because of his or her age or the death or divorce of the subscriber.

This clarification is for the benefit of HMOs which interpreted that the provision does not apply to them because they do not ordinarily offer individual enrollment. The revised language is consistent with the preamble discussion of the original provision, which was then designated as paragraph (g) of § 110.108 of the PHS regulations (before transfer of the HMO rules to the HCFA regulations by a final rule published on September 7, 1987, at 52 FR 36746).

Section 110.108(g) was first proposed in an NPRM published on September 11, 1978, at 43 FR 40383. The final rule was published on July 18, 1979, at 44 FR 42069. The preamble to the final rule does not indicate that there were any comments on the provision. However, item 29 (page 42063) stated:

> "29. The language of § 110.108(g), which refers to the conversion of membership, is retained. The Secretary notes that, even if the HMO as a general practice does not offer individual membership, it must arrange for a member of a group who so chooses, to remain as an HMO member when leaving the group. However, an HMO is allowed to establish a rate differential for individual members under its community rating system."

b. We have removed the content of paragraph (f) because the requirement that at least one third of the members of the policymaking body of a private HMO or the advisory board of a public HMO be enrollees, previously contained in section 1301(c)(5) of the PHS Act, was repealed by section 5(b) of the HMO Amendments of 1988 (Pub. L. 100–517).

c. Section 417.124(h), Certification of institutional providers, differs from the previous § 417.107(i) that it redesignates and revises. The revised section specifies the four kinds of certificates that HCFA may issue under recently revised regulations that govern licensing of laboratories.[1] Laboratories were required to register under the Clinical

[1] A fifth type of certificate, for physicians who do microscopy tests, will be added when it is established by final rule.

Laboratory Improvement Amendments Act (CLIA) by September 1, 1992. Although HCFA continues to pay Medicare claims, any such payments to unregistered laboratories may be subject to recoupment. Laboratories that file claims after September 1 1992, are being notified of the need to register if they have not already done so.

In redesignated § 417.126(b), we have changed from 180 days to 120 days (after the end of the fiscal year) the period during which an HMO must submit certain reports. This change conforms the rule to administrative practice that has been in effect for several years. Under the Health Maintenance Organization National Data Reporting Requirements (NDRR) (Form HCFA–906), annual reports must be submitted within 120 days of the end of the fiscal year. This requirement has been in effect since 1986 (the effective date of the current form), without objection by the HMOs subject to the deadline

2. Revision of § 417 436 Rules for Enrollees

This rule revises § 417 436 to restore content that was unintentionally removed by a final rule identified as BPD–718–IFC, and published in the **Federal Register** on March 6, 1992, at 57 FR 8194

3 General Approach in Presenting the Rules

Each of the sections that required changes is presented in one of the three portions of the rules text, so that readers and users can, by looking in one place, determine all the changes made in a particular section. The first portion of the rules (referred to as the "Body") presents those sections of part 417 that could be updated and clarified only through changes that go beyond correction of cross-references and changes in terminology. The second portion of the rules (identified as "Technical Amendments") presents the changes made in those sections that required technical and editorial changes in addition to the basic nomenclature changes. The final portion specifies the nomenclature changes for those sections that are not included in the "Body" or under "Technical Amendments".

This final portion gives specific locations for nomenclature changes except—

- Change from "Public Health Service Act" to "PHS Act"—which is made uniformly throughout part 417, and
- Change from "the Secretary" to "HCFA"—which is made uniformly throughout part 417, except in subpart V.

This exception means that a section that had only one or both of these nomenclature changes does not appear in the rules text However, for sections presented under "Technical Amendments", all nomenclature changes are also shown, and for sections included in the "Body", both technical amendments and nomenclature changes are shown.

For the convenience of the reader, the revised table of contents of part 417 is set forth below, with marginal notations to indicate in which portion of the rules each section is covered:

"Nomen"—indicates a section that required only nomenclature changes and is therefore covered in the final portion of the rules text.

"Tech."—indicates that the section required technical amendments as well as nomenclature changes and is presented in the middle portion of the rules.

"Body" identifies the section as one requiring changes that go beyond technical amendments and nomenclature changes and is therefore presented in the first portion of the rules.

"No change" refers to sections that are not covered at all in the rules, including sections that had only the nomenclature changes excepted above.

PART 417—HEALTH MAINTENANCE ORGANIZATIONS, COMPETITIVE MEDICAL PLANS, AND HEALTH CARE PREPAYMENT PLANS

Subpart A—General Provisions

Sec.
Body 417.1 Definitions.
Nomen 417 2 Basis and scope.

Subpart B—Qualified Health Maintenance Organizations: Services

Tech. 417.101 Health benefits plan: Basic health services.
Nomen 417.102 Health benefits plan: Supplemental health services.
Nomen 417 103 Providers of basic and supplemental health services.
Nomen 417.104 Payment for basic health services.
Nomen 417.105 Payment for supplemental health services.
Body 417.106 Quality assurance program; availability, accessibility, and continuity of basic and supplemental health services.

Subpart C—Qualified Health Maintenance Organizations: Organization and Operation

Body 417.120 Fiscally sound operation and assumption of financial risk.
Body 417.122 Protection of enrollees.
Body 417.124 Administration and management.
Body 417.126 Recordkeeping and reporting requirements.

Subpart D—Application for Federal Qualification

Body 417 140 Applicability
Body 417.141 Definitions.
Body 417 142 Requirements for qualification.
Tech. 417 143 Application requirements.
Tech. 417.144 Evaluation and determination of qualification.

Subpart E—Inclusion of Qualified Health Maintenance Organizations in Employee Health Benefits Plans

Tech. 417 150 Definitions.
Tech. 417.151 Applicability
Tech. 417.152 Requirements for a request for inclusion of the HMO option in a health benefits plan; employing entity response.
Tech. 417.153 Offer of HMO option to employees.
Tech. 417 154 HMOs that must be included in a health benefits plan.
Tech. 417 155 How the HMO option is to be included in the health benefits plan.
Nomen 417.156 When the HMO is to be offered to employees.
Tech. 417.157 Contributions for HMO option.
Nomen 417 158 Payroll deductions.
Tech. 417.159 Relationship of section 1310 of the PHS Act to the National Labor Relations Act, and the Railway Labor Act.

Subpart F—Continued Health Maintenance

Body 417.160 Purpose and applicability
Body 417 161 Compliance with assurances.
Body 417 162 Reporting requirements.
Tech. 417.163 Enforcement procedures.
Tech. 417 164 Effect of revocation of qualification for purposes of section 1310 of the PHS Act.
Tech. 417.165 Reapplication for qualification.
Nomen 417 166 Waiver of assurances.
Body 417.168 Special requirements: Titles XVIII and XIX of the Social Security Act.
Body 417.169 Special requirements: Federal employee health benefits program.

Subpart G—[Reserved]

Subpart H—[Reserved]

Subpart I—[Reserved]

Subpart J—Qualifying Conditions for Medicare Contracts

Tech. 417 400 Basis and scope.
Body 417 401 Definitions.
Body 417 402 Effective date of initial regulations.
Tech. 417 404 Introduction.
Tech. 417 406 Application and determination.
Tech. 417 407 Definitions of HMO and CMP.
Tech. 417 408 Contract application process.
Tech. 417 410 Qualifying conditions: General.
Nomen 417 412 Qualifying condition: Administration and management.
Nomen 417 413 Qualifying condition: Operating experience and enrollment.

Nomen 417.656 Notice of reconsidered determination.
No change 417.658 Effect of reconsidered determination.
Nomen 417.660 Right to a hearing.
Nomen 417.662 Request for hearing.
Nomen 417.664 Postponement of effective date of initial determination.
No change 417.666 Designation of hearing officer.
No change 417.668 Disqualification of hearing officer.
Tech. 417.670 Time and place of hearing.
Nomen 417.672 Appointment of representatives.
No change 417.674 Authority of representatives.
No change 417.676 Conduct of hearing.
No change 417.678 Evidence.
No change 417.680 Witnesses.
No change 417.682 Discovery.
No change 417.684 Prehearing.
No change 417.686 Record of hearing.
No change 417.688 Authority of hearing officer.
No change 417.690 Notice and effect of hearing decision.
No change 417.692 Reopening of initial or reconsidered determination or decision of a hearing officer.
No change 417.694 Effect of revised determination.

Subpart S—[Reserved]

Subpart T—[Reserved]

Subpart U—Health Care Prepayment Plans

Tech. 417.800 Reimbursement of health care prepayment plans; definitions and basic rule.
Tech. 417.801 Agreements between HCFA and health care prepayment plans.
Tech. 417.802 Allowable costs.
No change 417.804 Cost apportionment.
Tech. 417.806 Financial records, statistical data, and cost finding.
No change 417.808 Interim per capita payments.
Tech. 417.810 Final settlement.

Subpart V—Administration of Outstanding Loans and Loan Guarantees

Body 417.910 Scope and applicability.
Body 417.911 Definitions.
Tech. 417.912 Requirements for applications.
Tech. 417.913 Standards and procedures for review and comment by the appropriate health systems agency or State health planning and development agency.
No change 417.914 Additional conditions.
Nomen 417.915 Confidentiality requirements.
No change 417.916 Purposes for which grant funds may be used.
Tech. 417.917 Effect of a grantee's failure to become or to remain a qualified HMO.
Tech. 417.918 Obligation of the Federal Government to continue support for an approved project.
Nomen 417.919 Effect of a grantee's change from non-profit to for-profit status.
Body 417.920 Planning and initial development.
Tech. 417.921 Eligible applicants.
Tech. 417.922 Project elements for planning.
Tech. 417.923 Project elements for initial development.
Tech. 417.924 Funding duration and limitation.
Tech. 417.925 Evaluation and award: Planning and initial development.
Tech. 417.926 Loan guarantee provisions.
Body 417.930 Initial costs of operation.
Tech. 417.931 Definitions.
Tech. 417.932 Eligible applicants and projects: Initial costs of operation.
Tech. 417.933 Project elements for initial costs of operation.
Nomen 417.934 Reserve requirement.
Tech. 417.935 Evaluation and award: Initial costs of operation.
Tech. 417.936 Funding duration limitation.
Tech. 417.937 Loan provisions.

Waiver of Proposed Rulemaking

Most of the changes made by this rule are technical and editorial in nature, and aim to simplify, clarify, and update subparts B and C of part 417 of the HMO regulations, without substantive change. The removal of the requirement that ⅓ of the members of the policymaking or advisory body be HMO enrollees simply conforms to the statutory repeal of the requirement. The change in the deadline for submitting reports is substantive, but as noted above, all affected parties had notice of, and have acquiesced in, the 120-day deadline for at least 6 years.

Accordingly, we find that notice and opportunity for public comment are unnecessary and that there is good cause to waive proposed rulemaking procedures.

However, as previously indicated, we will consider timely comments from anyone who believes that, in making the technical and editorial changes, we have unintentionally altered the substance, or who objects to the change in the reporting deadline. Although we cannot respond to comments individually, if we change these rules as a result of comments, we will discuss all timely comments in the preamble to the revised rules.

Regulatory Impact Statement

Executive Order 12291

Executive Order 12291 requires us to prepare and publish a regulatory impact analysis for any rule that will have an economic impact of $100 million or more, cause a major increase in costs or prices, or meet other thresholds specified in section 1(b) of the order.

We have determined that a regulatory impact analysis is not required because it is obvious that this rule will have no discernible economic effect.

Regulatory Flexibility Analysis

Consistent with the Regulatory Flexibility Act (RFA) and section 1102(b) of the Social Security Act, we prepare a regulatory flexibility analysis for each rule, unless the Secretary certifies that the particular rule will not have a significant economic impact on a substantial number of small entities, or a significant impact on the operation of a substantial number of small rural hospitals.

We have not prepared a regulatory flexibility analysis because we have determined, and the Secretary certifies, that these rules will not have a significant impact on a substantial number of small entities or on the operation of a substantial number of small rural hospitals.

Paperwork Reduction Act

Sections 417.120, 417.122, 417.124, and 417.126 contain information collection requirements subject to review by the Office of Management and Budget under the Paperwork Reduction Act of 1980. The reporting and recordkeeping requirements include such things as general reporting and disclosure requirements, financial and marketing plans, and reporting under specified statutes. These requirements, which have been in effect for several years, currently are approved under OMB number 0938–0472.

We estimate that the financial plan requirement involves about 200 respondents and each requires about 8 hours to develop the plan. For "full and fair disclosure", which relates to marketing, all Federally qualified HMOs (about 350) are involved, and the time required is also 8 hours per respondent. General reporting and disclosure is required of all 350 HMOs, but can be accomplished in about 6 hours. Reporting under ERISA also involves all HMOs but requires only about 1 hour per respondent. For reports on significant business transactions, we estimate that there will be only 50 respondents who can prepare their reports in 1 hour.

If you comment on these information collection requirements, please send a copy of your comments directly to: Office of Information and Regulatory Affairs, Office of Management and Budget, room 3001, New Executive Office Bldg., Washington, DC 20503, Attention: Allison Herron Eydt, Desk Officer for HCFA.

List of Subjects in 42 CFR Part 417

Administrative practice and procedure, Health maintenance organizations (HMO), Medicare.

Derivation Table for 42 CFR Part 417, Subparts B and C

New section	Old section
Subpart B	
417.106(a)	417.107(h)
417.106(c)(3)	417.107(l)
417.106(d)	417.107(k)
Subpart C	
417.120	417.107 (a)(1) (i)–(iii), (v) & (vi) and (b)
417.122	417.107 (a)(1)(iv) and (a)(3)
417.124	417.107 (a)(2), (c)–(e), and (g)–(i)
417.126	417.107(j)–(m)

42 CFR part 417 is amended as set forth below:

PART 417—HEALTH MAINTENANCE ORGANIZATIONS, COMPETITIVE MEDICAL PLANS, AND HEALTH CARE PREPAYMENT PLANS

A. The authority citation for part 417 is revised to read as follows:

Authority: Secs. 1102, 1833(a)(1)(A), 1861(s)(2)(H), 1871, 1874, and 1876 of the Social Security Act (42 U.S.C. 1302, 13951(a)(1)(A), 1395x(s)(2)(H), 1395hh, 1395kk, and 1395mm); section 114(c) of Public Law 97–248 (42 U.S.C. 1395mm note); secs. 1301 through 1318 of the Public Health Service Act (42 U.S.C. 300e through 300e–17) unless otherwise noted.

B. Subpart A is amended as follows:

Subpart A—General Provisions

1. Section 417.1 is amended to revise the introductory text; remove the definitions of *HCFA* and *Member;* insert, in alphabetical order, a definition of *Enrollee;* and revise the definitions of *Community rating system, Health maintenance organization, Individual practice association, Medical group, Medically underserved population, Policymaking body, Qualified HMO, Service area, Staff of the HMO, Subscriber,* and *Unusual or infrequently used health services* to read as follows:

§ 417.1 Definitions.

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

* * * * *

Community rating system means a system of fixing rates of payments for health services that meets the requirements of § 417.104(a)(3).

* * * * *

Enrollee means an individual for whom an HMO, CMP, or HCPP assumes the responsibility, under a contract or agreement, for the furnishing of health care services on a prepaid basis.

* * * * *

Health maintenance organization (HMO) means a legal entity that provides or arranges for the provision of basic and supplemental health services to its enrollees in the manner prescribed by, is organized and operated in the manner prescribed by, and otherwise meets the requirements of, section 1301 of the PHS Act and the regulations in subparts B and C of this part, and §§ 417.168 and 417.169.

* * * * *

Individual practice association (IPA) means a partnership, association, corporation, or other legal entity that delivers or arranges for the delivery of health services and which has entered into written services arrangement or arrangements with health professionals, a majority of whom are licensed to practice medicine or osteopathy. The written services arrangement must provide:

(1) That these health professionals will provide their professional services in accordance with a compensation arrangement established by the entity; and

(2) To the extent feasible, for the sharing by these health professionals of health (including medical) and other records, equipment, and professional, technical, and administrative staff.

Medical group means a partnership, association, corporation, or other group:

(1) That is composed of health professionals licensed to practice medicine or osteopathy and of such other licensed health professionals (including dentists, optometrists, and podiatrists) as are necessary for the provision of health services for which the group is responsible;

(2) A majority of the members of which are licensed to practice medicine or osteopathy; and

(3) The members of which:

(i) After the end of the 48 month period beginning after the month in which the HMO for which the group provides health services becomes a qualified HMO, as their principal professional activity (over 50 percent individually) engage in the coordinated practice of their profession and as a group responsibility have substantial responsibility (over 35 percent in the aggregate of their professional activity) for the delivery of health services to enrollees of an HMO;

(ii) Pool their income from practice as members of the group and distribute it among themselves according to a prearranged salary or drawing account or other similar plan unrelated to the provision of specific health services;

(iii) Share health (including medical) records and substantial portions of major equipment and of professional, technical, and administrative staff;

(iv) Establish an arrangement whereby an enrollee's enrollment status is not known to the health professional who provides health services to the enrollee.

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Medically underserved population means the population of an urban or rural area as described in Sec. 417.912(d).

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Policymaking body of an HMO means a board of directors, governing body, or other body of individuals that has the authority to establish policy for the HMO.

Qualified HMO means an HMO found by HCFA to be qualified within the meaning of section 1310 of the PHS Act and subpart D of this part.

* * * * *

Service area means the geographic area as defined through zip codes, census tracts, or other geographic subdivisions, found by HCFA to be the area within which the HMO provides or arranges for basic and supplemental health services that are available and accessible to its enrollees as required by section 1301(b)(4) of the PHS Act.

* * * * *

Staff of the HMO means health professionals who are employees of the HMO and who—

(1) Provide services to HMO enrollees at an HMO facility subject to the staff policies and operational procedures of the HMO;

(2) Engage in the coordinated practice of their profession and provide to enrollees of the HMO the health services that the HMO has contracted to provide;

(3) Share medical and other records, equipment, and professional, technical, and administrative staff of the HMO; and

(4) Provide their professional services in accordance with a compensation arrangement, other than fee-for-service, established by the HMO. This arrangement may include, but is not limited to, fee-for-time, retainer or salary.

Subscriber means an enrollee who has entered into a contractual relationship with the HMO or who is responsible for making payments for basic health services (and contracted for supplemental health services) to the HMO or on whose behalf these payments are made.

* * * * *

Unusual or infrequently used health services means:

(1) Those health services that are projected to involve fewer than 1 percent of the encounters per year for the entire HMO enrollment, or,

(2) Those health services the provision of which, given the enrollment projection of the HMO and generally accepted staffing patterns, is projected will require less than 0.25 full time equivalent health professionals.

C. Subpart B is amended as follows:

1. The heading of subpart B is revised to read as follows:

Subpart B—Qualified Health Maintenance Organizations: Services

2. Section 417.106 is revised to read as follows:

§ 417.106 Quality assurance program; Availability, accessibility, and continuity of basic and supplemental health services.

(a) *Quality assurance program.* Each HMO or CMP must have an ongoing quality assurance program for its health services that meets the following conditions:

(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 change.

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

(b) *Availability and accessibility of health care services.* Basic health services and those supplemental health services for which enrollees have contracted must be provided or arranged for by the HMO in accordance with the following rules:

(1) Except as provided in paragraph (b)(2) of this section, the services must be available to each enrollee within the HMO's service area.

(2) *Exception.* If the HMO's service area is located wholly within a nonmetropolitan area, the HMO may make available outside its service area any basic health service that is not a primary care or emergency care service, if the number of providers of that basic health service who will provide the service to the HMO's enrollees is insufficient to meet the demand. As used in this paragraph, primary care includes general practice, family practice, general internal medicine, general pediatrics, and general obstetrics and gynecology. An HMO that provides the services covered by these fields through at least a general or family practitioner, or a pediatrician and a general internist, is considered to be providing primary care.

(3) The services must be available and accessible with reasonable promptness to each of the HMO's enrollees as ensured through—

(i) Staffing patterns within generally accepted norms for meeting the projected enrollment needs; and

(ii) Geographic location, hours of operation, and arrangements for after-hours services. (Medically necessary emergency services must be available 24 hours a day, 7 days a week.)

(c) Continuity of care. The HMO must ensure continuity or care through arrangements that include but are not limited to the following:

(1) Use of a health professional who is primarily responsible for coordinating the enrollee's overall health care.

(2) A system of health and medical records that accumulates pertinent information about the enrollee's health care and makes it available to appropriate professionals.

(3) Arrangements made directly or through the HMO's providers to ensure that the HMO or the health professional who coordinates the enrollee's overall health care is kept informed about the services that the referral resources furnish to the enrollee.

(d) *Confidentiality of health records.* Each HMO must establish adequate procedures to ensure the confidentiality of the health and medical records of its enrollees.

§ 417.107 [Reserved].

3. Section 417.107 is removed and reserved.

§§ 417.108 and 417.109 [Redesignated as §§ 417.168 and 417.169]

4. Sections 417.108 and 417.109 are redesignated under subpart F as §§ 417.168 and 417.169, respectively.

D. A new subpart C, containing §§ 417.120, 417.122, 417.124, and 417.126 is added to read as follows.

Subpart C—Qualified Health Maintenance Organizations: Organization and Operation

Sec.

Subpart C—Qualified Health Maintenance Organizations: Organization and Operation

§ 417.120 Fiscally sound operation and assumption of financial risk.

(a) *Fiscally sound operation—(1) General requirements.* Each HMO must have a fiscally sound operation, as demonstrated by the following:

(i) Total assets greater than total unsubordinated liabilities. In evaluating assets and liabilities, loan funds awarded or guaranteed under section 1306 of the Public Health Service Act are not included as liabilities.

(ii) Sufficient cash flow and adequate liquidity to meet obligations as they become due.

(iii) A net operating surplus, or a financial plan that meets the requirements of paragraph (a)(2) of this section.

(iv) An insolvency protection plan that meets the requirements of § 417.122(b) for protection of enrollees.

(v) A fidelity bond or bonds, procured and maintained by the HMO, in an amount fixed by its policymaking body but not less than $100,000 per individual, covering each officer and employee entrusted with the handling of its funds. The bond may have reasonable deductibles, based upon the financial strength of the HMO.

(vi) Insurance policies or other arrangements, secured and maintained by the HMO and approved by HCFA to insure the HMO against losses arising from professional liability claims, fire, theft, fraud, embezzlement, and other casualty risks.

(2) *Financial plan requirement.* (i) If an HMO has not earned a cumulative net operating surplus during the three most recent fiscal years, did not earn a net operating surplus during the most recent fiscal year or does not have positive net worth, the HMO must submit a financial plan satisfactory to HCFA to achieve net operating surplus within available fiscal resources.

(ii) This plan must include—

(A) A detailed marketing plan;

(B) Statements of revenue and expense on an accrual basis;

(C) Sources and uses of funds statements; and

(D) Balance sheets.

(b) *Assumption of financial risk.* Each HMO must assume full financial risk on a prospective basis for the provision of basic health services, except that it may obtain insurance or make other arrangements as follows:

(1) For the cost of providing to any enrollee basic health services with an aggregate value of more than $5,000 in any year.

(2) For the cost of basic health services obtained by its enrollees from sources other than the HMO because medical necessity required that they be furnished before they could be secured through the HMO.

(3) For not more than 90 percent of the amount by which its costs for any of its fiscal years exceed 115 percent of its income for that fiscal year.

(4) For physicians or other health professionals, health care institutions, or any other combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for their furnishing of basic health services to the HMO's enrollees.

§ 417.122 Protection of enrollees.

(a) *Liability protection.* (1) Each HMO must adopt and maintain arrangements satisfactory to HCFA to protect its enrollees from incurring liability for payment of any fees that are the legal obligation of the HMO. These arrangements may include any of the following:

(i) Contractual arrangements that prohibit health care providers used by the enrollees from holding any enrollee liable for payment of any fees that are the legal obligation of the HMO.

(ii) Insurance, acceptable to HCFA.

(iii) Financial reserves, acceptable to HCFA, that are held for the HMO and restricted for use only in the event of insolvency.

(iv) Any other arrangements acceptable to HCFA.

(2) The requirements of this paragraph do not apply to an HMO if HCFA determines that State law protects the HMO enrollees from liability for payment of any fees that are the legal obligation of the HMO.

(b) *Protection against loss of benefits if the HMO becomes insolvent.* The insolvency protection plan required under § 417.120(a) must provide for continuation of benefits as follows:

(1) For all enrollees, for the duration of the contract period for which payment has been made.

(2) For enrollees who are in an inpatient facility on the date of insolvency, until they are discharged from the facility.

§ 417.124 Administration and management.

(a) *General requirements.* Each HMO must have administrative and managerial arrangements satisfactory to HCFA, as demonstrated by at least the following:

(1) A policymaking body that exercises oversight and control over the HMO's policies and personnel to ensure that management actions are in the best interest of the HMO and its enrollees.

(2) Personnel and systems sufficient for the HMO to organize, plan, control and evaluate the financial, marketing, health services, quality assurance program, administrative and management aspects of the HMO.

(3) At a minimum, management by an executive whose appointment and removal are under the control of the HMO's policymaking body.

(b) *Full and fair disclosure*—(1) *Basic rule.* Each HMO must prepare a written description of the following:

(i) Benefits (including limitations and exclusions).

(ii) Coverage (including a statement of conditions on eligibility for benefits).

(iii) Procedures to be followed in obtaining benefits and a description of circumstances under which benefits may be denied.

(iv) Rates.

(v) Grievance procedures.

(vi) Service area.

(vii) Participating providers.

(viii) Financial condition including at least the following most recently audited information: Current assets, other assets, total assets; current liabilities, long term liabilities; and net worth.

(2) *Requirements for the description.* (i) The description must be written in a way that can be easily understood by the average person who might enroll in the HMO.

(ii) The description of benefits and coverage may be in general terms if reference is made to a detailed statement of benefits and coverage that is available without cost to any person who enrolls in the HMO or to whom the opportunity for enrollment is offered.

(iii) The HMO must provide the description to any enrollee or person who is eligible to elect the HMO option and who requests the material from the HMO or the administrator of a health benefits plan. For purposes of this requirement, "administrator" (of a health benefits plan) has the meaning it is given in the Employment Retirement Income Security Act of 1974 (ERISA) at 29 U.S.C. 1002(16)(A).

(iv) If the HMO provides health services through individual practice associations (IPAs), the HMO must specify the number of member physicians by specialty, and a listing of the hospitals where HMO enrollees will receive basic and supplemental health services.

(v) If the HMO provides health services other than through IPAs, the HMO must specify, for each ambulatory care facility, the facility's address, days and hours of operation, and the number of physicians by specialty, and a listing of the hospitals where HMO enrollees will receive basic and supplemental health services.

(c) *Broadly representative enrollment.* (1) Each HMO must offer enrollment to persons who are broadly representative of the various age, social, and income groups within its service area.

(2) If an HMO has a medically underserved population located in its service area, not more than 75 percent of its enrollees may be from the medically underserved population unless the area in which that population resides is a rural area.

(d) *Health status and enrollment.* (1) The HMO may not, on the basis of health status, health care needs, or age of the individual—

(i) Expel or refuse to reenroll any enrollee; or

(ii) Refuse to enroll individual members of a group.

(2) For purposes of this paragraph, a "group" is composed of individuals who enroll in the HMO under a contract or other arrangement that covers two or more subscribers. Examples of groups are employees who enroll under a contract between their employer and the HMO, or members of an organization that arranges coverage for its membership.

(3) Nothing in this subpart prohibits an HMO from requiring that, as a condition for continued eligibility for enrollment, enrolled dependent children, upon reaching a specified age, convert to individual enrollment, consistent with paragraph (e) of this section.

(e) *Conversion of enrollment.* (1) Each HMO must offer individual enrollment to the following:

(i) Each enrollee (and his or her enrolled dependents) leaving a group.

(ii) Each enrollee who would otherwise cease to be eligible for HMO enrollment because of his or her age, or the death or divorce of an enrollee.

(2) The individual enrollment offered must meet the conditions of subpart B of this part and this subpart C.

(3) The HMO is not required to offer individual enrollment except to the enrollees specified in this paragraph.

(f) [Reserved]

(g) *Grievance procedures.* Each HMO must have and use meaningful procedures for hearing and resolving grievances between the HMO's enrollees and the HMO, including the HMO staff and medical groups and IPAs that furnish services. These procedures must ensure that:

(1) Grievances and complaints are transmitted in a timely manner to appropriate HMO decisionmaking levels

that have authority to take corrective action; and

(2) Appropriate action is taken promptly, including a full investigation if necessary and notification of concerned parties as to the results of the HMO's investigation.

(h) *Certification of institutional providers.* Each HMO must ensure that its affiliated institutional providers meet one of the following conditions:

(1) In the case of hospitals, are either accredited by the Joint Commission on Accreditation of Health Care Organizations, or certified by Medicare.

(2) In the case of laboratories, are either CLIA-exempt, or have in effect a valid certificate of one of the following types, issued by HCFA in accordance with section 353 of the PHS Act and part 493 of this chapter:

(i) Registration certificate.

(ii) Certificate.

(iii) Certificate of waiver.

(iv) Certificate of accreditation.

(3) In the case of other affiliated institutional providers, are certified for participation in Medicare and Medicaid in accordance with part 405, 416, 418, 488, or 491 of this chapter, as appropriate.

§ 417.126 Recordkeeping and reporting requirements.

(a) *General reporting and disclosure requirements.* Each HMO must have an effective procedure to develop, compile, evaluate, and report to HCFA, to its enrollees, and to the general public, at the times and in the manner that HCFA requires, and while safeguarding the confidentiality of the doctor-patient relationship, statistics and other information with respect to the following:

(1) The cost of its operations.

(2) The patterns of utilization of its services.

(3) The availability, accessibility, and acceptability of its services.

(4) To the extent practical, developments in the health status of its enrollees.

(5) Information demonstrating that the HMO has a fiscally sound operation.

(6) Other matters that HCFA may require.

(b) *Significant business transactions.* Each HMO must report to HCFA annually, within 120 days of the end of its fiscal year (unless for good cause shown, HCFA authorizes an extension of time), the following:

(1) A description of significant business transactions (as defined in paragraph (c) of this section) between the HMO and a party in interest.

(2) With respect to those transactions—

(i) A showing that the costs of the transactions listed in paragraph (c) of this section do not exceed the costs that would be incurred if these transactions were with someone who is not a party in interest; or

(ii) If they do exceed, a justification that the higher costs are consistent with prudent management and fiscal soundness requirements.

(3) A combined financial statement for the HMO and a party in interest if either of the following conditions is met:

(i) Thirty-five percent or more of the costs of operation of the HMO go to a party in interest.

(ii) Thirty-five percent or more of the revenue of a party in interest is from the HMO.

(c) *"Significant business transaction" defined.* As used in paragraph (b) of this section—

(1) Business transaction means any of the following kinds of transactions:

(i) Sale, exchange or lease of property.

(ii) Loan of money or extension of credit.

(iii) Goods, services, or facilities furnished for a monetary consideration, including management services, but not including—

(A) Salaries paid to employees for services performed in the normal course of their employment; or

(B) Health services furnished to the HMO's enrollees by hospitals and other providers, and by HMO staff, medical groups, or IPAs, or by any combination of those entities.

(2) *Significant business transaction* means any business transaction or series of transactions of the kind specified in paragraph (c)(1) of this section that, during any fiscal year of the HMO, have a total value that exceeds $25,000 or 5 percent of the HMO's total operating expenses, whichever is less.

(d) *Requirements for combined financial statements.* (1) The combined financial statements required by paragraph (b)(3) of this section must display in separate columns the financial information for the HMO and each of these parties in interest.

(2) Inter-entity transactions must be eliminated in the consolidated column.

(3) These statements must have been examined by an independent auditor in accordance with generally accepted accounting principles, and must include appropriate opinions and notes.

(4) Upon written request from an HMO showing good cause, HCFA may waive the requirement that its combined financial statement include the financial information required in this paragraph (d) with respect to a particular entity.

(e) *Reporting and disclosure under ERISA.* (1) For any employees' health benefits plan that includes an HMO in its offerings, the HMO must furnish, upon request, the information the plan needs to fulfill its reporting and disclosure obligations (with respect to the particular HMO) under the Employee Retirement Income Security Act of 1974 (ERISA).

(2) The HMO must furnish the information to the employer or the employer's designee, or to the plan administrator, as the term "administrator" is defined in ERISA.

E. Subpart D is amended as set forth below:

Subpart D—Application for Federal Qualification

1. Sections 417.140 and 417.141 are revised to read as follows:

§ 417.140 Applicability.

The regulations in this subpart apply to any entity seeking a determination by HCFA, under section 1310(d) of the PHS Act, that it is a qualified health maintenance organization (HMO).

§ 417.141 Definitions.

As used in this subpart—

Operational qualified HMO means an HMO that HCFA has determined provides basic and supplemental health services to all of its enrollees in accordance with subpart B of this part and §§ 417.168 and 417.169, and is organized and operated in accordance with subpart C of this part and §§ 417.168 and 417.169.

Preoperational qualified HMO means an entity that HCFA has determined will, when it becomes operational, be a qualified HMO.

Transitionally qualified HMO means an entity that operates a prepaid health care delivery system and that HCFA has determined meets the requirements of § 417.142(b). A transitionally qualified HMO is considered a "qualified HMO" for the purpose of compliance by an employer with the requirements of section 1310 of the PHS Act and subpart E of this part. Under these requirements, the employer must include the HMO in its health benefits plan so long as the HMO's qualification has not been revoked under section 1312(b) of the PHS Act and § 417.163(d).

2. Section 417.142 is revised to read as follows:

§ 417.142 Requirements for qualification.

On the basis of an application submitted in accordance with this subpart and any additional information and investigation (including site visits) that HCFA may require:

(a) HCFA determines that the applicant is an operational qualified

HMO if HCFA finds that the applicant meets the requirements of subparts B and C of this part and §§ 417.168 and 417.169, and the applicant provides written assurances satisfactory to HCFA, within 30 days of the date of HCFA's determination, that it:

(1) Provides and will provide basic health services (and any contracted for supplemental health services) to its enrollees;

(2) Provides and will provide these services in the manner prescribed by section 1301(b) of the PHS Act and subpart B of this part and §§ 417.168 and 417.169;

(3) Is organized and operated, and will continue to be organized and operated, in the manner prescribed by section 1301(c) of the PHS Act and subpart C of this part and §§ 417.168 and 417.169;

(4) Under arrangements that safeguard the confidentiality of patient information and records, will provide access to HCFA and the Comptroller General or any of their duly authorized representatives for the purpose of audit, examination or evaluation to any books, documents, papers, and records of the entity relating to its operations as an HMO, and to any facilities operated by the entity; and

(5) Will continue to comply with any other assurances that the entity has given to HCFA.

(b) HCFA may determine that an applicant is a transitionally qualified HMO upon finding that it currently is organized and is providing prepaid health services as described in this paragraph and if it provides written assurances satisfactory to HCFA, within 30 days of the date of HCFA's determination, that it will:

(1) With respect to all new group and individual (nongroup) contracts that it enters into after the date of HCFA's determination, provide basic health services (and any contracted for supplemental health services) to enrollees enrolled under these contracts and will provide these services in the manner prescribed by subpart B of this part and §§ 417.168 and 417.169, and with respect to these enrollees will be organized and operated in accordance with subpart C of this part and §§ 417.168 and 417.169.

(2) With respect to its group and individual contracts that are in effect on the date of HCFA's determination and that are renewed or renegotiated during the period approved by HCFA under paragraph (b)(2)(iii) of this section in accordance with the plan so approved:

(i) Provide at least those services specified in the following sections (except that these services may be limited as to time and cost):

§ 417.101(a)(1) (physician services);

§ 417.101(a)(2) (outpatient services and inpatient hospital services) except that inpatient hospital services or outpatient services by a hospital, or both, need not be provided, or paid for by the HMO if the HMO can show that these services are, or insurance for these services is, being provided through arrangements made by entities other than the HMO;

§ 417.101(a)(3) (medically necessary emergency health services); and

§ 100.102(a)(6) (diagnostic laboratory and diagnostic and therapeutic radiologic services);

(ii) Be organized and operated in accordance with subpart C of this part and §§ 417.68 and 417.69, except that—

(A) It need not assume full financial risk for the provision of basic health services as required by § 417.120(b); and

(B) It need not abide by the insurance limitations of § 417.120 (b)(1) and (b)(3);

(iii) Provide that payment for basic health services will be in accordance with § 417.104 except that it need not comply with—

(A) The requirements for a community rating system as set forth in § 417.104(a)(3);

(B) The limitations on copayments as set forth in § 417.104(a)(4); and

(C) The requirement of § 417.105(b) that supplemental health services payments that are fixed on a prepayment basis be fixed under a community rating system;

(iv) Implement a time-phased plan acceptable to HCFA which specifies definite steps for meeting, at the time of renewal of each group or individual contract, but no later than 3 years after the date of HCFA's determination, all the requirements of subparts B and C of this part and §§ 417.168 and 417.169; and

(v) Upon completion of the time-phased plan—

(A) Provide basic and supplemental health services to all of its enrollees;

(B) Provide these services to all of its enrollees in the manner prescribed by subpart B of this part and §§ 417.168 and 417.169; and

(C) Be organized and operate in the manner prescribed by subpart C of this part and §§ 417.168 and 417.169.

(c) HCFA may determine that an applicant is a preoperational qualified HMO if it provides, within 30 days of HCFA's determination, satisfactory assurances that it will become operational within 60 days following that determination and will, when it becomes operational, meet the requirements of subparts B and C of this part and §§ 417.168 and 417.169. Upon notification by the applicant to HCFA that it has become operational, HCFA will, within 30 days of this notification, make a determination whether the applicant is an operational qualified HMO. In the absence of this determination, the organization is not an operational qualified HMO even though it becomes operational.

(d) If HCFA determines that an applicant meets the requirements for qualification and the applicant fails to sign its assurances within 30 days following the date of the determination, then HCFA will notify the applicant in writing that its application is considered withdrawn and that it is not a qualified HMO.

(e) An HMO that has more than one regional component, as described in § 417.104(b)(3)(iii), will be considered qualified for those regional components for which assurances have been signed in accordance with this section.

F. The title of subpart F is revised and subpart F is amended as set forth below:

Subpart F—Continued Regulation of Qualified HMOs

1. Sections 417.160 through 417.162 are revised to read as follows:

§ 417.160 Purpose and applicability.

This subpart applies to any entity that was determined by HCFA to be a qualified health maintenance organization (HMO) under subpart D of this part, or that provided written assurances to HCFA as a condition for receiving financial assistance under subpart V of this part, and sets forth procedures for enforcing the assurances given to HCFA by these entities.

§ 417.161 Compliance with assurances.

Any entity subject to this subpart must comply with the assurances that it provided to HCFA, unless compliance is waived under § 417.166.

§ 417.162 Reporting requirements.

Entities subject to this subpart must submit:

(a) The reports that may be required by HCFA under § 417.126, and

(b) Any additional reports HCFA may reasonably require.

2. Redesignated §§ 417.168 and 417.169 are revised to read as follows:

§ 417.168 Special requirements: titles XVIII and XIX of the Social Security Act.

(a) As provided in section 1307(d) of the PHS Act, an HMO that otherwise complies with section 1301(b) and section 1301(c) of the PHS Act, and with the applicable regulations of subparts B and C of this part and § 417.169, and that has enrollees who are entitled to insurance benefits under title XVIII of

the Act or to medical assistance under a State plan approved under title XIX of the Act, may still be considered to be an HMO if, with respect to its title XVIII and title XIX enrollees, it provides services and is operated as required by title XVIII or title XIX, as appropriate, and by implementing regulations.

(b) Notwithstanding any inconsistent requirements of subparts B and C of this part and § 417.169, an HMO that enters into a contract with HCFA under title XVIII of the Act or with a State under title XIX of the Act must, with respect to its enrollees entitled to insurance benefits or medical assistance under those titles, comply with the applicable title XVIII or title XIX requirements, including deductible and coinsurance requirements, enrollment mix and enrollment practice requirements, in accordance with the provisions of title XVIII or the title XIX State plan of the State with which it is contracting. Copayment options that are not in accordance with a title XIX State plan may not be imposed on title XIX enrollees.

(c) Any grievance procedures authorized under title XVIII or title XIX of the Act are not superseded by the provisions of § 417.124(g).

§ 417.169 Special requirements: Federal employee health benefits program.

An entity that provides health services to a defined population on a prepaid basis and that has enrollees who are enrolled under the health benefits program authorized by Chapter 89 of Title 5, United States Code, may be considered to be an HMO for purposes of receiving assistance under this part if, with respect to its other enrollees, it—

(a) Provides health services in accordance with section 1301(b) of the Act, subpart B of this part, and § 417.168; and

(b) Is organized and operated in the manner prescribed by section 1301(c) of the PHS Act, subpart C of this part, and § 417.168.

G. Subpart J is amended as set forth below:

Subpart J—Qualifying Conditions for Medicare Contracts

§ 417.401 [Amended]

1. In § 417.401 the following changes are made:

a. The following definitions are removed:

Affiliated organization.
Current demonstration project Medicare enrollee.
Current nonrisk Medicare enrollee.
Current risk Medicare enrollee.
Eligible organization.
Enrollee.
Entity with an existing cost contract.
Entity with an existing risksharing contract.
Reasonable cost reimbursement contract.

b. The definition of *Emergency services* is revised to read as follows:

§ 417.401 Definitions.

* * * * *

Emergency services means covered inpatient or outpatient services that—(1) Are furnished by an appropriate source other than the HMO or CMP;

(2) Are needed immediately because of an injury or sudden illness; and

(3) Cannot be delayed for the time required to reach the HMO's or CMP's providers or suppliers (or alternatives authorized by the HMO or CMP) without 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 HMO's or CMP'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.

* * * * *

c. In the definition of *Existing demonstration project*, the defined term is revised to read *Demonstration project* and the entire definition is placed in appropriate alphabetical order.

d. The definition of *New Medicare enrollee* is revised to read as follows:

§ 417.401 Definitions.

* * * * *

New Medicare enrollee means a Medicare enrollee who—

(1) Enrolls with an HMO or CMP after the date on which the HMO or CMP first enters into a risk contract under subpart L of this part;

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

(3) Was not enrolled with the HMO or CMP at the time he or she became entitled to benefits under Part A or eligible to enroll in Part B of Medicare.

* * * * *

e. The definition of *New risk contract* is removed and a definition of "Risk contract" is added to read as follows:

§ 417.401 Definitions.

* * * * *

Risk contract means a contract entered into under section 1876(g) of the Act on or after February 1, 1985.

* * * * *

f. The word "organization" in its singular, plural, and possessive forms is revised to read "HMO or CMP", "HMOs or CMPs", and "HMO's or CMP's", respectively, and the term "eligible organization" in its singular, plural, and possessive forms, is revised to read "HMO or CMP", "HMOs or CMPs", and "HMO's or CMP's", respectively, in the following definitions:

Adjusted average per capita cost;
Adjusted community rate;
Arrangement or arrangements;
Benefit stabilization fund;
Geographic area;
Medicare enrollee; and
Urgently needed services.

2. Section 417.402 is revised to read as follows:

§ 417.402 Effective date of initial regulations.

The changes made to section 1876 of the Act by section 114 of the Tax Equity and Fiscal Responsibility Act of 1982 became effective on February 1, 1985, the effective date of the initial implementing regulations.

3. Section 417.418 is revised to read as follows:

§ 417.418 Qualifying condition: Quality assurance program.

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

(b) *Standard.* An HMO or CMP must have an ongoing quality assurance program that meets the requirements set forth in § 417.106(a).

H. Subpart K is amended as set forth below:

Subpart K—Enrollment, Entitlement, and Disenrollment Under Medicare Contract

1. Section 417.436 is revised to read as follows:

§ 417.436 Rules for enrollees.

(a) *Maintaining rules.* An HMO or CMP must maintain written rules that deal with, but need not be limited to the following:

(1) All benefits provided under the contract, as described in § 417.440.

(2) How and where to obtain services from or through the HMO or CMP.

(3) The restrictions on coverage for services furnished from sources outside a risk HMO or CMP, other than emergency services and urgently needed services (as defined in § 417.401).

(4) The obligation of the HMO or CMP to assume financial responsibility and provide reasonable reimbursement for emergency services and urgently needed services as required by § 417.414(c).

(5) Any services other than the emergency or urgently needed services that the HMO or CMP chooses to provide as permitted by this part, from sources outside the HMO or CMP. A cost HMO or CMP must disclose that the enrollee may receive services through any Medicare providers and suppliers.

(6) Premium information, including the amount (or if the amount cannot be included, the telephone number of the source from which this information may be obtained) and the procedures for paying premiums and other charges for which enrollees may be liable.

(7) Grievance and appeal procedures.

(8) Disenrollment rights.

(9) The obligation of an enrollee who is leaving the HMO's or CMP's geographic area for more than 90 days to notify the HMO or CMP of the move or extended absence and the HMO's or CMP's policies concerning retention of enrollees who leave the geographic area for more than 90 days, as described in § 417.460(a)(2).

(10) The expiration date of the Medicare contract with HCFA and notice that both HCFA and the HMO or CMP are authorized by law to terminate or refuse to renew the contract, and that termination or nonrenewal of the contract may result in termination of the individual's enrollment in the HMO or CMP.

(11) Advanced directives as specified in paragraph (d) of this section.

(12) Any other matters that HCFA may prescribe.

(b) *Availability of rules.* The HMO or CMP must furnish a copy of the rules to each Medicare enrollee at the time of enrollment and at least annually thereafter.

(c) *Changes in rules.* If an HMO or CMP changes its rules, it must submit the changes to HCFA in accordance with § 417.428(a)(3), and notify its Medicare enrollees of the changes at least 30 days before the effective date of the changes.

(d) *Advance directives.* (1) An HMO or CMP must maintain written policies and procedures concerning advance directives, as defined in § 489.100 of this chapter, with respect to all adult individuals receiving medical care by or through the HMO or CMP and are required to:

(i) Provide written information to those individuals concerning—

(A) Their rights under State law (whether statutory or recognized by the courts of the State) to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate, at the individual's option, advance directives; and

(B) The HMO's or CMP's written policies respecting the implementation of those rights, including a clear and precise statement of limitation if the HMO or CMP cannot implement an advance directive as a matter of conscience;

(ii) Provide the information specified in paragraph (d)(1)(i) of this section to each enrollee at the time of enrollment;

(iii) Document in the individual's medical record whether or not the individual has executed an advance directive;

(iv) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

(v) Ensure compliance with requirements of State law (whether statutory or recognized by the courts of the State) regarding advance directives;

(vi) Provide for education of staff concerning its policies and procedures on advance directives; and

(vii) Provide for community education regarding advance directives either directly or in concert with other providers or entities.

(2) The HMO or CMP—

(i) Is not required to provide care that conflicts with an advance directive.

(ii) Is not required to implement an advance directive if, as a matter of conscience, the provider cannot implement an advance directive and State law allows any health care provider or any agency of the provider to conscientiously object.

2. Section 417.444 is revised to read as follows:

§ 417.444 Special rules for certain enrollees of risk HMOs and CMPs.

(a) *Applicability.* This section applies to any Medicare enrollee of a risk HMO or CMP who meets the following conditions:

(1) On February 1, 1985, was enrolled—

(i) In an HMO or CMP that had in effect a cost contract entered into under section 1876 of the Act in accordance with regulations in effect before February 1, 1985; or

(ii) In an HCPP that was being reimbursed on a reasonable cost basis under section 1833(a)(1)(A) of the Act.

(2) Has continued enrollment in the same entity without interruption or disenrolled after February 1, 1985, and later reenrolled in the same entity.

(b) *Retention of nonrisk status*—(1) A "nonrisk" enrollee is a Medicare beneficiary who meets the conditions of paragraph (a) of this section and is enrolled in an entity that enters into a risk contract as an HMO or CMP. A "nonrisk" enrollee may retain nonrisk status indefinitely unless HCFA determines under paragraph (c)(1) of this section, that the enrollee's status must be changed, or the enrollee requests the change, as provided in paragraph (c)(2) of this section.

(2) A nonrisk enrollee of a risk HMO or CMP is not entitled to additional benefits under § 417.442.

(c) *Conversion to risk status*—(1) *Conversion based on HCFA determination.* If HCFA determines that, for administrative reasons or because there are fewer than 75 current nonrisk Medicare enrollees remaining in the HMO or CMP, all of its nonrisk Medicare enrollees must be covered under the risk provisions of the contract, the conversion process is as follows:

(i) HCFA notifies each affected enrollee of the decision at least 90 days prior to the effective date.

(ii) The nonrisk Medicare enrollees complete and sign forms stating that they understand and accept the new rules and benefits that will be applicable to them.

(iii) The HMO or CMP 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) *Conversion based on enrollee's request.* A nonrisk Medicare enrollee requests, using a form identical or similar to the form described in paragraph (c)(1) of this section, that he or she be covered under the risk portion of the contract.

(d) *Notification.* An HMO or CMP converting from a cost contract to a risk contract must, within 60 days of signing the risk contract, inform nonrisk enrollees of their right to remain nonrisk Medicare enrollees or to convert to risk enrollment at any time in accordance with paragraph (c)(2) of this section.

3. Section 417.460 revised to read as follows:

§ 417.460 Disenrollment of beneficiaries and termination of payments to an HMO or CMP.

(a) *Disenrollment of health insurance program beneficiaries.* An HMO or CMP 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 HMO or CMP may disenroll a Medicare enrollee who fails to pay premiums or other charges imposed by the HMO or CMP for deductible and coinsurance amounts

for which the enrollee is liable, if the HMO or CMP—

(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 HMO's or CMP'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 for monthly capitation payments to the HMO or CMP on behalf of the enrollee ends as of the first day of the month following the month in which disenrollment 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 HCFA receives the disenrollment notice in acceptable form.

(iii) *Exception.* If a Medicare enrollee of an HMO or CMP 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 HMO or CMP may discontinue the optional supplemental benefits but may not disenroll the enrollee.

(2) *Enrollee moves out of the HMO's or CMP's geographic area*—(i) *Basic rule.* Except as provided in paragraph (a)(2)(iv) of this section, an HMO or CMP 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 HMO or CMP—

(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 HMO or CMP does not disenroll an enrollee who 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 HMO or CMP may retain a Medicare enrollee who is absent from its geographic area for an extended period, but who remains within the United States as defined in § 400 200 of this chapter if the enrollee agrees. For purposes of this exception, the following provisions apply:

(A) An absence for an extended period means an uninterrupted absence from the HMO's or CMP's geographic area for more than 90 days but less than one year.

(B) The HMO or CMP and the enrollee may mutually agree upon restrictions for obtaining services while the enrollee is absent for an extended period from the HMO's or CMP's geographic area. However, restrictions may not be imposed on the scope of services described in § 471 440.

(C) When the enrollee returns to the HMO's or CMP's geographic area, the restrictions under § 417.448(a), which prohibit Medicare payment for services not provided or arranged for by the HMO or CMP apply again immediately.

(D) HMOs and CMPs that choose to exercise this exception must make the option available to all Medicare enrollees who are absent for an extended period from the HMO's or CMP's geographic area. (However, HMOs and CMPs may limit this option to enrollees who go to a geographic area served by an affiliated HMO or CMP.)

(E) If the enrollee fails to return to the HMO's or CMP's geographic area within 1 year of the date he or she left the geographic area, then the HMO or CMP must disenroll the beneficiary on the first day of the month following the anniversary of the date the enrollee left the geographic area under the provisions of paragraph (a)(2)(i) of this section.

(F) As used in this paragraph "affiliated HMO or CMP" means an HMO or CMP that is under common ownership or control of the HMO or CMP that seeks to retain the absent enrollees, or has in effect an agreement to furnish services to enrollees who are on an extended absence from the geographic area of the HMO or CMP that seeks to retain them

(3) *Failure to convert to risk provisions of contract*—(i) *Disenrollment and notice* A risk HMO or CMP must disenroll a current nonrisk Medicare enrollee if the enrollee refuses to convert to the risk provisions of the HMO's or CMP's contract after HCFA has determined under § 417 444(a)(1) that all of the HMO's or CMP's current nonrisk Medicare enrollees must be converted. The HMO or CMP must notify the enrollee that failure to convert will result in disenrollment. The notice must be sent at least 30 days before the HMO or CMP 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 HMO or CMP enrollment card* (i) A Medicare beneficiary may be disenrolled by the HMO or CMP if the beneficiary knowingly provides, on the application form, fraudulent information upon which an HMO or CMP relies and which materially affects his or her eligibility to enroll in the HMO or CMP, or if the beneficiary intentionally permits others to use his or her enrollment card to receive services from the HMO or CMP.

(ii) In either case, the HMO or CMP 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) HCFA's liability for monthly capitation payments to the HMO or CMP on behalf of the beneficiary terminates as of the first day of the month in which the termination of enrollment 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 HMO or CMP 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) HCFA's liability for monthly capitation payments to the HMO or CMP 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 HMO or CMP under its regular plan if the HMO or CMP 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 HMO or CMP 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 HMO or CMP 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 enrollment in the HMO or CMP seriously impairs the HMO's or CMP's ability to furnish services to either the particular enrollee or other enrollees.

(ii) *Effort to resolve the problem.* The HMO or CMP 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 HMO or CMP must ascertain that the enrollee's behavior is not related to the use of medical services or mental illness.

(iv) *Documentation.* The HMO or CMP must document the problems, efforts, and medical conditions as described in paragraphs (a)(6)(i), (a)(6)(ii), and (a)(6)(iii) of this section.

(v) *HCFA review of an HMO's or CMP's proposed disenrollment.* HCFA decides based on a review of the documentation submitted by the HMO or CMP, whether disenrollment requirements have been met. HCFA makes this decision 20 working days of receipt of the documentation material, and notifies the HMO or CMP within 5 working days after making its decision.

(vi) *Effective date of disenrollment.* If HCFA permits an HMO or CMP to disenroll an enrollee for cause, the disenrollment takes effect on the first day of the calendar month after the month in which the HMO or CMP complies with the notice requirements in paragraphs (a)(1)(i)(B) and (a)(1)(i)(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.* HCFA's liability for payments to the HMO or CMP 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 HMO or CMP a signed, dated request in the form and manner prescribed by the HMO or CMP. The enrollee may request a certain disenrollment date but it may be no earlier than the first day of the month following the month in which the HMO or CMP receives the request. The HMO or CMP must submit a disenrollment notice to HCFA promptly.

(2) An HMO or CMP must provide the enrollee with a copy of the written request for disenrollment. Risk HMOs and CMPs must also provide a written statement explaining that the enrollee remains enrolled in the HMO or CMP until the effective date of the disenrollment, until that date, and is subject to the restrictions of § 417.448(a) which prohibit Medicare payment for services not provided or arranged for by the HMO or CMP.

(3) HCFA's responsibility for payments to the HMO or CMP ends with the close of the month of termination requested by the enrollee.

(4) If the HMO or CMP fails to submit the correct and complete notice required in paragraph (b)(1) of this section on a timely basis, the HMO or CMP 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 HMO or CMP 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 HMO or CMP defaults on the contract before the end of the contract year because of bankruptcy or other reasons, HCFA—

(i) Determines the month in which its liability for payments ends; and

(ii) Notifies the HMO or CMP and all affected Medicare enrollees as soon as practicable.

I. Subpart P is amended as set forth below:

Subpart P—Medicare Payment: Risk Basis

1. Section 417.590 is revised to read as follows:

§ 417.590 Computation of the average of the per capita rates of payment.

(a) *Computation by the HMO or CMP.* As indicated in § 417.584(b), before an HMO's or CMP's contract period begins, HCFA determines a per capita rate of payment for each class of the HMO's or CMP's Medicare enrollees. In order to determine the additional benefits required under § 417.592, weighted averages of those per capita rates must be computed separately for enrollees entitled to Part A and Part B, and for enrollees entitled only to Part B. Except as provided in paragraph (b) of this section, the HMO or CMP must make the computations.

(b) *Computation by HCFA.* If the HMO or CMP claims to have insufficient enrollment experience to make the computations required by paragraph (a) of this section, and HCFA agrees with the claim, HCFA makes the computations, using the best available information, which may include the enrollment experience of other risk HMOs and CMPs.

2. Section 417.597 is revised to read as follows:

§ 417.597 Withdrawal from a benefit stabilization fund.

(a) *Notification to HCFA.* An HMO's or CMP's request to make a withdrawal from its benefit stabilization fund for use during a contract period must be made when the HMO or CMP notifies HCFA of its ACR and the average of its per capita rates of payment for that contract period. In making its request, the HMO or CMP 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 HMO's or CMP's experience with fluctuations of revenue requirements relative to the additional benefits it provides to Medicare enrollees; and

(4) Document its experience during the contract period previous to the one for which it requests withdrawal to ensure that the HMO or CMP will not be using the withdrawn amounts to refinance losses suffered during that previous contract period.

(b) *Criteria for HCFA approval.* HCFA approves a request for a withdrawal from a benefit stabilization fund for use during the next contract period only if—

(1) The HMO's or CMP'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 HMO's or CMP's ACR for the next contract period is significantly higher than that of the previous contract period; or

(3) The HMO's or CMP'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 does not approve a request for a withdrawal from a benefit stabilization fund if the withdrawal would allow the HMO or CMP 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 HMO or CMP under § 417.584 during the period of the contract.

J. Subpart Q is amended as set forth below:

Subpart Q—Beneficiary Appeals

Section 417.606 is revised to read as follows:

§ 417.606 Initial determinations.

(a) *Actions that are initial determinations.* An initial determination is a determination made by an HMO or CMP, or a carrier or intermediary acting for the HMO or CMP, concerning the rights of an enrollee with regard to services payable under Medicare that are furnished by the HMO or CMP. 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 HMO or CMP that the enrollee believes—

(i) Are covered under Medicare; and

(ii) Should have been furnished, arranged for, or reimbursed by the HMO or CMP.

(3) The HMO's or CMP's refusal to provide services that the enrollee believes it should furnish or arrange for, when the enrollee has not received the services outside the HMO or CMP.

(b) *Actions that are not initial determinations.* The following are not initial determinations for purposes of this subpart:

(1) A determination regarding services that were furnished by the HMO or CMP either directly or under arrangement, for which the enrollee has no further obligation for payment.

(2) A determination regarding 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).

K. Subpart V is amended as set forth below:

Subpart V—Administration of Outstanding Loans and Loan Guarantees

1. Sections 417.910 and 417.911 are revised to read as follows:

§ 417.910 Scope and applicability.

(a) *Scope.* This subpart sets forth the requirements and procedures for grants, loans, and loan guarantees awarded before October 1986 under sections 1303, 1304, 1305, and 1305A of the PHS Act.

(b) *Applicability.* (1) Sections 417.911 through 417.915 apply, in general, to all three types of financial assistance granted under this subpart.

(2) Sections 417 916 through 417.919 apply only to grants.

(3) Sections 417.920 through 417 926 apply to grants and loan guarantees for planning and initial development projects.

(4) Sections 417.930 through 417.937 apply to loans and loan guarantees for initial costs of operation.

§ 417.911 Definitions.

As used in this subpart—

Any 12-month period means the 12-month period beginning on the first day of any month.

Expansion of services means—(1) The addition of any health service not previously provided by or through the HMO, that requires an increase in the facilities, equipment, or health professionals of the HMO; or

(2) The improvement or upgrading of existing facilities or equipment, or an increase in the number of categories of health professionals, of the HMO so that the HMO could provide directly services that it previously provided through contract or referral or which it could not previously provide with its existing facilities or equipment.

First 60 months of operation or expansion means the 60-month period beginning on the first day of the month during which the HMO first provided services to enrollees, or in the case of significant expansion, first provided services in accordance with its expansion plan.

Health system agency means an entity that has been designated in accordance with section 1515 of the PHS Act; and the term *State health planning and development agency* means an agency that has been designated in accordance with section 1521 of the PHS Act.

Initial costs of operation means any cost incurred in the first 60 months of an operation or expansion that met any of the following requirements:

(1) Under generally accepted accounting principles or under accounting practices prescribed or permitted by State regulatory authority, was not a capital cost.

(2) Was required by State regulatory authority to meet reserves or tangible net equity requirements.

(3) Was for a payment made to reduce balance sheet liabilities existing at the beginning of the 60-month period, but only if—(i) The payment had been approved in writing by the Secretary; and

(ii) The total of these payments did not exceed 20 percent of the amount of the loan.

(4) Was for a small capital expenditure, but only if—(i) The cost had been approved in writing by the Secretary; and

(ii) The total of these costs did not exceed $200,000 in any 12-month period, and $400,000 during the first 60 months of operation or expansion.

Nonprofit as applied to a private entity, means a private agency, institution, or organization, no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual.

Significant expansion means—(1) A planned substantial increase in the enrollment of the HMO, that requires an increase in the number of health professionals serving enrollees of the HMO or an expansion of the physical capacity of the HMO's total health facilities; or

(2) A planned expansion of the service area beyond the current service area, that would be made possible by the addition of health service delivery facilities and health professionals to serve enrollees at a new site or sites in areas previously without service sites.

Small capital expenditure means expenditures for—(1) Equipment as defined in 45 CFR 74.132; or

(2) Alterations and renovations required to change the interior arrangements or other physical characteristics of an existing facility or installed equipment, so that it may be more effectively used for its currently designated purpose, or adapted to a changed use.

2. Section 417.920 is revised to read as follows:

§ 417.920 Planning and initial development.

(a) Under section 1304 of the PHS Act, grants and loan guarantees were awarded for projects for planning and initial development of HMOs.

(b) Planning projects included projects for any of the following:

(1) Establishment of an HMO.

(2) Significant expansion of the HMO's enrollment or geographic area.

(c) Initial development projects included projects for any of the following:

(1) Establishment of an HMO.

(2) Significant expansion of the HMO's enrollment or geographic area.

(3) Expansion of the range or amount of services furnished by the HMO.

3. Section 417 930 is revised to read as follows:

§ 417.930 Initial costs of operation.

Under section 1305 of the PHS, loans and loan guarantees were awarded for initial costs of operation of HMOs.

§ 417.931 [Removed]

4. Section 417 931 is removed.

L. Technical Amendments

§ 417.101 [Amended]

1. In § 417.101, the following changes are made:

a. Throughout the section, "shall" is changed to "must" (9 times), "member" and "members" are changed to "enrollee" and "enrollees", respectively (7 times), "Public Health Service Act" is revised to read "PHS Act" (3 times), and, except in paragraphs (a)(1), (a)(2) and (a)(8), "which" is changed to "that" (4 times).

b. In paragraph (a)(7), "a member's" is changed to "an enrollee's".

c. In paragraph (c) "§§ 417.100 through 417.109" is revised to read "§§ 417.101 through 417.106 and §§ 417.168 and 417.169".

d. In paragraph (d)(16), "the Secretary" is changed to "HCFA".

§ 417.143 [Amended]

2. In § 417.143, the following changes are made:

a. In paragraph (b)(2), "Public Health Service Act" is revised to read "PHS Act". "§§ 417.100 through 417.109 and 417.140 through 417.144 of this subpart" is revised to read "subparts B and C of this part, this subpart D, and §§ 417.168 and 417.169 of subpart F".

b. In paragraph (g), "§§ 417.140 through 417.144" is revised to read "this subpart".

§ 417.144 [Amended]

3. In § 417.144, the following changes are made:

a. In paragraph (a), "§§ 417.100 through 417.109 of this subpart" is revised to read "subparts B and C of this part and §§ 417.168 and 417.169".

b. In paragraphs (a) through (e), "the Secretary" is changed to "HCFA" (11 times).

c. In paragraphs (a), (c), and (d), "§§ 417.140 through 417.144" is revised to read "this subpart".

d. In paragraph (b), "which" is changed to "that", and "the Secretary's" is changed to "HCFA's".

e. In paragraph (d), the phrase "of Health and Human Services" is removed.

f. In paragraph (e), second sentence, "contained" is changed to "obtained".

§ 417.150 [Amended]

4. In § 417.150, the following changes are made:

a. The introductory text is revised to read: "As used in this subpart—".

b. In the definitions of "carrier" and "employer", "which" and "which organization" are changed to "that".

c. In the definition of "employee", "full-" is changed to "full-time".

d. In the definition of "health benefits plan", "of this subpart" is removed.

e. In the definition of "public entity", "Public Health Service" is changed to "PHS".

§ 417.151 [Amended]

5. In § 417.151, the following changes are made:

a. In the introductory text, "§§ 417.150 through 417.159" is revised to read "this subpart".

b. Throughout the section, "which" is changed to "that" (4 times) and "Public Health Service Act" is revised to read "PHS Act".

§ 417.152 [Amended]

6. In § 417.152, the following changes are made:

a. Throughout the section, "which" is changed to "that" (3 times), "shall" is changed to "must" (8 times), "Public Health Service Act" is revised to read "PHS Act", and "the Secretary" is changed to "HCFA".

b. In paragraph (c), "§§ 417.140 through 417.144 of this subpart" is revised to read "subpart D of this part".

c. In paragraph (c)(3), "organization" is changed to "HMO", "members of a medical group(s)" is revised to read "members of medical groups", and "members of an individual practice association(s)" is revised to read "members of individual practice associations".

d. In paragraph (c)(4), "through an individual practice association(s)" is revised to read "through individual practice associations", and "membership" is changed to "enrollment".

e. In paragraph (c)(6), "members" is changed to "enrollees".

§ 417.153 [Amended]

7. In § 417.153, the following changes are made:

a. The term "shall" is changed to "must" (2 times).

b. The term "membership" is changed to "enrollment" (3 times).

c. "§§ 417.150 through 417.159" is revised to read "this subpart" (3 times).

§ 417.154 [Amended]

8. In § 417.154, the following changes are made:

a. In the heading, and throughout the text, "which" is changed to "that" (9 times).

b. In paragraph (a) introductory text, and paragraphs (a)(2), (b) introductory text and (c), "§§ 417.150 through 417.159" is revised to read "this subpart".

c. In paragraphs (a)(1) and (a)(2), "organizations" and "organization" are changed to "HMOs" and "HMO", respectively.

d In paragraph (a)(2), "shall" is changed to "must" (2 times) and "§ 417.100" is changed to "417.1".

e. In paragraph (b), "shall" is changed to "must".

f. In paragraphs (b) introductory text, (b)(2) and (c), "membership" is changed to "enrollment".

§ 417.155 [Amended]

9 In § 417.155, the following changes are made:

a. In paragraph (a), "which" is changed to "that" (2 times); "shall" is changed to "must" the first two times it appears, and to "may" the third time; and "§ 417.107(c) of this subpart" and "§ 417.107(c)" are revised to read "§ 417.124(b)".

b. In paragraph (b), "shall" is changed to "must" (3 times).

c. In paragraph (c), "membership" is changed to "enrollment", "§§ 417.150 through 417.159" is revised to read "this subpart" (twice), "shall" is changed to "must", and "which" is changed to "that".

d. In paragraphs (d) and (e), "shall" is changed to "must" (6 times), "members" is changed to "enrollees" (twice), "membership" is changed to "enrollment", and "which" is changed to "that".

e. In paragraph (g), "shall" is changed to "may".

§ 417.157 [Amended]

10. In § 417.157, the following changes are made:

a. The term "shall" is changed to "must" in paragraphs (a)(1), (a)(3), (b), (e), (f), (g) introductory text, (g)(2), and (h), and to "will" in paragraphs (d) and (g)(1).

b. The term "membership" is changed to "enrollment" in paragraphs (b) and (c).

c. The term "which" is changed to "that" in paragraphs (a)(2), (g)(2), and (h).

d. In paragraph (h), "the Secretary" is changed to "HCFA", "her" is changed to "its", the phrase "to the Secretary" is removed, and "§§ 417.150 through 417.159." is revised to read "this subpart.".

§ 417.159 [Amended]

11. In § 417.159, the following changes are made:

a. In the heading, "Public Health Service" is changed to "PHS", and "as amended" is removed (twice).

b. In the text, "§§ 417.150 through 417.159" is revised to read "this subpart", "membership" is changed to "enrollment", and "shall" is changed to "must".

§ 417.163 [Amended]

12. In § 417.163, the following changes are made:

a. Throughout the section (except the second time it appears in paragraph (d)(2)) "the Secretary" is changed to "HCFA" (26 times), and "his" is changed to "its" (3 times).

b. In paragraph (a), "shall" is changed to "must" and in paragraph (c), "shall" is changed to "will" the first 3 times it appears and to "must" the 4th and 5th times it appears.

c. In paragraph (b), "he" is changed to "it" (4 times), "§§ 417.160 through 417.166" is revised to read "this subpart", and the phrase "to him" is removed.

d. In paragraphs (c), (d)(1) and (d)(2), "which" is changed to "that" (5 times).

e. In paragraph (d), "Public Health Service" is changed to "PHS"; and "shall" is changed to "will" the first 5 times it appears, to "must" the 6th and 7th times it appears, and to "will" the 8th time it appears; "member" and "members" are changed to "enrollee" and "enrollees", respectively (6 times); "him" is changed to "it" (twice); "it" is changed to "the HMO"; and "he" is changed to "HCFA" (twice).

§ 417.164 [Amended]

13. In § 417.164, the following changes are made:

a. In the heading of the section, "Public Health Service" is changed to "PHS".

b. In paragraphs (a) and (b), "§§ 417.150 through 417.159 of this subpart" is revised to read "subpart E of this part" (4 times).

c. In paragraph (c), "§§ 417.120 through 417.126 and 417.130 through 417.137 of this subpart" is revised to read "subpart V of this part", and "§§ 417.140 through 417.144 of this subpart" is revised to read "subpart D of this part".

§ 417.165 [Amended]

14. In § 417.165, "Public Health Service Act" is revised to read "PHS Act", and "§§ 417.140 through 417.144 of this subpart" is revised to read "subpart D of this part".

§ 417.400 [Amended]

15. In paragraph (b), "It also specifies" is revised to read "Subparts N, O, and P set forth".

§ 417.404 [Amended]

16. In § 417.404, "eligible organization" is changed to "HMO" or CMP" (5 times), and "§§ 417.470 through 417.494" is revised to read "subpart L of this part".

§ 417.406 [Amended]

17. In § 417.406, the following changes are made:

a. The heading is revised to read: "Application and determination."

b. The term "eligible organizations" is changed to "HMO" in paragraph (a)(2), and to "HMO or CMP" elsewhere in the section (4 times).

c. In paragraph (a)(3), "Public Health Service Act" is revised to read "PHS Act", and "§§ 417.100 through 417.109" is revised to read "subparts B and C of this part and §§ 417.142, 417.168, and 417.169".

d. In paragraph (b)(2), "§ 417.494(b)(iii)" is changed to read "§ 417.494(b)".

§ 417.407 [Amended]

18. In § 417.407, the following changes are made:

a. The heading is revised to read: *"Definitions of HMO and CMP."*

b. Paragraph (a) is revised to read:

§ 417.407 Definitions of HMO and CMP.

(a) *State law.* To qualify as an HMO or CMP, an entity must be organized under the laws of any State and meet the definition under paragraph (b) or (c) of this section, respectively.

* * * * *

c. In paragraph (b), "Public Health Service (PHS)" is changed to "PHS" and "§§ 417.100 through 417.109" is revised to read "subparts B and C of this part and §§ 417.168 and 417.169".

d. In paragraph (c), "enrolled members" is changed to "enrollees" (thrice), "member" and "enrolled member" are changed to "enrollee", "§ 417.107(b)" is changed to "417.120(b)", and "§§ 417.107(a)(1)(i) through (iv) and (a)(3)" is revised to read "§§ 417.120(a)(1)(i) through (a)(1)(iv) and 417.122(a)".

§ 417.408 [Amended]

19. In § 417.408, the following changes are made:

a. The term "organization" is changed to "HMO or CMP" (5 times) and "organization's" is changed to "HMO's or CMP's".

b. In paragraph (a), "the Assistant Secretary for Health of the Department" is changed to "HCFA".

c. In paragraphs (b)(2) and (c)(3), "§§ 417.640 through 417.658" is revised to read "subpart R of this part".

§ 417.410 [Amended]

20. In § 417.410, the following changes are made:

a. The terms "organization" and "eligible organization" are changed to "HMO or CMP" (10 times) and "organization's" is changed to "HMO's or CMP's".

b. In paragraph (a), "members" is changed to "Medicare beneficiaries and other individuals and groups".

c. In paragraph (g), "§§ 417.530 through 417.598" is revised to read "subparts O and P of this part".

§ 417.414 [Amended]

21. In § 417.414, the following changes are made:

a. The terms "organization", "organizations" and "organization's" are changed to "HMO or CMP", "HMOs or CMPs", and "HMO's or CMP's", respectively (18 changes).

b. In paragraph (c)(2), "§§ 417.600 through 417.638" is revised to read "subpart Q of this part".

§ 417.418 [Amended]

21a. In paragraph (b) of § 417.418 "417.107(h)" is changed to "§ 417.106(a)".

§ 417.420 [Amended]

22. In § 417.420, the following changes are made:

a. The term "organization" is changed to "HMO or CMP" (5 times).

b. In paragraph (a), "§§ 417.470 through 417.494" is revised to read "subpart L of this part".

c. In paragraph (c)(2)(ii), "§§ 417.600 through 417.638" is revised to read "subpart Q of this part".

§ 417.422 [Amended]

23. In § 417.422, the following changes are made:

a. In the heading and in paragraph (a), "organization" and "organizations" are changed to "HMO or CMP" and "HMOs or CMPs", respectively (9 times).

b. In paragraph (a)(3), "this subpart or Subpart B of this part" is revised to read "subpart L of this part".

c. In paragraphs (b) and (c), "eligible organizations" is changed to "an HMO or CMP" (twice).

§ 417.424 [Amended]

24. In § 417.424, the following changes are made:

a. The terms "organization" and "organization's" are changed to "HMO or CMP" and "HMO's and CMP's", respectively (9 times).

b. In paragraph (a)(2), "§§ 417.412 through 417.418 of this part" is revised to read "subpart J of this part".

§ 417.426 [Amended]

25. In § 417.426, the following changes are made:

a. In paragraph (a)(1), "eligible organizations" is changed to "HMOs and CMPs".

b. In paragraphs (a) through (c), "organization" and "organization's" are changed to "HMO and CMP" and "HMO's or CMP's", respectively (6 times).

c. In paragraph (c) introductory text, "new members of" is revised to read "new enrollees under".

§ 417.440 [Amended]

26. In § 417.440, the following changes are made:

a. In the heading and throughout the section, "organization", "organizations" and "organization's" are changed to "HMO or CMP", "HMOs or CMPs", and HMO's or CMP's", respectively.

b. In paragraph (a)(2)(ii), "§§ 417.600 through 417.638" is revised to read "subpart Q of this part".

c. In paragraphs (b)(1) and (b)(4)(ii), "and supplies" is removed.

d. Paragraph (b)(3) is revised to read:

§ 417.440 Entitlement to health care services from an HMO or CMP.

* * * * *

(b) * * *

(3) *Supplemental services imposed by a risk HMO or CMP.* (i) Subject to HCFA's approval, a risk HMO or CMP may require Medicare enrollees to accept and pay for services in addition to those covered by Medicare. (ii) If the HMO or CMP elects this option, it must impose the requirement on all Medicare enrollees, without regard to health status. (iii) HCFA approves supplemental benefits of this type if HCFA determines that imposition of the requirements will not discourage other Medicare beneficiaries from enrolling in the risk HMO or CMP.

e. In paragraphs (d) introductory text and (e) introductory text, "of this part" is removed.

§ 417.448 [Amended]

27. In § 417.448, the following changes are made:

a. In the heading and throughout the section, the terms "organization", "organizations", and "organization's" are changed to "HMO or CMP", "HMOs or CMPs" and "HMO's or CMP's", respectively.

b. In paragraphs (b)(2) and (b)(3), "Current" is removed, and "nonrisk" is capitalized.

c. In paragraph (c), "the" is inserted immediately after "the organization and" and "membership" is changed to "enrollment".

§ 417.450 [Amended]

28. In § 417.450, the following changes are made:

a. In paragraph (a)(1), "Medicare's liability" is changed to "HCFA's liability".

b. In paragraphs (a), (b), and (c) "organization" is changed to "HMO or CMP" (7 times).

§ 417.452 [Amended]

29. In § 417.452, the following changes are made:

a. Throughout the section, except in paragraph (a)(2), "organization" and "organization's" are changed to "HMO or CMP" and "HMO's or CMP's", respectively (13 times).

b. In paragraph (b) introductory text, "or § 417.444(b)" is removed.

c. In paragraph (c), "payor" is changed to "payer".

d. At the end of paragraph (e), "Medicare enrollees in the organization" is revised to read "Medicare enrollee of the HMO or CMP".

§ 417.456 [Amended]

30. In § 417.456, the following changes are made:

a. Throughout the section, "organization" is changed to "HMO or CMP" (11 times).

b. In the definition of *amounts incorrectly collected*, "Medicare" is changed to "HCFA" the third time the word appears.

c. In paragraph (a)(3), "§§ 417.600 through 417.638" is revised to read "subpart Q of this part".

§ 417.470 [Amended]

31. In § 417.470, the following changes are made:

a. In paragraph (a), "§§ 417.472 through 417.494 implement" is revised to read "This subpart implements", and "organization" is changed to "HMO or CMP".

b. In paragraph (b) introductory text, "Sections 417.472 through 417.494 set forth" is revised to read "This subpart sets forth".

§ 417.472 [Amended]

32. In § 417.472, the following changes are made:

a. Throughout the section, "eligible organization" and "organization" are changed to "HMO or CMP" (6 times).

b. In paragraph (f), "of this part" is removed.

c. In paragraph (g), "the Secretary" is changed to "HCFA", and "he or she" is changed to "it".

§ 417.478 [Amended]

33. In § 417.478, the following changes are made:

a. In the introductory text and in paragraphs (c) and (d), "organization" and "organization's" are changed to "HMO or CMP" and "HMO's or CMP's", respectively.

b. In paragraph (c), "members" is changed to "enrollees".

c. In paragraph (d), "§ 417.107" is changed to "§ 417.126(a)", and the last sentence is removed.

§ 417.492 [Amended]

34. In § 417.492, the following changes are made:

a. Throughout the section, "organization" and "organization's" are changed to "HMO or CMP" and "HMO's or CMP's", respectively (9 times).

b. In paragraph (b)(4), "§§ 417.640 through 417.682" is revised to read "subpart R of this part".

§ 417.494 [Amended]

35. In § 417.494, the following changes are made:

a. The term "organization" and its plural and possessive forms are changed to "HMOs or CMPs", and "HMO's or CMP's", respectively.

b. In paragraph (b)(1)(iv), "subpart" is changed to "part".

c. In paragraph (b)(2), "§§ 417.640 through 417.682" is revised to read "subpart R of this part".

§ 417.520 [Amended]

36. In §§ 417.520, the following changes are made:

a. Throughout the section, "organization" is changed to "HMO or CMP" (6 times).

b. In paragraph (b)(2), "§§ 417.472 through 417.488" is revised to read "subpart L of this part".

§ 417.522 [Amended]

37. In § 417.522, the following changes are made:

a. The terms "organization" and "eligible organization" are changed to "HMO or CMP" (3 times).

b. In paragraph (a)(3)(iii), "this subpart" is changed to "this part".

§ 417.523 [Amended]

38. In § 417.523, the following changes are made:

a. In the heading and throughout the section, "organization" and "eligible organization" are changed to "HMO or CMP" and "organization's" is changed to "HMO's or CMP's".

b. In paragraph (b)(2), "this subpart." is changed to "subpart L of this part.".

c. In paragraph (c), "applicable" is inserted immediately before "requirements" and "§§ 417.410

through 417.418" is revised to read "subpart J of this part.".

§ 417.526 [Amended]

39. In § 417.526, the following changes are made:

a. "Sections 417.530 through 417.576 set forth" is revised to read "Subpart O of this part sets forth".

b. The term "eligible organization" is changed to "HMO or CMP" (twice).

c. "§§ 417.580 through 417.598 describe" is revised to read "Subpart P of this part describes".

§ 417.528 [Amended]

40. In § 417.528, the following changes are made:

a. In the heading and throughout the section, "payor" is changed to "payer" (6 times), and "eligible organization" and "organization" are changed to "HMO or CMP" (7 times).

b. In paragraph (a), "where Medicare is not the primary payor" is revised to read "for which Medicare is not the primary payer".

§ 417.530 [Amended]

41. In § 417.530, the following changes are made:

a. "Sections 417.530 through 417.576 set forth" is revised to read "This subpart sets forth".

b. Throughout the section, "organization" is changed to "HMO or CMP" (3 times).

§ 417.536 [Amended]

42. In § 417.536, the following changes are made:

a. In the heading, "the organizations" is changed to "HMOs and CMPs".

b. In paragraph (a), the phrase "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" is revised to read "are applicable to the costs incurred by an HMO or CMP or by providers and other facilities owned or operated by the HMO or CMP or related to it".

c. Throughout the section, except in the heading to paragraph (k), "organization" and "organization's" are changed to "HMO or CMP" and "HMO's or CMP's", respectively (17 times).

d. In paragraph (f)(3), "enrollee or" is revised to read "enrollee of".

e. In paragraph (g), "§ 405.420" is changed to "§ 413.80" and "deductions for revenue" is revised to read "deductions from revenue".

f. In the heading of paragraph (k), "organizations" is changed to "entities".

g. In paragraph (m)(1), "§§ 405.542, 405.544, and 413.170" is revised to read "§§ 413.170".

h. In paragraph (m)(3), "§ 413.110" is revised to read "§§ 405.517 and 410.29".

§ 417.548 [Amended]

43. In § 417.548, the following changes are made:

a. Throughout the section, "organization" and "organization's" are changed to "HMO or CMP" and "HMO's or CMP's", respectively (12 times).

b. In paragraph (a), the phrase "unless, upon the organization's petition to HCFA, the organization can demonstrate" is revised to read "unless the HMO or CMP petitions HCFA and demonstrates".

§ 417.550 [Amended]

44. In § 417.550, the following changes are made:

a. In paragraph (a), "Medicare reimburses" is revised to read "HCFA reimburses".

b. Throughout the section, "organization" and "organization's" are changed to "HMO or CMP" and "HMO's or CMP's", respectively (5 times).

c. In paragraph (d)(2), "membership" is changed to "enrollment".

§ 417.580 [Amended]

45. In § 417.580, the following changes are made:

a. In paragraph (a), "Sections 417.582 through 417.598 implement" is revised to read "This subpart implements".

b. In paragraph (b) introductory text, "Sections 417.582 through 417.598 set forth—" is revised to read "This subpart sets forth—"

c. In paragraphs (a) and (b), "organization" and "organization's" are changed to "HMO or CMP" and "HMO's or CMP's", respectively.

§ 417.582 [Amended]

46. In § 417.582, the following changes are made:

a. The introductory text is revised to read: "As used in this subpart—".

b. The term "organization" is changed to "HMO or CMP" and "organization's" is changed to "HMO's or CMP's".

§ 417.592 [Amended]

47. In § 417.592, the following changes are made:

a. In paragraph (a), the first "organization's" is changed to "HMO's or CMP's", the second "organization's" is changed to "its", and "organization" is changed to "HMO or CMP".

b. Paragraph (b)(1) is revised to read:

§ 417.592 Determination of required additional benefits.

* * * * *

(b) * * *

(1) A reduction in the premium or other charges imposed by the HMO or CMP in the form of deductibles and coinsurance; or.

* * * * *

c. In paragraph (d)(2)(i), "the organization has elected" is changed to "that it has elected".

d. Throughout the rest of the section, "organization" is changed to "HMO or CMP" and "organization's" is changed to "HMO's or CMP's".

§ 417.594 [Amended]

48. In § 417.594, the following changes are made:

a. Throughout the section, "organization" and "eligible organization" are revised to read "HMO or CMP" (26 times), "organization's" is changed to "HMO's or CMP's" (9 times), and "payor" and "payors" are changed to "payer" (2 times) and "payers" respectively.

b. In paragraph (a)(1), "membership" is changed to "enrollment".

c. In paragraph (b)(1)(ii), "purchase membership" is changed to "enroll".

d. In paragraph (c)(2), the "(i)" designation and paragraph (c)(2)(ii) are removed.

§ 417.598 [Amended]

49. In § 417.598, "organization" is changed to "HMO or CMP" (3 times), and "assure" is changed to "ensure".

§ 417.600 [Amended]

50. In § 417.600, "Sections 417.600 through 417.638 establish" is revised to read "This subpart establishes", and "organizations" is changed to "HMOs or CMPs".

§ 417.602 [Amended]

51. In § 417.602, "§§ 417.604 through 417.638" is revised to read "this subpart".

§ 417.604 [Amended]

52. In § 417.604, the following changes are made:

a. The phrase "§§ 417.604 through 417.638" is revised to read "this subpart" (3 times).

b. The term "organization" is changed to "HMO or CMP" (7 times), and "organization's" is changed to "HMO's or CMP's".

c. In paragraph (b)(1), "these sections" is revised to read "this subpart".

§ 417.640 [Amended]

53. In § 417.640, "Sections 417.640 through 417.694 establish" is revised to read "This subpart establishes", and the terms "eligible organization" and "organization" are changed to "HMO or CMP" (8 times).

§ 417.642 [Amended]

54. In § 417.642, "§§ 417.640 through 417.694" is revised to read "this

subpart", and "organization" is changed to "HMO or CMP".

55. In § 417.670, paragraph (c) is revised to read:

§ 417.670 Time and place of hearing.

* * * * *

(c) The hearing officer will give the parties reasonable notice of any change in time or place or of adjournment.

§ 417.800 [Amended]

56. In § 417.800, the following changes are made:

a. In paragraph (b)(1)(iii), "Public Health Service Act" is revised to read "PHS Act".

b. In paragraph (c)(1), the phrase "§§ 417.530 through 417.576" is revised to read "subpart O of this part".

§ 417.801 [Amended]

57. In the § 417.801, the following changes are made:

a. In paragraph (a)(2), "this subpart D" is revised to read "this subpart U".

b. In paragraph (b)(2), the phrase "as defined in § 417.800" is removed.

c. In paragraph (d)(1)(iii), "§§ 417.520 through 417.523" is revised to read "subpart M of this part".

§ 417.802 [Amended]

58. In § 417.802, paragraph (a), "§§ 417.530 through 417.550" is revised to read "subpart O of this part".

§ 417.806 [Amended]

59. In paragraph (a) "will" is removed.

§ 417.810 [Amended]

60. In paragraph (c)(2) "subchapter" is changed to "chapter".

§ 417.912 [Amended]

61. In § 417.912, the following changes are made:

a. Throughout the section, "Public Health Service Act" is revised to read "PHS Act" (8 times), "member" is changed to "enrollee" (once), and "members" and "enrolled members" are changed to "enrollees" (5 times).

b. In paragraph (b)(1), the last two words are corrected to read "an HMO".

c. In paragraph (b)(3), "this subpart" is revised to read "subpart B of this part" (the first time it appears) and "subpart C of this part" (the second time it appears).

d. In paragraph (b)(4), "organization" is changed to "HMO" (two times).

e. In paragraphs (c), (d) introductory text, and (g), "which" is changed to "that".

f. In paragraphs (d) introductory text, (f), (g), and (h), "shall" is changed to "must" (6 times).

g. In paragraph (h), in the second sentence, "of this section" is inserted after "paragraph (e)".

§ 417.913 [Amended]

62. In § 417.913, the following changes are made:

a. Throughout the section, "shall" is changed to "must" (5 times), "which" is changed to "that" (3 times), and "Public Health Service Act" is revised to read "PHS Act" (2 times).

b. In paragraph (b)(2), the phrase "under §§ 417.120 through 417.126, and 417.130 through 417.137 which is consistent" is revised to read "under this subpart, if the application is consistent".

§ 417.917 [Amended]

63. In the introductory text, "§§ 417.140 through 417.154 of this subpart" is revised to read "subpart D of this part".

§ 417.918 [Amended]

64. In paragraph (a), "§§ 417.120 through 417.126" is revised to read "§§ 417.920 through 417.926" (2 times).

§ 417.921 [Amended]

65. In § 417.921, the following changes are made:

a. Throughout the section, "which" is changed to "that" (5 times), and "membership" is changed to "enrollment" (2 times).

b. In the introductory text, "§§ 417.120 through 417.126" is revised to read "§§ 417.920 through 417.926" (2 times).

c. In paragraph (b), "§§ 417.140 through 417.144 of this subpart" is revised to read "subpart D of this part".

§ 417.922 [Amended]

66. In § 417.922 the following changes are made:

a. Throughout the section, except in paragraphs (f)(1) and (f)(5), "which" is changed to "that" (4 times).

b. In paragraph (f)(1), "shall" is changed to "must" and in paragraphs (f) introductory text and (f)(2) "Public Health Service Act" is revised to read "PHS Act".

c. In paragraphs (f)(5)(iii)(B) and (h)(1), "membership" is changed to "enrollment" (3 times), and in paragraph (h)(3) "members" is changed to "enrollees".

d. In paragraph (g), "§§ 417.100 through 417.109 of this subpart" is revised to read "subparts B and C of this part and §§ 417.168 and 417.169.".

e. In paragraph (h)(4), "§ 417.111(c)" is changed to § 417.911(c).

§ 417.923 [Amended]

67. In § 417.923, the following changes are made:

a. In paragraph (a), "§ 417.122(a), (b), (c), (d), and (e)" is revised to read "paragraphs (a) through (e) of § 417.922".

b. In paragraph (b), "Public Health Service Act" is revised to read "PHS Act", and in paragraph (b)(1), "§§ 417.100 through 417.109 of this subpart" is revised to read "subparts B and C of this part and §§ 417.168 and 417.169".

c. In paragraphs (d) introductory text and (e), "which" is changed to "that".

d. In paragraph (e), "§§ 417.100 through 417.109 of this subpart" is revised to read "subparts B and C of this part and §§ 417.168 and 417.169".

e. In paragraphs (f)(1) and (4), "membership" is changed to "enrollment", and in paragraph (f)(4) "§ 417.111" is changed to "§ 417.911".

§ 417.924 [Amended]

68. In § 417.924, the following changes are made:

a. In paragraphs (a)(1) and (b)(1), "Public Health Service Act" is revised to read "PHS Act" (3 times).

b. In paragraph (a)(2), "§§ 417.120 through 417.126" is revised to read "§§ 417.920 through 417.926; "which" is changed to "that"; "members", the first time it appears is changed to "enrollees"; "membership" is changed to "enrollment"; and "shall" is changed to "must".

c. In paragraph (a)(3), "shall" is changed to "may" and "§ 417.122" is changed to "§ 417.922".

d. In paragraph (b)(3), "§§ 417.120 through 417.126" is revised to read "§§ 417.920 through 417.926" (2 times), "members" is changed to "enrollees" the first time it appears, and "membership" is changed to "enrollment".

e. In paragraph (b)(4), "shall" is changed to "may", "§ 417.123(b)" is changed to "§ 417.923(b)", and "§ 417.123(e)" is changed to "§ 417.923(e)".

§ 417.925 [Amended]

69. In § 417.925, the following changes are made:

a. The section heading is revised to read "Evaluation and award: Planning and initial development.".

b. In paragraph (a) introductory text, "which" is changed to "that", "§ 417.107(c)" is changed to "§ 417.124(b)", "Public Health Service Act" is revised to read "PHS Act", and "§§ 417.120 through 417.126" is revised to read "§§ 417.920 through 417.926".

c. In paragraph (a)(1), "§ 417.122 or § 417.123" is revised to read "§ 417.922 or § 417.923".

d. In paragraph (b), "§§ 417.120 through 417.126" is revised to read

"§§ 417 920 through 417.926", "which" is changed to "that", and "members" the first time it appears is changed to "enrollees".

§ 417.926 [Amended]

70. In § 417 926, the following changes are made:

a. In paragraph (a), "§§ 417.120 through 417.126" is revised to read "§§ 417 920 through 417.926".

b. In paragraphs (a) and (c), "shall" is changed to "will", and "which" is changed to "that".

§ 417.931 [Amended]

71. In § 417 931, the following changes are made:

a. In paragraph (a) introductory text, "which" is changed to "that".

b. In paragraph (b), "members" is changed to "enrollees".

§ 417.932 [Amended]

72. In § 417.932, the following changes are made:

a. The section heading is revised to read "Eligible applicants and projects: Initial costs of operation."

b. In paragraph (a), "§§ 417.130 through 417.137" is revised to read "§§ 417 930 through 417 937" (2 times).

c. In paragraph (b), "pursuant to" is changed to "under" (2 times) "§§ 417.110 through 417.119 and §§ 417.130 through 417.137" is revised to read "this subpart", "membership" is changed to "enrollment", and "§ 417.111(c)" is changed to "§ 417.911(c)".

§ 417.933 [Amended]

73. In § 417.933, the section heading is revised to read "Project elements for initial costs of operation.".

§ 417.935 [Amended]

74. In § 417 935, the section heading is revised to read "Evaluation and award: Initial costs of operation", and in the introductory text "Public Health Service Act" is revised to read "PHS Act".

§ 417.936 [Amended]

75. In § 417 936, the following changes are made:

a. Throughout the section, "Public Health Service Act" is revised to read "PHS Act" (6 times).

b. In paragraph (a), "shall" is changed to "may".

c. In paragraph (b), "shall" is changed to "does".

d. In paragraph (c), "§§ 417.130 through 417.137" is revised to read "§§ 417 930 through 417 937", and "which" is changed to "that".

§ 417.937 [Amended]

76. In § 417 937, the following changes are made:

a. In paragraph (a), "§§ 417.130 through 417.137" is revised to read "§§ 417 930 through 417 937", and "shall" is changed to "will".

b. In paragraph (b), "shall" is changed to "will" (3 times), and "where" is changed to "if".

c. In paragraph (c), "shall" is changed to "will", and the phrase "sufficient to amortize" is revised to read "sufficient in amount to amortize".

M. Nomenclature Changes

1. In the following locations, the terms "member", "members", "member's", and "a member's" are changed to read "enrollee", "enrollees", "enrollee's", and "an enrollee's", respectively:

Sec.
417.102 (a) and (b).
417.103(a)(3)(ii)(C), (c)(2), (e)(1), (e)(2), and (e)(3).
417.104(a)(4) (5 times), (b)(1) (2 times), (b)(2)(i), (b)(4)(ii), and (c)(2).
417.105(a) and (b).
417.478(c).

2. In the following locations, the term "membership" is changed to "enrollment":

Sec.
417.104(a)(4)(ii).
417.158 (2 times).
417.540 heading and (a) and (b).

3. In the following locations, the term "eligible organization", in its singular, plural, and possessive forms, is changed to "HMO or CMP", "HMOs or CMPs" and "HMO's or CMP's", respectively; and the term "organization" in its singular, plural, and possessive forms is changed to "HMO or CMP", "HMOs or CMPs" and "HMO's or CMP's, respectively:

Sec.
417.412(b).
417.413(a), (b) heading, (b)(1), (b)(2), (b)(3), (b)(4) (2 times), (c) (2 times), (d)(1), (d)(2) (5 times), (d)(3) (3 times), (d)(4), (d)(5) (3 times), (d)(6) (4 times), (d)(7) (2 times), (e)(1), and (e)(2) (2 times).
417.416(a)(2 times), (c) (4 times), (d)(1), (d)(2), (e)(1), and (e)(2).
417.428(a) introductory text, (a)(1), (a)(4) (thrice), (b) introductory text, (b)(1), (b)(2) (thrice), (b)(3) (2 times), (b)(5) (2 times), and (c) (2 times).
417 430(a)(1), (a)(2), (b) introductory text, (b)(3), (b)(4)(i), (b)(4)(ii), (b)(6) introductory text (2 times), (b)(6)(i), (b)(6)(ii), (b)(7) and (b)(8)
417 432(a) (2 times), (b), (c), (e) (2 times).
417.434.
417 442 heading, (a) (thrice), (b) introductory text, and (b)(2).
417 454(a) and (b).
417.458 introductory text, (a), (b), and (c).
417.474(b).
417.480 heading, introductory text (2 times), (b)(1), and (b)(7).
417.481 heading and introductory text (2 times).
417.482 introductory text, (b), (c), (e), (f)(1) and (f)(2).
417 484(a) introductory text, (a)(1), (a)(3), and (b).
417 486 introductory text.
417.488 introductory text.
417 490 (2 times).
417.494 paragraphs (a)(1), (a)(2), (a)(3), (b)(1)(i), (b)(1)(ii), (b)(1)(iii), (b)(1)(iv) (2 times), (b)(2) (2 times), (b)(3), (b)(4), (c) introductory text (2 times), (c)(1), (c)(2) (3 times), and (c)(3).
417.521(c)(1) (2 times) and (c)(2) (2 times).
417.524 heading, (a) (2 times) and (b) (3 times).
417.531(a), (b) introductory text and (b)(1).
417.532(a)(1), (a)(1)(iii), (a)(2), (a)(3) (2 times), (a)(4) (4 times), (b) heading, (b)(3) (4 times), (c) introductory text (2 times), (c)(2), (e) heading and introductory text, (e)(1), (f) (3 times), (g) (3 times), and (h) (3 times).
417.533 introductory text and (a).
417 534(a) (3 times) and (b).
417.538(a), (b), (c), and (d).
417.544 heading and (a).
417.546(a), (b)(1) (4 times) and (b)(2) (4 times).
417 552(a).
417 554 (3 times).
417.556 heading, (a), (b), (c) (2 times), and (d) (2 times).
417.558 heading, (a), (b) heading, (b)(1), and (b)(2) (2 times).
417.560(a) introductory text (5 times), (b) (3 times), (c) (2 times), (d) introductory text, (d)(1), and (d)(2) (3 times).
417.562(a), (b)(3), (c) introductory text, and (d).
417 564(a) (2 times), (b) introductory text, (b)(1) (2 times) and (b)(2) (2 times).
417.566(b)(1) and (b)(2).
417 568(a)(1) (2 times), (b)(1), (c) (3 times), (d) (3 times), and (e).
417.570(a)(1) (2 times), (b) (2 times), (c) introductory text, (c)(3), and (d).
417.572(a), (b) introductory text, (b)(2), (c)(1), and (c)(2).
417.574(a) (3 times) and (b).
417.576(a) (2 times), (b)(1) (2 times), (b)(2)(i) (2 times), (b)(2)(ii), (b)(3), (c)(1) (2 times), (c)(2) (10 times), (d)(1), (d)(2), (d)(3), (d)(4), (e)(1), (e)(2) (3 times), and (e)(3).
417.584 heading, introductory text (2 times), (a) (2 times), (b)(2) (2 times), and (d) (3 times).
417.585(a), (b) introductory text, (b)(1), and (c).

417.586 section heading, (a), heading, (a)(1), (a)(2) (2 times), (a)(3), (b)(1) (2 times), (c) heading, (c)(1) (2 times), (d) (2 times), (e) introductory text (2 times), (e)(1), and (e)(2).

417.588(b) (2 times), (c)(1) (2 times) (c)(2) (2 times), and (c)(3).

417.596(a) (2 times), (b) (2 times), (c)(1), (c)(2) (3 times), (c)(3) and (d)(2).

417.608(a).

417.610(b)

417.616(a)(1), (c)(1), and (c)(2).

417.618.

417.620(b) introductory text (2 times), (b)(1) (2 times), and (b)(2) (3 times).

417.622(a).

417.632(c) (3 times).

417.634.

417.636(a) (2 times) and (b).

417.638.

417.644 (a), (b)(2) and (c).

417.656(a).

417.660(b) and (c).

417.662 (a).

417.664(a) and (b)(2).

4. Throughout part 417, "Public Health Service Act" is revised to read "PHS Act".

5. Throughout part 417, except in subpart V, "the Secretary" is changed to "HCFA", and the related pronouns are conformed.

6. In the following locations, "shall" is changed to "must":

Sec.

417.102(b) (2 times).

417.103(a)(1), (a)(3) (2 times), (b) introductory text, (d), and (e) introductory text.

417.104(a) introductory text, (b)(1) and (b)(2) (the second time the term appears), (d) and (e) introductory text.

417.105(b), (the first time the term appears).

417.156 introductory text (3 times) and paragraphs (a), (b) (3 times), and (c).

417.158.

417.915(a) (2 times).

417 919(a) and (b).

417.934 (2 times).

7. In the following locations, "shall" is changed to "will".

Sec.

417.104(b)(1) (the first time the term appears), (b)(2), and (b)(4).

417.105(b), (the second time the term appears).

8. In the following locations, "which" is changed to "that":

Sec.

417.102(a).

417.103(a)(1), (a)(3) (2 times).

417.104(a) introductory text, and paragraphs (b)(1) (3 times), (b)(2), (c)(1), and (d).

417.158 (3 times).

417 915(c).

417 919(a) (2 times) and (b).

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

Dated: March 2, 1993.

William Toby, Jr.,

Acting Deputy Administrator, Health Care Financing Administration.

Approved: April 2, 1993.

Donna E. Shalala,

Secretary.

[FR Doc. 93–16437 Filed 7–14–93; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

43 CFR Public Land Order 6989

[AK–932–4210–06; AA–51033]

Revocation of Executive Order No. 6546, Dated January 2, 1934; Alaska

AGENCY: Bureau of Land Management, Interior.

ACTION: Public Land Order.

SUMMARY: This order revokes in its entirety an Executive order as it affects approximately 4.94 acres of public land withdrawn and reserved for the use of the Territory of Alaska for burial purposes. The site is known as the Sitka Pioneer Cemetery. The protection of a withdrawal is no longer needed for this land. The land continues to be subject to the terms and conditions of an overlapping withdrawal and remains closed to all forms of appropriation and disposition, except for location for metalliferous minerals and selection by the State of Alaska.

EFFECTIVE DATE: August 16, 1993.

FOR FURTHER INFORMATION CONTACT: Sandra C. Thomas, BLM Alaska State Office, 222 W. 7th Avenue, No. 13, Anchorage, Alaska 99513–7599, 907–271–5477.

By virtue of the authority vested in the Secretary of the Interior by section 204 of the Federal Land Policy and Management Act of 1976, 43 U.S C. 1714 (1988), and by section 17(d)(1) of the Alaska Native Claims Settlement Act, 43 U.S.C. 1616(d)(1) (1988), it is ordered as follows:

1. Executive Order No. 6546, dated January 2, 1934, which withdrew public land for use as a burial site at the Sitka Pioneer Cemetery, is hereby revoked as it affects the following described lands:

Copper River Meridian

T. 55 S., R. 63 E.,

Beginning at corner No. 1, from which witness corner to corner No. 2, U S. Survey No. 1804, Alaska, bears S. 42°55′ E., 435.0 ft.; in approximate latitude 57°03′ N., longitude 135°20′ W.; thence from said point of beginning N. 67°35′ E., 263.6 ft. to corner No. 2; thence N. 0°09′ E., 279.9 ft. to corner No. 3; thence N. 59°07′ W., 383.3 ft. to corner No. 4; thence S. 82°10′ W., 324.7 ft. to corner No. 5; thence S. 37°19′ E., 670.0 ft. to corner No. 1, the place of beginning.

The area described contains approximately 4 94 acres.

2. Subject to the terms and conditions of Public Land Order No. 5186, the land described above remains closed to all forms of appropriation under the public land laws, including location and entry under the mining and mineral leasing laws, except for location for metalliferous minerals, 30 U.S.C. Ch. 2 (1988), and selection by the State of Alaska.

3. The State of Alaska application for selection made under section 6(a) of the Alaska Statehood Act and section 906(e) of the Alaska National Interest Lands Conservation Act, 43 U.S.C. 1635(e) (1988), becomes effective without further action by the State upon publication of this public land order in the **Federal Register,** if such land is otherwise available. This selection will be adjudicated in accordance with 43 CFR 2627 and the land will remain closed to metalliferous mining until a further opening order is published.

Dated: July 6, 1993.

Bob Armstrong,

Assistant Secretary of the Interior.

[FR Doc. 93–16717 Filed 7–14–93; 8:45 am]

BILLING CODE 4310–JA–M

FEDERAL EMERGENCY MANAGEMENT AGENCY

44 CFR Part 67

Final Flood Elevation Determinations

AGENCY: Federal Insurance Administration, FEMA.

ACTION: Final rule.

SUMMARY: Base (100-year) flood elevations and modified base (100-year) flood elevations are made final for the communities listed below.

The base (100-year) flood elevations and modified base flood elevations are the basis for the floodplain management measures that each community is required either to adopt or to show evidence of being already in effect in order to qualify or remain qualified for participation in the National Flood Insurance Program (NFIP).

EFFECTIVE DATES: The date of issuance of the Flood Insurance Rate Map (FIRM)